National Institute for Health and Care Excellence

Draft for consultation

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

[A] Evidence review for reducing recurrent short-term sickness absence

NICE guideline <number>

Evidence reviews

[May 2019]

Draft for consultation

This evidence review was developed by the Public Health Internal Guideline Development team

Disclaimer

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or service users. The recommendations in this guideline are not mandatory and the guideline does not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian.

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ISBN:

Contents

Reducing recurrent short-term sickness absence among employees

Review question

1a. What interventions, programmes, policies or strategies are effective and cost-effective in preventing or reducing recurrence of short-term sickness absence among employees?

1b. Are the interventions, programmes, policies or strategies acceptable to employees, employers and other key stakeholders, and what are the barriers and facilitators to their successful delivery?

Introduction

Frequent absence may indicate general ill health which requires medical investigation and, if continued, may indicate work stress or lack of capability to do the job. Repeated absence for short periods is likely both to undermine the individual employee's own performance and cause disruption for colleagues and the wider organisation, including:

- the need to find temporary replacement cover (sometimes for quite specialist tasks);
- increasing the workload of others;
- general disruption of the remaining workforce and workflow;
- other employees feeling resentful if they think an individual's repeated absences are not being addressed;
- reduction in employee morale;
- the risk that a culture of frequent absenteeism may develop across the wider workforce.

PICO table

The following table summarises the protocol for this review.

Table 1: PICO inclusion criteria for interventions to prevent or reduce recurrent short-term sickness absence

Population	Adult employees (≥16 years; full- or part-time; paid or unpaid) who: • have experienced 4 or more episodes of short-term sickness absence in a 12 month period (each episode lasting less than 4 weeks) *or* • are currently absent from work for less than 4 weeks due to sickness (with a minimum study follow-up of 12 months to enable patterns of recurrent absence to be identified) Organisational level All employers in the public, private and 'not-for-profit' sectors
Interventions	Any intervention to prevent or reduce recurring short-term sickness absence (4 or more episodes in a 12-month period, each episode lasting <4 weeks). Where interventions are not delivered in a workplace or primary care setting, there should be some element of employer or primary care involvement in the design, content, implementation or funding of the intervention.

Comparator	• No work-related intervention (includes 'usual care' or usual sickness absence practice / guidance) • Any other active comparator for managing sickness absence or return to work • Other active workplace comparator (intervention, programme, policy or strategy) • Time (before and after studies)
Outcomes	Effectiveness studies (review question 1a) *Primary outcome* • Short-term sickness absence, as measured and reported by the authors *Secondary outcomes* • Health-related quality of life - using validated patient-report measures, for example EQ-5D • Psychological and/or social functioning - using any patient-report measure • Adverse / unintended effects: - Self-reported presenteeism or work performance (individual-level studies); - Job satisfaction (individual or organisational-level) - Rate of staff turnover (organisational-level studies) - Number of grievances (organisational-level studies) Qualitative studies (review question 1b) Participant views on: • Intervention acceptability (including preferences for content, frequency, location, etc.) • Barriers and facilitators to successful intervention delivery

Methods and process

This evidence review was developed using the methods and process described in Developing NICE guidelines: the manual. Methods specific to this review question are described in the review protocol in appendix A.

Declarations of interest were recorded according to NICE's 2018 conflicts of interest policy.

Identification of public health evidence

Included studies

For all of the review questions in this update, there was one large overall search completed, see appendix C for the PRISMA diagram.

For this review question, one cluster randomised-controlled trial (cRCT) and 1 randomised-controlled trial (RCT) met the inclusion criteria for this review. Table 2 summarises the included effectiveness studies; see appendix D for the full evidence tables. No systematic reviews directly matched the review criteria but those identified as relevant to the topic area based on title and abstract were retrieved and cross-checked to ensure inclusion of all relevant primary studies. There were no qualitative studies that met the population inclusion criteria for this review.

Excluded studies

See appendix G for a full list of excluded studies and the reasons for exclusion from the overall search for this guideline update.

Table 2: Summary of public health studies included in the evidence review

Study [Country]	Setting	Population	Intervention	Comparator	Outcome(s)
Framke 2016 [Denmark] cRCT	78 Copenhagen pre-schools with ≥10 employees and relatively high rates and short-term sickness absence Follow-up 29weeks	All staff employed during study period (excluding student nursery nurses) N=3,039	Intervention to change management practice and work culture to focus more on core work tasks	Usual workplace sickness absence practice	• Short-term sickness absence
Notenbomer 2018 [The Netherlands] RCT	21 Dutch organisations each with more than 100 employees (7 industrial, 5 commercial and 9 in public services sector) Follow-up 1year	Employees with frequent SA (≥3 episodes in the year before recruitment, irrespective of the causes or duration of sick leave) N=82	e-Health intervention (alone or with added occupational physician consultation) to help employees with frequent SA to improve their health and self-management	Care as usual	• Sickness absence (no. of episodes and cumulative days)

Synthesis and appraisal

Data synthesis

There were two studies included, a cluster RCT and an RCT. These studies were not pooled by outcome into a meta-analysis, the studies included different interventions and had reported outcomes in different ways. The short term sickness absence data from one of the studies have been presented in a forest plot to enable discussion. Evidence statements have been presented on an individual study basis.

See appendix E and F for forest plots of analyses and GRADE tables by outcome.

Economic evidence

See the separate review 'Workplace health cost effectiveness outcomes' and the 'Workplace health modelling report' by York Health Economics Consortium (YHEC).

Evidence statements

ER1.1 Short-term sickness absence rate over 29 weeks

There is low quality evidence from 1 cluster RCT (Framke 2016), conducted in Denmark with a total of 3039 employees of 78 pre-school organisations with relatively high rates of short-term sickness absence of 14 or more days per episode. The intervention consisted of focusing on the core task at work, based on the theory that illegitimate tasks (those regarded by employees as unreasonable or unnecessary) lead to higher levels of stress, poor self-esteem and employee resentment, resulting in higher rates of short-term sickness absence. No difference was found in the rates of short term sickness absence over 29 months follow-up, compared with pre-schools with no intervention (8.7 vs. 9.2 STSA days per person-year; RR: 0.93; 95%CI 0.86 to 1.01 the proportion returning to work within 3 months (61% vs. 80%; RR 0.76; 95%CI 0.49 to 1.49. However, when adjusted for age, sex, type of workplace, workplace size, a reduction was found in the workplace average level of short-term sickness absence in the previous 12months; RR 0.89 (0.83 to 0.95). (Figure 1).

ER1.2 Proportion with frequent short-term sickness absence at 12 month follow-up

There is low quality evidence from 1 RCT (Notenbomer 2018), conducted in The Netherlands, with a total of 82 employees at 21 different organisations with a history of frequent sickness absence (3 or more episodes in the past 12 months). The intervention consisted of access to e-Health advice and support, with or without an additional preventive consultation with an occupational physician. No difference was found in the reduced frequency and duration of sickness absence, or in the number of sickness absence episodes, or in the total duration of all sickness absence in days.

Recommendations

On reviewing the evidence, the committee agreed that they would not make recommendations specifically relating to this review question.

Research recommendations

The research recommendation resulting from consideration of the reducing recurrent short-term sickness absence can be found in evidence review C, the evidence review for facilitating return to work from long-term sickness absence. These research recommendations were developed by the committee on reviewing the evidence for both of these questions and considering the evidence gaps within these.

Rationale and impact

Why the committee didn’t make any recommendations

The committee noted the lack of published evidence in this area with only two RCTs on effectiveness identified. The committee discussed the very low quality of the included evidence, the lack of direct applicability of this evidence to the current UK workplace context. They considered that this included evidence did not provide a sufficient basis for the development of recommendations. The committee discussed the possibilities that the interventions used in the included evidence may also be used for other workplace interventions being updated in this guideline. The committee discussed that recurrent short-term absence may also be an indication of other work or non-work issues, sickness absence is complex and may be multi factorial. The committee agreed that they wished to consider

the evidence in reviews B and C and the input and discussion of relevant expert testimony. Following this the committee agreed not to make specific recommendations, as described in the other factors the committee took into account.

Why we need recommendations on this topic

Recurrent short-term absence is difficult for employers to manage and may be a predictor of future long-term sickness absence. Frequent short-term absences can be warning signs of underlying physical or psychosocial conditions. In employees who are managing a long-term health condition, flares of symptoms requiring them to take recurrent short-term sick leave.

Impact of the recommendations on practice

The committee agreed that they would not make specific recommendations relating to recurrent short-term sickness absence could not be made.

The committee's discussion of the evidence

Interpreting the evidence

The outcomes that matter most

The committee agreed recurrent short-term sickness absence to be the most important outcome for decision-making. Recurrent short-term absence is as four or more absences over a 12-month period, with each absence lasting less than four consecutive weeks.).

The quality of the evidence

The evidence-base was limited, with only 2 studies identified for inclusion in the review. A cluster-randomised controlled trial involved a relatively large study population of over 3,000 employees (Framke et al. 2016) and a randomised controlled trial included 88 participants (Notenbomer et al. 2018). Data for the primary outcome in each study, short-term sickness absence (STSA), were collected from objective and reliable centralised sources.

The committee agreed that the study by Framke et al. 2016 was a study of a participatory approach to organisational change rather than a clearly defined intervention. In this study the individual-level data on STSA meeting the review definition recurrent are not reported. The committee agreed that this made the direct applicability to this review question difficult. They agreed that the quality of the evidence should be downgraded because the study population and outcome did not directly meet the review protocol inclusion criteria. The committee agreed that this represented very low quality evidence for this review question.

The study intervention was designed to increase focus on the primary task of the workplace. This was operationalised differently by participating organisations (for example, implementing changes to improve meetings, communication, or organisational procedures); activities acknowledged by the study authors to be indirectly focused on the primary task (Framke and Sørensen 2015). In the committee's view, this made it difficult to understand exactly what intervention might be recommended.

The committee were aware of limitations of the randomised controlled trial (Notenbomer et al. 2018), including potential self-selection bias due to low rates of voluntary participation (only 10% of those in participating organisations who were eligible to participate chose to do so). This, in combination with the sample being relatively highly educated may lead to a sample that may be more likely to be motivated to improve health and sickness absence. The committee agreed that the quality of the evidence should be downgraded because the study population did not directly meet the review protocol inclusion criteria. Reflecting the committee agreement to not specify MIDs for this question, the study was downgraded for

imprecision as it crossed the line of no effect. The committee agreed that this represented very low quality evidence for this review question.

The committee felt that the non-UK setting in both studies, and restricted focus on just one specific and female-dominated employment sector (that is, Danish pre-school education) in the largest study meant it was unclear whether the findings could generalise across occupational sectors within a UK setting.

The committee agreed that overall confidence in the evidence reviewed was very low. The committee agreed that the evidence base was very weak and that it was difficult to see direct applicability to the current UK situation. They discussed and agreed not to make specific recommendations in relation to reducing short-term sickness absence.

Benefits and harms

Framke et al. 2016 reported a significant reduction in rates of STSA favouring the intervention after adjusting for potential confounding factors, including organisational rates of STSA in the 12 months preceding the start of the study. Notenbomer et al. 2018 did not report a statistically significant reduction in frequency of sickness absence.

The committee discussed the difficulties with considering a trade-off between benefits and potential harms of the interventions because no adverse or unintended consequences (such as a measure of presenteeism or job satisfaction) were reported by the study authors in either study.

Nonetheless, the committee discussed the thatparticipation in the study by Framke et al. 2016 was mandated by the municipal authority where the study was conducted, due to concerns around the levels of short-term sickness absence among employees in this sector. The committee considered the possible risk of this approach, not only on the risk of bias of the study but also on the participants of the study in that the observed reductions in sickness absence may have been achieved at the expense of increased employee presenteeism.

The committee noted the potential influence of self-selection in the Notenbomer et al. 2018 study and the unknown possibility that that may have biased the study. They noted that this may be a difficulty with research relating to workplace health and return to work interventions in general.

Cost effectiveness and resource use

The included studies did not report any cost-effectiveness outcomes. The committee were unable to consider the implications of the study findings for resource use given the diffuse nature of the interventions and the fact that they were implemented differently across participating organisations. No other cost-effectiveness studies were identified that met the inclusion criteria for review question 1. A health economic model was developed to determine how cost-effective an intervention will be in helping employees on sickness absence to return to work. Because the interventions and size and type of organisation vary greatly and a myriad of factors can impact sickness absence and return to work, the model adopted a generalised approach and multiple sensitivity analyses were carried out which showed the results varied greatly by key model inputs such as the cost and effectiveness of the intervention, reduction in absenteeism and baseline rate of absenteeism. The committed noted that in general a company with high turnover costs or costs of absenteeism will likely benefit from an intervention to reduce sickness absence, particularly if the intervention is effective and less expensive than the overall costs of absenteeism or replacing a worker. The reverse is also true. For example, an organisation with low baseline turnover costs or low levels of absenteeism will find it more difficult to realise cost savings by implementing an intervention aimed at reducing sickness absence, though this does not mean that other

factors could not also benefit the organisation. The committee appreciated employers may be interested in factors other than pure cost savings. The overall willingness to pay for an intervention by an organisation is important: there is no requirement for the intervention to be cost saving if the organisation is willing to pay for an intervention that will benefit the workers and the organisation itself.

A key limitation of the analysis is the paucity of data from real world case studies. This is a particularly pertinent considering the multiple different interventions that could be implemented, and the various levels of effectiveness that the interventions will have on different aspects of sickness absence and wellbeing. The committee noted that this means the economic analysis is likely to underestimate the true benefits of each intervention.

Other factors the committee took into account

The committee further discussed this review question following the presentation of the evidence reviews for facilitating return to work from long-term sickness absence. They also considered the expert testimony views on recurrent short-term sickness. Experts in occupational health and employment research discussed with the committee that whatever the absence period be it recurrent short term or longer term absences that the components of the workplace culture, and support of management at all levels, are important and employees feeling supported in their return is critical. They further discussed that many of the issues and concerns of those who have recurrent short-term sickness absence may be similar to those who are aiming to return to work following long-term sickness absence. While the two groups cannot be viewed as interchangeable the committee considered that many of the workplace health recommendations would provide useful guidance for both groups. The committee reflected on the evidence for this review question and the evidence relating to returning to work following long term sickness absence, discussion of expert testimony and further committee discussion. This led them to conclude that due to the lack of evidence relating to recurrent short-term sickness absence that overall recommendations relating to return to work would be applicable for this group. Following the completion of the evidence reviews for review question B and C it was discussed and agreed by the committee that in practice the interventions that may be effective in supporting return to work after long-term absence may also help with recurrent short-term absences and to prevent the movement from short to long-term absence. Recommendations were therefore not made that distinguished between the types of absence. Though the committee did also note that evidence specifically relating to short term sickness absence, in a UK context, could contribute substantially to supporting those who have recurrent sickness absence in employment and so developed a research recommendation in this area.

It was noted that the NICE guideline Workplace health: management practices (NG13, 2015) includes recommendations for employers on how to change management practices and organisational culture in order to improve the health and wellbeing of staff.

References

Framke, E. and Sørensen, O.H. (2015) Implementation of a participatory organisational-level occupational health intervention – focusing on the primary task. Int. J. Human Factors and Ergonomics 3: 254–270

Framke E, Sørensen OH, Pedersen J, Rugulies R (2016) Effect of a participatory organizational-level occupational health intervention on short-term sickness absence: a cluster randomized controlled trial. Scand J Work Environ Health 42: 192-200

Notenbomer A, Roelen C, Groothoff J, van Rhenen W, Bultmann U. (2018) Effect of an eHealth intervention to reduce sickness absence frequency among employees with frequent sickness absence: randomized controlled trial. Journal of Medical Internet Research, 20: e10821

Appendices

Appendix A – Review protocol

Review protocol for reducing recurrent short-term sickness absence among employees (review questions 1a and 1b)

Field (based on PRISMA-P)	Content
Review question	1a. What interventions, programmes, policies or strategies are effective and cost-effective in preventing or reducing recurrence of short-term sickness absence among employees? 1b. Are the interventions, programmes, policies or strategies acceptable to employees, employers and other key stakeholders, and what are the barriers and facilitators to their successful delivery?
Type of review question	Mixed methods (intervention and qualitative)
Objective of the review	To identify which are effective and cost-effective interventions, programmes, policies or strategies for reducing the risk of employees having recurrent episodes of short-term sickness absence. The review question will also examine whether effectiveness (and cost effectiveness and acceptability, where appropriate) varies according to a range of factors, including how the intervention is delivered and by whom, the population receiving the intervention and any particular subgroups in whom the effects of an intervention might be expected to differ (e.g. gender, age, presence of a long-term health condition or disability).
Eligibility criteria – population	Individual level All adults over the age of 16 in full- or part-time employment, both paid and unpaid, who: • have experienced 4 or more episodes of short-term sickness absence in a 12 month period (each episode lasting less than 4 weeks) *or* • are currently absent from work for less than 4 weeks due to sickness (with a minimum study follow-up of 12 months to enable patterns of recurrent absence to be identified). Organisational level All employers in the public, private and 'not-for-profit' sectors
Eligibility criteria – intervention(s)/exposure(s) / prognostic factor(s)	Any interventions, programmes, policies or strategies that aim to prevent or reduce recurring short-term sickness absence (4 or more episodes in a 12-month period, each episode lasting <4 weeks).

Field (based on PRISMA-P)	Content
	Examples may include: ○ trigger mechanisms to identify frequent short-term sickness absence ○ risk assessments, modifications and reasonable adjustments to the physical and organisational work environment ○ training for line managers in handling and monitoring sickness absence ○ training for general practitioners in handling sickness absence ○ coordinated return-to-work programmes (this may include occupational therapy, workplace ergonomics, physical and psychological therapy) ○ information (including mental health support) and training for employers ○ information and support networks (including mental health support) for employees ○ physical conditioning and exercise programmes (that simulate work or functional activities in a safe and supervised environment). ○ flexible working and work-life balance policies for employees (including carer's and special leave when families have problems) ○ therapy (such as cognitive behavioural therapy) or stress counselling. Setting ○ any workplace, primary care or community setting where interventions can be delivered (including employees' own homes) ○ any setting to which an employer, workplace occupational health service or primary care practitioner could refer an employee who is experiencing sickness absence (for example, a physiotherapy service or a counselling service) ○ any other setting where an employer or primary care is involved in planning, commissioning, delivering, managing or funding an intervention to enable someone to return to or remain in work. Delivered by: ○ any workplace, primary care or other voluntary, private or statutory sector provider(s) ○ any mode, duration and frequency of contact, including face-to-face (individual or group-based), telephone, DVD or other digital media (e.g. online programs or mobile apps), and/or use of written materials.
Eligibility criteria – comparator(s)/control or reference (gold) standard	Any of: • other active comparator (intervention, programme, policy or strategy) for managing recurrent short-term sickness absence

Field (based on PRISMA-P)	Content
	• no work-related intervention, programme, policy or strategy • usual workplace sickness guidance (usual care)1 • time (before and after studies) [1] where the study comparator is 'usual workplace sickness guidance (usual care)', specific details will be extracted into evidence tables, where reported, to enable the committee to determine generalisability of the comparison to the UK context
Outcomes and prioritisation	**Quantitative outcomes (1a)** Effectiveness and cost effectiveness outcomes will be examined cumulatively (over the duration of the study), and separately for three different time periods: short-term (up to 3 months), medium-term (between 3 months to 1 year) and long-term (more than 1 year), where evidence allows. Work absenteeism is the key outcome for this review. Studies reporting any of the listed secondary outcomes but not sickness absence (the primary outcome) will be excluded. Primary outcome • Short-term sickness absence, as reported by the authors, including: ○ Proportion with any short-term sickness absence (less than 4 consecutive weeks duration) ○ Proportion with ≥4 episodes of short-term sickness absence over a 12 month follow-up ○ Number of episodes of short-term sickness absence (per participant) ○ Number of sickness absence days per episode ○ Number of sickness absence days (total) Secondary outcomes • Health-related quality of life (using validated patient-report measures, for example EQ-5D) • Psychological and/or social functioning (using any patient-report measure of, for example, depression / anxiety; job stress; self-efficacy; self-esteem) • Adverse or unintended (positive or negative) effects: *Individual level studies* ○ self-reported 'presenteeism' or work performance; ○ job satisfaction *Organisational level studies* ○ job satisfaction ○ rate of staff turnover ○ number of grievances **Qualitative outcomes (1b)** For types of intervention where there is published, quantitative evidence relating to sickness absence

Field (based on PRISMA-P)	Content
	outcomes, qualitative evidence relating to the following will be examined where available: Participant views on: • The acceptability of the intervention / policy / programme / strategy (including preferences for content, frequency, location, etc.) • Barriers to and facilitators of successful delivery of the intervention / policy / programme / strategy **Cost/resource use associated with the intervention / programme / strategy / policy** The following outcomes will be extracted in reviews of the health economic evidence, where available: • cost per quality-adjusted life year • cost per unit of effect • net benefit. • net present value • cost/resource impact or use associated with the intervention or its components
Eligibility criteria – study design	**Included studies** In the event of more evidence being identified than is feasible to consider in the time available, priority will be given to: ○ study design (SRs, RCTs, nRCTs) ○ evidence from a UK context (effectiveness evidence and qualitative evidence) <u>Effectiveness studies:</u> Comparative studies, including: • Systematic reviews of effectiveness studies • Randomised controlled trials (RCTs), including cluster RCTs • Non-randomised controlled trials • Non-comparative studies: • Longitudinal cohort and 'before-and-after' intervention studies (ie where there is at least one follow up measure after baseline) <u>Qualitative studies</u> • Focus groups or interview-based studies of any type of intervention that has been evaluated quantitatively for effects on employee sickness absence outcomes <u>Economic studies</u> • Economic evaluations • Cost-utility (cost per QALY) • Cost benefit (i.e. Net benefit)

Field (based on PRISMA-P)	Content

	• Cost-effectiveness (Cost per unit of effect)
	• Cost minimization
	• Cost-consequence
	
	Excluded studies
	• Cross-sectional surveys
	• Epidemiological studies
	• Correlation studies
	• Qualitative studies of:
	  ○ interventions where there are no published studies of their effects on sickness absence
	  ○ attitudes, barriers and facilitators to workplace sickness absence / return to work and its management more generally (that is, unrelated to a specific type of intervention / programme / policy / strategy)

Other inclusion / exclusion criteria	**Exclusion criteria** Population • self-employed individuals • pregnant women who have taken sickness absence related to their pregnancy • individuals who are not in employment • mixed populations (for example, study samples that include non-employees, with insufficient disaggregation to enable data relevant to this review to be extracted). Interventions / programmes / policies / strategies that: • aim to promote workforce general health and wellbeing or prevent the first occurrence of sickness absence or injury (primary prevention) • target pregnant women exclusively or focus on illnesses associated with pregnancy, during the course of a pregnancy • tackle workplace absences that are not reported or recorded as sickness absence (for example, carers' leave or maternity leave) • involve the clinical diagnosis, treatment (including pharmacological treatment) or clinical management of conditions where the primary focus is not on helping the employed person to stay in or return to the workplace • look at the effectiveness of private health insurance schemes, the benefit system or the claiming of statutory sick pay • could not feasibly be implemented by the primary audience for whom this guideline is intended (that is, UK-based employers and their representatives, GPs and occupational health professionals) Studies

Field (based on PRISMA-P)	Content
	As this is an update of existing guidance (PH19), studies included in the original evidence reviews which support the recommendations that are being updated will be assessed against the updated inclusion / exclusion criteria specified in this protocol. Studies will be excluded if they do not meet the updated inclusion criteria. Systematic reviews (SRs) identified from database searches will be included as a primary source of data only if they meet the following three criteria: • the SR is directly applicable to the review question; • the SR meets the inclusion criteria for this review; • the SR is of high quality (that is, it is unlikely that additional relevant and important data would be identified from the primary studies compared to what is reported in the SR, and it is unlikely that any relevant and important studies have been missed by the SR). In addition to any SRs meeting the above criteria, other primary studies will be included if they were published after the publication date of the SR and meet the protocol inclusion criteria. Where SRs identified from database searches do not meet the above criteria, they will be citation searched to identify any primary studies not already included in the database that meet the inclusion criteria for this review. Full economic analyses and costing studies identified from searches will be included. Costing data will not be used for the purpose of the effectiveness review. However, any studies identified for inclusion in the effectiveness review that also report economic analyses or costing information will be flagged to colleagues undertaking the health economic reviews and economic modelling. Only papers published in the English language will be included. Only studies carried out in OECD countries will be included.
Proposed sensitivity/sub-group analysis, or meta-regression	Where sufficient data are available, subgroup analyses or meta-regression will be conducted to address the following subsidiary review questions: 1.1 What is the frequency, content, length and duration of an effective or cost-effective intervention, programme, policy or strategy? 1.2 Does the effectiveness and cost effectiveness of interventions, programmes, policies or strategies vary for different groups? (For example groups may include: men and women, people of different ages, those with a disability or long-term physical or mental health condition, people

Field (based on PRISMA-P)	Content

	with differing levels of socio-economic deprivation or from different ethnic groups)
	
	1.3 Does the effectiveness of an intervention, programme, policy or strategy depend on the person leading it? (What skills, competencies and characteristics are needed?)
	
	The following population subgroups are of interest:
	• gender
	• age: <50 yrs vs. ≥50 yrs
	• long-term physical or mental health condition, comorbidity or disability
	• ethnic group
	• socio-economic deprivation
	• occupational group (e.g. manual vs. non-manual)
	• full-time vs. part-time employed
	• full- vs. partial sickness absence at baseline
	• size of employer organisation: small (<50 employees) vs. medium (50-250 employees) vs. large (≥250 employees)
	
	The following process and structural factors will be of interest in any meta-regression analyses:
	• intervention delivery:
	  ○ by [whom]? (skills / competencies / characteristics)
	  ○ [in what] setting?
	  ○ frequency, length and duration
	  ○ timing of start of intervention
	
	• intervention content:
	  ○ use of policies and procedures to monitor / address sickness absence
	  ○ use of trigger mechanisms to identify frequent short-term absence
	  ○ use of risk assessments, modifications and reasonable adjustment to the physical and organisational work environment
	  ○ provision of training for line managers in handling and monitoring sickness absence
	  ○ use of return-to-work interviews

Selection process – duplicate screening/selection/analysis	The review will use the priority screening function within the EPPI-reviewer systematic reviewing software (see Appendix B for more details). 10% of the abstracts will be blind-screened for inclusion by a second reviewer, with any disagreements resolved by discussion or, if necessary, escalation to a third independent reviewer. If the initial level of agreement is below 90%, a second round of blind-screening will be considered.

Field (based on PRISMA-P)	Content
	Only 10% of the search results will be checked as this is an intervention review and there is confidence that RCTs or controlled studies are unlikely to be missed at the sifting stage. The study inclusion and exclusion lists will be checked with members of the PHAC to ensure no studies are excluded inappropriately. 10% of data extraction and critical appraisal will be checked by a second reviewer, with any disagreements resolved by discussion or, if necessary, escalation to a third independent reviewer if agreement cannot be reached.
Data management (software)	EPPI Reviewer will be used: • to store lists of citations • to sift studies based on title and abstract • to record decisions about full text papers • to order freely available papers via retrieval function • to request papers via NICE guideline Information Services • to store extracted data • If meta-analysis is undertaken, Cochrane Review Manager 5 / Eppi Reviewer (TBC) will be used to perform the analyses. Any meta-regression analyses will be undertaken using the RStudio software package. Qualitative data will be analysed using the EPPI Reviewer qualitative functionality and summarised using an appropriate qualitative synthesis approach, such as secondary thematic analysis.
Information sources – databases and dates	**Database searches** A search for evidence will be carried out in the following databases: • Medline (including in-process records and epubs ahead-of-print) • Embase • PsycINFO • PEDro (Physiotherapy Evidence Database) • Cochrane Database of Systematic Reviews • CENTRAL • Epistemonikos • AMED (Allied and Complementary Medicine Database) • HMIC (Health Management Information Consortium) In addition the following databases will be used to find economic evaluations: • HTA database • NHS EED • Econlit

Field (based on PRISMA-P)	Content
	The Medline search strategy is given in appendix B. This will be adapted for use in other databases. The search strategy will not be used for the PEDro database. Instead all systematic reviews and primary studies tagged with *"reduced work tolerance"* in the *problem* field will be retrieved. In the Cochrane Database of Systematic Reviews all published reviews filed under the topic *Health and Safety at Work* or produced by the Cochrane Work group will be browsed for potential inclusion, in addition to using the normal strategy. **Citation searching** Backwards-and-forwards citation searching will be carried out on all included studies; relevant systematic reviews and key studies highlighted in the previous NICE surveillance report. Items which are relevant to the topic but which don't meet the exact review criteria (such as policy documents that cite research evidence) may also be used as a basis for additional citation searching at the reviewer's discretion. Results from citation searching will not be considered if they were published prior to 2007. Forwards citation searching will be carried out on all included studies for review questions 1-3 from the previous NICE guideline (PH19). Searches will be date limited to June 2007 as the previous NICE guideline searches were conducted between June and July 2007. **Websites** The following websites will be searched for relevant UK reports or publications: • Department for Work and Pensions Research Reports • NIHR Journals library • General search of the gov.uk portal • Work Foundation • Institute for Employment Studies • Centre for Musculoskeletal Health and Work • Health and Safety Executive research publications • Fit for Work **Limits** The following publication types will be removed at source where possible: • non-English language papers • editorials, letters and commentaries • conference abstracts and posters • books and book chapters

Field (based on PRISMA-P)	Content
	• theses and dissertations • duplicates • case reports • historical articles • withdrawn studies **Recording the searches** Results will be saved to an EndNote database and de-duplicated. A RIS file suitable for use in EPPI reviewer will be generated from the deduplicated results. Search dates; the number of records found; the number of duplicate records found and the search strategy used for each source will be reported. **Other notes** The same search approach will be used for review questions 1, 2 and 3.
Identify if an update	Update of PH19: Workplace health - managing long-term sickness absence and incapacity to work [Published March 2009]
Author contacts	Please see the guideline development page.
Highlight if amendment to previous protocol	For details please see section 4.5 of Developing NICE guidelines: the manual
Search strategy – for one database	For details please see appendix B
Data collection process – forms/duplicate	A standardised evidence table format will be used, and published as appendix D (effectiveness evidence tables) or H (economic evidence tables).
Data items – define all variables to be collected	For details please see evidence tables in appendix D (effectiveness evidence tables) or H (economic evidence tables).
Methods for assessing bias at outcome/study level	Standard study checklists will be used to critically appraise individual studies. For details please see section 6.2 of Developing NICE guidelines: the manual Where appropriate, the risk of bias across all available evidence will be evaluated for each outcome using an adaptation of the 'Grading of Recommendations Assessment, Development and Evaluation (GRADE) toolbox' developed by the international GRADE working group When applying GRADE, where RCTs are considered the best available evidence for the question and outcome in question, they will start as high quality evidence. Where RCTs are not the most appropriate study design for a

Field (based on PRISMA-P)	Content
	particular question or outcome, GRADE will be modified to allow for the study design considered most appropriate to start as high quality. GRADE-CERQual will be used to assess confidence in the findings from qualitative evidence syntheses.
Criteria for quantitative synthesis	Studies will be grouped according to the type of intervention as appropriate. For details please see section 6.4 of Developing NICE guidelines: the manual Where primary outcomes of interest are reported as continuous data in studies, the committee will discuss and decide how the data should be reported to enable them to make recommendations.
Methods for quantitative analysis – combining studies and exploring (in)consistency	It is anticipated that included studies will be heterogeneous with respect to participants and interventions. Data from different studies will be pooled and meta-analysed if the studies are similar enough in terms of population, interventions, comparators and outcomes. Methods for pooling cluster and individual randomised controlled trials will be considered where appropriate. Where meta-analysis is appropriate, a random effects model will be used to allow for the anticipated heterogeneity. This assumption will be tested with a fixed effects model. Heterogeneity in pooled analyses that cannot be explained through the subgroup analyses detailed above will be examined where appropriate with a sensitivity analysis to explore the impact of study risk of bias and level of intervention adherence (where reported). Additionally for review question 1, sensitivity analysis will be conducted to examine differences in effects between studies where recurrent short-term sickness absence is a recruitment inclusion criterion versus those where recurring short-term absence is a reported only as an outcome. If studies are found to be too heterogeneous to be pooled statistically, a narrative synthesis will be conducted.
Meta-bias assessment – publication bias, selective reporting bias	For details please see section 6.2 of Developing NICE guidelines: the manual.
Confidence in cumulative evidence	For details please see sections 6.4 and 9.1 of Developing NICE guidelines: the manual
Rationale/context – what is known	For details please see the introduction to the evidence review.

Field (based on PRISMA-P)	Content
Describe contributions of authors and guarantor	A multidisciplinary committee developed the evidence review. The committee was convened by Public Health Internal Guidelines Development (PH-IGD) team and chaired by Paul Lincoln in line with section 3 of Developing NICE guidelines: the manual. Staff from the Public Health Internal Guidelines Development team undertook systematic literature searches, appraised the evidence, conducted meta-analysis and cost-effectiveness analysis where appropriate, and drafted the evidence review in collaboration with the committee. For details please see Developing NICE guidelines: the manual.
Sources of funding/support	PH-IGD is funded and hosted by NICE
Name of sponsor	PH-IGD is funded and hosted by NICE
Roles of sponsor	NICE funds PH-IGD to develop guidelines for those working in the NHS, public health and social care in England.

1

Appendix B – Literature search strategies

Search summary

Guideline-wide search strategies were undertaken based on the review protocols provided for all review questions. Table 1 below details the sources searched and results retrieved for each database.

Table 1 Database searches and results (March 2018)

Database name	Date searched	Database Platform	Database segment or version	No. of results
Medline with daily update	13th March 2018	Ovid	1946 to date	10768
Medline in-process	14th March 2018	Ovid	13th March 2018	1835
Medline epubs ahead-of-print	14th March 2018	Ovid	13th March 2018	509
Cochrane CENTRAL	16th March 2018	Wiley	Issue 2 of 12, 2018	147 via searching + 10 via browsing
Cochrane Database of Systematic Reviews	16th March 2018	Wiley	Issue 3 of 12, 2018	1829
Embase	14th March 2018	Ovid	1996 to 2018 March 13	17599
PsychInfo	14th March 2018	Ovid	1987 to March Week 1 2018	5259
AMED	14th March 2018	Ovid	1985 to March 2018	1342
HMIC	14th March 2018	Ovid	1979 to January 2018	1578
Epistemonikos	16th March 2018	Native web platform	-	2051
PEDro	9th March 2018	Native web platform	-	311
Forward citation searching from PH19 included refs	5th March 2018	Web of Science	-	1896
Forward citation searching from NICE surveillance includes	5th March 2018	Web of Science	-	377
Backward citation searching from NICE surveillance includes	5th March 2018	Web of Science	-	1075
Website searches	26th March – 6th April 2018 (see below for specifics)	-	-	125
Total				46,711
Final (de-duplicated) results				24,610

Database name	Date searched	Database Platform	Database segment or version	No. of results
Medline with daily update	13th March 2018	Ovid	1946 to date	10768
Medline in-process	14th March 2018	Ovid	13th March 2018	1835
Medline epubs ahead-of-print	14th March 2018	Ovid	13th March 2018	509
Cochrane CENTRAL	16th March 2018	Wiley	Issue 2 of 12, 2018	147 via searching + 10 via browsing
Cochrane Database of Systematic Reviews	16th March 2018	Wiley	Issue 3 of 12, 2018	1829
Embase	14th March 2018	Ovid	1996 to 2018 March 13	17599
PsychInfo	14th March 2018	Ovid	1987 to March Week 1 2018	5259
AMED	14th March 2018	Ovid	1985 to March 2018	1342
HMIC	14th March 2018	Ovid	1979 to January 2018	1578
Epistemonikos	16th March 2018	Native web platform	-	2051
PEDro	9th March 2018	Native web platform	-	311
Forward citation searching from PH19 included refs	5th March 2018	Web of Science	-	1896
Forward citation searching from NICE surveillance includes	5th March 2018	Web of Science	-	377
Backward citation searching from NICE surveillance includes	5th March 2018	Web of Science	-	1075
Website searches	26th March – 6th April 2018 (see below for specifics)	-	-	125
Total				46,711
Final (de-duplicated) results				24,610

Table 2 Database searches and results (November 2018)

Database name	Date searched	Database Platform	Database segment or version	No. of results
Medline with daily update	7th November 2018	Ovid	1946 to date	859
Medline in-process	7th November 2018	Ovid	13th March 2018	525

Medline epubs ahead-of-print	7th November 2018	Ovid	13th March 2018	267
Cochrane CENTRAL	8th November 2018	Wiley	Issue 2 of 12, 2018	6
Cochrane Database of Systematic Reviews	7th November 2018	Wiley	Issue 3 of 12, 2018	2 via searching + 3 via browsing
Embase	7th November 2018	Ovid	1996 to 2018 March 13	1532
PsychInfo	8th November 2018	Ovid	1987 to March Week 1 2018	192
AMED	8th November 2018	Ovid	1985 to March 2018	34
HMIC	8th November 2018	Ovid	1979 to January 2018	9
Epistemonikos	8th November 2018	Native web platform	-	21
PEDro	8th November 2018	Native web platform	-	11
Forward citation searching from PH19 included refs	12th November 2018	Web of Science	-	1849
Forward citation searching from NICE surveillance includes	12th November 2018	Web of Science	-	477
Backward citation searching from NICE surveillance includes	12th November 2018	Web of Science	-	-
Website searches	13th November 2018	-	-	19
Total				5,806
Final (de-duplicated) results				1,805

Websites searched:

- Department for Work and Pensions Research Reports
- NIHR Journals library
- General search of the gov.uk portal
- The Work Foundation
- Institute for Employment Studies
- Centre for Musculoskeletal Health and Work
- Health and Safety Executive research publications
- Fit for Work

The MEDLINE search strategy is presented below. This was translated for use in all of the other databases listed.

MEDLINE search strategy

1	absenteeism.ti,ab.
2	absenteeism/
3	presenteeism.ti,ab.
4	presenteeism/
5	"sick leave".ti,ab.
6	"sick leave"/
7	"sick list*".ti,ab.
8	"sickness absence*".ti,ab.
9	(return* adj2 work*).ti,ab.
10	"return to work"/
11	(back adj2 work).ti,ab.
12	(fitness adj2 work).ti,ab.
13	"fit for work".ti,ab.
14	"fit note*".ti,ab.
15	"long term sick*".ti,ab.
16	"work readiness".ti,ab.
17	"vocational rehabilitation".ti,ab.
18	"Rehabilitation, Vocational"/
19	or/1-18
20	(200706* or 200707* or 200708* or 200709* or 20071* or 2008* or 2009* or 201*).ed.
21	19 and 20
22	limit 21 to english language
23	limit 22 to (comment or congresses or editorial or letter or case reports or historical article)
24	22 not 23
25	animals/ not (animals/ and humans/)
26	24 not 25
27	(exp child/ or exp infant/) not ((exp child/ or exp infant/) and (adolescent/ or exp adult/))
28	26 not 27

Appendix C – Public health evidence study selection

One overall search was undertaken across this guideline and was used to identify studies for all review questions.

Appendix D – Public health evidence tables

D.1 Effectiveness evidence

D.1.1 Framke (2016)

Bibliographic reference	**Framke E, Sørensen OH, Pedersen J, Rugulies R (2016) Effect of a participatory organizational-level occupational health intervention on short-term sickness absence: a cluster randomized controlled trial. Scand J Work Environ Health 42: 192-200**
Study type	Cluster RCT
Aim	To examine whether employees in pre-schools that implemented a participatory organizational-level intervention focusing on the core task at work had a lower incidence of short-term sickness absence compared to employees in control group pre-schools.
Location & setting	Denmark Pre-schools in Copenhagen with ≥10 employees. Of 221 eligible pre-schools, 78 with relatively high rates of short-term sickness absence were selected for participation.
Length of follow-up	June 2011 (group allocation) - December 31st, 2013 (end of data collection from sickness absence register). Sickness absence data available for 29 weeks.
Participant characteristics	**Inclusion criteria:** - All pedagogical leaders, nursery nurses, nursery nurse assistants and other employees (kitchen, cleaning, caretaking staff) employed at the 78 participating workplaces at some point between June 2011 and December 2013 **Exclusion criteria:** - Student nursery nurses **Baseline employee characteristics**[1]

<table>
<tr><td>Bibliographic reference</td><td>Framke E, Sørensen OH, Pedersen J, Rugulies R (2016) Effect of a participatory organizational-level occupational health intervention on short-term sickness absence: a cluster randomized controlled trial. Scand J Work Environ Health 42: 192-200</td></tr>
<tr><td></td><td>
<table>
<tr><th></th><th>Intervention group employees (n=1512) [a]</th><th>Control group employees (n=1064)</th></tr>
<tr><td>Age in years – mean (SD)</td><td>37.9 (12.0)</td><td>39.0 (12.0)</td></tr>
<tr><td>% male</td><td>18.5%</td><td>18.1%</td></tr>
<tr><td>Short-term sickness absence history:
- No. days per person-year in 12 months preceding intervention</td><td>11.65 days</td><td>11.43 days</td></tr>
<tr><td>Workplace size – mean no. employees (SD)</td><td>24.4 (9.0)</td><td>22.0 (9.8)</td></tr>
<tr><td>Occupational group – no. (%):
- Pedagogical leaders
- Nursery nurses
- Nursery nurse assistants
- Other job groups</td><td>
87 (5.8)
708 (46.8)
554 (36.6)
163 (10.8)</td><td>
66 (6.2)
470 (44.2)
421 (39.6)
107 (10.1)</td></tr>
<tr><td>Workplace type – no. (%):
- Integrated pre-school
- Day care
- Kindergarten</td><td>
1184 (78.3)
281 (18.6)
47 (3.1)</td><td>
803 (75.5)
214 (20.1)
47 (4.4)</td></tr>
</table>
[a] Excludes baseline data for employees from 3 intervention workplaces that subsequently dropped out of the trial.
No significant between-group differences in baseline characteristics.
</td></tr>
<tr><td>Number of study subjects</td><td>Total N = 3039 employees (78 recruited workplaces)
- intervention group: n=1760 employees (of 44 pre-schools randomised; note: 3 workplaces subsequently dropped out; primary outcome analysed on ITT basis)
- control group n=1279 employees (of 34 pre-schools).</td></tr>
<tr><td>Intervention details</td><td>Organisational-level intervention designed to focus on the core task at work, based on theory that illegitimate tasks (those regarded by employees as unreasonable or unnecessary) lead to higher levels of stress, poorer self-esteem and increased employee resentment.</td></tr>
</table>

Bibliographic reference	**Framke E, Sørensen OH, Pedersen J, Rugulies R (2016) Effect of a participatory organizational-level occupational health intervention on short-term sickness absence: a cluster randomized controlled trial. Scand J Work Environ Health 42: 192-200**
	Participating workplaces were asked to focus on improving performance of central work tasks and developing workplace-specific intervention activities and activity plans. A workplace steering group managed the intervention (comprising pre-school leader, employee representatives, shop stewards and OH representatives) with support from a working environment consultant to ensure all workplaces received same overall intervention. Activities common for all intervention group workplaces were: seminars and workshops for steering groups on how to develop workplace-specific intervention activities, change management training, workplace culture, and undertake evaluation.
Comparison details	No organisational intervention implemented (usual workplace sickness absence practice)
Methods and analysis	Data collection Sickness absence data drawn from the municipal sickness absence register. Incident event = each day a participant was on sickness absence during follow-up where episode did not exceed 14 days (e.g. over a calendar year, one sickness episode of 8 absence days duration, one episode of 18 days duration and one single sickness absence day is counted as 9 incident events). Long-term / part-time sickness absence, absence due to pregnancy-related sickness and children's sick days were excluded from analyses. Analyses The possibility that STSA occurred more than once in the same person within the predefined time period was allowed for in analyses. Monthly updates on individual participants' employment status were used to calculate time at risk (due to dynamic nature of study population, i.e. new participants added and some participants terminating employment before end of follow-up). To take account of the clustering effect of workplaces and correlation of repeated measurements of each participant, workplace and anonymized personal identification number were included in a repeated statement.

<table>
<tr><td>Bibliographic reference</td><td>Framke E, Sørensen OH, Pedersen J, Rugulies R (2016) Effect of a participatory organizational-level occupational health intervention on short-term sickness absence: a cluster randomized controlled trial. Scand J Work Environ Health 42: 192-200</td></tr>
<tr><td></td><td>Poisson regression was used, with time at risk for short-term sickness absence as an offset variable, to calculate incidence rate of short-term sickness absence (per person-year) for both the intervention and control groups and compare using unadjusted and adjusted rate ratios (RR).</td></tr>
<tr><td>Outcomes measures and effect sizes</td><td>Results

Outcome: Short-term sickness absence (≤14 days per absence) during a 29-month follow-up

<table>
<tr><th></th><th>Intervention (n=1760)</th><th>Control (n=1279)</th></tr>
<tr><td>Sum months</td><td>28,353</td><td>19,554</td></tr>
<tr><td>Sum sick days</td><td>20,583</td><td>14,903</td></tr>
<tr><td>Estimated mean no. STSA days per person-year</td><td>8.68</td><td>9.17</td></tr>
<tr><td><u>Analyses</u>
- Rate ratio (RR)[a] – crude analysis
- RR – Model 1[b]
- RR – Model 2[c]</td><td>
0.93 (0.86 to 1.00)
0.90 (0.84 to 0.97)
0.89 (0.83 to 0.96)</td><td>
1.00 (reference)
1.00 (reference)
1.00 (reference)</td></tr>
</table>
[a] Rate ratio (RR) comparing rates of short-term sickness absence (events per person-year, allowing recurrent events) in the intervention group with rates in the control group during 29 months of observations
[b] Poisson regression: adjusted for gender and age (continuous).
[c] Poisson regression: Model 1 + further adjusted for job group, type of workplace, workplace size (continuous) and workplace average level of short-term sickness absence during the 12 months preceding the intervention (continuous). Workplace and anonymized personal identification number are included in a repeated statement.

<u>Subgroup analyses [d]</u>
Poisson regression analyses comparing rates of short-term sickness absence in intervention and control group, stratified for participants' characteristics.</td></tr>
</table>

Bibliographic reference	**Framke E, Sørensen OH, Pedersen J, Rugulies R (2016) Effect of a participatory organizational-level occupational health intervention on short-term sickness absence: a cluster randomized controlled trial. Scand J Work Environ Health 42: 192-200**
	<table><tr><th></th><th>Intervention RR (95% CIs)</th><th>Control RR (95% CIs)</th></tr><tr><td>Age groups: <36 yrs (n=18,950) 36 to 50 yrs (n=18,643) >50 yrs (n=10,314)</td><td> 0.95 (0.85 to 1.06) 0.88 (0.78 to 0.98) 0.81 (0.69 to 0.96)</td><td>reference</td></tr><tr><td>Gender: Female (n=39,465) Male (n=8,442)</td><td> 0.90 (0.83 to 0.97) 0.85 (0.71 to 1.02)</td><td>reference</td></tr></table> [d] Post-hoc analyses. Note: differences between subgroups were not statistically significant. **Other outcomes reported:** Time of onset to first episode of long-term sickness absence (≥15 days) - data not extracted
Source of funding	Funded by a grant from the Danish Prevention Fund (grant number: 09-1-1a-096). Intervention evaluation funded by a grant from the Danish Working Environment Research Fund (grant number: 28-2010-03). Neither funding source had a role in study design, conduct, or write-up for publication.
Related publications	**Process evaluation** Framke E. and Sørensen O.H. (2015)
Comments	**Limitations noted by authors:** • Outcome data validity issues: only monthly updates on employment status and sickness absence per participant were available so number of sickness absence days could reflect one sickness absence spell or several spells added up. Also information on participants' holidays and non-sickness related leave were not available. • Unclear why STSA rates fell from pre-study levels in both intervention and control groups – potential contamination issues due to contacts and communication at management level • Unclear whether different approaches in the 44 intervention organisations resulted in different effects or effect mechanisms

Bibliographic reference	**Framke E, Sørensen OH, Pedersen J, Rugulies R (2016) Effect of a participatory organizational-level occupational health intervention on short-term sickness absence: a cluster randomized controlled trial. Scand J Work Environ Health 42: 192-200**		
	• Results may not generalise beyond Danish public-sector pre-school organisational setting **Limitations noted by reviewer:** • Loosely defined, non-standardised organisational intervention • Subgroup analyses undertaken post-hoc • Unclear what proportion of participant STSA was actually recurrent		
Quality assessment	**Outcome**	**Judgement**	**Comments**
	Random sequence generation	Low	Statistician randomized workplaces using a random number generator.
	Allocation concealment	Low	Unit of allocation was workplace, with all workplaces allocated at start of study via centralised randomisation scheme.
	Blinding of participants and personnel	Unclear	Not possible to blind participants to group allocation.
	Blinding of outcome assessment	Low	Not reported, however primary outcome is objective and data were obtained monthly from centralised register.
	Incomplete outcome data	Low	3 drop-out workplaces included in analysis of outcome (ITT).
	Selective outcome reporting	Low	Appropriate outcome specified and reported in analysis.
	Other sources of bias	Low	Consideration of the effect of clustering adjusted for in the analysis
Overall RoB	Very low		

D.1.2 Notenbomer 2018

Bibliographic reference	**Notenbomer A, Roelen C, Groothoff J, van Rhenen W, Bultmann U. (2018) Effect of an eHealth intervention to reduce sickness absence frequency among employees with frequent sickness absence: randomized controlled trial. Journal of Medical Internet Research, 20: e10821**
Study type	RCT
Aim	To evaluate the effect of an e-Health intervention, with or without additional occupational physician consultation, to reduce sickness absence frequency for employees with frequent sickness absence, versus care as usual (CAU).
Location & setting	The Netherlands. Study participants recruited from 21 Dutch organisations each with more than 100 employees (7 industrial, 5 commercial and 9 in public services sector).
Study dates	Recruitment: December 2013 - December 2014.
Length of follow-up	1 year
Participant characteristics	A list of all frequent absentees in participating organizations was derived from the occupational health service register and invitation letters to participate were sent. Participation was voluntary. **Inclusion criteria:** - Employees with frequent SA (≥3 episodes in the year before recruitment, irrespective of the causes or duration of sick leave). **Exclusion criteria:** - Unable to complete questionnaire in Dutch **Baseline characteristics of study participants:**

Baseline characteristics	EH intervention only (n=21)	EH intervention + OP (n=31)	Usual care control group (n=30)
Age (years) – m (SD)	44.9 (10.1)	45.9 (11.4)	46.9 (10.9)
% male	33	32	33
Educational level – (%)			
• Low	19	10	7
• Intermediate	43	32	37

Bibliographic reference	**Notenbomer A, Roelen C, Groothoff J, van Rhenen W, Bultmann U. (2018) Effect of an eHealth intervention to reduce sickness absence frequency among employees with frequent sickness absence: randomized controlled trial. Journal of Medical Internet Research, 20: e10821**
	• High: 38 / 58 / 57 Health characteristics: – Chronic illness (y) - %: 35 / 40 / 28 Health perception (SF-1): – Fair / bad - %: 19 / 33 / 50 – Good / very good / excellent - %: 82 / 68 / 50 Work characteristics: – Years with current employer – m (SD): 13 (8.9) / 14.4 (10.9) / 15.1 (11.6) – Hours worked per week – m (SD): 31.1 (7.4) / 34.9 (8.7) / 33.1 (11.1) – Irregular work (e.g. night shifts) - %: 24 / 19 / 17 Many participants found frequent SA a problem for themselves (71%), but few reported that they thought that this was the case for their managers (18%) or colleagues (13%). Information on self-reported factors playing a role in health and frequent SA could be categorized into 5 main categories: type of disease (eg, chronic disease and migraine, 34%), high job demands (15%), low job resources (5%), home demands (9%), and imbalance between demands and capacity (5%). An additional 26 participants (32%) did not answer this open question.
Number of study subjects	N=82
Intervention details	<u>(i) e-Health intervention alone</u> Intervention was designed to advise employees with frequent SA how to improve health and self-management, with help from relevant others, for example, the employer, OP, and general practitioner (GP). Consisted of: • Immediate fully-automated personalized web-based feedback, item by item, on: job demands (work pace, emotional demands, and work-home interference), job resources (feedback, learning opportunities, supervisor support, co-worker support, and autonomy), burnout, engagement, work ability, general health, chronic diseases, psychological health, lifestyle, and body mass index.

Bibliographic reference	Notenbomer A, Roelen C, Groothoff J, van Rhenen W, Bultmann U. (2018) Effect of an eHealth intervention to reduce sickness absence frequency among employees with frequent sickness absence: randomized controlled trial. Journal of Medical Internet Research, 20: e10821
	• Feedback consisted of the item score, interpretation of the score, general advice on possibilities to tackle this issue (in case of a poor score), reference to relevant internet sites for more information, further diagnostic tests or treatment, and referral to people who could help (depending on the issue: manager, colleagues, human resource management, OP, social worker, or GP). • The advice often contained a link to documents with more detailed advice. Advice was based on Netherlands Society for Occupational Physicians (NVAB) health guidelines, occupational health care practice, and suggestions from focus group participants with frequent SA from a prior study. • Cut-off points were either the existing cut-off points of the scales or the seventy-fifth percentile of a large reference group who participated in OHS health surveillance checks. • Participants who scored well on a particular scale received feedback that they had scored well and no specific actions were needed. <u>(ii) e-Health intervention + Occupational Physician consultation</u> Participants received the same advice and documents as the EHI-only group, and were also invited by email to a preventive advisory consultation with an OP. • The email contained the name and contact details of the OP to make an appointment. • OPs from the 21 participating organizations received written information on the study and an explanation of the goal of the study and the possibility of consultations with participants. • It was expected that this preventive consultation was the same as preventive consultations initiated by an employee in non-research situations: i.e. participants' questions on health and SA in relation to work and how to influence the employee's health or (work) situation. This could lead to making a joint plan-of-action, but it was not obligatory. • Standard time for this preventive consultation was 30 min. <u>Adherence</u> In total, 55 (70%) participants responded to the process evaluation. – A total of 3 participants (10%) in the EHI-OP group consulted the OP on study invitation. Two participants from this study arm had seen the OP at a later time (at the initiative of their employer) because of longer SA. – A total of 2 participants (10%) from the EHI-only group and 3 from the control group (10%) reported having consulted the OP.

Bibliographic reference	**Notenbomer A, Roelen C, Groothoff J, van Rhenen W, Bultmann U. (2018) Effect of an eHealth intervention to reduce sickness absence frequency among employees with frequent sickness absence: randomized controlled trial. Journal of Medical Internet Research, 20: e10821**
	– In the EHI-only group, 54% (7/13) process evaluation responders reported receiving the digital advice and 72% (13/18) in the EHI-OP group. – Of the 7 receivers in the EHI-only group, 4 (57%) had read the additional documents provided compared with 46% (6/13) of receivers in the EHI-OP group. – No participant made a plan-of-action as provided in the digital tool. Participants from all groups—intervention and control—took additional actions. No marked difference between intervention and control groups. A total of 16 participants (29%) took action at work (31% of the EHI-only group; 28% of the EHI-OP group; 29% of the control group, 29%). A total of 4 participants from the EHI-only group (31%) and 9 from the EHI-OP group (50%) had taken no (new) actions since study participation, including OP consultations. Reported reasons included having already taken a lot of actions before the study or still undertaking actions started before the study; not acknowledging the added value of the intervention when knowing the problem is not work-related; being too busy; low urgency, or optimism about their future health and SA.
Comparison details	<u>Care as usual (CAU)</u> • The control group received neither personalized advice nor support from the OP or researchers upon completion of the Web-based questionnaire. • CAU consisted of consultation with the OP at the request of the employer or control group participant. • In case of long-term SA, participants were invited for a consultation with the OP to certify SA within 6 weeks of reporting sick
Methods and analysis	**Power**: In a pilot study, frequent absentees had on average 3.79 (SD 1.27) SA episodes in 2013 to 2014 in the total employee population of a large Dutch OHS. No scientifically based intervention effect was available as this was the first intervention study among employees with frequent SA on SA frequency. Applying the results of closest scientific studies (but in different populations) the study researchers aimed for a reduction of 0.5 episodes (Cohen d=0.39). On the basis of an alpha of .05 (two-tailed) and a power of 80%, a sample size of 103 was needed.

Bibliographic reference	**Notenbomer A, Roelen C, Groothoff J, van Rhenen W, Bultmann U. (2018) Effect of an eHealth intervention to reduce sickness absence frequency among employees with frequent sickness absence: randomized controlled trial. Journal of Medical Internet Research, 20: e10821**
	After further consideration, before the start of the study, a second sample size calculation was undertaken to detect a difference of 1 SA episode per year (Cohen d=0.79) based on practice-based knowledge of relevant intervention effects in an occupational health setting. This calculation showed a minimum of 27 per group was needed. **Data collection**: Primary outcome: Frequency of sickness absenteeism (number of times of absenteeism in a period of 1 year) – data collected from sickness absence registration of occupational health provider. Sickness absence recorded from first day of sick leave to the day of RTW. Secondary outcomes: duration of absence from work (sum of all SA days at 1-year follow-up), and self-report (questionnaire-assessed) burn-out, engagement, work ability. **Statistical Analysis**: (i) Differences in outcomes at 1 year between EHI-only group, EHI-OP group, and the CAU group were analysed according to the intention-to-treat principle. Due to the non-normal distribution of incident SA episodes and days, differences were analysed using the nonparametric Kruskal-Wallis test. (ii) Intervention groups (EHI-only and EHI-OP) were merged, as all participants had had access to the same EHI and only 3 (13%) EHI-OP participants additionally consulted the OP upon invitation. Differences between the outcomes of the combined intervention groups and the control group were assessed using the nonparametric Mann-Whitney U test.
Outcomes measures and effect sizes	**Results** There was no significant difference in reduction of SA frequency between the 3 study arms (Kruskal-Wallis: P=.66). All 3 groups, EHI-only, EHI-OP, and CAU, showed a significant reduction in SA frequency over time (P values of respective Wilcoxon signed rank tests: EHI-only: P=.006, EHI-OP: P<.001, and control group: P<.001). Where all participants had frequent SA at baseline, at 1-year follow-up, 5 participants in the EHI-only group (5/21, 25%) had frequent SA, 16 participants in the EHI-OP group (16/31, 52%), and 12 in the CAU group (12/30, 40%, data not shown). Table 2 shows that there was no significant difference in SA frequency between the EHI groups and the CAU group at 1-year follow-up. Secondary Outcomes All 3 groups showed a reduction in total SA days over time. No significant difference was found between the EHI and CAU groups in the total number of SA days at 1-year follow-up (Table 2). In the EHI-only group, 3 (15%) had long-term SA (ie, ≥42 consecutive days) during 1-year follow-up, 7 in the EHI-OP group (23%), and 8 in the CAU group (28%, data not shown). **Outcome: Sickness absence (i) – 3 arm comparison**

Sickness absence	At baseline	At 1 year follow-up*

Bibliographic reference	Notenbomer A, Roelen C, Groothoff J, van Rhenen W, Bultmann U. (2018) Effect of an eHealth intervention to reduce sickness absence frequency among employees with frequent sickness absence: randomized controlled trial. Journal of Medical Internet Research, 20: e10821

	EHI only (n=21)	EHI + OP (n=31)	Control (n=30)	EHI only (n=21)	EHI + OP (n=31)	Control (n=30)
Proportion with frequent sickness absence (≥3 episodes) in past 12m – n (%)	21 (100%)	31 (100%)	30 (100%)	5 (25%)	16 (31%)	12 (40%)
Sickness absence episodes in past 12m – median (IQR)	3 (3-4)	4 (3-5)	3 (3-4)	1 (0.5-3.5)	3 (1-4)	2 (1-3)
Total no. sickness absence days – median (IQR)	22 (14.5-37.5)	17 (8-34)	20.5 (11.5-38.8)	5 (1-25)	11 (4-36)	12.5 (7.0-73.5)

* No significant difference in reduction of SA frequency between the 3 study arms (Kruskal-Wallis: p=0.66). All 3 groups, EHI-only, EHI-OP, and CAU, showed a significant reduction in SA frequency over time. Total number of sickness absence days over 12m follow-up did not differ between groups (p=0.15).

Outcome: Sickness absence (ii) – 2 arm comparison

Sickness absence	At baseline		At 1 year follow-up	
	EHI groups combined (n=52)	Control (n=30)	EHI groups combined (n=52)	Control (n=30)
Proportion with frequent sickness absence (≥3 episodes) in past 12m – n (%)	52 (100%)	30 (100%)	21 (40%)	12 (40%)

Bibliographic reference	**Notenbomer A, Roelen C, Groothoff J, van Rhenen W, Bultmann U. (2018) Effect of an eHealth intervention to reduce sickness absence frequency among employees with frequent sickness absence: randomized controlled trial. Journal of Medical Internet Research, 20: e10821**

Sickness absence episodes in past 12m – median (IQR)	3.5 (3-4.8)	3 (3-4)	2.4 (1-4)	2 (1-3)
Total no. sickness absence days – median (IQR)	19 (10.3-37.0)	20.5 (11.5-38.8)	8.7 (2.3-31.5)	12.5 (7.0-73.5)

* No significant difference in reduction of SA frequency between the 2 arms (Mann-Whitney U: p=0.91) nor in total number of SA days at 1-year follow-up (Mann-Whitney U: p=0.19)

Other outcomes reported:

- Burnout (self-report, assessed with 9-item Utrecht Burnout Scale)
- Engagement (self-report, assessed with 9-item Utrecht Work Engagement scale)
- Work ability (assessed with Work Ability Index - 1 question comparing current WA with lifetime best)

Source of funding	Investment by ArboNed (large Dutch OH provider) in the intervention. E-Health application made to specification by Byelex. ArboNed had no influence on the design, analysis, results, or presentation of the study results
Related publications	None identified
Comments	**Limitations noted by authors:** • Small sample size – may be underpowered to detect an effect • Low participation rate – only 9.9% (82/825) eligible frequent absentees agreed to participate in the study – may affect generalisability of results • Cannot draw conclusions about the effectiveness of blended (EHI + OP) care as too few participants consulted the OP when this was offered. **Limitations noted by reviewer:** None noted

Quality assessment	**Criterion**	**Judgement**	**Comments**

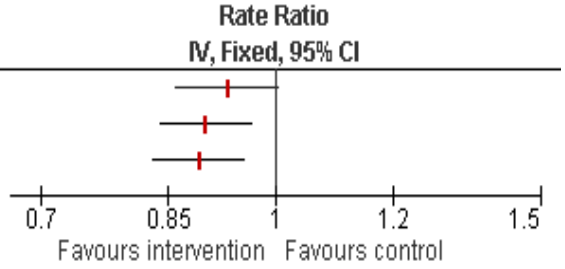
Bibliographic reference	Notenbomer A, Roelen C, Groothoff J, van Rhenen W, Bultmann U. (2018) Effect of an eHealth intervention to reduce sickness absence frequency among employees with frequent sickness absence: randomized controlled trial. Journal of Medical Internet Research, 20: e10821		
	Random sequence generation	Low	The source population (N=825) was pre-randomized into 3 arms by random integers using specialised software provider.
	Allocation concealment	Low	Participants were allocated prior to start of study.
	Blinding of participants and personnel	High	Participants blinded to group allocation until completion of the Web-based questionnaire, whereupon they did (intervention groups) or did not (control group) receive a personalized advice. OPs could not be blinded. Primary researcher knew to which group each individual belonged.
	Blinding of outcome assessment	Low	Sickness absence data were retrieved and analysed by a researcher blind to group allocation.
	Incomplete outcome data	Low	<5% loss to follow-up (for sickness absence data) in all groups
	Selective outcome reporting	Low	Outcomes pre-specified and reported as per published protocol (Netherlands Trial Register NL4157 (NTR4316) - https://www.trialregister.nl/trial/4157)
	Other sources of bias	Unclear	Self-selected population. Proportion of eligible employees with frequent SA who agreed to participate was very small: 7.8% of those pre-randomised to EHI only; 11.1% of those pre-randomised to EHI-OP, and 10.9% of those pre-randomised to CAU.
Overall RoB	Low		

Appendix E – Forest plots

Figure 1: Outcome: short-term sickness absence

Crude and adjusted incidence rate (STSA days per person-year) for intervention (organisational-level intervention designed to focus on the core task at work) vs. control (usual workplace sickness absence practice) group employees

Study or Subgroup	log[Rate Ratio]	SE	Intervention Total	Control Total	Rate Ratio IV, Fixed, 95% CI
Framke 2016	-0.0726	0.0399	1760	1279	0.93 [0.86, 1.01]
Framke 2016 (adjusted: model 1)	-0.1054	0.0352	1760	1279	0.90 [0.84, 0.96]
Framke 2016 (adjusted: model 2)	-0.1165	0.0356	1760	1279	0.89 [0.83, 0.95]



Poisson regression: Model 1- adjusted for sex and age

Poisson regression: Model 2 - adjusted for Model 1 + job group, type of workplace, workplace size and workplace average level of short-term sickness absence in 12 months preceding intervention (see evidence table in appendix D for details)

Appendix F – GRADE table

Quality assessment							No of participants		Effect estimate	Quality
No of studies	Design	Risk of bias	Indirectness	Inconsistency	Imprecision	Other considerations	Intervention	Comparator	Rate ratio (95% CI) Intervention vs. Comparator	
Outcome: Short-term sickness absence rate over 29 weeks (forest plot Figure 1) – ER1.1										
1[1]	cRCT	Serious[a]	Serious[b]	n/a	No serious	Serious[g]	1760	1279	Unadjusted RR 0.93 (0.86 to 1.00) Adjusted (model 2)[C] RR 0.89 (0.83 to 0.96)	Very low
Outcome: Proportion with frequent short-term sickness absence at 12 month follow-up – ER1.2										
1[2]	RCT	Serious[d]	Serious[e]	n/a	Serious[f]	None	EHI groups 21/52 (40.4%)	Usual care 12/30 (40.0%)	RR 1.01 (0.58 to 1.75)	Very low

Studies

[1] Framke 2016, *Organisational-level intervention designed to focus on the core task at work vs usual workplace sickness absence practice*

[2] *Notenbomer 2018, e-Health intervention or e-Health intervention and occupational physician consultation vs care as usual*

a Not possible to blind participants, but also no mention of blinding of outcome assessors
b Population does not match review protocol: study reports only organisation-level mean rates of STSA per person-year, so no individual-level data on employees with recurrent STSA (≥4 episodes within a 12 month period), although analyses take account of the fact that an individual may have more than one episode of STSA during follow-up
c See evidence table (D.1.1) for details of variables included in final adjusted model
d Potential self-selection bias due to low rates of voluntary participation (10% of eligible population with frequent sickness absence); relatively highly educated sample likely to be motivated to improve health and sickness absence
e Definition of frequent SA does not match review protocol criteria ("≥3 episodes in the year before recruitment, irrespective of the causes or duration of sick leave" cf." ≥4 episodes of less than 4 weeks duration in a 12m period")
f Wide 95%CI crossing line of no effect
g Limited information on adjusting for clustering

Appendix G – Excluded studies

Reference	Reason for exclusion
(2016) Facilitating the return to work of NHS staff with common mental health disorders: a feasibility study (Project record). Health Technology Assessment ,	Exclude on publication type
A Broughton, C Tyers, S Wilson, and S O'Regan (2009) Managing Stress and Sickness Absence: Progress of the Sector Implementation Plan Phase 2. : ,	Exclude on evidence - does not answer review questions
Aamland Aase, Oyeflaten Irene, and Maeland Silje (2017) Independent medical evaluation for sick-listed workers in Norway: A focus group study of the experience of IME doctors. Scandinavian journal of public health , 1403494817745001	Exclude on country - qualitative study from Norway
Aas R W, and Skarpaas L S (2012) The impact of a brief vs. multidisciplinary intervention on return to work remains unclear for employees sick-listed with low back pain. Australian Occupational Therapy Journal 59(3), 249-250	Exclude on publication type
Aas R W, Kjeken I, and Dagfinrud H (2008) Workplace intervention reduced the duration of sick leave in recently injured workers with subacute low-back pain, but graded activity did not. Australian Occupational Therapy Journal 55(2), 143-4	Exclude on publication type
Aas R W, Tuntland H, Holte K A, Roe C, Lund T, Marklund S, and Moller A (2011) Workplace interventions for neck pain in workers. Cochrane Database of Systematic Reviews (4), 94	Exclude on evidence - systematic review
Aas Randi W, Ellingsen Kjersti L, Lindoe Preben, and Moller Anders (2008) Leadership Qualities in the Return to Work Process: A Content Analysis. Journal of Occupational Rehabilitation 18(4), 335-346	Exclude on evidence - content analysis
Aas Randi Wågø, Tuntland Hanne, Holte Kari Anne, Røe Cecilie, and Labriola Merete (2009) Workplace interventions for low-back pain in workers. Cochrane Database of Systematic Reviews (4),	Exclude on evidence - protocol only
Abasolo L, Carmona L, Hernandez-Garcia C, Lajas C, Loza E, Blanco M, Candelas G, Fernandez-Gutierrez B, and Jover J A (2007) Musculoskeletal work disability for clinicians: Time course and effectiveness of a specialized intervention program by diagnosis. Arthritis & Rheumatism-Arthritis Care & Research 57(2), 335-342	Exclude on intervention
Abma Femke I, Bultmann Ute, Varekamp Inge, van der Klink , and Jac J L (2013) Workers with health problems: three perspectives on functioning at work. Disability and rehabilitation 35(1), 20-6	Exclude on country - qualitative study from Netherlands
Adaji A, Newcomb R D, Wang Z, and Williams M (2018) Impact of collaborative care on absenteeism for depressed employees seen in primary care practices: A retrospective cohort study. Journal of Occupational and Environmental Medicine 60(1), 83-89	Exclude on intervention
Addley K, Burke C, and McQuillan P (2010) Impact of a direct access occupational physiotherapy treatment service. Occupational medicine (Oxford, and England) 60(8), 651-3	Exclude on publication type
Adler David A, Lerner Debra, Visco Zachary L, Greenhill Annabel, Chang Hong, Cymerman Elina, Azocar Francisca, and Rogers William H (2015) Improving work outcomes of dysthymia (persistent depressive disorder) in an employed population. General hospital psychiatry 37(4), 352-9	Exclude on intervention

Reference	Reason for exclusion
Ahlgren Asa, Bergroth Alf, Ekholm Jan, and Schuldt Kristina (2007) Work resumption after vocational rehabilitation: a follow-up two years after completed rehabilitation. Work (Reading, and Mass.) 28(4), 343-54	Exclude on publication type
Ahlstrom Linda, Hagberg Mats, and Dellve Lotta (2013) Workplace rehabilitation and supportive conditions at work: a prospective study. Journal of occupational rehabilitation 23(2), 248-60	Exclude on evidence - no control group
Ahola K, Toppinen-Tanner S, and Seppanen J (2017) Interventions to alleviate burnout symptoms and to support return to work among employees with burnout: Systematic review and meta-analysis. Burnout Research 4, 1-11	Exclude on evidence - systematic review
Aikens K A, Astin J, Pelletier K R, Levanovich K, Baase C M, Park Y Y, and Bodnar C M (2014) Mindfulness goes to work: impact of an online workplace intervention. Journal of Occupational and Environmental Medicine 2014 Jul, and56(7):721-731 ,	Exclude on intervention
Alaszewski Andy, Alaszewski Helen, Potter Jonathan, and Penhale Bridget (2007) Working after a stroke: survivors' experiences and perceptions of barriers to and facilitators of the return to paid employment. Disability and rehabilitation 29(24), 1858-69	Exclude on intervention
Alexander L, Cooper K, Mitchell D, and MacLean C (2017) Effectiveness of vocational rehabilitation on work participation in adults with musculoskeletal disorders: An umbrella review protocol. JBI Database of Systematic Reviews and Implementation Reports 15(6), 1518-1521	Exclude on evidence - protocol only
Amick B C, Lee H, Hogg-Johnson S, Katz J N, Brouwer S, Franche R L, and Bultmann U (2017) How Do Organizational Policies and Practices Affect Return to Work and Work Role Functioning Following a Musculoskeletal Injury?. Journal of Occupational Rehabilitation 27(3), 393-404	Exclude on evidence - non-comparative study
Amir Ziv, Wynn Phil, Chan Fong, Strauser David, Whitaker Stuart, and Luker Karen (2010) Return to work after cancer in the UK: attitudes and experiences of line managers. Journal of occupational rehabilitation 20(4), 435-42	Exclude on evidence - closed question survey
Amir Ziv, Wynn Philip, Whitaker Stuart, and Luker Karen (2009) Cancer survivorship and return to work: UK occupational physician experience. Occupational medicine (Oxford, and England) 59(6), 390-6	Exclude on evidence - closed question survey
Andersen L N, Juul-Kristensen B, Sorensen T L, Herborg L G, Roessler K K, and Sogaard K (2015) Efficacy of Tailored Physical Activity or Chronic Pain Self-Management Programme on return to work for sick-listed citizens: A 3-month randomised controlled trial. Scandinavian Journal of Public Health 43(7), 694-703	Exclude on intervention
Andersen L N, Juul-Kristensen B, Sorensen T L, Herborg L G, Roessler K K, and Sogaard K (2016) LONGER TERM FOLLOW-UP OF THE EFFECTS OF TAILORED PHYSICAL ACTIVITY OR CHRONIC PAIN SELF-MANAGEMENT PROGRAMME ON RETURN-TO-WORK: A RANDOMIZED CONTROLLED TRIAL. Journal of Rehabilitation Medicine 48(10), 887-892	Exclude on publication type
Andersen Lotte Nygaard, Juul-Kristensen Birgit, Roessler Kirsten Kaya, Herborg Lene Gram, Sorensen Thomas Lund, and Sogaard	Exclude on intervention

Reference	Reason for exclusion
Karen (2015) Efficacy of 'Tailored Physical Activity' on reducing sickness absence among health care workers: A 3-months randomised controlled trial. Manual Therapy 20(5), 666-671	
Andersen Lotte Nygaard, Juul-Kristensen Birgit, Sorensen Thomas Lund, Herborg Lene Gram, Roessler Kirsten Kaya, and Sogaard Karen (2016) Longer term follow-up on effects of Tailored Physical Activity or Chronic Pain Self-Management Programme on return-to-work: A randomized controlled trial. Journal of rehabilitation medicine 48(10), 887-892	Exclude on intervention
Andersen Malene Friis, Nielsen Karina, and Brinkmann Svend (2014) How do workers with common mental disorders experience a multidisciplinary return-to-work intervention? A qualitative study. Journal of occupational rehabilitation 24(4), 709-24	Exclude on country - qualitative study from Belgium
Anderson B, Strand L, and Raheim M (2007) The effect of long-term awareness training succeeding a multimodal cognitive behaviour program for patients with widespread pain. Journal of Musculoskeletal Pain 15(3), 19-29	Exclude on population
Andren D, and Svensson M (2012) Part-Time Sick Leave as a Treatment Method for Individuals with Musculoskeletal Disorders. Journal of Occupational Rehabilitation 22(3), 418-426	Exclude on evidence - does not answer review questions
Andronis L, Kinghorn P, Qiao S Y, Whitehurst D G. T, Durrell S, and McLeod H (2017) Cost-Effectiveness of Non-Invasive and Non-Pharmacological Interventions for Low Back Pain: a Systematic Literature Review. Applied Health Economics and Health Policy 15(2), 173-201	Exclude on evidence - systematic review
Angel Sanne, Jensen Lone Donbaek, Gonge Birgitte Krois, Maribo Thomas, Schiottz-Christensen Berit, and Buus Niels (2012) Patients' interpretations of a counselling intervention for low back pain: a narrative analysis. International journal of nursing studies 49(7), 784-92	Exclude on country - qualitative study from Denmark
Arends I, Bruinvels D J, Rebergen D S, Nieuwenhuijsen K, Madan I, Neumeyer-Gromen A, Bultmann U, and Verbeek J H (2012) Interventions to facilitate return to work in adults with adjustment disorders. Cochrane Database of Systematic Reviews (12), 118	Exclude on evidence - systematic review
Ask Tove, and Magnussen Liv Heide (2015) Supervisors' Strategies to Facilitate Work Functioning among Employees with Musculoskeletal Complaints: A Focus Group Study. TheScientificWorldJournal 2015, 865628	Exclude on country - qualitative study from Norway
Atkins S, Ojajarvi U, Talola N, Viljamaa M, Nevalainen J, and Uitti J (2017) Impact of improved recording of work-relatedness in primary care visits at occupational health services on sickness absences: Study protocol for a randomised controlled trial. Trials 18(1), 352	Exclude on publication type
Aure OF, Nilsen JH, and Vasseljen O (2003) Manual therapy and exercise therapy in patients with chronic low back pain: a randomized, controlled trial with 1-year follow-up.. Spine 28(6), 525-31; discussion 531-2	Exclude on intervention
Bains Manpreet, Yarker Joanna, Amir Ziv, Wynn Philip, and Munir Fehmidah (2012) Helping cancer survivors return to work: what providers tell us about the challenges in assisting cancer patients with work questions. Journal of occupational rehabilitation 22(1), 71-7	Exclude on evidence - no specific intervention of policy

Reference	Reason for exclusion
Balasooriya-Smeekens Chantal, Bateman Andrew, Mant Jonathan, De Simoni , and Anna (2016) Barriers and facilitators to staying in work after stroke: insight from an online forum. BMJ open 6(4), e009974	Exclude on evidence - no specific intervention of policy
Bambra C, Whitehead M, Sowden A, Akers J, and Petticrew M (2008) "A hard day's night?" The effects of Compressed Working Week interventions on the health and work-life balance of shift workers: A Systematic review. Journal of Epidemiology and Community Health 62(9), 764-777	Exclude on evidence - systematic review
Bardgett Michelle, Lally Joanne, Malviya Ajay, and Deehan David (2016) Return to work after knee replacement: a qualitative study of patient experiences. BMJ open 6(2), e007912	Exclude on evidence - secondary care setting
Barnes Maria Carla, Buck Rhiannon, Williams Gareth, Webb Katie, and Aylward Mansel (2008) Beliefs about common health problems and work: a qualitative study. Social science & medicine (1982) 67(4), 657-65	Exclude on population
Beaudreuil J, Kone H, Lasbleiz S, Vicaut E, Richette P, Cohen-Solal M, Liote F, de Vernejoul , M C, Nizard R, Yelnik A, Bardin T, and Orcel P (2010) Efficacy of a functional restoration program for chronic low back pain: Prospective 1-year study. Joint Bone Spine 77(5), 435-439	Exclude on publication type
Bee Penny E, Bower Peter, Gilbody Simon, and Lovell Karina (2010) Improving health and productivity of depressed workers: a pilot randomized controlled trial of telephone cognitive behavioral therapy delivery in workplace settings. General Hospital Psychiatry 32(3), 337-340	Exclude on population
Beemster T T, van Velzen , J M, van Bennekom , C A M, Frings-Dresen M H. W, and Reneman M F (2015) Cost-effectiveness of 40-hour versus 100-hour vocational rehabilitation on work participation for workers on sick leave due to subacute or chronic musculoskeletal pain: study protocol for a randomized controlled trial. Trials 16, 14	Exclude on publication type
Beiwinkel Till, Eising Tabea, Telle Nils-Torge, Siegmund-Schultze Elisabeth, and Rossler Wulf (2017) Effectiveness of a Web-Based Intervention in Reducing Depression and Sickness Absence: Randomized Controlled Trial. Journal of medical Internet research 19(6), e213	Exclude on publication type
Bennett Hadyn (2002) Employee commitment: The key to absence management in local government?. Leadership & Organization Development Journal 23(8), 430-441	Exclude on evidence - does not answer review questions
Berglund Erik, Anderzen Ingrid, Andersen Asa, Carlsson Lars, Gustavsson Catharina, Wallman Thorne, and Lytsy Per (2018) Multidisciplinary Intervention and Acceptance and Commitment Therapy for Return-to-Work and Increased Employability among Patients with Mental Illness and/or Chronic Pain: A Randomized Controlled Trial. International journal of environmental research and public health 15(11),	Exclude on population
Bergstrom G, Lohela-Karlsson M, Kwak L, Bodin L, Jensen I, Torgen M, and Nybergh L (2017) Preventing sickness absenteeism among employees with common mental disorders or stress-related symptoms at work: Design of a cluster randomized controlled trial of a	Exclude on publication type

Reference	Reason for exclusion
problem-solving based intervention versus care-as-usual conducted at the Occupational Health Services. Bmc Public Health 17,	
Bernard M E, Rohrer J E, Swenson-Dravis D M, and Justice M W (2007) Impact of an occupational and environmental medicine curriculum on lost workdays. Journal of Occupational and Environmental Medicine 49(7), 771-775	Exclude on evidence - does not answer review questions
Bethge M (2017) Work-Related Medical Rehabilitation. Rehabilitation 56(1), 14-21	Exclude on evidence - systematic review
Bethge M, Herbold D, Trowitzsch L, and Jacobi C (2010) Return to Work Following Work-Related Orthopedic Rehabilitation: A Cluster Randomized Trial. Rehabilitation 49(1), 2-12	Exclude on publication type
Bevan Stephen (2015) Back to work: exploring the benefits of early interventions which help people with chronic illness remain in work. Work Foundation reports ,	Exclude on publication type
Bhui Kamaldeep S, Dinos Sokratis, Stansfeld Stephen A, and White Peter D (2012) A synthesis of the evidence for managing stress at work: a review of the reviews reporting on anxiety, depression, and absenteeism. Journal of environmental and public health 2012, 515874	Exclude on evidence - review of systematic reviews
Bilodeau K, Tremblay D, and Durand M J (2017) Exploration of return-to-work interventions for breast cancer patients: a scoping review. Supportive Care in Cancer 25(6), 1993-2007	Exclude on publication type
Birney Amelia J, Gunn Rebecca, Russell Jeremy K, and Ary Dennis V (2016) MoodHacker Mobile Web App With Email for Adults to Self-Manage Mild-to-Moderate Depression: Randomized Controlled Trial. JMIR mHealth and uHealth 4(1), e8	Exclude on intervention
Bishop Annette, Wynne-Jones Gwenllian, Lawton Sarah A, van der Windt , Danielle , Main Chris, Sowden Gail, Burton A Kim, Lewis Martyn, Jowett Sue, Sanders Tom, Hay Elaine M, Foster Nadine E, and team Swap study (2014) Rationale, design and methods of the Study of Work and Pain (SWAP): a cluster randomised controlled trial testing the addition of a vocational advice service to best current primary care for patients with musculoskeletal pain (ISRCTN 52269669). Bmc Musculoskeletal Disorders 15,	Exclude on population
Bjorkelund Cecilia, Svenningsson Irene, Hange Dominique, Udo Camilla, Petersson Eva-Lisa, Ariai Nashmil, Nejati Shabnam, Wessman Catrin, Wikberg Carl, Andre Malin, Wallin Lars, and Westman Jeanette (2018) Clinical effectiveness of care managers in collaborative care for patients with depression in Swedish primary health care: a pragmatic cluster randomized controlled trial. BMC family practice 19(1), 28	Exclude on intervention
Blanca-Gutierrez J J, Jimenez-Diaz M D. C, and Escalera-Franco L F (2013) Effective interventions to reduce absenteeism among hospital nurses. Gaceta Sanitaria 27(6), 545-551	Exclude on publication type
Bogefeldt J, Grunnesjo Marie I, Svardsudd K, and Blomberg S (2008) Sick leave reductions from a comprehensive manual therapy programme for low back pain: the Gotland Low Back Pain Study. Clinical rehabilitation 22(6), 529-41	Exclude on intervention

Reference	Reason for exclusion
Bohatko-Naismith Joanna, Guest Maya, Rivett Darren A, and James Carole (2016) Insights into workplace Return to Work Coordinator training: An Australian perspective. Work: Journal of Prevention, and Assessment & Rehabilitation 55(1), 29-36	Exclude on country - qualitative study from Australia
Bohatko-Naismith Joanna, James Carole, Guest Maya, and Rivett Darren A (2015) The role of the Australian workplace return to work coordinator: essential qualities and attributes. Journal of occupational rehabilitation 25(1), 65-73	Exclude on country - qualitative study from Australia
Bond Frank W, Flaxman Paul E, and Bunce David (2008) The influence of psychological flexibility on work redesign: mediated moderation of a work reorganization intervention. The Journal of applied psychology 93(3), 645-54	Exclude on evidence - does not answer review questions
Braathen T N, Veiersted K B, and Heggenes J (2007) Improved work ability and return to work following vocational multidisciplinary rehabilitation of subjects on long-term sick leave. Journal of Rehabilitation Medicine 39(6), 493-499	Exclude on population
Bramley-Harker Edward, Hughes Gordon, and Farahnik Joshua ( ) Sharing the costs - reaping the benefits : incentivising return to work initiatives. ,	Exclude on evidence - evidence review
Bramwell D, Sanders C, and Rogers A (2016) A case of tightrope walking: An exploration of the role of employers and managers in supporting people with long-term conditions in the workplace. International Journal of Workplace Health Management 9(2), 238-250	Exclude on evidence - no specific intervention of policy
Braun T, Bambra C, Booth M, Adetayo K, and Milne E (2015) Better health at work? An evaluation of the effects and cost-benefits of a structured workplace health improvement programme in reducing sickness absence. Journal of public health (Oxford, and England) 37(1), 138-42	Exclude on intervention
Brendbekken R, Eriksen H R, Grasdal A, Harris A, Hagen E M, and Tangen T (2017) Return to Work in Patients with Chronic Musculoskeletal Pain: Multidisciplinary Intervention Versus Brief Intervention: A Randomized Clinical Trial. Journal of Occupational Rehabilitation 27(1), 82-91	Exclude on intervention
Briand C, Durand M J, St-Arnaud L, and Corbiere M (2008) How well do return-to-work interventions for musculoskeletal conditions address the multicausality of work disability?. Journal of Occupational Rehabilitation 18(2), 207-217	Exclude on evidence - evidence review
Brouwers E, Tiemens B, Terluin B, and Verhaak P (2007) Effectiveness of an intervention to reduce sickness absenteeism from work in patients with emotional distress or minor mental disorders: a randomised controlled effectiveness trial. Huisarts en wetenschap 50(6), 238-244	Exclude on publication type
Brown J, Mackay D, Demou E, Craig J, Frank J, and Macdonald E B (2015) The EASY (Early Access to Support for You) sickness absence service: a four-year evaluation of the impact on absenteeism. Scandinavian Journal of Work Environment & Health 41(2), 204-215	Exclude on population
Brown KC, Sirles AT, Hilyer JC, and Thomas MJ (1992) Cost-effectiveness of a back school intervention for municipal employees.. Spine 17(10), 1224-8	Exclude on intervention

Reference	Reason for exclusion
Bruinvels D J, Rebergen D S, Nieuwenhuijsen K, Madan I, and Neumeyer-Gromen A (2007) Return to work interventions for adjustment disorders. Cochrane Database of Systematic Reviews (1), CD006389	Exclude on evidence - systematic review
Brusletto B, Torp S, Ihlebaek C M, and Vinje H F (2018) A five-phase process model describing the return to sustainable work of persons who survived cancer: A qualitative study. European journal of oncology nursing : the official journal of European Oncology Nursing Society 34, 21-27	Exclude on country - qualitative study from Norway
Burke SA, Harms-Constas CK, and Aden PS (1994) Return to work/work retention outcomes of a functional restoration program. A multi-center, prospective study with a comparison group.. Spine 19(17), 1880-5; discussion 1886	Exclude on intervention
Burton A K, Kendall N A. S, Pearce B, Birrell L, and Bainbridge L C (2009) Management of work-relevant upper limb disorders: a review. Occupational Medicine-Oxford 59(1), 44-52	Exclude on evidence - evidence review
Busch Hillevi, Bjork Bramberg, Elisabeth , Hagberg Jan, Bodin Lennart, and Jensen Irene (2017) The effects of multimodal rehabilitation on pain-related sickness absence - an observational study. Disability and rehabilitation , 1-8	Exclude on intervention
C Tyers, A Broughton, A Denvir, S Wilson, and S O'Regan (2009) Organisational Responses to the HSE Management Standards for Work-related Stress: Progress of the Sector Implementation Plan Phase 1. : ,	Exclude on evidence - does not answer review questions
Camden Matthew C, and Ludwig Timothy D (2013) Absenteeism in health care: Using interlocking behavioral contingency feedback to increase attendance with certified nursing assistants. Journal of Organizational Behavior Management 33(3), 165-184	Exclude on evidence - does not answer review questions
Campbell Paul, Wynne-Jones Gwenllian, Muller Sara, and Dunn Kate M (2013) The influence of employment social support for risk and prognosis in nonspecific back pain: a systematic review and critical synthesis. International archives of occupational and environmental health 86(2), 119-37	Exclude on evidence - systematic review
Cancelliere C, Donovan J, Stochkendahl M J, Biscardi M, Ammendolia C, Myburgh C, and Cassidy J D (2016) Factors affecting return to work after injury or illness: Best evidence synthesis of systematic reviews. Chiropractic and Manual Therapies 24(1), 32	Exclude on evidence - systematic review
Carlton J Fong, Kathleen Murphy, John D Westbrook, and Minda Markle (2015) Behavioral, psychological, educational and vocational interventions to facilitate employment outcomes for cancer survivors. Campbell Collaboration 11,	Exclude on evidence - systematic review
Carolan Stephany, de Visser , and Richard O (2018) Employees' Perspectives on the Facilitators and Barriers to Engaging With Digital Mental Health Interventions in the Workplace: Qualitative Study. JMIR mental health 5(1), e8	Exclude on evidence - does not answer review questions
Carolan Stephany, Harris Peter R, and Cavanagh Kate (2017) Improving Employee Well-Being and Effectiveness: Systematic Review and Meta-Analysis of Web-Based Psychological Interventions Delivered in the Workplace. Journal of medical Internet research 19(7), e271	Exclude on evidence - systematic review

Reference	Reason for exclusion
Caron Maryse, Durand Marie-Jose, and Tremblay Dominique (2018) Perceptions of Breast Cancer Survivors on the Supporting Practices of Their Supervisors in the Return-to-Work Process: A Qualitative Descriptive Study. Journal of occupational rehabilitation 28(1), 89-96	Exclude on country - qualitative study from Canada
Cheng A S. K, and Hung L K (2007) Randomized controlled trial of workplace-based rehabilitation for work-related rotator cuff disorder. Journal of Occupational Rehabilitation 17(3), 487-503	Exclude on country - study from China
Clayton S, Barr B, Nylen L, Burstrom B, Thielen K, Diderichsen F, Dahl E, and Whitehead M (2012) Effectiveness of return-to-work interventions for disabled people: a systematic review of government initiatives focused on changing the behaviour of employers. European Journal of Public Health 22(3), 434-439	Exclude on evidence - systematic review
Cochrane A, Higgins N M, FitzGerald O, Gallagher P, Ashton J, Corcoran O, and Desmond D (2017) Early interventions to promote work participation in people with regional musculoskeletal pain: a systematic review and meta-analysis. Clinical Rehabilitation 31(11), 1466-1481	Exclude on evidence - systematic review
Coffeng Jennifer K, Hendriksen Ingrid J. M, Duijts Saskia F. A, Twisk Jos W. R, van Mechelen , Willem , and Boot Cecile R. L (2014) Effectiveness of a combined social and physical environmental intervention on presenteeism, absenteeism, work performance, and work engagement in office employees. Journal of occupational and environmental medicine 56(3), 258-65	Exclude on intervention
Cohen D, Rhydderch M, Reading P, and Williams S (2015) Doctors' health: obstacles and enablers to returning to work. Occupational medicine (Oxford, and England) 65(6), 459-65	Exclude on population
Cohen Debbie, Allen Joanna, Rhydderch Melody, and Aylward Mansel (2012) The return to work discussion: a qualitative study of the line manager conversation about return to work and the development of an educational programme. Journal of rehabilitation medicine 44(8), 677-83	Exclude on evidence - does not answer review questions
Cohen Debbie, Marfell Naomi, Webb Katie, Robling Mike, and Aylward Mansel (2010) Managing long-term worklessness in primary care: a focus group study. Occupational medicine (Oxford, and England) 60(2), 121-6	Exclude on population
Comper Maria Luiza Caires, and Padula Rosimeire Simprini (2014) The effectiveness of job rotation to prevent work-related musculoskeletal disorders: protocol of a cluster randomized clinical trial. BMC musculoskeletal disorders 15, 170	Exclude on country - qualitative study from Brazil
Comper Maria Luiza Caires, Dennerlein Jack Tigh, Evangelista Gabriela Dos Santos, Rodrigues da Silva, Patricia , and Padula Rosimeire Simprini (2017) Effectiveness of job rotation for preventing work-related musculoskeletal diseases: a cluster randomised controlled trial. Occupational and environmental medicine 74(8), 543-544	Exclude on country - qualitative study from Brazil
Coole C et al (2010) Work problems due to low back pain: What do GPs do?. Fam Pract 27, 31-7	Exclude on evidence - closed question survey
Coole C, et al. (2015c) Recommendations to facilitate the ideal fit note: are they achievable in practice?. BMC family practice, 16, pp.138	Exclude on evidence – unclear if outcomes reported are relevant (not

Reference	Reason for exclusion
	acceptability or barriers/facilitators)
Coole C, Radford K, Grant M, and Terry J (2013) Returning to Work After Stroke: Perspectives of Employer Stakeholders, a Qualitative Study. Journal of Occupational Rehabilitation 23(3), 406-418	Exclude on evidence - no specific intervention of policy
Coole C, Watson P J, Thomson L, and Hampton R (2013) How do GPs complete fit note comments?. Occupational medicine (Oxford, and England) 63(8), 575-8	Exclude on evidence - content analysis
Coole Carol, Birks Emily, Watson Paul J, and Drummond Avril (2014) Communicating with employers: experiences of occupational therapists treating people with musculoskeletal conditions. Journal of occupational rehabilitation 24(3), 585-95	Exclude on evidence - closed question survey
Coole Carol, Watson Paul J, and Drummond Avril (2010) Low back pain patients' experiences of work modifications; a qualitative study. BMC musculoskeletal disorders 11, 277	Exclude on population
Coole Carol, Watson Paul J, and Drummond Avril (2010) Staying at work with back pain: patients' experiences of work-related help received from GPs and other clinicians. A qualitative study. BMC musculoskeletal disorders 11, 190	Exclude on population
Corbiere M, and Shen J (2006) A systematic review of psychological return-to-work interventions for people with mental health problems and/or physical injuries. Canadian Journal of Community Mental Health 25(2), 261-288	Exclude on evidence - systematic review
Critchley D J (2011) For sick-listed people with chronic low back pain, an integrated care programme costs society less and returns participants to work faster than usual management. Evidence-Based Medicine 16(4), 105-106	Exclude on publication type
D Hill, D Lucy, C Tyers, and L James (2007) What works at work? Review of evidence assessing the effectiveness of workplace interventions to prevent and manage common health problems. : Health Work Wellbeing,	Exclude on evidence - evidence review
D Lucy, C Tyers, and J Savage (2010) Healthy Workplaces Milton Keynes Pilot: Evaluation findings. : ,	Exclude on evidence - no relevant data reported
De Boer , A , Taskila T, Tamminga S, Feuerstein M, Frings-Dresen M, and Verbeek J (2015) Interventions to enhance return to work for cancer patients: A cochrane review and meta-analysis. Psycho-Oncology , 258	Exclude on evidence - systematic review
de Boer , Agem , Taskila T K, Tamminga S J, Feuerstein M, Frings-Dresen M H. W, and Verbeek J H (2015) Interventions to enhance return-to-work for cancer patients. Cochrane Database of Systematic Reviews (9),	Exclude on evidence - systematic review
de Weerd B, van Dijk M, van der Linden J, Roelen C, Verbraak M. (2016) The effectiveness of a convergence dialogue meeting with the employer in promoting return to work as part of the cognitive-behavioural treatment of common mental disorders: A randomized controlled trial. Work, 54:647-655	Exclude follow-up unclear
Deery Stephen, Walsh Janet, Zatzick Christopher D, and Hayes Andrew F (2017) Exploring the relationship between compressed work hours satisfaction and absenteeism in front-line service work.	Exclude on publication type

Reference	Reason for exclusion
European Journal of Work and Organizational Psychology 26(1), 42-52	
Demou E, Brown J, Sanati K, Kennedy M, Murray K, and Macdonald E B (2016) A novel approach to early sickness absence management: The EASY (Early Access to Support for You) way. Work-a Journal of Prevention Assessment & Rehabilitation 53(3), 597-608	Exclude on population
Desiron H A. M, de Rijk , A , Van Hoof , E , and Donceel P (2011) Occupational therapy and return to work: a systematic literature review. Bmc Public Health 11, 14	Exclude on evidence - systematic review
Desmeules F, Boudreault J, Dionne C E, Fremont P, Lowry V, MacDermid J C, and Roy J S (2016) Efficacy of exercise therapy in workers with rotator cuff tendinopathy: a systematic review. Journal of Occupational Health 58(5), 389-403	Exclude on evidence - systematic review
Dewa C S, Hoch J S, Carmen G, Guscott R, and Anderson C (2009) Cost, Effectiveness, and Cost-Effectiveness of a Collaborative Mental Health Care Program for People Receiving Short-Term Disability Benefits for Psychiatric Disorders. Canadian Journal of Psychiatry-Revue Canadienne De Psychiatrie 54(6), 379-388	Exclude on population
Dewa C S, Loong D, and Bonato S (2014) Work outcomes of sickness absence related to mental disorders: a systematic literature review. Bmj Open 4(7),	Exclude on publication type
Dewa C S, Loong D, Bonato S, and Joosen M C. W (2015) The effectiveness of return-to-work interventions that incorporate work-focused problem-solving skills for workers with sickness absences related to mental disorders: a systematic literature review. Bmj Open 5(6), 11	Exclude on evidence - systematic review
Dibben Pauline, Wood Geoffrey, Nicolson Rod, and O'Hara Rachel (2012) Quantifying the effectiveness of interventions for people with common health conditions in enabling them to stay in or return to work. : ,	Exclude on publication type
Dick F D, Graveling R A, Munro W, Walker-Bone K, Guideline Dev, and Grp (2011) Workplace management of upper limb disorders: a systematic review. Occupational Medicine-Oxford 61(1), 19-25	Exclude on evidence - systematic review
Doki S, Sasahara S, and Matsuzaki I (2015) Psychological approach of occupational health service to sick leave due to mental problems: a systematic review and meta-analysis. International Archives of Occupational and Environmental Health 88(6), 659-667	Exclude on evidence - systematic review
Donker-Cools Birgit H. P. M, Daams Joost G, Wind Haije, and Frings-Dresen Monique H. W (2016) Effective return-to-work interventions after acquired brain injury: A systematic review. Brain injury 30(2), 113-31	Exclude on evidence - systematic review
Dorrington S, Roberts E, Mykletun A, Hatch S, Madan I, and Hotopf M (2018) Systematic review of fit note use for workers in the UK. Occupational and environmental medicine 75(7), 530-539	Exclude on evidence - no relevant outcomes reported
Drews B, Nielsen C V, Rasmussen M S, Hjort J, and Bonde J P (2007) Improving motivation and goal setting for return to work in a population on sick leave: A controlled study. Scandinavian Journal of Public Health 35(1), 86-94	Exclude on intervention

Reference	Reason for exclusion
Dreyer R P, and Dickson V V (2018) Return to Work after Acute Myocardial Infarction: The Importance of Patients' Preferences. Circulation: Cardiovascular Quality and Outcomes 11(6), e004806	Exclude on publication type
Du Bois, M , and Donceel P (2012) Guiding Low Back Claimants to Work A Randomized Controlled Trial. Spine 37(17), 1425-1431	Exclude on intervention
Durand Marie-Jose, Corbiere Marc, Coutu Marie-France, Reinharz Daniel, and Albert Valerie (2014) A review of best work-absence management and return-to-work practices for workers with musculoskeletal or common mental disorders. Work (Reading, and Mass.) 48(4), 579-89	Exclude on evidence - content analysis
Durand M-J., Loisel P. (2001) Therapeutic return to work: rehabilitation in the workplace. Work. 17:57-63	Exclude – small sample size, intervention in RCT evidence
Ebert David Daniel, Lehr Dirk, Smit Filip, Zarski Anna-Carlotta, Riper Heleen, Heber Elena, Cuijpers Pim, and Berking Matthias (2014) Efficacy and cost-effectiveness of minimal guided and unguided internet-based mobile supported stress-management in employees with occupational stress: a three-armed randomised controlled trial. BMC public health 14, 807	Exclude on intervention
Ejeby K, Savitskij R, Ost L G, Ekbom A, Brandt L, Ramnero J, Asberg M, and Backlund L G (2014) Symptom reduction due to psychosocial interventions is not accompanied by a reduction in sick leave: Results from a randomized controlled trial in primary care. Scandinavian Journal of Primary Health Care 32(2), 67-72	Exclude on intervention
Eklund M (2017) Minor long-term effects 3-4 years after the ReDO T intervention for women with stress-related disorders: A focus on sick leave rate, everyday occupations and well-being. Work-a Journal of Prevention Assessment & Rehabilitation 58(4), 527-536	Exclude on publication type
Eklund M., Erlandsson LK. (2011) Return to work outcomes of the Redesigning Daily Occupations (ReDO) program for women with stress-realted disorders: a comparative study. Women Health. 51:676-92	Exclude – intervention Sweden specific
Ektor-Andersen J, Ingvarsson E, Kullendorff M, and Orbaek P (2008) High cost-benefit of early team-based biomedical and cognitive-behaviour intervention for long-term pain-related sickness absence. Journal of Rehabilitation Medicine 40(1), 1-8	Exclude on intervention
Elvsashagen H, Tellnes G, and Abdelnoor Mh (2009) Does early intervention by a specialist in physical medicine and rehabilitation reduce the duration of long term sick leave among persons with musculoskeletal diseases?. Norsk epidemiologi 19(2), 219-222	Exclude on publication type
Engers A, Jellema P, Wensing M, van der Windt , Dawm , Grol R, van Tulder , and M W (2008) Individual patient education for low back pain. Cochrane Database of Systematic Reviews (1), 37	Exclude on evidence - systematic review
Euler U, Wegewitz U E, Schmitt J, Adams J, van Dijk , J L, and Seidler A (2013) Interventions to support return-to-work for patients with coronary heart disease. Cochrane Database of Systematic Reviews 2013(9), CD010748	Exclude on evidence - systematic review
Faber E., Bierma-Zeinstra S.M.A, Burdorf A., et al (2005) in a controlled trail training general practitioners and occupational	Exclude – small sample size, intervention in RCT

Reference	Reason for exclusion
physicians to collaborate did not influence sickleave of patients with low back pain. J Clin Epidemiology. 58: 75-82	evidence, not >4weeks sick leave
Farzanfar Ramesh, Stevens Allison, Pham Quyen, and Friedman Robert (2008) A formative qualitative evaluation of usability and acceptability of a workplace mental health assessment and intervention system. International Journal of Mental Health Promotion 10(3), 17-25	Exclude on country - qualitative study from USA
Fisker A, Langberg H, Petersen T, and Mortensen O S (2013) Early coordinated multidisciplinary intervention to prevent sickness absence and labour market exclusion in patients with low back pain: study protocol of a randomized controlled trial. Bmc Musculoskeletal Disorders 14, 10	Exclude on publication type
Fong Carlton J, Murphy Kathleen M, Westbrook John D, and Markle Minda M (2018) Psychological Interventions to Facilitate Employment Outcomes for Cancer Survivors. Research on Social Work Practice 28(1), 84-98	Exclude on intervention
Framke Elisabeth, and Sørensen Ole Henning (2015) Implementation of a participatory organisational-level occupational health intervention - focusing on the primary task. International Journal of Human Factors and Ergonomics 3(3-4), 254-270	Exclude on country - qualitative study from Denmark
Franche R L, Cullen K, Clarke J, Irvin E, Sinclair S, and Frank J (2007) Workplace-based return-to-work interventions: a systematic review of the quantitative literature. Database of Abstracts of Reviews of Effects (DARE) ,	Exclude on evidence - systematic review
Franche Renee-Louise, Severin Colette N, Hogg-Johnson Sheilah, Cote Pierre, Vidmar Marjan, and Lee Hyunmi (2007) The impact of early workplace-based return-to-work strategies on work absence duration: a 6-month longitudinal study following an occupational musculoskeletal injury. Journal of occupational and environmental medicine 49(9), 960-74	Exclude on evidence - no control group
Frost Poul, Haahr Jens Peder, and Andersen Johan Hviid (2007) Reduction of pain-related disability in working populations: a randomized intervention study of the effects of an educational booklet addressing psychosocial risk factors and screening workplaces for physical health hazards. Spine 32(18), 1949-54	Exclude on intervention
Furlan Andrea D, Gnam William H, Carnide Nancy, Irvin Emma, Amick Benjamin C, III , DeRango Kelly, McMaster Robert, Cullen Kimberley, Slack Tesha, Brouwer Sandra, and Bultmann Ute (2012) Systematic Review of Intervention Practices for Depression in the Workplace. Journal of Occupational Rehabilitation 22(3), 312-321	Exclude on evidence - systematic review
Fylan F, et al. (2012) GPs' perceptions of potential services to help employees on sick leave return to work. pp.. Available at: https://www.gov.uk/government/publications/gps-perceptions-of-potential-services-to-help-employees-on-sick-leave-return-to-work-rr820.	Exclude on outcomes – lack of thematic analysis
Gard G, Gille KA, and Degerfeldt L (2000) McKenzie method and functional training in back pain rehabilitation. A brief review including results from a four-week rehabilitation programme. Physical Therapy Reviews 5, 107-15	Exclude on intervention

Reference	Reason for exclusion
Gardner B T, Pransky G, Shaw W S, Hong Q N, and Loisel P (2010) Researcher perspectives on competencies of return-to-work coordinators. Disability and Rehabilitation 32(1), 72-78	Exclude on evidence - does not answer review questions
Gaudine A, Saks A M, Dawe D, and Beaton M (2013) Effects of absenteeism feedback and goal-setting interventions on nurses' fairness perceptions, discomfort feelings and absenteeism. Journal of Nursing Management 21(3), 591-602	Exclude on population
Gaudreault Nathaly, Maillette Pascale, Coutu Marie-France, Durand Marie-Jose, Hagemeister Nicola, and Hebert Luc J (2014) Work disability among workers with osteoarthritis of the knee: risks factors, assessment scales, and interventions. International journal of rehabilitation research. Internationale Zeitschrift fur Rehabilitationsforschung. Revue internationale de recherches de readaptation 37(4), 290-6	Exclude on evidence - systematic review
Gayed A, Bryan B T, Petrie K, Deady M, Milner A, LaMontagne A D, Calvo R A, Mackinnon A, Christensen H, Mykletun A, Glozier N, and Harvey S B (2018) A protocol for the HeadCoach trial: The development and evaluation of an online mental health training program for workplace managers. BMC Psychiatry 18(1), 25	Exclude on publication type
Geraedts A S, Kleiboer A M, Wiezer N M, Cuijpers P, van Mechelen , W , and Anema J R (2014) Feasibility of a worker-directed web-based intervention for employees with depressive symptoms. Internet Interventions 1(3), 132-140	Exclude on intervention
Geraedts Anna S, Kleiboer Annet M, Twisk Jos, Wiezer Noortje M, van Mechelen , Willem , and Cuijpers Pim (2014) Long-term results of a web-based guided self-help intervention for employees with depressive symptoms: randomized controlled trial. Journal of medical Internet research 16(7), e168	Exclude on intervention
Gilworth G, Phil M, Cert Ad, Sansam K A. J, and Kent R M (2009) Personal experiences of returning to work following stroke: An exploratory study. Work (Reading, and Mass.) 34(1), 95-103	Exclude on evidence - no specific intervention of policy
Gilworth Gill, Eyres Sophie, Carey Amy, Bhakta Bipin B, and Tennant Alan (2008) Working with a brain injury: personal experiences of returning to work following a mild or moderate brain injury. Journal of rehabilitation medicine 40(5), 334-9	Exclude on evidence - no specific intervention of policy
Gloster R, Marvell R, and Huxley C (2018) Fit for Work: process evaluation and feasibility of an impact evaluation. : Department for Work and Pensions,	Exclude on evidence - no comparative data on outcomes of interest
Grossi G, and Santell B (2009) QUASI-EXPERIMENTAL EVALUATION OF A STRESS MANAGEMENT PROGRAMME FOR FEMALE COUNTY AND MUNICIPAL EMPLOYEES ON LONG-TERM SICK LEAVE DUE TO WORK-RELATED PSYCHOLOGICAL COMPLAINTS. Journal of Rehabilitation Medicine 41(8), 632-638	Exclude on evidence - does not answer review questions
Grunfeld E A, and Cooper A F (2012) A longitudinal qualitative study of the experience of working following treatment for gynaecological cancer. Psycho-oncology 21(1), 82-9	Exclude on evidence - no specific intervention of policy
Grunfeld Elizabeth A, Rixon Lorna, Eaton Emma, and Cooper Alethea F (2008) The organisational perspective on the return to work of employees following treatment for cancer. Journal of occupational rehabilitation 18(4), 381-8	Exclude on evidence - closed question survey

Reference	Reason for exclusion
Hadjisolomou Anastasios (2015) Managing attendance at work: The role of line managers in the UK grocery retail sector. Employee Relations 37(4), 442-458	Exclude on evidence - does not answer review questions
Haldorsen EM, Kronholm K, Skouen JS, and Ursin H (1998) Predictors for outcome of a multi-modal cognitive behavioural treatment program for low back pain patients-a 12-month follow-up study.. European journal of pain (London, and England) 2(4), 293-307	Exclude on intervention
Halonen J.I., Solovieva S., Virta L.J., et al. , (2018) Sustained return to work and work participation after a new leglislation obligating employers to notify prolonged sickness absence. Scan J Public Health. 46:65-73	Exclude – specific change in Finnish legislation
Hamberg-van Reenen, H H, Proper K I, van den Berg , and M (2012) Worksite mental health interventions: a systematic review of economic evaluations. Occupational and Environmental Medicine 69(11), 837-845	Exclude on evidence - systematic review
Hammond A, O'Brien R, Woodbridge S, Bradshaw L, Prior Y, Radford K, Culley J, Whitham D, and Pulikottil-Jacob R (2017) Job retention vocational rehabilitation for employed people with inflammatory arthritis (WORK-IA): a feasibility randomized controlled trial. Bmc Musculoskeletal Disorders 18,	Exclude on intervention
Hange D, Ariai N, Kivi M, Eriksson M, Nejati S, and Petersson E L (2017) The impact of internet-based cognitive behavior therapy on work ability in patients with depression - A randomized controlled study. International Journal of General Medicine 10, 151-159	Exclude on intervention
Hara Karen Walseth, Bjorngaard Johan Hakon, Brage Soren, Borchgrevink Petter Christian, Halsteinli Vidar, Stiles Tore Charles, Johnsen Roar, and Woodhouse Astrid (2017) Randomized Controlled Trial of Adding Telephone Follow-Up to an Occupational Rehabilitation Program to Increase Work Participation. Journal of occupational rehabilitation ,	Exclude on population
Hatanaka J (2016) The structure of occupational health nurses' support for return-to-work to workers with depression. Sangyo eiseigaku zasshi = Journal of occupational health 58(4), 109-117	Exclude on publication type
Haugli L, Steen E, Laerum E, Nygard R, and Finset A (2001) Learning to have less pain - is it possible? A one-year follow-up study of the effects of a personal construct group learning programme on patients with chronic musculoskeletal pain.. Patient education and counseling 45(2), 111-8	Exclude on intervention
Heber Elena, Ebert David Daniel, Lehr Dirk, Nobis Stephanie, Berking Matthias, and Riper Heleen (2013) Efficacy and cost-effectiveness of a web-based and mobile stress-management intervention for employees: design of a randomized controlled trial. BMC public health 13, 655	Exclude on intervention
Henderson M, Brooks S K, Del Busso , L , Chalder T, Harvey S B, Hotopf M, Madan I, and Hatch S (2012) Shame! Self-stigmatisation as an obstacle to sick doctors returning to work: A qualitative study. BMJ Open 2(5), e001776	Exclude on intervention
Higgins A, O'Halloran P, and Porter S (2012) Management of Long Term Sickness Absence: A Systematic Realist Review. Journal of Occupational Rehabilitation 22(3), 322-332	Exclude on evidence - Systematic realist review

Reference	Reason for exclusion
Higgins Angela, Porter Sam, and O'Halloran Peter (2014) General practitioners' management of the long-term sick role. Social science & medicine (1982) 107, 52-60	Exclude on intervention
Hoefsmit N, Houkes I, and Nijhuis F J. N (2012) Intervention Characteristics that Facilitate Return to Work After Sickness Absence: A Systematic Literature Review. Journal of Occupational Rehabilitation 22(4), 462-477	Exclude on evidence - Systematic review
Hoefsmit N., Houkes I., Boumans N., et al. (2016) The effectiveness of an intervention to enhance cooperation between sick-listed employees and their supervisors (COSS). J Occup Rehabil. 26:229-236	Exclude – small sample size, intervention in RCT evidence
Hoek Rianne J. A, Havermans Bo M, Houtman Irene L. D, Brouwers Evelien P. M, Heerkens Yvonne F, Zijlstra-Vlasveld Moniek C, Anema Johannes R, van der Beek , Allard J, and Boot Cecile R. L (2017) Stress Prevention@Work: a study protocol for the evaluation of a multifaceted integral stress prevention strategy to prevent employee stress in a healthcare organization: a cluster controlled trial. BMC public health 18(1), 26	Exclude on publication type
Hogarth T, Hasluck C, Gambin L, Behle H, Li Y, and Lyonette C (2013) Evaluation of employment advisers in the Improving Access to Psychological Therapies programme. : Department for Work and Pensions,	Exclude on publication type
Hogelund J, and Holm A (2006) Case management interviews and the return to work of disabled employees.. Journal of health economics 25(3), 500-19	Exclude on population
Hogelund J, Holm A, and Eplov L F (2012) The Effect of Part-time Sick Leave for Employees with Mental Disorders. Journal of Mental Health Policy and Economics 15(4), 157-170	Exclude on evidence - does not answer review questions
Hogelund Jan, Falgaard Eplov, and Lene (2017) Employment effects of a multidisciplinary health assessment for mentally ill persons - A quasi-randomised controlled trial. Scandinavian journal of public health , 1403494817723458	Exclude on intervention
Holland P, and Collins A M (2018) "Whenever I can I push myself to go to work": a qualitative study of experiences of sickness presenteeism among workers with rheumatoid arthritis. Disability Rehabilitation 40(4), 404-413	Exclude on evidence - no relevant outcomes reported
Holland Paula, and Collins Alison M (2018) "Whenever I can I push myself to go to work": a qualitative study of experiences of sickness presenteeism among workers with rheumatoid arthritis. Disability and rehabilitation 40(4), 404-413	Exclude on publication type
Holopainen K, Nevala N, Kuronen P, and Arokoski JP (2004) Effects of vocationally oriented medical rehabilitation for aircraft maintenance personnel - a preliminary study of long-term effects with 5 year follow-up. J Occup Rehabil. 14(4), 233-242	Exclude on intervention
Holzle P, Baumbach A, Mernyi L, and Hamann J (2018) Return to Work: A Psychoeducational Module - An Intervention Study. Psychiatrische Praxis 45(6), 299-306	Exclude on publication type
Hooson (2013) Patients' experience of return to work rehabilitation following traumatic brain injury: a phenomenological study. Neuropsychological rehabilitation, 23(1), pp.19-44.	Exclude on outcomes reported – qualitative study providing no outcomes on

Reference	Reason for exclusion
	perception of return to work interventions
Hou W H, Chi C C, Lo H L, Chou Y Y, Kuo K N, and Chuang H Y (2017) Vocational rehabilitation for enhancing return-to-work in workers with traumatic upper limb injuries. Cochrane Database of Systematic Reviews (12), 39	Exclude on evidence - systematic review
Hoving J L, Broekhuizen M L. A, and Frings-Dresen M H. W (2009) Return to work of breast cancer survivors: a systematic review of intervention studies. Bmc Cancer 9,	Exclude on evidence - systematic review
Hoving J L, Lacaille D, Urquhart D M, Hannu T J, Sluiter J K, and Frings-Dresen M H. W (2014) Non-pharmacological interventions for preventing job loss in workers with inflammatory arthritis. Cochrane Database of Systematic Reviews (11), 45	Exclude on evidence - systematic review
Hoving J L, Zoer I, Van Der Meer , M , Van Der Straaten , Y , Logtenberg-Rutten C, Kraak-Put S, De Vries , N , Tak P, Sluiter J K, and Frings-Dresen M (2014) E-health to improve work functioning in employees with rheumatoid arthritis in rheumatology practice: A feasibility study. Scandinavian Journal of Rheumatology 43(6), 481-487	Exclude on intervention
Howe E I, Langlo K P. S, Terjesen H C. A, Roe C, Schanke A K, Soberg H L, Sveen U, Aas E, Enehaug H, Alves D E, Klethagen P, Sagstad K, Moen C M, Torsteinsbrend K, Linnestad A M, Nordenmark T H, Rismyhr B S, Wangen G, Lu J, Ponsford J, Twamley E W, Ugelstad H, Spjelkavik , Lovstad M, and Andelic N (2017) Combined cognitive and vocational interventions after mild to moderate traumatic brain injury: Study protocol for a randomized controlled trial. Trials 18(1),	Exclude on publication type
Husabo Elisabeth, Monstad Karin, Holmas Tor Helge, Oyeflaten Irene, Werner Erik L, and Maeland Silje (2017) Protocol for the effect evaluation of independent medical evaluation after six months sick leave: a randomized controlled trial of independent medical evaluation versus treatment as usual in Norway. BMC public health 17(1), 573	Exclude on publication type
Irvine Annie (2011) Fit for work? The influence of Sick Pay and Job Flexibility on Sickness Absence and Implications for Presenteeism. Social Policy and Administration 45(7),	Exclude on evidence - does not answer review questions
Jensen AGC. (2013) A two-year follow-up bona a program theory of return to work intervention. Work. 44:165-175	Exclude – not a relevant intervention
Jensen C, Jensen O K, and Nielsen C V (2012) Sustainability of return to work in sick-listed employees with low-back pain. Two-year follow-up in a randomized clinical trial comparing multidisciplinary and brief intervention. Bmc Musculoskeletal Disorders 13, 9	Exclude on intervention
Jensen C, Jensen O K, Christiansen D H, and Nielsen C V (2011) One-Year Follow-Up in Employees Sick-Listed Because of Low Back Pain. Spine 36(15), 1180-1189	Exclude on intervention
Jensen C, Nielsen C V, Jensen O K, and Petersen K D (2013) Cost-Effectiveness and Cost-Benefit Analyses of a Multidisciplinary Intervention Compared With a Brief Intervention to Facilitate Return to Work in Sick-Listed Patients With Low Back Pain. Spine 38(13), 1059-1067	Exclude on intervention

Reference	Reason for exclusion
Jensen I, Dahlquist C, Nygren A, Royen E, and Stenberg M (1997) Treatment for 'helpless' women suffering from chronic spinal pain: A randomised controlled 18 month follow up study. Journal of Occupational Rehabilitation 7(4), 225-238	Exclude on intervention
Jensen IB., Bergstrom G., Ljungquist T., Bodin L. (2005) A 3-year follow-up of a multidisciplinary rehabilitation programme for back and neck pain. Pain. 115:273-283	Exclude on evidence - does not answer review questions
Jensen IB., Bodin L. (1998) Multimodal cognitive-behavioural treatment for workers with chronic spinal pain: a matched cohort study with an 18-month follow-up. Pain. 76:35-44	Exclude – small sample size, intervention in RCT evidence
Jensen L D, Maribo T, Schiottz-Christensen B, Madsen F H, Gonge B, Christensen M, and Frost P (2012) Counselling low-back-pain patients in secondary healthcare: a randomised trial addressing experienced workplace barriers and physical activity. Occupational and Environmental Medicine 69(1), 21-28	Exclude on population
Johansson Per, and Lindahl Erica (2012) Locking-in effects due to early interventions? An evaluation of a multidisciplinary screening programs for avoiding long-term sickness. Evaluation review 36(5), 323-45	Exclude on intervention
Johnsen T L, Indahl A, Baste V, Eriksen H R, and Tveito T H (2016) Protocol for the atWork trial: a randomised controlled trial of a workplace intervention targeting subjective health complaints. Bmc Public Health 16, 10	Exclude on intervention
Joosen M C. W, Frings-Dresen M H. W, and Sluiter J K (2013) Long-Term Outcomes Following Vocational Rehabilitation Treatments in Patients with Prolonged Fatigue. International Journal of Behavioral Medicine 20(1), 42-51	Exclude on intervention
Justesen J B, Sogaard K, Dalager T, Christensen J R, and Sjogaard G (2017) The Effect of Intelligent Physical Exercise Training on Sickness Presenteeism and Absenteeism among Office Workers. Journal of Occupational and Environmental Medicine 59(10), 942-948	Exclude on intervention
Kaldo V, Lundin A, Hallgren M, Kraepelien M, Strid C, Ekblom O, Lavebratt C, Lindefors N, Ojehagen A, and Forsell Y (2018) Effects of internet-based cognitive behavioural therapy and physical exercise on sick leave and employment in primary care patients with depression: two subgroup analyses. Occupational and Environmental Medicine 75(1), 52-58	Exclude on intervention
Karlson B., Jonsson P., Palsson B., et al. (2010) Return to work after a workplace-orientated intervention for patients on sick-leave for burnout – a prospective controlled study. BMC Public Health. 10:301	Exclude – partial sick leave
Karlson Bjorn, Jonsson Peter, Palsson Birgitta, Abjornsson Gunnel, Malmberg Birgitta, Larsson Britt, and Osterberg Kai (2010) Return to work after a workplace-oriented intervention for patients on sick-leave for burnout--a prospective controlled study. BMC public health 10, 301	Exclude on publication type
Karrholm Jenny, Ekholm Karolina, Ekholm Jan, Bergroth Alf, and Ekholm Kristina Schuldt (2008) Systematic co-operation between employer, occupational health service and social insurance office: A 6-year follow-up of vocational rehabilitation for people on sick-leave,	Exclude on intervention

Reference	Reason for exclusion
including economic benefits. Journal of Rehabilitation Medicine 40(8), 628-636	
Karstens S, Joos S, Hill J C, Krug K, Szecsenyi J, and Steinhauser J (2015) General Practitioners Views of Implementing a Stratified Treatment Approach for Low Back Pain in Germany: A Qualitative Study. Plos One 10(8), 14	Exclude on country - qualitative study from Germany
Kaufmann T, Wäschle R, Bauer M, and Schüpfer G (2010) Management of short-term absence in a hospital : empirical investigations for implementation of an intervention protocol. Der anaesthesist 59(5), 433-442	Exclude on publication type
Kausto J, Miranda H, Martimo K P, and Viikari-Juntura E (2008) Partial sick leave - review of its use, effects and feasibility in the Nordic countries. Scandinavian Journal of Work Environment & Health 34(4), 239-249	Exclude on publication type
Kausto J., Viikari-Juntura E., Virta L.J., et al. (2014) Effectiveness of new legislation on partial sickness benefit on work participation: a quasi-experimental in Finland. BMJ Open. 4:e006685	Exclude – specific change in Finnish legislation
Kausto J., Virta L.,Luukonen R., Viikari-Juntura E. (2010) Assocaitions between partial sickness benefit and disability pensions: initial findings of a Finnish nationwide register study. BMC Public Health. 10:361	Exclude – no intervention as such on helping return to work, Finland specific
Ketelaar S M, Schaafsma F G, Geldof M F, Boot C R. L, Kraaijeveld R A, Shaw W S, Bultmann U, Twisk J, and Anema J R (2017) Employees' Perceptions of Social Norms as a Result of Implementing the Participatory Approach at Supervisor Level: Results of a Randomized Controlled Trial. Journal of Occupational Rehabilitation 27(3), 319-328	Exclude on population
Ketelaar S M, Schaafsma F G, Geldof M F, Kraaijeveld R A, Boot C R. L, Shaw W S, Bultmann U, and Anema J R (2017) Implementation of the Participatory Approach for Supervisors to Increase Self-Efficacy in Addressing Risk of Sick Leave of Employees: Results of a Cluster-Randomized Controlled Trial. Journal of Occupational Rehabilitation 27(2), 247-257	Exclude on population
Keysor Julie J, LaValley Michael P, Brown Carrie, Felson David T, AlHeresh Rawan A, Vaughan Molly W, Yood Robert, Reed John I, and Allaire Saralynn J (2017) Efficacy of a Work Disability Prevention Program for People with Rheumatic and Musculoskeletal Conditions: The Work It Study Trial. Arthritis care & research ,	Exclude on intervention
Kidger Judi, Evans Rhiannon, Tilling Kate, Hollingworth William, Campbell Rona, Ford Tamsin, Murphy Simon, Araya Ricardo, Morris Richard, Kadir Bryar, Moure Fernandez, Aida , Bell Sarah, Harding Sarah, Brockman Rowan, Grey Jill, and Gunnell David (2016) Protocol for a cluster randomised controlled trial of an intervention to improve the mental health support and training available to secondary school teachers - the WISE (Wellbeing in Secondary Education) study. BMC public health 16(1), 1089	Exclude on intervention
Kittell J, and Karoff M (2008) Improvement of worklife participation through vocationally oriented cardiac rehabilitation? Findings of a randomized control group study. Rehabilitation 47(1), 14-22	Exclude on publication type

Reference	Reason for exclusion
Kraaijeveld R A, Schaafsma F G, Boot C R. L, Shaw W S, Bultmann U, and Anema J R (2013) Implementation of the Participatory Approach to increase supervisors' self-efficacy in supporting employees at risk for sick leave; design of a randomised controlled trial. Bmc Public Health 13,	Exclude on population
Kraaijeveld R A, Schaafsma F G, Ketelaar S M, Boot C R. L, Bultmann U, and Anema J R (2016) Implementation of the participatory approach for supervisors to prevent sick leave: a process evaluation. International Archives of Occupational and Environmental Health 89(5), 847-856	Exclude on population
Kroger C., Bode K., Wunsch E-M., et al. (2015) Work-related treatment for major depressive disorder and incapacity to work: preliminary findings of a controlled, matched study. J Occ Health Psych. 20:248-258	Exclude – small sample size, intervention in RCT evidence
Kroll Claudia, Doebler Philipp, and Nuesch Stephan (2017) Meta-analytic evidence of the effectiveness of stress management at work. European Journal of Work and Organizational Psychology 26(5), 677-693	Exclude on evidence - systematic review
Kuoppala J, and Lamminpaa A (2008) REHABILITATION AND WORK ABILITY: A SYSTEMATIC LITERATURE REVIEW. Journal of Rehabilitation Medicine 40(10), 796-804	Exclude on evidence - systematic review
Kuoppala J, Lamminpaa A, and Husman P (2008) Work Health Promotion, Job Well-Being, and Sickness Absences-A Systematic Review and Meta-Analysis. Journal of Occupational and Environmental Medicine 50(11), 1216-1227	Exclude on evidence - systematic review
Kuster A T, Dalsbo T K, Luong Thanh, Y B, Agarwal A, and Durand-Moreau Q V (2015) Web-based stress management for preventing stress and reducing sick leave in workers. Cochrane Database of Systematic Reviews 2015(10), CD011899	Exclude on publication type
Lagerveld S E, Blonk R W. B, Brenninkmeijer V, Wijngaards-de Meij, L , and Schaufeli W B (2012) Work-Focused Treatment of Common Mental Disorders and Return to Work: A Comparative Outcome Study. Journal of Occupational Health Psychology 17(2), 220-234	Exclude on intervention
Lam R W, Lutz K, Preece M, Cayley P M, and Walker A B (2011) Telephone-administered cognitive-behavioral therapy for clients with depressive symptoms in an employee assistance program: A pilot study. Annals of Clinical Psychiatry 23(1), 11-16	Exclude on intervention
Landstad BJ, Gelin G, Malmquist C, and Vinberg S (2002) A statistical human resources costing and accounting model for analysing the economic effects of an intervention at a workplace.. Ergonomics 45(11), 764-87	Exclude on intervention
Langbrandtner J, Raspe H, and Huppe A (2016) Employees with chronic diseases - Additional results of randomized controlled trial among adult members of a German statutory health insurance with inflammatory bowel diseases. Zeitschrift fur gastroenterologie 54(2), 139-145	Exclude on publication type
Lanhers Charlotte, Pereira Bruno, Gay Chloe, Herisson Christian, Levyckyj Christine, Dupeyron Arnaud, and Coudeyre Emmanuel (2016) Evaluation of the efficacy of a short-course, personalized self-management and intensive spa therapy intervention as active	Exclude on publication type

Reference	Reason for exclusion
prevention of musculoskeletal disorders of the upper extremities (Muska): a research protocol for a randomized controlled trial. BMC musculoskeletal disorders 17(1), 497	
Lardon A, Girard M P, Zaim C, Lemeunier N, Descarreaux M, and Marchand A A (2017) Effectiveness of preventive and treatment interventions for primary headaches in the workplace: a systematic review of the literature [with consumer summary]. Cephalalgia 2017 Jan, and37(1):64-73 ,	Exclude on evidence - systematic review
Larsen M.R., Aust B., Hogelund J. (2017) Improving the effectiveness of sickness benefit case management through a public-private partnership? A difference-in-deifference analysis in eighteen Danish municipalities. BMC Public Health. 17:329	Exclude – intervention Denmark specific
Leino P, Kivekas J, and Hanninen K (1994) Effects of work-oriented fitness courses in lumberjacks with low back pain. Journal of Occupational Rehabilitation 4(2), 67-75	Exclude on population
Lerner Debra, Adler David A, Rogers William H, Chang Hong, Greenhill Annabel, Cymerman Elina, and Azocar Francisca (2015) A Randomized Clinical Trial of a Telephone Depression Intervention to Reduce Employee Presenteeism and Absenteeism. Psychiatric Services 66(6), 570-577	Exclude on intervention
Lerner Debra, Adler David, Hermann Richard C, Chang Hong, Ludman Evette J, Greenhill Annabel, Perch Katherine, McPeck William C, and Rogers William H (2012) Impact of a Work-Focused Intervention on the Productivity and Symptoms of Employees With Depression. Journal of Occupational and Environmental Medicine 54(2), 128-135	Exclude on intervention
Letrilliart L, and Barrau A (2012) Difficulties with the sickness certification process in general practice and possible solutions: A systematic review. European Journal of General Practice 18(4), 219-228	Exclude on evidence - does not answer review questions
Letrilliart L, and Barrau A (2012) Difficulties with the sickness certification process in general practice and possible solutions: A systematic review. European Journal of General Practice 18(4), 219-228	Exclude on evidence - systematic review
Lewis M, Wynne-Jones G, Barton P, Whitehurst D G. T, Wathall S, Foster N E, Hay E M, van der Windt , and D (2015) Should General Practitioners Issue a Sick Certificate to Employees Who Consult for Low Back Pain in Primary Care?. Journal of occupational rehabilitation 25(3), 577-88	Exclude on evidence - does not answer review questions
Lexis Monique A. S, Jansen Nicole W. H, Huibers Marcus J. H, van Amelsvoort , Ludovic G P. M, Berkouwer Ate, Ton Gladys Tjin A, van den Brandt , Piet A, and Kant IJmert (2011) Prevention of long-term sickness absence and major depression in high-risk employees: a randomised controlled trial. Occupational and Environmental Medicine 68(6), 400-407	Exclude on intervention
Lie S A, Eriksen H R, Ursin H, and Hagen E M (2008) A multi-state model for sick-leave data applied to a randomized control trial study of low back pain. Scandinavian Journal of Public Health 36(3), 279-283	Exclude on intervention

Reference	Reason for exclusion
Lindsater E, Axelsson E, Salomonsson S, Santoft F, Ejeby K, Ljotsson B, Akerstedt T, Lekander M, and Hedman-Lagerlof E (2018) Internet-Based Cognitive Behavioral Therapy for Chronic Stress: A Randomized Controlled Trial. Psychotherapy and Psychosomatics 87(5), 296-305	Exclude on population
Linton S J, Boersma K, Jansson M, Overmeer T, Lindblom K, and Vlaeyen J W. S (2008) A randomized controlled trial of exposure in vivo for patients with spinal pain reporting fear of work-related activities. European Journal of Pain 2008 Aug, and12(6):722-730 ,	Exclude on evidence - no relevant outcomes reported
Linton Steven J, Boersma Katja, Traczyk Michal, Shaw William, and Nicholas Michael (2016) Early Workplace Communication and Problem Solving to Prevent Back Disability: Results of a Randomized Controlled Trial Among High-Risk Workers and Their Supervisors. Journal of occupational rehabilitation 26(2), 150-9	Exclude on population
Mackey S P, Diba R, McKeown D, Wallace C, Booth S, Gilbert P M, and Dheansa B S (2009) Return to work after burns: a qualitative research study. Burns : journal of the International Society for Burn Injuries 35(3), 338-42	Exclude on evidence - no specific intervention of policy
Malcolm RM., Harrison J., Forster H. (1993) Effects of changing the pattern of sickness absence referrals in a local authority. Occup Med. 1993:211-215	Exclude – small sample size, intervention in RCT evidence
Manas Israel Manas, Justo Clemente Franco, and Martinez Eduardo Justo (2011) Reducing levels of teacher stress and the days of sick leave in secondary school teachers through a mindfulness training programme. Clinica y salud 22(2), 121-137	Exclude on publication type
Martin Angela, Sanderson Kristy, Scott Jenn, and Brough Paula (2009) Promoting mental health in small-medium enterprises: an evaluation of the "Business in Mind" program. BMC public health 9, 239	Exclude on publication type
Martin M H. T, Nielsen M B. D, Madsen I E. H, Petersen S M. A, Lange T, and Rugulies R (2013) Effectiveness of a Coordinated and Tailored Return-to-Work Intervention for Sickness Absence Beneficiaries with Mental Health Problems. Journal of Occupational Rehabilitation 23(4), 621-630	Exclude on population
Martin M H. T, Nielsen M B. D, Pedersen J, and Rugulies R (2015) Stability of return to work after a coordinated and tailored intervention for sickness absence compensation beneficiaries with mental health problems: results of a two-year follow-up study. Disability and Rehabilitation 37(22), 2107-2113	Exclude on population
McEnhill Libby, Steadman Karen, and Bajorek Zofia (2016) Peer support for employment: a review of the evidence. : ,	Exclude on evidence - evidence review
McQueen J, and McFeely G (2017) Case management for return to work for individuals living with cancer: A systematic review. International Journal of Therapy and Rehabilitation 24(5), 203-210	Exclude on evidence - systematic review
Melton Larry, Anfield Robert, Kane Gail, White Nathan, Young Jeff, and Dunnington Katie (2012) Reducing the incidence of short-term disability: testing the effectiveness of an absence prediction and prevention intervention using an experimental design. Journal of occupational and environmental medicine 54(12), 1441-6	Exclude on intervention

Reference	Reason for exclusion
Merekoulias G, and Alexopoulos E C (2015) Prediction tools for sickness absenteeism. International Journal of Workplace Health Management 8(2), 142-151	Exclude on intervention
Merrick D, Sundelin G, and Stalnacke B M (2013) AN OBSERVATIONAL STUDY OF TWO REHABILITATION STRATEGIES FOR PATIENTS WITH CHRONIC PAIN, FOCUSING ON SICK LEAVE AT ONE-YEAR FOLLOW-UP. Journal of Rehabilitation Medicine 45(10), 1049-1057	Exclude on population
Mewes Janne C, Steuten Lotte M. G, Groeneveld Iris F, de Boer , Angela G E. M, Frings-Dresen Monique H. W, Ijzerman Maarten J, van Harten , and Wim H (2015) Return-to-work intervention for cancer survivors: budget impact and allocation of costs and returns in the Netherlands and six major EU-countries. BMC cancer 15, 899	Exclude on intervention
Meyer K, Fransen J, Huwiler H, Uebelhart D, Klipstein A (2005) Feasibility and results of a randomised pilot study of a work rehabilitation programme. Journal of Back and Musculoskeletal Rehabilitation 18: 67-78.	Exclude – data not usable
Mills Peter R, Kessler Ronald C, Cooper John, and Sullivan Sean (2007) Impact of a health promotion program on employee health risks and work productivity. American journal of health promotion : AJHP 22(1), 45-53	Exclude on intervention
Minicozzi Salvatore J, and Russell Brent S (2017) On-Site Chiropractic Care as an Employee Benefit: A Single-Location Case Study. Journal of chiropractic medicine 16(3), 183-188	Exclude on publication type
Mitchell RI, and Carmen GM (1994) The functional restoration approach to the treatment of chronic pain in patients with soft tissue and back injuries.. Spine 19(6), 633-42	Exclude on intervention
Molde Hagen E, Grasdal A, and Eriksen HR (2003) Does early intervention with a light mobilization program reduce long-term sick leave for low back pain: a 3-year follow-up study.. Spine 28(20), 2309-15; discussion 2316	Exclude on intervention
Moll L T, Jensen O K, Schiottz-Christensen B, Stapelfeldt C M, Christiansen D H, Nielsen C V, and Labriola M (2018) Return to Work in Employees on Sick Leave due to Neck or Shoulder Pain: A Randomized Clinical Trial Comparing Multidisciplinary and Brief Intervention with One-Year Register-Based Follow-Up. Journal of Occupational Rehabilitation 28(2), 346-356	Exclude on publication type
Momsen Anne-Mette H, Stapelfeldt Christina Malmose, Nielsen Claus Vinther, Nielsen Maj Britt D, Aust Birgit, Rugulies Reiner, and Jensen Chris (2016) Effects of a randomized controlled intervention trial on return to work and health care utilization after long-term sickness absence. BMC public health 16(1), 1149	Exclude on population
Momsen Anne-Mette Hedeager, Jensen Ole Kudsk, Nielsen Claus Vinther, and Jensen Chris (2014) Multiple somatic symptoms in employees participating in a randomized controlled trial associated with sickness absence because of nonspecific low back pain. The spine journal : official journal of the North American Spine Society 14(12), 2868-76	Exclude on intervention
Mortelmans AK., DOnceel P., Lahaye D., Bulterys S. (2006) Does enhanced information exchange between social insurance physicians	Exclude – intervention Belgium specific

Reference	Reason for exclusion
and occupation physicians improve patient work resumption? A controlled intervention study. Occup Environ Med. 63:495-502	
Munir Fehmidah, Kalawsky Katryna, Wallis Deborah J, and Donaldson-Feilder Emma (2013) Using intervention mapping to develop a work-related guidance tool for those affected by cancer. BMC public health 13, 6	Exclude on evidence - does not answer review questions
Munir Fehmidah, Yarker Joanna, and Haslam Cheryl (2008) Sickness absence management: encouraging attendance or 'risk-taking' presenteeism in employees with chronic illness?. Disability and rehabilitation 30(19), 1461-72	Exclude on evidence - evidence review
Munoz-Murillo A, Esteban E, Avila C C, Fheodoroff K, Haro J M, Leonardi M, and Olaya B (2018) Furthering the evidence of the effectiveness of employment strategies for people with mental disorders in europe: A systematic review. International Journal of Environmental Research and Public Health 15(5), 838	Exclude on publication type
Muschalla B (2017) Work-anxiety-coping intervention improves work-coping perception while a recreational intervention leads to deterioration: Results from a randomized controlled trial. European Journal of Work and Organizational Psychology 26(6), 858-869	Exclude on evidence - no relevant outcomes reported
Nelson Candace C, Shaw William, and Robertson Michelle (2016) Supervisors and presenteeism: How do supervisors accommodate and support skilled workers with chronic health concerns?. Employee Responsibilities and Rights Journal 28(4), 209-223	Exclude on country - qualitative study from USA
Netterstrom B., Bech P. (2010) Effect of a multidisciplinary stress treatment programme on the return to work rate for persons with work-related stress. A non-randomized controlled study from a stress clinic. BMC Public Health. 10:658	Exclude – participants not on sick leave, not a >4weeks for inclusion
Nevala Nina, Pehkonen Irmeli, Koskela Inka, Ruusuvuori Johanna, and Anttila Heidi (2015) Workplace accommodation among persons with disabilities: A systematic review of its effectiveness and barriers or facilitators. Journal of Occupational Rehabilitation 25(2), 432-448	Exclude on population
Neves Robson da Fonseca, Nunes Monica de Oliveira, and Magalhaes Lilian (2015) Interactions among stakehoklders involved in return to work after sick leave due to mental disorders: a meta-ethnography. Cadernos de saude publica 31(11), 2275-90	Exclude on evidence - low quality evidence (no quality assessment of included studies)
Nicholson P J (2018) Common mental disorders and work. British Medical Bulletin 126(1), 113-121	Exclude on publication type
Niemisto L, Rissanen P, Sarna S, Lahtinen-Suopanki T, Lindgren KA, and Hurri H (2005) Cost-effectiveness of combined manipulation, stabilizing exercises, and physician consultation compared to physician consultation alone for chronic low back pain: a prospective randomized trial with 2-year follow-up.. Spine 30(10), 1109-15	Exclude on intervention
Niessen M A. J, Kraaijenhagen R A, Dijkgraaf M G. W, Van Pelt , D , Van Kalken , C K, and Peek N (2012) Impact of a Web-Based Worksite Health Promotion Program on Absenteeism. Journal of Occupational and Environmental Medicine 54(4), 404-408	Exclude on intervention
Nieuwenhuijsen K, Faber B, Verbeek J H, Neumeyer-Gromen A, Hees H L, Verhoeven A C, van der Feltz-Cornelis , C M, and Bultmann U (2014) Interventions to improve return to work in	Exclude on evidence - systematic review

Reference	Reason for exclusion
depressed people. Cochrane Database of Systematic Reviews (12), 143	
Nieuwenhuijsen Karen, Schoutens Antonius M. C, Frings-Dresen Monique H. W, and Sluiter Judith K (2017) Evaluation of a randomized controlled trial on the effect on return to work with coaching combined with light therapy and pulsed electromagnetic field therapy for workers with work-related chronic stress. BMC public health 17(1), 761	Exclude on intervention
Nigatu Y T, Liu Y, Uppal M, McKinney S, Rao S, Gillis K, and Wang J (2016) Interventions for enhancing return to work in individuals with a common mental illness: systematic review and meta-analysis of randomized controlled trials. Psychological Medicine 46(16), 3263-3274	Exclude on evidence - systematic review
Noben C Y. G, Nijhuis F J. N, de Rijk , A E, and Evers Smaa (2012) Design of a trial-based economic evaluation on the cost-effectiveness of employability interventions among work disabled employees or employees at risk of work disability: The CASE-study. Bmc Public Health 12,	Exclude on publication type
Noben C, van Vilsteren , M , Boot C, Steenbeek R, van Schaardenburg , D , Anema J R, Evers S, Nijhuis F, de Rijk , and A (2017) Economic evaluation of an intervention program with the aim to improve at-work productivity for workers with rheumatoid arthritis. Journal of Occupational Health 59(3), 267-279	Exclude on intervention
Noben Cindy, Evers Silvia, Genabeek Joost van, Nijhuis Frans, de Rijk , and Angelique (2017) Improving a web-based employability intervention for work-disabled employees: results of a pilot economic evaluation. Disability and rehabilitation. Assistive technology 12(3), 280-289	Exclude on evidence - no relevant outcomes reported
Nogawa K, and Kojimahara N (2018) [Work accommodation at the time of Return-to-Work for workers on sick leave: a qualitative systematic review with recommendations for Return-to-work Guidance 2017]. Sangyo eiseigaku zasshi = Journal of occupational health ,	Exclude on publication type
Noordik Erik, van der Klink , Jac J L, Klingen Elmer F, Nieuwenhuijsen Karen, van Dijk , and Frank J H (2010) Exposure-in-vivo containing interventions to improve work functioning of workers with anxiety disorder: a systematic review. Bmc Public Health 10,	Exclude on evidence - systematic review
Norbye A D, Omdal A V, Nygaard M E, Romild U, Eldoen G, and Midgard R (2016) Do patients with chronic low back pain benefit from early intervention regarding absence from work? A randomized, controlled, single-center pilot study [with consumer summary]. Spine 2016 Nov 1, and41(21):E1257-E1264 ,	Exclude on publication type
Norbye A D, Omdal A V, Nygaard M E, Romild U, Eldoen G, and Midgard R (2016) Do Patients With Chronic Low Back Pain Benefit From Early Intervention Regarding Absence From Work?: A Randomized, Controlled, Single-Center Pilot Study. Spine 41(21), E1257-E1264	Exclude on intervention
Norlund A, Ropponen A, and Alexanderson K (2009) MULTIDISCIPLINARY INTERVENTIONS: REVIEW OF STUDIES OF	Exclude on evidence - systematic review

Reference	Reason for exclusion
RETURN TO WORK AFTER REHABILITATION FOR LOW BACK PAIN. Journal of Rehabilitation Medicine 41(3), 115-121	
Nystuen P, and Hagen KB (2006) Solution-focused intervention for sick listed employees with psychological problems or muscle skeletal pain: a randomised controlled trial [ISRCTN39140363].. BMC public health 6, 69	Exclude on intervention
Oakman J, Keegel T, Kinsman N, and Briggs A M (2016) Persistent musculoskeletal pain and productive employment; a systematic review of interventions. Occupational and Environmental Medicine 73(3), 206-214	Exclude on evidence - systematic review
O'Brien Kathryn, Cadbury Naomi, Rollnick Stephen, and Wood Fiona (2008) Sickness certification in the general practice consultation: the patients' perspective, a qualitative study. Family practice 25(1), 20-6	Exclude on evidence - does not answer review questions
Odeen M, Ihlebaek C, Indahl A, Wormgoor M E. A, Lie S A, and Eriksen H R (2013) Effect of Peer-Based Low Back Pain Information and Reassurance at the Workplace on Sick Leave: A Cluster Randomized Trial. Journal of Occupational Rehabilitation 23(2), 209-219	Exclude on intervention
Odeen M, Magnussen L H, Maeland S, Larun L, Eriksen H R, and Tveito T H (2013) Systematic review of active workplace interventions to reduce sickness absence. Occupational Medicine-Oxford 63(1), 7-16	Exclude on evidence - systematic review
Ojala B, Nygard C H, Huhtala H, and Nikkari S T (2017) Does perceived work ability improve after a cognitive behavioral intervention program?. Occupational Medicine 67(3), 230-232	Exclude on population
Olesen Mh, Høgelund J, and Mehlsen My (2014) Effects of a Self-management Course for Adults on Sick-leave; Outcomes in Registry Based Measures of Return to Work and Questionnaire Based Measures of Well-being and Quality of Life. Http://clinicaltrials.gov/show/nct02136056 ,	Exclude on publication type
Oleske Denise M, Lavender Steven A, Andersson Gunnar B. J, and Kwasny Mary Morrissey (2007) Are back supports plus education more effective than education alone in promoting recovery from low back pain?: Results from a randomized clinical trial. Spine 32(19), 2050-7	Exclude on population
Osilla Karen Chan, dela Cruz, Erin , Miles Jeremy N. V, Zellmer Steven, Watkins Katherine, Larimer Mary E, and Marlatt G Alan (2010) Exploring productivity outcomes from a brief intervention for at-risk drinking in an employee assistance program. Addictive behaviors 35(3), 194-200	Exclude on intervention
Oude Hengel, K M, Bosmans J E, Van Dongen , J M, Bongers P M, Van der Beek , A J, and Blatter B M (2014) Prevention program at construction worksites aimed at improving health and work ability is cost-saving to the employer: results from an RCT. American journal of industrial medicine 57(1), 56-68	Exclude on intervention
Oude Hengel, Karen M, Blatter Brigitte M, van der Molen , Henk F, Bongers Paulien M, van der Beek , and Allard J (2013) The effectiveness of a construction worksite prevention program on work ability, health, and sick leave: results from a cluster randomized	Exclude on intervention

Reference	Reason for exclusion
controlled trial. Scandinavian journal of work, and environment & health 39(5), 456-67	
Overland S, Grasdal A L, and Reme S E (2018) Long-term effects on income and sickness benefits after work-focused cognitive-behavioural therapy and individual job support: A pragmatic, multicentre, randomised controlled trial. Occupational and Environmental Medicine 75(10), 703-708	Exclude on population
Palmer K T, Harris E C, Linaker C, Barker M, Lawrence W, Cooper C, and Coggon D (2012) Effectiveness of community- and workplace-based interventions to manage musculoskeletal-related sickness absence and job loss: a systematic review. Rheumatology 51(2), 230-242	Exclude on evidence - systematic review
Palmer K, Coggon D, Linaker C, Harris E C, Barker M, Lawrence W, and Cooper C (2011) Effectiveness of community- and workplace-based interventions to manage musculoskeletal-related sickness absence and job loss: A systematic review. Occupational and Environmental Medicine , A62-A63	Exclude on evidence - systematic review
Park Joanne, Esmail Shaniff, Rayani Fahreen, Norris Colleen M, and Gross Douglas P (2017) Motivational Interviewing for Workers with Disabling Musculoskeletal Disorders: Results of a Cluster Randomized Control Trial. Journal of occupational rehabilitation ,	Exclude on intervention
Parry S P, Coenen P, O'Sullivan P B, Maher C G, and Straker L M (2017) Workplace interventions for increasing standing or walking for preventing musculoskeletal symptoms in sedentary workers. Cochrane Database of Systematic Reviews 2017(1), CD012486	Exclude on publication type
Pedersen P, Sogaard H J, Labriola M, Nohr E A, and Jensen C (2015) Effectiveness of psychoeducation in reducing sickness absence and improving mental health in individuals at risk of having a mental disorder: a randomised controlled trial. Bmc Public Health 15, 12	Exclude on population
Pedersen Pernille, Nielsen Claus Vinther, Jensen Ole Kudsk, Jensen Chris, and Labriola Merete (2017) Employment status five years after a randomised controlled trial comparing multidisciplinary and brief intervention in employees on sick leave due to low back pain. Scandinavian journal of public health , 1403494817722290	Exclude on intervention
Phoenix Nina, and Ghul Rayya (2016) Gender transition in the workplace: An occupational therapy perspective. Work: Journal of Prevention, and Assessment & Rehabilitation 55(1), 197-205	Exclude on evidence - does not answer review questions
Pincus Tamar, Woodcock Alison, and Vogel Steven (2010) Returning back pain patients to work: how private musculoskeletal practitioners outside the national health service perceive their role (an interview study). Journal of occupational rehabilitation 20(3), 322-30	Exclude on evidence - does not answer review questions
Poiraudeau S, Rannou F, and Revel M (2007) Functional restoration programs for low back pain: a systematic review. Annales de readaptation et de medecine physique : revue scientifique de la Societe francaise de reeducation fonctionnelle de readaptation et de medecine physique 50(6), 425-9, 419-24	Exclude on evidence - systematic review
Pomaki G, Franche R L, Murray E, Khushrushahi N, and Lampinen T M (2012) Workplace-Based Work Disability Prevention Interventions	Exclude on evidence - systematic review

Reference	Reason for exclusion
for Workers with Common Mental Health Conditions: A Review of the Literature. Journal of Occupational Rehabilitation 22(2), 182-195	
Poquet Nolwenn, Lin Chung-Wei Christine, Heymans Martijn W, van Tulder , Maurits W, Esmail Rosmin, Koes Bart W, and Maher Christopher G (2016) Back schools for acute and subacute non-specific low-back pain. The Cochrane database of systematic reviews 4, CD008325	Exclude on evidence - systematic review
Poulsen Otto M, Aust Birgit, Bjorner Jakob Bue, Rugulies Reiner, Hansen Jorgen V, Tverborgvik Torill, Winzor Glen, Mortensen Ole S, Helverskov Trine, Orbaek Palle, and Nielsen Maj Britt D (2014) Effect of the Danish return-to-work program on long-term sickness absence: results from a randomized controlled trial in three municipalities. Scandinavian Journal of Work Environment & Health 40(1), 47-56	Exclude on intervention
Provinciali L, Baroni M, Illuminati L, and Ceravolo MG (1996) Multimodal treatment to prevent the late whiplash syndrome.. Scandinavian journal of rehabilitation medicine 28(2), 105-11	Exclude on intervention
Rachman R, Bunce D, Thorley K, and Hendriksz J (2015) Patients' attitudes to sickness certification in general practice. Occupational medicine (Oxford, and England) 65(6), 485-8	Exclude on evidence - does not answer review questions
Radford K, Sutton C, Sach T, Holmes J, Watkins C, Forshaw D, Jones T, Hoffman K, O'Connor R, Tyerman R, Merchan-Baeza JA, Morris R, McManus E, Drummond A, Walker M, Duley L, Shakespeare D, Hammond A, and Phillips J (2018) Early, specialist vocational rehabilitation to facilitate return to work after traumatic brain injury: the FRESH feasibility RCT.. Health technology assessment (Winchester, and England) 22(33), 1-124	Exclude on evidence - no relevant outcomes reported
Radford K., Phillips J., Drummond A., et al, (2013) Return to work after traumatic brain injury: cohort comparison and economic evaluation. Brain Injury. 27:507-520	Exclude – participants in work at 4 weeks
Radford Kathryn A, Phillips Julie, Jones Trevor, Gibson Ali, Sutton Chris, Watkins Caroline, Sach Tracey, Duley Lelia, Walker Marion, Drummond Avril, Hoffman Karen, O'Connor Rory, Forshaw Denise, and Shakespeare David (2015) Facilitating return to work through early specialist health-based interventions (FRESH): protocol for a feasibility randomised controlled trial. Pilot and feasibility studies 1, 24	Exclude on evidence - protocol only
Rannard Anne, Gabbay Mark, Sen Dil, Riley Richard, and Britt David (2014) Feasibility trial of GP and case-managed support for workplace sickness absence. Primary health care research & development 15(3), 252-61	Exclude on evidence - no control group
Rantonen J, Vehtari A, Karppinen J, Luoto S, Viikari-Juntura E, Hupli M, Malmivaara A, and Taimela S (2014) Face-to-face information combined with a booklet versus a booklet alone for treatment of mild low-back pain: a randomized controlled trial. Scandinavian Journal of Work Environment & Health 40(2), 156-166	Exclude on intervention
Rashid M, Kristofferzon M L, Nilsson A, and Heiden M (2017) Factors associated with return to work among people on work absence due to long-term neck or back pain: A narrative systematic review. BMJ Open 7(6), e014939	Exclude on evidence - review of observational studies
Rasmussen Charlotte Diana Norregaard, Holtermann Andreas, Jorgensen Marie Birk, Orberg Anders, Mortensen Ole Steen, and	Exclude on intervention

Reference	Reason for exclusion
Sogaard Karen (2016) A multi-faceted workplace intervention targeting low back pain was effective for physical work demands and maladaptive pain behaviours, but not for work ability and sickness absence: Stepped wedge cluster randomised trial. Scandinavian journal of public health 44(6), 560-70	
Reed Kirk, and Kalaga Halina (2018) Focusing on employment in primary mental health care: A scoping review. Work (Reading, and Mass.) 59(1), 3-13	Exclude on evidence - scoping review
Reeuwijk Kerstin G, Robroek Suzan J. W, Niessen Maurice A. J, Kraaijenhagen Roderik A, Vergouwe Yvonne, and Burdorf Alex (2015) The Prognostic Value of the Work Ability Index for Sickness Absence among Office Workers. PloS one 10(5), e0126969	Exclude on evidence - correlation study
Rehwald K, Rosholm M, and Rouland B (2018) Labour market effects of activating sick-listed workers. Labour Economics 53, 15-32	Exclude on population
Reme S E, Tveito T H, Harris A, Lie S A, Grasdal A, Indahl A, Brox J I, Tangen T, Hagen E M, Gismervik S, Odegard A, Froyland L, Fors E A, Chalder T, and Eriksen H R (2016) Cognitive Interventions and Nutritional Supplements (The CINS Trial) A Randomized Controlled, Multicenter Trial Comparing a Brief Intervention With Additional Cognitive Behavioral Therapy, Seal Oil, and Soy Oil for Sick-Listed Low Back Pain Patients. Spine 41(20), 1557-1564	Exclude on intervention
Reme Silje Endresen, Grasdal Astrid Louise, Lovvik Camilla, Lie Stein Atle, and Overland Simon (2015) Work-focused cognitive-behavioural therapy and individual job support to increase work participation in common mental disorders: a randomised controlled multicentre trial. Occupational and environmental medicine 72(10), 745-52	Exclude on population
Richardson K M (2017) Managing employee stress and wellness in the new millennium. Journal of Occupational Health Psychology 22(3), 423-428	Exclude on publication type
Richmond Melissa K, Pampel Fred C, Wood Randi C, and Nunes Ana P (2017) The impact of employee assistance services on workplace outcomes: Results of a prospective, quasi-experimental study. Journal of occupational health psychology 22(2), 170-179	Exclude on evidence - does not answer review questions
Ridge Damien, Broom Alex, Kokanovic Renata, Ziebland Sue, and Hill Nicholas (2017) Depression at work, authenticity in question: Experiencing, concealing and revealing. Health (London, and England : 1997) , 1363459317739437	Exclude on evidence - seconady analysis of included studies
Riley R, Spiers J, Buszewicz M, Taylor A K, Thornton G, and Chew-Graham C A (2018) What are the sources of stress and distress for general practitioners working in England? A qualitative study. BMJ Open 8(1), 017361	Exclude on evidence - does not answer review questions
Rise M B, Skagseth M, Klevanger N E, Aasdahl L, Borchgrevink P, Jensen C, Tenggren H, Halsteinli V, Jacobsen T N, Loland S B, Johnsen R, and Fimland M S (2018) Design of a study evaluating the effects, health economics, and stakeholder perspectives of a multi-component occupational rehabilitation program with an added workplace intervention - a study protocol. Bmc Public Health 18, 11	Exclude on publication type
Roelofs Pepijn D. D. M, Bierma-Zeinstra Sita M. A, van Poppel , Mireille N M, Jellema Petra, Willemsen Sten P, van Tulder , Maurits W, van Mechelen , Willem , and Koes Bart W (2007) Lumbar supports	Exclude on intervention

Reference	Reason for exclusion
to prevent recurrent low back pain among home care workers: a randomized trial. Annals of internal medicine 147(10), 685-92	
Roelofs Pepijn D. D. M, Bierma-Zeinstra Sita M. A, van Poppel , Mireille N M, van Mechelen , Willem , Koes Bart W, van Tulder , and Maurits W (2010) Cost-effectiveness of lumbar supports for home care workers with recurrent low back pain: an economic evaluation alongside a randomized-controlled trial. Spine 35(26), E1619-26	Exclude on intervention
Roussel Nathalie A, Kos Daphne, Demeure Isaline, Heyrman Annette, De Clerck , Marleen , Zinzen Evert, Struyf Filip, and Nijs Jo (2015) Effect of a multidisciplinary program for the prevention of low back pain in hospital employees: a randomized controlled trial. Journal of back and musculoskeletal rehabilitation 28(3), 539-49	Exclude on intervention
Royal Emma, Reynolds Frances Ann, and Houlden Henry (2009) What are the experiences of adults returning to work following recovery from Guillain-Barre syndrome? An interpretative phenomenological analysis. Disability and rehabilitation 31(22), 1817-27	Exclude on intervention
Ruotsalainen Jani H, Verbeek Jos H, Mariné Albert, and Serra Consol (2015) Preventing occupational stress in healthcare workers. Cochrane Database of Systematic Reviews (4),	Exclude on evidence - systematic review
Russell Jill, Berney Lee, Stansfeld Stephen, Lanz Doris, Kerry Sally, Chandola Tarani, and Bhui Kamaldeep (2016) The role of qualitative research in adding value to a randomised controlled trial: lessons from a pilot study of a guided e-learning intervention for managers to improve employee wellbeing and reduce sickness absence. Trials 17(1), 396	Exclude on evidence - does not answer review questions
Ryan C, Bergin M, Chalder T, and Wells J S. G (2017) Web-based interventions for the management of stress in the workplace: Focus, form, and efficacy. Journal of Occupational Health 59(3), 215-236	Exclude on evidence - scoping review
S Bevan (2018) Improving health and employment outcomes through joint working. : Public Policy Institute for Wales,	Exclude on publication type
Sabariego C, Coenen M, Ito E, Fheodoroff K, Scaratti C, Leonardi M, Vlachou A, Stavroussi P, Brecelj V, Kovacic D S, and Esteban E (2018) Effectiveness of integration and re-integration into work strategies for persons with chronic conditions: A systematic review of European strategies. International Journal of Environmental Research and Public Health 15(3), 552	Exclude on publication type
Saha S, Grahn B, Gerdtham U G, Stigmar K, Holmberg S, and Jarl J (2018) Structured physiotherapy including a work place intervention for patients with neck and/or back pain in primary care: an economic evaluation. European Journal of Health Economics ,	Exclude on population
Sallis Anna (2010) Working towards a 'fit note': an experimental vignette survey of GPs. British Journal of General Practice 60(573),	Exclude on evidence - does not answer review questions
Salomonsson S, Hedman-Lagerlöf E, and Öst L G (2018) Sickness absence: a systematic review and meta-analysis of psychological treatments for individuals on sick leave due to common mental disorders. Psychological medicine , 1-12	Exclude on evidence - systematic review
Sanders T, et al. (2018) Acceptability of a vocational advice service for patients consulting in primary care with musculoskeletal pain: A	Exclude on intervention – no quantitative evidence is

Reference	Reason for exclusion
qualitative exploration of the experiences of general practitioners, vocational advisers and patients. Scandinavian Journal of Public Health, , pp.1403494817723194.	available for the intervention in this qualitative review
Sang Katherine J. C, Gyi Diane E, and Haslam Cheryl O (2011) Stakeholder perspectives on managing the occupational health of UK business drivers: a qualitative approach. Applied ergonomics 42(3), 419-25	Exclude on evidence - does not answer review questions
Satink T, Cup E H, Ilott I, Prins J, De Swart , B J, Nijhuis-Van Der Sanden, and M W (2013) Patients' views on the impact of stroke on their roles and self: A thematic synthesis of qualitative studies. Archives of Physical Medicine and Rehabilitation 94(6), 1171-1183	Exclude on publication type
Schaafsma F G, Whelan K, van der Beek , A J, van der Es-Lambeek , L C, Ojajarvi A, and Verbeek J H (2013) Physical conditioning as part of a return to work strategy to reduce sickness absence for workers with back pain. Cochrane Database of Systematic Reviews (8), 100	Exclude on evidence - systematic review
Schakenraad C H, Vendrig L, Sluiter J K, Veenstra W, and Frings-Dresen M H (2004) Evaluation of a multidisciplinary treatment for patients with chronic non-specific upper-limb musculoskeletal disorders: a pilot study.. Occupational Medicine 54(8), 576-578	Exclude on intervention
Schandelmaier S, Ebrahim S, Burkhardt S C. A, de Boer , W E L, Zumbrunn T, Guyatt G H, Busse J W, and Kunz R (2012) Return to Work Coordination Programmes for Work Disability: A Meta-Analysis of Randomised Controlled Trials. Plos One 7(11), 13	Exclude on evidence - systematic review
Scheenen M E, Visser-Keizer A C, De Koning , M E, Van Der Horn , H J, Van De Sande , P , Van Kessel , M , Van Der Naalt , J , and Spikman J M (2017) Cognitive Behavioral Intervention Compared to Telephone Counseling Early after Mild Traumatic Brain Injury: A Randomized Trial. Journal of Neurotrauma 34(19), 2713-2720	Exclude on intervention
Schiltenwolf M, Buchner M, Heindl B, von Reumont J, Muller A, and Eich W (2006) Comparison of a biopsychosocial therapy (BT) with a conventional biomedical therapy (MT) of subacute low back pain in the first episode of sick leave: a randomized controlled trial.. European spine journal : official publication of the European Spine Society, the European Spinal Deformity Society, and and the European Section of the Cervical Spine Research Society 15(7), 1083-92	Exclude on intervention
Schoutens Antonius M. C, Frings-Dresen Monique H. W, and Sluiter Judith K (2016) Design of a randomized controlled trial on the effect on return to work with coaching plus light therapy and pulsed electromagnetic field therapy for workers with work-related chronic stress. BMC public health 16, 597	Exclude on intervention
Schreuder Jolanda A. H, Roelen Corne A. M, van Zweeden , Nely F, Jongsma Dianne, van der Klink , Jac J L, and Groothoff Johan W (2011) Leadership styles of nurse managers and registered sickness absence among their nursing staff. Health care management review 36(1), 58-66	Exclude on evidence - correlation study
Schumacher L, et al. (2017) Usefulness and engagement with a guided workbook intervention (WorkPlan) to support work related goals among cancer survivors. BMC psychology, 5(1), pp.34.	Exclude on intervention – no quantitative evidence is available for the

Reference	Reason for exclusion
	intervention in this qualitative review
Schwarze Monika, Egen Christoph, Gutenbrunner Christoph, and Schriek Stephanie (2016) Early Workplace Intervention to Improve the Work Ability of Employees with Musculoskeletal Disorders in a German University Hospital-Results of a Pilot Study. Healthcare (Basel, and Switzerland) 4(3),	Exclude on intervention
Sennehed Charlotte P, Holmberg Sara, Axen Iben, Stigmar Kjerstin, Forsbrand Malin, Petersson Ingemar F, and Grahn Birgitta (2018) Early workplace dialogue in physiotherapy practice improved work ability at 1-year follow-up-WorkUp, a randomised controlled trial in primary care. Pain 159(8), 1456-1464	Exclude on population
Shaw W, Hong Q N, Pransky G, and Loisel P (2008) A literature review describing the role of return-to-work coordinators in trial programs and interventions designed to prevent workplace disability. Journal of Occupational Rehabilitation 18(1), 2-15	Exclude on evidence - systematic review
Shaw William S, Besen Elyssa, Pransky Glenn, Boot Cecile R. L, Nicholas Michael K, McLellan Robert K, and Tveito Torill H (2014) Manage at work: a randomized, controlled trial of a self-management group intervention to overcome workplace challenges associated with chronic physical health conditions. BMC public health 14, 515	Exclude on intervention
Shiri R, Martimo K P, Miranda H, Ketola R, Kaila-Kangas L, Liira H, Karppinen J, and Viikari-Juntura E (2011) The effect of workplace intervention on pain and sickness absence caused by upper-extremity musculoskeletal disorders. Scandinavian Journal of Work Environment & Health 37(2), 120-128	Exclude on intervention
Shultz IZ., Crook J., Berkowitz J., et al. (2008) A prospective study of the effectiveness of early intervention with high-risk back-injured workers – a pilot study. J Occup Rehabil. 18:140-151	Exclude – small sample size, intervention in RCT evidence
Simpson G W, Byrne P, Gabbay M B, and Rannard A (2015) Understanding illness experiences of employees with common mental health disorders. Occupational medicine (Oxford, and England) 65(5), 367-72	Exclude on evidence - does not answer review questions
Sinclair SJ, Hogg-Johnson SH, Mondloch MV, and Shields SA (1997) The effectiveness of an early active intervention program for workers with soft-tissue injuries. The Early Claimant Cohort Study.. Spine 22(24), 2919-31	Exclude on intervention
Siukola A, Virtanen P, Huhtala H, and Nygard C H (2011) Absenteeism following a workplace intervention for older food industry workers. Occupational medicine (Oxford, and England) 61(8), 583-5	Exclude on intervention
Sjobom V, and Marnetoft S U (2008) A new model for vocational rehabilitation at an organizational level -- a pilot study with promising results. Work (Reading, and Mass.) 30(2), 99-105	Exclude on evidence - does not answer review questions
Skoglund Ingmarie, Petersson Eva-Lisa, and Hange Dominique (2018) A bridge over troubled water? A qualitative study of primary care patients' experiences of a rehabilitation program. Journal of multidisciplinary healthcare 11, 457-466	Exclude on country - qualitative study from Sweden
Skouen J S, and Kvale A (2006) Different outcomes in subgroups of patients with long-term musculoskeletal pain. Norsk Epidemiologi 16(2), 127-135	Exclude on intervention

Reference	Reason for exclusion
Soeker Mogammad Shaheed, Wegner Lisa, and Pretorius Blanche (2008) I'm going back to work: back injured clients' perceptions and experiences of their worker roles. Work (Reading, and Mass.) 30(2), 161-70	Exclude on country - qualitative study from South Africa
Soeker Shaheed, Matimba Tandokazi, Machingura Last, Msimango Henry, Moswaane Bobo, and Tom Sinazo (2015) The challenges that employees who abuse substances experience when returning to work after completion of employee assistance programme (EAP). Work (Reading, and Mass.) 53(3), 569-84	Exclude on country - qualitative study from South Africa
Sogaard H J, and Bech P (2009) The effect on length of sickness absence by recognition of undetected psychiatric disorder in long-term sickness absence. A randomized controlled trial. Scandinavian Journal of Public Health 37(8), 864-871	Exclude on population
Sogaard H J, and Bech P (2010) The effect of detecting undetected common mental disorders on psychological distress and quality of life in long-term sickness absence: A randomised controlled trial. Scandinavian Journal of Public Health 38(8), 845-856	Exclude on intervention
Somville P R, and Mairiaux P (2015) Long-term work disability. Occupational risk factors and intervention strategies: A review. Archives Des Maladies Professionnelles Et De L Environnement 76(5), 458-467	Exclude on evidence - evidence review
Soukup MG, Glomsrod B, Lonn JH, Bo K, and Larsen S (1999) The effect of a Mensendieck exercise program as secondary prophylaxis for recurrent low back pain. A randomized, controlled trial with 12-month follow-up.. Spine 24(15), 1585-91; discussion 1592	Exclude on population
Squires H, Rick J, Carroll C, and Hillage J (2012) Cost-effectiveness of interventions to return employees to work following long-term sickness absence due to musculoskeletal disorders. Journal of Public Health 34(1), 115-124	Exclude on publication type
Stansfeld S A, Berney L, Bhui K, Chandola T, Costelloe C, Hounsome N, Kerry S, Lanz D, and Russell J (2015) Pilot study of a randomised trial of a guided e-learning health promotion intervention for managers based on management standards for the improvement of employee well-being and reduction of sickness absence: the GEM (Guided E-learning for Managers) study (Structured abstract). Public Health Research ,	Exclude on publication type
Stansfeld Stephen A, Berney Lee, Bhui Kamaldeep, Chandola Tarani, Costelloe Ceire, Hounsome Natalia, Kerry Sally, Lanz Doris, and Russell Jill (2015) Pilot study of a randomised trial of a guided e-learning health promotion intervention for managers based on management standards for the improvement of employee well-being and reduction of sickness absence: the GEM (Guided E-learning for Managers) study. ,	Exclude on population
Stansfeld Stephen A, Kerry Sally, Chandola Tarani, Russell Jill, Berney Lee, Hounsome Natalia, Lanz Doris, Costelloe Ceire, Smuk Melanie, and Bhui Kamaldeep (2015) Pilot study of a cluster randomised trial of a guided e-learning health promotion intervention for managers based on management standards for the improvement of employee well-being and reduction of sickness absence: GEM Study. BMJ open 5(10), e007981	Exclude on evidence - does not answer review questions

Reference	Reason for exclusion
Stapelfeldt C M, Christiansen D H, Jensen O K, Nielsen C V, Petersen K D, and Jensen C (2011) Subgroup analyses on return to work in sick-listed employees with low back pain in a randomised trial comparing brief and multidisciplinary intervention. Bmc Musculoskeletal Disorders 12, 13	Exclude on intervention
Stapelfeldt Christina M, Labriola Merete, Jensen Anders Bonde, Andersen Niels Trolle, Momsen Anne-Mette H, and Nielsen Claus Vinther (2015) Municipal return to work management in cancer survivors undergoing cancer treatment: a protocol on a controlled intervention study. Bmc Public Health 15,	Exclude on publication type
Steenstra I A, Ibrahim S A, Franche R L, Hogg-Johnson S, Shaw W S, and Pransky G S (2010) Validation of a Risk Factor-Based Intervention Strategy Model Using Data from the Readiness for Return to Work Cohort Study. Journal of Occupational Rehabilitation 20(3), 394-405	Exclude on publication type
Steenstra Ia, Anema Jr, Bongers Pm, Vet de Hc, Knol Dl, Loisel P, and Mechelen van W (2007) A workplace intervention, graded activity or both to prevent long-term sick leave for subacute back pain. A randomized controlled study. Nederlands tijdschrift fysiotherapie 117(6), 207-215	Exclude on publication type
Steenstra Ivan, Cullen Kimberley, Irvin Emma, Van Eerd , Dwayne , and team I W. H. Older Worker Research (2017) A systematic review of interventions to promote work participation in older workers. Journal of safety research 60, 93-102	Exclude on population
Steffens D, Maher C G, Pereira L S. M, Stevens M L, Oliveira V C, Chapple M, Teixeira-Salmela L F, and Hancock M J (2016) Prevention of Low Back Pain A Systematic Review and Meta-analysis. Jama Internal Medicine 176(2), 199-208	Exclude on evidence - systematic review
Stock S R, Nicolakakis N, Vezina N, Vezina M, Gilbert L, Turcot A, Sultan-Taieb H, Kathryn Sinden, R K, Denis M A, Delga C, and Beaucage C (2018) Are work organization interventions effective in preventing or reducing work-related musculoskeletal disorders? A systematic review of the literature. Scandinavian Journal of Work, Environment and Health, and Supplement 44(2), 113-133	Exclude on publication type
Streibelt M, and Bethge M (2014) Effects of intensified work-related multidisciplinary rehabilitation on occupational participation: a randomized-controlled trial in patients with chronic musculoskeletal disorders. International Journal of Rehabilitation Research 37(1), 61-66	Exclude on population
Streibelt M., Burger W., Nieuwenhuijsen K., Bethge M. (2018) Effectiveness of graded return to work after multimodal rehabilitation in patients with mental disorders: a propensity score analysis. J Occup Rehabil. 28:180-189	Exclude – rehabilitation as an inpatient programme
Sullivan MJ, Adams H, Rhodenizer T, and Stanish WD (2006) A psychosocial risk factor--targeted intervention for the prevention of chronic pain and disability following whiplash injury.. Physical therapy 86(1), 8-18	Exclude on intervention
Sun Yuanlu, Shigaki Cheryl L, and Armer Jane M (2017) Return to work among breast cancer survivors: A literature review. Supportive	Exclude on evidence - low quality evidence (no quality

Reference	Reason for exclusion
care in cancer : official journal of the Multinational Association of Supportive Care in Cancer 25(3), 709-718	assessment of included studies)
Taimela S, Aronen P, Malmivaara A, Sintonen H, Tiekso J, and Aro T (2010) Effectiveness of a Targeted Occupational Health Intervention in Workers with High Risk of Sickness Absence: Baseline Characteristics and Adherence as Effect Modifying Factors in a Randomized Controlled Trial. Journal of Occupational Rehabilitation 20(1), 14-20	Exclude on intervention
Taimela S, Justen S, Aronen P, Sintonen H, Laara E, Malmivaara A, Tiekso J, and Aro T (2008) An occupational health intervention programme for workers at high risk for sickness absence. Cost effectiveness analysis based on a randomised controlled trial. Occupational and Environmental Medicine 65(4), 242-248	Exclude on intervention
Taimela S, Malmivaara A, Justen S, Laara E, Sintonen H, Tiekso J, and Aro T (2008) The effectiveness of two occupational health intervention programmes in reducing sickness absence among employees at risk. Two randomised controlled trials. Occupational and Environmental Medicine 65(4), 236-241	Exclude on intervention
Tamminga S J, de Boer , Agem , Verbeek Jham, and Frings-Dresen M H. W (2010) Return-to-work interventions integrated into cancer care: a systematic review. Occupational and Environmental Medicine 67(9), 639-648	Exclude on evidence - systematic review
Tamminga S J, Hoving J L, Frings-Dresen M H. W, de Boer , and Agem (2016) Cancer@Work - a nurse-led, stepped-care, e-health intervention to enhance the return to work of patients with cancer: study protocol for a randomized controlled trial. Trials 17,	Exclude on publication type
Tamminga S J, van Hezel , S , de Boer , Agem , and Frings-Dresen M H. W (2016) Enhancing the Return to Work of Cancer Survivors: Development and Feasibility of the Nurse-Led eHealth Intervention Cancer@Work. Jmir Research Protocols 5(2),	Exclude on publication type
Telle Nils-Torge, Moock Jorn, Heuchert Sandra, Schulte Vivian, Rossler Wulf, and Kawohl Wolfram (2016) Job Maintenance through Supported Employment PLUS: A Randomized Controlled Trial. Frontiers in public health 4, 194	Exclude on evidence - no relevant outcomes reported
Theodore B R, Mayer T G, and Gatchel R J (2015) Cost-Effectiveness of Early Versus Delayed Functional Restoration for Chronic Disabling Occupational Musculoskeletal Disorders. Journal of Occupational Rehabilitation 25(2), 303-315	Exclude on population
Thijs Karin M, de Boer , Angela G E. M, Vreugdenhil Gerard, van de Wouw , Agnes J, Houterman Saskia, and Schep Goof (2012) Rehabilitation using high-intensity physical training and long-term return-to-work in cancer survivors. Journal of occupational rehabilitation 22(2), 220-9	Exclude on intervention
Thorslund KW. (2007) Solution-focused group therapy for patients on long-term sick leave. J Fam Psychotherapy. 18:11-24	Exclude – small sample size, intervention in RCT evidence
Tompa E, de Oliveira , C , Dolinschi R, and Irvin E (2008) A systematic review of disability management interventions with economic evaluations. Journal of Occupational Rehabilitation 18(1), 16-26	Exclude on evidence - systematic review

Reference	Reason for exclusion
Tompa E, Dolinschi R, de Oliveira , C , Amick B C, and Irvin E (2010) A Systematic Review of Workplace Ergonomic Interventions with Economic Analyses. Journal of Occupational Rehabilitation 20(2), 220-234	Exclude on evidence - systematic review
Toppinen-Tanner S, Bockerman P, Mutanen P, Martimo K P, and Vuori J (2016) Preventing sickness absence with career management intervention: A randomized controlled field trial. Journal of Occupational and Environmental Medicine 58(12), 1202-1206	Exclude on intervention
Torstensen T A, Ljungggren A E, Meen H D, Odl , E , Mowinckel P, and Geijerstam S (1998) Efficiency and costs of medical exercise therapy, conventional physiotherapy, and self-exercise in patients with chronic low back pain: A pragmatic, randomized, single-blinded, controlled trial with 1-year follow- up.. Spine 23(23), 2616-2624	Exclude on intervention
Trofimowicz S, and Hunter S (2014) Barriers to returning to work after stroke: A systematic review. International Journal of Stroke 9((Trofimowicz S.; Hunter S.) School of Health and Rehabilitation, Keele University, Stoke-on-Trent, U), 47	Exclude on publication type
Tsutsumi Akizumi, Shimazu Akihito, Eguchi Hisashi, Inoue Akiomi, and Kawakami Norito (2018) A Japanese Stress Check Program screening tool predicts employee long-term sickness absence: a prospective study. Journal of occupational health 60(1), 55-63	Exclude on evidence - no control group
Tyers C. et al. (2009) Organisational responsese to the HSE management standards for work-related stress:progress of the sector implementation plan phase 1. . Available at: http://www.employment-studies.co.uk/resource/organisational-responses-hse-management-standards-work-related-stress.	Exclude on evidence – does not answer review question
Ulrik Gensby, Thomas Lund, Krystyna Kowalski, Madina Saidj, Anne-Marie Klint, Jørgensen , Trine Filges, Emma Irvin, Benjamin C Amick, III, and Merete Labriola (2012) Workplace-based disability management programs for promoting return-to-work. Campbell Collaboration 8,	Exclude on evidence - systematic review
van der Giessen , R N, Speksnijder C M, and Helders P J. M (2012) The effectiveness of graded activity in patients with non-specific low-back pain: a systematic review. Disability and Rehabilitation 34(13), 1070-1076	Exclude on evidence - systematic review
van Duijn , M , Eijkemans M J, Koes B W, Koopmanschap M A, Burton K A, and Burdorf A (2010) The effects of timing on the cost-effectiveness of interventions for workers on sick leave due to low back pain. Occupational and Environmental Medicine 67(11), 744-750	Exclude on evidence - meta-analysis including studies with irrelevant intervention
van Duijn , Miranda , and Burdorf Alex (2008) Influence of modified work on recurrence of sick leave due to musculoskeletal complaints. Journal of rehabilitation medicine 40(7), 576-81	Exclude on publication type
van Geen , J W, Edelaar M J. A, Janssen M, van Eijk , and J T M (2007) The long-term effect of multidisciplinary back training - A systematic review. Spine 32(2), 249-255	Exclude on evidence - systematic review
van Middelkoop , M , Rubinstein S M, Kuijpers T, Verhagen A P, Ostelo R, Koes B W, van Tulder , and M W (2011) A systematic review on the effectiveness of physical and rehabilitation interventions for chronic non-specific low back pain. European Spine Journal 20(1), 19-39	Exclude on evidence - systematic review

Reference	Reason for exclusion
van Vilsteren , M , van Oostrom , S H, de Vet , H C W, Franche R L, Boot C R. L, and Anema J R (2015) Workplace interventions to prevent work disability in workers on sick leave. Cochrane Database of Systematic Reviews (10), 94	Exclude on evidence - systematic review
van Vilsteren , Myrthe , Boot Cecile R. L, Steenbeek Romy, van Schaardenburg , Dirkjan , Voskuyl Alexandre E, and Anema Johannes R (2012) An intervention program with the aim to improve and maintain work productivity for workers with rheumatoid arthritis: design of a randomized controlled trial and cost-effectiveness study. Bmc Public Health 12,	Exclude on intervention
van Wyk , B E, Pillay-Van Wyk, and V (2014) Preventive staff-support interventions for health workers. Cochrane Database of Systematic Reviews 2017(12), CD003541	Exclude on population
Varekamp I, van Dijk , and F J H (2010) Workplace problems and solutions for employees with chronic diseases. Occupational medicine (Oxford, and England) 60(4), 287-93	Exclude on publication type
Varekamp Inge, de Vries , Gabe , Heutink Annelies, van Dijk , and Frank J H (2008) Empowering employees with chronic diseases; development of an intervention aimed at job retention and design of a randomised controlled trial. BMC health services research 8, 224	Exclude on intervention
Vargas-Prada S, Demou E, Lalloo D, Avila-Palencia I, Sanati K A, Sampere M, Freer K, Serra C, and Macdonald E B (2016) Effectiveness of very early workplace interventions to reduce sickness absence: a systematic review of the literature and meta-analysis. Scandinavian Journal of Work Environment & Health 42(4), 261-272	Exclude on evidence - systematic review
Verbeek J, van der Weide W, van Dijk F (2002). Early occupational management of patients with back pain: a randomised controlled trial. Spine 17: 1844-1851	Exclude on population
Verhagen A P, Bierma-Zeinstra S M. A, Burdorf A, Stynes S M, de Vet , H C W, and Koes B W (2013) Conservative interventions for treating work-related complaints of the arm, neck or shoulder in adults. Cochrane Database of Systematic Reviews (12), 119	Exclude on evidence - systematic review
Verhagen A P, Karels C, Bierma-Zeinstra S M. A, Feleus A, Dahaghin S, Burdorf A, de Vet , H C W, and Koes B W (2007) Ergonomic and physiotherapeutic interventions for treating work-related complaints of the arm, neck or shoulder in adults. A Cochrane systematic review. Europa Medicophysica [Mediterranean Journal of Physical and Rehabilitation Medicine] 2007 Sep, and43(3):391-405 ,	Exclude on evidence - systematic review
Versloot JM, Rozeman A, van Son AM, and van Akkerveeken PF (1992) The cost-effectiveness of a back school program in industry. A longitudinal controlled field study.. Spine 17(1), 22-7	Exclude on population
Vikari-Juntura E., Virta LJ., Kausto J., et al. (2017) Leglislative change enabling use of early part-time sick leave enhanced return to work participation in Finland. Scand J Work Environ Health. 43:447-456	Exclude – specific change in Finnish legislation, not >4weeks sickness
Vogel N, Schandelmaier S, Zumbrunn T, Ebrahim S, de Boer , W E L, Busse J W, and Kunz R (2017) Return-to-work coordination programmes for improving return to work in workers on sick leave. Cochrane Database of Systematic Reviews (3), 105	Exclude on evidence - systematic review

Reference	Reason for exclusion
Vooijs M, Leensen M C. J, Hoving J L, Wind H, and Frings-Dresen M H. W (2015) Interventions to enhance work participation of workers with a chronic disease: a systematic review of reviews. Occupational and Environmental Medicine 72(11), 820-826	Exclude on evidence - systematic review
Wagner S L, Koehn C, White M I, Harder H G, Schultz I Z, Williams-Whitt K, Warje O, Dionne C E, Koehoorn M, Pasca R, Hsu V, McGuire L, Schulz W, Kube D, and Wright M D (2016) Mental Health Interventions in the Workplace and Work Outcomes: A Best-Evidence Synthesis of Systematic Reviews. International Journal of Occupational and Environmental Medicine 7(1), 1-14	Exclude on evidence - systematic review
Walker Vivienne, and Bamford David (2011) An empirical investigation into health sector absenteeism. Health services management research 24(3), 142-50	Exclude on evidence - does not answer review questions
Weckert C, Stern C, and Porritt K (2017) Experiences and expectations of return-to-work programs for nurses and midwives who have acquired a musculoskeletal disorder in the workplace: A qualitative systemic review protocol. JBI Database of Systematic Reviews and Implementation Reports 15(5), 1280-1287	Exclude on publication type
Weiler S W, Foeh K P, van Mark , A , Touissant R, Sonntag N, Gaessler A, Schulze J, and Kessel R (2009) Outpatient rehabilitation of workers with musculoskeletal disorders using structured workplace description. International Archives of Occupational and Environmental Health 82(4), 427-434	Exclude on publication type
Werner Erik L, Storheim Kjersti, Lochting Ida, and Grotle Margreth (2010) The COPE LBP trial: cognitive patient education for low back pain--a cluster randomized controlled trial in primary care. BMC musculoskeletal disorders 11, 33	Exclude on publication type
Williams R M, Westmorland M G, Lin C A, Schmuck G, and Creen M (2007) Effectiveness of workplace rehabilitation interventions in the treatment of work-related low back pain: A systematic review. Disability and Rehabilitation 29(8), 607-624	Exclude on evidence - systematic review
Wynne-Jones G, Mallen C D, Main C J, and Dunn K M (2010) Sickness certification and the GP: what really happens in practice?. Family practice 27(3), 344-50	Exclude on evidence - cross-sectional survey (no qualitiative data)
Wynne-Jones Gwenllian, Cowen Jemma, Jordan Joanne L, Uthman Olalekan, Main Chris J, Glozier Nick, van der Windt , and Danielle (2014) Absence from work and return to work in people with back pain: a systematic review and meta-analysis. Occupational and environmental medicine 71(6), 448-56	Exclude on evidence - systematic review
Wynne-Jones Gwenllian, Mallen Christian D, Main Chris J, and Dunn Kate M (2010) What do GPs feel about sickness certification? A systematic search and narrative review. Scandinavian journal of primary health care 28(2), 67-75	Exclude on evidence - low quality evidence (no quality assessment of included studies)
Yarker J, Munir F, Bains M, Kalawsky K, and Haslam C (2010) The role of communication and support in return to work following cancer-related absence. Psycho-oncology 19(10), 1078-85	Exclude on intervention
Zaman AnneClaire G. N. M, Tytgat Kristien M. A. J, Klinkenbijl Jean H. G, Frings-Dresen Monique H. W, de Boer , and Angela G E. M (2016) Design of a multicentre randomized controlled trial to evaluate	Exclude on publication type

Reference	Reason for exclusion
the effectiveness of a tailored clinical support intervention to enhance return to work for gastrointestinal cancer patients. Bmc Cancer 16,	
Zamanzadeh V, Valizadeh L, Rahmani A, Zirak M, and Desiron H (2018) Cancer survivors' experiences of return to work: A qualitative study. Psycho-oncology 27(10), 2398-2404	Exclude on country - qualitative study from Iran
Zampolini M, Bernardinello M, and Tesio L (2007) RTW in back conditions. Disability and Rehabilitation 29(17), 1377-1385	Exclude on evidence - evidence review

Appendix H – Research recommendations

The research recommendation resulting from consideration of the reducing recurrent short-term sickness absence can be found in evidence review C, the evidence review for facilitating return to work from long-term sickness absence. These research recommendations were developed by the committee on reviewing the evidence for both of these questions and considering the evidence gaps within these.

Appendix I – Expert testimony

I.1 The role of an occupational health and wellbeing service

Section A	
Name:	Giles Wright
Role:	Head of Service - Health & Wellbeing
Institution/Organisation (where applicable):	Occupational Health and Wellbeing
Guideline title:	Workplace health: long-term sickness absence and capability to work (Update)
Guideline Committee:	PHAC E
Subject of expert testimony:	The role of the Occupational Health and Wellbeing service in supporting the management of sickness absence and RTW at your NHS Trust
Evidence gaps or uncertainties:	1. How has the OH service contributed to achieving and maintaining the relatively low sickness absence rate in your Trust and what have been the key barriers and facilitators? Please include an outline of: • Mechanisms / pathways / triggers for referral; interventions offered, e.g. types of recommendations for self-care, workplace adjustments, breadth of signposting or referral to further specialist support/therapy services to assist employee's RTW • The proportion of referrals for frequent (i.e. recurrent) short-term sickness absence and for long-term absence. Is the reduction in absence rate attributable to a reduced frequency or duration of absence, or both? • Employee relations – ensuring the OH service is perceived as an impartial source of help and support • Any training / support provided for managers • Any support you provide outside the Trust - e.g. for SMEs that lack access to OH services. Does

	caseload / management differ from referrals within the Trust?

Section B

Summary testimony:

The occupational health and wellbeing service of Cambridge University Hospitals NHSFT provides its service both to the Trust's own workforce and to neighbouring NHS Trusts and other employers in the private, public and third sectors. The service benefits from having a multidisciplinary team including OH specialists, physiotherapy and psychiatry supported by experienced non-clinical leadership and administrative teams. It has developed a sustainable workforce model by 'growing its own' specialist OH staff and is the training centre for OH doctors in the East of England.

Workforce health has Board level engagement, interest and support. The CUH NHSFT sickness absence rates are consistently low compared to the NHS as a whole and compared against peers from the 'Shelford Group'. Anxiety, Stress and Depression is a growing reason for short term absence, particularly evident following the removal of 'other' category in the absence reporting system. Long term absence has been reducing gradually although psychological ill health is the biggest reason for LTA and growing. This is believed to be in part the result of reducing stigma, increasing awareness and a culture of care and support encouraging employees to report their ill health honestly and perhaps increased understanding of causation/symptoms they are experiencing. It is felt that 'true' and transparent reporting is a positive step in the journey to support the improvement of the workforce' mental wellbeing.

'Back problem' as a reason for absence has improved in recent years matched by improved NHS national staff survey scores for the Trust in respect of work related MSK issues. It is believed that this is in part due to increasing the provision of fast track physiotherapy, targeting areas with higher prevalence of cases and general increase in education and assessment.

Overall, the average 12 month absence duration has reduced from 7.45 days (October 2016) to 7.03 days (October 2018) over the last two years.

The Trust has strong values of together: safe, kind and excellent which its staff survey shows are consistently well known by the workforce. Policy and practice with regards to absence management is strongly focused on support. The approach is very much driven by all parties working together to achieve the goal of individuals being in work, healthy and productive. Since 2015-16 there has been a conscious effort to begin to educate and empower the workforce to be more aware of support services, tools and resources available which enable better health and wellbeing. The Trust has a range of self-referral routes including an Employee Assistance Programme, access to OH advice and fast track physiotherapy service for staff. Through OH there is also fast track access to psychiatry assessment.

For employees requiring formal occupational health support via management referral, this will typically occur after a period of absence or multiple short term absences, however there is an increasing anecdotal trend in managers feeling able to refer

based on their concerns and desire to support individuals earlier rather than waiting for particular policy triggers. This is considered to be a positive progressive step but it should be noted that this, of course, does cause demand pressures. It could also 'speak to' the traditional model of refer for intervention rather than self-managing locally within the team/department. This could be in-part due to line-managers lacking knowledge and or confidence, something the Trust is keen to make improvements in. The Trust believes that the best outcomes will come from managers feeling equipped to make early informal interventions with the formal pathways existing for employees who require the additional support. The working hypothesis the OH team are striving for is: 'If managers are empowered and equipped and prompt in nature then a given health issue may be prevented from having a greater impact on an individual and their work'.

It is felt that a successful outcome of a management referral case comes from the needs of all parties being considered carefully and appropriate recommendations made. The OH function plays a key role in 'brokering' the relationship between employee, manager, HR, GP and other medical/health professionals, as required. Within the Trust the working relationship between the HR/Employee Relations Team and OH Team is seen as very positive and the reputation of OH felt by managers has improved in recent years and feedback surveys suggest that recommendations given in response to a manager's referral are realistic and helpful.

If relationships are strained or difficult, adjustments are complex or progress is not being achieved as hoped OH organise case conferences with all parties present to discuss the issues and find a way forward, in a facilitated and positive way. The employee is pivotal to this process and included throughout.

The future direction will be further development of working in the prevention space, continuing to educate, sign-post and empower line managers in particular. The OH service hopes to continue to develop its resource to include a greater level of expertise in the mental health specialist area and how it continues to use data and insights to target 'hot spot' areas of the Trust and respond to emerging trends and health informatics.

References to other work or publications to support your testimony' (if applicable):

I.2 Support for employees with a mental health condition to return to and stay in work

Section A	
Name:	Chris Kingsbury & Claire Hodgkins
Role:	Partnerships Manager & Head of Operations for the Access to Work Mental Health Support Service
Institution/Organisation (where applicable):	Remploy Ltd
Guideline title:	Workplace health: long-term sickness absence and capability to work (Update)
Guideline Committee:	PHAC E
Subject of expert testimony:	Support for employees with a mental health condition to return to and stay in work

Evidence gaps or uncertainties:	• How do employees or employers access this support? Can referral come from elsewhere (e.g. GP, IAPT)?
	• Who is it for? (individual eligibility criteria re: length of condition; degree of functioning / impairment; employer criteria: SMEs? larger organisations?)
	• How does this support fit in with:
	  ○ Access to Work and the legal obligations of employers under the Equality Act?
	  ○ NHS and OH sources of support?
	• What types of support are provided and by whom? (please give details of how people are supported to return to work and stay in work; the background / training of people delivering the support intervention; modes of delivery; frequency & duration)
	• Evidence re: effectiveness; barriers & facilitators to delivery; acceptability to stakeholders

Section B

Summary testimony:

The Access to Work Mental Health Support Service was launched in December 2011 and is funded by the Department for Work and Pensions. It provides confidential vocational support, delivered by Vocational Rehabilitation Consultants (VRC), for employees with mental illness to help them to retain or regain their ability to participate at work, and is delivered at no cost to the individual.

All VRC's are experts in supporting people with mental health conditions and have completed their Certified Disability Management Professional qualification and are Mental Health First Aid Trained, with a small number coming from clinical backgrounds such as Occupational Therapy.

Remploy has delivered the service, which is a component of Access To Work, through two separate contracts (2011-18 and 2018-). During the previous contract more than 8,000 individuals were supported through the service. The current contract is delivered by two providers across England, Scotland and Wales.

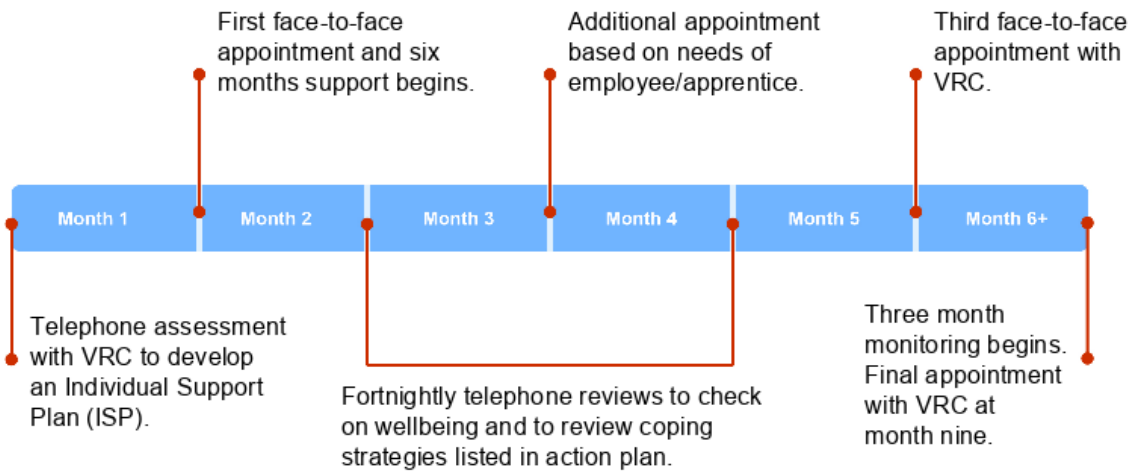
To access support, an individual must be in permanent or temporary employment and have a self-declared mental health condition (which can be either diagnosed or undiagnosed) that has resulted in workplace absence, or is causing difficulties for the individual to remain in work. Individuals who want to access the service must self-refer via a confidential helpline; email; the internet or by application to the DWP's Access to Work contact centre directly.

To promote the service, Remploy directly engages employers, including through use of free to access mental health webinars for HR professionals and line managers scheduled during lunchbreaks. More than 500 employers have joined these to date, and around 30% lead to referrals. We also directly engage HR and occupational health teams and provide materials for them to share with employees. The service typically compliments existing Occupational Health and Employee Assistance Programme support. In our experience, many of our referrals are made by employers making repeat use of the service after an initial positive experience.

Upon referral the individual will have an initial telephone interview with a VRC which establishes:

- The individual's job role, duties and responsibilities.
- The mental health condition and/or the symptoms the individual is experiencing.
- How the condition or symptoms are affecting the individual at work.
- Detail of the individual's responsibilities at work and targets that they may not be meeting.
- Whether the employer is aware of the difficulties the individual is experiencing
- What adjustments their employer may have already made for the individual
- Whether the individual have a clear idea of any help they require

After the initial telephone interview, eligible participants follow the client journey outlined in the below diagram:



Support and interventions available to individuals accessing the service include:

- Interventions such as:
  - Development of a Wellness Recovery Action Plan
  - Psychological wellbeing/self-esteem assessments
  - Mindfulness
  - Smartphone apps
  - Online CBT
  - Self-help
  - Resilience
  - Employer guidance for reasonable adjustments – Acting as a 3rd party can often help employers and employees reach agreements on adjustments or workplace accommodations
  - Application of interventions recommended by Occupational Health.
- Support through Access to Work funding including:
  - Holistic assessment
  - Job coaching
  - Support workers
  - Travel support
  - Training courses related to mental health.
- Signposting to external support, including:
  - Employee Assistance Programmes
  - GP support
  - Mental health charitable organisations

Under the previous contract (2011-18) Remploy successfully supported over 8,000 individuals through the service. Of these, 91% were still in employment after six months,

the main measure of programme success. The service supports individuals with a diverse range of conditions, including stress, anxiety, depression, bipolar and personality disorder. Of the cohort supported through the service, more than 70% had a secondary mental health condition. There was also 50% comorbidity with physical disability and health conditions.

This data is provided by the DWP and is based on the previous contract, which ended in August 2018. Public data for the current contract, which measures individuals still in work after 9 months, will not be available until a later date when official statistics are published.

References to other work or publications to support your testimony' (if applicable):

The report "Access to Work: Qualitative research with applicants, employers and delivery staff" commissioned by the DWP and written by IFF Research includes a section on applicant views on the effectiveness of the service, stating that "applicants felt that without AtW they would have been unable to remain in work. In some cases they had been on long term sick leave, with conditions that often made communication and making the steps towards a return to work particularly challenging. The tailored support they received through Remploy enabled them to progress towards a return to work or a new job"

I.3 Reducing sickness absence in the workplace

Section A	
Name:	Michael Whitmore
Role:	Research leader
Institution/Organisation (where applicable):	RAND Europe
Guideline title:	Workplace health: long-term sickness absence and capability to work (Update)
Guideline Committee:	PHAC E
Subject of expert testimony:	Reducing sickness absence in the workplace
Evidence gaps or uncertainties:	Please provide information on the following areas, where possible: • What key factors are associated with frequent short-term sickness absence in the UK? • What common and more innovative measures do employer organisations use to reduce rates of sickness absenteeism? • Is there evidence (unpublished / case studies, etc) for the effectiveness, barriers and facilitators or employee acceptability/engagement with such measures? • What are the key problems for research in this area and how could these be addressed? • What available options are there for SMEs that lack the resources to buy in their own EAP / OH provision to help them reduce sickness absence & support employees' RTW?
Section B	
Summary testimony:	

- **What key factors are associated with frequent short-term sickness absence in the UK?**

Top Issues

- MSK
- Mental health
- Poor job quality and management practices

Secondary Issues

- Sleep – Fatigue
- Alcohol
- Age

Financial Concern

Income

Emerging areas to consider more

- Platform working
- Menopause

Systems Issues - Employer/Employee/Population Health split

- Organisations push the responsibility of making improved lifestyle behaviour modifications onto the employee. Some organisations find this easier than to instigate their own cultural change to support this too e.g. revising management structures, training and job variety.
- Cross-sector support, to support sector-wide workforces could be better developed so that sector-wide issues can be addressed more specifically.

- **What common and more innovative measures do employer organisations use to reduce rates of sickness absenteeism?**

- Getting the basics right still might be the best thing to create strong impact in some organisations – it shouldn't be assumed a majority of organisations have got the basics in place well e.g. proactive OH, proactive communications of services and benefits to staff such as EAPs, proactive management support to staff.
- Use of incentive programmes is developing
- Digital enabled solutions are increasing – helps goal tracking
- Seeing wellbeing as a valid board level measurement as part of productivity metrics
- "Wellbeing is not about fruit": organisations are focussing on mental health and supporting employees to consider their whole selves and personal energy
- Visible senior sponsorship supports success

- **Is there evidence (unpublished / case studies, etc) for the effectiveness, barriers and facilitators or employee acceptability/engagement with such measures?**

- Key factors that determine the success of a workplace health promotion programme are commitment from leadership and senior management and making the health and wellbeing of staff an organisational priority.

- Aligns with previous work conducted by RAND Europe, which found that organisations that understand health and wellbeing as an indicator of organisational success generally have lower levels of absenteeism and presenteeism among their employees. Stepanek et el 2017 - The return of investment for preventive healthcare programmes.
- Promising practices for health and wellbeing at work (Whitmore et al 2018)

Also see:

https://www.vitality.co.uk/business/healthiest-workplace/findings/

https://www.ft.com/reports/health-at-work

https://whatworkswellbeing.org

- **What are the key problems for research in this area and how could these be addressed?**
  - In general there is little evidence specifically discussing practices in commissioning of workplace health published in academic journals.
  - How to evaluate workplace wellbeing programmes is a little more forthcoming but still relatively scarce.
  - The recognition that productivity is driven by staff wellbeing is in early stages but funding, such as that by the ESRC, is beginning to bridge the productivity gap.
  - Research agendas are not commonly led by employers or employees or their representatives.
  - There is a lack of clearly tracked health outcomes in workplace wellbeing. There is a new national workplace health workforce across the country funded by business – who knows if they're supported and effective in achieving health outcomes?

- **What available options are there for SMEs that lack the resources to buy in their own EAP / OH provision to help them reduce sickness absence & support employees' RTW?**

Enablers

- Shorter communication pathways and horizontal hierarchies
- Facilitate open discussions
- Managers able to act as role models increases their impact on the staff as they're in closer organisational proximity

Challenges

- Lack of time, financial resources and personnel
- Lack of strategic workplace health system and lead
- Legal and bureaucratic hurdles

Overcoming barriers

- Engagement with external stakeholders
- Participation in sector or regional associations e.g. local PHE representatives, regional health and work awards, Federation of Small Business. This

improves health and work knowledge and share ideas about implementation and best practice. Also it may improve access to external support to advise and establish in-house approaches and planning e.g. where public sector workers have an element of workplace health and wellbeing support in their remit.

- Consolidate efforts with other local employers to buy in OH provision. Some organisations target their offer to SME organisations - purchasing organisations could pool together their research of the market offerings, as well as agreeing a group-purchase approach with preferred providers.

References to other work or publications to support your testimony' (if applicable):

RAND Europe's partnership to provide VitalityHealth Britain's Healthiest Workplace, an annual health and wellbeing survey across the UK built up over a 6 year period.

I.4 Support available for return to work and workplace adjustment passports

Section A	
Name:	Angela Matthews
Role:	Head of Policy & Advice
Institution/Organisation (where applicable):	Business Disability Forum
Guideline title:	Workplace health: long-term sickness absence and capability to work (Update)
Guideline Committee:	PHAC E
Subject of expert testimony:	Support available from BDF for sickness absence / RTW management; use of workplace adjustment passports
Evidence gaps or uncertainties:	What forms of advice and support are offered by your organisation to businesses and how is this accessed? Please include an outline of: • Characteristics of businesses seeking advice/support – size, industry sectors, etc. • Most frequent types of advice/support sought • How is 'success' measured in relation to the support you offer • What are the key barriers and facilitators to ensuring successful outcomes from the support offered • What are workplace disability / adjustment passports; how can they support management of sickness absence and RTW in employees with a disability or health condition; information on uptake, promotion, acceptability, barriers and facilitators to implementation, etc.
Section B	
Summary testimony:	

A brief history of Workplace Adjustment Passports (WPA Passports)

WPA passports emerged in the 1990s when Business Disability Forum (then called Employers Forum on Disability) worked with the MS Society to produce a document for managers and employees to each have a record of agreed workplace adjustments support. This was designed particularly with fluctuating conditions (such as MS) in mind, where different support might be needed at times when an employee's symptoms are more pronounced than at other times. This document was then called a "Tailored Adjustments Agreement".

Very soon after this, BT quickly adopted its use and named it "Disability Passport". They also developed a similar document for employees with caring responsibilities (called a "Carer's Passport").

In 2013, many Civil Service Department's started using what they also called a "Disability Passport" and, in 2015, Cabinet Office published their Talent Action Plan which announced a move to one single and unified disability passport across all Civil Service Departments.

As adjustments management became a more embedded feature of workplace inclusion, organisations started to record details of adjustments in central management systems. As organisations became more sophisticated with their diversity practices and moved away from disability inclusion as 'legal duty' and instead towards wanting to engage and recruitment more diversely, the language of "agreement" became a term that felt 'at tension' with trying to adopt collaborative and supportive discussions. We then therefore changed the language, meaning the "Tailored Adjustments Agreement" became the "Tailored Adjustments Plan".[a]

The Tailored Adjustments Plan (or WPA passport) is now the document most requested by our Advice Service, alongside our resource to help employers decide what is 'reasonable'.

The purpose of WPA passports

There are three main purposes of the WPA passport:

1. To facilitate the portability of adjustments – i.e. when an employee moves teams or when line managers change, a passport would mean the employee does not have to go through discussing adjustments or how their disability impact them at work again. Employers find this increasingly unhelpful, though; as resources increasingly reduce, not every team can work in the same way, even within the same organisation, meaning we increasingly hear adjustments are now less portable between teams. Many employers therefore tell us portability is increasingly less of an option to them.
2. To structure a conversation about adjustments and support between the employee and people manager.
3. To plan for when an employee is unwell or needs additional support because of their disability or condition. Sections of the passport are designed to inform the people manager what to do when the employee has (for example) becomes mentally unwell or has a seizure, and how to keep in touch in the employee needs to go off sick.

Use of WPA passports

[a] We are currently reviewing our TAA document (see Appendix 2 below) and are likely to change the name (to be confirmed).

WPA passports are used across many sectors, but the most prominent use across a whole sector is in the Civil Service. Although, as above, the passport is the resource our Advice Service send out to employers the most, we know employers do not always use it consistently or in its entirety. For example, we know employees sometimes extract some of its content into their own people management guidance and procedures, or they will use it only in cases where communication has broken down between the employee and people manager, or where the manager is 'new' to managing disabled employees.

The passport is often voluntary; as above, not all employees like passports or like having a specific document that focusses on their condition in addition to their HR record. For this reason, some employers operate a 'voluntary' passport practice, whereby employees can 'opt' to use a passport if they want to.[b] There are, however, management difficulties with this, and our research shows often that where passports are 'voluntary', there is usually an inconsistent experience of workplace support which disabled employees find unhelpful. Some employers also operate 'voluntary' passport option as part of a pilot period to trail the use of passports.

The passport was originally created to be a 'live' document, 'owned' by the employee. However, this does not always work in practice. Our Advice Service hear of many cases which indicate it is more common for managers to introduce the passport to employees, and where employees are often reluctant to participate in completing a passport. We also hear of cases where employees want to have a conversation with their manager which uses the passport structure, but they do not want their passport shared beyond them and their manager or being kept on their HR file.[c]

The WPA passport necessarily sits outside of the workplace adjustments *process*. There can be an assumption that the WPA passport is the basis of a workplace adjustments process, but this is inaccurate. Although passports can be a helpful *feature* of a fit for purpose, centralised WPA process, passports cannot fulfil the duty of employers to make adjustments alone. Some employees who have good retention rates and an effective WPA process do not use passports, and some organisations who use passports do not have an effective WPA process. **The difference between extended periods of sickness absence and good employee retention is the WPA *process*, not the passport.**

Return to work and conclusions

Return to work practices need much improvement across all sectors. This essentially affects the likeliness of the employee returning to work. Some of the most common adjustments-related 'sore spots' in return to work processes are:

- The WPA process is generally practiced as support for employees when they are 'at work'. WPA conversations and support needs significant improvement during periods of an employee's long-term sickness period. All too often, the WPA process 'wakes up' again on Day One of the employee coming back to work, or if a phased return is suggested (because then occupational health generally tend to

[b] There are, however, management difficulties with this, and our research shows often that where passports are 'voluntary', there is usually an inconsistent experience of workplace support which disabled employees find unhelpful. Some employers also operate 'voluntary' passport option as part of a pilot period to trail the use of passports.

[c] This is, however, often the case when workplace support for a disabled employee has started 'too late' and by the time the passport is introduced, trust and communication between the employee and people manager or HR is already compromised.

get involved and the 'prompting' of adjustments is therefore introduced to the people manager or HR by them).

- Communication often breaks down when an employee is signed off sick. A huge number of calls to our Advice Service are from HR teams or people managers asking us how they should get *back* in touch with an employee who has been on long-term sick leave. We often see an employee declines to communicate with the employer during sickness absence (particularly when absence is due to work-related stress, which very many are) – even when arrangements for communicating during absence have been previously agreed in a WPA passport.
- Passports and the WPA process generally work for people who *already have* a condition or disability (and who have shared this information with their people manager). In many organisations, the WPA process and WPA passport work less well when an employee is off sick because they are 'newly' disabled or have recently acquired a condition (particularly as it is common or an employee not share information about a new condition until they have a confirmed diagnosis or prognosis). Often, employees are off work while waiting for a diagnostic assessment or waiting for a diagnosis from a NHS specialist; a phase which WPA processes do not always adequately address, and which is also often 'too soon' for a WPA passport to be agreed (because impact of the condition at work, or what would help, is not yet known).