



Job retention and vocational rehabilitation: The development and evaluation of a conceptual framework

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Job retention and vocational rehabilitation: The development and evaluation of a conceptual framework

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This report details the outcomes of a research project commissioned by the Health and Safety Executive (HSE) aimed at identifying the issues which employers, in partnership with their employees, need to address in order to facilitate the continued employment of such workers via the provision of vocational rehabilitation. The project consisted of two phases of work. Phase 1 consisted of two distinct tasks. First, the development of a relatively brief 'framework' document that sought to identify the process and practice activities central to the successful job retention by employers of employees possessing mental and physical impairments that affect their work performance and the factors that influence the adoption and operation of these processes and practices. Secondly, the presentation of this document to a conference of 'stakeholders' at which delegates were given an opportunity to discuss the appropriateness of its content, as well as explore a number of related issues. Subsequently, in Phase 2, the research team went on to conduct a review of the available research evidence concerning (a) the validity of this framework document and (b) the extent to which employers do currently undertake the types of activities detailed in it.

Overall, the research evidence reviewed lent some support to the propositions put forward in the project team's Framework Document as to the employer processes and practices that are central to the development of effective workplace rehabilitation programmes, as well as the internal and external factors that identified as potentially influencing the adoption and operation of them. It therefore tended also to support the view that the provision of rehabilitative support by employers is crucially influenced by the establishment and effective implementation of policy frameworks which enable the rehabilitative needs of workers to be identified in a timely and collaborative fashion and to be addressed in a co-ordinated and positive way. At the same time, the evidence reviewed also pointed to the fact that such arrangements are lacking in many organisations and that there is consequently a good deal of scope for encouraging employers to do far more to support the continued employment of ill, injured and disabled workers, particularly in smaller organisations, through the adoption of the types of processes and practices detailed in the Framework Document.

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EXECUTIVE SUMMARY

This report details the outcomes of a research project commissioned by the Health and Safety Executive aimed at identifying the issues which employers, in partnership with their employees, need to address in order to facilitate the continued employment of such workers via the provision of vocational rehabilitation.

PROJECT OBJECTIVES

The project, which was carried out by a research team based at Middlesex University and the University of Strathclyde, consisted of two phases of work. Phase 1 consisted of two distinct tasks. First, the development of a relatively brief ‘framework’ document that sought to identify the processes and practices activities central to the successful job retention by employers of employees possessing mental and physical impairments that affect their work performance and the factors that influence the adoption and operation of these processes and practices. Secondly, the presentation of this document to a conference of ‘stakeholders’ at which delegates were given an opportunity to discuss the appropriateness of its content, as well as explore a number of related issues. Subsequently, in Phase 2, the research team went on to conduct a review of the available research evidence concerning (a) the validity of this framework document and (b) the extent to which employers do currently undertake the types of activities detailed in it.

PROJECT METHODOLOGY

More specifically, the work undertaken by the project team comprised four sets of inter-related activities: the carrying out of a literature review, the conducting of interviews with a number of specialists in the area of job retention and vocational rehabilitation; the holding of ‘stakeholder’ meetings with representatives from a variety of government departments and agencies; and the organisation, in conjunction with the Health and Safety Executive, of the previously mentioned stakeholder conference.

The literature reviewed came from four sources. First, use was made of literature identified and utilised in previous research undertaken by the members of the project team on the management of long-term absence, employer approaches towards the management of disability and the regulation of health and safety at work. Secondly, a variety of databases were searched. Thirdly, further literature was identified through the course of the stakeholder meetings and interviews held during the course of the project. Fourthly, there was a tracking and evaluation of other literature cited within the studies already examined.

The interviews with specialist stakeholders were conducted during the development of the framework document and subsequent to its finalisation. At the development stage, most of the interviewees were supplied with an early draft of the document and asked to comment on its content and to suggest ways in which it could be improved. The later interviews were used to get further feedback on the final document and to also both assist in the identification of other relevant literature and to help confirm the findings that were emerging from the on-going review of the available research evidence. Those interviewed included representatives from voluntary sector bodies and charities, academics working in the field of job retention or in related fields, and insurers.

The interviews referred to above were supplemented by two ‘stakeholder’ meetings with representatives of relevant government department and agencies at which these representatives

were provided with the opportunity to comment on the proposed conceptual framework and thereby contribute to its revision. In the light of the feedback received from the stakeholder interviews and meetings, as well as comments made by a variety of Health and Safety Executive staff, the draft framework document was revised. The final version of the document was then presented at a Health and Safety Executive conference that was held in May 2002 at the British Library and was attended by a range of other stakeholders.

PROJECT OUTCOMES: THE FRAMEWORK DOCUMENT

The Framework Document developed by the project team is divided into three main sections. In the first a conceptual framework of the 'cycles of vulnerability' faced by ill, injured and disabled workers is put forward in order to distinguish between three different types of situation where rehabilitative action might be required and to identify how action of this type can contribute to the job retention of such workers. The following two sections then consider, in turn, the main processes and practices that are considered to contribute to effective rehabilitation activity on the part of employers, and the internal and external factors that support or act as barriers to their occurrence.

Three potential cycles, or types, of vulnerability are identified that can contribute to workers leaving their employment on a voluntary or compulsory basis. The first of these relates to workers who contract a condition that has the potential to affect their job performance in the future if the condition deteriorates. The second applies to the position of workers who while at work, have a disability or health condition that is affecting job performance. Finally, the third refers to workers whose disability or health condition is affecting their ability to attend work.

The central thesis of the 'cycles of vulnerability' framework is that appropriate rehabilitative action can be utilised in an attempt to address each of the above types of situation. However, it is further noted that such action cannot only result in a worker moving into a 'non-vulnerable' position via, for example, the making of workplace adjustments, but can also be associated with a movement between the cycles, either upward towards a lower level of vulnerability or, if the action is unsuccessful, downwards towards a position of greater vulnerability. In addition, another important point highlighted by the framework is that rehabilitation does not necessarily constitute a 'one off' activity. Rather, a series of rehabilitative initiatives may be needed to either address weaknesses in those already taken or to address any further deterioration in a worker's condition.

The Framework Document postulates that seven sets of management processes and practices contribute to the development and operation of effective workplace rehabilitation programmes. In summary, these are:

- Early and timely identification of vulnerable workers through information obtained via such means as recruitment and selection procedures, health checks and medicals, staff appraisals and other forms of performance discussions, absence statistics, the maintenance of regular contact with absent workers and return to work interviews and fitness for work assessments;
- Provision of rehabilitation support in the form of medical treatment and the provision of various 'vocational services' such as functional evaluations, training, 'social support' and workplace adjustments;
- Co-ordination of the rehabilitation process by the creation of systems that facilitate sufficient communication, discussion and 'joined-up' action between all potentially relevant actors, including human resource staff, safety practitioners, occupational physicians and

nurses, psychologists, disability advisers, equal opportunities personnel, trade union and other workplace representatives and external medical personnel;

- Access to worker representation as a means of ensuring that attempts at rehabilitation are made in an environment of openness and trust;
- Establishment of policy frameworks that clearly detail what can and should be done to support the rehabilitation of workers and also make clear who is responsible and accountable for carrying out the various laid down requirements;
- Systematic action, including the provision of required training, to ensure that any laid down policy frameworks are implemented properly and hence do, in practice, influence how particular cases are handled;
- Adoption of mechanisms that enable any weaknesses in the content and operation of established policy frameworks to be identified and addressed.

A wide variety of possible internal and external influences that can serve to facilitate or hinder the nature and impact of the rehabilitative processes and practices of employers are noted. These include the size and resources of employing organisations and the nature of the product and labour markets within which they operate. They also include the following:

- Organisational commitment and culture, including the attitudes and values of senior management;
- Availability of specialist advice, required financial resources and line management, as well as general workforce awareness and support of organisational policies and objectives;
- Nature of work tasks and processes, as well as surrounding pay and grading systems;
- Extent to which workers have access to systems of worker representation that provide them with an independent and meaningful ‘voice’ in discussions over rehabilitation issues;
- External guidance, support and financial incentives provided to employers;
- Nature of surrounding legal frameworks, including those relating to unfair dismissal, disability discrimination, health and safety at work and personal injury litigation;
- Employer access to external health care and specialist rehabilitative expertise;
- Worker access to various forms of external support, such as public transport, social security benefits, relevant training and educational opportunities and medical care and rehabilitative support.

PROJECT OUTCOMES: STAKEHOLDER RESPONSES TO THE FRAMEWORK DOCUMENT

In general, the developed Framework Document received a substantial degree of support from the nearly 80 delegates who attended the Health and Safety Executive’s stakeholder conference. At the same time, the conference delegates did make a number of valuable observations that have implications for both its content and applicability, as well as a number of broader issues concerning how current employer actions in the area could be improved.

Several improvements were suggested to the section on ‘cycles of vulnerability’ in order to (a) take account of the differences between the term ‘disability’, on the one hand, and those of ‘injury’ and ‘illness’, on the other, (b) accord greater recognition to the way in which ‘disability’ can be socially created by aspects of the working environment and (c) draw attention to the legal consequences of employers failing to take adequate rehabilitative actions to facilitate the job retention of workers. In addition, it was observed that, as a result of their lack of resources, specialist expertise and relevant experience, smaller employers are likely to face considerable difficulties in developing and operationalising the types of practices and processes

laid in the document, although these problems might be to some extent alleviated by the presence of closer personal contact between employers and workers. It was also further observed that the operationalisation of these processes and practices in respect of cases involving mental health and psychosocial issues could be particularly problematic.

A number of observations were also made in relation to the various internal and external factors that the Framework Document identifies as potentially facilitating or hindering the rehabilitation activities of employers. In general, the delegates lent strong support to the importance of organisational commitment and culture, as well as the need for adequate mechanisms to exist with regard to the co-ordination of the rehabilitation process. Some support was also provided, albeit sometimes implicitly, to the argument that employers need to provide training to support the implementation of laid down policy frameworks and the view that workplace rehabilitation activities can be affected, either positively or negatively, by such issues as the amount of external advice provided to employers, the attitudes of General Practitioners, as well as workers themselves, the provision of financial incentives to employers, and the accessibility of relevant treatment on the National Health Service. At the same time, it was felt that more attention could have been paid in the document to the role of workers in influencing the rehabilitation process and attention was drawn to several additional influences on the rehabilitation activities of employers, including the number of casual workers employed, the remoteness of workplace sites and the number of occupational hazards present. In addition, it was suggested that the adoption of a risk assessment approach to the development of supporting policy frameworks might be beneficial.

PROJECT OUTCOMES: THE VALIDITY OF THE FRAMEWORK DOCUMENT

In general, the research evidence reviewed did lend some support to the various processes and practices that the Framework Document identifies as being central to the development and operation of effective workplace rehabilitation programmes. For example, it pointed to the value of having in place arrangements to enable the speedy identification of vulnerable workers who are in need of help, indicated that the provision of timely and appropriate rehabilitative support can support the job retention of ill, injured and disabled workers and suggested that the provision of such support is facilitated by the presence of adequate mechanisms for the co-ordination of discussions and actions between relevant organisational actors and between them and outside medical and rehabilitation personnel. In addition, the evidence suggested that access to worker representation, at least if it is trade union based, can have a beneficial impact and that it is desirable for appropriate and mutually supporting policy frameworks to be established and for the implementation of these to be adequately supported and monitored.

Overall, the evidence reviewed also supported the relevance of the various internal factors that the Framework Document identifies as potentially influencing the nature and operation of employer rehabilitative activities. For example, it suggested that senior management commitment and a supportive organisational culture can act to facilitate the establishment of return to work policies and practices and that, linked to this, the operation of these policies and practices is influenced by such factors as the attitudes of line managers and co-workers and the skills and knowledge of such managers, as well as their access to relevant specialist support. It also appears that the perceived scope for and ease of, workplace adjustments can be influenced by the nature of work tasks and processes, although little can be said concerning the postulated influences on such adjustments of pay and grading systems and the tightness of prevailing staffing levels. Furthermore, substantial evidence was found to show that a range of psychosocial factors, including age and educational levels, the nature of family support, worker fears and views concerning their future prospects, and levels of job satisfaction, can influence the likelihood of workers returning to work.

As regards the various external influences identified, the evidence enables little to be firmly said about how the rehabilitative activities are influenced positively or negatively by the presence of external guidance, support and incentives. However, the fact that such guidance and support is utilised by many employers and that there seems some enthusiasm for the use of financial incentives, suggests that the roles of these sources of influence should not be discounted. In contrast, evidence was found to show how the actions of employers could be influenced by surrounding legal frameworks and the important way in which return to work activities can be hindered by long National Health Service treatment waiting lists and also, potentially, through the absence of adequate channels of communication and co-ordination between workplace personnel and outside medical staff and other specialists. Similarly, some evidence was identified to support the view that a lack of worker access to public transport and external guidance and support, as well as fears about future income security, can create return to work difficulties.

It is, nevertheless, acknowledged that this broad support for the Framework Document came from a research base that was problematic, both in terms of scope and quality, and whose support for the Framework Document was therefore often rather tentative, speculative and indirect. In particular, three specific weaknesses in this base were noted. First, it contained relatively few studies which have sought to explore the links between job retention and vocational rehabilitation at the level of the employing organisation and hence within the context of on-going employment relationships. Secondly, insofar as such studies had been conducted, they were found to often embody an emphasis on the analysis of quantitative survey data and a corresponding lack of focus on the in-depth exploration of the organisational dynamics that surround the management of workplace rehabilitation processes. Thirdly, in some areas of interest, due to a lack of relevant British evidence, it was found necessary to place heavy reliance on the findings of studies conducted in other countries, notably North America, Australia and Scandinavia, whose applicability to the British context is therefore inevitably open to question given the differing nature of their legal, healthcare and social security systems.

PROJECT OUTCOMES: CURRENT EMPLOYER PROCESSES AND PRACTICES

In order to explore how far British employers utilise the types of rehabilitation processes and practices a number of 'performance indicators' were identified in respect of factors for which evidence was known to exist. Even then, however, the available research evidence was found to be frequently poor and difficult to interpret. That which was available suggested that many employers conduct performance appraisals and collect and circulate absence data and hence have a potential means of identifying workers in need of rehabilitative support. It also suggested that the majority of employers have formal procedural provisions relating to the handling of employees who become ill, injured or disabled, most commonly under disciplinary and absence management procedures which may well contain rather limited provisions on rehabilitation, and that there is a widespread willingness to make workplace adjustments to accommodate the needs of workers, although the translation of this willingness into practice is sometimes problematic. However, it seemed that while some employers do provide employees with access to private medical care, counselling, physiotherapy and other 'treatment' provision, these constitute a very small proportion of employing organisations (and workplaces). Furthermore, there was also available line managers frequently that lack access to specialist support from human resource and occupational health specialists, and there are relatively few workplaces where the potential consequently exists to adopt a meaningful case management approach to workers whose job security is threatened by the onset of illness or disability.

1. INTRODUCTION

1.1 INTRODUCTION

The job retention of employees who have mental or physical impairments that affect their work performance has in recent years been attracting the attention of policy makers, as well as employers and trade unions, at both the domestic and international levels. Against this background, the Health and Safety Commission and Executive have been paying increasing attention to the question of what can be done to increase the likelihood that employees who are sick or injured are able to be retained in employment and returned to their jobs, or, failing this, are able to obtain alternative employment with the same or another employer. As part of this focus of activity, the Health and Safety Executive commissioned a team of researchers based at Middlesex University and the University of Strathclyde to undertake a research project aimed at identifying the issues which employers, in partnership with their employees, need to address in order to facilitate the continued employment of such workers via the provision of vocational rehabilitation.

1.2 PROJECT OBJECTIVES

The project consisted of two phases of work. Phase 1 consisted of two distinct tasks. First, the development of a relatively brief 'framework' document that sought to identify the processes and practices activities central to the successful job retention by employers of employees possessing mental and physical impairments that affect their work performance and the factors that influence the adoption and operation of these processes and practices. Secondly, the presentation of this document to a conference of 'stakeholders' at which delegates were given an opportunity to discuss the appropriateness of its content, as well as explore a number of related issues. Subsequently, in Phase 2, the research team went on to conduct a review of the available research evidence concerning (a) the validity of this framework document and (b) the extent to which employers do currently undertake the types of activities detailed in it.

1.3 PROJECT METHODOLOGY

More specifically, the work undertaken by the project team comprised four sets of inter-related activities: the carrying out of a literature review, the conducting of interviews with a number of specialists in the area of job retention and vocational rehabilitation; the holding of 'stakeholder' meetings with representatives from a variety of government departments and agencies; and the organisation, in conjunction with the Health and Safety Executive, of the previously mentioned stakeholder conference. It should be stressed that the interpretation of, and hence the conclusions drawn, from the stakeholder conference, interviews and meetings are those of the project team rather than the Health and Safety Executive.

1.3.1 Literature review

The literature used in the literature review came from four sources. First, use was made of literature identified and utilised in previous research undertaken by the members of the project team on the management of long-term absence (Cunningham and James, 2000; Dibben *et al*, 2001; James *et al*, 2002), employer approaches towards the management of disability (Bruyère and James, 1997; Cunningham and James, 1998; James *et al*, 1997; Cunningham *et al*, 2000)

and the regulation of health and safety at work (James and Walters, 1998). Secondly, a variety of databases, such as Medline, Bids, Ebsco, Emerald and Infotrac, were searched using a number of different key terms. These terms included, but were not limited to, the following: rehabilitation; vocational rehabilitation; job retention; workplace absence; management of absence; and sickness absence. Thirdly, further literature was identified through the course of the stakeholder meetings and interviews held during the course of the project (see below). Fourthly, there was a tracking and evaluation of other literature cited within the studies already examined.

1.3.2 Interviews with specialist stakeholders

The interviews with specialist stakeholders were conducted during the development of the framework document and subsequent to its finalisation. At the development stage, most of the interviewees were supplied with an early draft of the document and asked to comment on its content and to suggest ways in which it could be improved. The later interviews were used to get further feedback on the final document and to also both assist in the identification of other relevant literature and to help confirm the findings that were emerging from the on-going review of the available research evidence. Those interviewed included representatives from voluntary sector bodies and charities, academics working in the field of job retention or in related fields, and insurers.

1.3.3 Stakeholder meetings

The interviews referred to above were supplemented by two 'stakeholder' meetings with representatives of relevant government department and agencies at which these representatives were provided with the opportunity to comment on the proposed conceptual framework and thereby contribute to its revision. Departments and agencies represented at these meetings included the Home Office, Department of Work and Pensions, Department of Health, Employment Service, Small Business Services, ACAS, the Cabinet Office, and the Welsh and Scottish Offices.

The structure of the two meetings was identical in that they began with an exposition of the draft framework by the project director, Philip James. This exposition was followed by a discussion of the current policies and recent initiatives that had been undertaken by the represented departments and agencies in the area of job retention and vocational rehabilitation. The stakeholders were then asked to identify any gaps in the framework, suggests ways in which the gaps might be addressed, and to highlight any tensions that might be inherent in trying to address these gaps. Finally, there was a round table discussion of how wider government policies might impact on the development of employer strategies for job retention and rehabilitation.

1.3.4 HSE stakeholder conference

In the light of the feedback received from the stakeholder interviews and meetings, as well as comments made by a variety of Health and Safety Executive staff, the draft framework document was revised. The final version of the document was then presented at a Health and Safety Executive conference, entitled 'Turning a Challenge into an Opportunity', which involved a range of stakeholders.

The conference was held in May 2002 at the British Library. It was attended by nearly 80 delegates who were specifically invited to ensure an adequate representation of the following

types of individuals:

- Human Resources professionals
- Line managers and managers of small and medium sized enterprises
- Occupational health professionals
- Academics working in related fields
- Senior government policy officers
- Lawyers
- Health and safety professionals
- Mental health and employment specialists
- Rehabilitation service providers
- Insurers
- Trade union and employee representatives
- Representatives of employer's associations, trade organisations and professional bodies
- Pressure groups and charities
- Independent experts

The first part of the event consisted of presentations from Bill Callaghan, Chair of the Health and Safety Commission, the Project Director, Professor James, and three specialist speakers from the Professional Footballers' Association, Marks and Spencer plc and Powergen. The second part comprised syndicate discussions that were aided by the use of interactive computer technology provided by Crystal Innovation. Three of these sessions were led by members of the project team, and the fourth by Marilyn Howard, a social policy analyst. In addition, there was a final plenary session which included a summary by Professor James of some of the key findings from the afternoon's sessions, as well as a general question and answer session.

The syndicate discussions were focused around a series of questions. These questions centred on four main issues. First, the adequacy of the framework document's content. Second, the strengths and weaknesses of current employer approaches towards the job retention of ill, injured and disabled workers, including the extent to which employers were equipped to adopt and use effectively the types of processes and practices detailed in the document. Third, the relevance of a number of particular workplace management models of the rehabilitation process. Fourth, what could be done to develop and grow workplace managed rehabilitation. In each case, delegates were asked to pay particular attention to whether there were differences that needed to be taken into account in respect of psychosocial issues, the size of organisations, and organisational sector.

In general, the developed Framework Document received a substantial degree of support from the nearly 80 delegates who attended the Health and Safety Executive's stakeholder conference. At the same time, the conference delegates did make a number of valuable observations that have implications for both its content and applicability, as well as a number of broader issues concerning how current employer actions in the area could be improved.

Several improvements were suggested to the section on 'cycles of vulnerability' in order to (a) take account of the differences between the term 'disability, on the one hand, and those of 'injury' and 'illness', on the other, (b) accord greater recognition to the way in which 'disability' can be socially created by aspects of the working environment and (c) draw attention to the legal consequences of employers failing to take adequate rehabilitative actions to facilitate the job retention of workers. A number of observations were also made in relation to the various internal and external factors that the Framework Document identifies as potentially facilitating or hindering the rehabilitation activities of employers. In general, the delegates lent

strong support to the importance of organisational commitment and culture, as well as the need for adequate mechanisms to exist with regard to the co-ordination of the rehabilitation process. Some support was also provided, albeit sometimes implicitly, to the argument that employers need to provide training to support the implementation of laid down policy frameworks and the view that workplace rehabilitation activities can be affected, either positively or negatively, by such issues as the amount of external advice provided to employers, the attitudes of General Practitioners, as well as workers themselves, the provision of financial incentives to employers, and the accessibility of relevant treatment on the National Health Service. At the same time, it was felt that more attention could have been paid in the document to the role of workers in influencing the rehabilitation process and attention was drawn to several additional influences on the rehabilitation activities of employers, including the number of casual workers employed, the remoteness of workplace sites and the number of occupational hazards present.

1.4 STRUCTURE OF REPORT

The remainder of this report consists of four substantive chapters and two supporting appendices, which respectively reproduce the final version of the framework document, and detail those who took part in the meetings, and the Health and Safety Executive conference. Chapter 2 provides a summary of the framework document and outlines the comments subsequently made on it, and other issues, by the conference delegates and subsequent interviews with specialist stakeholders. Chapters 3 and 4 then go on, in turn, to consider how far the existing research evidence lends support to the document's contents and the light it sheds on the extent to which employers do currently utilise the types of processes and practices detailed in it.

2. THE FRAMEWORK DOCUMENT AND RESPONSES TO IT

2.1 INTRODUCTION

This chapter initially provides a summary outline of the Framework Document on the links between job retention and employer supported vocational rehabilitation developed by the project team. It then reviews the key comments and observations made on this, as well as a number of other related issues, by delegates who attended the Health and Safety Executive conference on the document held in May 2002.

2.2 THE FRAMEWORK DOCUMENT: A SUMMARY

The full Framework Document is provided in Appendix One. As will be seen, the document is divided into three main sections. In the first a conceptual framework of the 'cycles of vulnerability' faced by ill, injured and disabled workers is put forward, along with an accompanying flow diagram, in order to distinguish between three different types of situation where rehabilitative action might be required and to identify how action of this type can contribute to the job retention of such workers. The following two sections then consider, in turn, the main processes and practices that are considered to contribute to effective rehabilitation activity on the part of employers, and the internal and external factors that support or act as barriers to its occurrence.

2.2.1 Cycles of vulnerability

Three potential cycles, or types, of vulnerability are identified that can contribute to workers leaving their employment on a voluntary or compulsory basis. The first of these relates to workers who contract a condition that has the potential to affect their job performance in the future if the condition deteriorates. The second applies to the position of workers who while at work, have a disability or health condition that is affecting job performance. Finally, the third refers to workers whose disability or health condition is affecting their ability to attend work.

The central thesis of the 'cycles of vulnerability' framework is that appropriate rehabilitative action can be utilised in an attempt to address each of the above types of situation. However, it is further noted that such action cannot only result in a worker moving into a 'non-vulnerable' position via, for example, the making of workplace adjustments, but can also be associated with a movement between the cycles, either upward towards a lower level of vulnerability or, if the action is unsuccessful, downwards towards a position of greater vulnerability. In addition, another important point highlighted by the framework is that rehabilitation does not necessarily constitute a 'one off' activity. Rather, a series of rehabilitative initiatives may be needed to either address weaknesses in those already taken or to address any further deterioration in a worker's condition.

2.2.2 Employer processes and practices

The Framework Document postulates that seven sets of management processes and practices contribute to the development and operation of effective workplace rehabilitation programmes. In summary, these are:

- Early and timely identification of vulnerable workers through information obtained via such means as recruitment and selection procedures, health checks and medicals, staff appraisals

- and other forms of performance discussions, absence statistics, the maintenance of regular contact with absent workers and return to work interviews and fitness for work assessments;
- Provision of rehabilitation support in the form of medical treatment and the provision of various 'vocational services' such as functional evaluations, training, 'social support' and workplace adjustments;
 - Co-ordination of the rehabilitation process by the creation of systems that facilitate sufficient communication, discussion and 'joined-up' action between all potentially relevant actors, including human resource staff, safety practitioners, occupational physicians and nurses, psychologists, disability advisers, equal opportunities personnel, trade union and other workplace representatives and external medical personnel;
 - Access to worker representation as a means of ensuring that attempts at rehabilitation are made in an environment of openness and trust;
 - Establishment of policy frameworks that clearly detail what can and should be done to support the rehabilitation of workers and also make clear who is responsible and accountable for carrying out the various laid down requirements;
 - Systematic action, including the provision of required training, to ensure that any laid down policy frameworks are implemented properly and hence do, in practice, influence how particular cases are handled;
 - Adoption of mechanisms that enable any weaknesses in the content and operation of established policy frameworks to be identified and addressed.

2.2.3 Internal and external facilitators and barriers

A wide variety of possible internal and external influences that can serve to facilitate or hinder the nature and impact of the rehabilitative processes and practices of employers are identified in the Framework Document. These include the size and resources of employing organisations and the nature of the product and labour markets within which they operate. They also include the following:

- Organisational commitment and culture, including the attitudes and values of senior management;
- Availability of specialist advice, required financial resources and line management, as well as general workforce awareness and support of organisational policies and objectives;
- Nature of work tasks and processes, as well as surrounding pay and grading systems;
- Extent to which workers have access to systems of worker representation that provide them with an independent and meaningful 'voice' in discussions over rehabilitation issues;
- External guidance, support and financial incentives provided to employers;
- Nature of surrounding legal frameworks, including those relating to unfair dismissal, disability discrimination, health and safety at work and personal injury litigation;
- Employer access to external health care and specialist rehabilitative expertise;
- Worker access to various forms of external support, such as public transport, social security benefits, relevant training and educational opportunities and medical care and rehabilitative support.

2.3 FEEDBACK ON THE FRAMEWORK DOCUMENT

In general, in the view of the project team, the feedback received from conference delegates, as well as other stakeholders, lent considerable support to the proposed Framework Document. Nevertheless, a number of refinements to the document were identified. In addition, a variety of further observations were made concerning how workplace rehabilitative activities could be

improved. These refinements and observations are summarised briefly below under the following broad headings:

- Role of organisational commitment and culture
- Co-ordination of the rehabilitation process
- Issues relating to small and medium sized organisations (SMEs), particular industrial sectors, and psychosocial and mental health issues;
- Rationale for job retention and vocational rehabilitation;
- Nature of organisational policy frameworks;
- Worker responsibilities towards rehabilitation;
- Provision of external advice and financial incentives to employers;
- Language used in the ‘cycles of vulnerability’ component of the Framework Document.

2.3.1 Organisational commitment and culture

Organisational commitment and culture was identified by conference delegates as being by far the most important factor acting to shape the rehabilitation activities of employers. In addition, three more specific points were made in relation to this factor. First, that such commitment and culture played a particularly important role with regard to the handling of mental health and psychosocial issues. Secondly, that its extent was likely to be related to an organisation’s awareness of the issue of disability in general and the Disability Discrimination Act in particular. Thirdly, that it was intimately connected to the role which senior managers played in encouraging job retention and rehabilitation.

2.3.2 Co-ordination of rehabilitation

The importance of establishing adequate mechanisms for the co-ordination of rehabilitation activities was also strongly emphasised, as was the need for the employee to be central to the rehabilitation process. At the same time, this was felt to be an issue that organisations are at present very poorly equipped to deal with and that this situation is compounded by the fact that ‘outside systems do not speak to each other’. In particular it was suggested that employers often do not have the resources and expertise to carry out this role effectively and even if they do, such co-ordination is often not seen as a priority, with the result that frequently nobody is charged with fulfilling a ‘case management’ function. Furthermore, it was apparent that there was a good deal of disagreement about who should take on this role. For example, differing views were expressed concerning whether it should be vocational or medically based, whether the case manager should be internal or external to the organisation, an issue which was seen to be related by some to the question of how potential conflicts of interest between an employee and the organisation might best be handled, and whether the type of case manager required varied according to the particular circumstances of employees and the point they occupied on the rehabilitation ‘journey’.

In the afternoon session of the conference, as indicated in the previous chapter, delegates were afforded the opportunity to discuss various types of workplace management models that could be used to facilitate the co-ordination of the rehabilitation process. Those discussed included the following:

- joint ownership with trade unions
- a stick and carrot approach
- an NHS or community-based approach,

- a flexible integration model
- a hub and spoke model. Human resources or the line manager might be the hub, and there might be more than one wheel, based around for example the GP, the trade union representative, and human resources
- a triangle of employee, employer, and occupational health

The views expressed concerning the relative attractiveness of these different models varied. However, it was noted that all might well be hampered by the current lack of resources and knowledge available concerning rehabilitation issues, as well as the fact that many employers believe that it is often cheaper to replace workers than to rehabilitate them. In addition, the point was raised that to work effectively, the issue of rehabilitation needed to be seen as integral to an organisation's business strategy.

2.3.3 Issues in relation to SMEs, industrial sector and psychosocial and mental health issues

In terms of SMEs, it was suggested that the more informal and personal nature of the contact they have with employees might lead to an improved co-ordination of the rehabilitation process. However, in general it was considered that the provision of rehabilitation support, as well as its co-ordination, is more difficult in SMEs. This difficulty was seen to stem from a lack of awareness of relevant resources and expertise which was, in part, caused by the reduced likelihood that similar problems had occurred before. As a result, a number of people argued that the provision of external rehabilitative support, including case management, might be particularly relevant to such organisations. It was, nevertheless, noted that support of this type might lead employers to have less control over the process.

A number of other problematic issues were also raised in respect of SMEs. These included the absence of effective policy frameworks and worker representation. They also encompassed the fact that smaller employers, because of their lower staffing levels, may have fewer redeployment opportunities and might find it more difficult to cope with the costs of rehabilitation. Against this background, some felt that there may be a need for additional financial incentives to be provided to them, although others noted that there were smaller employers, such as law firms and advertising companies, who might have a greater ability to fund medical costs themselves.

In general, industrial sector was not seen as a key factor in influencing employer job retention and vocational rehabilitation activities. Rather, more importance was attached to a number of potentially related issues, such as whether organisations were unionised, the number of casual workers employed, the levels of local unemployment, the availability of local skills, and the remoteness of workplaces. In a similar vein, attention was drawn to the potential influence of occupational health hazards. Thus, some felt that the larger the number of these, the better equipped an organisation would be to engage in rehabilitation activities, although this was not a universally shared view since others considered that their influence in this regard varied between sectors. In addition and more generally, it was observed that the extent of such activities might be influenced by whether an organisation was a supplier to a large organisation with a good record on job retention and rehabilitation.

In respect of psychosocial and mental health issues, a number of delegates thought that organisational commitment and culture was even more important in these cases, as was management style, not least because of the climate of fear and shame that could be associated with them. It was also widely felt that a number of difficulties existed in respect of the carrying

out of rehabilitation in cases of this type. For example, attention was drawn to the difficulties that could arise in relation to the identification of workers in need of rehabilitative support, the establishment of appropriate policy frameworks, the adjustment of work tasks and processes, and the absence of relevant expertise and knowledge, notably among line managers. In addition, it was further noted that recovery times in such cases might be longer and more difficult to predict, and that difficulties could exist with regard to the defining of rehabilitation 'success'.

In general, it was felt that that the co-ordination of the rehabilitation of workers with psychosocial and mental health problems was more difficult and that line managers were less proactive in dealing with such cases because of fears that they might push employees 'over the edge'. In addition, attention was drawn to the difficulties that existed with regard to obtaining relevant treatment on the National Health Service, problems that were considered to partly stem from an acute shortage of relevant practitioners.

2.3.4 Establishing a rationale for job retention and rehabilitation

It was suggested that case studies should be used to develop a firmer rationale for job retention and rehabilitation, as a means of encouraging greater employer commitment in the area, and that more emphasis should, for the same reason, be placed on encouraging employers to benchmark their activities against those of other organisations. In addition, it was felt that more recognition should be accorded to the debate about what can be considered as 'best practice' and that cost-benefit analysis might have a role to play in stimulating employer action, although a number of potential problems surrounding such analyses were also noted, including the fact that predicted savings are uncertain and that it may take some time before any potential benefits become apparent.

2.3.5 The nature of policy frameworks

The importance of policy frameworks being fair, equitable and applicable to everyone was widely stressed. However, it was also noted that the interpretation of policy requirements and objectives might vary from senior management to the employee, with the result that care should be taken not to assume that they are the subject of a shared understanding. More specifically, it was observed that a risk assessment approach needed to be adopted towards the development of rehabilitation policies and that more emphasis should be placed on the disabling factors that exist within the work environment.

2.3.6 Employee responsibility

It was felt by a number of the delegates that the responsibilities of employees for their own job retention and successful rehabilitation should be more carefully discussed. For example, mention was made of their use of discussions with General Practitioners to explore return to work possibilities. However, it was also acknowledged that it was often particularly difficult for employees to take a proactive approach to their own rehabilitation in the case of mental health conditions.

2.3.7 External advice and financial incentives

The need to extend the range of external advice available to both workers and their employers was commonly recognised. With regard to this, a number of more specific observations were

made. These included the desirability of promoting systems of external accreditation, the paying of attention to the role played by General Practitioners and the giving of more detailed consideration to the support that could be provided to workers via Employee Assistance Programmes and mentoring or 'buddy' systems.

A good deal of support was also voiced for the introduction of new tax incentives for employers to engage in rehabilitation activities. In addition, a number of other potentially important financially-related issues were raised. These included the way in which the Public Finance Initiative might be used to promote greater rehabilitation, the paying of more attention to the interface between the issue of rehabilitation and both pension scheme requirements and statutory sick pay (SSP) and the value of using Income Protection insurance to influence the management of risks and absence.

2.3.8 'Cycles of vulnerability' and the language used

As noted above, the 'Cycles of vulnerability' identified in the Framework Document encompass workers who have an illness or disability that impacts on their work performance. Some of those who commented felt that, as a result, they misleadingly, although not deliberately, imply that workers who are disabled are automatically 'vulnerable'. Some also felt that the phrase 'full recovery' that is used to describe a worker's move out of 'vulnerability' should, for similar reasons, be changed. In addition, two other amendments to the accompanying flow diagram were proposed. First, it was suggested that the 'work environment' be inserted at the top of the diagram, to indicate that problems of job performance/attendance might arise as a result of disabling factors in the workplace. Secondly, a reference to employment tribunals at the bottom of the diagram, where reference is made to an employee 'exiting' the organisation', might be made in order to emphasise the possible implications of an employer failing to take appropriate action to facilitate an employee's job retention.

2.4 CONCLUSION

The Framework Document developed by the project team to shed light on the links between the job retention of ill, injured and disabled workers and the vocational rehabilitation activities of employers received a substantial degree of endorsement from those attending the conference organised by the Health and Safety Executive. Nevertheless, the conference delegates did make a number of valuable observations that have implications for both its content and applicability, as well as a number of broader issues concerning how current employer actions in the area could be improved.

Several improvements were suggested to the section on 'cycles of vulnerability' in order to (a) take account of the differences between the term 'disability', on the one hand, and those of 'injury' and 'illness', on the other, (b) accord greater recognition to the way in which 'disability' can be socially created by aspects of the working environment and (c) draw attention to the legal consequences of employers failing to take adequate rehabilitative actions to facilitate the job retention of workers. In addition, it was observed that, as a result of their lack of resources, specialist expertise and relevant experience, smaller employers are likely to face considerable difficulties in developing and operationalising the types of practices and processes laid in the document, although these problems might be to some extent alleviated by the presence of closer personal contact between employers and workers. It was also further observed that the operationalisation of these processes and practices in respect of cases involving mental health and psychosocial issues could be particularly problematic.

A number of observations were also made in relation to the various internal and external factors that the Framework Document identifies as potentially facilitating or hindering the rehabilitation activities of employers. In general, the delegates lent strong support to the importance of organisational commitment and culture, as well as the need for adequate mechanisms to exist with regard to the co-ordination of the rehabilitation process. Some support was also provided, albeit sometimes implicitly, to the argument that employers need to provide training to support the implementation of laid down policy frameworks and the view that workplace rehabilitation activities can be affected, either positively or negatively, by such issues as the amount of external advice provided to employers, the attitudes of General Practitioners, as well as workers themselves, the provision of financial incentives to employers, and the accessibility of relevant treatment on the National Health Service. At the same time, it was felt that more attention could have been paid in the document to the role of workers in influencing the rehabilitation process and attention was drawn to several additional influences on the rehabilitation activities of employers, including the number of casual workers employed, the remoteness of workplace sites and the number of occupational hazards present. In addition, it was suggested that the adoption of a risk assessment approach to the development of supporting policy frameworks might be beneficial.

As regards what can be done to improve the current level of employer provided rehabilitation, some possible areas of action received a degree of support. These included the provision of tax incentives to employers, the conducting of case studies to demonstrate the value of providing workers with rehabilitative support, encouraging employers to benchmark their arrangements against those of other organisations, improving National Health Service provision, notably in the area of mental health, and increasing the degree to which external systems of support 'talk to each other'. More generally, and in relation to this last point, action was seen to be also needed to improve the co-ordination of rehabilitation processes. However, views differed as to how this might be best done. In particular, differing views were expressed concerning such matters as whether 'case managers' should be vocational or medically based and whether they should be employed inside or outside of the employing organisation.

3. THE FRAMEWORK DOCUMENT: HOW FAR DOES IT RECEIVE RESEARCH SUPPORT?

3.1 INTRODUCTION

In the previous chapter the key features of the Framework Document developed by the project team on the relationship between job retention and employer vocational rehabilitation activities were outlined and attention paid to the comments on it made by delegates who attended a conference on the document organised by the Health and Safety Executive. In this chapter attention turns to a consideration of how far the various elements detailed in the framework receive support from research findings. Initially, this is done by considering the evidence that is available to support the various propositions put forward with regard to the employer processes and practices that contribute to the development and operation of effective workplace rehabilitation programmes. Following this, attention is then paid to how far the available research findings support the relevance of the various internal and external factors that the Framework Document identifies as exerting an important influence over the nature and operation of organisational rehabilitation activities.

3.2 THE KEY EMPLOYER PROCESSES AND PRACTICES

In the Framework Document seven key sets of broad and to some extent inter-related, sets of employer processes and actions are identified as central to the establishment and operation of effective workplace rehabilitation programmes. In summary, these processes and actions are:

- speedy identification of workers whose attendance or more general job performance is being adversely affected by illness, injury or disability in order to facilitate early and timely rehabilitative interventions;
- employer action to aid the job retention of ill, injured and disabled workers by (a) making provision for workers to have access to ‘medical’ treatment and (b) providing other forms of support, including any necessary re-training and adjustments to work processes and environments;
- putting in place of adequate mechanisms to facilitate communication, discussion and co-ordination between the individual worker and the various organisational actors, for example, human resource specialists, safety practitioners, occupational health personnel and trade union representatives, who can contribute to the rehabilitation process.
- provision of access to worker representation as a means of ensuring that rehabilitation processes occur in an atmosphere of openness and trust;
- establishment of policy frameworks which clearly detail not only what can and should be done, but also make clear who is responsible and accountable for implementing their requirements;
- systematic actions to ensure that laid down policy frameworks are implemented properly and hence do, in practice, influence how particular cases are handled; and
- creation of mechanisms to monitor the operation and effectiveness of established rehabilitation procedures with a view to identifying and addressing any weaknesses in them.
- Speedy identification of workers

The Framework Document's assertion that early and timely intervention exerts a crucial influence over rehabilitation outcomes does receive, at the prescriptive level, widespread support in the existing literature. It, nevertheless, needs to be acknowledged that, on the basis of existing knowledge, what constitutes 'early and timely intervention' cannot be defined with any greater precision. In part, this is because much will inevitably depend on the nature and severity of a worker's condition. It also reflects the fact that there exists a marked absence of scientifically based protocols that detail what makes up an effective vocational rehabilitation programme¹. For example, in the case of lower back pain, perhaps the best researched of all conditions, in a recent review of the research evidence on its management, it was argued that workers having difficulty returning to normal occupational duties after four to twelve weeks should be referred to an active, multi-disciplinary, programme comprising of six areas of intervention: education, reassurance and advice, exercise, pain management, work and rehabilitation encompassing symptomatic relief measures. The authors of the report, though, subsequently go on to note that there remains 'wide variation, lack of clear definition and considerable confusion about what constitutes an effective programme' (Faculty of Occupational Medicine, 2000: 27).

Notwithstanding these difficulties, the principle of 'early and timely intervention' does receive some support, at least in relation to workers who are absent from work as a result of their condition (see Habeck *et al*, 1991; Bendix *et al*, 1998; Hildebrandt *et al*, 1997; and Aronoff *et al*, 1987). For example, the Faculty of Occupational Medicine (2000) has noted that there is strong evidence from studies of workers suffering from lower back pain that once a worker is off work for 4-12 weeks, they have a 10-40% risk of still being off work after a year and that if absence extends to between one and two years, it is unlikely that they will return to any form of employment (see e.g Andersson, 1997; Waddell, 1998). It has been suggested that this reduced likelihood of return to work stems from a combination of factors, including physical deconditioning and psychosocial influences associated with time away from the workplace (Lancourt and Kettelhut, 1992).

The above evidence concerning the relationship between length of absence and subsequent return to work is given added weight by the findings of a number of other studies of lower back pain which indicate strongly that most workers are able to continue working or to return to work within a few days or weeks (Burton and Main, 2000; Hadler, 1997). It is further reinforced by research findings which suggest that an approach which emphasises to the sufferers of such pain that they continue ordinary activities as normally as possible is associated with shorter periods of work loss, fewer recurrences and less work loss over the following year (Waddell *et al*, 1997; Hiebert *et al*, 2000). Indeed, against the background of such findings, it has been argued, more generally, that there is a strong case for adopting an approach to rehabilitation that emphasises the paying of 'concurrent' or simultaneous, rather than 'sequential', attention, to its medical, social and vocational aspects (British Society of Rehabilitation Medicine, 2000)².

Further support for the desirability of minimising the time an employee is away from work is, arguably, also provided by several studies that have shown return to work rates to be higher the lower the time that an employee waits for treatment. For example, in a study of 503 vocational rehabilitation clients in Western Australia, which utilised an 'internal control group',

¹ Cox *et al* (2000) have, for example, drawn attention to the paucity of research evidence that exists concerning organisational interventions aimed at reducing work-related stress. See also Highley-Marchington *et al* (1998).

² This emphasis on the multi-disciplinary nature of rehabilitation processes is a common feature of the literature. See, for example, Ford (2000).

comprising injured workers who for one reason or another did not complete a rehabilitation programme, return to work was found to be negatively related to the number of working days that elapsed between their date of injury and date of referral for rehabilitation (Wood and Morrison, 1997. See also Marnetoft *et al*, 2001). In a similar vein, a prospective Dutch study of 143 patients suffering from chronic lower back pain found that 'complete return to work' was negatively associated with pre-treatment time off work (Vendrig, 1999).

More generally, it would seem that many human resource and occupational health specialists do believe that early intervention and the associated need to remain in contact with absent employees in order to identify when rehabilitative support is required, are of considerable importance. For example, in one survey of the return to work policies and practices of 160 employers, respondents were asked to state which elements of rehabilitation programmes were most effective (Industrial Relations Services, 2001a). The two most commonly reported elements mentioned in response to this question were 'early intervention to prevent acute conditions becoming chronic' (71 respondents) and 'maintaining contact with employees while off sick' (37 respondents). A similar picture was found in another survey of employers' efforts to tackle long-term sickness absence through the rehabilitation of workers. Thus, when asked to identify which two out of a list of 17 elements of a rehabilitation programme were the 'most effective in securing a successful rehabilitation', 54% of respondents identified early intervention and 47% maintaining contact with absent employees (Industrial Relations Services, 2002).

The findings of several other studies lend support to the view that on-going contact with absent employees can play an important role in supporting the process of intervention. A case in point is a German study that investigated the re-integration of ill, injured and disabled workers in five car factories, where it was found that the carrying out of absence, as well as return to work, interviews provided a valuable means of identifying both when assistance was needed and the types of support that could be provided (Schmal *et al*, 2000).

3.2.2 Provision of rehabilitative support

The above findings, by suggesting an association between return to work prospects and the length of time away from work, are compatible with the view that prolonged periods of absence away from work while awaiting medical treatment can act to reduce a worker's return to work prospects. They can also be seen to lend support to the argument that employers can potentially facilitate the job retention of ill, injured and disabled workers by providing them with access to speedier treatment where long delays in its provision would otherwise occur.

At the same time, it must be said that there is little firm British evidence to show that the provision by employers of speedier access to treatment can improve the job retention of workers (Pratt *et al*, 1997), although some employers have reported positively on the outcomes of rehabilitation initiatives they have adopted. It has been reported, for example, that a programme involving the provision of worker access to physiotherapy in plants belonging to Rover led to a marked reduction in worker absence (Chartered Society of Physiotherapists, 1999). Furthermore, similarly positive reports have been provided by employers in other countries (see e.g. Hollingworth and MacRae, 1995).

The findings obtained from a number of, primarily international, studies, do, however, appear to indicate the value of workplace adjustments and accommodations in securing returns to work. For example, one study utilised survey data from 1,850 workers who had been assessed for permanent disability assessment by Ontario Worker Compensation Board physicians. The workers in question had returned to work, on either a temporary or permanent basis, following

an absence stemming from a permanent partial impairment. Two of its key findings were that, after taking into account a range of biographical factors, such as age, gender and level of education, as well as the nature of the injuries suffered, those who had received accommodations, such as reduced working hours, and the provision of modified equipment and light work loads, were both significantly more likely to permanently return to work and were significantly less likely to experience further periods of absence stemming from their impairment (Butler *et al*, 1995). Thus, the chance of a successful return to work was found to increase by 35% for those offered modified equipment and the likelihood of returners having subsequent periods absence was reduced by 71% where such equipment was provided.

Several other studies have found similarly supportive evidence. For example, a comparative study which examined the experiences of workers who had been off work for more than three months with lower back pain in six countries found that there was a higher propensity for Dutch workers to return to work with their original employer and that this was, to some degree, related to the fact that they were more likely to receive working hours adaptations, changes to job design/processes and therapeutic work resumption interventions (Cuelenaere *et al*, 1999). More generally, Krause *et al* (1998) reviewed 13 studies which had, between them, examined the impact of a diverse range of 'modified work programs' on the return to work experiences of workers who had suffered either temporary or permanent disabling injuries³. On the basis of their review, the authors concluded that not only do programmes of this type cut the number of work days lost by a half, but that workers offered such programmes are twice as likely to return to work than those who are not. They do, however, go on to note that the robustness of these conclusions would be enhanced if a number of methodological problems surrounding the studies reviewed, such as the absence of control groups, were addressed in future studies.

Some indirect evidence to support the above findings is also provided by a recent British survey on the labour market position of disabled workers, that is those with a current long-term disability or health problem that limited the work that they could do or which had a substantial adverse affect on their day-to-day activities. Thus, this found that over 24% of those with disabilities who had lost their job as a consequence of their condition believed that they could have remained in employment if they had been provided with necessary workplace adaptations (Meager *et al*, 1998).

3.2.3 Co-ordination of the rehabilitation process

At the level of an employer, the co-ordination of the rehabilitation process can be seen to have an internal and external element. Internally, it involves the creation of mechanisms to ensure that adequate communication occurs between all the organisational actors who can play a role in supporting a worker's rehabilitation and that the actions of these actors are mutually supporting. Externally, it extends to encompass the interface between the employing organisation and outside medical and rehabilitation services.

As regards the first of these forms of co-ordination, there is some evidence that points to its value. For example, in the previously mentioned study conducted in five German car factories, a

³ The types of modified work programmes investigated in these studies varied. In addition, some of the studies examined the operation of more than one type of programme. Overall, 11 of the programmes covered the provision of light duties; two encompassed the use of graded work exposure; two concerned the use of work trials; two investigated employer provided accommodations; and one focused on the provision sheltered employment (involving work at a specially designated site designed to provide work as a social service).

central conclusion reached by the authors was that, while line managers played a critical role in the effective operation of the re-integration process, this role was very much facilitated by the use of 'case management' systems under which the position of an employee was kept under review by a committee consisting of an occupational physician, a union representative, a human resource specialist and a senior line manager. In particular, these committees were found to provide a useful means of (a) monitoring what line managers were doing and (b) resolving problems arising from conflicts between employees and their managers, or the refusal of a department to accept the redeployment of a worker from elsewhere in the factory (Schmal *et al*, 2000).

These findings are echoed in an account of the successful impact that return to work programmes, incorporating plant-based rehabilitation counsellors, had within the Boeing Corporation, where this success was attributed to the important role that these counsellors had played in overcoming the random and inadequate way in which injured employees had previously been treated (James and Bruyère, 1995). They also receive further emphasis as a result of the findings obtained from a study conducted in the Australian State of New South Wales of the rehabilitation processes experienced by 49 worker compensation claimants since it was found that those interviewed frequently experienced difficulties and frustrations as a result of 'a breakdown in the communication and information pathways among stakeholders in the occupational rehabilitation process', where these stakeholders include, as well as the rehabilitation co-ordinator and the workers themselves, managerial personnel, treating doctors, rehabilitation providers, insurers and their medical staff, and co-workers (Kenny, 1995a).

In a similar vein, the Faculty of Occupational Medicine (2000: 25), in its evidence review in respect of low back pain, notes that there is moderate evidence that 'communication, co-operation and common agreed goals between the worker with LBP, the occupational health team, supervisors, management and primary care professionals is fundamental for improvement in clinical and occupational health management and outcomes' (See e.g Frank *et al*, 1998; Hunt and Habeck, 1993)⁴. Furthermore, other research findings would seem to offer a degree of indirect support to the view that the provision of specialist advice and support to line managers can aid the rehabilitation process. For example, as will be considered in more detail below in the section on the implementation of policy frameworks, there is evidence which indicates that line managers frequently lack the skills and knowledge needed to address the needs of disabled workers (Floyd, 1995; Bruyère, 1999), often adopt, even within the same organisation, different and inconsistent approaches towards the handling of the issue of rehabilitation (James *et al*, 2002; Labour Research Department, 2002), and sometimes resist following laid down rehabilitation processes (James *et al*, 2002; Industrial Relations Services, 2001a and 2002).

At the same time, however, other research findings suggest that the mere establishment of systems of co-ordination is not in itself sufficient to ensure that intended rehabilitation processes will operate smoothly. Rather, much also depends on the skills and organisational location or status of those accorded co-ordination responsibilities and the manner in which these responsibilities are carried out.

With regard to the first of these issues, the previously mentioned research by Kenny (1995a) concerned with the rehabilitation experiences of 49 worker compensation claimants in New South Wales sheds some useful light on the role played by the rehabilitation co-ordinators that have to, by law, be appointed in all workplaces with 25 or more employees. In broad terms, her findings showed that while these co-ordinators can play a potentially important and valuable role in the rehabilitation process, this role was, in practice, often problematic as a result of two

⁴ The issue of co-ordination between workplace staff and outside medical and rehabilitation personnel is considered in more detail below in the section on employer access to external healthcare and specialist support.

factors. First, a lack of clarity concerning the knowledge and skills that they required. Secondly, the role conflict they experienced when seeking to balance the interests of workers with those of the employer. Indeed, as a result of this latter problem, she suggests that there was a case for introducing a greater degree of independence into the co-ordination role by making provision for it to be provided by staff from an outside agency (see also Kenny, 1995b).

This issue of the potential role conflict that can be experienced by those responsible for co-ordinating rehabilitation activities and the way in which this can impact on their work in supporting ill, injured and disabled workers can, in turn, be linked to the findings obtained from a study in the United States which used survey data from 220 companies to investigate the impact of workplace policies and practices on the prevention and management of disability (Hunt and Habeck, 1993). Thus, although this study found that the 'lost work day case rate' tended to be lower in organisations which had a 'proactive return to work program', a term that was defined to incorporate a number of practices, including 'co-operative involvement across departments in the firm', no such relationship was found for 'Disability Case Monitoring'. In the light of this latter finding, the authors speculate that it might well reflect the fact that such monitoring can be carried out in a supportive or punitive manner and that its impact will vary depending on which of these management styles is adopted – an interpretation which, if correct, suggests that the effectiveness of co-ordination, as well as the maintenance of on-going contact with absent workers, is likely to be influenced by the nature of the surrounding organisational culture and environment.

3.2.4 Worker representation

The issues raised above concerning the implications of management style for return to work can, indirectly, be seen to support the view put forward in the Framework Document that access to representation can aid the job retention of ill, injured and disabled workers by enabling attempts at rehabilitation to take place in an environment of openness and trust. Direct British evidence on this issue is, unfortunately, lacking. It is, nevertheless, worth noting that levels of employee dismissal have been found to be much lower in workplaces where trade unions are recognised, a finding which would seem to suggest that unions do play a more general role in enhancing employment protection - a factor that itself could facilitate the job retention of such workers, not least by enabling sufficient time to be available for rehabilitation activities to take place before employment is terminated (Cully *et al*, 1999). It should also be noted that in a British study on the integration of disabled workers in 40 'best practice', organisations, it was observed that the 'contribution of trade unions was widely regarded as positive' (Watson *et al*, 1997).

As regards non-British evidence concerning the role of worker representation, the most convincing is that provided in the already referred to study of Canadian worker compensation claimants, where it was found that those claimants who did not initially return to work were less likely to be union members (Butler *et al*, 1995). The authors of this study go on to suggest that this finding is likely to reflect the role that unions play in 'protecting worker's time-of-injury-jobs while they recuperate from their injuries'. They, however, do not shed any light on what, if any role, unions played in facilitating more directly the job retention of injured workers by the provision of individual representation in management-worker discussions concerning the accommodation of workers' needs.

3.2.5 Establishment of policy frameworks

The Framework Document suggests that the processes surrounding the return to work and job retention of ill, injured and disabled workers are likely to operate more effectively if clear procedural requirements are laid down and it is made clear who is responsible for ensuring that such requirements are fulfilled. This argument does receive some research support.

Insofar as the job retention of such workers overlaps with the issue of providing equal treatment for those disabilities, it can be viewed as part of the more general agenda of equal opportunities. Research in this latter field, particularly in relation to the avoidance of discrimination on the grounds of gender, does tend to highlight the importance of organisations developing appropriate policy frameworks (Kirton and Greene, 2000). For example, in the 1998 Workplace Employee Relations Survey it was found that the presence of a formal equal opportunities policy was associated with the more common use of a range of 'equal treatment practices', including 'making adjustments to accommodate disabled employees' (Cully *et al*, 1998).

More specifically, in relation to the job retention of ill, injured and disabled workers, the survey results obtained by Hunt and Habeck, in showing a relationship between the existence of a 'planned and co-ordinated effort by the organisation for the return to work of injured workers', and 'lost workdays per 100 employees, can be seen to point to the value of developing formal policy frameworks. The same is true of the study by Schmal *et al* (2000), where it was found that the existence of clear policy frameworks served to support and assist line management action with regard to the re-integration of ill, injured and disabled workers and the survey responses Bruyère obtained from over 760 British organisations that had a disability management or return to work/retention programme. Thus, in this latter study, when asked to indicate the degree to which this programme contributed to various aspects of the implementation of the Disability Discrimination Act, 69% believed it had made a 'great deal' or 'somewhat' of a contribution to raising acceptance of people with disabilities. In addition, 57% and 47% of respondents gave the same responses in respect of the programme's role in raising supervisory awareness of workplace adjustment processes and creating an organisational structure for such adjustments.

The available evidence, at least in respect of Britain, indicates that relevant policy provisions may be contained in a number of separate policy documents concerned with such matters as the management of absence, health and safety at work, equal opportunities in general and the treatment of disabled people in particular. It would also seem that a range of different types of organisational personnel can be responsible for their development and operation (see chapter 4). There is no evidence available to suggest that the use of such multiple-policy frameworks is necessarily problematic. However, there is some which suggests, as the Framework Document argues, that care needs to be taken to ensure that they are mutually supportive and hence do not lay down contradictory requirements or send contradictory messages. For example, the findings obtained from the survey of 1221 trade union safety representatives conducted by the Labour Research Department can be seen to point to an apparent tension in many organisations between the sympathetic and supportive treatment of ill, injured and disabled workers and the requirements of disciplinary policies. Thus, while 13.7% of respondents stated that counselling would be provided where an employee crossed an absence threshold, 15.9% reported that the response would be to hold a meeting under the disciplinary procedure (Labour Research Department, 2002). Furthermore, in relation to this same issue, the authors of one of the already mentioned surveys conducted by Industrial Relations Services, in noting that the issue of rehabilitation is often dealt with under sickness absence procedures that make 'heavy cross-reference' to disciplinary rules, observe that this means that 'rehabilitation becomes unavoidable linked with the staged system of review, warnings and action common in many disciplinary procedures' (Industrial Relations Services, 2001a: 43).

3.2.6 Implementation and monitoring of policy frameworks

In the Framework Document it is argued that the establishment of adequate policy frameworks needs to be supported by systematic action to ensure that they are implemented properly. In particular, the document draws attention to the need for training and other action to be taken to ensure that those who have responsibilities under them are aware of their obligations and the reasons for them, appreciate that their performance in respect of them will be monitored, and are provided with the skills, knowledge and other resources required to fulfil them. It also further argued that there would seem a case for taking steps to ensure that the whole workforce understands and is aware of relevant policy provisions, and the reasons for them, so that work colleagues support any actions taken to ensure the continued employment of those whose jobs may be at risk as a result of illness, injury or disability.

A useful starting point in considering the relevance of the above arguments, given that organisational requirements relating to the treatment of disabled workers are often detailed in broader equal opportunities policies (Goldstone, 2002), is to examine the substantial body of research that exists in respect of the operation of policies of this type. Such an examination does, in fact, add strong weight to the emphasis that the Framework Document puts on the taking of action to support the implementation of policy requirements relating to the rehabilitation of ill, injured and disabled workers. Thus, the available evidence does, indeed, reveal widespread evidence of the poor implementation of policy frameworks and in doing so identifies a range of factors that contribute to this problem. These factors include the continued use of inappropriate and unnecessary job selection criteria, the location of equal opportunities staff to marginal positions in management structures, with the result that their ability to reform traditional organisational practices is correspondingly weakened, competing organisational priorities and line manager and staff resistance to the laid down requirements (Kirton and Greene, 2000).

Much of the existing equal opportunities research, it must be acknowledged, has been focused on policies aimed at ensuring the fair and equal treatment of women and ethnic minorities. Nevertheless, there is evidence available to suggest that the dynamics surrounding organisational policies aimed at providing support to ill, injured and disabled workers incorporate similar implementation barriers. For example, a key conclusion put forward on the basis of the 40 case studies conducted by Watson *et al* (1987) is that while most of the employers involved had formal statements on equal opportunities and disability issues, in practice few seemed to be 'living documents'. Similarly, in the survey of union safety representatives conducted by the Labour Research Department, 24.3% of the respondents who answered a question concerning the implementation of their organisation's policy on absence reported that they were 'often not applied' (Labour Research Department, 2002), while the study conducted by James *et al* (2002) on the management of long-term absence in 30 organisations also revealed that problems frequently existed with regard to the operation of absence management procedures. For example, they found that laid down requirements concerned with the maintenance of contact with absent employees and the exploration of what could be done to assist them back to work were often implemented in a patchy and inconsistent way.

The available evidence suggests that the reasons for such problematic policy implementation echo those identified in the more general equal opportunities literature. For example, in considering the reasons for their findings, James *et al* identified a number of contributory factors. These include, line management unwillingness to handle sickness cases, a lack of relevant skills and procedural knowledge among them, a tendency on the part of some to differentiate between employees in terms of their 'deservingness' and a hesitancy to support the

temporary return of staff who were not fully fit to carry out their existing duties in the face of wider operational pressures. They also encompassed the presence of inadequate co-ordination between line managers and other organisational actors and a lack of budgetary and other resources that could be used by managers to help their staff to return to work.

Several other studies have obtained similar findings. In both of the previously mentioned surveys conducted by Industrial Relations Services (2001a and 2002), for example, one of the most commonly reported barriers to rehabilitation was identified as line management resistance to address the issue. In a similar vein, other studies have reported how line managers often suffer from a lack of requisite knowledge and skills with regard to the making of needed workplace adjustments (Floyd, 1998; and Bruyère, 1999), while the study by Watson *et al* (1997) suggests that the failure of many equal opportunity and disability policies to become real working documents was associated with a lack of 'personal commitment or status on the part of the relevant responsible manager'.

The above findings receive some further support from those obtained by Smith *et al* (1991) as a result of interviews conducted with 34 people with physical and sensory disabilities concerning the training needs of managers and supervisors. These indicated that there was a substantial need for such personnel to be provided with two types of training. First, training which challenged the misconceptions, prejudices and stereotypes held in respect of disabled people. Secondly, training that armed managers and supervisors with the skills and knowledge they need to identify the organisational barriers that confront disabled workers and to deal with the host of practical issues that can arise. Indeed, on the basis of their findings, one of these authors has made the point that although the first of these types of training is needed, on its own it is 'hopelessly inadequate' (Floyd, 1998).

Furthermore, it should be noted that a number of study's have obtained findings which indicate that problems can occur with regard to supporting the return to work and continued employment of workers as a result of negative views on the part of co-workers. For example, in Bruyère's study, the second most commonly reported barrier to the employment and advancement of people with disabilities reported among British respondents was the attitudes or stereotypes held by co-workers and supervisors. Meanwhile, in Kenny's study of the rehabilitation experiences of 49 worker compensation claimants, 56% of those interviewed reported that the attitudes of co-workers were positive and supportive, 30% considered them to be 'neutral' and 15% felt them to be negative. Where negative attitudes were reported, these were seen to mainly reflect concerns on the part of co-workers about either the implications that the support provided to the injured workers would have for their jobs or unhappiness at the perceived 'favourable' treatment involved in it (Kenny, 1995a).

In summary, then, the current evidence available does indicate that careful thought needs to be given to how best to ensure the effective implementation of any policies developed to support the return to work and job retention of ill, injured and disabled workers. In doing so, it also suggests that relevant issues to be considered in this regard include the paying of attention to the creation of senior management commitment, the generation of adequate awareness of the policy and its importance, and the provision, to those with implementation responsibilities, of access to adequate training, financial resources and appropriate avenues of specialist advice and support.

3.2.7 Policy monitoring and review

The above evidence would, in turn, seem, as suggested in the Framework Document, to support the view that the adequate implementation of return to work/job retention policies cannot be assumed. Rather, there is a need to put in place appropriate mechanisms to both monitor compliance with policy requirements and identify any difficulties surrounding their operation that need to be addressed, including weaknesses in the requirements themselves. At the same

time, no real evidence exists as to how these processes of monitoring and review are best conducted. As a result, it is not possible to say anything about the relative value of the various methods of monitoring and review that are identified in the Framework Document. The findings detailed below do, however, indicate that there is a need to ensure that the monitoring processes established extend to the keeping under review of any workplace adjustments made to accommodate the needs of ill, injured and disabled workers.

In a Swedish study, 261 people with visual impairments, 195 of whom had originally returned to work after the onset of their condition, were interviewed in order to explore the factors that increased the chances of an individual being reattached to the work process by means of 'real' and worthwhile job tasks that were subjectively viewed as meaningful (Jeppsson-Grassman, 1989). The results of the interviews, which were conducted four to six years after the onset of visual impairment, revealed that some 38 of those who had returned to work had subsequently left work again and that an important factor underlying this job loss was the fact that the adjusted jobs were frequently found to be less satisfying and challenging than those that had previously been carried out.

The results of the above study therefore highlight that although workers may initially return to work, with the help of workplace adjustments, they may still not be successfully re-integrated into the workplace in the longer-term if their re-designed jobs are considered to be demeaning or otherwise unsatisfying. In doing so, they also highlight the point that the adequacy of re-designed jobs, and other aspects of the surrounding employment environment, should be kept under review. This last point, moreover, receives further and more general, emphasis from the finding obtained in the study referred to above by Butler *et al* (1995) that no fewer than 40% of the workers who had initially returned to work, following injuries incurred between 1974 and 1987, were subsequently not employed in 1990 because of the effects of their injuries, with this being significantly more likely in the case of workers who had not been provided with workplace accommodations and among those with lower levels of education and more physically demanding jobs. It should also be noted that, in a subsequent analysis, it was found that this problem of subsequent job loss was most marked in the case of workers suffering from back pain (Johnson *et al*, 1998)

3.3 INTERNAL FACILITATORS AND BARRIERS TO REHABILITATION

Five groups of potentially important internal influences on the rehabilitation activities of employers are listed in the Framework Document. These are:

- Organisational commitment and culture;
- Organisational awareness, resources and expertise;
- Work tasks and processes;
- Attitudes of workers and co-workers; and
- Nature of worker representation.

3.3.1 Organisational commitment and culture

The Framework Document postulates that senior management commitment will exert an important influence over both the types of policy frameworks that exist to facilitate the return to work of ill, injured and disabled workers and the way in which they operate. The available evidence lends some support to this proposition.

A case in point is a North American survey undertaken by Shoemaker *et al* (1992). In this study, the authors set out to examine the extent to which the presence of return to work policies among 248 manufacturing companies employing 250 or more employees in Michigan varied in relation to three sets of explanatory variables: corporate culture; corporate structure; and corporate executives' beliefs. The findings obtained revealed that the presence of policies of this type was positively related to a senior management perception that 'early return to work promotes safety' and negatively related to their belief that (a) 'early return to work raises costs and lowers productivity' and (b) that such a return to work 'involves occupational difficulties' because of the problems associated with accommodating the returnees' working requirements. In addition, the presence of such policies was further found to be positively associated with the corporate culture variables of 'valuing employees' and the 'personnel principle of retaining and retraining workers'.

The findings of a number of other studies also appear to highlight the importance of senior management attitudes, beliefs and values, as well as the surrounding organisational culture. This appears true, for example, of the finding of Butler *et al* (1995) that, among their sample of Canadian worker compensation claimants, return rates were significantly higher among public sector workers - a relationship which the authors suggest reflects the stronger job guarantees that characterise public sector employment. It also true of Watson *et al's* observation reported earlier concerning the links between senior management commitment and the impact of formal statements developed in respect of equal opportunities and disability issues (Watson *et al*, 1997), as well as the findings obtained by Hunt and Habeck (1993) from their survey 220 companies in the United States. Thus, in this latter study the authors found a strong and positive relationship to exist between the adoption of proactive return to work programmes and the presence of a 'people orientated culture', that is a culture which embodied positive work relationships and employee morale, attention to interpersonal skills and open communication, regular and meaningful involvement of employees in company operations and decisions, and the sharing and seeking of information.

The Shoemaker *et al* (1992) study does also lend some support for the argument advanced in the Framework Document that senior management commitment to rehabilitation processes and activities is likely to be associated with the perceived costs and benefits associated with them. Furthermore, the findings obtained from the previously mentioned Industrial Relations Services surveys of employer return to work and rehabilitation policies do appear to confirm that cost considerations can act as a driver in encouraging organisations to accord greater importance to such issues. For example, more than 80% of the 160 organisations that responded to one of these surveys stated that rehabilitation at work had moved up the agenda over the previous two years (Industrial Relations Services, 2001a). Of these, 95 reported that this had occurred because of a 'Growing concern over the number of long-term absences', 45 reported that it reflected a 'Growing concern over the number of ill health retirements' and 22% indicated that it stemmed from a 'Growing concern at rising employers' liability insurance claims and premiums'.

That said, there is little evidence that sheds light on another proposition advanced in the Framework Document, namely that senior management commitment to rehabilitation will be higher where an attempt has been made to calculate the costs that are incurred as a result of a failure to adequately support and rehabilitate ill, injured and disabled workers. Indeed, more generally, and notwithstanding the findings reported in the previous paragraph, it must be noted that there is a need for caution in too readily jumping to conclusions about either the balance between the costs and benefits associated with employer-based rehabilitation activities or the extent to which such activities are systematically informed by an economic rationality. For example, in a recent study commissioned by the then Department for Education and Employment of a number government-led employment services for disabled persons, both in

this country and overseas, the authors note that a small number of projects within the New Deal for Disabled Persons Personal Adviser Scheme have aspired to encourage disability management schemes within employing organisations, particularly local authorities. They go on to observe in relation to these that ‘...although there was an awareness among managers of the compensation costs and staff costs of sickness absence, this was not a catalyst for intervention’ (Corden and Thornton, 2002: 67). Indeed, the authors further note that the expenses of re-training, inflexible attitudes to adjustments and a lack of belief in disabled people’s capacity to be re-employed ‘contributed to some resistance to facilitating the return to work of employees on long-term sick leave and hampered early intervention’.

3.3.2 Organisational awareness, resources and expertise

Earlier in this chapter it was noted that line managers frequently fail to adequately implement organisational procedures intended to aid the return to work and job retention of those whose work attendance and performance are adversely affected by ill health, injury or disability. It was further observed that this failure, in part, appeared to stem from a lack of awareness of the relevant procedural requirements and a shortage of required skills and resources, including budgetary ones and specialist advice. Such findings would consequently seem to indicate, as suggested in the Framework Document, that rehabilitation processes are facilitated by ensuring that line managers are able to make, or initiate, required expenditures, are adequately trained in their rehabilitation responsibilities and have access to, and guidance on, sources of specialist support.

Other research evidence also suggests that the provision of more general workforce training aimed at engendering awareness of the organisation’s approach to the treatment of ill, injured and disabled workers and the reasons for it, can pay dividends. For example, on the basis of the interviews conducted with disabled workers in their 40 case study organisations, Watson *et al* (1997) observe that those who had received tangible workplace adjustments commented particularly favourably on their experiences where they had been given ‘consideration as individuals’ and further note that one way in which this consideration was seen as being manifested was via the provision of ‘awareness training for colleagues’. Further, but less direct, support for such training would seem to be given by the previously mentioned findings of Bruyère (1999) relating to the extent to which attitudes or stereotypes among supervisors and co-workers acted as a barrier to the employment and advancement of people with disabilities and the earlier reported findings of Kenny (1995a) concerning the experiences of 49 worker compensation claimants in New South Wales with regard to the attitudes of their co-workers.

There is, furthermore, some evidence to support the argument that workplace rehabilitation activities are influenced by the specialist expertise available within organisations. For example, in a recent survey of management absence policy and practice conducted on behalf of the Chartered Institute of Personnel and Development, the 1,684 human resource respondents were asked to identify what constituted the most effective aspect to their approach towards the management of long-term absence (Chartered Institute of Personnel and Development, 2002). Strikingly, 68% made reference to the involvement of occupational health professionals and 45.8% to stress counselling/Employee Assistance Programmes.

This apparent endorsement of the role of occupational health specialists is echoed in the findings of James *et al* (2002) in their study of how long-term absence was managed in 30 organisations, where it was found that where occupational health services existed, management interviewees invariably indicated that they played a valuable role through such activities as the provision of advice on possible return-to-work mechanisms, liaising with General Practitioners and carrying out medicals. It also receives support from the previously mentioned survey of the

rehabilitation policies and activities of 171 organisations and a recent study of the role of General Practitioners in sickness certification. For example, in the former it was found that the presence of an in-house occupational health provision 'increased the chances of rehabilitation being on an organisation's agenda' and that occupational health respondents were much more likely than human resource ones to consider 'early intervention to prevent acute conditions becoming chronic' to be one of the two elements that are most likely to be effective in securing rehabilitation (Industrial Relations Services, 2002). Meanwhile, in the latter, the researchers found that General Practitioners thought that 'there was an important role to be played by employer-based occupational health specialists' in helping to manage return to work (Hiscock and Ritchie, 2001: 70). This belief was, in turn, found to reflect two main considerations. First, the ability of such specialists to provide advice in an area where General Practitioners felt their knowledge to be weak. Secondly, the role that they could play in reducing the sense of 'risk taking' that practitioners could feel when advising a patient to return to work.

3.3.3 Work tasks and processes

A number of British studies have revealed a willingness on the part of many British employers to make adjustments to accommodate the needs of disabled workers (e.g. Bruyère, 1999; Meager *et al*, 1998; Watson *et al*, 1998; Goldstone, 2002)) and also noted that such adjustments are generally considered to cost little. At the same time, it does not follow from this that the adjustments needed by workers are always provided or that the adjustments made are appropriate or provided in a sufficiently speedily and unproblematic fashion. Indeed, a number of the research findings already mentioned in this chapter would seem to demonstrate a need for caution concerning the extent, quality and smoothness of the adjustment process. These include the findings of Butler *et al* (1995) which indicate the frequent failure of first return-to-work, those of Meager *et al* (1998) on the extent to which those who had to leave their jobs as a result of a disability felt that they could have continued working if necessary adjustments had been made and the conclusions of James *et al* (2002) with regard to the budgetary and other problems that, at the level of line management, can adversely affect the making of adjustments.

In the Framework Document it was argued, against this background, that a number of factors relating to the nature of work tasks and processes, and the grading and payment systems surrounding them, could act to either limit or facilitate the rehabilitative support provided to workers. More specifically, the Document suggested that the availability and provision of workplace adjustments could be influenced by a number of specific features of these processes and systems. Those mentioned were team bonus schemes, grade-related pay differentials, the level and duration of sick pay entitlements, the 'tightness' of existing staffing levels and the intensity of work demands. The research evidence available to shed light on these postulated influences was found, for the most part, to be rather limited. Nevertheless, the findings obtained from several studies do tend to indicate that several of them can act to create difficulties.

In one study of relevance, Kenny (1999) obtained survey data from 614 New South Wales employers on their experiences of providing 'suitable duties' to worker compensation claimants. At a general level, the responses received showed that 20.4% of respondents found the provision of such duties to be 'very difficult', 31.1% to be 'difficult', and 32.8% to be 'neither difficult or easy', with the remaining 16.1% considering them to be 'easy' or 'very easy'. In addition, while 59.3% of those responding stated that they were able to provide suitable duties in either all or most cases, 8.4% reported that they could never provide such duties and a further 32.2% stated that they could only do so in some cases. At the more specific level, when those who replied that it was either very difficult or difficult to provide suitable duties were asked to provide reasons as to why this was, the most common explanations provided were: the nature of the work is not suitable (88.2%); suitable duties disrupt the workplace and are not productive

(34.3%); doctors' certificates do not specify what an employee can do (34%); and the organisation is too small (29.7%).

How far these findings are applicable to other national contexts is inevitably a matter of speculation. However, the earlier mentioned study of five German car factories found that considerable difficulties were often experienced in accommodating workers' needs (Schmal *et al.*, 2000). In a similar vein, one North American study found evidence to suggest that, at least within manufacturing, the growth in 'lean production' methods in recent years may have acted to reduce the ability or willingness of employers to provide workplace accommodations (Thomason *et al.*, 1998)⁵.

As regards the situation in Britain, the findings of a recent government survey of British employers, which explored their experiences of and attitudes towards making adjustments in respect of the most recent employee who had become sick or disabled, sheds some light on this issue. Thus, the responses obtained from the 286 relevant employers revealed that just over one in three (38%) had taken steps to allow the person to continue working. Of the remainder, nearly two-thirds (64%) reported that they would have been prepared to do so if this would have helped retain the employee and the rest stated that they had not attempted to make any adjustments and were not willing (or able) to make them (Goldstone, 2002).

No attempt was made in the above study to directly explore why respondents who had indicated a willingness to make adjustments, had not gone on to make them. However, the researchers did find that the respondents in question were particularly likely to envisage problems with making the required adjustments. Thus, while only one in four (41%) thought that the adjustments would have been easy, a similar proportion (44%) considered that they would have been difficult. In contrast, in the case of those respondents who had made adjustments that had led to the successful retention of an employee, 65% reported the former view and just 16% the latter. It is, however, a matter of speculation as to how far these differences in responses reflected variations in the nature of work processes and tasks, as opposed to the impact of other factors, such as employer attitudes, or the nature of a workers' condition.

3.3.4 Attitudes of workers and co-workers

The Framework Document suggested that the attitudes of workers towards 'recovery' would exert an important influence over the impact of rehabilitation processes and further postulated that these attitudes may well be influenced by a range of other factors. A number of possible such factors were identified, including the degree of job satisfaction experienced, the quality of the relationship that exists with the employer, the level of sick pay entitlements available, the nature of family circumstances and support, the balance that subsists between work income and social security benefits and the perceived availability of early retirement and other employment-related benefits.

In general, a good deal of research evidence points to the role that the individual characteristics of workers, the jobs they do and their positions in organisational hierarchies can play in influencing the rehabilitation process (see e.g. British Society of Rehabilitation Medicine, 2000; Faculty of Occupational Medicine, 2000; Ford, 2000). Indeed, a range of psychosocial factors are widely seen to exert a critical influence over rehabilitation outcomes.

⁵ It should be noted that several studies have also found that the perceived past performance of disabled employees, as well as the nature of the relationships they have with their line managers, exert an important influence over how they are treated (see Florey and Harrison, 2000).

Several studies of worker compensation beneficiaries in North America have found significant and negative statistical relationships between propensity to return to work and worker age and education levels (Tate, 1992; Butler *et al*, 1995; Straaton *et al*, 1995) and Tate further found in her study a similar relationship between salary levels and job seniority. In much the same vein, in the Australian study conducted by Wood and Morrison (1997), an inverse relationship was found between age and completion of a rehabilitation programme and in another Australian study of worker compensation claimants, older workers and those on lower rates of pay were found to have longer periods away from work (Kenny, 1994).

A number of other studies have also found negative statistical relationship between age and rehabilitation outcomes (see e.g Renzulli *et al*, 1988; Verbeek, 2001). In addition, some have found that women are less likely to undergo successful rehabilitation than men (Selander *et al*, 1999; Schmidt *et al*, 1995)⁶. It should, however, be noted that not all studies have found such gender differences (Butler *et al*, 1995), while some have, in fact, found the opposite relationship with female gender (Straaton *et al*, 1995).

The causal dynamics associated with such statistical associations as those detailed above are, for the most part, a matter of speculation. Possible interpretations of them have, however been put forward. For example, Butler *et al*, in common with other authors (Fenn, 1981; Butler and Worrall, 1991) have argued that the negative relationship discovered between age and return to work reflects the fact that ageing reduces the capacity of workers to recover from injury and increases workers' access to retirement benefits. These authors have also identified three explanations of the linkage they identified between education levels and return to work outcomes. First, that physical impairment is less likely to limit the job performance of better-educated workers because their jobs are not as physically demanding. Secondly, better educated workers have more control over the manner in which they perform their jobs, allowing them to compensate for physical limitations by changing the manner in which they do their usual work. Thirdly, the higher transaction costs of replacing better educated workers provides employers with a greater incentive to provide workplace accommodations: an argument which, insofar as it suggests that employers may well differentiate between employees on the basis of their perceived 'value', receives some support from other studies (see e.g James *et al*, 2002).

A British longitudinal study of invalidity benefits, it should be noted, adds weight to the above findings relating to the association between age and return to work in that it found that recipients aged 50 and over with the 'lowest [incapacity] severity scores' were less likely than those aged under 50 with the highest severity scores to be attached to the labour market: a finding that they attribute to a combination of attitudinal and labour market factors (Erens and Ghate, 1993). In addition, in relation to the above relationships discovered between return to work and educational and job grading levels, it appears likely that this may, in part be explicable in terms of differences in job satisfaction, given that this factor has itself been found to be linked to a number of job characteristics, such as skill variety and autonomy (Smulders and Nijhuis, 1999). Certainly, in a prospective study of return to work patterns among 328 Dutch workers, who had at its commencement had three to four months absence as a result of lower back pain, van der Giezen *et al* (2000) found that those who had returned to work one year after their first sick day reported significantly higher levels of job satisfaction than those who had not returned. It should, however, be noted that such an association with job satisfaction, and by

⁶ It has been argued, in the case of Sweden, that the poorer rehabilitation outcomes of women are associated with a discriminatory tendency to provide them with only on-the-job training, rather than 'educational' rehabilitation. In contrast, a recent Dutch study concluded that it was linked to the fact that women are less often 'bread winners', with the result that they have a lower economic incentive to return to work. See Ahlgren and Hammerstrom (1999); van der Giezen (2000) and Marnetoft *et al* (2001).

implication motivation, has not been found in some other studies (Lancourt and Kettelhut, 1992).

To confuse the issue further, it may be that the studies which have found a statistical relationship between return to work and such variables as age, gender and education may have done so because of the lack of attention paid to other important intervening psychosocial variables – factors that are often referred to in the medical world as ‘yellow’ and ‘blue’ flags (Faculty of Occupational Medicine, 2002). For example, in another North American study Ash and Goldstein (1995) investigated the predictors of return to work among 114 subjects who were receiving workers’ compensation benefits and vocational rehabilitation. The potential predictors explored encompassed measures of emotional and cognitive functioning and physical injury severity, as well as a range of demographic and financial variables, including age and gender, previous wage and levels of worker compensation payments. The findings obtained revealed that return to work was most closely associated with the scores clients obtained on the Beck Depression Inventory, in that those who were identified as being moderately or severely depressed were substantially less likely to have returned to work. In contrast, none of the other variables were found to constitute ‘significant variable predictors’. The authors do, however, draw attention to a number of limitations surrounding their study. Furthermore, it should be noted that studies that have used other measures of psychiatric health have generated rather mixed findings with regard to their relationship to return to work (see eg Mulcahy *et al*, 1988; Gatchel *et al*, 1995; Lancourt and Kettelhut, 1992; Vendrig, 1999).

Other studies have also pointed to the fact that a number of other psychosocial factors, including economic considerations, the attitudes of co-workers (see above), fears and beliefs about the nature and work implications of health conditions and the degree and nature of family support, can impact on the propensity of workers to return to work. In an experimental study, Symonds *et al* (1995) found that the circulation of a pamphlet which sought to overcome fear avoidance among those suffering from lower back pain led to a reduction in the proportion of related ‘extended’ absence spells and the days lost through such absence. Similarly, in another study, involving 52 patients suffering from non-specific lower back pain, researchers sought to determine the association between responses to three questions – ‘I am afraid to start working again, because I don’t think I will be able to manage’, ‘My closest relatives feel that I am too ill even to think about returning to work’, and my ‘closest relatives worry that my condition will deteriorate if I start working’ – and the outcome of a vocational rehabilitation programme (Sandstrom and Esbjornsson, 1986). The findings obtained revealed a close relationship between positive responses to each of these questions, particularly the first, and subsequent programme outcomes. Furthermore, it should be noted, in relation to the latter two questions, that other studies have obtained evidence which suggests that, in the case of workers who have suffered cardiac problems, their return to work can be facilitated or hindered by the extent to which the family provides positive encouragement to recommence work activities (De Velasco, 1986; Dafoe and Cupper, 1995).

As regards some of the other factors identified in the Framework Document as being likely to influence the attitudes of workers towards returning to work, reference has already been made earlier in the chapter to the potential role of co-worker attitudes, and Hunt and Habeck’s findings concerning the association between return to work and a ‘people orientated culture’, a relationship that would seem to point to the significance of the nature of the relationships that exist with employers (Hunt and Habeck, 1993). In addition, a number of studies have obtained evidence to suggest that economic factors can act to influence the motivation of workers to return to work. For example, van der Giezen *et al* (2000), in their study of a sample of sick listed workers suffering from lower back pain, found that returns to work were higher among those who were a ‘bread winner’, while North American studies have found return to work to be lower for those for whom worker compensation benefits constitute a relatively high proportion

of previous wages (Butler *et al*, 1995; Hyatt, 1996). It must, nevertheless, be borne in mind that, because North American worker compensation systems, although funded by employers, are concerned with the provision of longer-term benefits, such findings do not shed any direct light on how shorter-term sick pay arrangements impact on return to work behaviour. In fact, the authors were unable to identify any study that had empirically explored this issue. As a result, while recognising that in Britain sick pay arrangements are likely to be more generous in larger organisations and that, perhaps coincidentally, absence rates appear to be higher in such organisations (Confederation of British Industry, 2001), they caution against too readily assuming any clear relationship between sick pay provision and return to work behaviour. Indeed, it may be that return to work rates are, ultimately, better where relatively long periods of sick pay entitlements exist because of the greater time that workers are provided with to both receive any required medical treatment and recover⁷.

3.3.5 Nature of worker representation

In an earlier section it was noted that there is some British evidence to suggest that trade union recognition is associated with lower rates of worker dismissal in general and attention was drawn to the findings from a sample of Canadian worker compensation beneficiaries which indicated that trade union members had higher rates of return to work than their non-union counterparts (Butler *et al*, 1995). Against the background of these findings, it was therefore suggested tentatively that there would seem some grounds for believing that access to worker representation can act to facilitate the job retention of ill, injured and disabled workers. However, it was also observed that the above findings do not shed light on whether, as argued in the Framework Document, that such representation serves to ensure that discussions over rehabilitation took place in an environment of openness and trust. Indeed, it would seem that they could equally be seen to reflect the ability of unions to protect workers' jobs through more adversarial means.

It is therefore unsurprising that there similarly appears to be an absence of direct evidence to support the further argument advanced in the Framework Document that the impact of worker representation on the rehabilitation process would be stronger where the representation concerned provided workers with a meaningful 'voice'. There is, however, some evidence that, arguably, lends a degree of indirect support to this notion. The evidence in question comes from an analysis which sought to explain variations in rates of workplace dismissal and disciplinary action calculated on the basis of data from the 1990 workplace industrial relations survey. Thus, the results of this analysis showed that while variations in these rates were not significantly associated with whether or not trade unions were involved in dismissal and disciplinary proceedings, they did vary inversely with levels of union membership density – a variable that is often utilised as a proxy measure of 'trade union power' (Edwards, 1995).

3.4 EXTERNAL FACILITATORS AND BARRIERS TO REHABILITATION

Four sets of external factors are identified in the Framework Document as being likely to influence employer rehabilitation policies and actions and their impact. These are:

- Availability of external guidance, support and incentives;
- Surrounding legal frameworks;

⁷ This view, it should be noted, receives some support from the discussion provided later in the chapter that explores how the rehabilitation policies and practices of employers may be influenced by surrounding legal frameworks.

- Employer access to external health care and specialist expertise; and
- Resources available to workers

3.4.1 Availability of external guidance, support and incentives

Employers can be provided with such incentives, guidance and support from a number of sources. These sources include the grants and advisory support currently provided under the auspices of the government's Employment Service. They also include the information and advice that is available from charitable bodies, such as the Royal National Institute for the Blind (1999), which has published a series of advisory booklets on the subject of return to work, employers associations and other employer organisations, notably the Employers' Forum on Disability.

Some evidence is available on the use made of these various channels of assistance. In Bruyère's survey, information was sought on the resources that were used to handle disputes over Disability Discrimination Act issues and views as to the helpfulness of these sources of assistance (Bruyère, 1999). The results obtained showed that the then Employment Service's PACTS were the fourth most commonly used resource, the three others being legal advisors, safety staff and occupational health staff, and were reported to have been used by 47% of respondents. As regards, respondent views as to which resources were 'helpful' or 'very helpful', the three last sources of assistance were again mentioned in the top five, along with 'corporate HR' and the Employers' Forum on Disability, the last of these being mentioned as helpful or very helpful by 75% of those responding. In considering these results, however, it should be borne in mind that most of the organisations participating in the survey employed 500 or more people.

A number of other studies also indicate that employers do make use of a number of outside sources of guidance, advice and support. For example, in a survey which examined arrangements relating to the management of disability in 208 organisations, 45% of those responding reported having used the government's Access to Work scheme. Meanwhile, the more qualitative study by Cunningham and James (1998), which examined how 24 employers had responded to the Disability Discrimination Act, found that 58% had used advice from the Employers' Forum of Disability and Government agencies to inform the development of their disability policies, 45% had obtained such advice from both voluntary agencies and professional bodies and 35% had done so from external consultants.

The fact that employers do make use of such sources of external advice, support and guidance suggests, albeit by implication, that they may well serve a useful function in terms of influencing the disability-related policies and practices of employers. The same is true of other findings from Bruyère's study which indicated that 67% of UK respondents felt that the provision of grants to employers was 'effective' or 'very effective' in reducing barriers to the employment of persons with disabilities and that around two-thirds of them believed that the provision of short-term external assistance was of similar value.

On the other hand, these studies do not shed any direct light on how far employer rehabilitation policies and actions are hindered by a lack of awareness, or difficulties in easily accessing, external avenues of help. The findings from more representative surveys of employers do, however, suggest that many employers may well be unaware of the sources of external guidance and advice that are available. For example, in a recent large-scale survey of a representative sample of employers it was found that only 35% of respondents were aware of the government's

New Deal for Disabled People (NDDP) and just 23% were aware of the Access to Work (AtW) scheme (Goldstone, 2002).

It is also worth noting in this regard that another finding from Bruyère's survey, that 55% of UK respondents desired more information on the making of adjustments for those with mental health disabilities, suggests that, in some areas at least, there may well be a need to improve the present situation. In addition and more generally, in a recent survey that obtained responses from 618 employers, it was found that, when asked 'Do you know how to get rehabilitation support for an injured employee?', 363 of the respondents replied negatively and a further 99 indicated that they were 'unsure' (Wright and Marsden, 2002). Moreover, while a larger proportion of 'large' organisations did respond positively to this question, it was still the case that the majority of responses obtained fell into either the 'no' or 'unsure' category.

Interestingly, findings from this last study also sheds some further rather tentative and speculative light on whether financial incentives would act to encourage employers to pay more attention to the issue of rehabilitation. In the survey respondents were asked whether, if Employers' Liability insurance costs 'increased a lot', they would seek to 'improve the rehabilitation of injured/ill employees'. The responses obtained showed that 350 of the 599 respondents replying to this question felt that they would, with the remainder either replying in the negative (60) or reporting that they were unsure (178).

3.4.2 Surrounding legal frameworks

The legal framework for unfair dismissal, as a result of the way in which case law has evolved, effectively requires employers to go through certain processes in order to ensure that any dismissal carried out on the grounds that an employee is incapable of fulfilling their work duties because of ill health is held to be fair. In particular, employers are expected to consult with employees over their situation, obtain relevant medical information and consider whether it is possible to make an alternative job available. One consequence of these requirements it is likely that most employers make provision for these processes to be carried out under their disciplinary and absence management policies. It would therefore seem that unfair dismissal law provides an example of how legal regulation can be used to influence employer policies and actions relating to the investigation of employee health problems and possible ways in which these can be accommodated.

The evidence available on employer responses to the advent of the Disability Discrimination Act 1996 adds some weight to this last point. Thus, the findings of a number of studies show that the Act's provisions have prompted many employers to adjust their current policies relating to the treatment of disabled people. For example, a survey covering 218 organisations found that 31% of the organisations possessing a written policy on the employment of disabled people reported that they had made changes to their policies as a result of the Act and a further 17% stated that they were in the process of making such changes (Industrial Relations Service, 1997). In a similar vein, the earlier mentioned survey by Bruyère (1999) found that 33% of her British respondents had made changes to their absence management policies as a direct result of the DDA, with a further 21% indicating that the Act had prompted revisions to existing ill health/sick pay policies. In addition, a study based on face-to-face interviews in 24 organisations, found a similar picture with regard to the revision or introduction of written disability policies (Cunningham and James, 1998) and it would seem that the period since the advent of the DDA has seen a significant increase in the proportion of employers that have policies relating to the employment of disabled people (Goldstone, 2002).

More generally, it is noticeable that the legal systems in place in a number of other countries appear to reflect a belief that a crucial support to the rehabilitation and job retention of ill, injured and disabled workers resides in the provision of a substantial degree of legal job protection⁸. For example, in the Netherlands employers cannot, without approval, dismiss an incapacitated worker for 12 months (Cuelenaere and Prins, 1998) and in Germany severely disabled employees can only be dismissed with official approval from a public welfare authority (Albrecht and Braun, 1998).

Little evidence was found with regard to how far such job security provisions do, in practice, act to support the job retention of ill, injured and disabled workers. However, experience in the Australian State of South Australia suggests that they can have some impact. Here, under the relevant worker compensation legislation, employers are required to give the authority responsible for administering the worker compensation scheme 28 days notice of any proposed dismissal of a worker suffering a compensable disability and provision is made for financial penalties to be imposed if it is considered that it was reasonably practicable to provide the employee in question with 'suitable duties'. According to Purse (2000), during the period from April 1992 to March 1994, of the 845 dismissal proposals submitted by employers in pursuance of these requirements, 277 (32.8%) were subsequently 'avoided or rescinded'.

At the same time, it needs to be recognised that concerns have been voiced in British concerning whether the beneficial consequences of legal requirements relating to the job protection, non-discriminatory treatment and accommodation of ill, injured and disabled workers are tempered by contradictory pressures stemming from by the current system of personal injury litigation (Association of British Insurers, 1998; Althoff and Andruss, 1999; Association of British Insurers, 2002). In addition, similar worries have been expressed that employer concerns about the potential legal liabilities which may arise under health and safety law may act in some cases to make employers hesitant to continue to employ workers with physical and/or mental impairments. There is, in fact, some evidence available that sheds light on this issue.

As regards the case of personal injury litigation, Cornes *et al* (1986), in a study of the claims files of 209 employer liability claimants who were seeking damages of £5,000 or more, explored the question of whether the adversarial nature of such litigation acted to discourage return to work. On the basis of their findings, which indicated that half of the claimants had returned to work before the settlement of their claims and that most of the remainder had either unsuccessfully attempted to return or had been made redundant and subsequently engaged in active job search, they observed that litigation of this type 'may be a less formidable barrier to return to work than has sometimes been supposed' (Cornes *et al*, 1986: 126). However, they also went on to suggest that the legal system might 'inhibit some claimants either from returning to work or attempting to do so at the earliest opportunity'.

Turning to the issue of employer concerns about their liability under health and safety, it does seem that such concerns can play a role in influencing decisions about retaining ill, injured or disabled workers (Dench *et al*, 1996; Bruyère, 1999; Meager *et al*, 1999)⁹. This can be demonstrated by the findings of a recent study conducted on behalf of the Health and Safety Executive and the Disability Rights Commission (Hurstfield *et al*, 2003). In this, survey data was collected from 501 employers with up to 250 employees, 153 employers with 250 or more staff, 68 occupational health practitioners, 84 health and safety practitioners and 581 union safety representatives. In addition, this data was supplemented by interviews with 16 disabled people, 17 employer case studies and an examination of the extent to which health and safety

⁸ This belief can be seen to receive some support from the argument advanced by Butler *et al* (1995) that return rates among public sector workers are higher because of the job guarantees associated with such employment.

⁹ For a more general discussion of this issue see McGeer and Fidderman (2000).

issues featured in cases brought under the Disability Discrimination Act over the period from December 1996 to March 2002. Overall, the study's findings indicated that health and safety issues do impact on employer actions, although, for a number of methodological reasons, it is not possible on the basis of them to specify with any precision the scale of this impact. For example, it was found that 10% of small employers and one-third of large ones had dismissed on health and safety grounds. Furthermore, some evidence was obtained to suggest that some such dismissals had occurred because of 'false excuses' in that they did not arise from objectively valid health and safety concerns. Indeed, it was found that in nearly 30% of the Disability Discrimination Act cases investigated where employers had defended their actions on health and safety grounds, this defence was subsequently rejected by a tribunal

3.4.3 Employer access to external health care and specialist expertise

The issue of how delays in worker access to medical investigation and treatment can create problems for employers with regard to securing their return to work of workers has already been discussed earlier in the chapter. There is, moreover, some evidence to suggest that such delays are far from uncommon and that they are, in turn, often compounded by a lack of effective and adequate communications with outside health professionals.

The two Industrial Relations Services surveys already mentioned, for example, both found that the limited capacity of the National Health Service to provide rapid or fast access to services was commonly seen by employers to constitute an important barrier to rehabilitation (Industrial Relations Services, 2001a and 2002). These findings, furthermore, can be seen to receive some support from the fact that in their study of the role of General Practitioners in sickness certification Hiscock and Ritchie (2001) make reference to the frustrations experienced by such practitioners as a result of the length of National Health Service waiting lists for physiotherapy and counselling services.

As regards the lack of effective and adequate communications between employers and outside health professionals, this is, perhaps, most graphically illustrated by a study which examined 602 medical reports prepared by 400 consultants in respect of a representative sample of 203 employer's liability and third party motor claimants (Aitken and Bochel, 1990). Thus, this found that the advice provided with regard to 'employment handicap' largely consisted of unhelpful pointers to requirements for light work and the specification of work restrictions in a very general way, such as "no lifting" or "no standing". In addition, the study found not one example of a report in which a patient's requirements for technical aids to employment, job design or other workplace accommodations were given consideration.

Other studies, both in Britain and the Netherlands, have further highlighted problems in relation to the frequency of communication that occurs between General Practitioners and occupational physicians (Buijs, 1999; Parker, 1996) and between such practitioners and workplace personnel more generally. For example, the already mentioned study of General Practitioners conducted by Hiscock and Ritchie (2001) found that only in exceptional cases did some make contact with employers to discuss return to work issues, and that others were reluctant to get involved with employers. This reluctance was seen to stem from a number of factors, including a lack of time, a belief that it was not their responsibility and concerns arising from the need to maintain patient confidentiality. Against this background, a common desire was found among practitioners for the provision of greater help, for example, via the provision of a rehabilitation service, with regard to both assessing incapacity and assisting patients to optimise their employment or rehabilitation potential.

Interestingly, not dissimilar sets of findings were obtained from a recent Dutch study of the occupational physicians involved with 300 patients suffering from lower back pain. Thus, this

found that in only 19% of cases had there been communication between them and treating physicians, although in a further 5% it was reported that such communication was planned in the immediate future. Furthermore, when the occupational physicians were asked about the factors that were inhibiting a return to work, 25% made reference to the 'views of the treating physician' (Anema *et al*, 2002).

The findings of the recent study of trade union safety representatives conducted by the Labour Research Department (2002) also paint a rather similar picture to that detailed above with regard to both the degree of co-ordination and contact that exists between external health care staff and employers and the lack of access to speedy medical treatment (Labour Research Department, 2002). With regard to the survey findings obtained from 1221 representatives, for example, it was found that five percent felt that there was 'very close' and nine percent 'quite close' co-operation between NHS staff (other than General Practitioners) and the workplace, while 21% considered that 'quite close' co-operation existed with General Practitioners. In addition, 39.1% reported that employees had suffered delays in returning to work as a result of waiting for NHS appointments or treatment. As regards the case study findings, several of the employers studied highlighted difficulties in respect of their dealings with General Practitioners, as well as other external medical staff. These difficulties included, as well as references to treatment delays resulting from waiting lists, concerns about how such practitioners handle musculoskeletal and mental health issues, doubts about their abilities to assess prospects for a return to work and a belief that non-medical staff experienced problems when approaching them.

3.4.4 Resource available to workers

The Framework Document identified a number of resource issues that could impact on the willingness and ability of workers to return to work. Those identified encompassed the implications of transport, and related planning policies for travel to work opportunities, the relationships that exist with General Practitioners, the location and availability of re-training and educational facilities, and the various sources of income available to workers while they are absent from work. In general, there is some evidence that sheds light on each of these potential influences on return to work decision-making.

As regards the availability of transport, one of the previously mentioned surveys conducted by Industrial Relations Services does indirectly suggest that it could play a role in some cases, as do the findings obtained from Erens and Ghate's longitudinal survey of new invalidity benefit recipients. Thus, the first of these studies found that when the 171 survey respondents were asked to identify which of a range of activities were provided for in their rehabilitation programmes, 27% identified 'help to travel to work' (Industrial Relations Services, 2002). Meanwhile, the findings of the second led the authors to observe that many recipients were limited in their job search by their health problems and to further note that the difficulty mentioned most often had to do with their ability to travel to work, with about half saying that their health limited the distance that they would be able to travel and two-thirds stating that it was important to find a job close to home (Erens and Ghate, 1993).

Several other studies have also obtained findings that suggest more directly that access to public transport can have important implications for return to work. For example, a recent review of post-employment support and advancement programmes in OECD countries noted that 'it is only in the United States that many States, counties and voluntary organisations have recognised the importance of transportation for low-income workers and the difficulties they face accessing it either because of its cost and/or its availability' (Kellard *et al*, 2002:35). Similarly, a recent evaluation of the New Deal for Disabled Personal Adviser Scheme, in discussing the continued

barriers that clients faced in obtaining work, reports that 'some clients were unwilling to travel far to work for a number of reasons including the cost and availability of public transport (Loumidis *et al*, 2001: 76). Meanwhile, the recent study of attitudes towards and experiences of disability, found that 12% of working survey respondents faced difficulties in travelling to work and that a number of participants with whom in-depth interviews were conducted reported that work was difficult to access, particularly in rural areas, because of a lack of reliable, local public transport (Grewal *et al*, 2002).

Turning to the potential significance of the worker-General Practitioner relationships, the discussion provided earlier with regard to the role that 'fear' can play in shaping attitudes to return to work would seem to indicate that the nature of the discussions that take place with such practitioners can play a potentially significant role in terms of alleviating concerns regarding ability to work and the implications of work for future health. In addition, the potential role of such discussions is further highlighted by the fact that in one survey it was found that amongst those disabled people who perceived a need for workplace adjustments and sought relevant advice, a quarter approached a doctor (Meager *et al*, 1999).

Little direct evidence, unfortunately, exists on this issue. However, it does seem that the topic of return to work is often not discussed with General Practitioners. For example, the above mentioned longitudinal survey of new invalidity benefit recipients found that two-thirds of those who had not been assessed as being unable to return to work or were not planning to so return, reported that no discussions had taken place with their practitioner about the possibility of rehabilitation or training to help them return to work (Erens and Ghate, 1993). This finding, moreover, is echoed in the results of the study of the sickness certification role of General Practitioners insofar as this found that such practitioners varied widely in terms of how far they considered the issue of return to work as falling within their area of responsibility and the degree to which they adopted a proactive approach to the issue (Hiscock and Ritchie, 2001).

Another issue which also merits mention in relation to the role of General Practitioners and other doctors in supporting the return to work of ill, injured and disabled workers. This is the fact that there is some evidence to suggest that they play a relatively small role in co-ordinating the provision of non-medical support, with the result that the degree of co-ordination that exists between this part of the health care system and other avenues of worker support would seem to be poor. For example, the already mentioned evaluation of the New Deal for Disabled Persons Personal Adviser pilot scheme concluded that 'GPs seldom made referrals to agencies outside the health care field', despite the fact that they could have a key role in referring patients to job retention services (Loumidis, 2001). In a similar vein, in their study of 209 employer liability claimants Cornes *et al* (1985) found that in only ten cases was any referral made to vocational rehabilitation services.

These findings take on additional significance when considered alongside two other sets of research findings. First, the finding in the Loumidis (2001) study of the New Deal for Disabled Persons Personal Adviser Scheme that most of the scheme's clients interviewed felt that it had made a positive impact on their overall move to work as a result of a number of factors, including increased self-esteem, the identification of a future career path, raised confidence and access to a training course and financial support. Secondly, the fact that a North American study of the return to work experiences of 17 coronary heart disease patients found that around 80% of them were unable to identify the education, training, conditioning or accommodations they would need to work safely and productively – a finding that the authors argue points to the

useful role that can be played by vocational rehabilitation specialists that are skilled in job analysis, ergonomics and job site accommodations (Shrey and Mital, 2000)¹⁰.

Finally, in relation to the role played by the external sources of income which are available to workers while absent from work, there is some evidence that sheds light on this issue. However, it is far from conclusive. For example, in the United States a number of studies have identified a relationship between return to work rates and social security beneficiary status (Straatton *et al*, 1995). However, it has been argued that this relationship in large part reflects the healthcare entitlements that are provided under the social security system rather than the cash benefits provided under it. In addition, it has been further argued that one reason for the poorer return to work of beneficiary recipients is the fact that they tend to be older and to have more severe conditions (Habeck *et al*, 1997; Yelin, 1996).

A similar lack of clarity is apparent in the available British evidence. For example, in a longitudinal survey of invalidity benefit recipients, a 'lack of an obvious relationship between benefit/earnings ratio and attachment to the labour market' was found (Erens and Ghate, 1993:121). Indeed, the authors of this study go on to conclude that:

'.....there was no evidence to suggest that levels of benefits had much influence on recipients' attitudes towards returning to work. If anything, the attached were more likely than the others to have high benefit/earnings ratios (although within the attached group, those who were successful in returning to work were a bit more likely than those not working to have lower ratios' (Erens and Ghate, 1993)

On the other hand, this conclusion also needs to be considered alongside the findings of two other recent studies. First, the survey mentioned above concerned with the attitudes towards and experiences of disabled persons. Secondly, an examination of the impact of changes made to the Incapacity Benefit scheme aimed at assisting workers to re-enter or remain in employment. Thus, in the first of these it was found, on the basis of the in-depth interviews conducted with both those in and out of work, that 'financial considerations were paramount for some of those interviewed' and further observed that these considerations encompassed concerns about the loss of benefit entitlements if work was started against a background of uncertainty about whether it could be sustained (Grewal *et al*, 2002: 150). Meanwhile, in the second, it was noted that the clients interviewed emphasised the importance of maintaining income security and adequacy and, in this context, expressed concerns about such matters as the risk of losing benefits altogether, a possible risky transition in moving off incapacity benefits onto earnings, an inability to sustain paid work and worries about being able to afford work (Corden and Sainsbury, 2001).

Overall, therefore, it would seem that, on the basis of British findings, there is little evidence to suggest a clear and firm relationship between return to work rates and the proportionate relationship that exists between social security payments and work earnings. At the same time, there is some suggestion that concerns about the security of future work income and related fears about the loss of social security benefits can potentially influence return to work decision-making processes and hence decisions as to whether to return to work.

10 In connection with this point, it should be noted that the Loumidis (2001) study also found an often low level of joint working between the Personal Adviser Scheme and other welfare services, such as health, social services and social security, and that this hindered a joined up approach to helping individuals towards employment.

3.5 CONCLUSION

This chapter has sought to review the evidence available to support (a) the various propositions put forward in the authors' Framework Document with regard to the employer processes and practices that contribute to the development and operation of effective workplace rehabilitation programmes and (b) the relevance of the various internal and external factors that are identified in it as potentially exerting an important influence over the nature and operation of organisational rehabilitation activities.

As regards the propositions advanced in relation to employer processes and practices, the evidence presented would, at the general level, seem to lend some support to them. For example, it does point to the value of having in place arrangements to enable the speedy identification of vulnerable workers who are in need of help, indicates that the provision of timely and appropriate rehabilitative support can support the job retention of ill, injured and disabled workers and suggests that the provision of such support is facilitated by the presence of adequate mechanisms for the co-ordination of discussions and actions between relevant organisational actors and between them and outside medical and rehabilitation personnel. In addition, the evidence suggests that access to worker representation, at least if it is trade union based, can have a beneficial impact and that it is desirable for appropriate and mutually supporting policy frameworks to be established and for the implementation of these to be adequately supported and monitored.

Overall, the evidence reviewed also supports the relevance of the various internal factors that the Framework Document identifies as potentially influencing the nature and operation of employer rehabilitative activities. For example, it would seem likely that senior management commitment and a supportive organisational culture do act to facilitate the establishment of return to work policies and practices and that, linked to this, the operation of these policies and practices is influenced by such factors as the attitudes of line managers and co-workers and the skills and knowledge of such managers, as well as their access to relevant specialist support. It also appears that the perceived scope for and ease of, workplace adjustments can be influenced by the nature of work tasks and processes, although little can be said concerning the postulated influences on such adjustments of pay and grading systems and the tightness of prevailing staffing levels. Furthermore, substantial evidence was found to show that a range of psychosocial factors, including age and educational levels, the nature of family support, worker fears and views concerning their prospects to both recover and re-commence work, and levels of job satisfaction, can influence the likelihood of workers returning to work.

As regards the various external influences identified, the evidence enables little to be firmly said about how the rehabilitative activities are influenced positively or negatively by the presence of external guidance, support and incentives. However, the fact that such guidance and support is utilised by many employers and that there seems some enthusiasm for the use of financial incentives, suggests that the roles of these sources of influence should not be discounted. In contrast, evidence was found to show how the actions of employers could be influenced by surrounding legal frameworks and the important way in which return to work activities can be hindered by long NHS treatment waiting lists and also, potentially, through the absence of adequate channels of communication and co-ordination between workplace personnel and outside medical staff and other specialists. Similarly, some evidence was identified to support the view that a lack of worker access to public transport and external guidance and support, as well as fears about future income security, can create return to work difficulties.

It must, nevertheless, be acknowledged that this broad support for the Framework Document comes from a research base that is problematic, both in terms of scope and quality, and whose

support for the Framework Document is therefore often rather tentative, speculative and indirect. In particular, three specific weaknesses in this base should be noted. First, it contains relatively few studies which have sought to explore the links between job retention and vocational rehabilitation at the level of the employing organisation and hence within the context of on-going employment relationships. Secondly, insofar as such studies have been conducted, they have often embodied an emphasis on the analysis of quantitative survey data and a corresponding lack of focus on the in-depth exploration of the organisational dynamics that surround the management of workplace rehabilitation processes. Thirdly, in some areas of interest, it has been found necessary to place heavy reliance on the findings of studies conducted in other countries, notably North America, Australia and Scandinavia, whose applicability to the British context is therefore inevitably open to question given the differing nature of their legal, healthcare and social security systems.

4. CURRENT EMPLOYER APPROACHES TO WORKPLACE REHABILITATION: HOW FAR DO THEY ACCORD WITH THE FRAMEWORK DOCUMENT?

4.1 INTRODUCTION

The purpose of this chapter is to use existing research evidence to explore how far British employers have in place the types of processes and practices that are identified in the Framework Document as central to the establishment of effective workplace rehabilitation programmes. In order to achieve this objective it has been necessary to draw out, in the context of the presently available research base, a number of indicators that can be used to provide a relatively meaningful assessment of the use made of these processes and practices. The indicators so identified and the elements of the Framework Document which they are intended to shed light on, are detailed below, along with some brief explanation of the rationale for their use.

Table 1: Assessment of employer practice in relation to the framework document

Framework Elements	Indicators of employer practice	Rationales for practice indicators
Establishment of policy frameworks.	Use made of formal disciplinary, absence, disability and return to work/rehabilitation policies.	Evidence suggests that all these types of policy framework contain provisions relevant to the handling of workplace rehabilitation.
Speedy identification of vulnerable workers	Use of performance appraisal and regular health checks. Collection and use of absence data and the provision made for the holding of return to work interviews and the maintenance of contact with absence employees	All these processes potentially provide employers with information on the need of employees for rehabilitative support
Provision of rehabilitative support	Degree to which employers provide employees with access to rehabilitative 'treatment' via private medical/health insurance, 'in-house' occupational health services and the payment of <i>ad hoc</i> to private treatment. Extent to which workplace adjustments are made to accommodate worker needs	Measures of the rehabilitative support currently made available by employers
Access to worker representation	Presence of worker representatives in the workplace. Right of workers to be accompanied in disciplinary	Indication of the extent to which such access to representation

	proceedings by a colleague or representative.	potentially exists
Co-ordination of the rehabilitative process	Line management access to sources of internal specialist advice and guidance from human resource and occupational health professionals	Potential that exists for 'informed' co-ordination of worker rehabilitation and the development of a comprehensive case management approach to the issue
Implementation of policy frameworks and the monitoring and review of their operation	Degree to which training is provided to line managers and staff on policy objectives and requirements. Extent to which the operation of these requirements is monitored.	Measure of how far organisations are taking action to ensure the effective implementation and operation of laid down policy requirements

In what follows, the evidence relating to each of these sets of performance indicators are considered, in turn, under the heading of the elements of the Framework Document to which they relate. It should be noted that, given the purpose of the chapter, namely to review British employer practice at the aggregate level, the evidence considered is, in the main restricted to the results of survey data¹. In addition, it should be further noted that attention is primarily focussed on the most comprehensive, reliable and up-to-date data available.

4.2 ESTABLISHMENT OF POLICY FRAMEWORKS

As was noted in the previous chapters and indicated in the above table, the rehabilitation processes and activities of employers can be carried out under the auspices of a number of different and potentially overlapping, types of policy frameworks. In particular, they may be addressed in disciplinary procedures, absence management policies and policies concerned with either the general treatment of disabled people or the issues of job retention and rehabilitation. Consequently, in this section the evidence available on the extent to which employers do make use of these different types of policy framework is reviewed.

Data from the 1998 Workplace Employee Relations Survey provides information on the extent to which employers possess formal disciplinary procedures. This shows that 92% of workplaces with 25 or more employees had such procedures and that this was also the case for 70% of single-site businesses employing between 10-24 people and 96% of workplaces of this size that belonged to a larger organisation (Cully *et al*, 1999: 78 and 263). However, the data provides no

¹ This focus on quantitative survey data should not be taken to imply that the authors do not recognise the undoubted virtues of qualitative research. Rather, as indicated, it merely reflects the overall aim of the evidence review, namely to provide an aggregate overview of the extent to which British employers currently utilise the types of processes and practices detailed in the Framework Document

detailed information on the contents of these procedures. Nevertheless, given, as noted in the previous chapter, that unfair dismissal law requires employers to explore the medical position of employees who are incapable of carrying out their present duties and to pay attention to the possibility of re-deploying them to other jobs, it seems likely that many procedures will contain provisions of this type.

It further seems that in many workplaces and organisations formal disciplinary procedures exist alongside written ones relating to the management of absence which potentially contain more detailed provisions on the job retention of those with health problems. For example, the survey on employee absence conducted by the Chartered Institute of Personnel and Development (CIPD) found that, of the 1,684 responding organisations, three-quarters had written absence management policies and that their occurrence tended to be higher in larger organisations (Chartered Institute of Personnel and Development, 2002). In addition, a smaller survey of the sickness absence policies and practices of 182 employers found that many of these laid down 'separate procedures for the management of short- and long-term absences' (Industrial Relations Services, 1998: 13).

On the basis of these findings, it would therefore seem that a relatively large proportion of British workplaces do possess disciplinary and, possibly, absence management procedures that lay down some formal procedural requirements relating to the handling of work problems stemming from ill health. It also seems that these will frequently include provisions that require consideration to be paid to the redeployment of staff who are unable to carry out their existing work duties, either completely or partially. At the same time, it should be borne in mind that such provisions are essentially reactive in nature in that they apply to situations in which job performance/attendance has already been adversely affected. In addition, it needs to be noted that a recent survey of the return-to-work policies and procedures of 160 employers found rehabilitation to be almost a 'throwaway line' in some absence policies and therefore paid only 'lip service to the issue (Industrial Relations Services, 2001: 15).

Consequently, an arguably more rigorous test of how far British employers have formal and detailed policy requirements relating to the job retention and rehabilitation of workers is to consider the proportion that possess more general and specific policies concerning the employment of disabled workers and/or the job retention/rehabilitation of ill, injured and disabled workers². As regards the first of these types of policies, two recent studies have obtained relevant data. The first, by Goldstone (2002), involved the carrying out of 2008 workplace level telephone interviews with employers that employed 10 or more people. The results obtained indicated that 43% of organisations had either had a written policy covering the employment of disabled people or had an informal one that was formally monitored. They further showed that these policy arrangements often contained requirements on such matters as the provision of training and development, sickness and absence management and the making of workplace adjustments.

2 *The relevance of formal disability policies is highlighted by the fact that 'disability' for the purposes of the Disability Discrimination Act is defined as a physical or mental impairment that has a substantial adverse effect on day-to-day living and which has lasted, or is likely to last, 12 months.*

3 *It may also be that such formal and more specific policies may be applied in a relatively restricted way. Thus, Stuart et al (2002) found, when conducting their 50 follow-up case studies, that most of the employers did not know how many disabled people they employed and that 13 of them who, in the earlier telephone survey, had said they employed none did, in fact, employ at least one such person. The reason for this discrepancy was found to be that many of the employers applied the term 'disability' only to employees with a physical disability or those with an 'obvious' visual or hearing impairment and therefore did not extend it to incorporate other long-term conditions.*

The second recent study, which was also conducted on behalf of the Department of Work and Pensions, was conducted by Stuart *et al* (2002) and involved the use of survey data collected in 1998 to examine, on the basis of responses obtained from single-site organisations and the head offices of multi-site ones, how employers and service providers were responding to the requirements of the Disability Discrimination Act 1996. The results obtained showed that just 6% of employers had formal policies on the employment of disabled people, a finding that would appear to reflect the inclusion in the analysis of small, single-site organisations. In addition, during the course of 50 follow-up case studies, the authors found that most of these formal policies formed part of a more general equal opportunities one (Stuart *et al*, 2002)³.

On the basis of the above analysis it would therefore seem that disciplinary and absence policies provide the most common frameworks within which the rehabilitation of workers is handled and that in only a minority of workplaces (and organisations) is the issue likely to be addressed by more comprehensive and proactive policy arrangements. This view, furthermore, receives some support from a less statistically representative survey of 1,221 trade union safety representatives (Labour Research Department, 2002). Thus, in this, it was found that 26.4% of respondents, who answered a question concerning the policy framework that was used to encourage rehabilitation in their organisations, mentioned sickness/absence policies. In contrast, only 14.9% stated that it would be encouraged through more specific policies relating to such matters as health and safety (9.6%), equal opportunities (5.1%), disability (2.8%) and rehabilitation (1.5%)⁴. Interestingly, the responses obtained also seem to suggest that the issue of rehabilitation generally had a relatively low profile in the organisations concerned since not only did 48% of respondents not answer the relevant question, but, of those who did, 17% reported that it was handled via 'informal practice'.

4.3 SPEEDY IDENTIFICATION OF VULNERABLE WORKERS

Reasonable survey data exists to shed light on current employer practice in respect of four sets of activities that can potentially contribute to the speedy identification of vulnerable workers. These are the use made of general health checks, the carrying out of performance appraisals, the collection and analysis of absence data and the provision made for the holding of return to work interviews and the maintenance of contact with absent workers.

4.3.1 General health checks

The most reliable, comprehensive and up-to-date information on this issue is provided by a recent study of employer occupational health support conducted, on behalf of the Health and Safety Executive, by Pilkington *et al* (2000) via a survey of 4,950 organisations in the private and public sectors. The results of this indicated that 2,157 (43%) of the surveyed organisations, and 15% of all United Kingdom organisations, provided 'broad' occupational health support, in the sense that they were found to be engaging in (a) hazard identification, (b) risk management and (c) the provision of information. It further found that of the 3,329 (67%) organisations that engaged in at least one of these activities, 726 (22%) provided 'Well-person health checks (i.e. full medical health screening)'. However, it needs to be borne in mind that these last figures are not weighted to reflect the overall sectoral composition and size of United Kingdom employers.

⁴ In a similar vein, the above survey conducted by Industrial Relations Services found that in most cases the formal requirements relating to the issue were contained in sickness absence procedures and that only 10% of the organisations surveyed had standalone rehabilitation policies (Industrial Relations Services, 2001).

As a result, they are highly likely to considerably overstate the proportion of employing organisations that provide such checks across the economy as a whole. Indeed, it seems likely, as a rough estimate, that they are only used in something like five percent of all organisations.

The focus of the above survey on the collection of ‘organisation level’ data, however, runs the risk of providing a misleading picture of the coverage of such rehabilitative support at the workplace level because of the way in which arrangements in workplaces belonging to large multi-site organisations may be influenced by those adopted centrally by the parent organisation⁵. As a result, ideally its findings need to be supplemented by data collected at the workplace level.

Unfortunately, the only large-scale survey which sheds some reasonably comparable light is that conducted by Bunt (1993), again on behalf of the Health and Safety Executive, in 1992. This obtained information from three main sources, Firstly, face-to-face interviews with a sample of 912 employees conducted as part of an omnibus survey, the results of which were weighted to be representative of all employees. Secondly, survey responses from 820 private sector employers obtained mainly by telephone interview, the results of which were also weighted to make them more generally representative of employing establishments. Thirdly, telephone interviews conducted with representatives from 100 public sector organisations, the results of which were similarly weighted to be representative of all public sector employees.

In the course of the interviews with employers, the study asked about the presence of various categories of occupational health professionals (see further below). Overall, the responses obtained suggested that one or more of these types of health professionals existed in eight percent of private sector workplaces and that in 42% of these the professionals concerned were involved in the provision of ‘medicals’. As regards the situation in the public sector, the study further suggests that 93% of employees were covered by occupational health professionals and that the vast majority of them were working in organisations where these professionals carried out medicals. These last findings, however, need to be treated with considerable caution since it is far from clear whether the medicals concerned were carried out on an *ad hoc* or systematic basis and if the latter was the case, whether they were made available to all staff.

4.3.2 Appraisals

Performance appraisals provide employees and their managers with an opportunity to discuss current job performance and any problems surrounding this and to also identify potential actions that can be taken to overcome these problems. Such appraisals therefore provide a potentially useful means by which health problems that are creating work difficulties can be raised and discussed, although the extent to which they are used in this way is not known.

Detailed survey evidence on the use of performance appraisals in British workplaces is available via the 1998 Workplace Employee Relations Survey (Cully *et al*, 1999). This suggests that formal performance appraisals are conducted in 79% of workplaces with 25 or more employees, although in around a quarter of these they are not held for all non-managerial employees. It also suggests that, in the case of workplaces employing between 10 and 24 people, they are used (for at least 60% of non-managerial staff) in 32% of those that constitute a single-site business and 66% of those that are part of a wider organisation.

5 This parent organisation influence presumably explains, at least in part, the rather different findings obtained by Stuart *et al* (2002) and Goldstone (2002) on employer use of formal policies on the employment of disabled people.

4.3.3 Collection and use of absence data

The most comprehensive evidence available on the extent to which employers collect absence data and the ways in which they use it is provided by the Confederation of British Industry's (CBI's) annual absence survey and the already mentioned study conducted on behalf of the CIPD (2002). However, care needs to be taken in interpreting these findings since, in the case of both surveys, the responding organisations cannot be viewed as constituting a representative sample of British employers and it is likely, given the size distribution of the employers involved, that their results are likely to provide an overly favourable picture of current employer practice.

The CIPD survey found that nearly a fifth (18%) of the organisations surveyed did not have any data on their current level of sickness absence, while in the CBI study it emerged that 26% of the 461 responding employers did not keep records of the causes of absence and the specific types of illness involved. In broad terms, both surveys therefore found that a large majority of the responding organisations did collect absence data. This picture, moreover, accords with the findings of the Labour Research Department's survey of union safety representatives, where it was found that nine out of 10 workplaces apparently monitored absence (Labour Research Department, 2002).

As regards the way in which absence data is analysed by employers, no large-scale survey evidence is available. However, the CBI survey found that 66% of organisations did give absence statistics relating to manual employees to line managers and 81.9% did so in respect of non-manual ones. It further revealed that absence records were often taken into account in redundancy situations. Somewhat similarly, 82% of the CIPD survey respondents stated that sickness absence information was given to line managers⁶. While neither of the surveys go on to provide information on the frequency with which this information was supplied, or the nature of that given, the findings of one smaller scale survey of 182 organisations, suggests that it is most usually given on a monthly basis (Industrial Relations Services, 1998).

On the basis of a rather smaller survey of 300, primarily larger, employers, it would also seem that many organisations also lay down 'triggers' to initiate absence investigations. Thus, this survey found the absence policies of 73% of organisations to incorporate such triggers. In 51% of cases these triggers related to the number of spells of absence, in 45% to the number of days of absence per year and in 37% to the number of consecutive days of absence (James *et al*, 2000).

Less is known about employer policies and practices regarding the point at which an absent employee is referred to an occupational health service or 'company' doctor. It, nevertheless, seems likely that practice in this area varies markedly. For example, interviews with human resource staff in 30 organisations found the trigger point for referral to be eight weeks in a local authority, four weeks in a manufacturing company and a call centre and two weeks in another manufacturer (James *et al*, 2000). Similarly, an Audit Commission study of sickness management in ten local authorities found that the point at which those on long-term sick leave were referred to an occupational health unit varied from five weeks to six months (Audit Commission, 1990), while an examination of absence management in 12 National Health Service Trust noted that the way in which long-term absence is defined is important as it acts to trigger the institution of

6 In the Labour Research Department survey of safety representatives it was reported by 40.2% of respondents that sickness absence statistics are made available to employees or their representatives (Labour Research Department, 2002).

action and went on to report that the definitions used in the Trusts varied from four weeks to three months (National Health Service, Undated).

4.3.4 Maintenance of contact/return to work interviews

How and to what extent, employers maintain contact with absent employees is an issue that has been little explored. However, some relatively small-scale surveys and case studies, involving for the most part larger organisations, do provide some insights into the issue (Incomes Data Services; 1998; Industrial Relations Services, 1998 and 2000; Bevan and Hayday, 1998; Buchanan and Seccombe, 1995; James *et al*, 2002). In general, these sources indicate that employees are expected to contact their employer to report their absence as soon as possible and certainly by the end of the first day/shift. They further suggest that many formal absence policies make clear that regular contact should be maintained with an employee while they are absent – although little detailed information exists on either the nature of this contact or the degree to which it is, in practice, maintained.

As regards the extent to which employers require return to work interviews to be conducted with an employee once an absence has finished, some information on this is provided by the CPD and CBI absence surveys. In the case of the former, 80% of respondents reported using return to work interviews, with 57% stating that such interviews were required to be conducted after all absences and 23% after a long-term spell away from the workplace. As regards the CBI findings, these show that interviews of this type were utilised by 63.9% of organisations in respect of manual workers and by 76.7% with regard to non-manual employees.

4.4 PROVISION OF REHABILITATION

The earlier discussion of the use made of formal policy frameworks suggested that a substantial number of organisations do make some formal provision for the rehabilitation of workers and that some others may well pay attention to the issue informally. At the same time, the picture painted suggested that, at the formal level, the issue of rehabilitation may well not be addressed in a very detailed way, a situation which suggests that it has a relatively low profile. This view, moreover, appears to receive some support from the fact that only 24% of the trade union safety representatives in the recent survey conducted by the Labour Research Department (2002) indicated that their employer would 'definitely' actively encourage rehabilitation.

In order to explore the above picture in more detail, attention is paid in this section to two issues. First, the extent to which employers make some provision for workers to access rehabilitative 'treatment'. Secondly, how far they appear to seek to accommodate the needs of ill, injured and disabled workers through the making of workplace adjustments.

4.4.1 Treatment

Employers can provide employees with access to rehabilitative treatment in a number of ways. These include the provision of private medical insurance, the taking out of permanent health insurance with providers who offer some rehabilitation services, the use of internal or external occupational health and counselling services and the payment on an *ad hoc* basis of access to surgery or specialist advice. The evidence available, however, suggests that limited use is made of all of these means of treatment access.

The most comprehensive and up-to-date information on the above issues is provided by the previously mentioned 'organisational level' study conducted by Pilkington *et al* (2000). The results of this indicate that 1,189 (27%) of the 4,930 organisations surveyed provided employee counselling and that 1,759 (35%) had rehabilitation programmes, although it seems likely that these simply referred to workplace adjustments such as modified duties or reduced working hours. In addition, of the 3,329 companies that were found to engage in formal risk management, the measuring of workplace hazards or the training of staff on health-related issues, 752 (22%) had a private health care scheme/insurance. Once again, however, as noted above in relation to this survey's findings on the provision of general health checks, it must be borne in mind that the unweighted nature of these statistics means that they are likely to considerably overstate the proportion of employers in the economy as a whole that have these types of arrangements in place.

As regards the situation at the workplace level, little comparable data is available. However, the 1998 Workplace Employee Relations Survey found, for a representative sample of establishments with 25 or more employees, that 61% of private sector workplaces (and 46% of all establishments, including those based in the public sector) had private health insurance for managers and 22% (and 16% overall) had such insurance for employees in their 'largest occupational group' (Cully *et al*, 1999: 74). In addition, in her study Bunt (1993) found that of the eight percent of private sector workplaces that had occupational health professionals present, in four percent of them such professionals get involved in treating ill health and injuries. She also found that, depending on the sector, between nil and three percent of private sector establishments provided stress counselling and that such counselling was available to between nil and 11% of employees.

It should, nevertheless, be noted that the findings of less representative surveys of employers do tend to provide a rather more favourable picture than those detailed above. For example, the CIPD absence survey found that 11% of the 1,684 responding organisations provided rehabilitation services, 24% had 'rehabilitation programmes', and 35% made available stress counselling/employee assistance programmes (IPD, 2000). In a similar vein, in the CBI absence survey, 66.3% of the 454 respondents reported, in respect of non-manual employees, that workplace counselling was available, 68.9% made reference to occupational health provision, 60.1% to the provision of private medical insurance and 45.8% to the making of payments to cover *ad hoc* medical treatment (CBI, 2001).

4.4.2 Workplace adjustments

The findings of the survey by Pilkington *et al* (2000), as noted above, suggested that fewer than eight percent of British employers have a rehabilitation programme addressing such issues as changes to working hours or job tasks. However, once again, because of the company level focus of this survey, account also needs to be taken of corresponding workplace-based data.

The most comprehensive and recent such data is that provided in the earlier mentioned study by Goldstone (2002). In this, it will be recalled that of the employers with 10 or more employees surveyed, 43% had either a formal policy on the employment of disabled people or formally monitored the operation of an informal one. It further found that around two-thirds of these organisations made provision for the adapting of working hours and working patterns and for the provision of equipment and personal support, and that 66% of all respondents with sick/disabled employees reported that they had made adjustments to accommodate existing employees, a figure that rose to 78% after prompting. However, it was also found, in common with the Pilkington *et al* study, that adjustments were more likely to have been made in larger

workplaces⁷. Sectoral differences in the types of adjustments made were also found. For example, it is noted, that the 'trade sector' was more likely to provide flexible working patterns and special leave, while those who became disabled were seldom offered training or 'partnering' in the manufacturing sector.

Goldstone's study therefore suggests a rather more favourable picture than that of Pilkington *et al* concerning the extent to which employees are covered by formal policy provisions relating to the provision of adjustments to ill, injured and disabled workers. In addition, the findings of Goldstone that were reported in the previous chapter about the extent to which adjustments had been made and been successful in respect of the most recent employee who had become ill or disabled need to be borne in mind. Thus, the responses obtained from the 286 relevant employers revealed that just over one in three (38%) had taken steps to allow the person to continue working. Of the remainder, nearly two-thirds (64%) reported that they would have been prepared to do so if this would have helped retain the employee and the rest stated that they had not attempted to make any adjustments and were not willing (or able) to make them (Goldstone, 2002).

4.5 WORKER REPRESENTATION

It seems reasonable to assume, given the nature of the current legal framework for unfair dismissal and the provisions of sections 10-15 of the Employment Relations Act 1999, that where the issue of rehabilitation arises in the context of disciplinary proceedings, provision will generally be provided for workers to be accompanied, if not represented by a colleague or representative. In fact, this is borne out by the findings of the 1998 Workplace Employee Relations Survey which show that this right to be accompanied existed in 94% of workplaces with 25 or more employees.

There is, however, a marked absence of comprehensive survey data concerning how far workers do, in fact, choose to exercise their rights in this respect. There is also, more generally, a lack of reliable survey data that sheds light on the extent to which workers do draw on the support of colleagues or representatives in any discussions over rehabilitative needs that they have with their employer. However, the 1998 Workplace Employee Relations Survey does provide information on the potential access that workers have to worker representatives. This indicates that in 60% of workplaces with 25 or more employees no such representatives were present and in the remaining 40% the representation that existed comprised of non-union representatives in 7% of cases, union representatives in 28% and a combination of union and non-union representatives in 4% (Cully *et al*, 1999: 96). It further shows that in workplaces with between 10 and 24 employees, some form of worker representation existed in just 9% of them (Cully *et al*, 1999: 267).

More generally, relatively little information is also available on the extent to which worker representatives play a role in workplace rehabilitation processes and activities and what impact they have on their nature and operation. However, it is perhaps worth noting that the survey of union safety representatives conducted by the Labour Research Department (2002) found that unions were jointly involved with management in reviewing information about sickness absence

⁷ Findings from the company-level by Stuart *et al* (2002) also found such a relationship with size with regard to the responses they obtained to a question asking about the adjustments and changes that had been made in relation to current or past disabled workers.

in 27.1% of workplaces and that where such involvement existed, it appeared more likely that an employee with a work-affecting health problem would discuss it with either management or the union.

4.6 CO-ORDINATION

Insofar as formal procedures exist that lay down requirements relating to the treatment of ill, injured and disabled employees, it would seem reasonable to assume that they contain within them provisions that provide for the involvement of all relevant internal organisational actors. However, as the previous chapter highlighted, there is also ample British evidence to suggest that the achievement of this co-ordination is often problematic.

Unfortunately, there is no reliable survey data that can be used to provide a more aggregate and representative picture of how far rehabilitative actions are, in fact, effectively co-ordinated, although one survey of absence management in 300, primarily larger, organisations did find that 62% of respondents agreed to some extent that there was adequate 'co-ordination between relevant functions in managing long-term absence' (Cunningham *et al*, 2000). Some large-scale survey data does, however, exist to shed light on both the potential scope of the co-ordination involved and the extent to which line management is able to draw on the advice, guidance and support of other specialists.

This data, in part, comes from the above surveys by Pilkington *et al* (2002) and Bunt (1993), and also from the 1998 Workplace Employee Relations Survey. With regard to the Bunt (1993) survey, this found that three percent of private sector workplaces had a full/part-time doctor, one percent a full/part-time nurse and less than 0.5% had an occupational hygienist. As regards the Pilkington *et al* survey, the findings show that of the 3329 organisations identified as providing some occupational health support, 786 (24%) had the use of a full-time or part-time occupational health physician, 811 (24%) an occupational health nurse, 915 (28%) a General Practitioner, 205 (6%) a staff nurse with no occupational health qualifications, 196 (6%) an occupational hygienist, 207 (6%) an ergonomist, 1,383 (42%) a health and safety practitioner and 1,548 (46%) a health and safety officer. In considering these figures, however, it must be again remembered the corresponding figures for the economy as a whole could be, perhaps, two-thirds, or even more, lower as a result of the unweighted nature of the data.

Turning to the 1998 Workplace Employee Relations Survey, this provides establishment-level data on availability of human resource specialists (Cully *et al*, 1999). These show that, in the case of establishments with 25 or more employees, 30% had a personnel specialist present in them, with this figure ranging from 17% in workplaces that had 25-49 employees to 88% in workplaces that had 500 or more employees. They further show that such specialists existed in 9 percent of 'stand-alone' workplaces with between 10-24 employees and 17% of those that belonged to wider-organisations. Consequently, taken together these figures suggest that human resource specialists are present in a minority of British workplaces.

Overall, therefore, the above findings suggest that in only a relatively small minority of workplaces are line managers able to draw on the expertise of human resource specialists and that this is even more the case with regard to their ability to obtain support from occupational health personnel within private sector organisations and workplaces. Furthermore, given this, it would appear that only a very small minority of private sector companies and workplaces have the types of specialist support available to engage in the types of 'fully blown' or 'sophisticated' case management practices that have been reported to have been developed in some organisations (see e.g Holroyd, 1999; Industrial Relations, 2000 and 2002).

4.7 IMPLEMENTATION AND MONITORING OF POLICY FRAMEWORKS

Comprehensive survey evidence on the actions taken by employers to support the implementation of relevant policy frameworks and to monitor their operation is not available. The evidence that does exist, however, suggests that current practice in both of these areas embodies some areas of weakness and in doing so supports the observations made in the previous chapter concerning how laid down policy requirements are often not fully implemented.

With regard to the extent to which line managers are trained and made aware of relevant policy requirements, several surveys have found evidence to suggest that action in this area is patchy. For example, a recent survey of the management of discipline in 46 organisations found that 35 of them provided line management training, but that in 16 of these the training concerned was optional (Industrial Relations Services, 2001b). Meanwhile, the already mentioned CIPD absence survey found that in less than half (46%) of the responding organisations were managers trained in absence handling.

A rather similar picture emerges, by implication, when attention is paid to the training provided to support the implementation of policies relating to the employment of disabled persons, notwithstanding the fact that where such policies exist they frequently make reference to 'promoting disability awareness' (Goldstone, 2002: 16; Stuart *et al*, 2002). In the Stuart *et al* study, for example, information was sought in the 50 follow-up case studies they conducted on the extent of staff training relating to the employment of disabled workers. The responses obtained revealed 'minimal evidence of any formal training for staff on working with disabled colleagues' and further indicated that where such training had been provided, it had typically been carried out by larger organisations and usually as part of Equal Opportunities or general induction training (Stuart *et al*, 2002: 43). Inevitably, it is unclear how far these findings are representative of employers in general. However, it should be noted that in Goldstone's survey it was found that 51% of personnel specialists believed that line managers were fully aware of the policy requirements and 42% considered that they were partially aware, whereas the relevant figures for line management respondents were rather lower at 28% and 65% respectively.

Turning to the issue of the monitoring of policy implementation, reference has already been made to the evidence available on the use of performance appraisals and the collection and use of absence data by employers. As regards the other forms of monitoring mentioned in the Framework Document, there is some evidence that trends in early retirements are currently being watched closely by public sector organisations against a background of Government concerns about the level and costs of such retirements. More generally, both Goldstone (2002) and Stuart *et al* in their surveys obtained data on the extent to which employers made reference in their formal disability policies to the use of 'monitoring practices towards disabled employees' and 'consulting with disabled employees on their needs'. The first of these found that such references were included in 72% and 69% of policies respectively and the second in 29% and 42%. At the same time, however, Stuart *et al* (2002; 33) also found in their 50 follow-up case studies that, with one or two exceptions, the 'implementation of policies on disability is not monitored'.

4.8 CONCLUSION

This chapter has used existing research evidence to explore, at the aggregate level, how far British employers have in place the types of processes and practices that are identified in the Framework Document as central to the establishment of effective workplace rehabilitation

programmes. It has done so by employing the evidence to shed light on the extent to which a number of key indicators of these processes and practices are utilised.

The evidence reviewed suggests that most employers are likely to have formal procedural provisions relating to the handling of employees who become ill, injured or disabled. It also indicates that these provisions may be found in a number of different types of policy, including disciplinary, absence, equal opportunities, disability and rehabilitation/return to work ones and that, as a result, employers not infrequently possess a number of different, but relevant, policy frameworks. At the same time, there seem good grounds for believing that disciplinary and absence management procedures constitute those that are most commonly used in relation to cases where an employee is unable to attend work or otherwise fulfil fully their work duties.

Such procedures are, by definition, reactive in that they come into play once a work performance/attendance issue has emerged. It is, however, unclear how far the other types of policy mentioned do provide for the identification of potential problems arising from illness, injury and disability to be identified before this point. What is clear is that, at least in the case of workplaces employing 10 or more people, performance appraisal systems are relatively widely used and that these could, at least in theory, provide such a degree of proactivity.

As regards the management of absence, good quality and large-scale aggregate data on employer policy and practice in this area is lacking, with the result that what we do know largely comes from surveys that are based on unrepresentative samples. The findings of these tend to suggest that absence policies, at least within larger organisations, do tend to require line managers to keep in contact with absent employees, although it is likely that compliance with such requirements is highly variable. They further indicate that many employers do collect absence data, circulate it to line managers and utilise ‘trigger’ points to identify potential problem cases. These trigger points, it appears, sometimes, but not always, encompass an action threshold of so many consecutive days of absence. More generally, it would seem that organisations vary considerably in terms of how ‘long-term’ absence is defined and the length of absence that occurs before an employee is referred to occupational health staff or a ‘company’ doctor. Indeed, it is clear that in some organisations these thresholds can be measured in months rather than weeks.

The general picture to emerge from the review in relation to employer provided rehabilitation is that, while some employers do provide employees with access to private medical care, counselling, physiotherapy and other ‘treatment’ provision, these constitute a very small proportion of employing organisations (and workplaces) as a whole. On the other hand, it does appear that there is a relatively widespread willingness on the part of employers to make workplace adjustments to accommodate the needs of ill, injured and disabled workers, although it also seems that the translation of this willingness into actual practice is not always perfect.

Some of the likely reasons for this imperfect translation of willingness into practice were discussed in the previous chapter, where attention was drawn, for example, to the potential role of such factors as the lack of skills and knowledge of line managers, and their hesitancy to accept the redeployment or return to work of workers over whom doubts existed concerning the level of work performance that they could achieve. The evidence reviewed in this chapter has, however, served to draw further attention to two other related influences alluded to in chapter 3. First, the lack of access that line managers frequently have to specialist support from human resource and occupational health specialists and the consequent limitation this places on the adoption of a meaningful case management approach to workers whose job security is threatened by the onset of illness or disability. Secondly, the patchy way in which the implementation of policies intended to facilitate the job retention of workers is monitored and supported via training.

It, nevertheless, needs to be acknowledged, as will have become apparent during the course of this chapter, that the evidence currently available on the rehabilitative policies and processes of employers is often poor or difficult to interpret. In particular, at the aggregate level, a marked disjunction is apparent between the relatively detailed information that exists on employer policies and practices in respect of the employment of disabled workers and that available on how employers manage disciplinary and absence matters. For example, while a good deal is known about employer use of formal disability policies, much less is known about the utilisation of formal absence management ones. In addition, relatively little detailed data exists regarding the collection and use of absence data by employers, the structure and operation of the arrangements they use to maintain contact with absent employees, the extent to which contact of this type is used to explore what can be done to assist a return to work, and the mechanisms that are utilised to both identify potentially vulnerable workers and refer them to occupational health and other forms of medical support.

This disjunction between the research available on the disability policies and practices of employers and the nature and use of disciplinary and absence procedures is problematic for two reasons. The first is that it is far from clear how far the application of the former types of policies and practices is restricted to workers who are perceived as falling within the statutory definition of disability, as laid down under the Disability Discrimination Act, and hence are not applied to workers that have other conditions which have implications for their future employment. Secondly, and more importantly, it appears that it is through disciplinary and absence management policies and procedures that the job retention and rehabilitation of workers who become ill, injured or disabled during the course of their employment are most commonly handled.

5. CONCLUSIONS

5.1 INTRODUCTION

The job retention of employees who have mental or physical impairments that affect their work performance has in recent years been attracting the attention of policy makers, as well as employers and trade unions, at both the domestic and international levels. Against this background, the Health and Safety Commission and Executive have been paying increasing attention to the question of what can be done to increase the likelihood that employees who are sick or injured are able to be retained in employment or, failing this, are able to obtain alternative employment with the same or another employer. As part of this focus of activity, the Health and Safety Executive commissioned the present project with the aim of identifying the issues which employers, in partnership with their employees, need to address in order to facilitate the continued employment of such workers via the provision of vocational rehabilitation.

The project, which was carried out by a project team based at Middlesex University and the University of Strathclyde, consisted of two distinct phases of work. Phase 1 consisted of two distinct tasks. First, the development of a relatively brief ‘framework’ document that sought to identify the processes and practices that are central to the successful job retention by employers of employees possessing mental and physical impairments that affect their work performance and the factors that influence the adoption and operation of these processes and practices. Secondly, the presentation of this document to a conference of ‘stakeholders’ at which delegates were given an opportunity to discuss the appropriateness of its content, as well as explore a number of related issues. Subsequently, in Phase 2, the research team went on to conduct a more in-depth review of the available research evidence in order to (a) assess the validity of this framework document and (b) determine the extent to which employers do currently undertake the types of activities detailed in it.

In this concluding chapter readers are, initially, reminded of the way in which the Framework Document was developed by the project team and its key features. Following this, attention is paid, in turn, to the responses the document received from delegates who attended the Health and Safety Executive’s stakeholder conference, the extent to which the various propositions advanced in it with regard to the development and operation of effective workplace rehabilitation programmes receive research support and the degree to which British employers do already have in place these types of processes and practices. Finally, some concluding comments are made about the implications of the presented analysis for the possible direction of future research.

5.2 THE FRAMEWORK DOCUMENT’S DEVELOPMENT

The first draft of the Framework Document was developed by the project team on the basis of an initial review of relevant literature and the findings of previous research undertaken by it. This draft was then discussed with a number of specialist interviewees and at two stakeholder meetings attended by representatives of relevant government departments and agencies. In the light of these discussions, a number of revisions were made to the Document. For example, greater attention was paid to mental health issues and the business case argument for employers to accord greater attention to the rehabilitation of ill, injured and disabled workers. In addition, more attention was given to the way in which employer rehabilitation activities may be influenced by such factors as the attitudes, skills and knowledge of line managers, organisational size, various psychosocial characteristics of workers and the awareness that

General Practitioners and other medical specialists have of the job implications of medical conditions and treatment.

The final document, which is reproduced in Appendix 1 and discussed in detail in Chapter 2, was divided into three main sections. In the first a conceptual framework of the 'cycles of vulnerability' faced by ill, injured and disabled workers is put forward in order to distinguish between three different types of situation where rehabilitative action might be required and to identify how action of this type can contribute to the job retention of such workers. The following two sections then considered, in turn, the main processes and practices that are considered to contribute to effective rehabilitation activity on the part of employers, and the internal and external factors that support or act as barriers to their occurrence.

This version of the Document was, then, the subject of two 'validation processes'. The first of these comprised the seeking of feedback from delegates attending the previously mentioned stakeholder conference organised by the Health and Safety Executive. The second consisted of reviewing the Document's validity via a more in-depth exploration of the existing research evidence.

5.3 VALIDITY OF THE FRAMEWORK DOCUMENT

Overall, the Framework Document developed by the project team received a substantial degree of endorsement from the nearly 80 delegates who attended the Health and Safety Executive stakeholders conference. Nevertheless, as was outlined in Chapter 2, a number of valuable observations were made on its content and applicability, as well as a number of broader issues concerning how current employer actions in the area could be improved. As regards the former, several improvements were suggested to the section on 'cycles of vulnerability' in order to (a) take account of the differences between the term 'disability, on the one hand, and those of 'injury' and 'illness', on the other, (b) accord greater recognition to the way in which 'disability' can be socially created by aspects of the working environment and (c) draw attention to the legal consequences of employers failing to take adequate rehabilitative actions to facilitate the job retention of workers. A number of observations were also made concerning the various internal and external factors identified in the Framework Document as potentially facilitating or hindering the rehabilitation activities of employers. For example, it was felt that more attention could have been paid to the role of workers in influencing the rehabilitation process and attention was drawn to several additional influences on the rehabilitation activities of employers, including the number of casual workers employed, the remoteness of workplace sites and the number of occupational hazards present. In addition, it was suggested that reference could have been made to the way in which the development of supporting policy frameworks might be aided by the adoption of a risk assessment approach to policy formulation.

In general, the research evidence reviewed in chapter 3, and summarised in Tables 5.1 and 5.2 below, lend further support to the arguments advanced in the Framework Document regarding both the employer processes and practices that are central to the establishment of effective workplace rehabilitation programmes and the internal and external factors that serve to facilitate or hinder their development and operation. However, at the same time, as the discussion provided in section 5.5 below shows, it should be noted that this support came from a research base that was far from being unproblematic.

Table 5.1: Summary of evidence on the relevance of the employer processes and practices identified in the Framework Document

Identified employer processes and practices	Evidence on the relevance of identified processes and practices
Early and timely identification of vulnerable workers	What constitutes ‘early and timely’ intervention is difficult to define with any precision. However, there is reasonably strong evidence that the longer workers are away from work the less likely they are to return. In addition, some evidence also suggests that delays in the provision of rehabilitation can adversely affect return to work outcomes. See paragraph 3.2.1.
Provision of rehabilitation support in the form of medical treatment and the provision of ‘vocational services’, including workplace adjustments	Little good evidence to show that the provision by employers of speedier access to treatment can improve the job retention of workers, although some employers have reported this outcome and the evidence referred to in the above section would appear to lend logical support to its value. In contrast, international evidence does point to the value of workplace adjustments in terms of supporting the return to work and job retention of workers. See paragraph 3.2.2.
Co-ordination of the rehabilitation process between relevant internal and external actors	A number of studies have pointed directly to the importance of such co-ordination. In addition, some others have indirectly lent support to its relevance by shedding light on how rehabilitation can be hindered by breakdowns in communication and weaknesses in line management skills, knowledge and attitudes. At the same time, there is some evidence that the mere establishment of systems of co-ordination is not in itself sufficient. Rather, much depends on the skills and organisational location or status of those accorded co-ordination responsibilities and the manner in which those responsibilities are carried out. See paragraph 3.2.3.
Access to worker representation as a means of ensuring that rehabilitation activities take place in an atmosphere of openness and trust	Little direct evidence on whether access to worker representation has such an effect. However, British evidence suggests that dismissals are lower in workplaces where unions are recognised. Also, Canadian evidence shows a higher rate of return to work among union members. See paragraph 3.2.4.
Establishment of policy frameworks that clearly detail what can and should be done and also make clear who is responsible and accountable for carrying out laid down requirements	Limited evidence available. That which is available points to the importance of such policy frameworks. At the same time, there is also some British evidence to suggest that tensions and contradictions can arise between policy commitments and requirements concerning the supportive and sympathetic treatment of ill, injured and disabled workers and the demands of disciplinary rules and procedures. See paragraph 3.2.5.

Systematic action to ensure that laid down policy frameworks are implemented properly	Little direct evidence concerning the benefits of such action. However, reasonably strong evidence that policies are often poorly implemented as a result of such factors as a lack of budgetary and other resources, and the types of line management weaknesses discussed above. See paragraph 3.2.6.
Adoption of mechanisms that enable any weaknesses in the content and operation of established policy frameworks to be identified and addressed	The above problems of policy implementation suggest that such mechanisms have an important role to play. At the same time, no real evidence exists as to how this process of monitoring and review is best conducted. Several studies have, however, obtained findings which point to the importance of keeping under review any adjustments made to accommodate the needs of ill, injured and disabled workers. See paragraph 3.2.7.

Table 5.2: Summary of the evidence on the role of the internal and external facilitators and barriers identified in the Framework Document

Identified internal and external facilitators and barriers	Evidence on the relevance of the identified facilitators and barriers
Organisational commitment and culture, including the attitudes and values of senior management	Several studies have obtained findings which, directly or indirectly, indicate that senior management attitudes, beliefs and values influence the extent to which organisations adopt a proactive and supportive approach towards the return to work of ill, injured and disabled workers. The extent to which these attitudes, beliefs and values are shaped by 'business case' considerations is, however, rather unclear. See paragraph 3.3.1.
Availability of specialist advice, required financial resources and line management awareness and support of organisational policies and objectives	The problems identified in Table 5.1 with regard to line management's implementation of laid down policy frameworks would seem to support, albeit indirectly, the relevance of this factor by drawing attention to the potential importance of both training and access to budgetary and other specialist resources. Several surveys of human resource and occupational health specialists have, furthermore, found a common belief in the important role that occupational health expertise can play in the handling of rehabilitation/long-term absence. That said, there is little good quality evidence that sheds light on how this factor affects the development and operation of workplace rehabilitation programmes. See paragraph 3.3.2.
Nature of work tasks and processes, as well as surrounding pay and grading systems	Little direct evidence on the role of this factor. However, several studies have obtained findings which suggest that employers frequently encounter problems in

	accommodating the work needs of ill, injured and disabled workers. See paragraph 3.3.3.
Attitudes of workers and co-workers	A good deal of research evidence exists in this area. This suggests that a range of psychosocial factors can affect rehabilitation and return to work outcomes, although the evidence concerning the role of these factors is not always consistent. Factors that have been commonly found to be positively associated with return to work include age, education, male gender, and pay, although the precise reasons for these associations cannot be conclusively identified. Some studies have also found return to work rates to be lower among those with low job satisfaction, those suffering from depression and those with less positive attitudes towards recovery and future job prospects. See paragraph 3.3.4.
Extent to which workers have access to worker representation that provides them with an 'independent and meaningful voice'	There is an absence of any direct evidence which sheds light on the relevance of this issue. However, one British study provides some indirect support in that it found rates of worker dismissal to vary inversely with a proxy measure of trade union power, namely the level of union membership. See paragraph 3.3.5.
Provision to employers of external guidance, support and financial incentives	There is some evidence to show that employers, at least the larger ones, do draw on a range of outside sources of guidance, support and advice. At the same time, it also appears that many are unaware of relevant government schemes and do not know how to obtain rehabilitation support. That said, little systematic evidence exists to show a clear relationship between rehabilitation activities and such factors as the use made of outside support and access to financial incentives. See paragraph 3.4.1.
Nature of surrounding legal frameworks, including those relating to unfair dismissal, disability discrimination, health and safety at work and personal injury litigation.	It does seem that such legal frameworks can influence the processes and practices of employers. For example, in Britain, there seems good reason to believe that employer policies and practices have been influenced by unfair dismissal law and the requirements of the Disability Discrimination Act. There is also a common belief that the present system of personal injury litigation does act to discourage return to work, although one study concluded that while such litigation may inhibit the return to work of some claimants, it 'may be a less formidable barrier to return to work than has sometimes been supposed'. Finally with regard to statutory health and safety law, a recent study found that this has, in some cases, impacted on employer decisions concerning the continued employment of disabled workers. See paragraph 3.4.2.
Employer access to external	There is some British evidence that suggests, sometimes

health care and specialist rehabilitation support	by implication, that the ability of employers to support the return to work of workers is hindered by (a) a lack of speedy access to National Health Service treatment and (b) poor communication and co-ordination between treating physicians and the workplace. See paragraph 3.4.3.
Worker access to various forms of external support, such as public transport, social security benefits, relevant training and educational opportunities, and medical care and rehabilitative support	There is some evidence to support the relevance of these factors to return to work processes, although it mainly comes from studies that were not conducted at the level of the employing organisation. Thus, several studies have pointed to the transport to work difficulties that ill, injured and disabled workers can face. In addition, several others have highlighted that return to work issues are often not explored by General Practitioners and that the degree of co-ordination that occurs between such practitioners and other avenues of external worker support is often poor. As regards the role of social security payments in influencing return to work actions, the evidence is rather unclear. Overall, however, it would seem to suggest that there is no clear and firm relationship between return to work rates and the proportionate relationship that exists between such payments and work earnings. At the same time, there is some suggestion that concerns about future work income and related fears about the loss of benefits can influence return to work decisions. See paragraph 3.4.4.

5.4 CURRENT EMPLOYER PROCESSES AND PRACTICES

In chapter 4 existing research evidence was used to explore, at the aggregate level, how far British employers have in place the types of rehabilitative processes and practices identified in the Framework Document. It did so by employing the available, albeit often limited, evidence to shed light on the extent to which a number of key indicators of these processes and practices are utilised. In general, this evidence, which is summarised in Table 5.3 below, suggests that current arrangements often differ considerably from those detailed in the Framework Document.

Table 5.3: A comparison between current employer rehabilitation processes and practices and those detailed in the Framework Document

Framework processes and practices	Indicators of employer use of processes and practice	Evidence on use of process and practice indicators*
Establishment of policy frameworks.	Use made of formal disciplinary, absence, disability and return to	It appears that only a minority of employers have disability policies and that the use of standalone rehabilitation policies is very rare. In contrast, a relatively large proportion have

	work/rehabilitation policies.	disciplinary policies and many of these also have absence management ones. It therefore would appear that it is the latter types of policies that are most commonly used to handle return to work and job retention issues. However, one survey concluded that some absence policies 'pay only lip service' to the issue of return to work. See paragraph 4.2.
Speedy identification of vulnerable workers	Use of performance appraisal and regular health checks. Collection and use of absence data and the provision made for the holding of return to work interviews and the maintenance of contact with absence employees	Only a small proportion of employers carry out regular health checks, but a rather larger minority conduct performance appraisals. No reliable and comprehensive data exists on how and to what extent employers maintain contact with absent employees. There is a similar lack of data on the collection and use of absence statistics by employers. It does, however, seem likely that many larger employers do formally require such contact to be maintained and do also collect and circulate absence statistics to line managers. See paragraph 4.3.
Provision of rehabilitative support	Degree to which employers provide employees with access to rehabilitative 'treatment' via private medical/health insurance, 'in-house' occupational health services and the payment of <i>ad hoc</i> to private treatment. Extent to which workplace adjustments are made to accommodate worker needs	It seems likely that a relatively small minority of employers provide private medical cover to 'all employees' and that it is also rare for them to provide 'in house' treatment services. There does, however, seem a widespread willingness to make workplace adjustments to accommodate the needs of disabled workers, although there is also evidence to suggest that this adjustment process does not always work smoothly. See paragraph 4.4.
Access to worker representation	Presence of worker representation in the workplace. Right to be accompanied in disciplinary proceedings by a colleague or representative	Appears likely that in a large proportion of workplaces workers have the right to be accompanied in disciplinary proceedings. However, it also seems that worker representatives, whether union or not, exist in a relatively small minority of workplaces. See paragraph 4.5.
Co-ordination of the rehabilitative process	Line management access to sources of internal specialist advice and guidance	Overall, it would appear that in only a relatively small minority of private sector workplaces are line managers able to draw on the expertise of human resource specialists and that this is even

	from human resource and occupational health professionals	more the case with occupational health personnel. This situation, it would seem, contrasts sharply with that in the public sector. See paragraph 4.6.
Implementation of policy frameworks and the monitoring and review of their operation	Degree to which training is provided to line managers and staff on policy objectives and requirements. Extent to which the operation of these requirements is monitored.	There is a marked lack of good survey data on the actions taken by employers to both support the implementation of relevant policy frameworks and to monitor their operation. The data which is available, however, suggests that, in general, the action taken may often be rather limited. See paragraph 4.7.

* The summary of evidence provided relates to employers in general. It should, however, be borne in mind that the types of arrangements examined have commonly be found to be more common in larger workplaces and organisations. As a result, their coverage of workers, as opposed to workplaces and organisations, is likely to be rather higher.

5.5 KNOWLEDGE GAPS AND FUTURE RESEARCH

Overall, then, the research evidence reviewed in this report does lend a reasonable amount of support to the propositions put forward in the project team's Framework Document as to the employer processes and practices that are central to the development of effective workplace rehabilitation programmes, as well as the internal and external factors that identified as potentially influencing the adoption and operation of them. This support is, moreover, given additional weight by the fact that, in general, the types of processes and practices identified in the Document are echoed in those prepared by other commentators and policy-makers in respect of the management of both absence and employee rehabilitation/return to work (see e.g. European Foundation for the Improvement of Living and Working Conditions, 1997; Cabinet Office, 1998; Royal National Institute for the Blind, 1999; Royal College of Nursing, 2000; Trades Union Congress, 2000; Department of Work and Pensions, 2002).

The evidence reviewed would therefore tend to support the view that the provision of rehabilitative support by employers is crucially influenced by the establishment and effective implementation of policy frameworks which enable the rehabilitative needs of workers to be identified in a timely and collaborative fashion and to be addressed in a co-ordinated and positive way. It would also seem to suggest that there is a good deal of scope for encouraging employers to do far more to support the continued employment of ill, injured and disabled workers, particular in smaller organisations, through the adoption of the types of processes and practices detailed in the Framework Document.

The question of whether this encouragement is best provided by the provision of additional guidance, the introduction of new legal requirements, or a combination of the two, is one that extends beyond the scope of this study. It does, however, appear that such encouragement, particularly in the case of smaller organisations, would need to be supported by action aimed at improving aspects of the external environment within which workplace rehabilitation takes place. These aspects include the existence of often lengthy National Health Service waiting lists, notably with regard to the treatment of musculoskeletal and mental health conditions, the poor

co-ordination that often exists between the workplace and outside support systems and the problematic interface that exists between General Practitioners and other external avenues of worker support. In addition, and more generally, there seems a strong need to increase the specialist expertise and resources available to employers

It must, nevertheless, be acknowledged that this broad support for the Framework Document came from a research base that was problematic, both in terms of scope and quality, and whose support for the Framework Document was therefore often rather tentative, speculative and indirect. In particular, three specific weaknesses in this base were noted. First, it contained relatively few studies which have sought to explore the links between job retention and vocational rehabilitation at the level of the employing organisation and hence within the context of on-going employment relationships – a weakness that has also been noted elsewhere in both the British and North American literature (Habeck *et al*, 1991; Barnes *et al*, 1998). Secondly, insofar as such studies had been conducted, they were found to often embody an emphasis on the analysis of quantitative survey data and a corresponding lack of focus on the in-depth exploration of the organisational dynamics that surround the management of workplace rehabilitation processes. Thirdly, in some areas of interest, due to a lack of relevant British evidence, it was found necessary to place heavy reliance on the findings of studies conducted in other countries, notably North America, Australia and Scandinavia, whose applicability to the British context is therefore inevitably open to question given the differing nature of their legal, healthcare and social security systems.

It must further be noted that the evidence currently available on the rehabilitative policies and processes of employers is often poor or difficult to interpret. In particular, at the aggregate level, a marked disjunction was found between the relatively detailed information that exists on employer policies and practices in respect of the employment of disabled workers and that available on how employers manage disciplinary and absence matters. As a result, while a good deal is known about employer use of formal disability policies, much less is known about the utilisation of formal absence management ones. For example, relatively little detailed and reliable data was found to exist on the collection and use of absence data by employers, the structure and operation of the arrangements they use to maintain contact with absent employees, the extent to which contact of this type is used to explore what can be done to assist a return to work, and the mechanisms that are utilised to both identify potentially vulnerable workers and refer them to occupational health and other forms of medical support.

This disjunction between the research available on the disability policies and practices of employers and the nature and use of disciplinary and absence procedures was noted to be problematic for two reasons. First, because it is unclear how far the application of the former types of policies and practices is restricted to workers who are perceived as falling within the statutory definition of disability, as laid down under the Disability Discrimination Act, and hence are not applied to workers that have other conditions which have implications for their future employment. Secondly, and more importantly, because it appears that it is via disciplinary and absence management policies and procedures that the job retention and rehabilitation of workers who become ill, injured or disabled during the course of their employment is most commonly handled.

In the light of these weaknesses in the current research evidence available, it does therefore seem that further British research is needed to:

- explore the links that exist between job retention and vocational rehabilitation at the level of the employing organisation and hence within the context of on-going employment relationships; and

- provide detailed and reliable information about the rehabilitative processes and practices of British employers.
- Clearly, careful thought would have to be given to the design and objectives of such research. However, the present authors would suggest that the following four types of study could, in broad terms, be usefully considered:
- quantitative-based studies that seek to identify statistically significant relationships between job retention and particular employer policies and practices.
- qualitative-based studies that also seek to explore the link between job retention and employer policies and practices but via experimental case studies that embody control groups and seek to identify the impact of particular types of rehabilitation interventions;
- a comprehensive survey of how employers manage absence, including the collection and use of absence statistics, the maintenance of contact with absent staff, the provision of rehabilitative support, the management of workplace 're-entry' and the possible tensions that exist between disciplinary processes and the provision of support to workers;
- detailed case study research intended to provide more qualitative insights into the dynamics of such absence management processes and their impact on the job retention of ill, injured and disabled workers.

In addition, in carrying any such studies, it is further suggested that a key focus of enquiry should be the exploration of how rehabilitation processes are affected by the degree of co-ordination that exists between line managers and other internal organisational actors, on the one hand, and between such personnel and relevant external actors, including medical professionals, on the other.

APPENDIX 1

**Framework Document on Job Retention and Vocational Rehabilitation
Discussed at the HSE Conference ‘Turning a Challenge into an
Opportunity’ held at the British Library in May 2002**

JOB RETENTION AND VOCATIONAL REHABILITATION: A FRAMEWORK FOR DISCUSSION

1 Introduction

The role that vocational rehabilitation can play in supporting the job retention of disabled, ill and injured workers has in recent years become the subject of growing policy debate. This short paper, which forms part of a wider project funded by the Health and Safety Executive, is intended to contribute to this debate in two ways. First, by seeking to identify the key elements which contribute to the establishment by employers of effective rehabilitation programmes. Secondly, through the identification of the types of internal and external factors that can act to hinder or facilitate the development and successful operation of such programmes.

- 1.2 The paper is divided into three main sections. In the first section a conceptual framework of the 'cycles of vulnerability' faced by ill, injured and disabled workers is put forward in order to distinguish between three different types of situation where rehabilitative action may be required and to identify how action of this type can contribute to the job retention of such workers. The following two sections then consider, in turn, the main processes and practices that contribute to effective rehabilitation activity on the part of employers, and the internal and external factors that support or act as barriers to their occurrence.

2 Cycles of Vulnerability

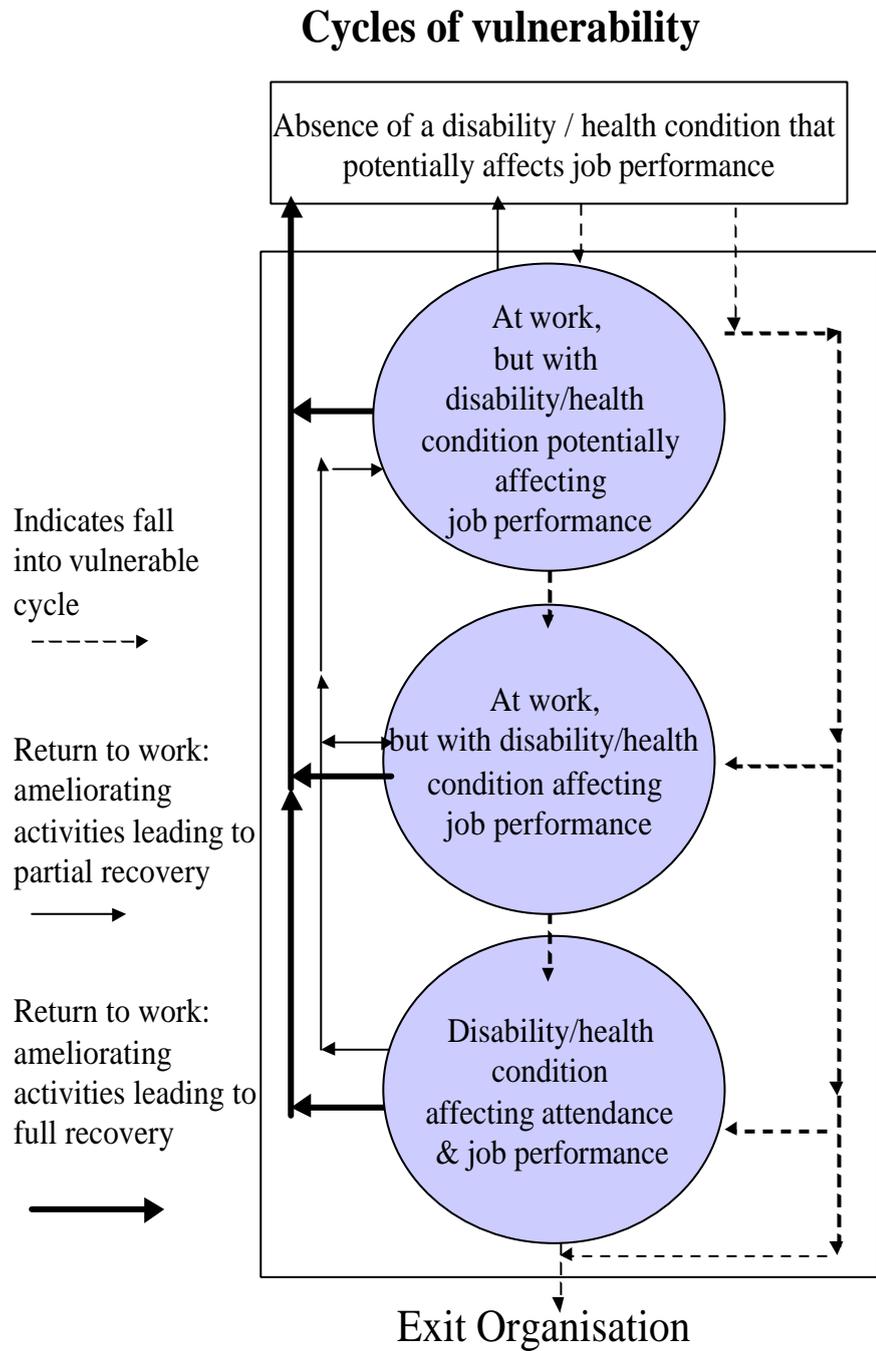
- 2.1 Figure 1 on the next page illustrates the potential problems that workers may face if they contract a disability or health condition that can affect their attendance and more general job performance. This might relate to a physical and/ or mental health condition. The problems that employees might face are highlighted by reference to three potential 'cycles of vulnerability'. A worker who descends into these cycles risks eventual exit from the organisation, on a voluntary or compulsory basis. The box at the top of Figure 1 represents that part of the workforce that does not have a disability or health condition that affects their job performance. This is not to say, however, that no employees within this group suffer from disabilities or health conditions. Rather, the crucial point is that these conditions do not carry any current or future threat to work abilities.
- 2.2 A consideration of the three cycles provides an insight into the types of situation that can potentially be addressed through rehabilitation and the chains of events that can act to facilitate or undermine continued employment.

2.3 Types of Rehabilitation Situations

- 2.3.1 The first cycle covers workers with previously no health or disability problems who contract a condition, whether or not it is work-related, that has the potential to affect job performance in the future if their condition deteriorates. The chances of the condition impacting on their work performance will depend on two factors. The first is the availability of treatment to cure or alleviate the effects of the relevant disability or health condition. The second is whether the employer, after becoming aware of the

condition, is willing and able to introduce workplace adjustments that offset any potential for it to be aggravated by work activities.

Figure 1



- 2.3.2 The second cycle represents the position of a worker who is at work, but has a disability/ health condition that is affecting job performance. A fall into this vulnerable cycle can occur when workers within the first cycle of risk fall into this second cycle if, for whatever reason, they do not receive the required treatment or desirable workplace adjustments. However, it can also occur if a worker, who previously had no disability or health condition, falls directly into this second vulnerable cycle as a result of contracting some physical or mental impairment.
- 2.3.3 Finally, the third cycle of vulnerability refers to workers with disabilities or health conditions that affect their attendance. Again, workers from previous cycles can fall directly into this third cycle in certain circumstances. These can include the failure of adjustments or treatment to alleviate the effects of the health condition or disability present in cycle 2. They also include workers who contract conditions that move them directly into this final cycle.

2.4 Rehabilitation and vulnerability

- 2.4.1 On the left-hand side of Figure 1 the opportunity for upward movement from these cycles of vulnerability and therefore towards greater employment security is depicted. The thicker line on the left illustrates the circumstances where an employee can exit a particular cycle and rejoin that part of the workforce that do not have a disability or health condition potentially affecting their job performance. For example, employees at each cycle can, perhaps after the ameliorating affects of work adjustments, recuperation and medical treatment, return without any risk to job performance. This does not exclude the possibility of continuing difficulties arising from their absence through ill-health. For example, an employer may include previous absence, for whatever reason, as a factor in making decisions about promotion and redundancy.
- 2.4.2 The thinner lines depict movements within the three cycles that encompass reductions in vulnerability. For example, a worker can return to work, but under restricted duties because the health condition or disability is continuing to affect his or her performance at work. Therefore, there is a movement from cycle three to two. Similarly, a worker can move from cycle two to one, or three to one, depending on the extent of recovery, the impact of medical treatment and workplace adjustments / ameliorating activities.
- 2.4.3 However, remaining within these cycles retains a degree of risk. Thus, the performance of workers returning to work with adjustments and continuing restrictions on their work capacity is likely to be closely monitored and may ultimately be deemed unacceptable in the longer term. In addition, there remains the potential for workers to fall down the cycles again if the adjustments prove unsatisfactory and, perhaps, serve to aggravate the remaining disability or health condition.

3 Employers and effective rehabilitation

- 3.1 In this section attention is drawn to a number of employer processes and practices that are seen to contribute to the development and operation of effective rehabilitation programmes. These are considered under the following broad and, to some extent, inter-related headings:
- identification and assessment of vulnerable workers
 - provision of rehabilitation support

- co-ordination of the rehabilitation process
- worker representation
- establishment of policy frameworks
- Implementation of policy frameworks
- policy monitoring and review

3.2 Identification and assessment of vulnerable workers

3.2.1 There is widespread agreement that early and timely intervention exerts a crucial influence over rehabilitation outcomes, not least because of the role it can play in minimising the emotional detachment (and associated mental health problems) that can develop among absent workers and avoiding acute conditions becoming chronic. It therefore follows that employers need to put in place mechanisms that facilitate the speedy identification and assessment of workers whose attendance or more general job performance are, or could be, adversely affected by illness, injury or disability. A number of different methods can be used to aid these processes of identification and assessment. They include the following:

- information gained through recruitment and selection procedures
- results of any health checks and medicals carried out
- staff appraisals and other forms of performance discussions
- collection and analysis of absence statistics, together with the collection of more detailed information on the situation of workers whose attendance is deemed problematic
- maintenance of regular contact with absent workers in order to establish the reasons for absence and whether anything can be done to assist them to return to work
- use of return to work interviews and fitness for work assessments to identify any on-going problems that workers face in terms of their work performance

3.3 Provision of rehabilitation support

3.3.1 Rehabilitation can be seen to encompass two broad categories of activity. First, the provision of treatment aimed at maximising recovery. Secondly, the provision of various 'vocational services', such as functional evaluations, training, 'social support' and workplace adjustments. These categories are discussed below.

3.3.2 Treatment

Many employers place primary, or sole, reliance on the provision of treatment via the National Health Service (NHS). However, some make provision for workers to have access to other sources of support that may provide speedier help. This support may be made available through one or more of the following means:

- payments, perhaps on an ad hoc basis, to receive a private consultation with a consultant or to undergo minor surgery
- provision of private medical cover, either on a discounted or non-contributory basis
- provision of Permanent Health / Income Protection insurance and other forms of insurance under which the insurer makes some forms of rehabilitation available

- employment, either internally or externally, of such specialists as physiotherapists, occupational therapists, counsellors, psychologists and occupational physicians and nurses

3.3.3 Workplace adjustments

Willingness on the part of employers to adjust work processes and environments and to provide other forms of work support can do much to facilitate the job retention of workers. The provision of such support is, of course, encouraged by the duty of reasonable adjustment imposed on employers under section 6 of the Disability Discrimination Act (DDA) in respect of those falling within the statutory definition of disability.

Adjustments of the above type can encompass a wide variety of actions. They include:

- making adjustments to premises
- allocating some of a disabled employee's duties to another person
- transferring the employee to an existing vacancy
- altering the employee's working hours, on either a temporary or permanent basis
- allowing the employee to be absent during working hours for rehabilitation, assessment or training
- giving the employee additional training
- acquiring or modifying equipment, including workstations
- modifying instructions or reference manuals
- modifying procedures for testing or assessment
- providing a reader or interpreter
- providing supervision
- modifying work or management systems and styles.

The types of adjustments required will, of course, vary. For example, in the case of physical limitations, they may consist of changes to working hours and work equipment. In contrast, where workers are suffering from stress-related conditions, they may encompass actions to clarify and reform job roles, adjust workload demands, change management styles and improve inter-personal relationships. Furthermore, it needs to be recognised, more generally, that steps may need to be taken to change worker expectations of their future work activities.

Adjustments may be made on a permanent or temporary basis. In all cases, however, systems should be put in place to ensure that the continued appropriateness of the adjustments made is kept under review in order to ensure that they are 'fit for purpose' and take account of any changes in a worker's condition.

3.4 Co-ordination of the rehabilitation process

- 3.4.1 The process of facilitating the return to work and continued employment of disabled staff and those suffering from ill health and injuries can potentially require inputs from a variety of functions and specialists, some of whom may be based outside of the organisation. For example, it may require the involvement of human resource staff, safety practitioners, occupational physicians and nurses, psychologists, disability advisers, equal opportunities personnel, and trade union and other worker

representatives, as well as liaison with medical personnel, such as hospital consultants and General Practitioners.

- 3.4.2 As a result, systems need to be put in place to both facilitate sufficient communication and discussion between these various categories of actor and to ensure that any resultant actions are adequately co-ordinated. In particular, an important role of such systems should be to ensure that any dialogues with outside medical and rehabilitation professionals are informed by a mutual understanding of the realities of the work environment and the specific job roles that are carried out by workers.
- 3.4.3 No hard and fast rules can be laid down as to the type of personnel that should fulfil this co-ordinating, 'case management', role. For example in small organisations it may fall within the remit of the owner/ manager or a senior line manager and be conducted in a relatively informal way. In contrast, in larger organisations the role is likely to be more formalised and may be played by a more junior line manager or a human resource or occupational health professional. Indeed, in some large organisations it may be that the allocation of the role will vary according to the types of conditions and difficulties that a worker is experiencing. However, it is clear that, whatever the approach adopted, the provision of adequate consultation with the affected worker is central to the role's performance.

3.5 Worker Representation

- 3.5.1 Workers who have a disability, have suffered an injury or are experiencing mental or physical ill health are likely to suffer considerable anxiety and uncertainty, particularly where their condition is of a long-term nature. As a result, they may frequently be suspicious of management intentions regarding them. For example, an employer's request that they attend a medical may be seen as the first step towards their dismissal.
- 3.5.2 It is therefore important that attempts at rehabilitation are made in an environment of openness and trust. One way in which an environment of this type can be created is by both facilitating and supporting worker representation. Trade union representatives provide an obvious source of such representation. However, where union organisation is absent, other forms of representation can be encouraged. For example, non-union representatives can be elected or provision made for workers to be accompanied by a work colleague of their choice.

3.6 Establishment of policy frameworks

- 3.6.1 In order for the above processes and activities to be carried out effectively, policy frameworks need to be established which clearly detail not only what can and should be done, but also make clear who is responsible and accountable for carrying out their various requirements. Such frameworks may be contained within one document or spread over a number of different ones, including absence, equal opportunities and health and safety policies. However, in all cases, care needs to be taken to ensure that the relevant provisions are mutually supportive. For example, thought needs to be given to ensuring an appropriate balance is struck between the disciplinary and rehabilitative elements of absence management procedures in order to make sure that the former do not act to hinder the latter.
- 3.6.2 Issues that can usefully be addressed through policy documents include the following:

- attendance monitoring arrangements that enable potential health problems to be identified as early as possible
- requirements for the maintenance of contact with absent workers
- the development of return to work plans
- procedures concerning the handling of long-term absence cases that, among other things, provide for the obtaining of relevant medical information and advice and the carrying out of consultation with the worker concerned
- the use of return to work interviews and fitness to work assessments
- the support that is available with regard to workplace adjustments and other forms of rehabilitation
- sources of advice that are available within the organisation concerning the actions that can be taken to facilitate a worker's return to work and continued employment
- budgetary arrangements that exist to support such actions
- sick pay and other forms of internal financial help
- the provision of leave and time off to aid recovery and to attend medical appointments
- types of financial and other assistance that can be obtained from government agencies, charitable bodies and other industry and specialist organisations
- provision of employee consultation and representation
- the information that should be provided and requested when making occupational health/ medical referrals

3.7 Policy implementation

3.7.1 The presence of adequate policy frameworks relating to the job retention of ill and disabled workers is important. However, systematic action also needs to be taken to ensure that these frameworks are implemented properly and hence do, in practice, influence how particular cases are handled. In particular, training and other action needs to be taken to ensure that those, including line managers, who have responsibilities under them:

- are aware of their obligations and those of others with whom they will need to co-operate
- understand the importance and reasons for complying with the specified obligations and are therefore committed to them
- appreciate that such compliance will be effectively monitored
- possess the skills and knowledge required to carry out the laid down obligations, including problem solving and sources of specialist advice
- have access to the financial and other resources needed to fulfil the obligations concerned
- attempt to ensure that there is fairness and equity in their treatment of individual employees

3.7.2 More generally, it would seem desirable to ensure that the whole workforce understands and is aware of the relevant policy provisions and the reasons for them as a means of making sure that work colleagues are supportive of any actions taken to support the continued employment of those whose jobs might be at risk as a result of illness or disability.

3.8 Policy monitoring and review

3.8.1 The operation and effectiveness of policies need to be kept under constant review so that any existing weaknesses, either in terms of the current laid down procedures or the way in which they are being implemented, can be identified and addressed. A variety of different methods can be utilised to support this review process. These include:

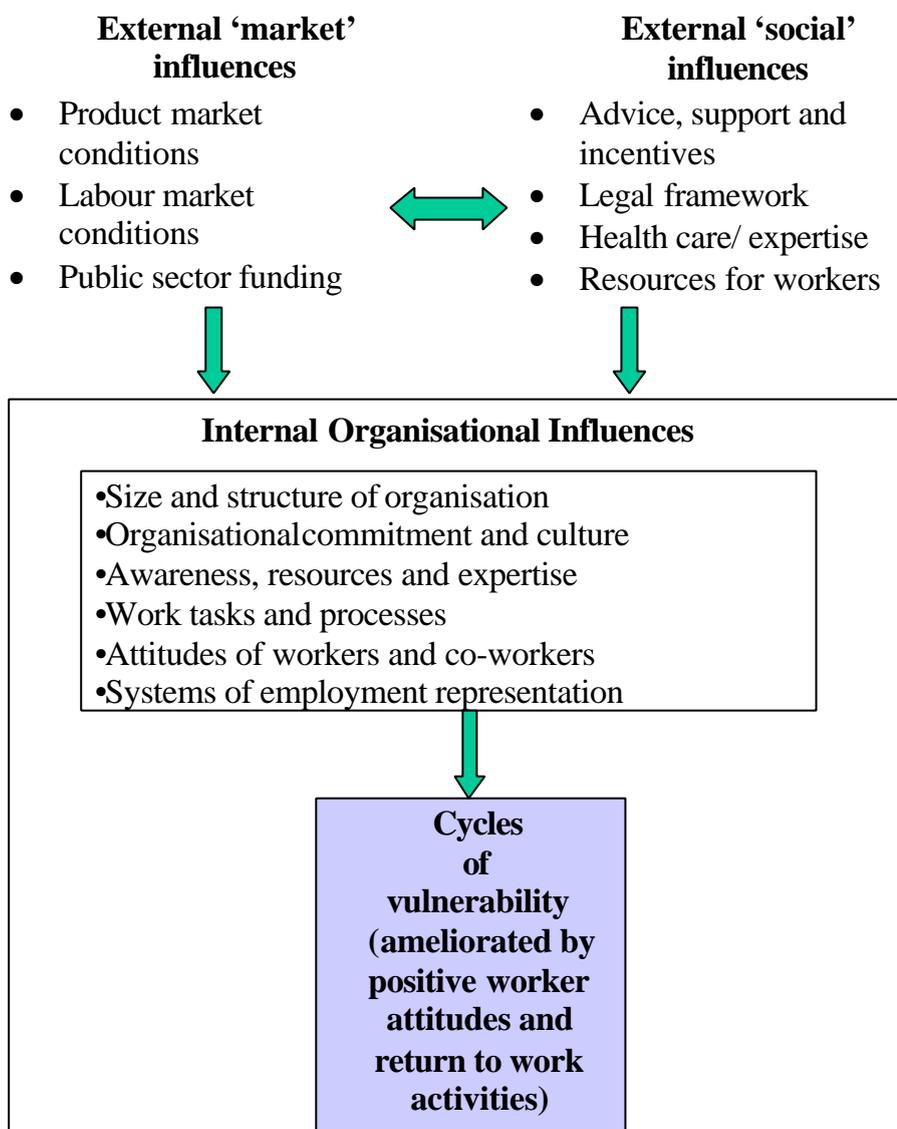
- consultation forums for disabled workers
- feedback from individual workers and trade union and other representatives
- health and safety committees and other consultative bodies
- absence statistics, particularly those relating to long-term absence and its symptoms and causes
- occupational health records
- views of line managers, human resource personnel, safety practitioners and occupational health physicians and nurses
- staff appraisals
- disability/ equal opportunity surveys
- staff attitude surveys
- self-report workforce health surveys
- ill health retirement data
- health insurance claims

4 Internal and external facilitators and barriers to rehabilitation

4.1 A host of internal and external factors are likely to exert an important influence over the nature and operation of organisational rehabilitative activities. Some of the more important of these are highlighted in Figure 2 on the next page and their relevance explored briefly in the next two sections. However, as Figure 2 also indicates, it should be borne in mind that these factors are themselves likely to be shaped to some extent by a range of other contextual influences, notably organisational size, and the type of labour and product markets within which organisations operate. For example, small organisations are likely to have fewer financial resources and less access to specialist advice and the same is likely to be the case for organisations where market competition is strongly cost-based. Similarly, it would seem likely that the priority accorded to worker retention will partly be determined by the availability of suitable replacement labour.

Figure 2

Internal and External Influences on Job Retention and Vocational Rehabilitation



5 Internal factors

5.1 Internal factors that are likely to exert an important influence over the nature and operation of organisational rehabilitative activities can usefully be considered under five headings:

- organisational commitment and culture
- awareness, resources and expertise
- work tasks and processes
- attitudes of workers and co-workers
- nature of worker representation

5.2 Organisational commitment and culture

5.2.1 Existing research within the fields of both workplace health and safety and equal opportunities points to the fact that the nature of organisational policies, and the way in which they operate, are crucially influenced by the extent to which senior management commitment is present. The same is almost certainly true with regard to employer actions in the field of worker rehabilitation.

5.2.2 Senior management commitment may stem from personal views and values. However, its level is also likely to be influenced by the perceived costs and benefits associated with processes and practices and hence the extent to which it is considered that there is a 'business case' for investing in rehabilitative support. Insofar as this is the case, it could be that such commitment will be higher in organisations where an attempt has been made to calculate the costs that are incurred as the result of a failure to adequately support and rehabilitate ill, injured and disabled workers.

5.2.3 Senior management attitudes are, in turn, liable to exert an important influence over the culture of an organisation and, in particular, how far it is 'people- or welfare- centred'. More specifically, they are likely to influence a number of other factors that can potentially influence the way in which the issue of workplace rehabilitation is handled. These include:

- the priorities of line managers and the nature of the relationships that they have with staff
- the degree of trust that exists between managers and workers,
- the consistency with which cases are handled, irrespective of differences in worker characteristics such as length of service and gender
- the extent to which job retention and rehabilitation issues are handled in an open and co-operative way.

5.3 Awareness, resources and expertise

5.3.1 As the earlier discussion indicated, rehabilitation activities can be facilitated by the extent to which advice, perhaps of a multidisciplinary nature, is available from a range of specialists, including human resource and safety practitioners, ergonomists, psychologists, physiotherapists, occupational physicians and nurses and equal opportunities and disability advisers. The work carried out by such specialists, as well as by line managers, will also be influenced by the financial resources that are available to support workplace adjustments and other forms of rehabilitative support- an issue that is likely to vary between large and small organisations.

- 5.3.2 Much of the day-to-day rehabilitative support provided to workers is nevertheless often likely to come from line managers. Consequently, the quality of support they receive will reflect the degree to which these managers have been made aware of their responsibilities and have been provided with training on relevant organisational policies and the skills needed to implement them. It is also likely to be influenced by how far such managers are monitored in terms of the degree to which they implement the laid down policies.
- 5.3.3 A further issue of potential importance in this area is that of how far the general workforce has been made aware of relevant organisational policies and objectives, and the rationales that underlie them. This is because such awareness will influence the extent to which colleagues are supportive of the actions taken to help those who are in need of rehabilitative assistance.

5.4 Work tasks and processes

5.4.1 The nature of the work tasks and processes undertaken by workers have important implications for the forms and levels of support they need. Such tasks and processes, and the grading and payment systems which surround them, can also exert an important influence over the extent to which these needs can be met. For example:

- team bonus schemes could act to limit the willingness of fellow workers to accept the redeployment of a member of staff and differences in pay levels between grades might similarly create difficulties in this respect
- the level and duration of sick pay entitlements may act to influence the time-scales within which rehabilitation can be provided and be allowed to 'deliver'
- the 'tightness' of existing staffing levels and the intensity of work demands may impact on the willingness and/ or ability of organisations to hold jobs open and offer workers the option of 'light' or 'restricted' duties or adjusted working hours
- grading systems and associated pay scales, could act to limit the nature and scale of redeployment opportunities provided to workers who are unable to perform their usual work roles.

5.5 Attitudes of workers and co-workers

The needs and attitudes of workers suffering from an injury, illness or disability are also of relevance to both the process and outcomes of rehabilitation. The existence of positive attitudes towards 'recovery', for example, is likely to be an important factor. In addition, the motivation of a worker to undergo rehabilitation and to return to work may be influenced by a number of other social and/ or psychological factors. These may include issues such as:

- the degree of job satisfaction experienced
- the quality of the relationship that exists with the employer
- the level of sick pay entitlements available
- changes to terms and conditions associated with reduced working hours and other forms of workplace adjustments
- individual and, perhaps, community work ethics, which might be related to broader socio-economic problems
- self-beliefs about current and future work activities
- family circumstances and support

- the balance between work income and social security benefits and qualification conditions concerning social security benefits
- the perceived availability of early retirement and other employment-related long-term benefits
- the opportunities for alternative employment outside of the organisation.

5.5.2 In addition, it is important to consider the attitudes of fellow workers, perhaps, particularly when an employee is suffering from mental health problems, or stress-related conditions. Thus, the existence of peer support, or conversely expressions of intolerance, might act to either facilitate or inhibit successful rehabilitation, for example work colleagues may object to what they perceive to be more favourable treatment being provided by means of workplace adjustments.

5.6 Nature of worker representation

5.6.1 Earlier it was argued that worker representation can potentially play an important role in supporting the rehabilitation process and hence establishing it as an arena of joint endeavour. Consequently, the presence of such representation and the extent to which it provides workers with an independent and meaningful 'voice' seem likely to be influential factors in shaping the nature of the process. The same is also likely to be true of the quality of the relationships that exist between management and worker representatives

6 External factors

6.1 A variety of external factors appear likely to influence employer rehabilitation policies and actions and the way in which they operate in practice. Reference, for example, has already been made to the interaction that may exist between rehabilitation and features of the social security system. Possible influences can be usefully grouped under the following headings:

- availability of external guidance, support and incentives
- surrounding legal frameworks
- employer access to health care and specialist expertise
- resources available to workers

Relatively little research has been conducted into how these various external factors can act to facilitate or hinder employer rehabilitation activities and the job retention of ill, injured and disabled workers. However, a number of possible causal links can be proposed. For example, the following relationships can be suggested:

6.2 Availability of external guidance, support and incentives

- employer awareness of what can be done to support a worker's continued employment is encouraged by the availability and accessibility of external guidance from both official sources, such as the Disability Rights Commission, the Health and Safety Executive, and the Employment Service, and charitable and industry-based bodies
- employer willingness to provide such support is influenced by the availability of financial and other forms of practical support, such as that provided through the Employment Service and under the New Deal. It may also be amenable to being shaped by the provision of financial incentives through such means as employers' liability insurance, the National Insurance system and the Industrial Injuries scheme.

6.3 Surrounding legal frameworks

- unfair dismissal law and the requirements of the Disability Discrimination Act have acted to support the greater use of workplace adjustments and the collection of medical evidence relating to a worker's condition and future employment prospects. More recently, this influence is likely to have been enhanced by the work of the Disability Rights Commission. It may also be increased further when the scope of the DDA is extended to cover all employers, and as a result of future age discrimination legislation
- personal injury litigation may often serve to hinder the rehabilitation and return to work of employees
- statutory Health and Safety requirements may, either legitimately or otherwise, act in some cases to adversely affect the continued employment of ill and disabled workers
- more generally, employment protection rights that serve to reduce the ease with which workers can be dismissed may potentially impact on the timescales within which rehabilitative action to protect jobs can be taken

6.4 Employer access to health care and specialist expertise

- the development of rehabilitation activity has been hindered by national shortages of relevant specialist expertise
- community- and industry-based initiatives, such as 'good neighbour' schemes, as well as NHS Plus, could act to increase employer access to occupational health skills and knowledge that are relevant to the provision of rehabilitation support to workers
- the time it takes for workers to receive treatment can influence their prospects of continued employment
- the awareness of GPs and specialist mental health specialists of the job implications of medical conditions and treatment

6.5 Resources available to workers

- the interplay between transport and planning policies at both a local and central level may act either to promote or to impede travel to work opportunities and hence the continued employment of ill and disabled workers
- the relationship between General Practitioners and their clients can impact upon the extent to which the employee is supported through the rehabilitation process
- the location and availability of re-training or educational facilities may influence the ability of workers to cope with needed changes in job roles
- employee decision making in respect of rehabilitation may be affected by the 'income' they can obtain, via such means as incapacity benefit, Disabled Persons Tax Credit, statutory sick pay and industrial injuries benefits, while being either unable or partially able to carry out their work. A similar influence may stem from the forthcoming introduction of the Working Tax Credit

7 Summary

This report initially identified three cycles of employment vulnerability that potentially face ill and disabled workers. It then went on to seek to identify:

- the key elements which contribute to the establishment by employers of effective rehabilitation programmes; and
- the types of internal and external factors that act to hinder or facilitate the development and successful operation of such programmes

The authors do not claim that the report provides a definitive analysis of the above issues. However, they hope to have succeeded in putting forward a framework of analysis that can add greater focus to current debates concerning how the job retention of ill and disabled workers can be enhanced. Indeed, the intention is that the framework will, after widespread consultation and further research, be revised and improved. In short, the report, through drawing attention to different levels of influence and possible interactions highlights key issues that might form the basis for further discussion and debate.

APPENDIX 2

ATTENDEES AT GOVERNMENTAL STAKEHOLDER MEETINGS AND WORKSHOP ON JOB RETENTION AND VOCATIONAL REHABILITATION

The two meetings held with representatives of relevant government departments and agencies on 18 March and 25 March 2002 and the 'Turning a Challenge into an Opportunity' workshop held on 22 May 2002, took place after the first version of the Framework Document had been prepared.

Consequently, they focused largely on the Document's strengths and weaknesses. The final version of the Document was therefore drafted in the light of the comments made during these meetings.

Delegates from the organisations listed below attended the above meetings.

Advisory, Conciliation and Arbitration Service
AON Ltd
Armstrong World Industries Ltd
Association of Occupational Health Nurse Practitioners
Backcare
BAE Systems
BOHRF
British Heart Foundation
British Society of Rehab Medicine
Cabinet Office
Cardiff Law School
College of Occupational Therapists
Department for Transport, Local Government and the Region
Department of Health
Department of Work and Pensions
Disability Employment Consultant
Disability Rights Commission
Dudley Group of Hospitals
Employers' Forum on Disability
Employers' Organisation for Local Government
Employment Service
Engineering Employers Federation
Federation of Small Business
Forum of Private Business
GMB
Halifax Plc
Health and Safety Commission
Health and Safety Executive
Health Development Agency
Health Education Board for Scotland

Home Office
Human Focus Return to Work
Institute of Directors
IRS
Kings College London
Logica
London Borough of Camden
London Underground
Marks and Spencer
McNicholas Construction
Middlesex University Business School
National Assembly for Wales
PCS
Powergen Plc
Professional Footballers' Association
Rehab Scotland
RMT
Rolls Royce
Royal College of Nursing
Royal Sun Alliance
Salus OH&S
Scottish Office
Small Business Service
Smiths Group
South West Water Ltd
Swiss Re Life and Health
Trades Union Congress
TSSA
University of Liverpool
University of Strathclyde
University of York
UNUM Provident
Watson Wyatt
Wood Ross Resourcing Ltd
Wycombe District Council

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