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**Department for Work and Pensions**

**Research Report No 339**

# **Experiences of the Job Retention and Rehabilitation Pilot**

**Christopher Farrell, Katharine Nice, Jane Lewis and Roy Sainsbury**

A report of research carried out by the National Centre for Social Research and Social Policy Research Unit at the University of York, on behalf of the Department for Work and Pensions

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# Summary

## Chapter 1: Introduction

This report presents findings from qualitative research with participants in the Job Retention and Rehabilitation Pilot (JRRP) and staff of organisations providing job retention and rehabilitation services. The JRRP was developed by the Department for Work and Pensions (DWP) to test interventions which might decrease the length of time people spend away from work through sickness and increase job retention for people with a health condition or impairment. The pilot ran as a randomised controlled trial for a period of two years from April 2003 in six areas of the UK.

Participants in the pilot were assigned randomly to one of three intervention groups or to a control group. The three intervention groups were:

- health intervention group – providing only services to address participants' health conditions;
- workplace intervention group – providing services to address workplace issues;
- combined intervention group – providing both health and workplace services.

This report draws on three data sources: a longitudinal panel study of 36 participants in the pilot, in-depth interviews with 46 people allocated to the control group, and a study involving staff from the JRRP provider organisations.

Using these three studies, the report explores the experiences of clients and provider staff of receiving and providing services and, from their different perspectives, perceptions of the impact<sup>1</sup> of the pilot on people's job retention and rehabilitation. Lessons for future policy thinking are also drawn.

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<sup>1</sup> Throughout the report, references to the 'impact' are based on the perceptions and assessments of study participants. Impact should, therefore, be understood as changes they ascribe to JRRP – not as statistical estimates of net impacts, for which see Purdon *et al.* (2006).

## Chapter 2: Taking sick leave and being off sick from work

Drawing on data from the longitudinal panel and control group studies, Chapter 2 reports that people's absences were generally not planned and that people were sometimes reluctant to take time off work. People described how being off sick from work had made them feel bored, frustrated, isolated and guilty, and how longer-term absence had begun to have a negative impact on their mental health or wellbeing. Being off work for an extended period also had financial implications for some, which could lead people to return to work before they were ready.

In terms of the health care services they received outside JRRP, people reported contact with and treatment from GPs and referrals for scans, consultations, and specialist treatments. GPs were generally supportive of people's judgements that they were not well enough to be in work and so were willing to provide the necessary sickness certificates. However, there was a common feeling among those interviewed that it was not their GP's role to advise them on when they might be ready to return to work. There was evidence that some GPs managed people's health care more actively than others. Whilst some people reported improvements in their health as a result of the NHS help they received, others experienced long waits for the scans or treatment they needed. In response to this, some people were able to access private treatment in order to speed up their treatment, whereas others had had to wait until treatment became available on the NHS.

Contact with line managers was varied in terms of how often it took place, its tone and content, the form it took and how it made people feel about returning to work. Those who had regular contact with line managers which focused on their health and wellbeing more than on when they expected to return to work, were generally more positive about returning to work. Experiences of employer occupational health services were also mixed and there was an underlying feeling of distrust among all those in receipt of occupational health support, at least initially. People also received support from colleagues, union representatives, family and friends and services provided by Jobcentre Plus.

## Chapter 3: Using the provider services

People mainly heard about the JRRP services from GP practices, other health care providers, employers and trades unions. At the stage of making contact, their knowledge of what type of help was available was generally limited. People did not always have clear reasons for contacting the services, nor clear ideas of what help they wanted. Where they did have a specific aspiration, it generally related to health care, and it seemed to be difficult for people to envisage workplace help in particular. The process of making contact was generally smooth, although there were some misunderstandings of the concept of randomisation. People on the whole understood which intervention group they had been assigned to. Reactions to being in the control group varied considerably from mild disappointment to strongly expressed frustration.

People described a range of health and workplace services. Particularly well received were psychological therapies, physical therapies, help with NHS case management, complementary therapies, support in negotiations with employers, and workstation or functional capacity assessments and advice. Both individual types and more extensive combinations of help could be useful. The case manager role emerged as an important element of the service. Although not everyone described a very positive relationship with a case manager, and there were some suggestions that the relationship could become one of dependency, in general the emotional and practical help it involved was highly valued.

People were generally positive about the staff they met, the premises and the pace at which help was provided, and could be particularly impressed by how it compared with NHS provision. They were happy with the proposals for help made by staff, although they did not appear to have been very actively involved in making decisions about the help they would receive.

They also seemed, on the whole, to look to staff to maintain contact, rather than initiating it themselves, although there were exceptions to this. Contact sometimes fell away if staff did not maintain it, and this could leave people somewhat in limbo, waiting to hear from a provider or uncertain about whether they would be contacted again. The extent to which people's needs were met varied across the sample. However, gaps in service provision arose in a number of ways: from a type of help being unavailable because of the intervention group, dwindling contact, or where a particular type of help appeared, from the client's account, not to have been offered, sometimes (they had been told) for financial reasons.

## Chapter 4: Employment outcomes and the perceived impact of JRRP

Chapter 4 is divided into two parts. The first half looks at the experiences of those who went back to work and the second half the experiences of those who did not go back to work. The chapter draws on the experiences of people in the control group and JRRP participants.

Motivations, developments in health and fitness and the availability and suitability of work all influenced people's decisions to return to work. Financial pressures and fears about job security were key reasons why some people went back to work before they were fit enough. For others, a return to work had happened as a result of some improvement in health, as a result of NHS or privately provided treatments, treatments provided through JRRP, and as a result of rest and being away from the stresses and strains of work. Others saw more limited improvements to health due to incurable conditions, treatment being held back by a lack of diagnosis or waiting lists, treatments not being offered and ineffective treatments.

Returns to original jobs were the most common route back to work for those who went back to work, and these were aided by the availability of light duties and

phased returns. Redeployment and finding alternative work were much less common routes to work for those who went back to work.

Overall, improvements to health were what allowed people to go back to work and this is where they felt that JRRP had the most impact. People's experiences of being back at work were mixed and some people were unable to sustain a return to work due to difficult relations with employers, a lack of return to work support such as phased returns or light duties, or as a result of having returned to work too soon due to financial or job worries.

Persistent health problems and difficulties in finding suitable work were the barriers to returning to work among those who did not return to work. People felt unfit to work because their health conditions had not seen a significant improvement. Health was not a barrier for everyone, however, as some people had seen improvements in their health and felt fit enough to return to work, thanks to NHS, private health care and JRRP interventions.

Not having suitable work to go back to was a barrier to returning to work both for those who did feel fit enough to work and those who did not. Where people were still employed at the time of interview, being unsure of whether they could go back to work due to poor relations with their employers or incomplete redeployment or redundancy negotiations remained a barrier. Not everyone was still employed, however. People had become unemployed through dismissals and retirements on the grounds of ill health, and one case of early retirement.

Among those who were no longer employed, some were too ill to consider a return to work whereas others were applying for jobs or studying to gain skills for planned new jobs. Where people had not gone back to work, the impact of JRRP was constrained by the fact that contact with service providers tailed off, the help available from JRRP was patchy or ineffective, or because no help was made available. There were some suggestions in the data that people in the control group may have been more active in pursuing a return to work. It is possible that, while JRRP clients looked to the services for a lead, the absence of an alternative source of help provided an impetus for some in the control group to take the lead themselves.

## Chapter 5: What works? The staff perspective

Chapters 5 and 6 draw on data from discussions with frontline staff and managers from provider organisations.

In answering the question 'what works' in delivering a job retention service, a number of approaches in working with clients, services, key actors and working relationships were identified by staff as important. Above all else, staff felt it was important to be responsive to individual clients' needs. In addition, important elements in the way they worked with clients were the capacity to intervene early, focusing on the client at all times, taking an holistic approach and trying to tackle a range of problems in a coordinated fashion, tailoring packages of support for

individuals, being readily available to talk to clients, having the flexibility to spend money as required, and providing quick access to intensive and focused interventions.

A number of services and interventions were identified by staff as having been effective for clients, either on their own or in combination with others. Amongst the health interventions discussed here were psychological therapies, physiotherapy, access to specialist medical help, complementary therapies and exercise programmes and facilities. Staff said positive changes in mobility, mental health, confidence, lifestyle and people's general outlook on life had resulted from the application of these services and the advice obtained throughout. Workplace mediation, assessments and the provision of equipment, and graded returns to work were thought to have made impacts on clients and been valuable to their employers. Key to all these workplace interventions was having contact with the workplace, in order to understand cultures and processes and to try and work in partnership with employers. Having someone to represent employees' interests was considered by staff to have been valuable to their clients. Positive impacts described were changing employees' and employers' perceptions of health conditions and capacity for work, and educating and encouraging employers about vocational rehabilitation methods.

The case management model was popular and staff identified themselves as a valuable resource. From the perspective of provider staff, case managers emerged as key players in helping people to make progress by identifying problems, needs and possible service responses; facilitating and coordinating with service providers and other stakeholders; supporting and empowering individuals; and in providing specific services.

Other stakeholders highlighted by staff as having been helpful at times in their work with clients were employers, GPs, other NHS workers, family and friends, Jobcentre Plus advisers and trades unions representatives. Employers described by staff as especially helpful in clients' progress to work were those who were willing to help employees return to work, willing to work with JRRP, open to new ideas for rehabilitation, and who had effective occupational health services and supportive sick pay schemes. Staff believed some GPs aided client progress by encouraging people to think positively about work and to proceed with JRRP rehabilitation plans. They also provided useful background information for provider staff and made helpful suggestions for referrals.

## Chapter 6: Barriers and constraints

Having drawn out the parts of the service that they felt had been effective, staff also discussed what had held them back or impeded them in their efforts to help people back to work.

There were examples from staff of how the pilot's structure and the trial restrictions therein, in-house working and external providers had impeded their work or caused problems. However, the main barriers and constraints discussed were associated



with the attitudes of, and working relationships with employers, GPs and other health services.

Staff perceived employers as being resistant to being in contact with them and did not always allow access to workplaces. Where contact was established, not all employers were thought to be interested in helping employees back to work. Employers were perceived by staff as less supportive where they did not understand the effects of particular illnesses, or where employees' health conditions were undiagnosed and the duration of their absence was unknown. Being inflexible and not forward-thinking were criticisms made of employers who would not consider rehabilitation plans including lighter duties and phased returns. There were concerns that people who were not paid full pay during phased returns would be financially disadvantaged. In general, a lack of knowledge about sickness absence management and vocational rehabilitation amongst some employers was thought to be a major constraint.

A number of barriers and constraints were perceived as emanating from health care professionals and services. Staff felt that there was a general lack of awareness and knowledge of vocational rehabilitation amongst GPs. Medical opinion was perceived by staff as being very influential for patients. Therefore, they felt people had been held back when GPs agreed that they could not work, issued sick notes for long periods and after limited inquiry, failed to encourage a focus on rehabilitation and on what people felt able to do, and had not given full advice on how individuals might manage their conditions or indicated a range of services that might be helpful. Provider staff felt that some GPs had hindered their work through their inaction in making referrals and confirming diagnoses. The actions of GPs and other health care staff had also impeded staff where they encouraged patients not to seek or use the help offered by JRRP, or gave opinions contrary to those of JRRP staff about people's readiness for work. There were also some difficulties in communicating with GPs. Within the NHS, delays, inadequate provision of services and a lack of proactive case management were identified by staff as reasons why people made slow progress back to work.

According to staff, barriers and constraints could also be linked to clients themselves. It was particularly difficult to work with people who were not looking to return to work, had multiple and complex health problems, perceived many reasons why they could not work, were looking for specific help that could not always be found within JRRP, and were not comfortable with the services offered. Financial support through occupational sick pay or incapacity benefits were thought to contribute to some people's lack of progress back to work.

Staff were invited to highlight important lessons they had learned and what they hoped would be incorporated in any future service. There was consensus for job retention services to be delivered by a large organisation that would be recognised by the public and have the capacity to cope with provider demands, but opinion was divided between government and independent organisations having responsibility.

An advantage of NHS control was perceived as quick and easy referrals to improved NHS occupational health services. An alternative suggestion was to link access to vocational rehabilitation services with receiving incapacity benefits. There was also support for giving primary responsibility for vocational rehabilitation to employers and their occupational health teams, and providing case management teams within GP practices for employers who could not afford these resources.

## Chapter 7: Conclusions and discussion

The findings from the studies reported here are broadly in line with recent policy initiatives from the DWP, Department of Health and the Health and Safety Executive (HSE). In particular, they support the recommendations for enhancing occupational health and vocational rehabilitation advice and support within the NHS and among employers, increasing employers' engagement with vocational rehabilitation, enhancing GPs' training and encouraging health professionals' management of returns to work. The studies highlight the social as well as the financial value of vocational rehabilitation, given people's experiences of sickness absence.

The findings suggest that more may need to be done to support people in being active users of the services, and that the 'diagnostic' role played by case managers is a critical one which perhaps needs more support. The findings also highlight that there is scope for GPs and other health professionals to do more to actively manage, and support, people's returns to work. Employers emerge from the study as powerful players in returns to work and, although experiences vary, there is a clear need for more work with employers. The experiences of clients highlight the complex three-way relationship that exists between employee, line manager and occupational health services and suggest that improvements in practice among line managers and occupational health staff are required if employer-based services are to play an effective expanded role.

Finally, the study does not provide strong evidence of an impact of JRRP (in line with impact estimates from the randomised controlled trial (Purdon *et al.*, 2006). However, it highlights a range of issues which do support the emphasis on developing vocational rehabilitation services. What emerges as important from these studies are that services provide early intervention, recognise the importance of avoiding job loss, provide flexible joined-up services supported by skills and resources, support clients as active players in their returns to work, and operate across institutional and organisational boundaries. There are clearly different options for where vocational rehabilitation services might be located, but the study provides support for services which employees can access directly alongside those which provide advice and support to employers.



# 1 Introduction

This report presents findings from qualitative research with participants in the Job Retention and Rehabilitation Pilot (JRRP) and staff of organisations providing job retention and rehabilitation services. The JRRP was developed by the Department for Work and Pensions (DWP) to test interventions which might decrease the length of time people spend away from work through sickness and increase job retention for people with a health condition or impairment. The pilot ran as a randomised controlled trial for a period of two years from April 2003 in six areas of the UK.

Participation in the pilot was voluntary. Potential participants were accepted onto the pilot if they had been on sickness absence from employment for between six and 26 weeks and passed a screening test designed to exclude people with a high likelihood of returning to work without any intervention. Participants were assigned randomly to one of three intervention groups or to a control group. The three intervention groups were:

- health intervention group – providing only services to address participants' health conditions;
- workplace intervention group – providing services to address workplace issues;
- combined intervention group – providing both health and workplace services.

A comprehensive package of evaluation research was developed alongside the pilot to measure its impact on rates of people returning to work and job retention, explore the experiences of the key actors in the implementation of JRRP services (clients, providers, employers and GPs) and to assess the cost-effectiveness of the scheme.

The impact assessment is being carried out using a survey of all randomised clients, including the control group. The process evaluation with key actors comprises a number of complementary research studies:

- a longitudinal panel study of clients;
- a one-off study of people in the control group;

- a series of ‘focused studies’ around specific research questions of relevance to the pilot, covering the following topics:
  - experiences of JRRP provider staff in establishing and delivering services;
  - employers’ attitudes and policies towards sickness absence;
  - employers’ experiences of JRRP services;
  - how GPs work with patients on sickness absence;
  - JRRP provider organisations’ perspectives on effective practices.

This report draws on data from the longitudinal panel study, the control group study, and the second focused study involving provider staff perspectives on effectiveness. The other studies in the process evaluation have either been published, reported in interim reports to DWP or are still in preparation.<sup>2</sup>

In this introductory chapter, Section 1.1 summarises the provision of services by JRRP organisations which will serve as context for later chapters, Section 1.2 describes the research design and methods for the work with clients and provider staff, and Section 1.3 explains the structure of the report.

## 1.1 Job Retention and Rehabilitation Pilot services<sup>3</sup>

JRRP services were provided by four organisations operating in six areas of the UK: Greater Glasgow, Newcastle and North Tyneside, Teesside, Sheffield, Birmingham and West Kent.<sup>4</sup> There is no centrally-held dataset of people away from work through sickness that might have been used for publicising the pilot. Provider organisations, therefore, used a variety of means to market their services, including advertising in the general media and in GP surgeries and direct approaches to selected employers.

To take part in the pilot, potential clients were required to call a central telephone contact centre where their eligibility for the pilot was checked and the screening instrument mentioned above was administered. People who were screened in were allocated randomly to one of the intervention groups or the control group. They learned about which group they been assigned to at the first meeting with the provider organisation during which they were shown a video presentation explaining

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<sup>2</sup> A report on employers’ attitudes to sickness absence was published as Nice and Thornton (2004). The GP study was published as Mowlam and Lewis (2005).

<sup>3</sup> Data in this section was collated from site visits to provider organisations and from information provided in the second staff-focused study.

<sup>4</sup> Human Focus (together with Atos and Health First) operated in West Kent and Birmingham, Routeback in Tyneside and Teeside, Healthy Return in Greater Glasgow, and WorkCare in Sheffield.

the randomisation process and the consent procedures they would be asked to complete. Potential clients were given time to think about their participation and then asked to give their written consent.

The provider organisations structured the delivery of services differently; some provision was available **internally** from their own staff or from contracted professionals working within the provider's premises. Other services were bought in under contract as and when needed.

Common to all provider organisations, however, was the allocation of each client to a member of staff who acted as **case manager** (though not all organisations used this term). The case managers acted as the focal point of contact for clients, gathering information from them, advising them on options, acting as gatekeepers to other services, or in some cases providing actual services themselves.

Within the portfolio of resources available to case managers, some were limited to the health intervention group only, while others were limited to the workplace group. In practice, this meant that case managers working with clients in these groups were precluded from using some options. However, there was also a range of options for clients and case managers that were not precluded but might be used within any of the intervention groups. Organisations' portfolios of resources changed over time partly in response to client demand. The range of resources being used by the time of the final fieldwork interviews in the spring of 2005 is summarised below.

### **1.1.1 Health intervention services**

Within the health intervention group the services available to clients included:

- access to medical tests, consultations, treatment and rehabilitation programmes;
- various forms of psychological therapy, including psychotherapy;
- physiotherapy and hydrotherapy;
- complementary therapies, including aromatherapy, reflexology and massage;
- exercise programmes and facilities, including membership of gyms.

Some of these services were available through in-house arrangements where case managers had the necessary clinical expertise or where the organisation had employed specialists to work on the project. All medical tests and other treatments and consultations were with specialists such as podiatrists, chiropractors, osteopaths and dieticians, not employed by the provider organisations. Provider organisations also had funding available to pay for some services or health investigations and treatments.

### 1.1.2 Workplace intervention services

Services and facilities available under workplace interventions included:

- mediation with employers;
- ergonomic and equipment assessments at the workplace;
- occupational therapy;
- advice on welfare rights;
- career advice;
- CV preparation;
- jobsearch.

Mediation was conducted by in-house staff. Life coaching or mentoring and consultations with occupational hygienists<sup>5</sup> were available through some, though not all, provider organisations.

There was greater emphasis on using **in-house** resources to deliver workplace interventions compared with health interventions, although external contacts were necessary in sourcing equipment, and obtaining advice from specialist disability services.

Services available for both the health intervention and workplace intervention groups were all available to clients allocated to the **combined intervention group**.

### 1.1.3 Resources not limited to a particular intervention group

Where appropriate, for example, when clients had become unemployed, case managers could seek advice from, work in partnership with, or signpost clients to, disability services such as Disability Employment Advisers (DEAs) within Jobcentre Plus offices, Access to Work funding and New Deal for Disabled People (NDDP) Job Brokers. Case managers also referred clients to Citizens Advice offices, charities and support groups when they felt this to be helpful. Giving advice on legal issues, benefits, debt and managing time was a role fulfilled by frontline staff with the necessary knowledge or access to knowledge.

Equipment companies were another external resource open to case managers working on any of the intervention groups. Spending money on equipment was sometimes necessary both for workplace situations and to help people in the health stream in their daily activities. Another use of funds available to case managers was to pay for travel costs, such as taxis, to treatment venues.

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<sup>5</sup> The anticipation, recognition, evaluation and control of workplace hazards or stresses which may lead to illness or discomfort are the primary roles of the occupational hygienist.

## 1.2 Research design and methods

As mentioned earlier, findings in this report are derived from three studies: the longitudinal panel study of clients, the one-off study of members of the control group, and the second piece of work involving staff of the provider organisations. Full details of the studies and their implementation are included in the methodological appendix but the principal features are set out below.

### 1.2.1 The longitudinal panel study

The purpose of this study was to explore how clients experience the JRRP service. The panel study included 36 people in total divided into three cohorts to enable the capture of differences in experiences as services developed and matured.<sup>6</sup> This report draws on data from all three cohorts: The first interview was conducted face-to-face, usually in the client's own home. All interviews were tape recorded, with permission, and transcribed for analysis. Follow-up interviews were conducted by telephone at roughly monthly intervals. Data from these interviews were extracted directly into the analysis instruments.<sup>7</sup>

The panel study was designed to provide detailed descriptive data about clients' experiences to allow us to explore their decision-making as they used the service and to identify any changes in their feelings, views and intentions as they occurred.

The sample was purposively selected to ensure coverage of the following variables:

- intervention group – 12 respondents from each of the three intervention groups;
- service provider – nine respondents from four of the six locations where service providers operate<sup>8</sup>;
- participant characteristics – the sampling strategy was also designed to reflect diversity in sex, age, occupation, employer type, industry sector, length of time off sick when people first contacted the service, type of employment contract (full- or part-time; permanent or fixed-term), and main health condition.

Clients continued to be interviewed regardless of the outcome of their involvement with JRRP. Some stopped using the service during the period covered by the research, returned to work, or moved on to Incapacity Benefit (IB).

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<sup>6</sup> The fieldwork for the three cohorts ended in January 2004, October 2004 and April 2005 respectively.

<sup>7</sup> Analysis was conducted using the Framework technique developed by the National Centre for Social Research (see Ritchie *et al.* (2003)).

<sup>8</sup> Given that two of the service providers operate in two areas, it was decided to focus the qualitative research on four of the six areas to avoid duplication. The areas that were chosen were West Kent (Human Focus, Health First and Atos), Tyneside (Routeback), Glasgow (Healthy Return) and Sheffield (WorkCare).



### 1.2.2 The control group study

This study comprised in-depth interviews with a sample of 46 people who had been among those randomly assigned to the control group, to explore their experiences of sickness absence and their pathways in returning to work. The aim was to provide information about how a group of people with similar characteristics to those receiving JRRP services experienced sickness absence and returning to work in the absence of receiving additional help. The sample was divided between people who had returned to work (36) by the time of the research interview and those who had not (10). In this way we could ensure generating data on how some people had arranged and managed their return to work, and learn about the continuing barriers of those still off sick or out of work.

The sample was purposively built to ensure coverage of the following key variables:

- age;
- sex;
- type of employer (size and sector);
- occupational group;
- main health condition;
- household circumstance.

Interviews were carried out in West Kent, Sheffield, Glasgow, Newcastle and North Tyneside and Teesside<sup>9</sup> in the summer of 2005. The sample was taken from people who had been interviewed as part of the Outcome Survey between January and April 2005.

As in the panel study, interviews were tape recorded, with permission, and transcribed for analysis.

### 1.2.3 Focused study with JRRP staff on effectiveness

This focused study was conducted towards the end of the JRRP in late 2004 and early 2005. The aim was to increase understanding of how the pilot services had helped clients to return to work, the types of support that were useful in different circumstances, and how clients responded to services provided. The principal research question addressed was 'what had worked/not worked and for whom' from the perspectives of the providers of job retention and rehabilitation services. In addition, we wanted to generate insights and ideas for how job retention and rehabilitation services might best be organised in the future.

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<sup>9</sup> Teesside was included in the control group (but not in the panel study) because of the limited sample available in the other four study areas.

In order to collect a mix of reflective and forward-looking data six focus groups of case managers were set up from each of the pilot sites. In total 18 people attended the groups. We also invited provider organisations to nominate someone from each area who had managerial control over the team of case managers to be interviewed individually covering the same areas of interest. Five such interviews were achieved.

The group events comprised three sessions using innovative participatory techniques rather than a straightforward group discussion approach. (The technical appendix contains full details of the group events.) The first session explored directly the question 'What works, for whom, in what circumstances?' and reviewed the resources available to case managers. The second explored the factors that helped case managers in carrying out their role ('enablers'), or hindered them ('constraints'). Included in discussions were views on external actors (such as employers and GPs) and the external environment in which they had to operate (such as local health services and labour market conditions). The final session sought to draw lessons from their experience of the pilot that could inform future policy making on job retention and rehabilitation.

The research with provider staff was not designed to complement the client research studies directly or to provide explanations for what emerged from those enquiries. We have, however, indicated in Chapters 5 and 6 where findings from the staff discussions help to explain, in part, some of the findings from the client data.

### 1.3 Structure of the report

Chapters 2 to 4 draw on data from the longitudinal panel study and the control group study. Chapter 2 looks at the process of taking sick leave and people's expectations and experiences of being off sick from work. The financial implications of being off work and people's experiences of claiming sickness benefits are explored, followed by an examination of people's contacts with health services and with their workplace. Views about returning to work in the future are also examined.

Chapter 3 concentrates on people's expectations and experiences of contacting and using the provider services beginning with how people heard about services and why they got in touch. We present findings on experiences of telephoning the contact centre, randomisation and consent procedures and assessments. The chapter then focuses on the experiences of people in the intervention groups, looking at the specific services they received and their contact with case managers. We look at what people thought of the help they were given, and packages or combinations of help, their involvement in decisions and broader aspects of the style of service delivery. The chapter ends by exploring reported gaps in service provision and how contact with JRRP services was ended.

Chapter 4 is in two halves. This first half explores the experiences of those who went back to work in the panel and control group studies including their motivations and developments in their health. We look at the availability and suitability of work to

return to and assess the overall impacts of JRRP on those who went back to work. The first half ends by examining people's experiences of being back at work. The second half of the chapter focuses on those who did not go back to work, and, as in the first half, looks at motivations and developments in health and assesses the impact of involvement with JRRP services. The chapter ends with a discussion of people's barriers to work and experiences of longer-term sickness absence.

Chapters 5 and 6 draw on data from group discussions with provider staff and individual in-depth interviews with provider organisation managers to look at staff's perspectives on the operation of JRRP. Chapter 5 explores which services, actors and working relationships were considered effective in helping clients progress towards work, and why. Key messages from JRRP staff about 'what works' are summarised, and services and interventions identified as particularly effective are then explored in detail. The chapter finishes with an examination of the way that working relationships with key actors such as employers and health professionals contributed to client progress.

Chapter 6 concerns the barriers and constraints staff encountered in trying to help clients move towards work. These include those that clients faced in trying to get back to work, and therefore, that staff were trying to tackle in helping their clients, and those staff faced in providing the services needed by their clients. Key messages emerging from discussion with staff are summarised. The barriers and constraints are then broken down into three discrete areas and reported in more detail, starting with impediments associated with JRRP service provision, followed by problems linked to key actors, such as employers, GPs and other NHS staff, and concluding with other barriers and constraints concerning the clients themselves and the wider socio-economic environment. The chapter finishes with staff reflections on what they had learned from their experiences and what they would like to see happen in the development of future services.

The final chapter draws out the key findings across the three studies within seven themes: the experience of sickness absence; issues involved in engaging with and using JRRP services; key components and features of a vocational rehabilitation service; returning to work; the role of GP and the NHS in vocational rehabilitation; the role of employers; and implications for future development of vocational rehabilitation services. The chapter also discusses the implications of the study findings for the development of vocational rehabilitation services in the light of recent policy initiatives from the DWP, Department of Health and Health and Safety Executive.

## 2 Taking sick leave and being off sick from work

This is the first of three chapters to draw on findings from the panel study and the qualitative research conducted with members of the control group. The aim of this chapter is to explore the process of taking sick leave and the experience of being off sick from work.

The chapter begins with a look at the reasons behind people's sickness absence (Section 2.1) and then moves on, in Section 2.2, to explore whether the absence was planned or not. Section 2.3 briefly explores how long people expected their sickness absence to last when they first went off sick. Section 2.4 discusses how people felt about taking time off work and in particular examines the widespread reluctance of people to be away from work. People's feelings about being off work once the decision to take sick leave had been made is covered in Section 2.5. The financial implications of being off work and people's experiences of claiming sickness benefits are explored in Section 2.6. Sections 2.7 and 2.8, respectively, examine people's contact with health services available outside of Job Retention and Rehabilitation Pilot (JRRP) and their workplace and their experiences of this. Section 2.9 looks at what other support was available to people off sick from work, with the exception of JRRP services which are covered in Chapter 3. The chapter ends with a brief look at people's thoughts about returning to work in the future, in Section 2.10. Finally, a conclusion to the chapter is provided in Section 2.11.

### 2.1 Reasons behind sickness absence

The panel study and the control group samples broadly reflected the composition of the JRRP database<sup>10</sup> as a whole. Thus, musculoskeletal conditions were the most common conditions to have led to sickness absence across the samples of both

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<sup>10</sup> The Management Information and Evaluation Database contains screening information, details of services received from Providers and outcomes for all JRRP participants (see Purdon *et al.*, 2006).

studies. These included problems relating to the upper torso (particularly the back) as a result of injuries (especially those associated with falls or lifting in the workplace) or deterioration over time. Arthritic pain, broken limbs, muscle strains and nerve damage were also key reasons for taking sick leave.

Mental health problems, including stress, depression, anxiety, panic attacks and agoraphobia, were also an important set of reasons given for taking sick leave. These types of conditions were described by participants as stemming from personal problems (such as relationship breakdowns or a family bereavement), the effects of a change in existing medication, or issues related to the workplace. There were reports of stress, depression and panic attacks as a result of workplace bullying. Heavy workloads, unpleasant working environments, incidents or accidents in the workplace or people's general dissatisfaction with the nature of their work were also part of people's descriptions of why they became depressed or stressed in relation to the workplace.

Cardiovascular diseases and a variety of other conditions, ranging from strokes, heart and lung problems and breathing difficulties to bowel complaints, diabetes and chronic fatigue syndrome were also discussed in relation to the reasons behind sickness absence. Finally, some people suffering from physical pain had not yet had their conditions diagnosed which often made treating them difficult.

## 2.2 How sick leave occurred

In general, people's absences were not planned. Some experienced the sudden onset of pain or discomfort, as a result of a recent injury or the deterioration of an existing condition. When describing what had led to their need for sick leave, people in this situation often talked about having woken up one morning in severe pain which left them unable to get out of bed, let alone contemplate work. Some people with developing mental health conditions, such as depression or work-related stress, described a broadly similar situation with regard to the beginning of their sickness absence. Experiences such as panic attacks and breakdowns sometimes characterised by uncontrollable crying or mental and physical exhaustion led to people having time off without warning.

People experiencing stress in the workplace talked about problems such as bullying or threatened disciplinary action building up until they reached the point where they could no longer manage them and went off sick. For some this was very sudden and led to them leaving during the working day. Sickness absence that was unexpected also occurred where people were hospitalised as a result of the sudden onset of pain or an infection or following an accident such as breaking a limb.

It was clear from people's accounts that sometimes the decision to take sick leave was really made by a third party, most commonly a GP. The involvement of GPs in such decisions occurred where people were reluctant to take sick leave or where they were unaware of the severity of their condition. In the first instance, some people talked about how they had become ill and had made an appointment to see

their GP in the hope of being prescribed medication rather than having to take time off from work. Despite people often being in considerable mental distress or physical pain, they did not decide to go off sick until their GP had forcefully insisted that they should, and saw the decision as having been made by the GP. Where people had been unaware of the severity of their condition, they were advised by their GPs or other health care professionals to take time off due to a deterioration in their condition that only became evident during a more routine check-up. Employers were also sometimes involved in people's decisions to take time off due to illness, according to those interviewed. There were reported cases of managers, an occupational health doctor and a union representative sending people home where they were reluctant to take the decision themselves. One person recalled how his sickness absence began with him being told by his work's doctor '*under no circumstances have you to come back [to work] until you have seen the surgeon*'. Finally, families were also said to have had a part to play in convincing people that they needed to take time off from work.

This pattern of sickness absence arising suddenly was also evident for people with longstanding conditions, who described trying to continue to work despite a gradual deterioration until they reached the point when they had to stop. There were few examples of people trying to access help from an employer to remain in work. One person had tried to get help from a superior when she was being bullied, but said no action had been taken. Some people had requested light duties, usually unsuccessfully. Employers were reported to have said that such duties did not exist or that having a sick employee in the workplace posed a health and safety risk or went against company policy. In other cases, people were offered new duties which they felt would have aggravated their health conditions. There was one example of someone being offered a different location, and another of someone being offered reduced hours, to help them to stay in work, although neither strategy was ultimately successful.

There were some cases where absences had been planned in advance, such as where it was known that time off would be needed for surgery or in-patient treatment. In such cases, people had already discussed their need for time off in advance with employers.

### 2.3 Expectations of the duration of sickness absence

Where absences were planned, people tended to have a clearer idea of how long they were likely to be off work. They felt this was appreciated by their employer, and these people were less likely to describe being put under pressure to come back to work before they were ready. In contrast, people whose absences were unplanned sometimes talked about how they had underestimated how much time they expected to have off. People whose absences lasted several months had often only anticipated being off work for a week or two. As discussed in Section 2.8.1, employers' enquiries about predicted lengths of sick leave could sometimes make people feel under pressure to return to work before they were ready.

## 2.4 Feelings about taking sick leave

The need for third party involvement in decisions to take sick leave highlights the fact that some people were reluctant to take time off, even when in considerable pain. A reluctance to take time off was particularly evident among some people whose absence was the result of a sudden deterioration in an existing condition. Up to this point, these people had kept on working, often despite severe pain, and the advice of a GP. For these people, taking time off from work only happened when there was no other option: when they were physically unable to work.

There appeared to be a number of different reasons behind people's wishes to avoid taking sick leave<sup>11</sup>. For some it was about not wanting to be away from a job they enjoyed, but also about not wanting to let employers and colleagues down. People worried that taking time off for ill-health was a sign of a lack of commitment to work and often said they were proud of the fact they had not taken sick leave in the past and would do anything to avoid taking it in the future. Taking sick leave was also avoided where people thought it might have implications elsewhere. Some people, for example, had concerns about how future employers might react to seeing their records of sickness absence, especially with conditions, like mental illness, that were perceived to have a certain stigma attached. A fear of being disciplined or even dismissed as a result of time off was a also concern for some. Where people had experienced bullying in the workplace, there was sometimes a perception that taking time off was a sign that the bully had 'won'. In general, the financial implications of taking time off did not enter into people's considerations about taking sick leave, except where they were unclear about their entitlement to occupational sick pay as a result of having taking time off already or where they had recently moved to a new job.

Despite this widespread reluctance to take time off work, people nevertheless often experienced a sense of relief at not being at work. For some, the relief was associated with having the time to rest and recover, whereas for others it was the relief of being away from a stressful work environment or a bullying boss.

## 2.5 Feelings about being off sick from work

Being off sick from work was recurrently described as boring and frustrating. The boredom people described typically related to being at home with nothing to occupy their time. Boredom was especially pertinent where restricted movement as a result of painful conditions limited the activities open to people. It was also linked to people missing their work activities and the social interaction of the workplace.

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<sup>11</sup> It is important to note that these views come from a group of people on sick leave who had chosen to access help to return to work: they are thus, not necessarily generalisable to the wider population of people on sickness absence.

Frustration arose from different aspects of people's situations: not being able to manage everyday tasks such as getting dressed or preparing food, restrictions imposed by physical conditions or mental health problems such as agoraphobia, a lack of improvement in health, long waits for treatment or a lack of diagnosis.

People also described strong feelings of isolation. Those who spent most of their days alone at home, with few visitors, said they felt isolated, but this was also connected to people missing the social interaction of the workplace. Not wanting to leave colleagues with extra work to do also instilled feelings of guilt in some people.

It was rare for people to describe their time at home as enjoyable. Those who did were either occupied with other activities (such as voluntary work, housework, looking after children, or a second job), or were people who did not feel a strong association with working because they were close to retirement, did not need to work for financial reasons or did not enjoy work.

It was also clear from some people's accounts that being off sick from work, and the feelings associated with that, had begun to affect their mental health or wellbeing or aggravated existing conditions. The reported effects on mental health ranged from people saying they '*felt a bit down*' or '*moody*' to people experiencing panic attacks or feeling suicidal. People also talked about becoming '*depressed*' due to worries about the financial implications of not being in work, how and whether their health was improving, and fears associated with going back to work or not going back to work.

## 2.6 Financial implications of being off sick from work

In addition to the impacts on mental health and wellbeing, sickness absence often had financial implications for those off sick from work. This section first describes the sources of income people had whilst on sick leave. It then explores the implications of changes in income during this time and finally examines people's experiences of claiming benefits.

### 2.6.1 Income received during sickness absence

The sources of income available during sickness absence typically involved a period of full pay, followed by a period of half pay and then a period of Statutory Sick Pay (SSP), and sometimes a move on to Incapacity Benefit (IB) or other benefit. The length of time during which occupational sick pay was paid ranged from two weeks' full pay and two weeks' half pay up to nine months' full pay, although both extremes were unusual. One man had been suspended for 11 months on full pay to allow his employers to investigate his reason for sickness absence following a successful appeal against his dismissal from work. A more common pattern of occupational sick pay was six months' full pay and six months' half pay. However, some people had moved straight on to a period of half pay from their first day off work, because they had had time off earlier in the year. There were also cases of people who were not entitled to any occupational sick pay because they only worked part-time or had



not been in their jobs long enough to qualify. Often, these people received SSP instead and then moved on to IB once it ended. However, there were two cases of people who said they were receiving no income at all as they were not entitled to occupational sick pay, SSP or any other relevant benefit such as IB or Income Support (IS). One appeared not to have made enough National Insurance contributions to be able to receive SSP and lacked her GP's support in order to claim IS. The other was not a permanent UK resident and so was not entitled to any benefits after her sick pay ran out.

Some people also had access to other sources of income during their time off work: a spouse's, partner's or sometimes an offspring's income, income from a second job or the person's own business, savings, tax credits, Disability Living Allowance (DLA), insurance pay-outs (typically to cover mortgage payments), and income from state and private pensions. There were also instances of people receiving money from compensation claims associated with injuries in the workplace, although this tended to happen later on in people's absences (sometimes triggered by dismissal due to incapacity) by which time they had built up a lot of debt.

### **2.6.2 Implications of changes in income**

People who remained on full pay throughout their absence from work tended not to experience any financial difficulties except where the loss of income from regular overtime was significant. Here, the impact of any drop in income tended to be minimal, and they talked about cutting back on what they saw as luxuries.

However, people experienced a significant reduction in income as a result of the transition from full pay to half pay or from occupational sick pay to SSP or IB, or in those more exceptional cases where people were not receiving any income from these sources. These drops in income, which were sometimes up to 75 per cent, often had serious implications for household spending. Living on a reduced income led to an increase in debt and arrears. People reported taking out loans, borrowing from friends and family and an increased reliance on credit cards and overdrafts in order to make ends meet. They also talked about how they were increasingly unable to service existing debts or pay other outgoings such as mortgage and rent payments. One person saved money by moving back in with her parents and another resorted to selling personal items. Others faced threats of eviction due to rent arrears or repossession as a result of having been unable to meet mortgage repayments. In another case, a person had been able to agree a rent reduction with his landlord.

Recovery of overpayments of IB, Council Tax Benefit (CTB), Housing Benefit (HB) and tax credits was another financial burden some households had to face. In addition, one woman was threatened with having to pay back occupational sick pay. Her employer was disputing her claim that the condition which had led to her absence from work was work-related, although it was unclear why her employer thought this did not entitle her to sick pay.

Having to pay for private treatment also had a financial impact on some households. In one extreme case, a man had chosen to pay £18,000 to fund an operation he needed in order to get back to work before he lost his job.

The financial effects of sickness absence, thus, caused considerable concern for some people. A reduction in income also impacted on people's mental health and personal relationships. Worrying about paying bills, meeting mortgage and rent commitments and mounting debts and other financial worries put a strain on personal relationships. People described arguments over money, and working spouses or partners reportedly resenting having to work more hours to cover the shortfall in household income.

Financial hardship exerted a strong pressure on people to move back to work. There was a definite pattern across the sample of people moving back into work either shortly before or just after a change in income – most commonly at six months where occupational sick pay was reduced to half. Whilst some people said that the timing of their move back to work had nothing to do with the transition from full pay to half pay, there were others who said it had been a key influence on their decision to return to work at this stage. Some people who described financial pressures as being central in their decision to return to work felt, either at the time or in retrospect, that they had returned too soon, an issue explored further in Chapter 4.

Not everyone experienced financial difficulties during their period of sickness absence, however. A number of different factors influenced this. These were:

- a low starting income. Some people said that the money they received in the form of SSP or IB compared favourably with the money they earned when in work either due to low wages or part-time hours. One woman said that her income on benefit was more than what she had earned when in work, and was concerned that if this was a common situation it might act as a disincentive to work for some people;
- a second income. One man said that he did not worry about his sick pay running out as he would be able to rely on the income generated from the business he had been building up alongside his regular work;
- a spouse or partner in a well paid job. Some people talked about how their partner's income could more than easily sustain their lifestyle alone. In one example, the person's husband had been promoted at the point where her own income had dropped, which meant that the increase in his salary made up for the shortfall in hers. In another, a woman talked about how she felt she would have been able to manage financially without sick pay or benefits as her income was normally used to pay for luxuries like holidays;

- low outgoings. Some people reported that they were able to manage on a reduced income because they did not have much household expenditure: they had no debts or housing costs as a result of living with parents or because their mortgages were either paid off or were covered by payment protection insurance. In fact, one person thought that although he only received 80% of his salary whilst off sick, he was probably slightly better off than he would be if working as his mortgage was being paid by an insurance company.

Although financial pressures did not play a part in these people's motivations to return to work, they were still keen to return to work for other reasons, as discussed in Chapter 4.

### 2.6.3 Experiences of claiming benefits

IB was the most commonly claimed benefit among those interviewed, and so is the focus of this section, but there were also instances of people having claimed DLA, IS and Jobseeker's Allowance (JSA). Additionally, some people were in receipt of CTB, HB and different forms of tax credits.

People who were on long-term sick leave for the first time tended to have been unaware of the existence of IB until other sources of income ran out. It was not always clear how people became aware of IB, but it was not uncommon for people to have heard about it from their employers at the point where sick pay ended. One person, for example, explained how she had received a letter with her final pay slip advising her to '*contact the DSS*', and that without that letter she would not have known what or how to claim. Becoming aware of IB at such a late stage sometimes meant that people had a period without income before their claim came through. Some people had not tried to claim IB as they assumed they would be ineligible, although they did not have any strong basis for such an assumption. A woman who was in receipt of IB towards the end of her sickness absence said she had been surprised that she had been eligible as she thought it was only for people in a much more financially desperate situation than herself. There was also reluctance among some people to make a claim as they felt there was some stigma attached to receiving benefits. One woman who was on SSP at the time of her interview said she did not want to claim IB unless she had to, as she saw it as '*sponging off the state*'; another said that her claim had been her first and was proud of the fact that she had never claimed before.

Although some people's claims for IB went smoothly, others experienced difficulties. There were instances of having to make a new claim due to a mix-up over job termination dates, and having difficulties locating appropriate forms and documents to complete their application which led to delays. There was a view that the forms were deliberately complicated to put people off applying.

## 2.7 Contact with health care services

### 2.7.1 Contact with GPs

All those interviewed as part of the two studies had some contact with a GP, in order to obtain sick notes, be prescribed medication, receive advice or counselling, or be referred for scans, consultations or specialist treatments. People's opinions of their GPs varied. Whilst some were very positive about their GPs and their role in their health developments and movements towards a return to work, others were more critical of the services provided by GPs.

In some cases, people felt the treatment provided by GPs, either directly or through referrals, had had a noticeable impact on their physical or mental health. This ranged from the pain relief or improvements in mental health resulting from medication prescribed by GPs to the health benefits achieved through referrals to specialist services like psychological therapy or physiotherapy. In other cases though, people felt the treatments they had received through their GP were ineffective, inappropriate, or lacking. Concerns about ineffective or inappropriate treatment were often associated with GPs treating mental health problems. Some people complained about being prescribed anti-depressants where they had concerns about becoming addicted but also where counselling, which they often assumed to be a more effective form of treatment, was not offered by GPs.

#### *GPs and sickness absence management*<sup>12</sup>

Although it was not always clear from people's accounts, there was evidence that some GPs were managing people's health care more actively than others. GPs appeared to be more actively managing people's health care where they took a structured approach to diagnosing health problems through a programme of tests and consultations, regularly monitored people's conditions through regular appointments, provided extended appointment times to allow a more thorough discussion of symptoms, feelings or concerns, picked up on any impacts of prolonged absence on mental health and prescribed treatment, attempted to speed up specialist treatment by assigning referrals as urgent or by writing letters to consultants or private health insurers, or made emergency referrals for pain relief or treatment for serious mental health problems like suicidal tendencies.

Experiences which suggested GPs were less active in managing their patients' health care emerged where people felt they lacked a diagnosis or when they felt they had not been properly diagnosed, and also where they felt that their GP was slow to suggest and make appropriate referrals. One man described his GP as having '*abdicated responsibility*' for his welfare because most of his treatment was being

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<sup>12</sup> See also Mowlam and Lewis (2005) for research among GPs exploring their management of sickness absence and approaches to vocational rehabilitation.

provided by his employer's occupational health department. Whilst he appreciated the help he received from occupational health he felt his GP could have continued to make suggestions for other types of help.

### *GPs and sickness certification*

On the whole, GPs were said to be supportive of people's judgements that they were not well enough to be in work. There was one exception: a woman who had been back to work but then off sick again on three occasions during the course of the panel study. This happened because her GP had refused to renew her sick notes on each occasion as he felt she was ready to return to work. However, she felt that she was returning to work before she was well enough and as a result ended up needing further time off sick each time because her condition had worsened due to the strain of work. Eventually she resigned.

People were generally satisfied with the length of sick certificates they received from their GPs, although sometimes people considered their initial sick notes to be too long where they had not anticipated having to take time off work. Once people realised that there were unlikely to be going back to work in a matter of weeks they began to accept that longer sick notes were appropriate. Nevertheless, based on their own experience, people tended to prefer GPs who were only willing to write sick notes for what they considered genuine absences. Some said they felt more able to trust the judgement of a GP they considered more '*reluctant*' to write sick notes, especially where fitness for returning to work was concerned.

People were not interested in being offered the chance of more time off where they felt fit enough to return to work, and were often suspicious of GPs' motives where it was offered. One woman, for example, who felt she had been given a opportunity to '*cheat the system*', by means of her GP's offer to write her a sick note for as long as she wanted, felt that this was her GP's way of making up for what she considered to be his misdiagnosis of her condition. However, there were some cases where extending a sick note beyond the point where people felt ready to return to work was seen as appropriate and was much appreciated. In some cases GPs had reportedly extended sick notes to allow people time to negotiate returns to work. One person, for example, who could not find a new job until his employer came to a decision over a redundancy package was very grateful to his GP for providing a sick note to cover this period. Another person talked about how her GP continued to provide sick notes in order to ensure that she found a new job rather than go back to the original job which had been instrumental in making her ill.

### *GPs and returns to work*

On the whole, the work of GPs focused on improving people's health rather than on their returns to work, although, as discussed below, GPs did sometimes advise people about what work might suit them best. There was no evidence, however, of people being referred to specialist rehabilitation services except for JRRP, and referrals to JRRP tended to be focused on accessing health care services that were unavailable, or required a wait, on the NHS.

People generally welcomed GPs' advice or support about returning to work where they felt they felt their health had improved enough to enable them to work in some capacity. They were particularly appreciative of GPs who encouraged people to consider alternative forms of employment, wrote letters to employers to request light duties, changes to shift patterns or reduced working hours and where GPs were considered to be sympathetic when discussing any negative experiences with employers.

However, people had mixed views on whether GPs had a role to play in advising them *when* they were ready to return to work, although their views on this were often dependent on whether GPs agreed with their own assessments of fitness for work or not. This meant that GPs' opinions were often not sought for fear that they would contradict what people thought. In practice, GPs' opinions were treated as more relevant where employers were said to require some sort of statement of fitness before allowing people back to work, or where people felt pressurised by an employer to return to work before they were ready. Where people had gone back to work despite their GP's advice not to, they often regretted not heeding their GP's advice and had become more trusting of their GP's judgement as a result. The role of GPs in people's returns to work is discussed further in Chapter 4.

### **2.7.2 Contact with other health care services**

As described above, it was common for people to have been referred by their GPs for scans, consultations and specialist treatments, particularly physiotherapy, counselling, pain management, MRI scans and psychiatric support. However, waiting lists were a widespread problem among those interviewed which meant that these services were not always received during the period of the research. People recurrently mentioned having been told that they would have to wait for scans, surgery, psychological therapy and physiotherapy if they wanted to be treated on the NHS. The longest reported wait was three years in the case of an operation for a back problem. People were generally shocked, and sometimes disgusted, by the length of time they were expected to wait for treatment. They often found it difficult to understand why treatment could not be speeded up especially where they felt that a lack of treatment was what was preventing them from going back to work. Some people commented on how they felt that the money spent by their employers on sick pay could have been better spent on the treatment they needed to get back to work. In some cases people had already gone back to work before receiving the NHS treatment they had been promised. One man said that his GP had not referred him for physiotherapy as he was likely to return to work before he received it, which he did. Others were offered alternative treatment which they considered to be less effective, such as being offered anti-depressants in lieu of counselling.

Where people were faced with long waiting lists they sometimes turned to private health care. MRI scans, counselling, physiotherapy, specialist consultations and an operation were all funded privately through private health care, employer occupational health services, people's own money, and in one case by an insurance company where a condition had resulted from a car accident.

Some people described taking the initiative in their own health care. One person, for example, asked his GP for a TENS<sup>13</sup> machine after it had been recommended by a neighbour. In another case, an NHS nurse determined to receive a diagnosis had referred herself to a number of different departments within the hospital in which she worked before confirming her own diagnosis after reading the notes of a patient in her care who was displaying similar symptoms to her own. Similarly, a person suffering from chronic fatigue syndrome discovered her own stamina building regime through research on the internet. There was also an instance of a person successfully speeding up some treatment by getting her MP involved. In this study, these examples arose particularly among people in the control group. The samples are small and do not support statistical inference. However, it is possible that people in the control group, denied the support of JRRP, were particularly proactive in managing their own returns to work whilst JRRP clients, as discussed in the next chapter, looked to the services for support.

## 2.8 Contact with the workplace<sup>14</sup>

Contact between employers and their absent employees varied widely in terms of who was involved, how it was initiated, how often it took place and in what form, what its purpose was and what people thought about it. There were no obvious differences between the experiences of people who worked in the public sector and those who worked in the private sector. It was difficult to be conclusive about any differences between large, medium-sized and small employers as there were so few medium-sized or small employers in the sample (see Appendix A for more details).

### 2.8.1 Contact with line managers

There was an underlying perception among those interviewed that contact between employer and employee should be initiated by the employer. There was also a view that line managers, team leaders or supervisors should be the key point of contact, as they had most dealings with people when they were working. However, line managers were not seen as the most appropriate person where people did not have good relationships with them. This was particularly relevant where people had been bullied by their managers. One man, for example, found it traumatic to be telephoned every month by the line manager he said had bullied him.

The frequency or amount of contact also varied, as did people's opinions of what was appropriate. This meant that what one person appreciated was seen as unhelpful by someone else. People who received little or no contact from their managers felt this showed a lack of interest which left them feeling undervalued and unwanted, or *'just another number'* – a phrase that was used recurrently throughout

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<sup>13</sup> A Transcutaneous Electrical Nerve Stimulation machine, which delivers pulses of electrical energy and provides pain relief.

<sup>14</sup> See also Thornton and Nice (2005) which explores employers' approaches to managing sickness absence and the role of occupational health services.

the interviews. At the same time, however, very regular contact could be perceived as intrusive and pressured, or in some cases as an attempt to check-up on employees in order to ascertain whether their sickness absence was legitimate or not. People's views about what was appropriate depended to some extent on their state of health at the time. Frequent contact when someone was feeling very ill, or if they were very depressed, was sometimes not thought to be helpful. One person, for example, who suffered from a depressive illness, said that she did not think she would have been in a fit enough state to deal with her manager had she been contacted during the early stages of her absence.

Ultimately, though, the tone and content of contact with managers had more influence than the frequency on whether contact was seen as helpful. People were more positive about contact with managers where it focused on their health and wellbeing rather than on when they expected to return to work. People also appreciated being kept informed of what had been happening at work since they had been away or being invited to workplace social events, as this helped them to feel as though they were still a *'part of the team'*. Being warned about pending changes in income, such as when SSP was due to end, and being sent information about how to claim IB were also valued by those off sick from work.

People did appreciate discussions about how and when they might return to work when they felt they happened at an appropriate time, that is when they felt they were ready to return to work. These discussions were described most positively where they had been initiated by people themselves, as there was less likelihood of feeling pressured by employers to return to work. However, return to work discussions prompted by employers were appreciated. In one example, a person's employer offered him light duties whilst he waited for surgery so that he did not have to go on to SSP. However, people were not always happy with discussions they had with their managers about their future return to work. Some were unhappy because their requests for light duties or phased returns had been declined, whereas others said they felt under pressure to return to work before they were ready. Words like *'harassed'* and *'hounded'* were sometimes used by people to describe how they felt when asked by their managers for an indication of when they might be coming back to work. Some people reported having been asked to provide a return to work date, or having been given a date by which time they had to return or they would be dismissed.

The format of contact between people and their line managers ranged from written correspondence and telephone contact to meetings and home visits. For some, contact was limited to telephone calls to update their employers about any changes to their situation, or sending in renewed sick notes. Others talked about attending meetings with managers at their place of work, or sometimes being visited at home. On the whole, people were happy to attend meetings at their workplace except where their conditions restricted their mobility or where meetings were perceived as taking place too often and, as a result, made people felt that they were being checked up on. Home visits were appreciated where people felt they would have found it difficult to make the journey to their workplace and where they felt isolated



at home. However, sometimes home visits were seen as intrusive, especially where people felt under pressure to return to work or where people felt their employers were sceptical about the genuineness of conditions.

Finally, the nature of contact sometimes altered when there had been a change in personnel. One person reported how she only began to have regular contact with her employer five months into her sickness absence when she was assigned a new line manager. In contrast, another said that after an initial home visit from his manager he had no further contact. He later discovered that this was due to the manager having left the job.

### **2.8.2 Contact with occupational health staff**

Occupational health support was not widely received or available. Where it was, it was most commonly initiated by an employer, for example, where it was company policy for all absent employees to be examined by an occupational health doctor. But there were also instances of people referring themselves. Sometimes this was a way of maintaining some link with their employers where contact with line managers or other colleagues was limited. Individuals also reported having referred themselves in order to access medical treatment and counselling, but also as a source of advice and someone to talk to. Finally, one person said they knew that they would eventually be referred to occupational health if they remained off sick for an extended period and so wanted to pre-empt any potential future problems by keeping their occupational health department informed of their progress from an early stage.

Experiences were mixed. There were some reports of occupational health services having supported people during their sickness absence. People appeared to feel less guilty about having time off when an occupational health doctor confirmed that their absence was genuine. Contact with occupational health services had practical outcomes too. It was reported that occupational health staff tried to help speed up treatment by writing letters to consultants. They also made suggestions about how best people should manage their return to work, organised and funded private treatment, such as physiotherapy and psychological therapy, and sometimes provided people with someone to talk to about their problems.

There were also instances of people finding occupational health services unhelpful. Some people complained about how staff treated them. One person described his employer's nurse as *'cold and unsympathetic'* in the way she questioned the seriousness of his condition. Another was shocked at the reportedly rude way in which his employer's nurse reacted to him telling her that he was receiving physiotherapy through JRRP. Others complained about how they felt obliged to visit their occupational health department, even where it had a detrimental impact on their health. One man, for example, talked about how he was required to visit his occupational health doctor one week and the company physiotherapist the next, despite the fact that both the travelling and the physiotherapy were slowing down, rather than speeding up, his recovery.

There was an underlying feeling of distrust among all of those in receipt of occupational health support, at least initially. A referral by an employer to occupational health was perceived by some people as a means for an employer to assess the genuineness of someone's absence, or to provide an employer with grounds for dismissal. This was sometimes reinforced by the behaviour of occupational health personnel. One woman, for example, believed that she was being checked up on after having had four separate medical examinations by her employer's occupational health department. A man who had referred himself to the service, said the occupational health doctor he saw claimed his role was to provide the employer with the grounds to dismiss staff. Sometimes occupational health staff had said they were themselves suspicious of an employer's motive for an employee's referral. One occupational health doctor, for example, was reported to have told someone that he could not see why he was being asked to assess someone who had already been seen by one of the top specialists in the field. This meant that some people felt unable to confide their true feelings in their occupational health doctor or nurse for fear that it would get back to their manager and be used against them. One person, for example, felt uncomfortable in discussing an underlying mental health problem for fear that, if disclosed to his employer, it might affect his return to work. The same concern about disclosure led some people to decline counselling services offered by employers.

People sometimes felt that the information or advice provided by their employer's occupational health department was not used by their managers, or was discredited. There were instances where occupational health advice about how employees should return to work on reduced hours or duties was felt to have been ignored by managers or where confirmations that health conditions were work-related were disputed by managers.

### **2.8.3 Contact with unions and colleagues**

Some people also had contact with their trades union representatives. People used their unions for legal advice, to organise and drive grievance procedures and legal proceedings, to launch appeals, to agree pay deals, to mediate at meetings with management, and to provide emotional and, in one case, financial support. However, not everyone was a member of a union, and even where they were, unions were not always able or willing to help.

Finally, flowers and cards, and visits from colleagues were also much appreciated by those who received them, as it showed that they were in people's thoughts and were missed. Some said how such gestures had made them feel more confident about going back to work, as they knew that they would receive a warm welcome back and would not have to worry about any resentment among colleagues about having taken time off.

Chapter 4 looks in more detail at how people's contact with the workplace impacted on going back to work.

## 2.9 Other support received

Families, especially spouses or partners, were an important source of emotional, practical and financial support to those off sick from work. People talked about how they relied on their partners as someone to talk to about how they were feeling. However, they also felt that sometimes their partners were unable to understand what they were going through which could lead to arguments and put a strain on relationships. Partners, and children where earning, were often relied upon to make up the shortfall in any loss of income as a result of sickness absence. This again could put a strain on family relationships, especially where they needed to take on extra work to increase household income.

Where people had contact with Jobcentre Plus staff and services, this generally involved using mainstream job search services, but individuals also reported having received help from a Disability Employment Adviser (DEA), an IB Personal Adviser and the Access to Work scheme. People's reactions to how useful they found the services on offer were varied. Positive reactions came from someone whose taxis to work were paid for by Access to Work, a person who received help with a rehabilitation plan and through this was encouraged and helped to find voluntary work, and a person who attributed their success in finding alternative employment to the job search service provided by a DEA. People who were less impressed by the agency's services were a man who was only indicated job vacancies which involved driving which was the one thing that prevented him from doing his existing job, and a person who was advised to consider selling his house when he enquired about his benefit entitlement.

## 2.10 Motivation to return to work

In general people had, at the start of their absence period, wanted to go back to work, which is perhaps not surprising given some people's reluctance to take time off in the first place. People wanted to go back to work for a number of different reasons. People missed working; they missed the perceived '*normality*' of being in work, their specific duties and their colleagues. People also wanted to return to work to escape from the feelings of boredom, frustration, isolation and guilt associated with being inactive. They also hoped that a return to work would improve their emotional and mental wellbeing. Financial problems, such as increased debt or arrears, and fears about job security were also reasons why people wanted to get back to work as soon as possible.

However, there were some people who, at this early stage, had no interest in going back to work. These people tended to be those suffering from work-related stress or depression. For some it was a fear about returning to an environment where they felt they had been badly treated, for others it was about anger at having been treated in this way. Once away from the workplace, with time to think, these people decided that they too wanted to go back to work, as they did not want to be '*beaten*' by their conditions or their employers. By the time they approached the JRRP services they

had thus, decided they did want to return to work although, as Section 3.1.2 discusses, hoping for improvements in health was in itself an important motivation to take part.

This common desire to return to work remained over time. However, the longer people were away from work, the more they feared or had concerns about returning to work, regardless of how much they wanted to. This was most evident among those nearing retirement age, who had begun to consider taking early retirement as their absences continued, especially if they could agree an attractive pay package with their employer. Fear of going back to work was also significant among those who were faced with looking for a new job, either because they had lost their jobs or their health condition prevented them from continuing in their existing ones.

Chapter 4 looks in detail at whether or not people went back to work and what influenced this.

## 2.11 Conclusions

People's sickness absence was often unplanned due to the sudden onset of pain or discomfort but also because people tended to be reluctant to take time off work unless they were physically unable to work or where workplace-related stress, sometimes caused by bullying, became unmanageable. This reluctance to take sick leave stemmed from people not wanting to let colleagues and employers down, to appear uncommitted to their work, or to show bullying bosses they had '*won*'. People also feared that taking time off could lead to disciplinary action or that future employers might not react favourably to long or recurrent periods of sickness absence.

However, there was little evidence of people worrying about what impact work might have on their financial circumstances at the point of taking sick leave, despite the fact that people often experienced financial difficulties, such as increased debt and arrears and threatened evictions or house repossessions, as their sick leave continued. Drops in income, whilst punitive in themselves, were sometimes exacerbated by other financial pressures, such as the recovery of benefit overpayments and, in one case, occupational sick pay but also the cost of private treatment. Whilst financial problems put personal relationships under strain and caused people worry, perhaps their greatest impact was on sending people back to work before they were fully fit.

In other cases, people managed financially despite a drop in income due to the fact that they were on a low wage to begin with or because they could manage without their normal income thanks to other sources such as a partner or spouse's income.

There was a patchy awareness of the existence of IB and of how to claim it among those interviewed in both studies. Employers appeared to be a key source of information for some but there were also instances where people had not claimed because they were ill informed about eligibility rules.

GPs varied in terms of how actively they managed people's health care but they were generally supportive of people's own views that they were not fit enough to return to work. There was no evidence of people wanting to extend their sick leave where they felt well enough to return to work, except where it allowed them to finalise return to work arrangements. In general, people did not think that it was their GP's role to advise them about when they were ready to return to work except where their GP's assessment chimed with their own. However, people did appreciate their GP's involvement where they supported or recommended phased returns and light duties, where they provided evidence of people's incapacity to employers who felt that absences were not genuine, and where they gave advice on what types of alternative work might best suit people with on-going health problems.

Waiting lists for diagnostic tests and treatments were a significant barrier to some people's recoveries, which encouraged some people to obtain private treatment, sometimes out of their own pockets. Improved access to health care was an important motivation to join JRRP. In the control group, in the absence of this help, some people took the initiative in their own health care by referring themselves for treatment, doing their own research into conditions and possible treatments or enlisting the help of their MP.

On the whole, people wanted their employers to remain in contact with them as this made them feel valued and part of the team and ultimately made them more likely to feel they could return to work in the future. However, contact with human resources or occupational health staff was not sufficient. People tended to expect their main point of contact would be with their line manager and their colleagues. The level of employer contact needed to be frequent enough to show concern and interest in the employee but not so much that it appeared 'pushy' or intrusive. Contact was more appreciated where it focused more on people's health and wellbeing and less on when they expected to return to work, but people did want their employers to discuss return to work options, such as phased returns, light duties or redeployment when they felt they were nearer a return to work. The format of any contact needed to be appropriate to people's health needs, for example, home visits suited those whose mobility was impaired but could feel intrusive for those with mental health problems like depression.

Views of employer occupational health services were mixed but people appreciated their intervention where they paid for private treatment, wrote letters to try and speed up NHS treatment and confirmed that people were unfit to work. However, people were often sceptical of occupational health services' role within employer organisations and of their ability to influence unsupportive managers, which made it difficult for people to fully engage with often very supportive people and services.

Whilst people could rely on their families for emotional support, more practical support such as help with negotiations with employers or benefit and careers advice was not always available or effective.

# 3 Using the Job Retention and Rehabilitation Pilot services

Having explored the broader context, this chapter now moves on to look specifically at the Job Retention and Rehabilitation Pilot (JRRP) services and people's experiences of contacting and using them. It draws mainly on the interviews conducted with provider clients in the panel study although data from the control group study is also reported where relevant.

Section 3.1 looks at how people heard about the provider services, why they got in touch and how clear their expectations or hopes of the services were. In Section 3.2, the process of becoming a client is explored. The section looks at experiences of telephoning the contact centre, understanding of, and reactions to, randomisation and their own allocation, and experiences of consent procedures and assessments. These two sections draw on data from the control group study as well as the panel study. The chapter then focuses on the experiences of people in the intervention groups, looking in Section 3.3 at the specific services people received including contact with case managers, what people thought of the help they were given, and packages or combinations of help. Section 3.4 looks at choice and clients' involvement in decisions about their care. Section 3.5 explores broader aspects of the style of service delivery: views about other staff members, venues and accessibility, pace and communication. Section 3.6 looks at gaps in service provision and how they arose, and finally in Section 3.5, how contact was ended is explored.

Chapter 4 explores the impact of JRRP on people's returns to work, and Chapters 5 and 6 explore the delivery of the services from the perspectives of staff.

## 3.1 Finding out about the services

### 3.1.1 Hearing about the services

People mainly heard about the service from GP practices and employers. In GP practices, they described being told about the service by their GP, seeing a leaflet or poster in the reception area, or seeing information attached to their sickness certificate. The encouragement of a GP could be important in people's decisions to get in touch, but some were told very little about the service by their GP or found their GP did not know about it. Other health care professions were also a source of information, where people described being told about the service by occupational therapists, physiotherapists or counsellors, or seeing information at a hospital.

Where it was the employer who had told people about the services, this had arisen in meetings with line managers, with human resources staff, or with occupational health services staff, and one person described being sent a leaflet with their wage slip. Trades unions also emerged as a source of information. People were generally open to the approach from their employer, although one person was suspicious of her employer's motives when she was told to return the form to the employer rather than to the provider.

In other cases people found out about the services from radio and newspaper advertisements, a leaflet delivered to their home, a Disability Employment Adviser (DEA), a family member who worked for the Department for Work and Pensions (DWP), or a stand at a shopping centre.

### 3.1.2 Reasons for making contact and expectations of the service

It was sometimes difficult for people to disentangle what they knew or expected of the service at different stages in making contact with them, but it seemed that at the stage of making contact, people generally knew relatively little about the service. They talked, often somewhat vaguely, about knowing the service provided help for people on sick leave with returning to work, and particularly help with health. Some were aware the service was government-based. Knowing that it was voluntary and free provided encouragement to people to get in touch.

Perhaps because of this lack of specific knowledge, people did not always have clear reasons for deciding to contact the service, nor clear expectations or hopes of what it might provide for them. They talked about it as something that *'could do no harm'*, and said that at this stage they would have tried anything that might help or *'would have clutched at any straw'*, especially if they found it difficult to see how their situation could improve. It was also seen as a chance to prove to an employer that they were trying everything they could to return to work or that their sickness was genuine.

Where people did have a specific aspiration of the service this generally related to health care, sometimes reflecting the fact that their GP had told them about the service and encouraged them to use it to get additional health care. Here, people

said that they hoped the service might provide physiotherapy, pain relief, complementary therapy, counselling, a quicker appointment with a consultant or for a scan or surgery. One person hoped it would sort out confusion around medical appointments, and another that it might provide a second opinion on NHS rehabilitation which they felt was harmful to them. Workplace support seemed to be much less expected, a view expressed by provider staff too (see Section 6.4.1). However, some people talked about hoping the service would help them to negotiate a return to work plan, provide support with returning to work after a long period off, reinforce to an employer their GP's advice not to return to work, or help them find another job. There was a more general hope that joining the service might reduce the pressure from employers to return before the employee felt able to, and one person talked about feeling that the employer could not sack them and their job would be safe if they were '*backed up*' by the service.

In the study samples, these more specific expectations emerged, particularly within the control group. The samples are small and not designed for statistical analysis, so it would be inappropriate to place much weight on this finding. It may be that it was harder for people who subsequently had more contact with the services to remember their initial motivations. But it may be that being refused support in some way crystallised the aspirations of people in the control group or gave them a stronger feeling about what they had missed out on. This might help to explain the suggestions in the data, reported in Chapter 4, that there were examples of people in the control group who appeared to be particularly determined to return to work and who were particularly active in driving the process of returning to work.

## 3.2 Becoming a client: the contact process

### 3.2.1 The Contact Centre

People who took part in the studies found it difficult to recall what took place at different stages in the consent process. In relation to the Contact Centre, people talked about a '*call centre*', telephoning a freephone number, or talking to someone with an unfamiliar or Scottish accent<sup>15</sup>. Some recalled being asked about their employment history and medical condition, and reassurances that the service was voluntary.

### 3.2.2 Understanding of the concept of randomisation

Understanding of the concept of randomisation was varied. Some people were fairly clear about it and described it as being like a lottery, like numbers going into a hat, or being done by a computer. One person had taken part in a medical trial involving random allocation and saw the design as being the same. Other people misunderstood some aspects of it, for example, thinking that their chance of being accepted on to the trial altogether, rather than of being in the control group, was one in four.

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<sup>15</sup> The Contact Centre was based in Glasgow.



There was more widespread misunderstanding too though, where people thought they had been assigned to their group by the provider following their initial assessment, or based on the information they had provided to the Contact Centre. Sometimes these views were held by people who at the same time described the process as random. It is perhaps particularly of concern that these views were held by people in the control group too. Here, people thought they might have been put in the control group because they had not seemed sufficiently needy or desperate when they first got in touch, were too close to retirement age, still had a job, or because there was limited funding or the service was not operating in their area. But others in the control group did understand that allocation was random and also understood, as discussed below, the purpose of a control group.

### 3.2.3 Understanding of the intervention groups and reactions to allocation

For people who were randomised to an intervention group, there were not always strong views about the group to which they had been allocated: people were pleased to be getting any sort of help. However, there was some disappointment with being assigned to the workplace group and not getting health care, particularly if this had been a specific reason for getting in touch. One person, for example, who had very much wanted specific types of health support and who had a good relationship with her employer, withdrew from the service when she found out she had been put in the workplace group.

People were not always clear about the three intervention groups, or *'categories'*, *'pathways'*, *'packages'* or *'streams'*, and some described only two. Some described the groups broadly accurately, but others were less clear and talked about telephone and other help; or psychological therapy and physical therapy; or advice and physical help. The health group was described as *'medical'*, *'supporting me healthwise'*, *'help with health problems'*, and *'physical therapy'*. The workplace group was described as *'the work path'*, *'the work focused group'* and *'the return to work group'*. The combined group was described as *'the middle group'*, *'the occupational therapy group'*, *'the intensive group'* or *'the group that gets everything'*. Within this array of terms, people in the intervention groups generally seemed clear which group they were in, although one man in the workplace group thought he was in the control group. He had received no help following his assessment, apart from being asked to return for a further assessment and understood that he had been allocated to the group which receives no services and is *'just being monitored'*.

The situation was, understandably, rather different for people in the control group. Here, people generally remembered little about the different intervention groups, but were keenly aware that they were not receiving help. They used the term *'control group'* but talked also about the *'survey'* or *'questionnaire group'*, the *'placebo group'*, or the *no (additional) help group'*. Some remembered knowing, before they were told which group they had been allocated to, that there would be a chance they would not receive any services. Although some had a broad understanding of the purpose of the control group, there were also

misunderstandings, with people seeing the whole initiative as simply involving research or surveys rather than any services, or not understanding why one group of people should not receive any help. One person understood the reference to 'groups' to mean locally-based support groups.

Reactions to discovering they were in the control group encompassed recognising the need for a control group; feeling that they had *'not lost anything'*; mild disappointment; being resigned to not getting help or describing the idea of the service as *'too good to be true'*; and anger, frustration and strongly expressed disappointment. People described less strong reactions if they had initially made contact with limited enthusiasm or little sense of the help they wanted, or if by the time of the research interview they did not feel they really needed extra support, for example, if they had quickly returned to work. The strongest reactions were expressed by people who, by the time of the research interview, were still off work and felt their situation had deteriorated or at least not improved. Here, people talked about *'yet another let down'*, and being *'dumped'*.

There were also different responses to subsequently being asked to take part in research. One person could not see the relevance of their involvement in the research, and there was frustration that people had provided lots of their time and got nothing in return. People gave their time with varying degrees of enthusiasm, but there was a group who seemed to have a clear sense of being part of an important experiment and of the value of their participation. These feelings may explain the difficulties experienced in recruiting people from the control group to the study (see Appendix A).

### **3.2.4 Consent processes**

The first contact with providers was initially conducted by telephone by one provider but for most people involved a meeting, either with someone who would later be their case manager or with a different person or a group of professionals. Meetings lasted between twenty minutes and an hour and a half, and sometimes involved several different sessions. When they were specifically asked about it, people generally recalled seeing the video and that it was about the randomisation, and were generally positive about it. There were different levels of recall of the consent process, but people recalled consenting to sharing medical records or to employers being contacted, consenting to the randomisation process, signing disclaimers or signing forms to confirm they understood the service was confidential or voluntary. People appeared to be broadly happy with these arrangements.

### **3.2.5 Assessments and action plans**

Initial meetings also involved some form of assessment. People described questions about health and work, sometimes including a paper or computer-based questionnaire, detailed mental health assessments, and physical assessments, for example, of mobility. People were generally very positive about the staff at this stage, describing them as courteous, friendly, professional and sympathetic, and

saw the assessment as thorough and a positive experience. There were some concerns, however. One woman felt overwhelmed by being asked to complete several questionnaires, including a mental health assessment which she found insensitive and depressing. A man with back problems, whose initial assessment was conducted over the telephone, was happy with this at the time but later, prompted by a more thorough assessment by a private health professional which included a physical examination, felt that a telephone assessment alone had not been sufficient.

When asked specifically, some people recalled being given a written document about their treatment, although spontaneous mentions of action plans were rare. Few people could specifically recall signing the document, being given a copy of it, or it being reviewed or revised, although staff did find action plans helpful (see Section 5.3.1). Despite the limited salience of action plans to people using the service, they were generally happy with the services proposed for them at the assessment stage.

### 3.3 The services received

These sections describe the help people received and their reactions and views about its effectiveness. Chapter 4 includes discussion of the impacts of different forms of help, and Chapters 5 and 6 explore staff perspectives on the services provided. Given that there was a lot of diversity in the types of help people received, some types of help were described by only small numbers of people in the study samples.

#### 3.3.1 Health-related services and reactions to them

People in the health and combined groups described receiving the following services.

##### *Psychological therapy*

Such as cognitive behavioural therapy and counselling. There were some negative experiences of these in the first cohort of interviews, where people described the therapist '*playing mind games*', sessions leaving them feeling depressed, an approach which they felt was bullying or critical, or the therapy not being sufficiently work focused. But other people found these interventions a very helpful opportunity to understand their situation and how to manage their condition.

##### *Physiotherapy and similar*

Such as exercise programmes, pilates sessions, gym membership, a personal trainer, accompanied swimming sessions, advice about pain management and use of a TENS machine. These were generally very well received by people, and some described dramatic improvements in their mobility and becoming pain-free which was a critical part of being able to return to work. They described learning how they could manage pain or constraints on movement, reaping benefits from improving

their posture, and acquiring new habits which they felt stood them in good stead for the future. One person felt the physiotherapy they received was not as good as the sessions they had had on the NHS because the therapist lacked experience of their specific condition, but was pleased that more sessions were available than they had been allowed on the NHS. Another, mentioned earlier in relation to assessments, subsequently had physiotherapy from a private provider and felt that his work with a personal trainer had not addressed the core problem with his back, and that the private physiotherapy he later received was more helpful. In general, however, people found these types of help very effective.

### *Health care referrals*

To consultants and specialists, scans and other diagnostic tests, expedited NHS appointments or results, a suggestion for changing medication, and in one case a minor operation. These forms of help were generally very well received by clients, particularly since many had experienced delays and frustrations within the NHS. A session with a specialist or a diagnostic test could provide people with new information or certainty about their condition, a pathway to appropriate treatment, and an understanding of how their condition affected their work capacity.

### *Complementary and similar therapies*

Acupuncture, hypnotherapy, relaxation sessions, breathing sessions and aromatherapy. These were generally found helpful by people and could boost confidence and general happiness or lower stress. However, one person said that he had been hypnotised without his consent in a session with a psychotherapist, and felt this was unethical and inappropriate.

### *Occupational therapy*

Help with understanding and managing a fluctuating condition, including completing a diary of activities and energy levels, which was very well received.

The most extensive combinations of help were described by people who received consultant appointments and scans as well as physiotherapy or one or more complementary therapy, or by people who received combinations of physiotherapy, complementary therapy and information and advice about managing their condition. However, a single type of help could also be seen by clients as very effective, for example, where people felt that a service such as physiotherapy, a physical trainer, a complementary therapy or cognitive behavioural therapy had played a very significant role in their recovery.

### 3.3.2 Interaction with NHS help

As Chapter 2 has highlighted, people used JRRP services alongside continuing contact with the NHS. There were several patterns in how JRRP health care interacted with NHS health care:

- providing much more extensive support than the NHS: for example, one man who saw stress and back pain as the reasons why he had to go off sick was being given medication by his GP. Through the provider service he was given physiotherapy, accompanied swimming lessons and a TENS machine. A man with chronic fatigue syndrome appeared to be getting no health treatment from the NHS, but from the provider got physiotherapy, pilates sessions, relaxation sessions, and information and advice about living with his condition;
- adding a different form of health care to what was being received from the NHS: for example, a complementary therapy where someone was being treated with medication; gym membership where they were having investigative appointments with specialists; or cognitive behavioural therapy or counselling where their condition was being treated with medication;
- providing the same type of help as the NHS but with what the client saw as greater effectiveness: for example, where a personal trainer was able to help someone make much more rapid progress than earlier NHS physiotherapy, or where a consultant appointment provided via JRRP added to, or replaced more quickly, the specialist consultations provided via the NHS.

In other cases, however, the approach of the service appeared to be that there was little or nothing they could provide while the client waited for investigations that were proceeding within the NHS.

### 3.3.3 Workplace services and reactions to them

In the workplace and combined groups, people described the following services.

#### *Mediation with employers*

Being accompanied to meetings with employers or occupational health services, and direct contact between the provider and the employer. These interventions could be very effective and well received by clients. People felt that having a third party involved, even where the provider had corresponded with the employer rather than being involved in joint meetings, had led to a change of approach by the employer. Some people said it had been helpful that the provider had reminded the employer of their legal responsibilities. They described employers showing more concern and flexibility, being more proactive in initiating discussions about the return to work and making suggestions for how this might be facilitated. One person described this as making their employer '*sit up and take notice*'.

Being accompanied to meetings with a line manager, human resources staff and occupational health staff was also seen as very helpful, particularly where people had not found their employer's approach supportive. They talked about the added confidence of knowing that someone was '*on your side*' at the meeting, and described provider staff helping them to answer difficult questions, asking pertinent questions which the employee had not thought of, and highlighting the significant health improvements they had made. One woman, who was unable to return to her previous job but was concerned about being moved to another inappropriate site, said the provider helped her to understand what redeployment might mean and that it could be positive, reinforced her argument to the employer that the wrong site could be harmful to her health, and was central to the negotiation of a successful return to a different job.

There were also criticisms of provider staff's work here though. People who felt they had not been fully informed about provider staff's contact with their employer found this very unhelpful. Some people felt the staff member did not seem to be sufficiently experienced or skilful at negotiating with employers and felt they lacked credibility and effectiveness. One person said the provider put unhelpful pressure on the employer, pressing for a return to work which the client themselves thought was far too rapid.

#### *Advice about strategies for returning to work*

Such as graduated returns, lighter duties, working from home. This was helpful to people who had not considered these options themselves, but they were not always able to persuade employers to allow them. Although people were generally happy with the help, one woman felt the graduated return plan drawn up by the provider was too rushed and reflected their lack of understanding of her condition. She instead followed the more gradual plan proposed by their employer's occupational health service and found even this quite demanding but felt the provider's suggestion would have been harmful to her.

#### *Workplace assessments and advice*

Workstation assessments, functional capacity assessments and advice from occupational therapists. As with health interventions, this included help with understanding how to manage a condition and using diaries to understand what levels of activity could be sustained. These types of help could also be helpful in understanding job options and whether a return to previous work was feasible. No one in the study samples described equipment being provided by the services, but one person had been offered it (shortly before the last research interview), and another had been advised on the set-up of her workstation.

#### *Vocational guidance*

Psychometric tests, vocational assessments or careers advice. This did not seem to be experienced as particularly helpful by people because, in the cases in the study sample, it did not generally identify what they saw as a feasible vocational direction.

One person, for example, described being told of far too many possible job options which made it difficult for him to see how he could follow up on the advice.

#### *Jobsearch support*

Help with CVs, advice about applying for jobs, encouragement to contact Jobcentre Plus services or other organisation such as Remploy<sup>16</sup>. This was welcomed and in one case led to a job being identified for which the client successfully applied.

#### *Information about training courses*

There were mixed reactions to this, depending on how far it helped people to move forward. One man was pleased with the help he received and enrolled on a course which he thought would be helpful in developing his career. But a woman who was encouraged to apply for a course was disappointed because she had wanted to be given information about jobs, and could not see how the course would be relevant to finding appropriate work.

#### *Advice about money management and benefits*

Help with completing forms. This could be very helpful to people, especially if they had no experience of the benefits system and found applying bewildering or undermining. However, one man felt it had come too early, at a point when he still hoped to return to work, and he could not recall the details once he did have to apply. A woman was surprised to be told that she should come off Income Support (IS) and apply for Jobseeker's Allowance (JSA) instead to indicate her commitment to returning to work, at a time when she felt far from well enough to do so.

The most extensive combinations of support were described by people who were accompanied to meetings with employers, helped with investigating other jobs (either by discussion with the case manager, or being put into contact with Access to Work or a DEA, or given vocational advice, help with CVs and help with job applications), and given advice about benefits and/or debt management. Alongside this, there were cases where only one type of help – mediation between the client and the employer – had been effective. However, there were also cases where people in the workplace group had received no help, instead being encouraged to contact the service when they felt well enough to return to work, or if they had questions in the meantime.

### **3.3.4 Interaction with the client's contact with employers**

As Chapter 2 highlighted, people described different attitudes and approaches on the part of their employer. Where they felt they had a positive and supportive employer, it was often difficult for them to see what further role the service could play. People in these circumstances preferred to deal direct with their employer and

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<sup>16</sup> Remploy provide a range of employment support services to disabled clients.

sometimes felt the involvement of a third party might be detrimental. Where people had poor relationships with their employer, it was clear as described above that the service could play an effective role.

### 3.3.5 Combinations of help described by people in the combined group

The most extensive combinations of help were described by people who were given both health and workplace support. Examples of more extensive packages were:

- expedited scans and surgery, advice from an occupational therapist, contact with the employer and assessment of job options;
- physiotherapy, liaison with the NHS, contact with employers and benefits advice;
- contact with occupational therapists and physiotherapy, cognitive behavioural therapy, pain management, gym sessions, group discussion work, information about conditions and contact with the employer.

There were cases where the fact that the service combined workplace and health support was seen as helpful, although health support tended to be more dominant in people's thoughts about the services that had been valuable to them (see Chapter 4). But other people described getting only health-related help, or only workplace support. This could be sufficient to address their needs but in other cases left gaps, an issue explored further in Section 3.6. Staff, too, felt it was important to be able to provide combinations of help which spanned health and workplace support (see Section 5.2.3).

### 3.3.6 The case manager role

Having regular contact with someone in a case management role was a feature of the service which was described recurrently, and which emerged as a very important type of support in its own right. Some people, however, described the service using a team approach, regular contact with several members of staff or a change of lead person during their use of the service. The term 'case manager' was rarely used by people, but the post was very apparent where people referred to this person by name, by their professional specialism, as a 'case worker', 'administrator', or 'key worker', or more generally as '*the person who keeps in touch with me*' or who is '*in charge of everything that happens to you*'. Contact was regular and frequent particularly while the client was receiving services, and became less frequent over time and once they were no longer receiving services. It was often initially face-to-face and then by telephone.

The help provided by people in the case manager role was seen as very valuable, and encompassed:

- some of the workplace or health support described in the previous two sections;
- suggestions about how to proceed, referrals to, or suggestions to, contact other services;



- coordination of appointments with other members of staff or services;
- encouragement, motivation and confidence building;
- being a sympathetic listener;
- checking progress and providing encouragement where other professionals were providing services;
- generally asking how the person was, whether their circumstances had changed and whether they needed further help.

This type of emotional and practical support was generally seen as very important and helpful by clients. They were impressed and found it very supportive that they were seen as important by an individual member of staff. They valued having a dedicated contact with whom they could build a relationship, so that they were not '*passed around*' and did not have to retell their circumstances again and again. They appreciated having someone who would listen, whether they had good or bad things to say. Some said they found their case manager easier to talk to than their GP or employer, or even than family members, as they were prepared to hear about their despondency or lack of progress, did not judge them, and were always '*on my side*'. They gained confidence from their case manager and felt more positive about their future, their ability to return to work, and about dealing with difficult situations such as a meeting with an employer. Overall, it was encouraging to know that '*someone is there*'. Staff described the case management role in very similar terms (see Section 5.3.1) and like users of the service, they felt it was an important aspect of the help provided.

Not everyone described their contact person in such positive terms. Some people did not form a good relationship with their case manager, did not feel that the suggestions and offers made were followed up and described contact dwindling or stopping abruptly (see Section 3.5.4). One person was told that a nurse would be in charge of their use of the service but never met or spoke to this person and was left unclear as to who was actually in charge of his care. Another felt that his contact with the case manager was too perfunctory and compared it with the research interviews which he said had been much more effective in helping him to evaluate his situation and how it had changed. The importance of an opportunity to reflect and review is perhaps also illustrated by other participants in the panel study who felt the research interviews had played a part in helping their return to work.

Finally, there were occasional cases where it seemed that people had become particularly dependent on the case manager and withdrew somewhat from taking action themselves. One man, for example, said he needed the motivation of his case manager to continue with an exercise programme and stopped following it as contact dwindled and then ceased. He felt the pace of his progress was slow and had wanted more help but thought that the provider '*had a plan*' and so did not press for more. A woman described knowing her provider would answer all her questions and that she would never need to look elsewhere for help; she was pleased that the

provider had *'taken ownership'* of her problems so that she did not need to worry about them. Another man seemed to be very reliant on his case manager's liaison between different consultants and worried about what would happen when the service was no longer involved but did not anticipate taking on this liaison himself. Provider staff also reflected on the way in which dependency can arise and noted that the 'sick role' can be reinforced in the way in which some people relate to a case manager (see Section 6.4.1).

The balance between a relationship of support and one of dependency is obviously subtle and complex. Despite this, it was clear that the case management role is an important part of the service provided.

### 3.4 Choice and client involvement

Although it was sometimes difficult to get a clear picture from participants, they did not generally appear to have been very actively involved in making decisions about the type of help they would get from the services. As noted in Section 3.1.2, people often did not have a clear requirement of the service when they got in touch, or a view of exactly what help they wanted. Where people said they had been asked what help they wanted early in their contact with the service, some described giving a very general reply, such as any extra help they could get or help with getting back to work, although others had specific types of help in mind. In some cases, the types of help they actually received were all identified in the initial assessment. In others, different types of help were offered or provided in response to information and discussion in case managers' regular contact with clients, but were generally described as the suggestion of the case manager rather than requested by the client.

A picture emerged of providers making suggestions or proposals, to which people were invited to react. In general, people felt happy with this approach and felt they had been sufficiently involved in decisions. They felt able to (and did) say no to things they did not want, although one woman felt she was put under undue pressure to attend a course on managing bullying which she felt would be detrimental.

However, it was clear from people's accounts that they did not always know enough about what help might be available to play a greater role in determining their own service. It was also difficult for people to respond to open questions about what help they wanted if they were unclear about what would help them in a situation that was unfamiliar. Even by the end of their contact with the service or the final research interview, some people were still unclear as to the range of help that could be provided by the services. Although this was not problematic if they were happy with the help they had received, there were also those who would have liked to know more about what was available and to have had more say in their own support. There were examples where people were unsure they had been told about or had had access to everything available.

People could also make assumptions about what was or was not available based on the help they had received, for example, where people in the combined intervention group had received only health support, or only workplace support, and did not know that the other type was also available. Conversely, a man in the health group who was particularly concerned about losing his job assumed his provider would be able to help, and indeed understood his case manager as having indicated this. It is possible that people did not recall all the details of what they had been told, perhaps particularly if they had had several meetings with the provider before the first research interview, but this does highlight the need for repeated information about what is available.

Finally, there were also cases where people did not appear to know enough about a specific type of help they were offered to be able to play an active part in decision-making. For example, one person seemed content to start a course of aromatherapy despite not knowing what it was; some embarked on counselling or cognitive behavioural therapy without seeming to know what it might involve and felt they could have been better prepared for a challenging experience, and one man was expecting isometric tests but had no idea what they were.

As noted above, people could be happy with their involvement in decisions, and with the help they received, despite these issues. But there is not a strong picture of people actively engaging with the services. Although this was not necessarily problematic, it may help to explain why gaps in the service sometimes arose, and why contact sometimes waned – issues discussed in Sections 3.6 and 3.5.4.

## 3.5 Other aspects of service delivery

### 3.5.1 Service provider staff<sup>17</sup>

People's descriptions of the staff with whom they had contact were generally very positive. They described staff members' interpersonal skills in very favourable terms, seeing them as *'friendly'*, *'courteous'*, and *'charming'*. They were impressed by how engaged staff were with them, how they listened, were sympathetic and caring, seemed genuinely interested in them as an individual, and did not judge or criticise them. They described staff showing concern for people's health, through regularly asking how they were or actions such as rearranging furniture to meet clients' needs. Although there were exceptions, people also talked about not feeling under pressure from staff to return to work. Simply finding someone who did not question whether they were ill or imply that they were malingering, and who engaged wholeheartedly with them, could be an enormous boost to people. For some it contrasted very sharply with the treatment they had received from employers and health care professionals.

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<sup>17</sup> Research participants did not generally know whether the people they saw were employed by the provider organisation or worked in another capacity, and the term 'staff' is used here to refer to both employees and contractors.

There was also praise for the professional skills of those with whom they had contact. People were impressed with the detailed knowledge that staff members sometimes showed of particular conditions, the skill with which they provided particular therapies, and the time and commitment they gave. There were positive comments about people's skills in organising, liaising and persuading, and about the appropriateness of the advice they gave. Again, there were exceptions here where people felt a staff member did not seem experienced, for example, in liaising with employers, where communication did not go smoothly, and where contact was not sustained (see Section 3.5.4).

### **3.5.2 Premises and accessibility**

There were many positive comments about providers' premises and the atmosphere people found. People responded positively where they thought attention had been paid to the impression that surroundings created, and there were positive comparisons with NHS premises. They also valued a warm welcome from other members of staff, and a friendly and relaxed environment. Some premises were described as cramped, and an office was seen by one person as not the right environment for therapy sessions. Some people faced long journeys to the premises, and bus journeys of over two hours were described which could be demanding on people with limited energy and, for example, back pain. It was generally appreciated where taxis were provided, or in a case where the client was visited at home. Overall, however, access had worked smoothly.

### **3.5.3 Pace**

The speed at which different types of help were arranged, either following on from the initial assessment or in responding to circumstances as they changed, could be very impressive to people. One person, for example, was very pleased to be given physiotherapy at the first meeting with the provider. This speed contrasted sharply with long waits for NHS services. However, there were also examples where progress was slower. It could also be too rapid. One woman found the assessment traumatic and draining, particularly when she had to complete several questionnaires, including a mental health assessment she found particularly painful. She felt rushed and '*railroaded*' when she was offered an appointment with a professional for the next day and appointments made with other professionals in the following fortnight, and decided to withdraw from the service.

People were generally happy with the pace at which services were delivered, in terms of the frequency of sessions. There were cases where people found a service too intense, such as twice-weekly sessions of cognitive behavioural therapy, or weekly contact from the case manager at a time when they felt their situation was simply not changing. Equally, some people would have liked more intensive help, such as where there were several weeks between appointments for different therapies. It was important to people to know in advance that a particular type of treatment was coming to an end.

### 3.5.4 Communication and contact

As noted in Section 3.3.6, people placed a high value on regular contact from their case manager. Communication between provider staff and clients was generally seen as good although, as described below, clients were reliant on case managers to sustain contact and this did not always happen. There were some individual difficulties, for example, when a client was not told that a session of physiotherapy had been arranged. A more recurrent difficulty was where suggestions or plans for other types of help did not appear to be followed up with the client and such help did not materialise. The way in which provider staff communicated with employers and GPs was also generally seen as helpful. It was important to people to be kept informed, to know who was communicating what to whom, and that communication happened as they were expecting. There were again individual cases where people were not happy with this aspect of the service, where information had been passed on without them expecting this, or had not been passed on where they had wanted it to be.

There were also instances where it appeared that the client had not told their case manager about a change in circumstances, such as new health problems, new dissatisfaction with NHS services, or a worsening relationship with an employer. It was not always clear why they had not told the case manager about this, but uncertainty about what the services provide appeared to be relevant. People sometimes also described being asked specific questions by the case manager, such as how physiotherapy was going, which may not have provided the prompt for new information.

The picture that emerged was generally one of clients expecting provider staff to lead on communication with them. There were exceptions to this, where people saw it as their responsibility to keep in contact with their case manager. But on the whole, people described provider staff as having initiated each contact. This worked well where provider staff were in touch regularly, but where they were not it meant that contact could dwindle and cease without this being what the client wanted, and without the client themselves taking steps to resurrect contact. When people cancelled or missed an appointment they did not always get in touch to make the next one, assuming that the provider staff would contact them. Although people were not concerned about this loss of contact if they did not want any further help, they were less happy if they did.

In cases where people looked to the provider to sustain contact but where communication appeared to have fallen away, they could be left somewhat in limbo. Some people were waiting to hear from their provider and did not appear to be taking responsibility themselves for progressing health care or contact with the workplace, assuming there would be further contact in due course.

It was not always easy for people to explain why they had not been in touch themselves and they sometimes expressed themselves apologetically, vaguely or somewhat defensively in talking about it. But some possible explanations emerged.

Where there was a lot of other change or activity in someone's life, for example, a lot of health care appointments, contact with an employer or a review of Incapacity Benefit (IB) entitlement, it could be hard for them to find the time or energy to contact the provider too. Some people simply felt too ill to be in contact or to use the services. Feeling very depressed or down could also make people reluctant to get in touch. One man, for example, telephoned the service when he had not heard from them for some time but felt too disheartened to talk when the telephone was answered and hung up. Someone who had no follow-up contact after the assessment said they were reluctant to get in touch in case it got a member of staff into trouble. If people had not been impressed by the help they had so far received, there could be a lack of confidence that getting in touch would lead to something useful. The patchy knowledge of the services and what they could provide also appeared to be relevant. Where contact had dwindled people sometimes found it difficult to know what help the service might be able to provide. It appeared that not being able to place their own needs within a wider framework of the help available made it difficult for them to see the value of getting in touch.

It also seemed to be easy for people to assume that they were not seen as a priority by the provider staff, or that staff had lost interest in them, particularly where people sensed that the services were busy and pressed. This was the assumption, for example, of someone who felt they faced particularly significant barriers and '*would be a hard case*'. One man felt he was not a priority because he had lost his job; another, perhaps more surprisingly, assumed he was not seen as a critical case because he still had a job to return to. Where people were told to get in touch when they felt ready to return to work, continued ill-health meant they did not feel it would be appropriate to be in touch.

There were cases where people's circumstances changed without the provider services knowing about it, because contact had lapsed. There were examples of people returning to work, finding that contact with an employer which had been going well began to be problematic, being offered a job, starting to look for work, or experiencing new difficulties with their health or their NHS treatment. People did not always identify a need for help in these cases, and of course it is impossible to know whether the service could have intervened usefully.

However, the possibilities opened by a more proactive approach on the part of a service are illustrated by one case in particular. The client, in the workplace group, was off work with severe back pain. She had a good relationship with her employer, was disappointed to be put in the work place group and after the first meeting did not think she would be in touch again. Shortly before the second research interview, her case manager telephoned and asked about her pay situation, which triggered the offer of a session with a benefits adviser although this did not, in fact, take place. At the third research interview, she again had no plans to be in touch. Before the fifth interview she was planning to return to work. She was again contacted by the case manager, and the discussion triggered the offer of assistance with providing equipment. Before the sixth interview, she herself had telephoned the case manager

to talk about the possibility of other support for the return to work, and although this was not funded she was planning to get in touch again if the return to work did not happen.

Communication and contact strategies were not explored specifically with case managers, but they did not comment on difficulties in maintaining contact with clients.

### 3.6 Gaps in service provision

In some cases, people talked explicitly about help they would have liked but did not get. However, people did not always know the full range of services available from JRRP, nor necessarily what might help them in their own particular circumstances. It is, therefore, also useful to explore possible gaps in provision by comparing people's accounts of their health and work circumstances with the services they received, and with the services other people received.

Inevitably, one set of gaps in service provision arises as a result of the intervention groups to which people were assigned. There were people in the workplace group who would have liked particular types of health support, and people in the health group who would have liked help with contacting employers or financial advice. People sometimes described provider staff expressing their own frustration that a particular type of help which the client needed would have been available had they been in a different intervention group.

There were also instances where people were told that the help they wanted was not available for financial reasons. This included medical treatment, an MRI scan, reflexology, work clothing and an exercise bike. Some people said they had been told that funding was limited, for example, to £300 or £1,000. This was met by acceptance or mild disappointment, but also, in some cases, by frustration. One man, for example, felt the limit of £300 indicated that this was not a serious attempt by the government to address complex issues. In other cases, people would have liked **more** of a particular type of help, such as physiotherapy sessions, gym membership or reflexology, but were either told or assumed that no more was available. As discussed in Section 6.2.1, staff felt that budgets were generally sufficient, except where operations were required.

Gaps also arose where a particular type of help was mentioned or offered, but never materialised, for reasons that were unclear to the client, or where contact with the service dwindled.

There were also cases where people described aspects of their health, or their employment situation or contact with employers, which appeared not to be addressed by the service. In the workplace and combined groups, this emerged where people seemed not to have been offered help with liaising with employers, or with looking for different jobs, or with benefit or debt management. In the health and combined groups there were examples where people were not offered scans or

other investigations which were delayed or not being offered in the NHS, or where people who described themselves as depressed were not offered any support for this. Of course, it is important to acknowledge that the research team does not know the full circumstances of people's contact with services. It is possible that a particular type of help was offered but was not recalled by the client, or there may have been good reasons why it was not offered. However, it was sometimes striking that a type of help which other participants had received was not offered in a case where the client described similar circumstances.

Section 3.4 noted that clients appeared not always to be actively involved in their own services within JRRP, with limited knowledge about what was available. This may be relevant in explaining why they did not ask for particular types of help, or indicate particular needs, or why they did not follow up on suggestions or offers of help that did not materialise. People seemed quick to assume that something was not available, or that their case manager had a good reason for deciding not to offer it, or did not press for types of help that had been mentioned if they did not really understand what they were.

Staff too noted barriers to and constraints on their work associated with JRRP service provision (see Section 6.2). Overall, however, an important element of explaining gaps in service appeared to lie in the fact that contact between the client and the service dwindled, as explored in Section 3.5.4.

### 3.7 Ending contact

People who saw themselves still in touch with the provider services at the final research interview were either still receiving services, receiving regular contacts from a case manager to see how they were, or intending to get in touch once they were in a position to return to work. Where contact had ended, this was sometimes by agreement, particularly if someone had returned to work. In other cases, contact had, as described in Section 3.5.4, ended without acknowledgement by the provider. There was sometimes a lack of clarity about whether contact had ended. Some people who assumed the provider was no longer planning to be in touch were surprised, subsequently, to receive a letter or telephone call; conversely, others who assumed they were still in touch were surprised not to receive any contact.

There were also cases where clients had withdrawn from the service because they were unhappy with the service or the way they had been treated or felt there was nothing, or nothing further, that the service could provide. And there were two cases where contact had been formally ended by the service provider. People's reactions to contact ending depended on whether they felt that the service could, or should, have done more to help them. Although they recurrently talked about having been told they should get in touch if ever they needed to, there was little evidence of people doing so.

Finally, some people in their third cohort in the panel study were still in touch with the services at the point when they were beginning to wind-down for the cessation of service delivery in March 2005. Some recalled having been told, early on in their



contact with the provider, that the services would cease, and people had received letters or telephone calls shortly before the services did stop. Generally this seemed to have run smoothly, although one person felt his case manager became concerned with his own next post, and another would have liked a final '*sign off*' meeting with their case manager.

### 3.8 Conclusions

The panel study highlights the diversity in patterns of contact with the services. Within this, there are some clear messages.

There were a number of individual types of help which could be very well received by clients, particularly psychological therapies, physical therapies, help with NHS case management, complementary therapies, support in contact and negotiations with employers, and workstation or functional capacity assessments and advice. Both individual types of help and combinations of support could be useful, and the help provided could interact constructively with, and clearly add to, NHS care and support from employers.

Ultimately, though, what made a difference was the fit between a client's needs and the help they received. This is mirrored by the emphasis staff place on client-centred help which is flexible and tailored to the individual (see Sections 5.1 and 5.3.1). Although some people did get the help they needed, others identified types of help which they felt could have been of value but which was not offered or was not available. This sometimes reflected the intervention group to which a client had been allocated. There were also cases where people faced obstacles for which other clients (in the relevant intervention group) had been offered help, but which did not appear to have been offered to them.

There were some aspects of clients' engagement with providers which were not conducive to effective service delivery and which may explain why gaps arose. People did not always have a clear idea of what the services could provide. They appear to have looked to staff to suggest forms of help rather than actively engaging in discussing what would be appropriate, and do not always appear to have told staff about relevant changes in their circumstances. They relied on case managers to initiate and maintain contact, and contact sometimes dwindled. There were instances where clients appeared to have become somewhat reliant on the provider for action, and where they were effectively waiting for the service to make contact and appeared not to be taking action themselves in the meantime.

These issues help to explain why needs were not always met, and why there were sometimes gaps in the services provided. The implication is that the process of finding out about clients' needs must be a continuous one, and that clients need more information and more support to become active users of the JRRP services.

Finally, the experiences of the panel study highlight the central role of case management within the JRRP services, an issue which is explored from the perspective of staff in Chapter 5.

# 4 Employment outcomes and the perceived impact of the Job Retention and Rehabilitation Pilot

## 4.1 Introduction and context

This chapter is divided into two key sections: This first half of the chapter explores the experiences of those who went back to work in the panel and control group studies. Its main aim is to understand why people went back to work. Section 4.2 briefly describes the nature of employment outcomes for those who went back to work to provide a context for the subsequent sections. What motivated people to return to work is covered in Section 4.3 and Section 4.4 describes the developments in people's health and their role in promoting fitness for work. Section 4.5 then goes on to explore the availability and suitability of work to return to. The first half of the chapter ends with a summary of the overall impacts of Job Retention and Rehabilitation Pilot (JRRP) on those who went back to work in Section 4.6 and a discussion of people's experiences of being back at work in Section 4.7. The second half of the chapter focuses on those who did not go back to work. It begins with a brief introduction and description of the circumstances of those who did not go back to work in Section 4.8 and moves on to look at people's attitudes towards returning to work in Section 4.9. Sections 4.10 and 4.11 respectively examine the health and employment barriers to returning to work. Section 4.12 presents a summary of the role of JRRP in the cases of people who did not return to work. The chapter ends with a discussion of people's experiences of longer term sickness absence in Section 4.13 and with a conclusion to the chapter as a whole in Section 4.14.

As noted earlier, throughout this chapter references to the 'impact' are based on the perceptions and assessments of study participants. Impact should, therefore, be understood as changes they ascribe to JRRP – not as statistical estimates of net impacts, for which see Purdon *et al.* (2006).

The chapter draws on data from the control group study and the panel study. The control group study involved 36 interviews with people who had gone back to work and ten interviews with people who had not. The panel study involved 19 people who had returned to work by the time of the final<sup>18</sup> research interview and 17 people who had not.

## 4.2 Returning to work: context

To provide a context to the discussion of people's returns to work, this section begins by describing the range of work outcomes and the numbers of people returning to work in different forms. These numbers are given to indicate the sample sizes drawn on in the discussion that follows. They should not be read as indications of the prevalence of different outcomes: robust statistical evidence of these is provided in Purdon *et al.* (2006). As noted above, 36 participants in the control group study and 19 in the panel study returned to work. Of these, 42 had returned to their original jobs, nine had been redeployed by their original employer and four had found new jobs with new employers. Seven people (five of which were panel study respondents) were not working at the time of the (final) research interview due to further sickness absence or because they were no longer employed as a result of resignation or dismissal due to ill health, a planned retirement and a redundancy. Where people had returned to work for their original employers, phased returns and light duties had often been used.

One might expect that people returned to work only when their health had improved and they felt fit enough to do so. However, some people's motivations to return to work were more important in the decision to return to work than changes in health. Being able to return to work was also dependent on people having suitable work to return to. The following sections explore how motivations, developments in health and fitness and the availability and suitability of work all had a part to play in people's decisions to return to work.

## 4.3 Motivations to return to work

Chapter 2 discussed how some people had been reluctant to take sick leave because they enjoyed their job, they had an emotional and financial need to be working, or they felt guilty about letting colleagues and employers down by not being in work. These same reasons were also often highlighted in people's explanations of their returns to work.

An additional set of motivations were described by people who did not feel they had been well supported by their employers either in the period leading up to their sickness absence or when they had been off work. This arose where people had faced bullying, and where they described employers questioning the genuineness of

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<sup>18</sup> See Appendix A for a description of the panel study design.

their condition or putting pressure on them to come back to work before they were ready or to consider giving up work. Here, people described a growing determination to return to work because they did not want to let their employers 'win' or wanted to prove the genuineness of their sickness absence, particularly if they had worked for the employer for some time. Some people also wanted to ensure that their pension provision did not suffer from leaving work early because of their employer's behaviour. This determination had sometimes led people to return to work even though they suspected it could be detrimental to their mental health, and in some cases against the advice of health care practitioners (see Section 4.4.3).

A further set of motivations were particularly relevant to people who had gone back to work before they were fully fit:

- Financial pressures. As Chapter 2 highlighted, being off sick from work could have serious financial implications for some people. There was a clear pattern of people returning to work either shortly before or after a drop in income, particularly at six months when occupational sick pay schemes were commonly reduced by half. For some people, the return to work was, therefore, a response to financial difficulties, such as running up debts or the threat of losing their home, or a decision made in anticipation of financial problems.
- A fear of losing one's job. People also went back to work before they were fully fit, to safeguard their jobs. As Chapter 2 reported, people had felt under pressure from their employers to return to work. Some had been told they had to return to work by a certain date or they would be dismissed; others assumed that they would lose their jobs if they were off sick for much longer.
- To improve mental and emotional wellbeing. Returning to work was seen as a means of improving mental and emotional wellbeing both for those whose wellbeing had been affected by being off sick from work, as reported in Chapter 2, but also where a mental health condition had led to sickness absence in the first place. In either situation, people described having gone back to work in the hope that work would have a positive impact on their health, in addition to any improvements as a result of treatment received, by providing them with the direction in life or the routine they associated with being in work.

Redeployment, phased returns and light duties were often instrumental in allowing people to return to work despite continuing health problems, and are discussed in more detail in Sections 4.5.2 and 4.5.3, but there were also cases where people returned to work without these types of help because financial pressures or fears about job security were so great. As Section 4.7.4 describes, these returns to work were not always sustained.

#### 4.4 Developments in health and fitness for work

This section looks at how people's health developed between going off sick and going back to work and the influences on this. It then examines how people thought about their fitness for work and the influences on this.

#### **4.4.1 Developments in health**

There was much variation in how physical health conditions had developed among those who had gone back to work. In both the control group and the panel study samples there were instances of people who described a near or full recovery from back pain and other musculoskeletal conditions, infections, a broken limb and mental health conditions. Whilst some improvements in health conditions, typically a reduction in pain, were reported among the remainder of the sample, there were also cases of people having returned to work where there had been little improvement in conditions. Some people, especially those with long term conditions with little hope for improvement, said they had learned to live with a certain level of pain or limitation.

#### **4.4.2 What led to developments in health**

Chapters 2 and 3 described the range of health care services received by panel and control group respondents. The focus of this section is the impact that NHS and private health care services and those provided through JRRP had on the health developments described above.

People in the control group and panel study respondents who went back to work described their health as having been significantly improved through NHS or private health care encompassing: surgery, physiotherapy, the use of a TENS machine, psychological therapies and medication (particularly pain relief and anti-depressants). People also said they had experienced pain relief and improvements in conditions through rest and being away from work duties that had caused or aggravated their condition. Improvements in health were reported as the main reason why these people had been able to return to work.

In other cases, though, people had experienced little or no improvement in their condition, and had not received any effective treatment. This arose in a number of ways:

- Incurable conditions. Some people said they had been told their conditions were incurable or that any potential cures, such as surgery, carried other health risks.
- Treatment held back by lack of diagnosis. Pain relief was often the only treatment available to those awaiting a diagnosis.
- Delays in treatment. Some people had not received treatment because of NHS waiting lists (particularly for operations, counselling and physiotherapy), or, in one case, because of a delay in an insurance company agreeing the necessary funding for private treatment.
- Treatment not offered. There were instances of people who felt they would have benefited from treatments, such as counselling or physiotherapy, sometimes while they were waiting for other treatment, but were not offered them.
- Ineffective treatments. Finally, others had received treatment but not found it effective.

### *Role of JRRP in health developments*

The impact of JRRP health services varied among people in the health and combined intervention groups<sup>19</sup> who went back to work. In some cases, JRRP had had a clear impact: individuals with back problems, depression and chronic fatigue syndrome said that they did not feel they would have been able to return to work if it were not for health care services provided by JRRP. The services described here were cognitive behavioural therapy, physiotherapy, a personal trainer and a combination of pilates and occupational therapy.

In other cases, people in the health and combined intervention groups had returned to work, but did not feel that JRRP had had an impact on their health. In some cases, no health services had been received, where people had already returned to work shortly after their assessment, where no services were seen as necessary in addition to those being provided privately or on the NHS or, in one case, where no contact was maintained after the initial assessment. As Section 3.6 described, there were also cases where people appeared not to have been offered services which might have been helpful, and which were offered to other participants with similar conditions. In other cases, people had received health services from JRRP but did not think they had been effective or significant in the health improvements that allowed them to return to work, although they did sometimes feel they had helped them remain in work, as discussed in Section 4.7.2.

#### **4.4.3 Fitness for work**

It was clear from the experiences of those who went back to work in the two studies that people did not have to have fully recovered from a health problem to consider themselves ready to return to work. People who had experienced some improvement in health often felt fit enough to do some work even if it was not their normal duties. However, for some, the return to work had happened too soon and made it difficult for them to remain in work over the longer term, as discussed in Section 4.7.4.

In general, people made their own assessments of whether they were fit for work. However, others were influenced by GPs, other medical professionals and JRRP service provider staff.

Where GPs had been involved, people generally talked about their GP having **agreed with** their own view that they were ready to return to work, rather than having **advised them** that they were now well enough to return. There were few reports of GPs having had a more active role in people's decisions to return to work, but where they did it tended to be considered unhelpful. One person, for example, who felt she was too ill to work had returned to work on a number of occasions before she was ready because she said her GP had refused to renew her sick notes. Another said her confidence about returning to work had been damaged by her

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<sup>19</sup> Of the 19 panel study participants who went back to work, 15 of them were either in the health or combined intervention groups.

GP's suggestion that she consider early retirement. People who returned to work for financial reasons or because of job security concerns sometimes talked about having '*convinced*' their GPs to agree to them returning to work. Some people described their GPs agreeing only on condition that they ask their employers for light duties or phased returns or at least try to '*take things easy*'. Others said their GPs had said they did not agree with them going back to work or had advised a return could be detrimental to their health. However, as already discussed in Chapter 2, people did not follow this advice if they felt they were fit enough to go back to work or if they faced significant financial or job security pressures, although they sometimes regretted this later. Others described how their GPs had supported their decisions to return to work or how they had been encouraged to decide for themselves on whether they were ready to return to work or not.

As reported in Chapter 2, people did not always feel that it was their GP's role to decide when they were ready to go back to work, and so the GP's input was sometimes only sought where it was needed to secure a return to work, such as where employers required a GP's letter before allowing someone to come back to work. In contrast, where people were receiving specialist treatments or had been in hospital, they generally did seek the advice of their consultant about whether they were ready to return to work. However, here again advice was not always followed where it went against returning to work.

Employer occupational health staff were also sometimes involved in helping people decide when they were ready to go back to work. However, again, this was typically described in terms of seeking their **consent** to the return to work rather than their **advice**, and was often linked to arranging phased returns or light duties.

#### *Role of JRRP in establishing fitness for work*

People who received JRRP services did sometimes describe discussing whether and when to return to work with JRRP staff. However, in both the panel study and the control group study, it was largely people's own assessments which drove their decisions, and in both samples people returned to work before they were fully fit. People in the panel study did not talk in terms of JRRP providers influencing their own assessments of their fitness for work, or helping them to recognise that they could return before they had fully recovered. The only example of any direct influence was the case of a man contemplating his employer's offer of a return to light duties who was reassured by a JRRP provided workability assessment that he was fit enough to work.

## 4.5 Availability and suitability of work

Regardless of people's motivation or how ready they felt to return to work, there needed to be work available which was suitable for their level of fitness. This section examines how the return to work was managed and the different forms it took.

#### 4.5.1 Arranging the return to work

The way in which people arranged their returns to work varied in terms of who was involved, how long the process took, what was discussed and how straightforward negotiations were. Line managers, senior managers, human resources and occupational health staff were all mentioned as being involved in return to work discussions, either individually or in combination. Meetings were the most common format for return to work discussions with employers but varied in their formality. For some people, particularly those returning to existing jobs, their return to work involved a short meeting or sometimes a single telephone call with a line manager or representative of occupational health or human resources departments to discuss how the return would happen and any arrangements were put into place shortly after. For those with more complex needs, such as those seeking redeployment, negotiations sometimes needed more time and involved a number of meetings or discussions. Individuals also reported being encouraged by an employer to visit the workplace before deciding whether they were happy to come back or not, and being allowed to shadow a colleague before deciding to take on a new role permanently.

##### *Role of JRRP in arranging returns to work*

As noted in Chapter 3, some people in the combined and workplace intervention groups who went back to work also received help in negotiating their returns to work from JRRP. This took the form of being accompanied to meetings or letters sent by case managers to employers to remind them of their responsibilities under the Disability Discrimination Act. These interventions were generally seen to have been important in assisting the return to work. A woman who was accompanied to meetings said she felt more confident about asking for the support she wanted, and others said they noticed a more positive attitude from their employers towards their cases following their service providers' interventions. For control group respondents, help with arranging returns to work was sometimes available from union representatives, in the form of mediation, or from GPs or specialist health care staff who sent letters to employers requesting changes to duties. But for others there had been no support available. When asked, some of those who had experienced difficulties in liaising with their employers at the point of returning to work said they would have appreciated someone helping them with their negotiations.

However, as Chapter 3 described there were also gaps in the provision of workplace support according to panel study respondents. And whilst some felt they did not need any help in negotiating their return to work with their employers, others said they would have appreciated more support.

#### 4.5.2 Returning to an existing job

The most common route back to work among those interviewed was to return to their original job where it remained open to them. However, this did not mean that people always went back to full duties straight away: light duties and phased returns could be very important in enabling people to return to work particularly where people were not fully recovered.



### *Light duties*

Light duties allowed people to avoid activities which were detrimental to their health, such as lifting, operating heavy machinery or tasks that were seen as particularly stressful. Sometimes this entailed simply removing certain tasks from people's regular duties, reducing their hours or changing their shift pattern for a prolonged period, but in other cases it meant a totally new set of duties such as moving from manual work to desk-based duties. It also sometimes involved people carrying out their office based duties at home. Light duties were generally a temporary measure where further improvements in health were expected, or where people were awaiting further treatment such as surgery, but were established as a permanent arrangement, or became permanent, where their conditions were unlikely to improve considerably. Light duties were not always permitted by employers, however. People described being told that they had to return to their full duties or not at all, either because light duties did not exist within their field of work or because to return before they were fully recovered would be considered a health and safety risk.

Employers and health care professionals were both reported as having been involved in the organisation of light duties. Employers were described as having suggested light duties to encourage an employee to return to work, or having required light duties if they felt people's continuing health problems posed a health and safety risk. GPs and other health care professionals were also described as having suggested light duties, sometimes as a condition to allowing a return to work. Some GPs had made direct requests to employers to restrict people's working duties so as not to aggravate existing health problems. However, as noted earlier, GPs sometimes did not agree with a return on light duties where it was felt there was still a risk of aggravating a person's health condition.

### *Role of JRRP in arranging light duties*

There were examples of light duties within both the panel and the control group samples. Among those panel study participants who said they had returned to work on light duties, only three were in the workplace or combined intervention group and all three said that it had been their employers who had made the suggestion. However, JRRP had sometimes had an impact on how these duties were set-up and managed. In the case mentioned earlier, a workability assessment carried out by a service provider reassured someone that his health would not be at risk if he accepted his employer's offer of light duties. The same person also felt that the whole process had started to speed up once he became involved with JRRP. In the other two cases JRRP had had no involvement. In one case the client had withdrawn from JRRP shortly after the initial assessment and in the other case the client had returned to light duties that had been arranged prior to their absence.

### *Phased returns*

Phased or graduated returns, whereby people built up their hours over time until they went back to normal duties, were also an important part of the process of

returning to work, either in place of, or in addition to, light duties. They were suggested by managers, occupational health staff, human resources staff, GPs and other health care professionals and by employees themselves, where they had past experience of them. How long phased returns lasted varied. This was sometimes influenced by existing company policy or by the recommendations of health care professionals. On the whole people welcomed the idea of being allowed to return to work gradually and felt it had been important in helping them to sustain their return. People had generally been happy with the pace of return, with one exception discussed below, and the only point of difficulty was the requirement by some employers that annual leave should be used to cover days not in work. However, others were reluctant to use a gradual return. One person objected to using his annual leave to cover the hours not worked and opted instead to return full-time. Others said they had decided to go back to full-time hours straightaway as they felt this showed their employer they were more committed, or simply because they felt well enough to do so.

#### *Role of JRRP in arranging phased returns*

Again, phased returns were used to help the return to work within both the control group and the panel studies. In comparison with light duties, there were panel study cases where JRRP service providers had been involved in the suggestion and organisation of phased returns. Although phased returns had sometimes already been suggested by employers, health care professionals or by people themselves, there were cases where they were suggested by service provider staff. In fact, there were even instances of phased returns having been suggested by JRRP staff where clients were in the health intervention group. JRRP's involvement in the actual organisation of phased returns, among workplace or combined intervention group clients, was more limited, however. From the accounts of employees, their employers appeared to prefer to organise phased returns themselves. There was only one example of a phased return having been designed by a JRRP service provider, and this proved unsuccessful as the client found the pace of the return too fast and ultimately followed a plan designed by her employer's occupational health department instead.

#### **4.5.3 Redeployment with an existing employer**

Redeployment was a less common approach to returning to work among those interviewed. It arose where people's jobs had already been filled whilst they were on sick leave, or where they considered a return to their original job could be damaging to their health, for example, because of bullying or stress.

Redeployments were initiated either by the individual (where they did not want to return to their original job) or by the employer. Redeployments could take some time to set up and the process ran more smoothly for some than others. Whilst some people described supportive managers and occupational health staff, others felt that their employers were deliberately delaying the process in order to put them off returning to work. One person, for example, had to ask repeatedly before she was

sent vacancy information. Another person said that her employers strongly intimated that other parts of the organisation would not be willing to take on the '*failures*' and '*cast offs*' from her department.

#### *Role of JRRP in redeployments*

Redeployments were described by both control group and panel study respondents. There were only two cases in the panel study, and one described significant help from JRRP. She talked about how her provider had helped her understand the benefits of redeployment where she had had concerns and were instrumental in negotiating a return to a job that more suited her health needs.

#### **4.5.4 Finding alternative work**

Having to find a job with a new employer was the least common route back to work among those interviewed, and was seen as a last resort. Those who had considered finding alternative work, but had in fact returned to work for their original employers, described how they had feared they would find it difficult to adapt to a new role and employer or thought employers would be put off by their sickness absence record. Those who started work with a new employer had often had similar fears but had had to overcome them as they had lost their original jobs, and so had no choice but to look for alternative work. It was rare for those who went to work with a new employer to receive any help with looking for work, although one person had found the Disability Employment Adviser (DEA) at her local Jobcentre Plus helpful. In other cases, people had had to rely on their own efforts to find work.

#### *Role of JRRP in finding alternative work*

Only two panel study respondents had found work with new employers and they were both in the health intervention group and so received no help from their JRRP service providers in looking for work.

### 4.6 Overall perceptions of the impact of JRRP on returns to work

Of the 19 panel study participants who had gone back to work, only a small group directly attributed their returns to work to the interventions provided by JRRP, and in all cases it had been significant improvements in health as a result of services provided by JRRP that had allowed them to go back to work. A further person said that although her health had improved sooner as a result of the diagnostic tests and treatment she received through her service provider, she had already decided to go back to work before her health had started to improve.

Significant health improvements, as a result of NHS and private health care interventions rather than JRRP interventions, were also a key factor in the returns to work of the some of the remaining panel study respondents and control group study respondents.

Other panel study and control group study respondents went back to work despite more limited improvements in health due to financial pressures and fears about job security, because they felt they were fit enough to do other types of work through redeployment or the provision of light duties and, in the case of one panel study participant, because her GP had reportedly refused to renew her sick note.

Phased returns and light duties were important ways of returning to work in both the control group and the panel group studies. There were no examples of JRRP providers initiating the suggestion of light duties, although they had been helpfully involved in their organisation in some cases. There were, however, examples of JRRP staff initiating the idea of phased returns, although they were generally not involved in their organisation.

Nobody in the panel study attributed their returns to work to the workplace support they received from JRRP. Although some people had found the involvement of their service provider helpful, they felt that without JRRP's intervention they would still have been able to negotiate their return to work on similar terms, that is they would have still been able to return to light duties or on a gradual basis. It is possible that the more intangible nature of workplace support, such as mediation or letters to employers, compared to the more tangible health support that people received from JRRP, led people to underestimate the impact of workplace interventions. However, their assessments are consistent with the statistical net impact estimates (Purdon *et al.*, 2006). Additionally, people often saw health as the main obstacle to returning to work. They felt that once they had overcome this, the negotiation of their return to work with their employers did not present the same level of difficulty, and therefore, was not a critical area where they needed help.

In both study samples there were examples of people who were particularly active in managing their returns to work and particularly determined to get back to work, often with a greater focus on health barriers. These included a woman who got her MP involved in speeding up her treatment, a woman who had made a series of self referrals to different departments in the hospital in which she worked in order to obtain a diagnosis, a man who funded his own operation so as not to lose his job, and a man who went back to working under the boss whose bullying had reportedly caused his sickness absence.

Although these examples were present in both studies there seemed to be more evidence in the control group sample of this type of active behaviour in managing their health and their pathways towards work. The samples of course are small and not designed for statistical comparison, and it is difficult to know whether this apparent difference has any real significance. However, it may suggest an over-reliance on the service among some people in the panel study, and a stronger impetus among people in the control group to take ownership of their return to work. As noted in Chapter 3, there is not a strong sense of people engaging actively with the service: people did not generally take the initiative in maintaining contact with the service and communication sometimes lapsed. It may be that in these instances, people were slow to take action themselves, expecting that the service

provider would continue to lead their case. Some acknowledged that they had become reliant on their case manager for support and motivation, and again this may have discouraged them from being more active in managing their own return to work. It is possible that the absence of an alternative source of support for people in the control group provided some impetus to them to take a more active role in managing their return to work.

## 4.7 Experiences of being back at work

### 4.7.1 People's feelings about going back to work

Once the return to work was imminent, people typically described a combination of concern and positive anticipation.

People reported three main areas of concern: The first was how colleagues would react to their return. This was a particular concern for those who had been off work due to a mental health problem. They worried about seeing colleagues who had witnessed unusual behaviour before they went off sick, being asked about their absence and the reasons behind it, and about people not knowing how to act around someone with a mental health condition. The second area of concern was about managing health problems once back in work. People worried about how their work might aggravate their conditions and lead to further time off work. The third concern was about being able to do their duties especially after a long time away from the workplace and where people were starting new roles or jobs.

These concerns were balanced, to varying degrees, by more positive feelings: looking forward to returning to a job they enjoyed, catching up with friends and colleagues, getting back into a routine, and the relief associated with receiving a regular income.

### 4.7.2 Positive experiences of being back at work

Some people who had gone back to work were clearly enjoying being back and were confident that they would remain in work for the long term. They were enjoying particular aspects of their jobs, such as working with children or the camaraderie of the workplace, or were just happy to be working as it gave them the purpose and routine they lacked during their time off sick and a feeling that they had returned to 'normal'. For others, this enjoyment arose from job satisfaction. For some people being in work was perceived to have had a positive impact on their emotional and mental wellbeing. Some talked about how they and others had noticed positive changes in their behaviour, such as boosted confidence, since going back to work.

However, people were most positive about their ability to cope with work. Section 4.7.1 described how people commonly feared that their health conditions might not allow them to work or that their work might be damaging to their health. It was a very positive experience for them that these fears were not realised. For some this

had been achieved because their health had seen significant improvements before they returned to work, but it was also about avoiding any stresses or strains that working might place on people's health. Avoiding stresses and strain was achieved in a number of different ways. Phased returns were seen as particularly helpful. Even those who had experienced fuller recoveries appreciated having been allowed to return to work on a gradual basis. People were often surprised at how difficult they found the first few days back at work, and so could only imagine how much more difficult this would have been had they returned to their normal hours of work straightaway. Some people said they felt they would not have managed to return to work without a phased return. Light duties or changes to duties through redeployment were also ways in which the return to work was eased for people, especially for those with musculoskeletal problems.

People also talked about the support they received from their colleagues. Some described how colleagues would carry out heavier tasks on their behalf or switch duties with them if it was obvious they were becoming tired, and others clearly benefited from the emotional support provided by colleagues especially where they had feared their colleagues might react negatively to their return to work.

Support from employers also had a part to play in easing the return to work. People appreciated employers who were sympathetic to their conditions and understood their limitations back at work. Individuals talked about how their employers had let them continue to take time off as they needed, reassured them that their job was not at risk if they needed any further time off, and gave them advice on taking regular breaks in order to reduce the strain of work on their health. In other cases, people appreciated being given their own office so their work was not disturbed by noise, having a specially adapted chair to suit a back condition, funding for taxis from Access to Work and the availability of a lift at the workplace.

### *Role of JRRP*

As noted earlier, there were instances where JRRP services had been helpful in establishing a phased return to work or a return on lighter duties, but JRRP also sometimes had a positive impact on people's experiences once they were back at work where they remained in contact with their service provider. Among those who went back to work, there were no reports of people having contacted their service provider with a specific request for help. Instead, contact continued as a result of case managers staying in touch or where a course of treatment continued after people had returned to work. People were most positive about this contact where they felt it had an impact on them remaining in work over the longer term. One person talked about how she would have found her work a lot more tiring if her service provider had not negotiated a reduction in her working hours on her behalf. Another person felt that the pilates and reflexology sessions she received after she had gone back to work had helped her to make a success of a new job.

### 4.7.3 Negative experiences of being back at work

For others, the experience of being back at work was much less positive. People who had gone back to work before they were fit because of financial reasons or worries about losing their job had often found their jobs too much for them. Some reported being in physical pain whilst at work due to working long hours or because of the nature of their duties. People also found the return to work difficult where they had had to return to their normal duties straight away, because help like phased returns or light duties were not available or had not been considered. Where this type of help was available it was not always seen as effective. Phased returns were sometimes criticised for being too fast and light duties sometimes involved work that was considered more strenuous than people's regular duties which aggravated health conditions. At the same time, others felt bored or frustrated by their lighter duties or new roles.

Some people found working a strain because of the pressure employers put on them to return to normal duties. Individuals reported being pressured to take on overtime, being told to do strenuous tasks that made a condition worse or employers refusing to uphold changes to duties recommended by their own occupational health staff.

Other negative working experiences were also linked to how people were treated by their employers. Some people whose sickness absence had been due to bullying and stress said they continued to be treated badly once back at work. Others who had experienced problems with their employers during their sickness absence, such as employers not believing conditions were genuine or putting people under pressure to return to work before they were ready, said their relationships with managers and supervisors had been damaged as a result. Finally, some others said that they felt insecure in their jobs. Some feared, or had been told, that they would be dismissed if they had any further time off sick. One person felt she was being constructively dismissed and another person had been told he could not remain in his redeployed duties indefinitely.

Finally, there were also instances of people's health conditions deteriorating since returning to work but for reasons not related to the return to work.

### 4.7.4 Sustainability of work

Where people experienced these types of difficulties in work, they sometimes contributed to them leaving work. At the point of interview<sup>20</sup>, five people had lost their jobs. Two people had resigned from their jobs due to ill-health. Another had been dismissed due to an incident in the workplace but was due to start another job. Two others were no longer in work as a result of retirement and redundancy, both of which had been planned before they had become ill. Finally, two people were on sick leave when they were interviewed.

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<sup>20</sup> This refers to the final interview conducted where the panel study is concerned.

Others found being in work so difficult that they had begun to think about retiring, looking for another job, or hoped for redundancy.

#### *Role of JRRP*

There was little evidence of panel study respondents who had a more negative experience in work seeking further help from JRRP. The exception was a man who had felt he would have benefited from some further sessions from his JRRP-provided trainer after a fall in the workplace which had aggravated his condition. However, when he enquired about this with his service provider he was told that there was no more funding for his case so he sought help via the NHS. It was not always clear why others had not sought further help from JRRP. However, as Chapter 3 noted there were a range of reasons why people did not initiate contact with the service providers, and some had lost contact by the time they returned to work. There also seemed not to be an active awareness that the service provided in-work support.

## 4.8 Not returning to work: context

This section of the chapter examines the experiences of panel and control group study respondents who had not gone back to work during the period of the research. In a similar way to the first half of the chapter, the aim is to understand why people did not go back to work, by exploring the role of people's attitudes towards returning to work and the barriers to returning to work associated with health developments and the availability of suitable employment. It then briefly explores people's experiences of being off work for the longer term and their hopes for the future.

Of the 25 people who had not gone back to work across the two study samples, 14 were no longer employed. Eleven of these had been dismissed on the grounds of ill-health, two had been retired on the grounds of ill-health and one person had taken early retirement. The remaining 11 people were still off sick from work at the time of interview.

## 4.9 Attitudes towards returning to work

Among those people who had not gone back to work at the point when they were interviewed, only one person said that they did not want to return to work. She had been dismissed from her job and did not consider herself fit enough to work. She had enjoyed being at home, and had anyway planned to retire in the next few years to coincide with her husband's own retirement, and said she did not intend to return to work. All the remaining people said they wanted to go back to work at some point in the future. People missed the enjoyment of working, felt that they should be in work, found that being at home made them feel depressed, and experienced financial pressures to return to work. However, a desire to return to work was not enough to overcome continuing health problems or difficulties in finding suitable employment, as the following sections explore.



## 4.10 Health barriers to returning to work

Persistent health problems were a very significant barrier to returning to work among those who had not gone back. Here, people generally felt that they had not seen a significant improvement in their health. For some this was because they were still waiting for treatment, such as an operation, or diagnostic tests without which treatment could not begin. Some people reported a deterioration in their condition or new problems, which further complicated their health care. In other cases, people were receiving some treatment but it had not proved effective. Some people talked about their treatment as being about *'trial and error'* as they had to continue trying different types of medication until they found one that worked for them. Finally, for some other cases no treatment appeared to be being proposed. If there was no treatment for a condition people had to wait until they recovered naturally or learn to live with their conditions. In other cases, people felt that treatments were available but had not been offered to them. Some people blamed inefficient GPs for this.

GPs, medical consultants and employers' occupational health staff appeared to have had more of an influence on the perceptions of fitness for work of those who did not go back to work compared to those who did. The advice of these professionals was predominantly that the person was not well enough to return to work. The fact that this advice was heard more readily among these people than among those who did return to work appears to reflect the fact that their conditions were more acute, and that it chimed with their own view that they were not yet well enough to work. However, some people's perceptions of their conditions and the implications for returning to work had become more optimistic as a result of discussions with health care practitioners. Accepting the limitations of a condition that was considered unlikely to improve significantly meant people were more likely to think about what work activities they might be able to do. People also talked about how their GPs or consultants had encouraged them to investigate alternative sources of employment where original duties were perceived to be damaging to people's health. In general, these suggestions were positively received as people were keen to get back to work.

Health was not a barrier for everyone, however. Some people felt their health conditions had improved sufficiently for them to go back to work in some capacity, but not always in their original job. In some cases these partial improvements had been the result of rest, but in others they were due to NHS and private health care intervention, a case of a referral by an Incapacity Benefit (IB) Personal Adviser to the Condition Management Programme and in some cases as a result of treatment provided through JRRP, as discussed below.

### 4.10.1 Role of JRRP in removing health barriers to returning to work

Some people, in the health and combined intervention groups, who had not gone back to work had received health care help through their service providers. The

services received varied in terms of the impact they had had on people's health. One person who considered himself fully fit by the final research interview, attributed his improvements to the physiotherapy he received from his service provider. Others had experienced some improvements in their health as a result of the help they received from JRRP but not enough for them to feel fit enough to consider a return to work. One person, for example, had found the gentle exercise programme she had been given helpful in managing her condition but said she not expect to see any significant improvement in her health until she had undertaken the surgery that had been arranged on the NHS. There were also reports of treatments provided by JRRP that were perceived to have been unhelpful or inappropriate. One person decided to turn to the NHS for physiotherapy as he felt the sessions provided by JRRP were not extensive enough. He had expected more help than the home exercise routine he was given. Another criticised his JRRP service provider for having only treated more minor health problems rather than tackle the mental health problem that was preventing him from going back to work. There was also one extreme case of a person who felt his health had been damaged by some psychological therapy provided by his service provider.

There was little explicit evidence of service provider staff having played an active role in helping people assess their fitness for work. However, there was evidence from the accounts of those health and combined intervention group respondents who were still in contact with their service providers at the final interview that service providers were generally supportive of people's own judgements about fitness for work. The one exception was a client in the workplace intervention group who described his case worker as having tried to 'push' him back to work before he was ready.

As reported in Section 3.6, gaps were sometimes evident in JRRP's service provision. Whilst some people appeared not to have been offered services which might have been helpful and which had been offered to others with similar health problems, others talked about how the services they needed, such as surgery, were not available through JRRP because of a lack of funding.

## 4.11 Employment barriers to returning to work

What prevented people who felt fit enough to return to work from going back to work was work itself, or a lack of it. This was also perceived as a barrier by those who did not yet feel fit enough to go back to work. As already mentioned in Section 4.8, 14 people were no longer employed and 11 were still employed but had not yet been able to go back to work. Section 4.11.1 looks at the circumstances of those at those who still had jobs to return to, and Section 4.11.2 at those who were no longer employed.

### 4.11.1 Employment barriers for those off sick but still employed

Chapter 2 reported how people who had had little contact with their employers, especially line managers and to a certain extent colleagues too, during their sickness

absence often felt uncertain about whether their employers wanted them to come back, where they remained employed. This was perceived as an issue both by those who felt fit enough to return to work and those who did not, and was particularly a concern among control group respondents. Among those who felt fit enough to return to work, the lack of contact with employers was said to have made people feel uncertain about how to proceed and in some cases had led people to start thinking about alternative sources of work.

For others, including panel study respondents, negotiations with employers about redeployment opportunities and redundancy packages needed to be concluded before they could get back to work.

#### *Role of JRRP in removing employment barriers to returning to work*

Workplace and combined intervention group clients who felt fit enough to return to work had not yet gone back to work either because they were uncertain about how to negotiate their return to work with their employers, as a result of a lack of contact with line managers during their sickness absence, or were still negotiating redeployment opportunities and a redundancy package. Whilst it is possible that JRRP could have had a role to play in helping those who were uncertain about returning to work negotiate with their employers, none of this group of people had remained in contact with their service providers by the time of the final interview.

Among those who were in negotiation with employers, the involvement of JRRP in these cases, and the effectiveness of any involvement, was varied. The client negotiating a redundancy package with his employer praised his case manager for having suggested he ask for redundancy and having accompanied him to the early meetings with his employer but was disappointed when his case manager's support dwindled when the pilot was coming to an end. A JRRP service provider had also been involved in one of two cases of panel study respondents seeking redeployment. This client appreciated being accompanied by her case manager to meetings with her employers, but felt his contact with her case was patchy. In the second case, the client said she had not needed any help from JRRP in negotiating her return to redeployed duties as she found her employers supportive, but did say that if the redeployment fell through she would most likely contact her case manager for help with looking for alternative work.

Among those workplace and combined group respondents who did not yet feel fit enough to return to work, two said they felt they could contact their service providers for help with negotiating a return to work in the future whereas the other two were no longer in contact with their service providers.

#### **4.11.2 Employment barriers for those no longer employed**

##### *How people left employment*

As discussed at the beginning of Section of 4.8, dismissal on the grounds of ill-health was the most common way in which people in the sample became unemployed.

Prior to dismissal, people tended to have been given a date by which they needed to return to work, and so were not surprised by their employer's decision to terminate their contract of employment. One person agreed to a dismissal because he did not want to proceed with the employer's investigation of his health condition, but otherwise the decisions concerning dismissals were generally made by employers alone. The remaining three people who were no longer employed at the point of interview had all retired. Two had been retired on the grounds of ill-health based on an assessment by their employer's occupational health doctor and the third person had decided to take early retirement as he knew he would not be fit enough to return to his original job and no alternative duties were available.

Attempts by people or their employers to avoid termination of employment were recurrently reported by those who did not go back to work, and JRRP staff had sometimes been involved in trying to keep the job open. In some cases, people had asked their employers for light duties or reduced hours but their requests had been refused on the grounds that changes to duties could not be accommodated. Employers also sometimes made suggestions but these were perceived as inappropriate by those interviewed. There were also cases of people having attempted to return to work managing only a day or two before having to go off sick.

There were no complaints about how the employment termination process was managed and, in general, people felt that their employer's decision was fair. Only one person strongly disagreed with her dismissal as she had hoped to be retired on the grounds of ill-health. However, people were often disappointed or upset that they no longer had a job to return to, especially if they had worked in the same job for many years. There were more mixed feelings where people had been off sick as a result of work-related stress. Whilst they were unhappy about having lost their jobs they were also relieved to be away from a stressful working environment.

#### *Barriers to finding new work and role of JRRP*

Where people were no longer employed, some were not yet thinking about a return to work as they considered themselves still too ill to work or, in one case, because the person was considering retiring. Others were applying for jobs but without success, or had begun courses to develop the skills needed for their planned new jobs.

There were mixed reports of using Jobcentre Plus services, but generally there appeared to be little help available to those looking for alternative employment. Few people had had help from their JRRP service providers. Where they had it involved careers advice, help with CVs or advice about applying for jobs, but no one had found this effective and it had not resulted in work. Those who perceived themselves as being closer to finding work had found their own efforts to find work more fruitful than those of any third parties that had been involved, although they did say that they would have appreciated some help if it had been more useful.

## 4.12 Overall role of JRRP where people did not return to work

The panel study and control group study respondents were broadly similar in terms of the circumstances that had prevented them from returning to work: they were either too ill to return to work or had no work to return to. Given JRRP's design (see Chapter 1) it clearly had the potential to have a positive impact on these two barriers to work, but in practice it had had a very limited impact on the pathways to work of those panel study respondents who had not gone back to work. A key reason behind this lack of impact was that at the time of the final interview, a significant number of panel study respondents were no longer in contact with their service providers for the reasons discussed in Chapter 3. In addition, people had either not been given the help they needed (sometimes because of the intervention group but also, as Chapter 3 notes, in cases where they were eligible for such help), or felt the help they had had was ineffective (for example, where job searches had been poorly targeted or where mediation had been unproductive). Nevertheless, people who had seen improvements in their health as a result of JRRP interventions or had been accompanied to meetings by service provider staff, as detailed in Sections 4.10 and 4.11, did appreciate the help they had received from JRRP even though it had not been enough for them to return to work.

As noted in Section 4.6, there were also some suggestions in panel study respondents' accounts that they were perhaps less active in the management of their own health or pathways towards work compared to the behaviour of some of the control group study respondents, because they expected help from their service provider even where contact appeared to have ended. This is supported by some people's own admission of an over-reliance on the emotional and practical support provided by case managers.

## 4.13 Experiences of longer term sickness absence

This section explores people's experiences of being absent from work over the longer term and also looks at their thoughts about the future .

People who remained off sick described the feelings and concerns reported in Chapter 2. They recurrently talked about feeling bored, frustrated or '*depressed*' but also angry and worried. However, these feelings were no longer only associated with being unoccupied at home, limited improvements in health or difficulties with mobility or managing everyday tasks. They also stemmed from people's reactions to delays in receiving treatment or the ineffectiveness of the health care they had received and their thoughts about their future, both in terms of health and work. People also continued to worry about the financial implications of being off work, especially where they were anticipating a drop in income or had built up debts. There were also concerns about moving on to IB, as described in Chapter 2.

### 4.13.1 Thoughts about the future

People's thoughts about the future focused on health and work. Where people remained unwell they hoped that their health would improve over time, although their perceptions of how much and how soon this might happen varied. Those who were due to have surgery or other treatments were more hopeful that they would see an improvement in the near future. People who had yet to be diagnosed or faced a natural recovery knew they had longer to wait before they saw any improvements in their health. And for others, their thoughts were about accepting that they might never see a significant improvement and would have to get used to a certain level of pain or limitation.

Getting back to work was, with the exception of one person, everybody's goal. For some a return to work was dependent on how their health developed, whereas for others it was about finding suitable work. Some people expected to be back in work quite soon and were waiting to hear the outcomes of job interviews or redeployment panels. Others had decided to do courses or voluntary work not only to gain new skills but also to get them used to a routine. Those further away from returning to work were more concerned about the feasibility of finding suitable work. They talked about how their age, sickness absence record, and experience and qualifications might affect their chances of securing work. It was clear to people that the longer they were off sick, the more difficult it would be for them to return to work, and this was itself a cause of considerable concern.

## 4.14 Conclusions

The experiences of both those who went back to work and those who did not, have clearly shown that overcoming health and employment barriers is key to people getting back to work. Although support from the provider services was well received and found to be helpful, the data overall suggest that the role of JRRP in overcoming these barriers was limited.

On the whole, people had experienced some improvement in their health before they felt ready to return to work. For people with very acute health problems, seeing little improvement to their health was a significant barrier to work. However, people were able to return to work with only limited improvements to their health, particularly with support such as light duties and phased returns. Employers and GPs as well as JRRP staff could play a role in these decisions, but people appeared not to look actively to GPs for advice about whether and how to return to work, and did not always follow such advice if it did not chime with their own assessments of their fitness for work. Where returns to work before a full recovery were driven by financial concerns or worry about job loss, they were not always sustained, and it appears that clients did not readily look to JRRP for in-work support when they faced these or other problems.

Where people did attribute their returns to work to the interventions provided by JRRP, it was the provision of health care that they felt had enabled them to return to

work. NHS and private health care services had also played a role in health improvements where people went back to work, but there was still a need for a boost to existing services.

No one in the panel study attributed their returns to work to JRRP workplace interventions, although some services, such as mediation or recommendations for phased returns, were perceived as having helped people make successful returns to work. Supportive employers providing phased returns, light duties and redeployment opportunities played an important role in successful returns to work, but people were also important in negotiating their own return to work. However, poor relations with employers impeded some people's returns to work and this underlines the importance of mediation services like those offered by JRRP.

It was striking that returns to work were more common where people still had a job to go back to. This allowed them to either return to their original roles or be redeployed within their employer organisation. Of course, having a job open may also reflect the attitude of the employer, the severity of their health problems or the duration of their sickness absence. But within both the panel and the control group studies, once people had lost their jobs they found it very difficult to get back to work. Keeping a job open relied on maintaining a good relationship with employers and people sometimes felt that the involvement of JRRP had been helpful here. These findings also highlight the importance of help with finding alternative work, and how JRRP could have played an important role here.

Overall, a number of factors appear to be relevant in explaining JRRP's limited impact, based on participants' own assessments. It reflects, to some extent, the design of the trial, and the fact that people were not eligible for services which they appeared to need<sup>21</sup>. In terms of the way in which the service operated, its potential impact was undermined by the fact that at the time of the final interview a significant number of panel study respondents were no longer in contact with their service providers. There were also cases where help which appeared relevant did not seem to have been offered, or where the help received was considered inappropriate or ineffective. There are suggestions in the data that people in the control group may have taken a more active role in directing their own return to work, whilst those using JRRP services looked to the services to provide a lead which did not always come. Outside the operation of JRRP, delays, inadequate or ineffective provision within the NHS service were also relevant. Finally, the accounts of employees suggest that inflexible or unsupportive approaches by employers are also implicated.

Looking across the sample at those who did return to work and those who did not, the areas of greatest need for help and thus, the areas where JRRP had the potential to make the greatest impact are:

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<sup>21</sup> Note, however, that the randomised controlled trial (Purdon *et al.*, 2006) showed no positive impact among any of the three intervention groups.

- the speeding up of diagnoses and treatments for those faced with NHS waiting lists;
- mediation with employers where relations are poor to lessen the risk of job loss; and
- the provision of effective careers advice and job search support to those looking for alternative work.





## 5 What works? The staff perspective

The next two chapters draw on data from group discussions with provider staff and individual in-depth interviews with provider organisation managers. Chapter 1 set out the range of services available to people in the health and workplace intervention groups and those available to all. Provider organisations took different approaches in establishing their frontline teams, and thus, the participants in the group discussions varied accordingly. Some had case managers with clinical or vocational expertise who also provided specific services, such as physiotherapy or careers advice. Some employed people with clinical or vocational backgrounds as case managers only, who referred clients to other in-house specialists and external providers for service delivery. Some organisations employed non-specialists as their case managers, who facilitated access to in-house specialists. The term 'frontline staff' will be used throughout the remainder of the report to describe case managers (some of whom were also specialists) and other specialist staff employed directly by the provider organisation and considered to be a part of the in-house team.

Together, Chapters 5 and 6 explore staff's perspectives on the operation of the Job Retention and Rehabilitation Pilot (JRRP). Provider staff's views on what worked are considered in this chapter. Discussion in Chapter 6 focuses on the barriers and constraints perceived by staff in trying to help their clients make progress towards returning to work.

This chapter explores which services, actors and working relationships were considered effective in helping clients progress towards work, and why. Firstly, the key messages from JRRP staff about 'what works' are summarised. Key services and interventions identified as particularly effective, and combinations of them, are then explored in detail in Section 5.2. This is followed in Section 5.3 by an examination of the way that working relationships with key actors such as employers and health professionals contribute to client progress.

Group participants were asked what they felt had worked for their clients. In making their responses, discussions centred more on how improvements in general had

come about for people, and less on case examples of how individuals made returns to work. Improvements such as greater confidence and improved physical fitness were reported as evidence of how people had made general progress towards work.

## 5.1 Key messages about what works

To many of the staff, the question of what success meant and how to achieve it depended very much on the individual circumstances and needs of each client. JRRP staff were keen to stress above all else the importance of being responsive to individual clients' needs. Key attributes of approaches adopted were:

- the capacity to intervene early to avoid becoming distanced from the workplace and '*getting lost*' in health and welfare systems;
- to be client-centred at all times and, therefore, to be led by client needs and not those of services accessed;
- thinking holistically, and aiming to tackle clinical, psychological and social aspects of people's problems in a coordinated way;
- to offer tailored packages of support, layering support in combinations or sequences as appropriate;
- making themselves available for clients at all times;
- having the flexibility to spend money as required;
- a central role for case managers;
- quick access to, and the intensive and focused application of, a broad range of high quality services.

Important to provider organisations whose case managers had clinical and vocational experience was inter-disciplinary working. Organisations using validated assessment tools<sup>22</sup> felt it was important to get a good initial understanding of clients' circumstances and then measure the point at which a return to work was possible.

Despite the emphasis they gave to their own working, in effecting successful outcomes for clients, they also recognised that they could not have worked alone and did not in practice. Some people needed certain medical interventions and depended on employers to return to the workplace. Heavy emphasis was given to the importance of liaising directly with employers. Key actors, such as employers, GPs, other health services staff, family and friends, helped to remove barriers, change clients' perceptions about themselves and work, offered encouragement and support, and imparted knowledge.

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<sup>22</sup> A range of assessment tools was described but not all were named. The tools described aimed to identify clients' most pressing problems, their level of depression and anxiety, and their activity levels. Beck's Anxiety and Depression Inventory was one named tool.

It seemed no less important to most people to highlight the role of the client themselves in moving towards work. Some staff stressed that clients needed to want to do something, even if they did not perceive work as an immediate goal. Clients' own motivation to work was perceived as an influential factor, such that those people who were '*doing all the right things*', such as contacting employers and seeking advice from local benefits advisory services, were thought to be more likely to return to work.

## 5.2 Key services

The services and interventions outlined below are those identified by staff as being particularly effective. The effectiveness of some interventions was suggested more widely than others, possibly due to the interventions' availability across the pilot sites, the number of clients for whom such interventions were appropriate, and staff members' personal preference for, or belief in, particular interventions. Similar views about the effectiveness of individual interventions and those experienced in combinations were made by clients and are reported in Section 3.3.

### 5.2.1 Health interventions

#### *Psychological therapies*

Types of psychological therapy, including cognitive behavioural therapy, psychotherapy and directive counselling, were highly regarded amongst all provider organisations offering such services. It was felt to be appropriate for people with stress and other anxiety disorders, low self-confidence, and who faced problems at work, such as bullying. In order to produce successful outcomes it was felt clients needed to have quick access, before their problems worsened. Bearing this in mind, frontline staff also spoke about how therapy could be effective at various stages in a sequence of coordinated support. Providers who offered therapy in a variety of formats, thought it best to hold individual therapy sessions first if people were not ready to engage in group sessions. On the other hand, referrals to therapists were postponed when clients were nervous about the prospect of therapy, and some saw other specialists, such as physiotherapists, first instead.

According to some staff, many clients made progress quickly. They said clients felt better able to cope with their problems, had increased confidence, realised they did not have to live with workplace bullying or stress and were able to start making decisions and plans about employment in the future. Some JRRP staff saw these improvements over a short period, with some people returning to work after six to eight weeks. The strength of such therapy was perceived to lie not only in helping people to think about who they are and how they interact, but also to take steps in making changes.

### *Physiotherapy*

Clients experiencing physical problems and pain were referred directly to physiotherapists working on the pilot. This help was said to be highly sought after by clients in areas where staff considered the NHS provision to be slow to access and not intensive enough.

Again, improvements were reported to be quick to emerge and were noticeable in clients' posture and functionality. Staff explained its importance as treating people quickly and intensively over a short period of time, and educating as well as treating clients. It was believed to be helpful to clients when the physiotherapist's advice on home exercises was recorded in a plan, and supplemented by a referral to an exercise programme at a gym.

### *Accessing medical tests, consultations and treatment*

Paying for tests, such as MRI and CT scans and X-rays, was thought to reduce a client's waiting time, by as much as nine months in some areas. Having quicker tests and consultations, and therefore, earlier information about the nature and extent of the health condition, shortened the amount of time in uncertainty and, for some, the amount of time off work. Some spoke of instances when clients returned to work after a scan or consultation, because they felt reassured and more confident about their capacity to work, and their employer considered them as less of a risk. The knowledge gained from tests also brought forward treatment which helped to hasten some people's returns to work.

Some provider organisations helped pay for relatively expensive surgery, such as knee surgery. One provider paid for a small number of clients to undergo spinal surgery and said that all returned to work within four to six weeks. Providers were prepared to pay for, or contribute to, such treatment because, for some people, getting the medical treatment they needed addressed the sole or main problem preventing them from working. For example, it was thought that one public sector worker would have been off work waiting for a knee operation for 18 months if JRRP had not paid for a quicker operation. Staff did, however, face budget restrictions and felt this was sometimes a major constraint on how they could help clients (see Section 6.2.1).

### *Complementary therapies*

Some frontline staff described complementary therapies, such as reflexology and acupuncture, as effective. Although some staff were not confident about complementary therapies' capacities to stimulate physical changes in clients, they felt such therapies could bring about positive changes in clients' attitude, outlook and personal confidence. It was felt to be particularly helpful to people dealing with mental health problems, particularly stress, and people facing chronic problems like ME, who could not be cured by the therapy but whose outlook on life and their prospects could be influenced. Changes of lifestyle, such as healthier eating, were said to ensue from consultations with some clients. In general, the success of

complementary therapies was attributed to having someone people could talk to, to receive attention from, and for this to be a regular occurrence.

Staff said that in general clients were pleased with the service they received, some to the extent that sessions were extended into the initial period back at work or clients chose to continue receiving various therapies on a private basis. It was recognised, however, that clients had to be receptive to the ideas inherent in complementary therapies and that sceptics did not find it beneficial.

### *Exercise programmes and facilities*

Highlighted as a helpful resource were links with local leisure facilities and gyms, where they had offered gym membership at a reduced rate, advice from experts such as personal trainers and dieticians, and led clients in designing home exercise plans. Frontline staff who indicated its importance said that it had been particularly helpful for people with mental health problems and those with musculoskeletal conditions.

Physical, psychological and social benefits were reported. According to some frontline staff, improved mobility and weight loss were physical gains in themselves, but had also aided access to other help, such as bringing forward an operation. Attending the gym was said to be important to some people with mental health conditions because it helped build structure and routine into their lives. Exercising was also thought to have produced a '*feel-good factor*' and general positive outlook, which in turn was considered by staff to have reinforced any other support people received. Exercise programmes were thought to have helped clients with all kinds of health conditions to feel better about themselves, regain some control and feel motivated to make changes to their life, as well as provided an excellent opportunity to meet and socialise with other people.

## **5.2.2 Workplace interventions**

Much of the help given in respect of the workplace was felt to have been of value to both employees and employers. Not only were both thought to have benefited financially from employees' returns to their workplaces, but both learnt from the experience of being off work and about methods to aid rehabilitation. There was hope from some JRRP staff that successful use of gradual returns and workplace adaptations would encourage employers to use such methods in the future.

Chapter 3 reports that some clients in the workplace interventions group did not receive any services and were asked to come back when they were well enough to return to work. In the staff discussions, people said that they found it difficult to help clients in the workplace interventions group who needed expensive surgery because they were not able to provide health care support. They also felt they could not help these clients focus on their future employment prospects because they did not know what their capabilities would be after receiving treatment (see Chapter 6 for further discussion). However, some staff working with clients in the workplace interventions

group said they had used mediation with employers for people who had unresolved health problems (see below). They said some clients had returned to work before they were fully fit because suitable working conditions had been provided for through mediation. There was some recognition that the return to work process had sometimes taken a long time because they were waiting for medical intervention, but that clients had been supported throughout.

### *Mediation*

Some staff at all organisations providing workplace interventions gave strong support for the use of mediation with employers. For staff who did not have recourse to health interventions, meeting and negotiating with employers was considered to be their key intervention. Contact with the workplace was felt to be crucial to workplace rehabilitation, in order to obtain an appreciation of the workplace cultures and processes, and thus, to make it work in the client's favour. Although it was believed to be potentially beneficial to all clients, it was felt particularly useful for clients who had stress and anxiety related to the workplace. Its importance lay chiefly in what was produced from liaising with personnel from employing organisations, such as the contents of return to work plans.

According to staff, some clients said they valued having someone come with them, particularly if they were nervous about meeting with their employer. Indeed, people who had been reassured by the prospect of having a JRRP staff member as a 'buffer' between themselves and their employer had felt able to visit the employer and open communication channels again. Some staff thought that clients did not only appreciate having someone to represent their interests, but also welcomed their expertise in making suggestions, such as a phased return, that they would not have known to pursue otherwise. One helpful outcome was breaking down barriers and changing **employees'** negative perceptions of their employer.

Some people spoke about building '*partnerships*' with employers, to aid clients' returns to work. Such partnerships were fostered more easily and successfully when staff had a clear point of contact, such as one line manager, or when occupational health professionals were involved. Partnerships with large private sector companies were given as examples. One opinion was that some employers might have dedicated more time and support to individual employees when they knew JRRP was involved. Having established a '*positive*' partnership, some JRRP staff felt they were in a better position to make enquiries about the workplace and suggestions for rehabilitation plans. Good working relationships also facilitated access to other types of help on occasions, such as arranging for a car parking permit nearby.

Where employers were not experienced in managing people back to work, or perhaps initially hesitant or unwilling to take the employee back, JRRP staff were able, in some cases, to persuade them to give the employee another opportunity and to be willing to make concessions, such as taking someone back when not fully fit and making reasonable adjustments. It was felt to have been important in some cases to have educated employers and changed their perceptions, for example,

improving their understanding of individual clients' health conditions and capabilities, the therapeutic qualities of working, and their options, such as offering a phased return, lighter duties, and working from home.

Government responsibility for the pilot was considered by some to have aided their work with employers. They felt it had helped to make an impression on employers, and to give reassurance to employers that their employees would continue to be supported and their progress monitored.

### *Assessments and providing equipment*

One provider specialised in conducting functional capacity assessments using a purposely built suite of mock workplace environments. Staff at this organisation felt it was suitable for a wide range of clients and produced '*scientific*' results in which employers had confidence. In this way, assessments conducted by JRRP staff had helped to inform discussions with employers.

Likewise, ergonomic assessments conducted in the actual workplace had helped to inform negotiations with employers, by identifying equipment needs. Although it was suggested that larger employers were better able to purchase necessary equipment, many employers were said to have welcomed JRRP staff's site visits and advice and felt more confident in ensuring clients returned to the right conditions as a result. One case manager said that in some cases, purchasing equipment for work had removed the single barrier keeping people from returning to their workplace.

Some staff identified Access to Work as an effective scheme for meeting clients' equipment needs. Provider organisations were not always able to meet the cost themselves and Access to Work made a '*crucial contribution*' by funding the cost of travelling to work for some clients. Staff from one provider organisation described how they filled gaps in Access to Work provision by providing equipment quicker than it would otherwise have arrived, and to people who did not qualify for Access to Work help.

### *Gradual returns to work*

Some people stressed gradual or phased returns to work as something clients perceive as the most important aid to their return to work. It was considered effective for clients with physical problems and physical jobs. People who had numerous and complex health conditions needed additional interventions to make a successful return to work. Some frontline staff said that increasing numbers of employers were willing to take employees back on a gradual basis. This was considered to be due, in part, to the actions of employers' legal representatives in reminding employers of their duties under the Disability Discrimination Act to make reasonable adjustments. The work done by JRRP staff in communicating with employers about individuals was also described as having informed employers about graduated returns and reminded them of their legal responsibilities.



Plans for gradual returns were described as emerging through mediation with employers. According to some staff, JRRP staff helped employers and employees break jobs down into their component parts and gave advice on how employees could modify their work and break patterns, the time of day that they worked, the tasks they did and the equipment they used. For example, one client who had suffered a stroke worked his way back to his original job, after JRRP staff liaised with the workplace and conducted a risk assessment, and having spent six weeks doing tasks below his level of competence. In some cases, a supportive occupational health department was thought to be useful in convincing employers to try a phased return, as was stressing the long-term, if not immediate, benefits of having an employee back in the workplace. Once embarked upon, phased returns were considered successful when clients followed the programme set out for them and felt financially supported throughout. Several members of staff stressed the importance of paying employees full pay whilst on phased returns, not only in influencing their initial decision to return to work, but in helping them finish the phase-in period. As discussed in Chapter 4, there was some disquiet amongst clients about being asked to use annual leave to cover days not worked during phase-in periods.

### *Advising and supporting clients*

In addition to what has been set out above, staff variously mentioned mentoring, group work, occupational therapy and forms of financial advice, as important in achieving desirable outcomes for clients. The interventions mentioned depended on which ones the organisation made available and reflected the expertise amongst frontline staff, some of whom delivered such services themselves. Important, and seemingly common, elements of these forms of help were described as having had the opportunity to talk to someone or engage with a group of people, to have received help to make lifestyle changes, and to have built confidence. In the view of some staff, such support helped resolve problems that were exacerbating people's main health conditions and which had taken the focus of their attention away from work. For example, talking through financial problems with a mentor, debt counsellor or welfare rights adviser helped some people consolidate debt and learn about their rights and options with regard to employment and benefits. The staff discussions support the client data reported in Section 2.6.3, about clients having little knowledge about claiming state benefits. Having received financial and welfare advice, staff said people had felt able to focus on their health and make informed decisions about work without feeling under pressure. Examples were given of how people had credit debts written off, made successful appeals for Disability Living Allowance (DLA) and obtained grants from charitable trusts.

### **5.2.3 Combinations of interventions**

Many of the JRRP staff who took part in this research study underlined the importance of being client-centred and needs-led, such that they delivered tailor-made packages of support to individuals. In practice, this meant that staff attempted to base decisions about the form, range, timing, combination and order of support

on their perceptions of clients' individual needs. Therefore, in their view some clients needed only one intervention and some several. Where several interventions were received, some people received them sequentially and some people concurrently.

Having stated this first, frontline staff illustrated how they compiled packages of support. Some identified natural links between interventions, such as providing equipment after conducting ergonomic assessments, as well as links they had found useful. For example, in one provider organisation, complementary therapy was conceptualised by staff as more pertinent to people with mental health conditions and so might follow a course of cognitive behavioural therapy. In this organisation and others, people with **physical** health problems were more likely to have consulted a physiotherapist, undertaken an exercise programme and completed a gradual return to work. Despite this apparent segregation of interventions according to health condition, staff also suggested that physical and emotional problems were not mutually exclusive and that people with physical problems had fears and beliefs that could be addressed by various forms of psychological therapy. Many staff described how their work with employers was an additional, and critical, layer to the delivery of other interventions, such as cognitive behavioural therapy.

The order in which interventions were received depended largely on the clients' wishes and the time at which they revealed additional problems and issues. Regular contact was important in raising new issues, in helping case managers to notice changes in clients and to meet changing needs appropriately. It emerged that some clients in the combined stream did not welcome talking about work when they first arrived, and case managers had, therefore, focused initially on trying to resolve health and other problems. Some people were said to have talked about personal issues, such as financial difficulties, only once they had established a trusting relationship with their case manager. In such cases, the help JRRP could give was thought to have been delayed. Offering services only in response to finding out clients' particular needs may help to explain why some clients said they did not know the full range of services available through JRRP, as reported in Section 3.4. One provider organisation's team found that they could not have offered therapeutic help to clients whilst they were under severe financial stress. Giving financial advice was, therefore, a facilitator to other interventions.

There were examples of how tailor-made packages of support were effective in helping clients back to work sooner than they perhaps would otherwise have been, and when others had apparently '*written them off*'. One such example was of a woman who had a damaged knee and was waiting for NHS physiotherapy. She returned to work three weeks after being referred to the JRRP provider physiotherapist, was given a home exercise plan and recommended to a local gym. One man in a physically demanding job had had an accident at work, was depressed, and was given long-term sick notes from his GP but no other support. He returned to work eight weeks after joining the pilot, having received counselling and intensive physiotherapy, and after discussions were held with his employer.

### 5.3 Key actors and working relationships

Throughout the group discussions, staff suggested that certain individuals, in their capacity as supporter, employer or clinician, had important positive impacts on clients. This section aims to identify how key actors, working individually or in collaboration with others, helped clients make progress. These same key actors and relationships were also identified by staff as contributing to barriers and constraints in their work with clients and this is discussed in Chapter 6.

#### 5.3.1 JRRP case managers

Packages of support included varying amounts of contact with case managers. Frontline staff and managers regarded case managers as a valuable resource and source of support for clients. Their perspectives on the composition and importance of the case manager role are largely consistent with those of clients, as described in Chapter 3. This subsection seeks to describe the elements of the case manager's role as highlighted by staff, and to explain how they were thought to be effective in helping people make progress towards work.

Although each provider organisation constructed their teams differently, it is possible to construct a model of case management built around five core elements, from staff accounts:

- identifying problems, needs and possible service responses;
- facilitating and coordinating service responses;
- supporting the individual;
- empowering the individual, by improving their knowledge and confidence, to take action themselves;
- providing specific services.

All but one team of case managers described all five elements in their role. Providing specific services, such as physiotherapy, was the one element not common to all. This was not present in the team of case managers without clinical or vocational expertise and dealing with clients engaged in each of the three intervention groups. The five elements are discussed further below, followed by a summary of ways of working that staff found particularly helpful.

#### *Identifying problems, needs and possible service responses*

At the initial stage of contact, case managers said they set out to identify how they might best offer help. Case managers used various assessment tools to identify clients' needs and barriers to progress. In talking with the client they felt they were sometimes able to '*make sense*' of everything that was happening, identify problems and highlight key problems to focus on. Sometimes this included translating medical terminology and '*de-medicalising*' client perceptions of themselves, to help them understand their problems and focus on their functional

capacity. At this time they also said they identified and explained appropriate and timely responses to clients' needs, and suggested ways of making progress towards work. In doing so, case managers had a role in promoting JRRP as a valuable service for the individual and managing expectations about what would be possible. Staff said that clients were involved in decision making about what services to try. Further to this, client choice was supported in some organisations by funding client requests for specific help, such as a training course.

### *Facilitating and coordinating service responses*

Once plans of action were agreed, case managers were mostly responsible for sourcing appropriate provision, facilitating access and ensuring that the form, nature and timing of the interventions were tailored to the needs and circumstances of the individual.

One provider organisation said they encouraged clients to find their own providers in the local area. Clients were also required to take responsibility for accessing help where case managers could only signpost to services, such as Citizens Advice. Signposting occurred when services were not accessible to people in particular intervention groups due to pilot restrictions.

One organisation introduced an intermediary step between the case managers and service providers. Non-specialist case managers referred clients to in-house specialists in occupational therapy and occupational medicine who then delivered services, accessed other resources, were able to refer clients for medical treatment, and communicated with stakeholders such as employers as necessary. Here, case managers retained a role in overseeing the provider organisation's response to clients' needs, providing funds, and providing personal support through regular contact, but did not communicate with all interested parties. In organisations where there was no such physician to make medical referrals, case managers had relied on physiotherapist staff members to do so, or attempted to persuade the clients' GPs to make them.

According to case managers, a degree of oversight and review was necessary to ensure clients remembered their appointments, services continued to meet needs, or that new forms of help were identified and accessed. In order to do this, case managers said they were proactive in following up after clients' appointments with providers. In general, relationships between staff and external providers were good and there were few problems. Staff appreciated feedback from all providers and welcomed their honesty in recognising when interventions were not working. Several comments were made about the generally quick access to services, and this was felt to be one of the pilot's strongest attributes. Case managers said that liaising between JRRP providers and clients about the appropriate number and frequency of sessions sometimes sped up the process of delivering support, and perhaps progress made.

Case managers' role as coordinators meant they sought to establish contact with those their clients had links with. From staff's perceptions of who they and their clients communicated with, it became apparent that JRRP staff were not often in contact with other parties when their clients were not also in contact with them. This concurs with statements from frontline staff about supporting and empowering clients to take control of their own lives. Wariness about infringing client confidentiality held some staff back from communicating directly with the clients' GPs, preferring instead for information to be passed through clients. It also reflects their awareness of needing client consent. When staff and not clients were in contact with other parties it was with the clients' knowledge and consent. Examples of such occasions were seeking advice from bodies such as the Health and Safety Executive (HSE), and when clients preferred not to be in touch, such as with creditors who were perceived as *'threatening'*.

In contacting and coordinating with sometimes multiple in-house and external providers and other key actors, case managers considered themselves as having been the *'lynchpin'*. In gaining an appreciation of the existing work- and health-related inputs in clients' lives, and knowing what others had told clients, case managers had attempted to give clients easy-to-understand overviews of what was happening. This was felt to be important in stopping clients' confusion, which itself had made some people feel anxious and acted as a barrier to work. It also helped people who felt unable to make contact with other parties themselves. Knowing what was planned with external parties meant case managers could ensure clients did not miss appointments and therefore, not miss the opportunity to receive help and to challenge or question experts.

In addition, staff said that collaborating with others ensured that some people accessed services and support they might not otherwise have got, and at appropriate times. For example, one provider organisation made itself known to NHS physiotherapists who then suggested to some patients that they seek extra help from JRRP that was unavailable on the NHS, such as functional capacity assessments and advice. Collaborating closely with others, such as devising a return to work plan with a trades union representative, was thought to combine and boost the support for clients. Joining forces was also thought to help persuade other decision makers. One example was of an employer-based occupational health department which, in supporting a JRRP rehabilitation plan, convinced an employer to put the plan into practice. On occasions, case managers said they had acted as the client's advocate. Case managers with clinical backgrounds, and who felt comfortable talking to health professionals, had sometimes contacted GPs directly to suggest courses of action. It was believed that the referrals which followed may not have been made otherwise, or at least not so early. There were also reports of some GPs having become more supportive of JRRP rehabilitation plans, and thus, lending further encouragement to individuals, once they had been in contact with a provider staff member who had explained the support on offer.

### *Supporting the individual*

Once clients had joined the pilot, the case managers considered themselves as a source of personal support. Staff from several different provider organisations highlighted the therapeutic importance of being empathetic and non-judgemental, trying to motivate people to work towards their goals, and having the time to listen to clients, something felt to be lacking in other services. According to some frontline staff, some people felt important when someone was listening and interested in them. As a result, staff believed that such clients began to think more positively and to feel better in themselves. It was also suggested that feeling valued in this way may also have encouraged some people to become more involved and to pursue other recommendations.

Furthermore, some said that continued contact over a period of time and a sense of the case manager's impartiality from employers and health professionals, had helped some clients foster relationships of trust with frontline staff, and in the provider organisations as a whole. Case managers felt they needed to be flexible and responsive in the time they offered clients, making themselves readily available when clients needed them. It was possible for contact to continue until a period after clients returned to work, thus covering the potentially difficult transitional period. Although particular circumstances in which clients had chosen to stop their involvement with the pilot were identified by staff (and reported in Chapter 6), in general, maintaining contact with clients over a period of time was not perceived as problematic. This contrasts with evidence from some clients, reported in Chapter 3, that their case manager failed to maintain contact as they had expected them to do.

### *Empowering the individual to take action themselves*

In supporting the individual towards their personal goals the case managers said they had a role in empowering clients. In practical terms, they sought to listen to clients and to be led by individuals' goals. They also said they helped clients build realistic action plans, and challenged and encouraged some clients to take action for themselves, such as making contact with their GPs or employers.

Together with their role as listener, educating about health conditions was felt to have an empowering effect, such that some clients began to see how they could help themselves. There was a feeling that some people had become overwhelmed by information from various sources, including medical experts, occupational health and line managers, and had begun to lose control over their lives. Case managers hoped to give people back a '*sense of ownership*' by improving their knowledge of their health condition and what they could do to help their rehabilitation, and through boosting their confidence. For those staff who had the necessary expertise, imparting clinical knowledge was perceived to have influenced clients' experience of pain and discomfort and answered concerns about further damage, such that some people felt more confident about trying new activities. Staff pointed to cases where people had returned to work having been reassured about their health condition and the likely effects of working.

This picture of clients actively engaging with provider organisations and services and perhaps taking a lead and gaining control is not wholly supported by the client data reported in Chapter 3. In general, clients who said they had chosen to take part in services from those suggested by case managers, had not led discussions and had looked to provider staff to maintain contact. It may be that frontline staff's strategies to encourage clients to take responsibility for their own rehabilitation, and for initiating contact with staff and services, were experienced by clients as the case manager withdrawing contact. This highlights how complex client-staff relationships are and the need for very skilful communication strategies. Section 3.3.6 reports that some particularly dependent clients were looking to their case managers to take charge, provide guidance and motivation, and to do what was necessary to help them. These people may help to illustrate that case managers were not always successful in trying to help people assume control over their lives, or that it could sometimes be a long process.

#### *Providing specific services*

To varying degrees, all case managers were providing a service through the four elements discussed above. However, in addition to these more generic services, some case managers provided particular services, such as physiotherapy, mediation with employers and job-search advice (see Chapter 1). Those case managers providing services themselves, possessed expertise in a particular field, such as physiotherapy, or had experience of working in an advisory capacity. Staff's perceptions of the effectiveness of such services are explored in Section 5.2.

#### *Aids to case management*

A number of factors were perceived by case managers as particularly useful in enabling them to help people make progress:

- **knowing their service providers well** was considered helpful by some staff. In doing so they could assess whether the support provided would meet the client's needs, give the client some background information about the provider, and feel comfortable in liaising with the provider;
- **action plans** were perceived as useful in ensuring clients and case managers understood what steps were to be taken and by whom;
- **continuity of contact** not only helped to build a relationship between case manager and client, but also enabled case managers to become more familiar with the client's situation and aspirations;
- **giving clients positive examples** of helping other people in similar circumstances was felt to be a useful tool;
- **operating within a team environment**, in which experience and learning was shared and methods reviewed, helped some staff to feel that service delivery improved over the course of the pilot;

- **access to good quality staff training** was also felt to be important in activating improvements. For example, learning about motivational interviewing gave case managers confidence in asking clients the 'right' questions and speaking to employers in a positive and persuasive way.

### 5.3.2 Employers

JRRP staff contacted employers to promote the pilot and with regard to individual employees. Examples were given of contact with line managers, human resources staff, occupational health departments, finance departments and health and safety officers.

Promoting JRRP to employers was not widely discussed with people in the group discussions. One provider organisation had made presentations to many employers, many of whom had '*signed up*' to say they would alert staff to JRRP after six weeks' absence. Conducting presentations had a positive impact on the relationship with employers, as employers were said to be more aware of JRRP and, in some cases, willing to strike up '*partnerships*' for the benefit of employees.

Willingness on the part of the employer to help the employee and see them return to work was felt to be a key factor in aiding people's progress. A willing employer not only kept the job open but was open to help from JRRP and therefore, to ideas that were perhaps new. Some such employers were described as caring and supportive and had effective occupational health provision, but still regarded JRRP's existence as an opportunity to obtain extra help. Staff became more involved and developed working '*partnerships*' with some of these employers.

Some employers were understood to be more cautious, choosing to keep minimal contact with absent employees for fear they would be perceived as harassing individuals. Some of these small and medium-sized employers were said to be surprised that JRRP was available, and pleased that there was assistance for them. One project manager thought that some employers were good at sending employees to provider organisations because they did not have their own provision of occupational health services. One observation was that employers were sometimes prepared to do more to help individuals when they were long-serving or valued employees.

Section 5.2.2 reported frontline staff's views on how working with employers helped to achieve successful outcomes for some clients. Some employers were identified as effective without establishing a partnership with JRRP. These employers operated sickness absence management procedures and sick pay schemes believed, by some JRRP staff, to be based on best practice. Larger employers with their own occupational health provision were said to be more knowledgeable about helping people return to work. Examples were given of employers who would '*do anything*' to help valued employees, such as providing a bed in the staff room to allow an employee to rest at work, and paying full wages to employees phasing their return. In some cases, feeling financially well supported by employers had enabled clients to



make considered choices about when and how they returned to work. It was acknowledged that the more generous sick pay schemes were found amongst public sector and larger private employing organisations. Staff were impressed where human resources were working closely with line managers, and when employees had built relationships of trust with occupational health personnel.

Clients' own relationships and communication with their employers were sometimes sufficient in negotiating a successful return. In such situations JRRP staff focused their support on empowering clients to meet and negotiate with their employer.

Chapter 6 discusses problems associated with employers and their role in job retention and rehabilitation.

### 5.3.3 GPs

All providers, except for the organisation working with workplace only interventions, had some experience of direct contact with GPs and health services. Again, the purpose of contact was either to promote awareness of JRRP or concerning an individual client.

GPs proved to be good links into JRRP where they were aware of the pilot's existence. Promotional events aimed at an audience of GPs, and the inclusion of promotional information with sick notes, were tactics employed in some pilot areas.

Research participants gave some positive messages about working with GPs and some examples of how relationships with GPs improved as the pilot became better known amongst practices.

Some frontline staff said that GPs became more supportive after JRRP staff had explained their aims and the methods they were employing. Other provider staff attributed the improvement in relations to GPs' recognition of the professionalism amongst JRRP staff, which in turn had been the focus of a marketing campaign. Some GPs told JRRP staff that they had limited knowledge of occupational health issues and welcomed the assistance JRRP was offering their patients.

Some staff perceived GPs as aiding progress by helping clients directly, and some by helping JRRP staff. They felt that some clients placed importance on the opinion of a medical expert, and were encouraged to think that work was possible and to go forward with JRRP rehabilitation plans if their GP sanctioned it and was generally supportive. Some GPs helped JRRP staff by passing on useful information about individual clients, such as how family members might inhibit a return to work. They also made helpful suggestions for referrals after frontline staff had approached them. Other examples of collaborative working included liaising with NHS physiotherapists about clients' needs and how JRRP help might complement NHS treatment.

The ways in which GPs were perceived to have hindered the work of JRRP staff is reported in Section 6.3.2.

### 5.3.4 Family and friends

According to some staff, family members and friends proved to be important in clients' decision making. Some ways in which they were thought to have had a positive impact were in changing clients' perceptions of themselves, what they were capable of doing and whether or not a return to work was possible. Some provider organisations worked directly with family and friends. One provider organisation's provision of sessions designed specifically for significant others fitted their overarching philosophy that people have attitudinal as well as physical barriers that need addressing. The purpose of the sessions was to help staff identify ways of supporting clients. Other providers had routine contact with family or friends when they attended appointments with clients.

### 5.3.5 Other contacts

Throughout the course of the pilot, staff were in contact with a number of other interested parties. Some staff sought advice from government departments and agencies, such as local Jobcentre Plus staff and the HSE. There were mixed reports of contact with trades unions representatives. Where they were thought to be representing employees effectively, JRRP staff found that their own services had little to add to what the trades unions were providing, although there were examples of collaborating with representatives to create return to work plans and support clients in negotiations with their employer. However, not all advice from trades unions representatives was considered to have been helpful.

## 5.4 Conclusions

In general, provider staff were positive about their work and the impact they felt they had made on their clients, in contrast to the more mixed views from clients reported in Chapters 3 and 4.

Employing specialist staff and sub-contracting to other providers enabled JRRP provider organisations to offer a broad range of support, thus aiding their attempts to cater for all needs. In general, frontline staff and project managers were content with the range of resources and with their working relationships with service providers. Where it occurred, mixing in-house and external provision was unproblematic, largely due to the overseeing and coordinating role performed by case managers.

The most significant differences between the different provider organisations centred on how they employed staff with clinical and vocational experience and the extent to which services were delivered by external providers. Organisations employing physiotherapists and physicians in the in-house team were able to provide more direct, and perhaps quicker, access to medical advice and treatment and did not have to rely on GPs making referrals. The provision of workplace interventions, compared with health interventions, seemed to lend itself more readily to delivery by in-house staff. This is perhaps due, in part, to a relative shortage

of external specialist workplace expertise compared with health care expertise. The need for more specialist equipment, knowledge and clinical governance in delivering health interventions may help to explain the difficulties in delivering health interventions from within small organisations.

Responding to individual needs was at the centre of 'what works' for people, as described by JRRP staff. Staff identified the following as key elements in providing an effective service:

- early intervention, before conditions deteriorate and problems worsen;
- focusing on client needs, not the needs of service provision;
- thinking holistically, in order to tackle a range of attitudinal and physical problems;
- offering tailor-made packages of support, combining services and interventions as necessary;
- flexibility in spending money;
- central role for case managers, as facilitators and coordinators with services and other key actors;
- intensive and focused application of a broad range of high quality services.

An interesting part of the discussion on resources was the staff's identification of themselves as a resource. The case management model was popular and staff were positive that they themselves made a difference for some clients, in addition to the help received from services provided by others. Even those case managers who had no role in delivering specific services and who had expected little contact with clients beyond an initial induction and assessment, spoke of how they had played a significant role in client's development by becoming coach, supporter and motivator. Their role as coordinator of different inputs in people's lives and enabler in giving people options and control over their lives was also described as significant, especially as it seemed that no one else was fulfilling this role. It seems important that support for individuals continued over a period of time and that relationships of trust were built. Ongoing support from case managers was thought to have enabled some clients to open up about all their problems, and thus, give services the opportunity to attempt to remove all barriers to work.

A number of interventions, such as cognitive behavioural therapy, physiotherapy and mediation were also reported to be effective. Some common elements of effective interventions were:

- quick access;
- intensive application;
- the opportunity to talk and engage with someone;
- help aimed at changing lifestyles.

The **combination** of effective interventions was considered to be a good way of meeting people's different needs and thus, tackling more barriers to work. It was believed that flexible and coordinated responses using a range of interventions had helped some clients return to work sooner than they might otherwise have done. Flexibility in spending money was thought to aid staff's ability to build tailored packages of support and thus, to respond to individual needs.

Employers could also be an important part of how clients made progress towards work. Ways in which employers were said to have helped employees were:

- providing adequate financial support;
- being open to frontline staff's help and willing to rehabilitate employees;
- already implementing good sickness absence management and rehabilitation procedures, such as keeping in contact with absent individuals and making adjustments to the workplace.

According to some staff, communicating with employers, making suggestions and negotiating returns to work had seemingly exposed some employers to new ideas and good practice regarding sickness absence management and vocational rehabilitation. In this way the pilot may have made a lasting positive contribution to those employers who now have a better understanding and employ more effective procedures in retaining their employees.



## 6 Barriers and constraints

This chapter again draws on data from group discussions and interviews with provider staff, and concerns the barriers and constraints staff encountered in trying to help clients move towards work. The barriers and constraints considered included both those that clients faced in trying to get back to work (and, therefore, those that staff were trying to tackle), and those staff faced in providing the services needed by their clients. Examples of the first kind were some employers' attitudes and practices regarding the return of their employees. The second kind was illustrated by barriers such as insufficient funds to pay for surgery.

In Section 6.1 the key messages emerging from discussion with staff are summarised. The barriers and constraints are then broken down into three discrete areas and reported in more detail, starting with impediments staff associated with the Job Retention and Rehabilitation Pilot (JRRP) service provision in Section 6.2. Hindrances linked to key actors, such as employers, GPs and other NHS staff, are reported next. They are then followed in Section 6.4 by other barriers and constraints encountered, such as those concerning the clients themselves and those relating to the socio-economic environment, such as clients' employment circumstances, state benefits, and other financial disadvantages. Section 6.5 draws on a different kind of data, generated by asking staff to reflect on what they had learned from their experiences and what they would like to see happen in the development of future services.

### 6.1 Key messages

In broad terms, the clear message from all the provider organisations was that the main barriers and constraints on their work with clients emanated from external sources. Although they identified problems associated with the structure of the pilot and service provision, the biggest impediments to client progress were associated with the attitudes of, and working relationships with, employers, GPs and other health services. It was noted that employers have a lot of power concerning employees' future employment, and to this extent, JRRP providers have been reliant on employers to make a return to work possible. A common complaint was that there was not enough joined-up working across all the stakeholders concerned in

clients' cases, meaning that clients were sometimes left confused about their situation and encountered delays. It was also felt that the current welfare benefits system was acting as a deterrent for some people to work. Financial considerations were perceived as very influential in people's decisions about returning to work; the provision of benefits were thought to have encouraged people to stay off work if they understood they would be worse off financially upon returning to paid work.

## 6.2 Barriers and constraints associated with JRRP service provision

In talking about barriers and problems associated with service provision, staff spoke about factors that restricted their work with clients, and problems which did not have an impact on client progress. These criticisms were related to the structure of the pilot nationally, as well as to individual organisations' ways of working in-house and with external providers.

### 6.2.1 Barriers, constraints and problems associated with the pilot structure

Since provider organisations adopted different service delivery models, it is perhaps to be expected that they experienced different restrictions and problems relating to the way the pilot was set up. Problems highlighted by staff related to:

- the allocation of clients into three discrete intervention groups;
- the restrictions on which services and personnel staff could collaborate with;
- financial limitations;
- its operation as private organisations;
- the exclusion of certain groups of clients.

Restrictions imposed by the pilot's trial status were felt more keenly by organisations delivering health or workplace interventions only. Staff working on the health interventions only path were frustrated that they could help people move **towards** work but not actually **into** work because they were prevented from liaising with employers. Similarly, staff providing only workplace interventions could do little to help clients whose health problems were the main barriers to work and were waiting for NHS provision.

Some staff reported that they were not permitted to contact other services, such as social services, irrespective of the intervention group they were working with because such help did not fall within the pilot's '*remit*'. This meant that they were not always able to help clients whose barriers to work went beyond the scope of 'health' and the 'workplace'. For example, one staff member was prevented from using a social services auxiliary helper to provide temporary social care to a family and enable a parent to work.

For most cases, staff felt the budget they could spend on clients was sufficient. However, some staff members working with health interventions were frustrated that the budget was not high enough to allow spending on all kinds of necessary surgery. This was especially frustrating where an operation was considered to be the key to getting a client back to work. Some clients in this position were, according to some staff, left uncertain about how long their absence from work would last and whether or not they would ever be fit to return to their previous job. Although some staff said having a budget limit for individual clients had helped them to prioritise interventions, they also felt they needed greater flexibility in using money left over from some individuals to help others whose needs outstripped the budget limit.

There were feelings amongst some staff that the positioning of JRRP within the private sector, albeit with government backing, meant that they lacked standing and authority in trying to influence key actors. They felt ignored by some GPs and health professionals, and had to spend time explaining who they were and what they were doing in persuading and reassuring others.

Although not impeding the work they did with clients, some provider staff had concerns about the intentional and unintentional exclusion of certain groups of clients from the pilot. Since clients had volunteered, staff felt they were largely working with people who **wanted** to return to work and thus, were not as challenging as other people might be. Conclusions about the success or otherwise of the pilot were, therefore, thought to be limited by the omission of harder to help groups, for example, people with severe mental health problems who do not feel able to use the phone and access services. People who worked 15 hours per week or less were prevented from gaining access to the pilot. One person felt this was a key group needing help from JRRP, as they were the lowest paid, the least likely to access mainstream services and the most likely to drift on to state benefits.

### **6.2.2 Barriers, constraints and problems associated with in-house working**

Staff reported problems relating to procedure, team-working and early skills deficiencies of some in-house staff.

For one team, a lack of clearly defined processes, such as an exit strategy, meant achieving '*closure*' with clients was difficult. These difficulties are perhaps reflected in some clients' lack of clarity about whether contact with the provider organisation had ended. Clients' experiences of ending contact with the pilot are discussed in Section 3.7. Some staff felt restricted by the requirement to follow time-consuming procedures, such as completing paperwork and chasing up clients when they had returned to work. Administration was not always efficient, as demonstrated by some delays in paying clients' travel expenses.

One team of non-clinicians felt that, as case managers, they lacked standing within the provider organisation which had an effect on their self-esteem and morale. They felt the way they managed cases was affected by a lack of control over the budget



because they did not know how much they were spending on each client. They also believed that the organisation's work with clients would be less convoluted and more efficient if case managers, and not in-house specialists, had responsibility for communicating with all internal and external stakeholders, including employers and GPs. A complex management structure and no obvious line manager meant that one team felt they did not have a voice in how the project developed, and thus important information about the provider organisation's front-line operation was overlooked. They also felt that '*big decisions*' did not get made and problems were not resolved efficiently. Some clinically-trained case managers were unhappy that non-clinical managers were making what were perceived to be clinical decisions about what services could and could not be accessed by staff. Changes to personnel had also disrupted team dynamics and meant staff did not have a stable working environment.

Some staff working with workplace interventions only, felt that their own skill levels and experience contributed to some clients' slow progress in the early days of the pilot. Some of these case managers had initially found it difficult to appreciate how clients could progress without medical intervention and what alternatives they could provide to '*lift*' clients. However, over time they learned the value of the services they provided and improved their skills in working with individuals, for example, improving the way they conducted initial assessments to pinpoint clients' difficulties.

### **6.2.3 Barriers, constraints and problems associated with external providers**

Few problems in accessing and mobilising resources were reported. However, there were sometimes difficulties in accessing psychology services, where based at hospitals and contact had to be made through secretaries. In addition, some problems with providers had resulted in discontinuing involvement with them. According to one team of case managers, one provider could not devote enough time to JRRP because of other commitments, leaving clients without the service they had been promised. The working relationship with another external provider was discontinued because JRRP staff felt the kind of help they had expected was not being provided. In both examples, the discontinued service was not missed because case managers and other providers were able to deliver the service instead.

## **6.3 Barriers and constraints associated with key actors**

The majority of discussion with service provider staff on barriers and constraints centred on the action, inaction and working relationship with external key actors, including employers, GPs, health services, Jobcentre Plus, and family and friends. They stressed the importance of the roles played by these actors and that difficulties in communication and understanding, and a lack of coordination and flexibility were major reasons why clients did not make progress, or found it difficult to do so.

It should be noted that some of the data in this section did not come from staff's own experiences of contact with others, but from what clients had told them about employers, GPs and others. Also, the **reasons** reported here for difficulties experienced are those suggested as possibilities by frontline staff. Clients' own views about how employers and GPs acted as barriers and constraints are reported in Chapter 4 and present similar messages to those from staff.

### 6.3.1 Employers

There were both positive and negative reports of employers' contact with clients and frontline staff. In thinking about how employers hindered the work of provider organisations, significant factors were employers' attitudes, policies and procedures regarding absence management and rehabilitation, their occupational health services, and financial concerns.

#### *Attitudes, policies and procedures*

Sometimes staff approached employers about visiting the workplace and sometimes clients preferred to contact their line manager first. Frontline staff found some employers resistant to being in contact with them. Such employers were described as not wanting to meet with staff, listen to their representations made on behalf of clients, or allow staff access to the workplace. Some employers were said to have denied the possibility of contact between JRRP and contracted-out occupational health services by refusing to pass on details. A possible explanation offered by provider staff for employers' reluctance was that employers already thought they had excellent occupational health services and were sensitive about JRRP staff asking questions and offering help. Some staff had doubts about the quality of such occupational health provision and gave examples of known poor practice, which included not keeping line managers informed of employee progress, a perceived unwillingness to implement gradual returns to work, and not following statutory guidelines about obtaining sickness certificates. Staff also suggested that some employers were reluctant because they were unsure of the provider organisation's credibility because JRRP was unfamiliar to them. Some employers were later perceived as reassured by staff members' credentials. In more exceptional circumstances, employers were understood to be unwilling to meet JRRP staff because the client had had an accident at work, which was the main cause of their absence.

When provider staff were able to communicate with employers, employers' attitudes, policies and procedures could also be perceived as barriers and constraints to client progress. Staff gave examples of employers who were not interested in helping individuals back to work where they were not valued and, therefore, considered dispensable. Staff thought that some employers were less supportive or did not want to continue employing employees whose health condition was undiagnosed and the duration of their absence was unknown. One observation was that employers could be unsupportive where employees had conditions such as Chronic Fatigue Syndrome or mental health problems, because they did not understand these conditions and their effects on individuals.

Employers were criticised by staff as inflexible and not forward-thinking when they would not consider rehabilitation programmes and phased returns to help ease the employee back to work, insisting that there were no light duties or that the employee had to be one hundred per cent fit to return. Similar criticisms about employers were made by clients, as reported in Chapter 4. Even when phased returns were accepted, employer-imposed rigid conditions about the length of the phase-in period were not always considered appropriate for the individual. Some people felt that '*hard policies*', especially those disciplining absent employees, were '*destructive*' as they caused individuals to worry about returning. Some procedures regarding return to work were also considered obstructive, such as the requirement to visit occupational health first, even where there was a long waiting list to do so.

Progress was felt by some staff to be affected where clients in the workplace interventions only stream were subject to disciplinary action by their employer. In such cases mediation was no longer considered to be an effective tool because they felt the employer was not open to help at that time. These staff members said they would not become involved until the disciplinary process was complete. This applied more readily to some larger employing organisations with formal procedures, who did not welcome interference from outside.

It was felt that some employers were not knowledgeable about sickness absence management and vocational rehabilitation, and that this was a major constraint. Examples included where line managers had not been in regular contact with employees, or where they were uncertain about what work they could give to a returning employee. Staff were worried that clients' attempts to sustain work in an environment unsympathetic towards, and uninformed about, rehabilitation issues would ultimately be unsuccessful. However, provider staff were positive that such situations could be avoided when they were able to liaise with employers and give them advice.

#### *Occupational health services*

Some occupational health services and departments were also criticised by provider staff for failing to keep line managers informed of employees' situations and failing to give managers advice on employees' prospects for returning to work. One point of view was that occupational health departments did not always work in the employee's best interests and aimed to get them back to work. Clients had their own suspicions about the role and partiality of occupational health personnel, as discussed in Section 2.8.2. It was implied that occupational health services balance the interests of employer and employee and may favour the employer in some circumstances. This was compared with their own work which strove to work for the employee's interests.

#### *Financial barriers*

Failing to pay employees full pay whilst on gradual returns to work was perceived as a barrier to work for people who would be financially disadvantaged without full pay.

People suggested a number of financial reasons why employers might be reluctant to rehabilitate an absent employee. These reasons were:

- concern that the employee would not be able to do their job and would, therefore, cost the employer in productivity losses;
- fear of the cost of litigation in the event of an unsuccessful return to work or an accident at work;
- insufficient resources to pay the returning employee whilst simultaneously paying their replacement worker.

### 6.3.2 GPs and health care services

There was uncertainty amongst staff about whether or not they were permitted to communicate directly with GPs and health services. Issues of client confidentiality and pilot contamination<sup>23</sup> served to put doubts in the minds of some staff about the validity of striking up such working relationships. Instead, some sought to give advice on how **clients** might best communicate with health professionals, and gave clients copies of reports, such as an occupational therapist's assessment, to pass on.

Where there was communication between JRRP staff and GPs and other health care personnel, there were mixed views about the working relationships formed and GPs' contributions to client progress. Although there were supportive GPs and practices from the outset, and over time communication had improved with some GPs, problems were still encountered.

#### *Attitude towards JRRP and vocational rehabilitation*

A barrier staff felt clients had come up against was the general lack of awareness and knowledge of vocational rehabilitation amongst GPs. Staff argued that GPs do not have an agenda to focus on return to work issues, nor do they have the requisite training to advise patients in this field, and patients are not, therefore, encouraged to think about work. This is perhaps supported by clients who said their GP had not adopted an active role in their decisions to return to work, and by clients who were unsure their GP should give advice on when to return (see Sections 2.7.1 and 4.4.3). Furthermore, staff felt that some GPs' perceived ignorance of vocational rehabilitation is demonstrated in their stances towards patients' conditions, prognoses and the issuing of sickness certificates. Some staff felt that, in general, sick notes are too easy to obtain, that clients are not questioned sufficiently and that some GPs sign people

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<sup>23</sup> Staff working with clients allocated to the workplace interventions group were not permitted to offer health care interventions or to become involved in clients' medical treatment. This was done to protect the segregation between health and workplace support, as the pilot was designed to test the effectiveness of each independently. It was unclear from the discussions whether staff were allowed to contact GPs for background information when clients were receiving only workplace support.

off work when they know the patient has some capacity to work. In issuing sick notes for long periods, it was felt GPs were giving the wrong signals to patients and that their confidence and motivation regarding returning to work could be deflated. Staff members from one organisation said that some GPs '*write off*' their patients, assuming that their health will not improve. They believed that this led clients to reject JRRP and their chances of returning to work. Despite these difficulties, staff remained hopeful that in such circumstances they could influence the client and change their perceptions about themselves and work by giving them more vocationally orientated advice.

According to some people, some clients had been given inadequate information about their condition and treatment, and not given advice on what they could do to help their condition. JRRP staff identified this as a gap they could address, by educating clients about their condition and how they could manage its effects better. One suggestion was that inadequate consultation and advice was a sign of the time pressure GPs face and a consequence of not spending enough time with each patient. There were suggestions that GPs were too busy to tell patients about a range of services that could help them, such as a free counselling service. One argument was that spending extra time with patients at the beginning of their time off sick could save time and money in the long term.

Provider staff highlighted a number of ways in which they perceived GPs could hinder their work. They felt some GPs slowed clients' progress through their inaction. They gave examples where, despite recommendations made by JRRP staff, GPs failed to make referrals to certain services, or delayed doing so. Staff surmised that hesitancy and a conservative attitude towards confirming patients' medical status, and in expectations about patients' capabilities, was borne out of their desire to '*cover their backs*' and avoid mistakes. But this uncertainty was felt to be unhelpful to patients and they argued that clients and employers need more certainty if they are to return.

Furthermore, it was felt that GPs and other health care staff had hindered JRRP work through what they did and what they said. Some people believed health care staff had deterred patients from approaching JRRP or from using particular services offered. In one pilot area, a newsletter had been issued by the local medical authority, advising patients to avoid JRRP. Giving opinions contrary to those of frontline staff and providers about clients' readiness for work and the services needed was problematic for JRRP staff. Some clients were said to have told JRRP staff that their GP advised them not to do arranged phased returns because they needed more time off work. The discussion in Chapter 4 shows that clients reported this too. Similarly, some JRRP staff said other NHS personnel had told patients they did not need JRRP, or specific services offered such as psychotherapy. Staff suggested that GPs were perhaps averse to working with JRRP because they wanted to maintain ownership of the client's case, did not like being told what to do and did not want another professional telling their patient what to do. Included in those who felt this to be the case were JRRP staff who had clinical backgrounds. On a less personal level,

staff felt that GPs' reluctance may have been in working with organisations outside the '*establishment*', set apart by their status as a private organisation or by the overarching research element of their practice. It was some staff's understanding that some GPs had concerns about the use of a randomised controlled trial.

The level, mode and outcome of communication with some GPs proved to be less than collaborative and mutually beneficial than JRRP staff had hoped. Some GPs frustrated staff by proving difficult to contact. It had been hard to speak to them in person on the telephone and was a common experience for GPs to fail to return staff's calls. The charges made by some GPs for the reports they provided to JRRP further illustrated staff members' perceptions of difficult working relationships.

### *National Health Service*

Provider staff identified delays, inadequate provision of services and a lack of proactive case management as reasons why some of their clients made slow progress back to work. People were said to get lost in a system where they were left waiting for diagnoses and treatments. Some people were frustrated when the key help for their clients was NHS treatment, which they had to wait for and which JRRP could not speed up due to budget restrictions or the measures in place to avoid pilot contamination. At times staff had felt they could do nothing to effect a return to work. However, in some circumstances JRRP had been able to circumnavigate NHS waiting lists by funding less expensive private treatment. Staff also helped clients chase up referrals and appointments. Interventions such as complementary therapies and helping clients to stay motivated and to build confidence were sometimes ways in which people could be supported whilst waiting for treatment. Even when NHS treatment was accessed it was not always considered adequate, such as physiotherapy sessions only once a month.

### **6.3.3 Others**

Jobcentre Plus and clients' families were also identified as having become barriers or constraints to the work done with clients. One complaint was that Jobcentre Plus was not set up to work with JRRP clients, unless they lost their jobs and became unemployed, and therefore, once the client's problems had intensified. In practical terms, JRRP case managers sometimes faced difficulties identifying sources of support for clients, such as help in searching for alternative jobs, once clients had exhausted the support JRRP could provide.

Clients were thought by staff to have made slow progress, or to have ended their contact with provider organisations, when their partners were not perceived to be supportive or interested in their rehabilitation plans.

## **6.4 Other barriers and constraints**

Discussion with provider staff also highlighted problems associated with the clients themselves and the wider socio-economic environment, encompassing general observations about the state benefits system, the NHS and conditions of employment.

### 6.4.1 Clients

It proved difficult to work with clients whose problems, needs and aspirations were felt to extend beyond the pilot's remit. This applied to people not looking to return to work, people with particular health conditions, those looking for specific help, and people not comfortable with the services offered.

#### *Wanting to return to work*

The pilot was considered to be less successful where the service approach and aims, to return people to work, did not fit with individuals' needs and aspirations. Various explanations offered for people's attendance at JRRP when they did not want to return to their jobs were:

- feeling coerced to attend by an employer or occupational health;
- looking to 'offload' and perhaps enjoy social and regular contact with a case manager;
- to prove their sickness and to support the 'sick role' they had adopted;
- to obtain advice about what steps to take in bringing a claim against an employer for unfair dismissal or for compensation for injuries sustained at work.

Motivation to do **something** on the part of the client was felt to be essential. Some staff encouraged those who did not feel ready for work to do other activities in **preparation** for work at a later time (see Chapter 5 for staff discussions about supporting and motivating clients). Some staff recalled losing '*unmotivated*' clients when they were asked to do something towards taking responsibility for their rehabilitation, such as a '*homework*'<sup>24</sup> task.

#### *Health conditions, problems and perceptions*

The nature and severity of clients' health conditions were thought to be barriers to progress in some cases. Clients with long-term psychological problems, clients being tested for cancer, those '*bedridden*' by illnesses such as Chronic Fatigue Syndrome, people needing major surgery, and those with multiple health problems were thought to be harder to work with. Some frontline staff said their organisations were not set up to tackle severe mental health problems and provided cognitive behavioural therapy services only to clients who '*fitted the model*', because they were in the '*right frame of mind*' and could be helped within a limited and small number of sessions. Other organisations, however, were able to provide intensive occupational therapy and psychotherapy over many weeks to clients with serious psychological problems, for example, one client moved into work after 32 sessions of occupational therapy and psychotherapy. These differences in provision seemed to be attributable to differences in clinical approach adopted by provider organisations, rather than the depths of their resources.

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<sup>24</sup> The content of such homework tasks was not explained in the group discussions.

Staff found it harder to help people who had numerous health-related and non-health-related problems and who perceived their main reason for being off work as making work impossible. For example, staff could not influence a return to work where a client's daughter's illness was regarded as the core problem and reason for being off work.

In some cases, clients' perceptions of their health problems were barriers to work. It was the view of some frontline staff that a '*medicalised*' perception of their condition and its treatment had encouraged some individuals to believe they could do nothing until they received medical intervention. Case managers tried to intervene and change perceptions by '*de-medicalising*' the process, focusing less on their medical status and what they could not do, and focusing more on what functional capacity they **did** have, and the benefits of working.

Drawing on their experiences of contact with clients, frontline staff spoke about other barriers to work perceived by clients. They said some clients felt too old to work or unable to see how they could continue other commitments, such as caring for relatives and doing voluntary work, whilst in paid employment. Some clients told frontline staff that they feared returning to their employer, particularly where they had been through absence-related disciplinary procedures and issued warnings. Some staff were also mindful that clients might create a false image of an unreasonable employer where they had other reasons for not wanting to return to their job. Again, frontline staff said they attempted to change clients' perceptions by demonstrating the benefits of returning to work and by helping clients achieve a balance between work and other commitments.

### *Openness to interventions offered*

There were perceptions that it was very difficult to help clients who came with '*shopping lists*' for particular interventions, if those interventions were not available to them. In this situation clients were thought to be more likely to drop out of the pilot. Staff said that not many people came looking explicitly for help in the workplace, although this could be explained, in part, by people's lack of knowledge about the availability of such help. This is supported by evidence from clients, as reported in Section 3.2.3.

Some clients were said to be uncomfortable with taking up certain services or were put off by their experiences of services. Staff talked about instances when clients had turned down counselling because of the perceived stigma attached to receiving such help, or had been averse to the idea of staff contacting their employer. They also explained that the bio-psychosocial model adopted by some providers (addressing medical, psychological and social aspects of problems) did not sit comfortably with all clients and felt that some had chosen to leave the pilot as a result. Some clients needed longer periods of one-to-one support before entering group settings.

Frontline staff from one provider organisation remarked that particularly challenging cases involved people who rejected all their employer's suggestions for returning to



work. Such clients were asked to compile a list of their needs and wants to aid negotiation with their employers.

### **6.4.2 Socio-economic environment**

Staff said they had to bear in mind things in the wider environment which they were not able to exercise control over. These were:

- clients' employment circumstances;
- the system of social security benefits;
- insurance companies;
- long waiting lists for NHS tests and treatment;
- independent occupational health services;
- employment legislation and legal representation.

Some of these parameters had restricted the work JRRP staff could do with clients.

#### *Employment circumstances*

Irrespective of an employer's attitude towards and role in helping an employee back to work, the type of work undertaken and working environment were thought to act as barriers in rehabilitating some people. Staff considered some jobs as demanding a high level of physical fitness and that some individuals' health limited their capacity to do the essential parts of all jobs offered by their employers. Poor interpersonal relationships with colleagues were believed to make a return to work unappealing. Difficulties in travelling to work posed potential problems for some, but had been overcome where Access to Work funding for transport had been accessed.

There was disagreement amongst provider staff about whether clients in secure financial positions whilst out of work were more likely to prolong their absence, especially if their experiences of work contributed to their sickness absence. However, there was more consensus in the belief that people felt under pressure to work before they were ready when their full occupational sick pay ended. Staff were concerned that such pressure would encourage more people to make poor decisions about when and how they return to work, and that work may not be sustainable. Chapters 2 and 4 contain examples of clients who returned to work due to financial pressures and who could not subsequently sustain their return (see Sections 2.6.2 and 4.3).

Not receiving full pay during a graduated return to work was thought to operate as a disincentive to rehabilitation, especially to clients who are their family's primary wage-earner. There was a suggestion that the benefits system makes up the shortfall when employers are unable to fund it, to ensure this effective method of rehabilitation remained accessible to all.

The resourcefulness of case managers was challenged when working with self-employed clients, as changes to working conditions, tasks and roles were not easy to implement. Staff said that self-employed people face higher risks in returning to work, especially if their enterprise depends entirely on their personal capacity. They gave examples of people who faced difficulties because they had lost all their previous contracts and feared that they would not cope if they returned to work.

#### *The system of social security benefits*

Staff from all the providers recognised that the benefits system had produced disincentives for some clients to work. Primary wage-earners with low skills, or with commitments to care for children or other relatives, were harder to help because they perceived themselves as financially disadvantaged in returning to paid work.

Some staff were also concerned that once people are on benefits they are harder to help because they begin to believe they cannot work.

Problems encountered in using the benefits system were said to have prevented some clients from concentrating on return to work issues. Appealing against fitness for work decisions, confusion in navigating the claiming process, and the insecurity of their financial situation had caused stress for some clients, which was believed to have slowed their progress with JRRP.

#### *Other financial disadvantages*

The conditions of insurance against loss of earnings had played a part in some people's thinking about returning to work. According to some staff, failed insurance claims to continue paying debts such as mortgages whilst out of work, had forced some people to return to work too early. Conversely, some people were believed to be encouraged to take longer in recuperating, to ensure they made a sustained return to work, as their insurers would not pay out again within a certain period of time.

## 6.5 Lessons for future service development and delivery

Having discussed what had worked well and what barriers and problems had been encountered, frontline staff and managers were invited to highlight important lessons they had learned about structure and service delivery and what they hoped would be incorporated in any future service. This section, therefore, draws on different data, as people reflected on their experiences and offered ideas for the future.

All supported further development of job retention services. Consideration was given to the idea of implementing the pilot provision on a national scale, and to integrating job retention services with established provision, such as NHS and Jobcentre Plus services. Common themes emerged relating to the location of organisational responsibility, the point of access to help, the use of the case management model, the need for more joined-up working and other considerations about service delivery.

### 6.5.1 Organisational responsibility

Opinion was divided over the question of who should hold responsibility for job retention services. Expressions of support were heard both for governmental responsibility and independence from government. Irrespective of these differences, there was consensus about the need for job retention services to be delivered on a large scale and thus, by an organisation large enough to cope with the responsibility. From staff members' perspectives, a larger and well-known organisation would be better recognised and respected, it would have effective and efficient payment systems in place to meet provider demands, and would have access to large networks of resources and expertise.

#### *Governmental control*

Government '*branding*' was identified by some as a useful tool in making services known, in showing a sense of authority and in gaining users' trust. There was some disagreement about which government department should have responsibility. One argument was that it would fit better within the Department of Health and could boost the current provision of NHS occupational health services. NHS provision was thought to be well respected and more identifiable to users. A closer alliance with Primary Care Trusts and GPs was another suggestion, by basing vocational rehabilitation teams at GP practices.

Limitations regarding being located within the NHS were identified. That NHS occupational health services are biased towards the provision of health care services, that the NHS in general is '*culturally divorced*' from vocational rehabilitation, and NHS staff are not adept at working across service boundaries, were views offered. It was, therefore, envisaged that work would need to be done to boost the provision of workplace interventions and to ensuring the appointment of a range of occupationally trained individuals. Concerns were also expressed about the availability of funds within the NHS and the ability to use money productively to ensure aims, such as quick intervention, were met. One suggestion was to ring-fence money for vocational rehabilitation services to ensure their longevity and quality of service.

In thinking about alternatives to NHS control, some people considered the involvement of the Department for Work and Pensions (DWP). Although some felt that being associated with the DWP had given them credibility with employers, there were also fears that it was detrimental to their work with some clients who made negative associations between the Department and social security benefits.

Some people saw merits in having formal ties with both the NHS and benefits system. They advocated joined-up working across workplace and health cultures and believed that those working within these spheres needed to be involved. Some project managers noted how reforms to incapacity benefits could also work for the JRRP client group because they shared principles about getting people back to work. They envisaged clinicians and vocational rehabilitation experts working on the reforms and JRRP could join forces to work with both client groups.

### *Independence from government*

Some staff from (private) organisations that existed before the pilot, argued for job retention services to be located within not-for-profit organisations or commercial organisations. Such organisations were perceived as possessing expertise in getting value for money, having flexible budgets, and boosting the perception of impartial support for **individuals** through their independence from government and employers. It was suggested that small and medium-sized employers which do not have their own occupational health resources could jointly fund a service for use as and when it is needed. Some expressed a desire to maintain good links with the NHS and perhaps to second staff from the NHS or use NHS providers, to ensure clinical governance over the health interventions provided.

One project manager's vision gave primary responsibility for vocational rehabilitation to employers through the promotion of best practice in managing absence and return to work and involving in-house or contracted occupational health experts. There would, however, need to be a second tier of support available to employees whose employers could not provide such resources. Such employees would be referred to case management teams based around clusters of GP practices. Their assessments and advice would be forwarded to GPs who could make better informed decisions accordingly.

### **6.5.2 Point of access**

Early intervention was felt to be key in helping people back to work and many observed that this needed to feature in future service provision. Various ideas about the timing of access and nature of participation were aired, and were often linked to opinions about organisational control. Those who felt the NHS should have overall responsibility also saw a role for GPs referring people to job retention services upon issuing sickness certificates, after two weeks, or after six weeks off work. Ease of access could be improved by enabling any NHS clinician to refer patients, and continuing to allow self-referrals. People who advocated the involvement of the benefits system suggested that accessing help from a vocational rehabilitation service be a condition of receiving benefits. Justifications for compulsory participation included that it would reduce people's capacity to exclude themselves from the help on offer, and would enable the service to reach a higher number of clients. Against this was the argument that if people are to engage with the service on offer and make successful returns to work then they need to want to be helped, and so participation must remain voluntary.

### **6.5.3 Case management and the composition of provider teams**

In talking about their visions for future job retention services all of the staff assumed or explicitly supported the adoption of the case management model used in JRRP. There were subtle variations in opinion about the level of expertise required to become a case manager.

Those who talked about the ideal composition of a case management team supported the approach taken by their respective organisations. Those whose teams were composed of a mix of clinical and vocational expertise thought a mix of skills and knowledge was necessary, but those working with non-clinician case managers thought they had shown clinical expertise was not required. The first group identified case managers as needing to make clinical decisions about clients, and therefore, at least one case manager needed to be suitably qualified. The second argued that not every client needs to see an occupational health nurse or physician and thus, non-medically qualified people, or people trained as occupational health advisers and therapists, can deliver occupational health services. The issue was considered to be important because currently there is a national shortage of occupational health specialists. This deficit would need to be addressed if vocational rehabilitation services were established and employed large contingents of occupational health specialists.

#### 6.5.4 Joined-up working

There was unanimous support for the idea of combining health and workplace interventions in a coordinated approach. Staff thought this would allow case managers to work holistically with clients, trying to meet all their needs. Fragmented service delivery was not thought to be adequate for people who could not sustain work having received only workplace support, nor for those who moved **towards** and not **into** work having received only health care interventions.

It was also felt necessary to have someone playing a central role as coordinator between various interested parties. Staff in this study welcomed greater joined-up working between employers, GPs, health services, trades unions and others, and felt that case managers could become the focal point where all interested parties converge and work together to get people back to work. Ideas of possible links included enabling GPs and employers to refer clients to case managers, liaising with benefits advisers to help make returns to work financially viable, and sharing a common database with all involved. Another suggestion was to establish centres of excellence, bringing together various specialists in occupational health and vocational rehabilitation. Access would be open to all, including potential clients, GPs and employers.

#### 6.5.5 Service delivery

Staff also offered advice and ideas about elements of service delivery.

##### *Flexibility*

Some people explained various ideas to ensure the service remained as flexible and responsive to individuals' needs as possible. Using a triage system and short, intensive programmes was suggested as a method for getting some, perhaps less needy, clients through the system quicker and back to work. Clients could be given the choice of phone-based or face-to-face meetings, to suit people's circumstances and preferences. Working from a number of remote sites in local communities was also recommended as a way of becoming more accessible to users.

### *Teaching*

Some staff, who had clinical or occupational health expertise, saw themselves having a role in educating employers and health professionals about best practice in vocational rehabilitation. It was believed that some employers need help to develop effective sickness absence management policies. Some health professionals need to deepen their knowledge so that they avoid making assumptions about patients' jobs and 'sweeping judgements' about their fitness for work.

### *Other advice*

Further advice offered about elements of service delivery was:

- ensuring staff are trained according to the needs of the job and supervised closely so that they feel well-supported and have opportunities for reviewing skills and professional development;
- removing administrative duties from the case manager's role. Some thought it was wasteful for clinical staff to spend time chasing people about administrative matters, such as consent forms;
- establishing a finite period of contact between case manager and client, so that both can achieve a sense of 'closure'.

### *Recommendations for change in the wider environment*

Recommendations from frontline staff for change in the wider environment fell into three main areas:

- **employers.** Work is needed to change employers' perceptions of employees' health conditions and capacity to work. Also, increasing employers' involvement in helping employees return to work by penalising them for failing to cooperate with rehabilitation plans and by expecting them to fund certain interventions, or the treatment of work-related injuries and illnesses;
- **the NHS.** The NHS could fast-track services to workers if it made a distinction between chronic and acute conditions, and thus, prioritise quick intervention to those with acute problems. Quicker diagnosis and treatment would be more achievable with more resources, such as scanners, technicians and physiotherapists;
- **the system of social security benefits.** Aside from messages about wholesale reform of the sickness certification and Statutory Sick Pay (SSP) process, suggestions were made about topping up pay with benefits during gradual returns to work, where employers do not pay full wages.

## 6.6 Conclusions

Much as staff discussed their perceptions of how some clients made progress towards work, they also identified clients who did not make progress and sought to explain why. Common barriers and constraints on progress were described as relating to clients' health conditions, clients' perceptions of their capacity to work and of their employers' attitudes, and the attitudes and actions of employers and GPs.

For some clients, health problems were significant barriers because their ability to return to work depended on receiving medical treatment. Gaps in the service provisions were identified where JRRP provider organisations did not have enough money to access quicker private treatment, or where clients could only access workplace support; and in the NHS where long waiting lists were perceived as prolonging clients' absence from work.

Support for a combined approach emerged from people's accounts of their frustration when working with clients in the single intervention streams. Being able only to help people move towards and not into work, or to make changes in the workplace but not address core health problems, were ways in which staff helped clients but did not feel they had met all of their needs. The ability to cut across sector divides and work with a full range of health, workplace and other interventions, such as social services, would perhaps give provider staff a better chance of meeting a wider range of needs presented by clients.

A powerful message from staff was that they can only help people who want to be helped and who are, therefore, willing to take at least partial responsibility for their rehabilitation. Most clients were said to want to work, and so the pilot does not perhaps shed light on how to meet challenges in the wider population, where people do not want to work and do not know about or seek help from services. Some frontline staff saw clients' perceptions of their capacity to work and of their employers' attitudes as constraints on their work. However, they also thought that these problems could sometimes be overcome, as perceptions could be changed by encouraging people to think positively about what they were capable of, and by meeting with employers.

Employers' attitudes, policies and procedures were also commonly highlighted as contributing to clients' difficulties in trying to get back to work. Effective ways of working with individuals, such as gradual returns to work, were, in some cases, perceived to be undermined by some employers who did not cooperate. There were also concerns that returns to work would not be sustained if employer support for individuals' rehabilitation did not continue. Improving employers' knowledge of the management of sickness absence and vocational rehabilitation may help to set precedents where employees are helped to rejoin the workforce and given support to stay at work. There are perhaps arguments for locating occupational health services independently of employers, as questions were raised about their impartiality and, consequently, their ability to gain the trust of employees.

A general criticism made of the NHS was that patients are not case managed proactively and coordination of care is poor, except in acute emergency cases. In contrast, this was believed to be a strength of the JRRP services. Case managers argued that they were in a better position to help clients because they had more time and expertise regarding return to work issues. Whilst this may be true, it was also apparent that JRRP staff felt that clients set a lot of store by what their GP told them. This emphasises the importance of vocational rehabilitation providers working in partnership with GPs.

It seems that the establishment of good working relationships with some employers and GPs was hindered by misunderstandings relating to the provider organisation and their services. Perhaps this can be remedied with greater publicity and early information-giving to potential interested parties, such as employers and GPs.

Frontline staff and managers of different provider organisations were all very positive about the way the pilot operated in their area. The barriers and constraints identified regarding in-house working suggests that some organisations needed some fine tuning and that there were perhaps ways in which the operation of the pilot could have been improved. However, none of the problems encountered stood out as major barriers or constraints to their working with clients. The implication from the evidence is, therefore, that no one pilot delivery format stood out as more successful or workable than the others.





## 7 Conclusions and discussion

This final chapter draws out the key findings across the three study samples within seven themes. Section 7.1 looks at the experience of sickness absence. Section 7.2 discusses the issues involved in engaging with and using Job Retention and Rehabilitation Pilot (JRRP) services. Section 7.3 discusses the key components and features of a vocational rehabilitation service. In Section 7.4, findings relating to the process of returning to work are discussed. Sections 7.5 and 7.6 look respectively at the role of GP and the NHS, and the role of employers, in vocational rehabilitation and returns to work. Finally, Section 7.7 discusses the implications for future development of vocational rehabilitation services.

The chapter also discusses the implications of the study findings for the development of vocational rehabilitation services, and draws out linkages with the various recent policy initiatives which have contained proposals to strengthen vocational rehabilitation. The Department for Work and Pensions (DWP) published its *UK Framework for Vocational Rehabilitation* in 2004 (DWP, 2004), and vocational rehabilitation is emphasised in its *Five Year Strategy* (DWP, 2005). The Department of Health white paper, *Choosing Health* (DH, 2004) emphasises the importance of healthy workplaces. The Health and Safety Commission's *Strategy for workplace health and safety in Great Britain to 2010 and beyond* (HSC, 2004) contained wide-ranging proposals, and progress was reported in *Workplace Strategy: Moving to Delivery* (HSC, 2005). And the cross-department *Health, work and well-being – Caring for our future* (DWP, DH, HSC, 2005) emphasised the three themes of engaging stakeholders, improving working lives and health care for people of working age.

The findings from the studies reported here are in line with the policy recommendations in these various initiatives, and particularly:

- wider recognition of the benefits of returning to work and that jobs can be part of the route to improved health;
- encouraging employers to engage actively with supporting their employees' returns to work;

- enhancing the occupational health and vocational rehabilitation advice and support available to employers;
- emphasising the importance of job modifications and adjustments to facilitate returns to work;
- enhancing vocational rehabilitation training in the training of GPs and other health professionals;
- encouraging health professionals to manage returns to work to recognize the importance of work, to focus on the return to work as an outcome of their intervention, and to plan and access specialist support;
- developing occupational health services within the NHS;
- addressing sickness certification procedures and monitoring GPs' approaches.

They also support the emphasis (DWP, 2004), in providing vocational rehabilitation, on:

- early intervention;
- integrated and flexible provision which is not constrained by institutional barriers;
- and client-centred, holistic approaches which empower clients.

## 7.1 The experience of sickness absence

The research highlights that sickness absence is a difficult and unpleasant experience for people. Within the study samples it often arose suddenly, and was associated with much anxiety and a degree of shock. There was often little opportunity to discuss impending sickness absence with employers or to put into place strategies to avoid or to limit it. Where people had advance notice of the need to take time off they did sometimes attempt to negotiate changes that might help them to stay in work, but employers appeared not always to support such attempts. People generally had little idea of how long they would need off work, unless it was a planned absence, and were unpleasantly surprised at how long their absence lasted. Although going off sick brought relief where people had been struggling, the overwhelming sense is of an event that was unfamiliar, unexpected and unwanted.

Being off sick brought boredom, anxiety, isolation and frustration for people, and affected their mental and emotional wellbeing. It also brought financial pressures and debt, to varying degrees, which were a source of worry and which sometimes affected their personal relationships. There was a clear pattern of people returning to work shortly before or shortly after a change in sick pay, and this re-entry to work sometimes proved too early. There seemed to be a limited awareness of the availability of longer term sickness-related state benefits. People sometimes approached the end of Statutory Sick Pay (SSP) with no clear idea of what their next source of income would be, and sometimes learnt about Incapacity Benefit (IB) from employers.

A strong motivation to return to work was widespread: there was only one person, across the panel and control group study samples, who by the time of the (final) research interview did not say they wanted to return to work. Where people were off sick for longer, they were conscious of a growing distance from work and of facing significant difficulties in returning, and this was a cause for concern to them.

JRRP provider staff also pointed to the sometimes extensive barriers to work that their clients faced. They saw clients' motivation to, and confidence about, returning to work as critical, and felt there was much they could do to sustain both. They also noted that people's perceptions of their health, and of their broader circumstances while off sick, could be problematic, and felt it was important that the service addressed worries about money and other issues if people were to be helped to return to work.

The negative experiences of sick leave and emphasis on motivation to return to work no doubt reflect the particular sample population – people who have volunteered to participate in vocational rehabilitation service. However, these issues underline the social as well as financial value of vocational rehabilitation support. They also highlight the importance of early intervention and of an holistic approach in which all barriers, not just those immediately relevant to health and the workplace, are addressed. It is clear too that vocational rehabilitation services need to be able to engage with people who are in very difficult personal circumstances, whose worries may feel overwhelming to them, and whose sense of personal agency will sometimes be limited. Supporting people in these circumstances and helping them to regain a sense of control of their lives is a key challenge.

## 7.2 Engaging with and using JRRP services

At the point when people approached the service, they generally knew very little about what help JRRP might provide. Employers and GPs provided an important point of entry to the trial, but appeared to give little detailed information about the services. Although part of this reflects the trial arrangements<sup>25</sup>, it is also likely to reflect the difficulties inherent in marketing a new service to a range of stakeholders including employees, employers, trades unions, GPs, and other health care providers (Stratford *et al.*, 2005). The fact that vocational rehabilitation is not necessary a familiar concept, even to GPs and employers (Irving *et al.*, 2004) may also be relevant here. People did not always have clear expectations or requirements of the service. Where they did, their expectations mostly related to health care. This no doubt reflects the importance of GPs and other health professionals in referring people to the service, but it seemed to be particularly hard for people, at this early stage, to envisage non-health related support that would help them.

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<sup>25</sup> The requirement to minimise changes in behaviour resulting from early contact with the trial meant that only limited information about the possible interventions could be provided in publicity materials to clients.

Users of the JRRP services were generally happy with the explanations about the service and the trial arrangements that they were given (see also Stratford *et al.*, 2005), but lacked detailed knowledge about what help might be available. This sometimes persisted right through their engagement with the services: they remained unsure what help was available, and whether they had tried everything. It was also hard for people to identify the help they needed, and to envisage what might work for them in an unfamiliar situation. There were cases where circumstances changed in material ways (for example, changes in experiences of NHS health care, in contact or relationships with employers, in health) but where people did not tell case managers about this.

The 'diagnostic' role played by case managers is, therefore, critical and demanding. The findings suggest that more attention needs to be paid to how people are told about the types of help that are available, and to discussions about what might be suitable for their own circumstances. There will be issues people do not want to raise until they have built a relationship with the case manager, and their circumstances will anyway change. This suggests that information about what is available needs to be given clearly, repeatedly, and perhaps also in writing. Examples of how the service has helped clients in similar circumstances might also be useful. At the same time, of course, it is important to avoid pressuring clients. The negotiation of provision needs to be seen as a continuing process, with discussion of needs and provision reopened and reviewed periodically. Otherwise there is a danger of an unhelpful narrowing of the issues or a focus on the issues initially identified, where clients are unaware that a type of help is available or a type of need can be addressed and do not tell case managers of broader or changing circumstances.

A picture also emerges of clients' engagement with the services often being passive. The data suggest a different conceptualisation of the services by staff and by some clients, with staff describing the service as client-centred and clients essentially seeing it as led by the case manager. There were examples of clients who were proactive in their engagement with the services, seeing it as their responsibility to keep in touch and to keep case managers informed about their progress. However, in general clients appeared to look to case managers to sustain contact and did not initiate it themselves, even in some cases not rescheduling a missed appointment. People did not always follow up on suggestions of forms of help, either because they thought there was a good reason why the help was not being offered, or because they were unsure what was available. It was easy for them to assume that the absence of contact by the case manager meant they were a low priority, a difficult case, or that there was nothing the service could offer. And some acknowledged that they were dependent on the emotional and practical support provided by case managers. This stance perhaps also reflects their continuing ill-health and the decline in confidence which stemmed from long periods of sickness absence.

As a result people sometimes lost contact with the service, or were waiting for the service to get in touch with them. This may lie behind the suggestions in the data that people in the control group were sometimes more active in managing their own

health care and returns to work. It is possible that, in some cases, being connected with a service which was not actively providing support may have discouraged people from taking their own steps forward and delayed progress towards work.

These issues highlight the importance of finding ways of helping people to make better use of the services and to become more active players in their returns to work. Effective approaches to providing information about what is available seems critical here. The findings also highlight the importance of regular contact. Provider staff did not raise contact as a problematic issue, which suggests that more needs to be done to develop effective contact strategies; staff may need to take the initiative more in sustaining contact. There is clearly a subtle balance between sustaining contact and taking over, between empowering clients and encouraging dependency. This is an area where more work on exploring interactions and developing ways of working is perhaps needed.

### 7.3 Key aspects of a vocational rehabilitation service

As discussed in Section 7.7, the panel study provides limited evidence of JRRP being perceived by clients to have had an impact on employment outcomes, achieving a return to work which the client did not think would otherwise have happened. It is arguable that this is a manifestation of a service which effectively empowers its users so that they ascribe returns to work to their own agency rather than to the service. But there is little in the data to support this, and the findings reflect the impact estimates produced by the randomised controlled trial (Purdon *et al.*, 2006). It is, therefore, difficult to discuss 'what works' in providing JRRP services on the basis of these studies. However, a number of features of the service are emphasised, in the accounts of staff and clients, as being important and valued.

#### 7.3.1 Case management

The case management role emerged as a central feature of the service, and there was a high degree of consistency in the accounts of staff and clients in their discussion of what the role involved and why it was important. What emerged as key components of the role were:

- identifying problems or barriers and service responses;
- referring beyond the service;
- coordinating and facilitating service provision;
- reviewing progress and case managing;
- liaising with relevant stakeholders;
- encouraging, motivating and boosting confidence;
- making suggestions and providing advice;
- being there to support the individual, listening and empathising;
- providing specialist services.

It was clear that clients valued a dedicated point of contact and the support of a friendly, positive, able and non-judgmental person.

As noted above, there were suggestions in the data that people could become over-reliant on the case manager and that there could be a degree of dependency in the relationship. The case manager role is a complex and subtle one, and needs to be well supported within organisations. However, the study suggests it has a strong part to play in vocational rehabilitation services.

### **7.3.2 Specialist services**

There was again a high degree of consistency among clients and provider staff in the specialist services they saw as particularly valuable. The health services which emerged as important were:

- psychological therapies: counselling, cognitive behavioural therapy and psychotherapy;
- physiotherapy, gym membership, pilates and other exercise programmes;
- referrals to specialists within the NHS, or suggestions to GPs to make such referrals;
- provision of operations and other treatments;
- complementary therapies.

The importance of surgical and diagnostic interventions in particular clearly has financial implications for vocational rehabilitation service provision. Although delays in providing them can be a real obstacle to progress, they are undoubtedly the most expensive form of intervention to provide. There is also an issue of equity, if publicly-funded health care is provided more quickly to working people than to those who are unemployed or otherwise not in work.

In terms of workplace services, the following emerged as important:

- contact with employers, meetings and mediation;
- developing strategies for returning to work such as phased returns and light duties;
- functional or ergonomic assessments and provision of equipment;
- vocational help and job search support where a change of job or of occupation is required;
- money management, debt counselling and benefits information; and
- perhaps also in-work support, given the problems sometimes experienced by people who returned to work (see Section 7.4).

The findings suggest that staff faced more challenges in providing effective workplace services. This may reflect the complexity of three-way liaison between case manager, employer and employee, and the very powerful position held by

employers in negotiating returns to work. It perhaps also suggests that at least some providers were more able to build in specialist expertise in health care than in workplace interventions.

Returns to work were more common where people still had a job to go back to. Once they had lost their job, a return to work was very unlikely within the study samples. Although this undoubtedly reflects wider factors such as employer attitudes, the employee's health and the duration of sickness absence, it also highlights that the closure of a job is, in itself, a critical event which increases the risk of longer-term sickness absence. This suggests that a key focus of workplace support should be keeping the job open. Early intervention and effective mediation with the employer will be important here. It also highlights the importance of effective job search support and vocational guidance. Vocational rehabilitation services may need to work closely with Jobcentre Plus if they cannot provide this internally.

### **7.3.3 Features of service delivery**

The JRRP providers operated within a range of organisational set-ups, a key variation being whether provision was predominantly internal or external. Neither model was seen by staff as necessarily superior. However, provider staff felt that internal access to services such as physiotherapy was helpful for more direct and speedier referral, and that workplace provision was well suited to being provided in-house. They also felt that clients' health circumstances are likely to be so varied that the services needed external specialist health service provision.

Staff also stressed the importance of effective management, clear case management processes, sufficient administrative support and avoidance of unhelpful bureaucracy. They emphasised the value of multi-disciplinary team-based working which was supported by case reviews and case conferences, clinical supervision, and opportunities to share learning. Other features of service delivery which the accounts of clients or staff suggested were important are:

- early intervention;
- a client-centred approach;
- an holistic approach which is able to address a range of difficulties or barriers to work;
- support that is tailored to the individual, with appropriate layering and sequencing;
- staff being available to clients, initiating and sustaining contact with them;
- empowering clients, both to use the service effectively and more broadly to take control of their own circumstances and returns to work;
- access to budgets which are sufficient and can be used flexibly, and which can provide intensive support where this is required;
- speedy access to a range of services;



- effective and credible liaison with health care providers, employers and other stakeholders;
- the ability to operate across professional or institutional boundaries.

It is impossible to say that these features and components are 'what works' in providing vocational rehabilitation services, but they were viewed as helpful by people who have delivered and used JRRP.

## 7.4 The process of returning to work

People in the panel and control group studies generally seemed familiar with the idea that it is not necessary to make a full health recovery to return to work, and saw the return to work as itself likely to aid recovery at least in relation to mental health issues. JRRP provider staff felt that they played a role in encouraging this mindset. However, it was not always supported by employers or by GPs (see Sections 7.5 and 7.6).

Phased returns and light duties were an important part of the process of returning to work where people had not made a full recovery. Indeed, even if people felt fully fit, returning to work could be very demanding after a long absence and here too people welcomed not having to return immediately to the full load of their original job. A common problem, however, in relation to graduated hours was not being on full pay, or being expected to use annual leave to cover the shortfall of hours or days. Although some people accepted this, others saw it as very unfair or a real problem. Being able to take days of annual leave at the same time as working reduced hours was sometimes important in managing the return to work, allowing a longer period of rest and recuperation. Requiring annual leave to be used to cover shorter working hours could therefore be counter-productive if it makes managing the return to work harder. It is perhaps worth considering whether there is scope for SSP to be made available to people on phased returns to cover days or hours not worked.

Even with phased returns and light duties, returning to work was an anxious time for people. They were concerned about how others would react and about how they would manage their health alongside work, particularly if they were returning to an environment they had found stressful or damaging. Returning to work could be a very good experience. People felt very positive about managing the return to work successfully, and work itself could have a beneficial impact on mental health and wellbeing and could aid social inclusion and the rebuilding of confidence.

But there were also negative experiences. These emerged where people had returned too early or to an environment that was too demanding, where financial pressures or the threat of job loss had driven the return, and where people had difficult relations with employers. These pressures, combined with continuing ill health, led to some people not being able to sustain the return to work.

People in these circumstances seemed not to look readily to JRRP to provide in-work support, or support once they had lost their job. The reasons for this include loss of

contact with the service and lack of clarity about whether in-work support is available. But the data suggest that in-work support would be a valuable component of a vocational rehabilitation service, particularly providing advice about how to deal with difficulties that arise, mediation or negotiation with employers, education for employers, and helping to sustain people's confidence in the early weeks of re-entry. Research into in-work support as part of the provision of New Deal for Disabled People (NDDP) (Lewis *et al.*, 2005) highlighted that specific strategies are required to make clients aware of in-work support and to overcome potential barriers to its use, and forthcoming research on in-work support as part of the IB Pilots will also shed useful light on this.

## 7.5 The role of GPs and the NHS in vocational rehabilitation and returns to work

The findings echo research carried out as part of the JRRP research programme which explored GPs' management of sickness absence (Mowlam and Lewis, 2005) in highlighting that more work is needed to encourage GPs to engage with vocational rehabilitation in their own work, and to ensure that NHS health provision actively supports the return to work. This underlines the value of the priority attached to initiatives in this area within recent policy documents.

From the studies reported here, it was clear that the NHS could play an important role in facilitating people's returns to work, particularly through the provision of surgery, physiotherapy and psychological therapies. There was also evidence of GPs becoming involved in patients' returns to work where, for example, they suggested light duties and phased returns, liaised with employers, or advised that other employment options may need to be considered.

However, there was also evidence of a less supportive role. There was not always a sense, from clients' accounts, of GPs taking an active approach to managing their patients' care, and there were recurrent descriptions of long waits for treatment, surgery or diagnostic tests. Clients appeared generally not to look to their GPs for advice about when to return to work. GPs sometimes gave very cautious advice which did not chime with people's own views that they were ready to return, although they sometimes, on reflection, felt the GP may have been right. But people talked of having to 'convince' a GP that they could return to work, of the GP having 'allowed' it or imposed conditions, or of GPs advising against a return.

Provider staff too were of the view that GPs are sometimes too conservative in their advice, that they discourage returns to work and that this can undermine the efforts made by professional staff who have worked closely with a client. They perceived a lack of active case managing, where clients made slow progress within the NHS, were not referred to suitable specialists, and were not encouraged to take action to help themselves. They described cases where GPs provided sick notes of long duration, which provider staff felt could deflate clients' confidence and discourage a focus on returning to work. Provider staff had limited direct contact with GPs,

sometimes because of concerns or uncertainty about client confidentiality, but also because of difficulties getting access to GPs and responses which were sometimes less than fully co-operative. They acknowledged the time pressures under which GPs work, but did not always see GPs as active partners in supporting clients' returns to work.

There is clearly scope for vocational rehabilitation services to provide quicker, smoother and more actively managed health care. But the findings also endorse the policy recommendations to reinforce vocational rehabilitation in GPs' training; encourage them to plan and access specialist vocational rehabilitation services; encourage a focus on the therapeutic benefits of work and on actively managing returns to work; encourage more active management of sickness certification with better recording of decisions, review and feedback; and review of SSP documentation. The findings also suggest that the initiative to place employment advisers in GP surgeries may be a useful way of linking returns to work and health care in ways which are not currently happening.

## 7.6 The role of employers in vocational rehabilitation and returns to work

Employers clearly have a key role in vocational rehabilitation and returns to work, and emerge from this study as powerful players in employees' routes to work. The perspectives of employers were explored in other research as part of the JRRP programme (Nice and Thornton, 2004).

Beyond sending in updated sickness certificates, people seemed largely to look to their employer to initiate and maintain contact. They wanted contact which made them feel valued as employees who would return, which kept them in touch with work, and in which the return to work was discussed in a supportive way without ignoring their health or making them feel pressurised or threatened.

Although some clients and staff experienced this type of contact, others did not. People felt harassed or harried by over-frequent contact and felt the genuineness of their absence was being questioned. They described feeling under pressure to return to work before they were able to, their job being under threat, and timetables driven by employers' demands or policies. There were also accounts of employers insisting that employees should not return to work before they were fully fit, turning down requests for light duties or phased returns, or being rigid in setting a timeframe for a return to full duties which did not accommodate the individual's health needs.

Provider staff felt some employers lacked knowledge about health conditions and flexible work practices, and did not have access to the specialist advice they needed. They felt there is a need to educate employers about conditions and capacity, and about how to work well with employees' rehabilitation. They formed good constructive relationships with some employers, both where a single employee was

involved and where they had repeated contact with the same employer in relation to different clients. But they also reported employers being reluctant to engage with the services, particularly in cases which involved disciplinary proceedings or accidents at work.

This suggests that there is a clear need for more work with employers – particularly given that, as noted earlier, once a client had lost their job it seemed to be much more difficult for them to find other work. There is a need for better employment practices in relation to support for and contact with employees who are off sick; active engagement with helping people to return to work; understanding of legal responsibilities; flexibility about job structures; and healthy workplaces and working practices. This reinforces the value of current policy initiatives to make the business case for managing health and safety; to encourage employers to play an enhanced role in actively engaging with employees' returns to work; to encourage more use of existing rehabilitation services; to provide advice on managing sickness absence (including contact with employees) and returns to work via the Health and Safety Executive (HSE) website; to increase access to occupational health services via initiatives such as NHS Plus and Workplace HealthConnect; and to encourage healthy workplaces which includes a focus on workplace stress.

Some particular issues emerged in the study about the role of employer-based occupational health services which are relevant given the proposal that employer occupational health services should be expanded. From the accounts of clients and staff, it is clear that such services can play a useful role in speeding up access to treatment, giving advice about health conditions, and advising individuals and employers on how to structure, manage and support the return to work.

However, there was a strong sense of distrust of employers' occupational health services among clients which was reinforced if occupational health staff seemed to doubt the genuineness of their condition, were either coercive and pressurising or alternatively discouraging or obstructive to a return to work, and where staff were felt to have taken the employers' side. Provider staff too had experienced these problems. Equally, there were reports, among both employees and providers, of occupational health staff recommendations not being followed by line managers. The findings echo Nice and Thornton's (2004) study which also pointed to tensions in relationships between employer-based occupational health services and line managers.

These issues highlight the complex three-way relationship which exists between employee, line manager and occupational health. They suggest that improvements in practice, among both line managers and occupational health staff, will be required if employer occupational health services are to play an effective expanded role. Occupational health services may need to relate in a more even-handedly way to both employer and employee, and this may be better achieved by external vocational rehabilitation services rather than, or as well as, expanded employer-based provision.

## 7.7 Future directions for vocational rehabilitation services

The research highlights a number of problems which support the emphasis in DWP and Department of Health policy on developing vocational rehabilitation services. However, in line with the randomised controlled trial results (Purdon et al., 2006) and other research (DWP, 2004), it does not provide strong evidence of an impact of JRRP on employment outcomes. There is not a single or a clear explanation for this but, drawing on the individual cases in the studies reported here, the following emerge as relevant:

- the fact that people withdrew, or were not offered any treatment;
- gaps in service provision. Although provider staff felt that the interventions provided did generally have an impact, gaps in service provision appear to have arisen from:
  - clients not engaging actively with the service, not being fully aware or fully understanding the type of help that might be available, and not being actively involved in decisions about their help;
  - clients looking to providers to sustain contact, but providers not doing so. As a result, providers were sometimes not aware of how clients' circumstances had changes and of new needs that had arisen;
  - similarly clients were sometimes left uncertain as to whether they were still part of the service and were somewhat in limbo as they waited for contact or action from the provider;
  - cost constraints, in some individual cases, although provider staff generally felt budgets were sufficient except where operations were required;
  - the fact that people may have been assigned to an intervention which made ineligible a form of help they needed, or that people in the combined group received either health or workplace support but not both;
- there are suggestions in the data that people in the control group were more active in pursuing their own returns to work, knowing that JRRP was not available to them, whilst those in the intervention groups waited for support which did not always materialise;
- the fact that, for both JRRP clients and people in the control group, there were significant barriers from external sources:
  - gaps in service provision by GPs and the NHS leading to a lack of active case management and delays while people waited for diagnosis or treatment;
  - employer working practices which did not support returns to work.

Despite this, there is clear evidence of a need for more support for clients who are off sick from work, and it seems unlikely that, without very significant and rapid change, this could be met by employers and the NHS alone. Given the varied current practices of employers and GPs, there are clear arguments for vocational rehabilitation services which employees can access directly.

Different options for where vocational rehabilitation services might sit were discussed by provider staff. One option discussed was for services to be situated within GPs, primary care trusts or elsewhere within the NHS. This could support ready access to existing health specialisms, an issue emphasised as important by staff. However, there were concerns about cultural fit, particularly whether the NHS would support an emphasis on vocational as opposed to medical rehabilitation, work which cuts across organisational and institutional boundaries, and non-health interventions.

An alternative option discussed was to situate new services within the DWP. This could support closer linkage with existing services and expertise such as the IB pilots (which include a condition management programme), NDDP and other Jobcentre Plus provision.

Alternatively, staff suggested that services could be located independently of the DWP or the NHS. This was thought to offer the advantages of expertise and working practices which cut across institutional boundaries and could, thus, integrate health and workplace support. There was thought to be value in them being provided by a known, recognised body which has access to networks.

It was suggested that SSP could provide a point of entry to such services. In principle, one way of increasing engagement with vocational rehabilitation services might be to include an element of compulsion. There were different views about this among staff. There was a view that vocational rehabilitation would be most effective if it was a condition of benefit entitlement. Other staff members, however, emphasised that this could impair people's engagement with vocational rehabilitation services and undermine trust. It may be worth considering whether there would be merit in an element of compulsion, for example, requiring an initial meeting or periodical reviews with a vocational rehabilitation service as a condition for employers or SSP. However, it is important to stress that the studies reported here do not provide evidence upon which such a strategy can be assessed.

Finally, the research suggests that three themes will be particularly critical in developing and providing vocational rehabilitation services: First, the ability to intervene early, to avoid job loss, to support clients before they become isolated, and to sustain constructive relationships between employers and employees. Second, the skills and resources to provide flexible joined-up services, and to work in ways which support clients as active players in their pathways to work. And third, the ability to earn trust within a complex set of relationship between the individual, their employer and their GP. The research suggests that trust lies not only in demonstrating skill and credibility, but also in being able to support the client from a position of independence, and working in partnership with the individual, health professionals and employers. This would point to a need for vocational rehabilitation services which employees can access directly, alongside services which provide advice and support to employers.



# Appendix A

## Technical appendix

The following appendices provide further information about the conduct of the three research studies reported, and copies of key study documents.

### A.1 The longitudinal panel study

#### A.1.1 Summary of the research design

The purpose of this study was to interview a panel of Job Retention and Rehabilitation Pilot (JRRP) clients at regular intervals over six months to collect information about experiences and events close to their actual occurrence, when recall was expected to be good. It was designed to provide detailed descriptive data about clients' experiences, to explore their participation as they used the service and to observe any changes in their feelings, views and intentions as they occurred.

The panel comprised 36 people, in three cohorts, purposively selected to ensure coverage of the following variables:

- intervention group – 12 respondents from each of the three intervention groups;
- service provider – nine respondents from four of the six locations, providing coverage of the six different providers but avoiding duplication for the two providers which operate in two areas<sup>26</sup>;
- duration of the trial – the sample was divided into three cohorts to allow differences in experiences as services developed and matured to be included;

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<sup>26</sup> The areas chosen were West Kent (WorkCare), Tyneside (Routeback), Glasgow (HealthyReturn) and Sheffield (WorkCare).



- participant characteristics – the sample was also designed to reflect diversity in sex, age, ethnicity, occupation, employer size and activity, industry sector, length of time off sick when people first contacted the service, type of employment contract (full- or part-time; permanent or fixed-term), self-employment and health condition.

Each cohort followed 12 JRRP clients over a six-month period beginning as soon as possible after their first contact with the service provider. The first interview took place in the participant's home in order to build rapport and because of the detail and length of this interview. Participants were then interviewed approximately every four weeks by telephone to examine any developments in their health, any movements towards a return to work and any impact JRRP may have had on these. Clients continued to be interviewed regardless of whether they were still in contact with a JRRP provider.

Fieldwork for the three cohorts were completed in January 2004, October 2004 and May 2005 respectively.

### **A.1.2 Recruitment**

The first stage in recruiting people to the panel was to send a letter explaining the research and inviting people to take part (see Appendix B). Shortly afterwards, people were telephoned to talk further about taking part in the research and to answer any questions. As is usual with any piece of qualitative work, people were reassured that their responses would not be reported in a way that could identify them. However, in order to reassure people that the research was legitimate, they were invited to discuss their participation with the service providers who could confirm that National Centre for Social Research (NatCen) and Social Policy Research Unit (SPRU) were involved. Where people did discuss their participation with their service providers this had implications for preserving respondents' anonymity from the service providers. This was explained to participants but did not deter any from taking part and did not appear to inhibit their responses to the research questions.

Making contact with people by telephone at this stage was not always straightforward, and could require several phone calls. The sample frame for each cohort was deliberately restricted in order to protect the total sample frame available for the Outcome Survey<sup>27</sup>. The idea behind this was that people who were contacted (by letter or telephone) but not subsequently recruited to take part in the panel study might be discouraged from taking part in the survey at a later date. With this in mind, in each cohort, letters had been sent out to only 24 clients at first, and individuals in a reserve sample of another 12 clients were only contacted once the initial sample had been exhausted.

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<sup>27</sup> The Outcome Survey is a face-to-face survey conducted with all those randomised into the JRRP trial. See Stratford *et al.* (2005) for more details.

Small numbers entering the trial in some pilot areas also affected sampling. In the third cohort, for example, the numbers in one location were so low that in one of the intervention groups there was only one potential respondent. Widening the sample frame to include database extracts from previous months was avoided as much as possible because of the drawback that the first panel interview would have taken place much further from the point of first contact with JRRP and thus, have implications for recall.

Despite some refusals due to people having withdrawn from the service, disappointment with the service or for reasons not disclosed, 36 people were successfully recruited to the panel.

Appointments were made for a face-to-face interview with those people who agreed to take part. Before this initial interview people were asked whether anything could be done to make their participation easier, such as an interpreter or signer. All those who took part wanted to be interviewed at home, and nobody required an interpreter or signer, but there were occasional problems in communication with two panel members for whom English was not a first language. As a result, some topics were difficult to explore with these people.

### **A.1.2 Fieldwork**

#### *First interview*

The interview began with an explanation of the purpose of the study and what would be involved, including a reassurance that participation was voluntary. A topic guide (Appendix C) was used to guide discussion across the main areas of interest. The time spent on different topics and the direction of discussion varied between interviews, according to people's own circumstances, experiences and views. The first interviews generally lasted between one and a half and two hours, which was, in part, due to the explanations about the study at the beginning and end of the interviews. The discussions were tape-recorded, with the permission of respondents, and transcribed for analysis.

By the end of the initial interview the respondents had been told about the intended five monthly follow-up telephone calls on at least three separate occasions (in the letter of invitation; in the telephone contact; and at the start of the first interview). They had all indicated their agreement to keep in touch in this way, in principle. At the end of the initial interview the researcher checked again that this was acceptable, and agreed a date and time approximately one month later for the first follow-up call. A sheet of headed paper, with a number of short questions designed to prompt people's memories, was left with each participant, in case they wanted to make a note of anything that happened during the next month, which they might want to remember to tell the researcher next time.

On return to the office, the researcher sent a short letter of thanks confirming the arrangements for the next telephone call. As soon as possible afterwards, the researcher extracted the data from the transcript (see Section A.5), in time for preparation for the first telephone interview.

### *First follow-up interview*

The aim of the first follow-up interview, one month after the initial face-to-face interview, was to gather information on people's experiences since the previous interview, and to look especially for any developments and changes in their views, including:

- current thoughts about returning to work;
- health and workplace services received and planned from JRRP;
- impressions of the services;
- contact with employer;
- contact with GP and other health service providers;
- activities undertaken contributing to return to work;
- expectations for the future.

In each case, follow-up telephone calls were made by the same researcher who had conducted the personal interview. This was important to maintain rapport. It was also important in enabling the researchers to use the interview opportunities to greatest advantage, building on what had been learned from the previous interactions.

The researchers had variable experience in re-establishing contact and arranging a telephone interview for the first follow-up. Most people seemed to be expecting the call and some were ready to take part straight away or later on the same day. In a few cases people were more difficult to contact, and did not respond to messages left on answerphones or broke their appointments. A first follow-up interview was eventually achieved with all 36 panel members.

In each case, the researcher prepared for the follow-up interview by reading the data extracted from the initial personal interview, and making notes about individual circumstances and issues that it was important to pursue for each person. The researchers used a second topic guide (Appendix C) to steer discussion through the main areas of enquiry, but the direction and balance of the discourse differed, according to what had been happening for individual people.

The follow-up interviews were again tape-recorded, with respondents' permission, and were generally much shorter than the personal interviews. Agreement was sought for further contact, and arrangements made.

Soon afterwards, the researcher extracted the data from the tape-recording on to the same set of data extraction charts set up for the initial interview.

### *Intermediate follow-up interviews*

The procedure just explained was repeated to achieve the second, third and fourth follow-up telephone interviews. In each case, the researcher prepared for the discussion by going back to the data charts, thinking about what was happening for

the individual person and making notes about questions to ask. The same topic guide was used each time, but the discussions went in increasingly variable directions according to people's different circumstances and whether they had been in contact with the service provider. Where there had been little change in people's circumstances or views the discussions became shorter.

### *Final panel interview*

At the end of the fourth follow-up interview the researchers explained that in the last interview they would be interested in people's current circumstances, but would ask people also to look back over the six months since their first contact with the service provider, and to think about their experience of taking part in a series of interviews. In looking back at their contact with the service providers, people were asked to consider what had worked well and less well in terms of contact with providers, treatment plans and the services and help they had received. They were also asked to reflect on whether they felt JRRP had helped them towards a return to work. In looking back at their experiences of taking part in the study, people were asked to say what they thought about the number of interviews, the mix of telephone and face-to-face contact, the duration of the study, the fact that respondent payments were paid in instalments and whether they felt that taking part had had any impact on their dealings with their JRRP service provider. A separate topic guide was used in the final interview. A copy can be found in Appendix C.

In addition, in the first cohort only, the researchers had agreed to incorporate a suite of questions from the Outcome Survey into the final telephone interview with panel members. These additional questions sought to collect information on household structure, work history, views of JRRP and health, and to seek permission for this data to be linked with administrative records about benefits, using the person's National Insurance number. The original intention had been to remove the qualitative panel from the Outcome Survey, which was conducted using computer-aided interviewing techniques. However, low numbers emerging for the survey led to reconsideration. It was, therefore, decided to ask panel members if they would also answer a suite of the survey questions, adapted for Computer Aided Telephone Interviewing (CATI).

People who took part in the final interviews in the first cohort of the study were told about this additional suite of questions at the end of the fourth follow-up interview. It was explained that the final interview would include some questions which would be read out in a standard way, and which would seem rather different from the informal conversational approach that had been used so far. The researchers explained that this might take an additional 15 minutes at the end of the interview; that the additional questions would be mainly about what people had been doing since they first went off sick; and, that the reason for doing this was so that their answers might be included in a larger survey of all people who had used service providers offering this kind of support. People to whom this was explained agreed to take part.

As before, the qualitative component of the final interview was tape-recorded. Responses to the CATI questions were recorded within the computer programme used for the main Outcome Survey.

### A.1.3 Panel participation

On the whole, continued participation in the panel study was good. In summary, 27 of the 36 panel recruits took part in the planned schedule of six interviews. Five others took part in five interviews, of whom three took part in the important final interview and two completed all stages except the final interview. The remaining four people dropped out after early follow-ups. See Table A.1 for a more detailed view of panel study participation.

It was generally not evident why people dropped out of the panel study as no-one formally withdrew. Only one person offered an explanation: this person had been in hospital due to health problems. They had said they wanted to continue with the research and would get in touch but only did so a year after the research had ended which meant that the data from this final interview was not included in the analysis. In the remaining cases people were no longer contactable despite numerous attempts by the researchers involved. Some were sent letters asking them to get in touch if they wished, but no-one did.

**Table A.1 Panel participation**

	Int 1	Int 2	Int 3	Int 4	Int 5	Int 6
<b>Cohort 1</b>						
Provider A						
Health intervention	*	*	*	*	no	*
Workplace intervention	*	*	*	no	no	no
Combined intervention	*	*	no	no	no	no
Provider B						
Health intervention	*	*	*	*	*	*
Workplace intervention	*	*	*	*	*	*
Combined intervention	*	*	*	*	*	*
Provider C						
Health intervention	*	*	*	*	*	*
Workplace intervention	*	*	*	*	*	*
Combined intervention	*	*	*	*	*	no
Provider D						
Health intervention	*	*	*	*	*	*
Workplace intervention	*	*	*	*	*	*
Combined intervention	*	*	*	*	no	*

Continued

**Table A.1 Continued**

	Int 1	Int 2	Int 3	Int 4	Int 5	Int 6
<b>Cohort 2</b>						
Provider A						
Health intervention	*	*	*	*	*	*
Workplace intervention	*	*	*	*	*	*
Combined intervention	*	*	*	*	*	*
Provider B						
Health intervention	*	*	*	*	*	*
Workplace intervention	*	*	*	*	*	*
Combined intervention	*	*	*	*	*	*
Provider C						
Health intervention	*	*	*	*	*	*
Workplace intervention	*	*	*	*	*	*
Combined intervention	*	*	*	*	*	no
Provider D						
Health intervention	*	*	*	*	*	*
Workplace intervention	*	*	*	*	*	*
Combined intervention	*	*	*	*	*	*
<b>Cohort 3</b>						
Provider A						
Health intervention	*	*	*	*	*	*
Workplace intervention	*	*	no	*	no	no
Combined intervention	*	*	*	*	*	*
Provider B						
Health intervention	*	*	*	*	*	*
Workplace intervention	*	*	no	no	no	no
Combined intervention	*	*	*	*	*	*
Provider C						
Health intervention	*	*	*	no	*	*
Workplace intervention	*	*	*	*	*	*
Combined intervention	*	*	*	*	*	*
Provider D						
Health intervention	*	*	*	*	*	*
Workplace intervention	*	*	*	*	*	*
Combined intervention	*	*	*	*	*	*

### A.1.4 Sample achieved

Table A.2 profiles the sample achieved for the panel study as a whole and for each of the three cohorts.<sup>28</sup> Given the large number of variables present in the sample frame it was necessary to prioritise certain criteria over others. Intervention group, gender, age, duration of sickness absence and main health condition were, therefore, established as the primary sampling criteria. The aim was to achieve a broadly even split across the dimensions of each criterion, where the sample frame allowed. However, some characteristics, for example lone parenthood, self-employment and minority ethnic backgrounds, were scarce within the available sample frame.

Within the sample of 36 there was a broadly even split across gender and age group. However, duration of sickness absence and main health condition reflect the composition of the JRRP database<sup>29</sup> as a whole: more people had been off sick for between six and 12 weeks than for longer periods, and mental health and musculoskeletal conditions were the most common conditions in the database.

In terms of secondary criteria, there was an equal split between those with dependent children and without, although there was only one lone parent. Four respondents were from a minority ethnic group. The majority had worked 35 hours or over per week which was consistent with the profile of all JRRP participants. The occupations of those interviewed were broadly balanced between the public and private sectors. Two respondents were self-employed, and one of these was also employed.

**Table A.2 Panel study sample**

	Total	Cohort 1	Cohort 2	Cohort 3
<b>Gender</b>				
Male	19	4	7	8
Female	17	8	5	4
<b>Age</b>				
16-35	11	4	4	3
36-50	13	4	3	6
51-65	12	4	5	3

Continued

<sup>28</sup> Most of this information is derived from the JRRP evaluation database of participants from which respondents were sampled.

<sup>29</sup> The Management Information and Evaluation Database contains screening information, details of services received from service providers and outcomes for all JRRP participants.

**Table A.2 Continued**

	Total	Cohort 1	Cohort 2	Cohort 3
<b>Domestic situation</b>				
Single people without children	9	2	4	3
Lone parents	1	1	0	0
Couples without children	9	1	2	6
Couples with dependent children	17	8	6	3
<b>Ethnicity</b>				
White	32	11	10	11
Other ethnic group	4	1	2	1
<b>Duration of sickness absence</b>				
6-12 weeks	17	4	7	6
13-19 weeks	12	4	5	3
20-26 weeks	7	4	0	3
<b>Main health condition</b>				
Mental health	10	4	4	2
Musculoskeletal	14	3	4	7
Cardiovascular	4	2	1	1
Other	8	3	3	2
<b>Industry sector</b>				
Private	16	5	7	4
Public	19	6	5	8
Self-employment	1	1	0	0
<b>Working hours</b>				
Full-time (35+ hrs)	29	9	11	9
Part-time (16-34 hrs)	7	3	1	3

### **A.1.5 Reflections on taking part in the panel**

Those who took part in the final interview were asked to reflect on the design and conduct of the panel study. In general, people had not found the interviews intrusive, and some said they had enjoyed talking to the researchers as it had provided them with an opportunity to reflect on their own experiences, especially where contact with service provider staff was erratic or had dwindled as discussed in Chapter 3. The follow-up interviews had sometimes felt rather close together and somewhat repetitive for people for whom nothing much had changed, but had worked well for others. Some thought it would have been helpful to have a second face-to-face interview either half way through or at the end, to maintain rapport and interest. On the other hand, some people preferred talking on the telephone, and saw advantages in being able to rearrange appointments more easily, or said they felt *'braver'* in saying how they felt. Everyone felt that it had been important for the initial interview to be face-to-face as it made them feel more comfortable in the follow-up interviews as they could *'put a face to the person on the telephone'*. One



person said they would have liked to take part in a group discussion to hear how other people had got on. The final interview had seemed too long for some people who took part in the first cohort, when the Outcome Survey questions had been incorporated. The money gifts (3 x £20, see Section A.4 for more details) had been generally appreciated but were not seen as an incentive to take part. Some people said they had wanted to take part in the research because they wanted to '*give something back*' or because they saw the research as being important and were pleased to be potentially helping other people who found themselves in similar situations. Only one person's comments suggested that he had felt under some obligation to take in the study but not in a way that was burdensome.

Apart from the difficulties caused by the inclusion of the CATI questions in the final interviews in the first cohort, the researchers had not met major problems in conducting the panel interviews. There were some concerns about causing distress to participants who seemed especially tired when contacted, or angry and upset about things that had happened. Giving such people every opportunity to withdraw from or avoid painful discussions included writing to enquire about preference in continuing with further interviews, or agreeing to avoid some topics. The researchers sometimes found the interviews uncomfortable where there had been few developments since the previous interview or where circumstances had deteriorated, as they were conscious not to make the interview a negative experience for participants. The researchers drew on discussions with their colleagues for their own support after difficult discussions.

### **A.1.6 Developments in the design of the panel study**

After the first cohort of the panel study was complete (and briefly after the second cohort had finished) the qualitative research team, and a member of the survey research team, met to discuss whether they thought the research design was working and whether any changes should be made to the remaining two cohorts. The following questions were considered:

- **Was there a need to reduce the number of interviews, frequency of interviews or length of the interviewing period?** It was suggested that fewer or less frequent interviews (e.g. four interviews at six weekly intervals), or that possibly a shorter interviewing period (such as four months) might have been more appropriate as some people in the first cohort had experienced difficulties in finding things to say when little had changed since the previous contact. However, it was felt that less frequent interviewing might have made it more difficult for respondents, who had had things to say during their interviews, to recall things that had happened in the ensuing period and that this contradicted the 'real time' design of the study. Overall, it was impossible to be conclusive about the potential impact of any changes given the low numbers the discussion was based on, and so it was decided not to change the approach at this stage.

- **Was there a need to make changes to the mode of interview conducted?** Respondent feedback on the panel study led the research team to consider whether the structure of the interviews conducted should be changed. Some people had suggested that they might have appreciated a further face-to-face interview at the end of the six months. However, after discussion there were no strong reasons put forward for a need to replace the final telephone interview with a second face-to-face interview.
- **Was there a need to replace the interviews lost in the first cohort?** There was some attrition during the first cohort but no replacements were made due to the fact that clients dropped out at a late stage in the interviewing period which would have meant that any replacements would have only been followed for three months rather than six. In considering the design of the second cohort, it was felt that the same problems with late replacements would remain. It was decided not to replace any of the lost interviews by increasing the number of interviews carried out in the subsequent cohorts.
- **Was there a need to increase the number of respondents interviewed to ensure equal coverage across six providers rather than four?** This consideration was discussed but it was concluded that the scope of the study was to look across the providers rather than at individual providers and that there was more of a focus on the intervention groups which had equal coverage with the current design.
- **How should the Outcome Survey interview be conducted with members of the Panel Study?** There was a general agreement among the research team that inclusion of the CATI schedule in the final interview, in the first cohort, had been difficult to manage in terms of the different questioning techniques involved and the increased length of the interviews. One result of this was some concern that some topics had not been pursued as far as researchers would have liked. It was also felt that the style of interviewing and questioning was at odds with the rapport built up over the six months through qualitative interviewing. It was, therefore, decided that the panel sample would not in future be removed from the Outcome Survey sample, and that the Outcome Survey questionnaire would be conducted by survey interviewers in future cohorts. It was felt important for the qualitative interviewers to inform panel study respondents (in the introductory letter) that there would be a 'seventh interview', following on from the qualitative work. It was also agreed that regardless of the 'target date'<sup>30</sup>, the CATI interview

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<sup>30</sup> For those who were off sick between six and 22 weeks at the time they entered the trial, the 13-week return to work had to have occurred at or before 42 weeks after they went off sick so that the target date for its measurement through the Outcome Survey was 44 weeks after they went off sick; for those who were off sick between 23 and 26 weeks at the time they entered the trial, the 13-week return to work had to have occurred at or before 46 weeks after they went off sick so that the target date for the Outcome Survey was 48 weeks after they went off sick.

would always take place after the qualitative interviewing has finished, and that the qualitative interviewers would alert the Outcome Survey team as soon as the qualitative work was completed.

- **Was there a need to make changes to the sampling criteria used?** Broadly, it was decided to retain the same sampling criteria for the subsequent cohorts, which included sampling on the basis of randomisation group, gender, age, duration of absence, and main health reason for being off work, as well as endeavouring to obtain a mix of the following secondary criteria: ethnicity, domestic situation, part- or full-time employment, employment sector and size of employer. In addition, it was also decided to obtain further sampling information to reduce the incidence of recruiting clients to the panel study who had already returned to work or who were no longer in contact with service providers at the point of the first qualitative interview. The intention was to boost the study's coverage of people receiving interventions so that their experiences could be explored. Where sufficient data existed,<sup>31</sup> Action Plan data was used to identify people who were expected to receive treatment from JRRP and Outcome Survey data (either in the form of an outcome variable (e.g. 'back to work') or a back to work date) was used to attempt to avoid people who were already back in work before the first panel interview.

## A.2 The control group study

The aim of this study was to interview a sample of people who were randomly assigned to the control group to explore their experiences of sickness absence and their pathways towards work.

The study was designed to include both people who had returned to work and those who had not, so that their experiences could be compared. In addition, purposive sampling was used to ensure the following variables were covered:

- service provider location – as with the panel study, it was decided to concentrate on four locations (Glasgow, Sheffield, West Kent and Tyneside/Teesside) so that each of the six service provider organisations were covered;
- participant characteristics – the sample was also designed to reflect diversity in age, gender, health condition, level of contact with health care services outside JRRP, marital status, number of dependent children, take up of benefits, personal income, employment sector and size and occupational group.

Forty-six people were interviewed face-to-face (or by telephone) in the summer of 2005 in their homes, place of work or other location chosen by them.

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<sup>31</sup> These two criteria were not always input into the database, so it was not always possible to use them for sampling.

### A.2.1 Recruitment and sampling

Recruiting participants for this study involved following up people in the control group who had recently taken part in the Outcome Survey. This sample frame was perceived to be the best source of information on employment outcomes and the other sampling variables described below. Some additional information was derived from the JRRP database. In order to generate sufficient sample, it was decided to follow up four months of Outcome Survey interviews conducted with people in the control group, given that, on average, 25 interviews were carried out with people in the control group every month. The control group Outcome Survey interviews conducted between January and April 2005 provided a sample frame of 75 people (due to lower numbers than anticipated having entered the trial at this stage) for the qualitative study, from which 50 interviews were proposed.

Although permission to re-contact was sought in the Outcome Survey, this was explicitly with reference to possible re-contact 'in a year or two'. So, before contacting any potential respondents, it was necessary to conduct an opt-out exercise. This involved sending out a letter (see Appendix B) to all those in the sample frame, explaining the study and giving them a two-week period in which to telephone NatCen on a freephone number to say they did not wish to be contacted. The letter also made it clear that participation was voluntary.

Table A.3 profiles the sample achieved for the control group study.<sup>32</sup> As with the panel study, it was necessary to prioritise certain criteria over others. Working status at the time of the Outcome Survey interview, service provider location, age, gender, health condition, contact with health care services at the time of the Outcome Survey interview, and relationship status were chosen as the primary sampling criteria, and quotas were set to ensure a range across each criterion. The quotas were set to reflect the bias in the sample frame towards certain variables and the scarcity of others. (The quotas set and the potential sample available are also detailed in Table A.3.) The remaining variables were designated as secondary sampling criteria but no quotas were set, because it was felt they (number of dependent children, take-up of benefits and personal income) would fall out naturally or because the sample source did not always contain the necessary information for all cases, as with employment size and sector and occupational group.

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<sup>32</sup> This information was either collected during the interviews or came from the Outcome Survey and JRRP evaluation database of participants from which respondents were sampled.

**Table A.3 Control group study sample (primary criteria)**

	Sample achieved	Sample quotas	Sample available
<b>Working status at qualitative interview (at OCS)<sup>1</sup></b>			
Working	36 (31)	30+	44
Not working	10 (15)	20+	31
<b>Service provider area</b>			
Glasgow	22	8+	28
Sheffield	11	8+	18
Tyneside/Teesside	8	8+	17
West Kent	5	8+	12
<b>Age</b>			
21-49	22	20+	40
50-64	24	20+	35
<b>Gender</b>			
Male	18	20+	32
Female	28	20+	43
<b>Main health condition<sup>2</sup></b>			
Mental health	16	N/A	24
Musculoskeletal	22	N/A	37
Cardiovascular	1	N/A	4
Other	7	N/A	10
<b>Level of health care contact<sup>3</sup></b>			
Some contact	31	12+	54
No contact	15	12+	21
<b>Relationship status</b>			
Married/cohabiting	35	10+	56
Single/divorced/separated	11	10+	19

<sup>1</sup> The figure outside the parentheses represents working status at the point of the qualitative interview whilst the figure within the parentheses is the working status recorded during the Outcome Survey.

<sup>2</sup> No quotas were set for this variable due to the scarcity in some of the dimensions.

<sup>3</sup> Contact with a GP or other health care professional in the four weeks up to the point of the OCS interview.

Twenty-two people refused to take part in the qualitative study. The reasons are discussed in Section A.2.2. Because of this and the fact that the sample frame was relatively small to begin with it was not always possible to achieve the quotas set, and often the numbers achieved reflected the biases of the sample frame used. Despite this, 46 out of the 50 interviews were achieved and the sample was sufficiently diverse. For this reason it was decided, in conjunction with the Department for Work and Pensions (DWP), not to boost the sample. Additionally, there was a

concern that boosting the sample by following up control group participants who took part in the Outcome Survey prior to January 2005, by approaching people in the control group who refused to take part in the Outcome Survey between January and April 2005, or by interviewing people who had been screened out<sup>33</sup> and had taken part in the Outcome Survey between January and April 2005 might have impacted on participation in any future surveys.

As Table A.3 shows, some people identified as not having returned to work at the Outcome Survey interview had returned to work by the time they were interviewed for the qualitative study reported here. This meant that the split between those who had returned to work and those who were not working did not reflect the quotas set.

The remaining quotas were broadly met, except for the variables relating to conducting interviews in West Kent and with males. In general, the numbers achieved for each criterion broadly match the structure of the sample frame.

### **A.2.2 Participation**

At the design stage it was anticipated that there might be potential difficulties in recruiting control group participants to take part in the study, especially after having taken part in two surveys<sup>34</sup> already. It was thought that people in the control group might be reluctant to take part in this additional piece of research due to disappointment at having received no help from JRRP. In practice, there was a significant number of refusals (22) which had an impact on the research team's ability to recruit the proposed number of interviews. The reasons for refusing to taking part were varied and not always the same as those that had been anticipated. As anticipated, some people said they did want to take part in the qualitative study as they felt they had already contributed enough by taking part in the surveys, especially since they had received no help from JRRP. Being too busy to take part in the study, as a result of family or work commitments, was another reason commonly given for refusing to take part. Some other people did not give a reason for not wanting to take part and one person was said by his spouse to be too ill to take part in the research.

In contrast, other people, like in the panel study, felt that the research was important and hoped their responses might help others in the future if they could. Some people saw the study as an opportunity to talk to someone about their experiences of sickness absence. This was especially true of those who had experienced bullying or stress in the workplace, or difficulties in obtaining the necessary health care treatments.

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<sup>33</sup> People who were otherwise eligible to take part in the trial but were screened-out as not at risk of losing their job. See Stratford *et al.* (2005) for more details.

<sup>34</sup> Outcome Survey and Survey of Screened-Outs and Controls, see Stratford *et al.* (2005) for more details.

There was a feeling among the research team that the study was potentially a burden on the members of the control group invited to take part. This feeling stemmed from those people who refused to take part because they felt they had already contributed enough to the research, but also from some interviewers' own discomfort in conducting interviews with a group of people who had experienced health problems or difficulties with employers and had received little help in getting back to work, both from JRRP and more generally. A key concern came from a respondent who intimated in her interview that she had agreed to take part in this additional research as she hoped it might improve her chances of getting help from JRRP. The researcher conducting this interview felt uncomfortable explaining that there was no chance of the respondent receiving any help due to the nature of the trial's design.

Although people were not asked specifically to reflect on having taken part in the study, due to limited interview time, there was no sense from the participants that the qualitative study had been a negative experience.

### A.3 Focused study with JRRP staff on effectiveness

The aim of the final focused study with staff was to contribute to the understanding of how the pilot services helped clients to return to work, the types of support that staff found useful in different circumstances, and how they felt clients responded to services provided. It was appropriate, therefore, to gather staff views, from their perspectives as providers of job retention and rehabilitation services, on 'what has worked/not worked and for whom'.

The study concentrated on the core staff of JRRP provider organisations, i.e. the appropriate operational manager(s) and caseworkers/case managers. We expected these to be able to provide an overview of all the services that might be provided to individual clients, and to be able to assess what inputs or combination of inputs are effective in helping clients. The study did not extend, therefore, to external service providers, or professionals such as physiotherapists or Cognitive Behavioural Therapy (CBT) therapists employed or retained by a JRRP provider.

#### A.3.1 Research topics and questions

The topics chosen for exploration emerged from the other elements of the evaluation to that point (including from the initial site visits and the first focused study of JRRP staff) and included:

- the role and impact of 'external' services (including their quality, range and levels);
- the role and impact of 'internal' services (including their quality, range and levels);
- working with other key players, such as GPs and other health professionals, and employers;
- organisational enablers and constraints (including range of services available, team size, targets, paper work, supervision/case conferences);

- structural enablers/constraints (including labour market, benefits, tax credits staff training and skills; sources of help/advice);
- contact and communications; personal support (with clients and between key actors);
- what prevents people from returning to work; lessons from the three intervention groups;
- gaps in the provision of internal and external services.

### A 3.2 Methods

The topics above were suited to group techniques as well as to individual interviews. Hence, it was decided to convene, where possible, groups or pairs of case managers. In the groups a range of techniques were used to stimulate discussion including small group exercises. The research instrument used (and the accompanying documents) are reproduced in Appendix C. The groups lasted in the region of three hours split into two sessions so that different techniques could be used.

JRRP management staff, however, were interviewed individually. The topic guide is included in Appendix C.

Interviews and discussions were tape recorded, with the participants' permission, and transcribed for analysis.

### A 3.3 Focused study participants

The staff of the job retention and rehabilitation pilot organisations who took part in the focused study are described in the table below. Participation in the groups was voluntary. An example of the introductory letter sent to case mgrs can be found in Appendix B.

**Table A.4 Staff focused study participants**

Research activity	Number
Individual interviews with JRRP management	5 (see notes below)
Group discussions	6
- number of case managers	- 18

Notes:

One manager interview was conducted on the telephone after two face-to-face interviews were cancelled.

One manager was not interviewed because she felt she had little to add. She agreed to a phone interview if there were any gaps to fill, but researchers were unable to contact her after several attempts. The researchers decided there was little need to pursue further contact.



## A.4 Conduct of fieldwork

The interviews and focus groups conducted as part of the three studies reported here, employed responsive questioning and probing to ensure that all relevant issues were fully explored. They were conducted using topic guides to ensure that a similar series of issues was explored with each respondent. These were designed in collaboration with the DWP and with reference to the key objectives of the studies. A copy of each of the topic guides used can be found in Appendix C.

All interviews and focus groups were tape recorded with the permission of respondents and, with the exception of the follow-up panel study interviews<sup>35</sup>, were transcribed verbatim. All respondents were guaranteed anonymity and confidentiality at all stages of the research. All those who took part in the control group study were given a gift of £20 as a token of appreciation for their participation, and to cover any expenses incurred in taking part, and were sent a thank-you letter shortly afterwards. Money gifts of £20 were made at three points in the period of contact with each panel study participant: after the initial interview, after the fourth interview and after the final contact (a total of £60 for people who stayed with the panel). A thank-you letter was sent to all participants following the final interview. This letter also reminded them that they would shortly be contacted by a survey interviewer and invited to take part in the Outcome Survey.

## A.5 Analysis

The panel control group and staff study interview data were analysed using thematic charting techniques based on *'Framework'* (Ritchie *et al.*, 2003). The first stage of analysis involves familiarisation with the data generated by the interviews and identification of emerging issues to inform the development of a thematic framework. This is a series of thematic matrices or charts, each chart representing one key theme. The column headings on each chart relate to key sub-topics, and the rows to individual respondents. Data from each case is then summarised in the relevant cell. The context of the information is retained and the page of the transcript from which it comes is noted, so that it is possible to return to a transcript to explore a point in more detail or extract text for a verbatim quotation. This approach ensures that the analysis is comprehensive, consistent and that links with the verbatim data are retained. Organising the data in this way enables the views, circumstances and experiences of all respondents to be explored within a common analytical framework which is both grounded in, and driven by, their accounts. The thematic charts allow for the full range of views and experiences to be compared and contrasted both across and within cases, and for patterns and themes to be identified and explored. The final stage involves classificatory and interpretative analysis of the charted data in order to identify patterns, explanations and hypotheses.

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<sup>35</sup> Data from these interviews were extracted directly from tapes into the analysis instruments.

In the panel study, data were extracted as soon as possible after each interview, to help the researcher think about what was happening for each participant and prepare for the next interview in the series. For the final analysis, an additional new chart was constructed for each client to summarise what had happened for them during the period of study; their reflections on the service and its impact, looking back over the whole experience; their reflections on taking part in the panel interviews and the researcher's own reflections on conducting these panel interviews.



# Appendix B

## Letters sent to participants

### Panel Study – Introductory letter

Dear [name]

We understand that you have agreed to take part in [Provider Name], a research trial to explore what services are most helpful in getting people back to work. As part of this research we are carrying out an in-depth study of people's experiences of [Provider Name]. We may be in touch with you soon to tell you more about the study and to see if you would be prepared to take part.

The study would involve taking part in an interview about your circumstances and your experiences of [Provider Name] so far. We can arrange the interview at a time and place to suit you and it would last around an hour and a half. After that we would like to keep in touch with you regularly, by telephone, to find out whether your circumstances have changed and whether the services provided have been helpful. This would involve contacting you roughly every month for five months. Each telephone call should last no longer than half an hour. We can arrange other ways of keeping in touch if using a telephone is difficult for any reason.

We will be giving people £20 at the first interview, another £20 after the fourth interview and a further £20 at the very end, as a thank-you.

Taking part is entirely voluntary and you can decide to withdraw at any time. However, we hope you will decide to help us with our research, which will be much appreciated. The research is being carried out by [the National Centre for Social Research (NatCen)/SPRU] an independent research institute, on behalf of the Department for Work and Pensions and the Department of Health. Everything you tell us will be treated in strict confidence in accordance with the Data Protection Act. The research will not be reported in any way that could identify you. Your involvement in this study will not affect any benefits you receive, or any dealings you may have with any government department or agency.

We are only talking to a small number of people in this part of the research so if we do not contact you, thank you for your time so far. Whether or not you take part in this study, our colleagues [at the National Centre for Social Research] will also be in touch to invite you to take part in a separate telephone or face to face survey.

If you have any queries about the research, or if there is anything we can do to make it easier for you to take part, please call me at [NatCen / SPRU] on [PHONE NUMBER].

With thanks

Yours sincerely

## Panel Study – Face-to-face interview confirmation letter

Dear [name]

Thank you very much for agreeing to take part in our research study, which will be looking at the experiences of clients of [Provider Name]. As discussed over the phone, this will involve talking to you in some depth about your health and working history. Everything you tell us will be treated in strict confidence in accordance with the Data Protection Act and nothing will be reported in a way that could identify you. The [National Centre for Social Research (NatCen)/Social Policy Research Unit (SPRU)] is an independent research institute. [Provider Name] will not know that we are talking to you and will not have access to anything you may wish to say about the services they provide. Should you wish to talk to [Provider Name] about our interview with then please feel free to do so.

The initial face-to-face interview will take place on:

**date:**

**time:**

**location:**

The interview will last about an hour and a half, and will be carried out by XXXXX.

We would like to keep in contact with you on a monthly basis over a five-month period. After this first interview we will contact you once a month and ask you some questions over the telephone. The length of the calls will depend on how you have been getting on and how much you have to tell us, but will not last longer than ½ hour. Once again, we will call at a time convenient to you. We can arrange when to make our first follow-up telephone call at the end of the face-to-face interview.

We would like to reassure you that taking part in the research is entirely voluntary, and that you are free to withdraw at anytime. However, we hope that you will continue to help us over the next five months so that we can learn from your experiences.

If you have any questions or would like to talk about the research at all, or if there is anything that we can do to make it easier for you to take part, please contact me on XXXXX.

Yours sincerely,

## Panel Study – Letter sent prior to final interview

Dear [name]

Thank you once again for agreeing to let me stay in contact with you over the last few months. Your thoughts and experiences are very valuable to us in our understanding of the services provided by [Provider Name].

Attached to this letter is the time and date when I plan to telephone you for the last time. If you are unable to talk to me at this time we can arrange a more suitable time and / or day for me to call you.

As this next interview will be the last, it will not only help me to understand what has happened most recently but it will also allow us to take a look back over the six months since your first contact with [Provider Name], and think about the experience as a whole.

Following this final interview, I will send you out £20 in cash as a thank-you for your continued help. I also mentioned to you on the phone that, once this part of the research is complete, one of my colleagues from the survey team will be in touch shortly afterwards to ask you to take part in a additional telephone survey. Although participation is entirely voluntary, I hope that you will agree to take part, as your comments will be very valuable to them.

I would like to reassure you that everything you have talked to me about over the last few months remains confidential in accordance with the Data Protection Act and nothing will be reported in a way that could identify you.

If you have any questions at all, please do not hesitate to contact me.

Yours sincerely,

## Panel Study – Thank-you letter

Dear [name]

Thank you very much indeed for taking part in the final research interview, and for all your help with the research over the last six months. It has been very valuable for us to be able to keep in touch with you and to see how things have developed for you since you first made contact with [brand name]. We are really very grateful to you for your time and thought.

I am enclosing £20 to thank you for your involvement in the research. As before I would be grateful if you could sign the enclosed receipt and put it in the post back to me in the enclosed pre-paid envelope. I would also like to reassure you, once again, that everything we have discussed is treated in strict confidence in accordance with the Data Protection Act.

Now that this part of the research is complete, one of my colleagues from the survey team will be in touch very soon to ask you to take part in a telephone survey. Although participation is entirely voluntary, I hope that you will agree to take part, as your comments will be very valuable to them.

Thank you once again for all your help.

With very best wishes for the future,



## Control Group Study – Opt-out letter

Dear [name]

### **Study of Work and Health**

Thank you very much for taking part in the recent survey of people's experiences of being off sick from work, that we conducted on behalf of the Department for Work and Pensions and the Department of Health. Your contribution will help us to better understand people's experiences of being off sick from work.

As part of this on-going research project, we are inviting a small number of people to take part in a more in-depth study about how people's health and work circumstances have changed since they first went off sick. We are particularly interested in talking to those people who did not receive any additional help, such as that provided by [brand name] to understand their experiences of being off work due to ill health. A researcher from NatCen or the Social Policy Research Unit at the University of York may be in touch in the next few weeks to find out if you would be interested in taking part. If you are, they will arrange for a researcher to come and visit you in your home, or at a more convenient location chosen by you, to hear about your experiences. The interview normally lasts about an hour and a half. Everyone who takes part is given £20 as a thank you for the time involved. **Everything you say will be treated in strict confidence** in accordance with the Data Protection Act.

We may not need to make contact with everyone we write to, so if we do not, thank you for your time so far. However, we hope that, if we do get in touch, you will decide to take part. If you do not wish to be contacted, please get in touch with me by calling 0800 XXX XXXX (Freephone) or by writing to Christopher Farrell at the Freepost address at the top of this letter, before 22<sup>nd</sup> June 2005, giving your name and the reference number (in bold) at the top of this letter.

**Your involvement is completely voluntary and will not affect any benefit you receive, or any dealings you have with any government agency or department.**

Thank you for your further help.

Yours sincerely

## Control Group Study – Interview confirmation letter

Dear

### **Study of Work and Health**

Thank you for agreeing to take part in our research. I can confirm that an interview with you has been scheduled as follows:

**Date:**

**Time:**

**Location:**

**Interviewers:**

I would like to reassure you that everything you talk to us about remains confidential in accordance with the Data Protection Act and nothing will be reported in a way that could identify you or your company.

If you have any queries about the research or need to rearrange the time or date of the interview please contact me on 020 XXXX XXXX. We look forward to meeting you.

Yours sincerely

## Control Group Study – Thank-you letter

Dear [name]

### **Study of Work and Health**

Thank you so much for taking part in our research into people's experiences of sickness absence. Your thoughts and comments have been very valuable to this study.

I would like to reassure you that everything we have discussed is treated in strict confidence in accordance with the Data Protection Act.

Thank you once again for all your help. If you have any concerns or questions please do not hesitate to contact me on the number below.

With very best wishes for the future,

## Staff Study – confirmation letter for group event

Dear

### **JRRP evaluation research – group event for [name of organisation] case managers**

This is a short note to give you some idea about how we hope to use the meeting. Apologies for using email but it does save time. As you know, the pilot phase of JRRP is coming to an end next year so we are keen to draw upon the experiences of all the key people involved in the delivery of the project. Part of the day will be looking backwards at how the pilot has worked since April last year, and part will be looking forwards at how the lessons learned so far could be taken forward in developing policy on job retention and rehabilitation.

My colleague xxx and I will be attending from [SPRU/NatCen]. We have structured the morning around a series of exercises and discussions that we hope you will find interesting and enjoyable. You do not need to do any formal preparation but you might like to think about some of the issues before we meet. We would like to start at 9.30 with coffee and move swiftly on to business! We aim to finish for lunch by 12.30. The draft programme is as follows:

#### **Session 1 - Exploring the question 'What works, for whom, in what circumstances?'**

In this session we will be reviewing the resources available to you as case managers, and reflecting on your clients and their circumstances, and what happened to them. We will have a break after session 1 for refreshments.

#### **Session 2 – Exploring 'enablers' and 'constraints'**

The idea here is to look at what has either helped you in carrying out the role of case manager, or proved to be a constraint. We will divide this session into three parts to consider (a) the skills and competencies of the case manager, (b) working with other 'key actors', and (c) the external world you operate in (local health services and labour market conditions, for example).

#### **Session 3 – Looking to the future**

The aim of this session is to draw out the main lessons from your experience of the pilot that can inform future policy making on job retention and rehabilitation.

I hope this gives you some idea of what we are planning and look forward to seeing you.

With best wishes



# Appendix C

## Topic guides



Topic guide: panel study, first interview

### **JRRP Process Evaluation – Panel Study Cohort 3**

#### **Face-to-face interviews – Topic Guide**

The aim of this first interview is to gather key client background information including:

- their current employment and employment history;
- the process that led to them being on sick leave;
- their thoughts about returning work;
- reasons for using the service;
- the health care and workplace services they received and currently receive;
- their impressions of the service so far and their expectations for the future.

#### **INTRODUCTION**

Introduce self and National Centre/SPRU. Then explain that:

- We will be following a small number of clients over the next six months from when they start to use the service. We want to understand people's experiences and decisions over this period, to understand how their circumstances change in relation to health, employment and more broadly, and whether and how the service is useful to them. This information will be used to understand how we can improve the sorts of services available to those on sick leave that help them return to work. We are interested in what happens, whether or not people continue to use the service, and whether or not they return to work. We are there to observe and not influence any of their decisions or behaviours over the six months.
- This is the first of six interviews. This will be the only face-to-face interview; the remaining five interviews will be conducted over the telephone at a time and on a date convenient to them. These follow-up interviews will take place approximately once a month. The length of the interviews will vary according to what they have to say but will not exceed half an hour on each occasion. We will book a provisional time and date for the first telephone interview at the end of this interview.

- In this interview we are interested in finding out some background information about them including: their current employment, how they came to be on sick leave, what they think about returning to work in the future, as well as their thoughts on what they have experienced of the service so far. In the subsequent interviews, we will be interested in exploring how things change for them: their experiences of the service, any contact with their employer, developments in their health, any contact with GPs, and any changes at home which are relevant.
- The interview remains confidential; that NatCen/SPRU are independent of the service providers and of DWP and DoH, and will not report anything clients say back to the providers nor to DWP and DoH in a way that could identify them. Explain tape recording and length of interview (one and a half hours). Explain that other than the research team no one will listen to the tapes or read any transcripts. Stress that taking part is entirely voluntary. They will be paid £20 for taking part in this first interview, another £20 after the fourth interview and a further £20 after the sixth interview.

## 1. BACKGROUND AND PERSONAL CIRCUMSTANCES

- Age
- Personal circumstances
  - Household composition
  - Dependants/caring responsibilities
  - Tenure

## 2. CURRENT EMPLOYMENT

**Aim:** to establish whether they remain employed and gain details about their current or most recent job and their thoughts about it.

- **Explore their current working situation at the point of interview**
  - Are they still officially employed
  - If lost job, explore when and reasons (e.g. retirement, redundancy etc)
- **Gain details of current/most recent job held**
  - Whether self employed or an employee
  - Job title and description
    - Key activities/tasks
    - Physical/mental demands
    - Level of autonomy in job



- Key details

Hours worked

Contract: permanent/freelance/part-time/full-time etc

Explore history with that employer

- **Explore perceptions of job and work**

- Aspirations/attitudes towards the job/work in general

What do they enjoy/dislike

What rewards does their job bring (financial or otherwise)

What are their thoughts about the future

Why took on job in question

- **Description of the employer**

- Nature of business and activities

- Public vs private

- Number of employees

### 3. WORK AND EDUCATION HISTORY

**Aim:** to establish whether they remain employed, details about their current job and their thoughts about their current job, their work history, their educational background and their sources of income now they are off work.

- **Explore work history**

- History of other jobs (*over view of labour market mobility*)

- What areas have they worked in

- Nature and duration of jobs/any spells on sick leave/any period of unemployment

- How related/unrelated are previous jobs to the current job

- **Explore education history**

- When they left school, any qualifications

- What about training courses

#### 4. HEALTH

**Aim:** to understand their health condition and any treatment received prior to JRRP.

- **Explore how respondents came to be on sick leave focusing on health condition.**
  - When did they start to be concerned about their health/being able to stay at work
  - Understand the nature of their health condition, exploring:
    - Multiple conditions and impacts on mental health
    - How it affects them at work/how work affects their condition
    - When did it start to affect their work
- **Explore any treatment received prior to going off sick**
  - Nature of treatment received
    - Length of time treated for (on-going or completed)
    - Satisfaction/impact of treatment on health
- **Explore nature of contact with existing GP/health care services**
  - Regularity of contact
  - Explore relationships with health professionals, looking at
    - How their health problems dealt with/discussed
  - Satisfaction with diagnosis/suggested treatment
    - How this matched their own perceptions/opinions
- **Explore how JRRP expected to fit in with current treatments/contact with health care service**
  - Understand how JRRP differs from other health care services/treatments
  - Explore whether JRRP has added value to current services or replaced them

#### 5. SICK LEAVE

**Aim:** to understand what factors influenced their decision to go on sick leave.

- **Explore when and how the decision to take sick leave was taken**
  - What were the determining factors
    - Health condition
    - Workplace
    - Advice of GP/other health care professionals
    - Views of employer, family, others

- Anything else which is making it hard for them to be at work at the moment
- **Explore any previous sick leave**
  - Was this related to current condition or not
- **Explore any steps taken to try and remain in work**
  - Discussions with employer
    - Any changes in the workplace considered, suggested, made
    - Support from OH services/colleagues/managers
  - Contact with GP/other health professionals
  - Other services (e.g. CAB, JC+)

## 6. IMPLICATIONS OF SICK LEAVE

**Aim:** to understand the impacts taking sick leave have had on employer relations, family life and finances.

- **Explore how relationships with employers have changed since taking sick leave**
  - Explore any changes in the following:
    - Employer's attitudes towards time off sick
    - Employer's policies regarding absences
  - Explore any contact with employer,
    - Who with (e.g. OH, HR, line manager etc)
    - How initiated
    - Content/purpose
- **Explore impacts of sick leave/health condition on...**
  - Family life/relationships
  - Daily life (inc mobility)
  - Caring responsibilities
  - Confidence in general and in relation to working
  - Self-employment (what is happening while they are on sick leave)

- **Understand financial implications**

- Explore impacts on own income (wages) and other sources (partner's income etc)
- Explore current sources of income (*sources only, not amounts*)
  - Income from current job, SSP
  - Benefits (*NB Check whether they have started to claim IB since joining pilot*)
  - Partner's income
  - Other
- Explore longer term implications
  - How long will this source remain available
  - What would happen if/when it ends
  - What impacts do any money issues have on health/move towards work
- Explore any expected financial implications held before going off sick
  - Expected income sources
  - Awareness of benefits available
  - Sources of knowledge
- Understand whether any debt/welfare advice has been received
  - What impact has this had

## 7. RETURN TO WORK

**Aim:** to understand what are the key barriers to a return to work

- **Understand how they feel about returning to work**
  - Whether they want to; reasons
  - Any lack of confidence about returning to work
  - E.g. enjoyment of job/financial needs etc
- **Explore any steps taken towards a return to work prior to JRRP**
  - Understand influences on any decisions/thoughts
    - Health condition
    - Financial needs
    - Need to work/job satisfaction
    - Health care professionals/employer/colleagues
    - Family
    - Other
- **Understand what would need to happen for them to be able to return to work**
  - When would they see themselves back in work

## 8. INITIAL CONTACT WITH JRRP

**Aim:** to understand clients' experiences so far.

- **Explore how respondents came to join JRRP**

- How did they hear about the service
- What motivated them to take part
  - What attracted them in particular
  - What were they told about it, what did they understand JRRP was for
  - Involvement of anyone else in decision to take part
  - Initial expectations

- **Respondents to take us through what JRRP has involved so far**

Respondents to take us through the steps they have taken so far, from ringing up to the present day. At this point we will let respondents lead us to what they want to discuss. The discussion should cover the topics covered in the rest of the guide below. Consent, dealings with the Contact Centre and randomisation only need to be covered if raised spontaneously.

- **Explore impressions of service providers (in-house and external)**

- Manner
- Expertise/credibility
- Ability to deliver

## 9. ASSESSMENTS AND DECISION MAKING

**Aim:** to understand how they have been assessed and how decisions regarding their treatment (both medical and related to the workplace) have been made, and how Action Plans are used.

- **Explore discussions about the condition and any assessments**

- What/who did this involve
- Impressions
  - Appropriateness/effectiveness/anything lacking
  - Manner of staff
  - Compared to previous examinations/discussions (GP etc)

- **Explore what action is planned**

- Who was involved in the decision
- How was the client involved
- Explore level of satisfaction with involvement/action planned

- **Explore understanding and awareness of action plans**

- How familiar is the term to them
  - What was explained
  - What is its purpose, how will it be used
- How was this developed
  - What input did they have, views on the level of input
  - When was it drawn up
  - Were they given a copy
  - Was this signed by both parties
- Explore awareness of consenting to receiving the treatments by signing the action plan

- **Explore nature of any follow-up assessments**

- How many
- Purpose
- Who was involved
  - Involvement of client and satisfaction with this
- How did they differ from the initial assessment
- Outcome
  - Any changes to Action Plans
  - Other plans drawn up

## 10. ON-GOING CONTACT AND TREATMENTS

**Aim:** to understand the nature of any treatment received and planned, and understand any impact JRRP has had on returns to work so far, and to explore reasons for any discontinued contact with JRRP.

- ***For those who have already received treatment, explore nature of treatments and contact***

- What did this involve
  - Where did it take place and who was involved (any issues surrounding treatments carried out off site)
- Purpose
- Frequency
- Impressions
  - Appropriateness/effectiveness
  - Their own level of involvement
  - Communication
  - Anything lacking

- Explore whether had to do some things for themselves (e.g. join a gym).
  - Feelings about this
  - How is this followed-up/supported by providers
- **Explore impacts of any treatments so far**
  - Key impacts
  - Effectiveness compared to treatment outside JRRP
    - How has JRRP treatment fitted in with any other treatment
    - How has this impacted on dealings with other health professionals
- ***For those who plan to remain with JRRP, explore what future treatments are planned***
  - What help/support are they expecting
  - Explore their feelings about appropriateness – will it help them get back to work
  - Anything lacking
  - Accessibility (physical and other):
  - How aware are they of where the treatment/support will take place and who will provide it
  - How easily can they get to the providers (*provision of transport/transport costs?*)
  - What other facilities are available, views on adequacy/appropriateness
- ***For those already back in work, explore what helped them return to work***
  - Explore the role of JRRP in that help
    - Effectiveness/impact of JRRP
    - Experience of the process of JRRP
- ***For those no longer in contact with JRRP, explore reasons why***
  - Why are they no longer in contact
  - What was lacking
  - What would have made them remain in contact

## 11. FINALLY

**Aim:** to understand clients' expectations of the service as it develops and continues.

- **Explore perceptions about will happen next**

- What are their expectations
- What do they truly want, and do they expect to get this
- Any fears/concerns
- Any other thoughts/questions

### **NEXT STEPS**

Check respondent's ethnicity.

Arrange a provisional time and date for the first telephone interview.

Reiterate why we want to stay in touch, that we're interested however their circumstances change, that we don't want our involvement to influence their contact with the service. Topic guide: panel study, follow-up telephone interviews.



Topic guide: panel study, follow-up telephone interviews

### **JRRP Process Evaluation**

#### **Panel Study Cohort 3 – Telephone Follow-up Interviews**

##### **Draft Topic Guide**

###### **Purpose of follow up interviews**

The aim of follow up interviews is to gather information on experiences and changing views/attitudes since previous interview including:

- current thoughts about returning work;
- health care and workplace services received and planned;
- impressions of the service;
- activities contributing to return to work;
- experiences of any return to work;
- expectations for the future.

**We are looking for signs of change/development.**

**Respond to points made on sheet left.**

**Make reference appropriately to factual, concrete information from previous interview. Avoid prompting people about views and feelings expressed previously; explore how and why views differ.**

Remind of date of last contact.

Seek permission to tape-record

###### **1. Health situation**

- how feel now
- any changes since last spoke
- any new conditions: impact

###### **2. Personal situation**

- any changes in household, where living, family health/employment

###### **3. Work situation**

- in work, still aiming to return to work, or not aiming at work (retired, caring, studying, etc)

- changes since last contact

why  
feelings

- **Ask those back in work:**

check whether job same as before or new role/employer etc  
details of job: start date, job title, hours, contract, roles  
how getting on – suitability, impact of previous health problem  
impact of work on health  
what are their expectations

- **Ask those not in work, but aiming to return:**

- current views about returning to work
  - changes; reasons for change (including health status)
  - what would need to happen for them to be able to return to work  
(*Probes: condition/job/other*)
  - what level of fitness would they need to reach in order to be back at work (*i.e. does it have to be 100%,*)
  - what influences their perception
  - how does this perception change over time
  - when would they see themselves back in work
- any return to work activities outside pilot, e.g. job search, self employment
  - what, how came about, outcomes
  - views

#### **4. Financial circumstances**

- changes in sources/levels of income, impact
- changes in expenditure

#### **Explore the following contacts, developments and experiences as they arise (follow up developments expected by clients in previous interview)**

#### **5. Contacts, developments and experiences with JRRP provider, ie case manager/in-house staff (including action plans; financial advice)**

- who initiated interaction; who involved
- nature of interaction (face to face, telephone, written)
  - what has been the respondent's role in this
- substance (topics covered/discussed; assessments or treatments done)
- communication/co-ordination between team, external providers, GPs, employers, client etc
- outcome (decisions reached; plans agreed; next steps)
- views (delivery, choice, pace; staff expertise, manner, understanding)

- satisfaction with service: suitability, gaps, match with expectations
- accessibility and environment
- contribution towards returning to work, staying in work, changing job
  - speed/ease of any return to work
- influence on health
- response of service provider to change in health/work circumstances and quality of response
- views on case manager
- further use of action plans (whether revised, copied and signed by client)

**6. Contacts, developments and experiences organised through JRRP provider (i.e. service interventions)**

- who initiated; who involved
- nature of interaction (face to face, telephone, written)
  - what has been the respondent's role in this
- substance (discussion, assessments, advice, consultation, medical treatment/ intervention, financial help)
- communication/co-ordination
- views on interventions (delivery, choice, pace, expertise, manner, understanding)
- satisfaction: suitability of service, gaps, match with expectations
- accessibility and environment
- perceived impact
- perceived influence on return to work
- influence on health
- response of service provider to change in health/work circumstances and quality of response
- views on case management

**7. Contacts, developments and experiences with employers (including in work help; work trial; graduated return)**

- who initiated; who involved (client contact/involvement of JRRP)
- purpose and nature of interaction/involvement: preparation for return to work; post-return; getting new job; self employment
- substance of interaction (topics discussed, assessments, work trial, in-work help)

- employer's policies and attitudes; response to participation in JRRP
- perceived impact, outcome
- influence on/contribution to returning to/staying in work, or getting new job
- views on JRRP involvement in interactions with employers (satisfaction: suitability, pace, expertise, manner)

#### **8. Contact with other health professionals (including GP) outside JRRP**

- nature and substance of interaction (consultations/treatments/medication/support)
- difference made, impact, comparison with JRRP services
- perceived contribution to returning to work, changing job, staying in work, giving up work
- attitudes of health professionals towards JRRP participation
- any contact between JRRP and other health services
- any impact of JRRP on use of health services outside JRRP

#### **9. Contact with other providers of work-related or support services outside JRRP (e.g. training, rehab, counselling, self-help groups)**

- nature and substance of interaction
- difference made, impact, comparison with JRRP services
- perceived contribution to returning to work, changing job, staying in work, giving up work

#### **10. Other contacts (e.g. family, friends) relevant to job retention**

- what happened, who involved
- difference made
- contribution to returning to work, changing job, staying in work, giving up work.

#### **11. Anticipated developments by time of next interview**

Thank you. Remind about further contacts, letting them know the stage we are at (e.g. this is the second contact out of six, so four more to go etc) and payments to be sent recorded delivery.

Arrange date of next telephone call

Explain will write enclosing sheet to record comments; explore usefulness of sheet

Explore reasons for declining further participation.

## Topic guide: panel study, final interview

### JRRP Process Evaluation

#### Panel Study Cohort 3

#### Telephone Follow-up Interviews

#### Final interview: Topic Guide

The aim of the final interview is to:

- gather information on experiences and views about current work situation; health care and workplace services received and planned, and expectations for the future (the 'last instalment' of people's account);
- invite reflection on the overall experience of services received from the provider;
- invite reflection on the experience of taking part in the series of interviews.

Remind date of last contact

Seek permission to tape-record and switch on

Explain the approach in this final interview:

As this will be our last contact with you, we would like to take the opportunity to ask you some additional questions. So in addition to our regular **update about what has been happening over the last month**, we would like to get your **overall view of using the services provided by PROVIDER**, and also get **some feedback from you about what it was like to take part in this research and the way we maintained contact over the six months**.

Check for understanding and agreement to taking part in this way.

#### **A. BRINGING THE ACCOUNT UP TO DATE**

I would like to start by finding out about what has been happening since we last spoke to you.

##### **1. Current circumstances of:**

**Health situation**

**Personal and household situation**

**Work situation**

**Financial situation**

Explore as in previous follow-up interviews, looking for any changes since last contact; the reasons for such changes; views and feelings; impacts on decisions concerning work; expectations of future developments.

**2. Any contacts with JRRP provider and/or services organised through JRRP provider since last interview**

- nature and substance; outcome
- views; suitability; satisfaction
- influence on contribution to work related decisions and behaviour

**3. Relevant contacts with employers (including in work help; work trial) since last interview (explore involvement of JRRP)**

- purpose, nature and substance; perceived impact and outcome
- any impact of JRRP
- views on JRRP involvement: suitability, satisfaction
- influence on/contribution to work related decisions and behaviour

**4. Relevant contact with other health professionals (including GP) outside JRRP**

- purpose, nature and substance; perceived impact and outcome
- any impact of JRRP
- appropriateness, suitability, satisfaction
- influence on/contribution to work related decisions and behaviour

**5. Relevant contact with other providers of work-related or support services outside JRRP (e.g. training, rehab, counselling, self-help groups)**

- purpose, nature and substance
- any impact of JRRP
- appropriateness, suitability, satisfaction
- influence on/contribution to work-related decisions and behaviour.

**6. Other contacts (e.g. family, friends) relevant to job retention**

- what happened; difference made
- influence on/contribution to work related decisions and behaviour.

**B. LOOKING BACK ON USING (PROVIDER) SERVICES**

Thank you for bringing me up to date. May we now look back on what has happened since you made contact with PROVIDER. I first came to see you in ..... and since then we have been in touch each month to talk about any developments. Looking back helps us get an understanding of your overall experience. Check if happy to look back.

**7. Looking back, did PROVIDER make any contribution to your trying to stay/staying in work?**

- what and how
- what would have happened/done if PROVIDER had not been involved

**8. What other things were important in your trying to stay/staying in work?**

- e.g. role of GP, employers, family, others
- any conflict with role of JRRP

**9. Did the overall service you received from PROVIDER match what you hoped or expected?**

**Exploring content and delivery (choice and pace; staff/people; communication and co-ordination) in terms of:**

- expectations fulfilled/not met (had they had any expectations)
- additional/extra parts of service not initially expected
- how involved/in control did people feel in what services were received
- how involved/in control did people feel in how communication managed
- between staff and each other, and health care professionals, employers etc
- gaps, disappointments, frustrations
- impressions of how contact ended and impressions

**10. Looking back, was any part of your experience with PROVIDER helpful?**

- which part of service, in what way
- at what stage/time was it helpful
- which people were involved
- could it have been improved even further

**11. Was any part of your experience with PROVIDER unhelpful?**

- which part of service, in what way
- could it have been improved or made more helpful; how

**12. From your experience, should the government go on developing services like PROVIDER or try to find other ways of helping people who want to stay in work?**

**C. EXPERIENCE OF TAKING PART IN THE RESEARCH**

Thank you for providing that overall view. We would like to finish by asking you about the experience of taking part in the research. We don't often get an opportunity to stay in touch with people over a period of time and we would like to know what you think of this way of doing research

**13. What did you think of the length of time we stayed in touch with you?**

Explore in relation to: gathering a full picture of what happens  
amount of respondent's time taken up any  
repetition, tedium

**14. What did you think about the different ways we talked to you: coming to talk to you face to face and then keeping in touch by telephone?**

Explore in relation to: suitability of, preferences for medium looking  
forward to calls or not intrusion,  
inconvenience

**15. What would have been the best mix of face to face and telephone interviews, for us to gain the best overall picture about your experience with PROVIDER?****16. We are making an overall gift to you of value £60. What do you think about that amount; the 3-stage payment?****17. Do you think that taking part in the research has had any impact on how you have used the service?**

**Before we end the interview is there anything else you would like to say either about PROVIDER or about taking part in this research?**

Thank you very much indeed.

Remind no further contacts from us, but that a colleague of ours from the Survey Team will be in contact in the next few weeks to ask them to take part in a telephone survey. You may need to remind them that this was explained in our initial letter to them, but that participation is entirely voluntary.

Thank them for their participation and explain that the final £20 will follow in the mail as a thank-you.



## Topic guide: control group study

**JRRP PROCESS EVALUATION - FOCUSED STUDY 6**  
**EXPERIENCES AND PATHWAYS IN THE ABSENCE OF JRRP**  
**TOPIC GUIDE REVISED 07/07/05**

The aims of this study are to explore Control Group respondents’:

- experiences of sickness absence and how it impacts on factors such as daily life, financial circumstances, mental health and motivations to return to work;
- contact with the workplace and its influence on returning to work;
- contact with GPs and other health care professionals and its influence on returning to work;
- contact with other sources of support, help and advice and their influence on returning to work.

The study also seeks to examine:

- why some people return to work and others do not;
- the processes involved in returns to work;
- Control Group respondents’ experiences of returning to work and remaining in work.

We anticipate that some people will have returned to work when we interview them, whether to their original job or a new one, whereas others may be still off sick and others may no longer have a job. Because of the diversity of people’s circumstances, it has been necessary to design a topic guide that can be used in all cases.

The interview aims to cover two key topics: people’s experiences of sickness absence, and their experiences of the process of returning to work and being back at work, of losing their job or of remaining on sick leave for a longer period of time. It will be necessary to explore how contact with the health service, employers and other sources of support have influenced both people’s experiences of sickness absence and their pathways towards work. However, it may be more useful to explore these influences separately. For example, it may be useful to separate the influences of GPs or employers on decisions to take sick leave from their influences on any decisions to return to work.

It will be important to explore respondents’ experiences in chronological order, starting with the period of absence that relates to the point where they would have contacted [JRRP provider name] and then moving on to how their circumstances

changed up to the present day. Before looking back at the point where people first went off sick, it will be necessary to establish when this happened and to understand respondents' situations at the point of interview. In order to do this, a 'scene setting' section has been included at the beginning of the guide. This is designed to provide a 'snap-shot' of people's current circumstances in terms of health and employment and of how they came to be off sick from work.

## INTRODUCTION

Introduce self and NatCen/SPRU

Explain that we are interested in talking to those people who contacted [JRRP provider name] but were allocated to a group which did not receive any services. It is important for us to be able to understand how this group of people's circumstances have developed since they first went off sick. We are particularly interested in whether and how employers, GPs and other people and organisations have supported them over this period.

Explain that we are interested in obtaining information about:

- their employment situation
- what led to their sickness absence
- how their health condition has changed over time
- any contact they may have had with their employer during their sickness absence
- any contact with GPs during this time
- any other support they may have received
- how and why they decided to contact [JRRP provider name]
- and if they returned to work, how this came about.

Explain that this study is different from the survey they will have taken part in recently. Explain that whilst this interview may cover some similar areas to the survey, it will do so in more depth. Highlight that this is their opportunity to tell us what they think about the help and support available to help people on sick leave get back to work.

Explain that the interview remains confidential; that NatCen/SPRU are independent of the service providers and of DWP and DoH, and will not report anything they say back to the DWP and DoH in a way that could identify them. Explain tape recording and length of interview (1½ hours). Explain that other than the research team no one will listen to the tapes or read any transcripts. Stress that taking part is entirely voluntary. They will be paid £20 for their time.

## 1. BACKGROUND AND PERSONAL CIRCUMSTANCES

- **Age**
- **Personal circumstances**
  - Household composition
  - Dependants/caring responsibilities
  - Tenure

## 2. SCENE SETTING

**Aim:** to obtain a factual snap-shot of respondent's current circumstances in terms of employment and health, and to understand the chronology of the sickness absence associated with them contacting [JRRP provider name].

- Explore current employment situation at point of interview

### **If working...**

- Understand at what point they went back to work
- Gain details of current job
  - Identify whether new or original job
    - ~ Job details (e.g. title, duties, hours, contract etc)
    - ~ Explore how current job compares to original job if different
  - Identify whether new or original employer
    - ~ Organisation details (size, sector, business/activities)

### **If not working...**

- Identify whether off sick or no longer in work
- If unemployed gain brief details of:
  - How job ended
  - When this took place in relation to start of sickness absence
- If on sick leave, establish length of absence
- Identify any gaps (e.g. returns to work etc)
- Briefly establish how feel about return to work, in terms of:
  - Whether they want to return to work
  - Whether they feel it is likely

- **Explore employment situation prior to absence (if different)**
  - Job details
  - Organisational details
- **Gain details of employment and educational history**
  - Any qualifications held
  - Other work done in past/qualified for
- **Summarise and check chronology of events**

### 3. SICKNESS ABSENCE

**Aim:** to understand circumstances of respondent's sickness absence in more detail and their experience of being absent from work. Absence period may be in the past or continuing to present day. Exploring any previous absences will allow us to identify any influences on more recent absences e.g. employer's reaction in light of previous absences.

- **Circumstances surrounding sickness absence**

Explain that we are interested in the sickness absence period around the time they made contact with [JRRP Provider Name]

  - Identify date of beginning of relevant sickness absence
  - Briefly explore how they came to be off sick, in terms of
    - ~ The health condition
    - ~ How it affected their life and work
- **Understand decision making process concerning sickness absence**
  - Identify point at which decision to go off sick was taken and why
  - Explore influences on decision (e.g. condition, GP, employer etc)
  - Explore any steps taken to try and remain in work
- **Explore respondent's experience of sickness absence**
  - Thoughts and feelings associated with being ill and absent from work
  - Explore impacts on:
    - ~ Family roles and day-to-day life
    - ~ Income/household finances
      - Nature of income (sick pay, benefits etc)
      - If absence continuing, anticipated impact in long term
    - ~ Mental health
    - ~ Thoughts and feelings associated with returning to work

- **Examine history of any previous absences**
  - Frequency and duration of absences
  - Reason for absence (i.e. health condition)
    - ~ How compares to absence discussed above

#### 4. CONTACT WITH THE WORKPLACE DURING SICKNESS ABSENCE

**Aim:** to explore whether employers maintained contact with the respondent during their sickness absence and how supported they felt as a result. Need to establish a chronology of events.

- **Understand nature of any contact with the workplace, in terms of:**
  - Who contact was with (management, union, OH, colleagues etc)
  - How contact was initiated (by whom)
  - Frequency, duration and form of contact
  - Content of/reason for contact
    - ~ Explore any early offers of help to return to work
- **Explore reactions to contact/lack of contact with workplace**
  - Feelings and thoughts (supported/not supported etc)
  - Impact on thoughts and feelings about work/returning to work
- **Explore any developments over time**
  - Any changes to nature of contact, why
  - Any changes to employer attitude, why

#### 5. CONTACT WITH GPs & OTHER HEALTH CARE SERVICES

**Aim:** to explore nature and extent of contact with GPs and other health care professionals and any help received during sickness absence and the impact this has had on the respondent's circumstances. Need to establish a chronology of events beginning immediately prior to the decision to take sick leave described above.

- **Explore nature of contact/treatment, in terms of:**
  - Who contact/treatment was with (GP, OH staff, consultants, specialists etc)
  - How contact was initiated (by whom)
  - Frequency, duration and form of contact/treatment
  - Content of/reason for contact/treatment

- Establish chronology of help received
- Appropriateness and effectiveness of contact/treatment
- Whether contact/treatment was focused on work/return to work
  - ~ Explore whether respondent thinks health care support should be linked to return to work plans
- Any impacts on feelings/thoughts about returning to work

#### **IF NO HEALTH CARE RECEIVED...**

- **Explore barriers to receiving treatment**

E.g. lack of/insufficient diagnosis, waiting lists for treatments, other

- **Examine what has been happening in the meanwhile**

#### **6. OTHER RETURN TO WORK SUPPORT**

**Aim:** to explore what other forms of return to work related support have been available to the respondent and what impact these may have had on their circumstances.

- **Identify what other forms of help or support have they received**

- Explore how heard about support
- Effectiveness of support
- Explore and identify any impacts

- **Explore what other support is available and why not taken up**

#### **7. CONTACT WITH JRRP**

**Aim:** to understand what prompted the respondent to contact [JRRP provider name] and how they reacted to being assigned to the Control Group

- **Identify point at which they contacted [JRRP provider name]**

- Explore why at this point

- **Identify sources of information about [JRRP provider name]**

- Understanding/expectations of [JRRP provider name] at the time

- **Explore their understanding of the purpose of a Control Group**
  - Reactions to being allocated to the Control Group
  - Examine whether feel part of [JRRP provider name]
  - Perception of their role in [JRRP provider name]
  - Explore whether contact with [JRRP provider name] has had any influence on how they have managed their sickness absence/return to work
- **Explore what difference they think [JRRP provider name] might have made to their current situation**

## 8. OUTCOMES

This section has been split into three sub-sections. Each deals with a different outcome: 8.1 covers those who are currently working and those who may have been working at the time of their Outcome Survey interview; 8.2 is for those who lost their jobs and will most likely be claiming benefit; and 8.3 deals with those who have remained on sick leave.

### 8.1 RETURNING TO WORK

**Aim:** to explore the process and experience of returning to work and the experience of being back in work.

- **Establish working situation, in terms of**
  - Whether in a new job or returned to original employer
  - Whether and how type of work has changed (role, responsibilities, hours, pay etc)

**The following questions should be tailored according to the respondent's situation, i.e. whether they returned to their original job/employer or found new work**

- **Explore how the return to work happened**
  - Influences
  - Those involved (managers, HR, OH, union, family, GP, Jobcentre Plus etc)
    - ~ Understand how involved respondent felt in decision
  - Identify what support received in returning to original work/finding new job (e.g. graduated returns, job searches etc)
    - ~ Appropriateness
    - ~ Effectiveness
  - Explore whether anything was lacking/what would have been helpful
    - ~ Examine extent of alternatives (redeployment, other job opportunities etc)

- **Understand decision making process concerning return to work**

Establish chronology of what happened when

- Identify point at which decision was taken and why
- Explore influences on decision (e.g. health condition, GP, employer etc)
- Examine views on appropriateness of a return to work at this time

- **Explore feelings about returning to work**

- Positive expectations
- Worries

- **Explore reactions of others to the planned return to work (e.g. family, GP etc)**

- **Understand feelings and thoughts about being back at work**

- Explore any positive and negative experiences

- **Explore views on sustainability of remaining in work**

- Examine impact of health on work
- Examine impact of work on health
- Other impacts

## 8.2 IF ORIGINAL JOB ENDED

**Aim:** to understand the circumstances of those not working at the time of interview and what has influenced them.

- **Examine how job ended**

- Identify what form the termination took (dismissal, retirement due to ill health etc)
  - ~ Identify whether other options had been explored
    - Reasons why not implemented
  - ~ Identify whether any attempts were made to get them back to work
    - Reasons why not implemented
- Reasons given for job ending
  - ~ Reactions
  - ~ Perception of how fair reasons were
- Those involved in decision making (e.g. managers, HR, OH, union, family, GP etc)
  - ~ Understand how involved respondent felt in decision



- **Feelings about their current situation**
- **Explore short and long term implications of unemployment, on:**
  - Family roles and day-to-day life
  - Income/household finances
    - ~ Source of income
    - ~ Explore take-up of benefits, in terms of:
      - Type of benefit
      - Feelings about being on benefit
      - How found out about benefit
      - Process of making a claim
    - ~ Impact of income on ability to make ends meet
  - Mental and physical health
- **Explore respondent's feelings about work/returning to work**
  - Understand desire/need to work or not
  - Explore any attempts to get back to work
  - Understand what barriers exist to working
  - Identify nature of job/work would like to do

### 8.3 IF STILL OFF SICK FROM WORK

**Aim:** to understand the circumstances of those still on sick leave at the time of interview and what has influenced them.

- **Identify their perception of employer's attitude towards their absence**
  - Understand any changes over time
- **Explore views on sustainability of situation**
  - Explore whether and when sick leave might end
- **Explore impacts of continued absence on:**
  - Income/household finances
    - ~ Source of income (SSP/OSP, benefits etc)
    - ~ Explore take-up of benefits, in terms of:
      - Type of benefit
      - Feelings about being on benefit
      - How found out about benefit
      - Process of making a claim

- ~ If not on benefits, explore sustainability of current income (SSP etc)
    - Explore what will happen if/when it runs out
    - Awareness/perceptions of benefit system
  - ~ Impact of income on ability to make ends meet
  - Mental and physical health
  - Perceived employability
  - **Explore respondent's feelings about work/returning to work**
    - Understand desire/need to work or not
    - Explore any attempts to get back to work
    - Understand what barriers exist to working
    - Identify nature of job/work would like to do
  - **Explore views on what employer could have done to help**
    - Identify any gaps in employer support
- ## 9. FUTURE
- **Explore their expectations/hopes of what will happen in next 6 months:**
    - Regarding their physical and mental health
    - Regarding their employment situation
    - Regarding their financial situation
  - **Explore their expectations/hopes beyond 6 months**
    - Explore how likely they feel future/sustained paid work will be for them
    - Identify what would have to change to permit this
  - **Explore their views on what services should be available to help people like them**
    - Thoughts on changes to existing services/help (health care, social security, employers responsibilities etc)
    - Thoughts about new services/help
    - Explore what advice they would like to give to the Government about how to help people on sick leave
  - **Explore what advice they would give to a friend contemplating taking sick leave**

Topic guide: staff study, interview with manager

### **JRRP Focused Study – staff views on effectiveness**

#### **Topic Guide**

#### **Service Provider Managers**

Key research issues:

- to reflect on the experience of the pilot;
- to address the key policy question of what works, for whom, in what circumstances.

More specifically we need to understand:

- what lessons have emerged for the level and range of resources available to JRRP providers;
- what lessons have emerged for the organisation and management of JRRP provision;
- what lessons there are for policy.

The aim is to complement the group event with case managers by addressing similar issues from the perspective of management staff.

The topic guide has been kept short with the intention of allowing managers to talk in depth about what has been important for them. From interviews and other contacts with the individuals so far, we think that it is better to proceed in this way.

The purpose of the interview is to draw widely on their experiences of management of the JRRP. It should be explained to the respondents therefore that we have a short topic guide to facilitate discussion, and that they are free to raise any issues they want to.

It will be important not to dwell on issues associated with the random allocation of clients to the intervention groups. However, we probably do need to allow a little space for managers to air their views.

The interview starts with a discussion of the 'what works?' question

#### **1. What works, for whom, in what circumstances?**

INTERVIEWER NOTE: The aim is to reflect on the big question that government wants answering: What works, for whom, in what circumstances? Explore initially whether the respondent thinks the question can be answered at all. We want to encourage responses beyond 'it all depends on the client', or 'it all depends on the employer'.

Explore views about how this question can be answered?

Probe for ‘what works’:

### **Internal services**

- What ‘internal’ services have been particularly valuable? How? For whom?
- What ‘internal’ services have not met your expectations? Why?

### **External services**

- What ‘external’ services have been particularly valuable? How? For whom?
- What ‘external’ services have not met your expectations? Why?

### **Lessons from clients using JRRP**

Has JRRP worked especially well for clients with particular circumstances?

Probe:

- Have there been barriers that have hindered/prevented people from returning to work that have been particularly difficult to address? Any particular types of client?
- Are there any lessons about clients that could usefully inform development of JRR provision?

### **Reflections of the external environment within which JRRP operates**

How has the external environment (a) constrained, and (b) facilitated the effectiveness of JRRP provision? Have these been fixed, or have you been able to influence any of these?

Prompt for different aspects of ‘external environment’:

- Local labour markets (including types of job, levels of pay, job security)
- Local health services
- Employer attitudes and practices
- Employer sickness arrangements
- Employment legislation (including DDA)
- The system of social security benefits
- The system of tax credits.

## **2. Looking to the future – what needs to be done?**

INTERVIEWER NOTE: Explain that we are looking to the future and wanting their ideas for development of JRR provision on the assumption (*for the purposes of this exercise only*) that provision will be taken forward in some way.

In helping them to think of ideas for development ask them to consider:

- What are the key changes they would like to see to JRRP provision?
  - Are there gaps in services that need filling?
  - What would make their jobs easier/more effective?
- What are the key messages for their own organisation?
  - Are changes to the JRRP provider organisation needed?
  - If you starting afresh, would you design your provision differently?
- What are the key messages for DWP, Department of Health and government ministers?

If asked for their top ideas, what would they be? Probe for reasons for choice. Topic guide: staff study, group event

Topic guide: staff study, group event

**FOCUSED STUDY 4 – JRRP PROVIDER STAFF  
GROUP EVENT WITH CASE MANAGERS**

**Structure**

First half.... “What works, for whom, in what circumstances?” (80 minutes)

Introduction

1. Establishing the resources available to case managers (20 minutes)
2. Reviewing the clients (30 minutes)

‘Enablers and constraints’

3. Reviewing the skills and competencies needed for being a case manager (20 mins)

Refreshment break – 15 mins

Second half.... ‘Enablers and constraints’ (continued) (70 minutes)

4. Working with other key actors (20 mins)
5. Reviewing the external parameters within which case managers operate (15 mins)
6. Can the question ‘What works, for whom, in what circumstances?’ be answered? (20 minutes)
7. Looking to the future – what needs to be done? (15 mins)

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**FACILITATOR’S INTRODUCTORY NOTES**

Explain this focused study as one of the last pieces of fieldwork for the qualitative evaluation.

Main functions of the day:

- Address the big question of what works, for whom, in what circumstances? All government programmes are being asked the same question.
- Consider the skills and competencies required of case managers.
- Consider the impact of the external environment in which you operate: such as local labour markets, the tax and benefit systems, employers and health services, employment and disability legislation.

## First half.... “What works, for whom, in what circumstances?”

### 1 Establishing the resources available to case managers

#### Facilitator summary

Recap purpose of this part of day.

Discuss broad types of resources

Exercise 1 – List/map resources available to case managers

#### Recap purpose

SCRIPT: One of the key questions set by DWP for the evaluation is ‘What works, for whom, in what circumstances?’

In the first half of the afternoon/morning we want to try and unpick this question and consider if we (providers and researchers) can offer any answers.

We will approach this in stages. First of all we want to get a picture of what **resources** you have that you can use or you can organise. This will help us understand what we are talking about when thinking about ‘what works?’

#### Discuss broad types of resources

SCRIPT: To start you thinking we have drawn on what we have learned so far in the research project. There seem to be different types of resources that we have differentiated in the following way.

- Things you can offer directly to your clients (e.g. providing personal support, advising on benefits and services available locally (‘signposting’), help with jobsearch, CVs)
- Services you can call upon from within your organisation – either from your own staff or people contracted to you in some way
- Services that are part of some external organisation that you can arrange

FACILITATOR ROLE: check that these are meaningful distinctions. Amend or add as necessary. It is not vital to define resources in any particular way. The idea is to identify the extent to which they feel they have some control over resources. The expectation is that services that are ‘internal’ are easier to arrange than ones that rely on some other organisation. This will be relevant for thinking about what works and, in thinking about organisational enablers/constraints later on.

### Exercise 1 – List/map resources available to case managers

FACILITATOR ROLE: Give group members 5 minutes (or more as necessary) to compile list of their resources. Suggest doing this in pairs.

FACILITATOR ROLE: Use flip chart to collect and organise the resources. Prompt and suggest other resources that they appear to have missed. For example, 'personal support' might not be seen as a 'resource' but it has emerged from work with provider staff and clients as important. We might need to prompt for any sources of money they have access to.

The flip chart might be used to create lists under different headings or to create a spider diagram. Adopt whatever approach seems appropriate/useful.

## 2 Reviewing the clients

### Facilitator summary

Introduction

Discuss broad types of client, and amend as appropriate Explore characteristics of each category of client

Exercise 2 – What happens to clients

### Introduction

SCRIPT: The next stage in answering the big question is to consider your clients. We want to get an idea of the types of people you are working with, and the extent to which your task of helping them return to work is difficult or easy. It seems that case managers get an early impression of a new client (usually within the first or second meeting with them). And this helps them form a view about how to proceed – i.e. informing the 'action plan' (regardless of how far this is formalised).

### Discuss broad types of client, and amend as appropriate

FACILITATOR ROLE: Hand out card 'How case managers sometimes talk about clients, their circumstances and prospects'

### How case managers sometimes talk about clients, their circumstances and prospects

- Should not have major problems, (case manager) very confident of a return to work
- Will not be easy or quick, but confident of a return to work
- Not easy, client might be able to return to work, but not certain
- Unlikely to return to work



FACILITATOR ROLE: Ask if these statements are recognisable to them. If group members want to amend or add then use flip chart to record new list/categories. This new list will form the basis of following discussion.

### **Explore proportions of each category of client**

FACILITATOR ROLE: Using agreed categories ask group to suggest the proportions of their clients who fall into each. Note these on flip chart. Emphasise that this is not a scientific exercise; it is intended to give us a rough idea about the task they face.

### **Exercise 2 – What happens to clients**

SCRIPT: The next exercise is also not scientific but will help us to explore the ‘what works?’ question further.

We want you to think about what happens to people, where they end up after having been your client.

FACILITATOR ROLE: Hand out partially completed copies of TABLE 1.

SCRIPT: On the table we have put across the top, some descriptions of what happens to your clients. By this we mean what happens by the time you are not having further contact with them. We have included the following:

- Return to work (for same employer)
- Enter other paid work
- Other activity – e.g. voluntary work; training; education
- Stop work – inactive
- Don't know/Lose touch

Down the left side we want you to put in the categories of client we have just arrived at.

FACILITATOR ROLE: We want the case managers to give us an indication of what happens to the clients in each of the categories. We need to be flexible here – the idea is to use the table to stimulate discussion.

Initially ask them tick boxes where they have had experience.

You could then ask them to add an assessment of where their clients fall in the table - you might want to use something descriptive, such as ‘many’, ‘a lot’, ‘very few’ rather than proportions.

FACILITATOR ROLE: Allow 5 minutes for this task. Put people in pairs for this task, but give them a blank each in case they want to enter different responses.

NOTE ON FACILITATOR ROLE – The idea now is to get them to discuss, as a group, what might explain what happens to people. For example, using Table 1, ask the group what they put for the cell A and ask for real examples of what happened to a client here – what prevented the expected outcome of a return to work? What was tried? What could have helped?

Similarly, we could explore how possibly unexpected outcomes came about (cells B and C). Or, looking at cell D, why nothing could be done to help people here.

(POSSIBLE FACILITATOR ROLE: As examples of barriers emerge, note these on flip chart for use in next exercise.)

It will be important not to dwell long on barriers that are a result of the random allocation of clients to the intervention groups. However, we probably do need to allow a little space for case managers to make the point that they couldn't help people because they were precluded from some course of action.

### **‘Enablers and constraints’**

SCRIPT: The aim of this part of the afternoon is to see what helps or hinders you in doing the job of a case manager. We will start by looking at skills and competencies, then at working with other key actors and finally beyond all these to the external world you and your clients inhabit, over which you have little influence.

### **3 Skills and competencies**

#### **Facilitator summary**

Exercise 3 – Compile list of case manager skills and competencies

Case managers to rate themselves

Discuss what is needed to increase skills and competencies

#### **Exercise 3 – Compile list of case manager skills and competencies**

SCRIPT: We want you to think about what skills and competencies you consider are needed to do your job. To do this we want you to draw up the ‘person specification’ for your job description (recognising that you do different things as case managers).

FACILITATOR ROLE: Case managers to do this in pairs for 5 minutes. Remind them to distinguish between skills and competencies if they can. Remind them that *training* is NOT appropriate in either category. Training is a means of acquiring skills and competencies. But reassure them that we are interested in their own training and will bring this into discussion in due course.

Collect suggestions on flip chart. Identify on flip chart any skills and competencies associated with particular intervention groups.

#### **Case managers to rate themselves**

FACILITATOR ROLE: Ask case managers to reflect on the list and give themselves an overall rating from 1-10. Encourage a realistic assessment. (Reassure that their responses are not being reported back to anyone.)

Ask case managers to say why they (a) scored less than 10, and (b) what has contributed to the score they have given themselves.

FACILITATOR NOTE: Probe responses. We expect a range of things to emerge, such as training, previous experience, experience from the pilot, case conferences.

**Discuss what is needed to increase skills and competencies**

FACILITATOR ROLE: Take forward preceding discussion to identify how to improve skills and competencies of case managers. Collect ideas on flip chart. Encourage reflection on how *important* it is to improve case manager skills and competencies, and what they would prioritise.

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BREAK FOR REFRESHMENTS

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## Second half....

### 4 Working with other key actors

#### Facilitator summary

Exercise 4 – Compile list/map of other key actors (beyond service providers)  
Discuss role and importance of communications between key actors

#### Compile list/map of other key actors (beyond service providers)

SCRIPT: We are interested in how you work with other key actors who might play a part in a client's return to work (or other outcome). We are raising this because it has emerged as important for some of the clients we have interviewed.

Can we start by charting the territory? We would like to draw a map of who these actors are? We know that for some intervention groups certain people might be excluded.

FACILITATOR NOTE: Use flip chart and draw circles for case manager, client and other main players we expect them to be in contact with, including:

- Employers (current and prospective)
- GPs
- Other health/social care professionals (e.g. primary care workers, consultants, social workers, CPNs)
- Other (e.g. private) sources of treatment/help
- Jobcentre Plus staff, including benefits staff, PAs, DEAs
- Family members/friends
- Advice workers (such as welfare rights, CAB)
- Trades unions

Ask case managers to check those already drawn up and to add to the map any key people not yet mentioned.

Ask them to draw lines between the actors where communications happen.

#### Discuss role and importance of communications between key actors

FACILITATOR ROLE: Using the 'map' we want group members to discuss communications between the key actors. Use the following questions to prompt a response, *and choose connections on the map to explore key relations in more detail.* (For example, ask about GPs and, if appropriate, why they do/don't talk to them. Ask for examples.)

- How important is it that the key actors communicate with you? And with each other?
- Are you happy with the contact you have with key actors?
- Is there a role for the case manager in facilitating communications?
- Are there any barriers to communication? What is stopping you?
- What are the advantages of communicating with other key actors? Ask for examples of where this was important. Any examples of negative effects of lack of communications?
- Is this an important issue? What action is necessary?

## 5 Reviewing the external parameters within which case managers operate

### Facilitator summary

Open discussion of enabling/constraining role of 'environment' factors

SCRIPT: As the research has progressed we have learned that you have to operate within an external economic and social environment over which you have little or no direct control or influence. Things that have been mentioned have included:

- Local labour markets (including types of job, levels of pay, job security)
- (for some case managers and clients) local health services
- (for some case managers and clients) employer attitudes and practices
- Employer sickness arrangements
- Employment legislation (including DDA)
- The system of social security benefits
- The system of tax credits.

Are there any other things that should be added to the list?

Having said you have little control or influence over these things, can I ask whether you feel the same? Are there things you can do in individual cases to help your clients?

Can we take each in turn and ask how, if at all, you have felt (a) constrained by these, and (b) helped in any way. What examples are there of clients being helped or hindered?

## 6 Can the question ‘What works, for whom, in what circumstances?’ be answered?

### Facilitator summary

Stimulate open discussion of the big question. Use script and follow up questions as appropriate.

FACILITATOR NOTE: The aim of this final discussion before taking a break is, drawing on the discussions and exercises so far, to reflect on the big question that government wants answering: What works, for whom, in what circumstances? It is worth exploring initially whether people think the question can be answered at all. We want to encourage people to explore beyond a possible response of ‘it all depends on the client’, or ‘it all depends on the employer’.

SCRIPT: We started by posing the question that has been set us: What works, for whom, in what circumstances? Can we first ask – if a government minister asked you this, what would you say?

FACILITATOR NOTE: Possible follow up questions to probe further:

- What ‘internal’ services have been particularly valuable? How? For whom?
- What ‘internal’ services have not met your expectations? Why? (E.g. quality problems)
- What ‘external’ services have been particularly valuable? How? For whom?
- What ‘external’ services have not met your expectations? Why? (E.g. quality problems)
- Have there been barriers that have hindered/prevented people from returning to work? Any particular types of client? (FACILITATOR NOTE: Could use flip chart list generated at end of previous discussion here – e.g. to recap on barriers raised so far and ask for additions.)

## 7 Looking to the future – what needs to be done?

### Facilitator summary

Generate ideas for change: Encourage assessments of what would have the greatest positive impact

FACILITATOR NOTE:

In this final part of the afternoon, when people are getting tired, encourage a free flow of ideas for any ideas for change. What we are looking for are *key changes and messages*.

Introduce this final element by explaining that we are looking to the future and wanting their ideas for development of JRR provision on the assumption (*for the purposes of this exercise only*) that provision will be taken forward in some way. (Emphasise we are not privy to any policy information her.)

In helping them to think of ideas for development ask them to consider:

- What are the key changes they would like to see to what they do?
  - Are there gaps in services that need filling?
  - What would make their jobs easier/more effective?
- What are the key messages for their own organisation?
  - Are changes to the JRRP provider organisation needed?
- What are the key messages for DWP, Department of Health and government ministers?
  - If asked by the Secretary of State what would be their top three ideas? Probe for reasons for choice.

Try to keep the discussion short and snappy. Use your judgment about whether to give people 5 minutes to think or to use flip chart to list ideas directly.

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END OF SESSION

Thank all concerned.

Mention plans for future qualitative work and reporting arrangements.



Topic guide show card: staff study, group event

## SHOW CARD FOR EXERCISE 2

**Table 1 - What happens to clients**

Initial assessment	Return to work	Enter other paid work	Other activity (voluntary work; training; education)	Stop work - inactive	Don't know/lose touch
'Easy'					
'Not easy, but confident'					
'Not easy, not confident'					
Unlikely to return to work					

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