

**MANAGING REHABILITATION:**

**A COMPETENCY FRAMEWORK FOR MANAGERS  
TO SUPPORT RETURN TO WORK**

**RESEARCH REPORT**

**for the**

**BRITISH OCCUPATIONAL HEALTH  
RESEARCH FOUNDATION**

**Goldsmiths**  
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## **Acknowledgements**

Thanks go to the employees, managers, occupational health and human resource professionals who all contributed to and supported this research. Many thanks to The Chartered Institute of Personnel and Development, The Health and Safety Executive, Affinity Health at Work, Healthy Working Lives and Loughborough University who all hosted workshops and provided further support for this research. We would also like to thank Ian Hannent for his general support and expertise on the web page and Aadil Kazi who provided assistance in recruitment. Finally, we would like to thank the BOHRF advisory group and the peer reviewers who have provided sound advice and support throughout this research.

## **EXECUTIVE SUMMARY**

This research was conducted because the crucial role of the line manager in the return to work process has received little evidence based research attention to date. This research has significant and interesting findings that impact on how employers will be expected to manage the change from 'sick note' to 'fit note' (and the Fit For Work/ Working Healthy Services in Scotland). The research findings are summarised below. The implications of the research findings for line managers, for organisations and for policy makers are summarised on pages 35-37 of the main report. The behaviour based Competency Framework for Managers to Support Return to Work is reproduced on page 22 of the full report. Guidance is available in a separate short document (Manager support for return to work following long term sickness absence: Guidance) available on the BOHRF and CIPD websites

Line managers are important in the return to work process for a number of reasons:

- Line managers are often the first contact point when the employee is unwell and does not attend work;
- Line managers are responsible for the day-to-day management of the employee on their return;
- Line managers are the key to work adjustments and implementation of work redesign initiatives;
- Line managers may be the first person called upon by the employee when they need to meet HR/OH to discuss returning to work;
- The introduction of the 'Fit Note' places a greater responsibility on the line manager to support an early return to work.

**The objectives of this study were:**

1. Identify the specific competencies required by line managers to encourage and support the return to work of employees following a period of long term sickness absence due to stress, anxiety and depression, back pain, heart disease or cancer
2. Build a model of the competencies required by line managers to support an effective return to work
3. Test the validity of the Competency Framework for Managers to Support Return to Work, and through doing so, develop a Competency Measure for Managers to Support Return to Work
4. Develop practical guidance and tools for employers, Occupational Health/Human Resource professionals and line managers that specify the competencies required for effective rehabilitation

## **RESEARCH METHODOLOGY**

A combined qualitative and quantitative approach was used to identify manager behaviours and develop a Competency Framework for Managers to Support Return to Work. Data was accumulated from a range of professionals (employees, line managers, HR and OH), in key sectors (Education, Healthcare, Government, Technology, Finance, Manufacturing and Transport) using focus groups, semi structured one-to-one interviews and a questionnaire survey completed by employees and managers at two time points six months apart. This multi-method, multi-perspective approach has been successfully employed previously to develop performance-based competency frameworks, and more recently to develop a framework for managers to prevent and reduce work stress. The five stages of the research are summarised in tabular form on page 10 of the main report.

## **MAIN FINDINGS OF THE RESEARCH**

### ***Participants***

A total of 347 employee and 177 manager responses were suitable for analysis at Time One. 111 employees completed the questionnaire at Time Two. Over half of the participants reported taking long term absence for stress, anxiety and/ or depression health condition (58%), following this, back pain (16%), cancer (13%) and heart disease (8%). The average length of absence taken in the last two years was 105 days, with employees with stress, anxiety and depression, and cancer taking the longest lengths of absences. 31% of participants reported that they had relapsed i.e. taken a second period of sickness absence following their initial return.

## Competency Framework for Managers to Support Return to Work

The competency framework was developed using information collated from interviews with employees and managers, and workshops with human resource and occupational health professionals. The final Competency Framework for Managers to Support Return to Work was trialled and refined following the Time One questionnaire and comprised of four competencies.

Competency	Sub-competency	Do (✓) / Don't (*)	Examples of manager behaviour
While the employee is off		✓	<p><b>During the employee's absence, the manager...</b></p> <ul style="list-style-type: none"> <li>Regularly communicates with the individual via telephone or email</li> <li>Regularly communicates work issues with the individual to keep them in the loop</li> <li>Focuses conversations more on the individual's wellbeing</li> <li>Is in touch with the individual's close colleagues with regards to their health</li> <li>Encourages work colleagues and other members of the organisation to keep in touch with the individual</li> <li>Relays positive messages through family or friends</li> <li>Makes it clear that the individual should not rush back to work</li> <li>Makes it clear that the company will support the individual during their absence</li> <li>Reassures the individual that their job will be there for them when they return</li> <li>Prevents the individual from pushing him/herself too much to return to work</li> </ul>
The initial return to work		✓	<p><b>Once the employee has returned to work, the manager...</b></p> <ul style="list-style-type: none"> <li>Gives the individual lighter duties/ different jobs during their initial return to work</li> <li>Incorporates a phased return to work for the individual</li> <li>Remains objective when discussing return to work adaptations for the individual</li> <li>Explains the return to work process/procedures to the individual before they return</li> <li>Explains any changes to the individual's role, responsibilities and work practices</li> <li>Meets the individual on their first day back</li> <li>Makes the individual's first weeks back at work as low stress as possible</li> </ul>
Negative behaviours		x	<ul style="list-style-type: none"> <li>Loses patience with the individual when things become difficult</li> <li>Displays aggressive actions</li> <li>Questions the individual's every move</li> <li>Goes against the individual's requests for certain adjustments to be made to their work</li> <li>Makes the individual feel like a nuisance for adding extra work to their schedule</li> </ul>
General behaviour	Managing the team	✓	<ul style="list-style-type: none"> <li>Asks the individual's permission to keep the team informed on their condition</li> <li>Makes the individual feel like they were missed by the organisation</li> <li>Encourages colleagues to help in the individual's rehabilitation process</li> <li>Promotes a positive team spirit</li> <li>Regularly communicates with HR/OH and keeps the individual informed</li> </ul>
	Open and sensitive approach	✓	<ul style="list-style-type: none"> <li>Is proactive in arranging regular meetings to discuss the individual's condition and the possible impact on their work</li> <li>Communicates openly</li> <li>Listens to the individual's concerns</li> <li>Understands that, despite looking fine, the individual is still ill</li> <li>Appreciates the individual's wishes</li> <li>Has an open door policy so the individual can always approach them with any concerns</li> <li>Adapts their approach to be more sensitive towards the individual</li> <li>Allows the individual to maintain a certain level of normality</li> <li>Is quick to respond to the individual via email or telephone when they have a concern</li> <li>Takes responsibility for the individual's rehabilitation</li> <li>Acknowledges the impact the individual's illness has on them</li> <li>Remains positive with the individual throughout their rehabilitation</li> </ul>
	Legal and procedural knowledge	✓	<ul style="list-style-type: none"> <li>Shows awareness of their relevant legal responsibilities</li> <li>Understands the need to make reasonable adjustments by law</li> <li>Follows the correct organisational procedures</li> </ul>

### **Competency Measure for Managers to Support Return to Work:**

The final competency measure comprised of 42 questions, across the four Competencies for Managers to Support Return to Work. Analysis of the Competency Measure showed:

- The measure to have high internal reliability ( $\alpha = .93, .91, .89, .98$  respectively).
- No significant differences in responses between gender, age, organisation type or tenure.
- Union members reported poorer behaviour from their line manager than non-members.
- Employees with stress, anxiety and depression, and back pain, typically rated their manager lower than those with heart disease or cancer.
- When comparing Time One and Time Two responses employees rated their line managers lower on the same behaviours, suggesting that as time goes on they perceive their line manager to behave less positively.

### **The Competency Measure for Managers to Support Return to Work and return to work outcomes**

Analysis of the Competency Measure for Managers to Support Return to Work and the return to work outcomes showed:

- Different aspects of the competency model were associated with different return to work outcomes including absence, general well-being, psychological distress, work limitations, positive and negative affect and job satisfaction and job performance. This indicates that at different points on the return process, and for different reasons, each of the four competencies play an important role in supporting the employees' return to work.
- The competency 'While the employee is off work' was most frequently associated with return to work outcomes at Time One. When data was analysed using only those behaviours shown once the employee returns, all three of the remaining competencies were found to be associated with a range of return to work outcomes.
- The competency measure was most strongly associated with return to work outcomes for employees with stress, anxiety and depression. The smaller sample sizes for the remaining conditions may account for this difference and further research is warranted to better understand how the model works for other illness conditions.
- The line manager competencies showed weaker relationships with the return to work outcomes at Time Two than demonstrated at Time One. However, the competencies 'Initial Return to work' and 'Negative behaviours' were associated with absence, general well-being, psychological distress, work limitations, positive affect and job satisfaction.

Analysis of absence patterns and absence behaviour showed:

- Employees perceived themselves to be primarily responsible for their own return, while line managers perceived themselves to be responsible for the employees return.
- Returning to normality, being eager to return to work and for financial gain were the most frequently cited reasons by employees for returning to work.
- Employees cited overcoming their own anxiety as the most significant barrier to returning to work (60%), this was followed by a lack of understanding and support from their line manager/ organisation (31%) and nearly a quarter reported that there was a lack of advice on how their health condition affected their work, poor communication between all parties involved and insufficient workplace adjustments.
- Very few employees cited their medical condition, or their ability to manage their illness at work, as a barrier to returning to work suggesting that it may be the organisational and social factors associated with returning that pose the largest problem to return to work, rather than the illness itself.

- Managers and employees hold different definitions of a successful return to work; managers tended to rate the return as more successful than the employee. This may be because the managers' focus is on getting the employee back into the workplace and return equates to success, whereas employees use more complex or subtle factors (such as a sense of reintegration or return to full functioning) to evaluate the process.

## **IMPLICATIONS FOR LINE MANAGERS, ORGANISATIONS AND POLICY MAKERS**

### Line managers:

- With the introduction of the 'Fit Note' which will place greater emphasis on the line manager supporting an early return to work, there is ever more need to understand what behaviours are important to support returning employees;
- A range of behaviours are important to support employees to return to work following long-term sick-leave: there is no one behaviour or competency needed;
- The Competency Framework for Managers to Support Return to Work can be used to identify strengths and areas which may require further training or support when dealing with a returning employee;
- That good people management skills, including effective communication, sensitivity to and understanding of the individual, are the most valuable skills when supporting an employee and these should be on going throughout the whole return to work process; before the employee is absent, while they are off and once they have returned to work;
- To seek support and advice from OH and HR who will have a better understanding of the employees condition, work adjustments and any concerns which may become apparent.

### Organisations:

- With the introduction of the 'Fit Note' more responsibility will be placed onto the line manager who in turn will need more support and guidance. This can be offered through the Competency Framework for Managers to Support Return to Work which provides a common language to facilitate discussions between HR, OH and the line manager;
- Raising awareness of the competencies, and integrating the competencies into existing people management processes such as training and development, will help to reduce absence, promote successful return to work and improve the employees psychological health and job performance and satisfaction on return;
- Organisations need to promote a positive people management culture and provide appropriate management training and development to emphasise good people management skills for all line managers. If an employee perceives their line manager to have been the cause of, or obstructing, the absence then if possible an alternative manager should be nominated to manage the employees return;
- Informal, non-work related communication by the line manager while the employee is absent is welcomed by the employee and so OH/ HR need to encourage the line manager to maintain contact, and support them in their efforts to do so.

### Policy makers:

- With the introduction of the 'Fit Note' more responsibility will be placed on the line manager to support an early return to work of the employees following long term absence and so certain skills will be required. Promotion of the Competency Framework for Managers to Support Return to Work and greater availability of guidance and accessible training will help enhance these skills;
- National policy needs to raise the profile of a multidisciplinary approach to return to work which engages the line manager, occupational health, human resources, general practitioner and other healthcare specialists to support the returning employee.

## **1. BACKGROUND**

There have been significant advances in our understanding of the cost of rehabilitation, rehabilitation policies and return to work interventions (e.g. Bevan & Hayday, 2001; CBI, 2004; Joling et al, 2004) and, more recently, the biopsychosocial correlates of return to work outcomes (Baaders et al, 2001; Munir et al, 2005b;). However, research suggests that many employees continue to experience difficulties returning to work. In practice, well designed return-to-work systems are likely to fall short where line managers are ill-equipped to manage the returning employee (Bevan, 2003). The purpose of this research was to identify the behaviours required by line managers to support employees returning to work following a period of sickness absence (4+ weeks).

### **Sickness absence**

Sickness absence is a persistent problem for organisations, and presents a major public health and economic concern. Although the latest CIPD Absence Management Report (2009) suggests that the average level of employee absence has fallen from 8.0 days to 7.4 days per employee per annum, there is still an estimated 175 million working days lost in Britain due to sickness absence, with the annual costs of these absences and unemployment totalling over £100 billion; greater than the annual budget of the NHS (Health, Work and Wellbeing Programme, 2008). While long term absences (typically defined as four weeks or more continuous absence, IRS, 2009) account for only 5% of absence episodes, these absences account for over 40% of the total working time lost (CBI/AXA, 2008). The most prevalent conditions for long term sickness absence are: anxiety and depression, back pain, heart disease and cancer (HSE 2004, Henderson et al, 2005).

There are also significant consequences of long-term sickness absence for the employee. It is now widely accepted that work is good for health and can help to reduce health inequalities (Waddell & Burton, 2006; Department of Health, 2004). For many, work is an important source of normality, self respect, self-esteem, mental health and social inclusion as well as financial stability and independence (Evans & Repper, 2000; Jolly, 2000; Askey 2003;). Furthermore, those who do not return to work are likely to transfer onto incapacity benefit. The extent to which employees successfully return to work remains unclear; it is not known how many long term sickness episodes are followed by illness relapse, a further period of absence for a secondary illness such as depression, early retirement or unemployment.

There is a voluminous body of literature, in both the academic and practitioner domains, that aims to understand the causes of absence and identify organisational, health and rehabilitation interventions to improve the return to work process. These include phased- or staged- return programmes; the use of multi-disciplinary approaches, including psychological rehabilitation such as confidence building, counselling or Cognitive Behavioural Therapy (Mental Health Foundation Report, 2009); and an increasing focus on appropriate return-to-work adjustments such as the reduction of the physical or mental workloads. Many organisations use these methods as a way of easing the employee back into the working environment to help them overcome some of the initial anxieties they may have regarding their return to work. More recently, research has shown that employees returning to work often require ongoing support, beyond the initial return period (Munir et al., 2008). For example, Pryce et al (2007) found that employees returning to work following cancer treatment, required ongoing adaptations to their workplace or additional support from colleagues due to the late side effects of cancer treatment, such as fatigue. The line manager plays a pivotal role in the return to work process – for example, by being part of a multi-disciplinary team and supporting work adjustments – and is in a unique position to provide ongoing support to the employee through, and beyond, their return.

## **The importance of the line manager in the return to work process**

There is growing recognition that the line manager plays a vital part in the return to work of employees following long term sickness absence. Research by Rick and Thompson (2004) suggested that line managers have a crucial role to play in the rehabilitation of employees following work related stress and this may hold true for rehabilitation following other types of ill health. Whilst there is growing understanding of what employers, human resource and occupational health professionals can do to encourage and support the return to work of employees, there is little understanding of the line manager's role in this process. In practice, well designed and managed return-to-work systems are likely to fall short where line managers are ill-equipped to manage the absent and returning employee (Bevan, 2003). This was recently echoed by Dame Carol Black (2008) who stated that it was important for a line manager to feel confident about approaching sensitive and difficult areas of conversation regarding an employee's absence and return to work. She believed this would come through better training and knowledge on the return to work process.

Line managers are important in the return to work process for a number of reasons:

- Line managers are often the first contact point when employees are unwell and do not attend work;
- Line managers are responsible for the day-to-day management of employees on their return;
- Line managers are the key to work adjustments and implementation of work redesign initiatives (Saksvik et al, 2002);
- Line managers may be the first person called upon by employees when they need to meet HR/OH for advice on their condition and the return to work;
- Line managers' behaviour can influence employees' exposure to workplace psychosocial hazards (e.g. work demands, control etc) (Cherniss, 1995; van Dierendonck et al, 2004.). These psychosocial hazards are likely to be felt more keenly by those returning following a period away from the workplace;
- Line managers' behaviour can cause employees' stress (or prevent additional stress) (Tepper, 2000). Stress or anxiety caused by managers is again likely to be felt more keenly by those returning following a period of sickness absence.

Although limited, previous studies have shown line managers to have a significant impact on the health and effective return to work of employees on long term sick leave.

- Labriola et al (2006) examined the psychosocial and physical work-environment factors predicting long-term sickness absence (>8 weeks) at both the individual and the workplace level. Data was collected in a prospective study among 1610 employees from 52 workplaces registered on the Danish national absence register over a period of 5 years. It was found that the risk of long term sick leave increased with lower support from the manager and poor management quality.
- This was consistent with research from Vaananen et al (2003) who examined the psychosocial antecedents of sickness absenteeism in the industrial sector in Finland. The effects of job characteristics (job autonomy and job complexity), physical and psychological symptoms, and social support (from co workers and supervisors) on sickness absenteeism were investigated. The number of long (4-21 days) and very long (above 21 days) sickness absence episodes of 3895 people (76% men and 24% women, mean age 44 years) were obtained from the health registers of a multinational forest industry corporation in 1995–1998. A questionnaire survey was also carried out in 1996 on the working conditions and health of the workers. It was found that a lack of manager support to women and co-worker support to men increased the frequency of sick leave.

- Holmgren (2007) examined supervisors' views on employer responsibility in the return to work process and any factors that influenced the support of sick-listed employees. Using a focus group approach, 23 supervisors experienced in managing sick-listed employees participated. The results suggested that the managers defined themselves as the key persons responsible for the rehabilitation of sick listed employees and for creating a good working environment in order to prevent ill health and sickness absence among the employees.
- Aas et al (2008) aimed to determine the leadership qualities valued in the return to work process. This was a qualitative study that included interviews with 30 employees on long-term sick leave due to various health conditions (8 weeks or above) and their 28 supervisors from 19 companies. Content analysis was used to analyse the transcripts and identify the leadership qualities. The leadership qualities valued by employees were: ability to make contact, being considerate, being understanding, being empathic and being appreciative. Interestingly, the leadership qualities which were valued by employees were different to those that managers believed the employees preferred. This highlights the difficulties and potential confusions that managers face when facilitating the return to work of employees.

*The need for further research to understand the line managers' role in the return to work*

While the research outlined above contributes to our understanding of the importance of line managers in the return to work process, it is not without limitations:

- Much of the research has been carried out in Scandinavia, where there is a different work culture and benefits and support system to the UK. Therefore it is difficult to establish if the findings of the research could be transferred across to the UK.
- The studies draw from single methodologies, using either purely quantitative or purely qualitative approaches to examine the line manager's role in the return to work process.
- Much of the research presents a unitary perspective, i.e. the return process as viewed by the employee. While Aas (2009) goes some way towards bringing together the manager and employee perspectives when identifying relevant leadership qualities, and Pransky et al (2009) identify a range of skills, behaviours and roles required by a return to work co-ordinator, there is need for a model that incorporates the views of all those involved in the return process.
- Only the study conducted by Aas (2009) has examined the role of the line manager in depth. This research aimed to identify leadership values. While understanding leadership values is important, values are often intangible and difficult to translate into training and guidance; they do not specify what the manager should and should not do to encourage a successful return to work. Furthermore, this research focussed on the period during which the employee was absent from the workplace. It is highly likely that the employee will have different requirements of their line manager while they are absent from the work place to when they first return. Further research is therefore needed to explore the period when the employee has re-entered the workplace and how their needs may change.
- None of the research to date, to the authors' knowledge, has examined or compared the role of the line manager across the four main health conditions responsible for long term sickness absence.

## **Adopting a Competency-based approach for supporting return to work**

This study aims to address a gap in research by identifying the behaviours required by line managers to encourage and support the return to work of employees following a period of long term sickness absence due to: stress, anxiety and depression, back pain, heart disease or cancer.

A competency framework refers to a complete collection of skills and behaviours required by an individual to do their job (Boyatzis, 1982). It includes information on how the individual goes about their task and the expected outcomes. Competency frameworks are now an accepted part of modern people management (Rankin, 2004) and are frequently used to guide human resource interventions such as:

- Selection and assessment: competency frameworks are a key part of job descriptions and person specifications (Rankin, 2004). They can be used as a basis to design exercises and set out interviews for assessment centers and other selection methodologies.
- Training and development: competency frameworks can be used as a way to identify an individual's development needs. They can also be used to design training programmes to help learners change their behaviour or develop skills required for particular competencies.
- Performance management: competency frameworks can be used to define how people are expected to behave in a certain situation or particular role. By understanding what is meant by competent behaviour in a certain situation, then individuals can be assessed in line with this, and where they do not meet the ideal can seek further training and development.

Competency frameworks have also been used to guide development and support best practice in issues relevant to occupational health. Such examples include the Management Competencies required to Prevent and Reduce Stress at work (HSE, 2007) which outline the behaviours required by a manager to reduce stress in their employees and maintain their well being. By using a competency framework it has allowed a clear specification of what is expected of managers when managing stress and has allowed HR professionals and managers to easily understand stress management and then develop interventions to ensure managers have the correct skills necessary for managing stress (HSE, 2007).

Recently, Pransky et al (2009) developed a Competency Framework for Return to Work Coordinators and identified the most important competencies required by these professionals when facilitating the return to work of injured or ill workers. This framework can be used by these professionals to develop their skills in certain areas to aid them better when dealing with returning employees. Other examples of competency frameworks can be seen in professional standards such as the NHS and the Chartered Management Institute which use them to guide development and support best practice.

This research uses a behavioural competency-based approach to identify the behaviours required by line managers to support the return to work of an employee following long term sickness absence. Managers will be able to use the competency framework as a guide to inform how they interact with returning employees. Furthermore, the framework can be used to identify their strengths and development needs, thereby pointing to further training needs or areas where they may require support when working with the employee to secure a successful return to work. Human Resource and Occupational Health professionals will also be able to use the framework to guide managers and give them support when managing returning employees. As many organisations use competency frameworks, it is hoped that this framework will fit easily into existing management frameworks within an organisation and therefore not be seen as an additional management responsibility.

## **Chronic illness and return to work**

This research places a focus on the four most prevalent conditions for long term sickness absence: anxiety and depression, back pain, heart disease and cancer (HSE, 2004, Henderson et al, 2005). A brief overview of each illness, including prevalence and symptoms, is presented below:

### *Stress, anxiety and depression: current prevalence and typical symptoms*

Anxiety and depression are reported to be the most common mental health problems affecting around 20% of the UK working population (Mind, 2005). At any one time, one in six workers will be experiencing depression, anxiety or problems relating to stress. As the economy shifts away from agricultural and manufacturing jobs to educational, financial and service sector jobs, it is likely that the prevalence of this condition will continue to rise (Bupa, 2009). Coupled with this, is the predicted increase in 'presenteeism'; i.e. when an employee attends work despite illness. The Sainsbury Centre for Mental Health (2007) has already suggested that in the UK, presenteeism accounts for 1.5 times as much working time lost as absenteeism. Furthermore, with managers suggesting they are not confident or trained enough to pick up the signs of mental health conditions (Diffley, 2003; Munir et al, 2005) more people could suffer from chronic cases of stress, anxiety and depression.

There are many reported typical symptoms of stress, anxiety and depression which include a lack of energy, mental and physical exhaustion, headaches, increased heart rate, loss of appetite, disturbed sleeping patterns, excessive worrying, irritability and poor self esteem and a feeling of worthlessness.

### *Back pain: current prevalence and typical symptoms*

Back pain is currently the most commonly reported reason for sickness absence in the UK (HSE, 2006) and is one of the leading causes of musculoskeletal disorders. The HSE (2006) estimated that in 2005/2006, musculoskeletal disorders were responsible for 9.5 million lost working days. Although back pain is particularly associated with manual labour jobs, which are on the decline, research has shown that rather than occurring as a result of a specific incident or injury, the onset of pain is spontaneous and gradual in the majority of back pain cases (Snook, 2004). As age is a significant risk factor for back pain, it has been projected that the prevalence of back pain will continue to rise in line with our ageing workforce (The Work Foundation 2009)

Chronic back pain is commonly described as a deep, aching, dull or burning pain in one area of the back or travelling down the legs. Patients may experience numbness, tingling, burning sensations in their legs and regular daily activities may prove difficult or impossible. It is not unusual for people with back pain to also experience depression as a result of significant changes to their physical abilities and lifestyle, and the chronic pain.

### *Coronary heart disease: current prevalence and typical symptoms*

More than 1.4 million people suffer from angina and 275,000 people have a heart attack annually (British Heart Foundation 2010). A recent Bupa report (2009) has suggested that coronary heart disease (CHD) is one of the most costly diseases to both employers and the NHS. While the Department of Health (2009) considers coronary heart disease to be a preventable disease, with predicted rises in obesity (Bupa, 2009) and due to the fact that less than 40% of the population meet recommended physical activity guidelines (Health Survey of England, 2006), means it is likely that coronary heart disease is a condition that will continue to impact working life.

Typical symptoms reported from people suffering from coronary heart disease are a shortness of breath on exertion, chest, jaw, back and arm pain on exertion, dizziness, light-headedness and irregular heartbeat.

*Cancer: current prevalence and typical symptoms*

Approximately 90,000 people of working age are diagnosed with cancer every year and it is estimated that one in three people will receive a diagnosis in their lifetime, for many this will be while they are still at work (Cancer Research UK, 2008). Advances in treatment have meant that many people continue or resume their everyday lives, and this includes their working life. The most common cancers are breast, lung, bowel and prostate which make up over half of all cancer cases in the UK each year (Cancer Research UK, 2009). Cancer treatments can include surgery, radiotherapy, chemotherapy and hormone therapy and regimes vary dependent on the type, location and size of the cancer. Subsequently, the impact of cancer on an employees' ability to continue to work through treatment, or return following treatment, will vary greatly.

Cancer is a broad term that encompasses many different types of cancer, and it is the treatment regime, rather than the type of cancer itself, that typically determines the symptoms or side effects experienced by the patient. For example, a woman undergoing breast cancer surgery to remove a tumor may experience physical pain and reduced arm movement for a contained period, while a woman who also receives radiotherapy may experience chronic fatigue for many years following treatment. Patients tend to experience one or more of the following side effects: persistent fatigue, unintentional weightloss, pain, fever, bowel changes, chronic coughs, and concentration and memory difficulties (Macmillan Cancer Support, 2010).

### **Non-work and work-related factors associated with return to work outcomes**

There has been extensive research into the general predictors of return to work for the major health conditions. While it is out of the scope of this report to review them in detail here, a summary of the non-work and work-related risk factors are presented in the two tables below.

*Table 1: Non-work related risk factors associated with return to work outcomes*

Illness	Non-work risk factors	Examples of research studies
Stress, anxiety, depression	Age, education, fear of relapse, fear of exposure to initial scenario which caused the illness, severity of the illness	European Commission, 2003; Nieuwenhuijsen et al, 2003; Aan et al, 2005; Munir et al, 2007; Baanders et al, 2001.
Backpain	Co-morbidity of depression, age, education, severity of condition, high and persistent pain levels, poorer self reported health status and functional limitations, poor expectations of recovery, fear that undertaking activities will aggravate the problem, high fear avoidance beliefs	Sanders, 1995; Linton & Halldén, 1998; European Commission, 2003; Currie and Wang, 2004; Kuijer et al, 2006; Meijer, 2006; Dionne et al, 2007.
Heart disease	Co-morbidity of depression, age, education, type and severity of condition, functional limitations, expectations of work ability, perceived importance of job, perception of condition	Schleifer, 1989; Boudrez et al, 1994; Petrie et al, 1996; Soderman, 2003; Sykes, 2004; Bhattacharyya et al, 2007.
Cancer	Co-morbidity of depression, age, education, type and severity of condition, treatment regime, amount of fatigue, amount of reported pain, expectations of recovery, own assessment of work ability, work recovery expectations, self assessed work ability	Spelten et al, 2002; Reiso <i>et al</i> , 2003; Ekbladh <i>et al</i> , 2004; Turner <i>et al</i> , 2006; Verbeek, 2006; De Boer et al 2008.

Table 2: Work-related risk factors associated with return to work outcomes

Illness	Work risk factors	Examples of research studies
Stress, anxiety, depression	Poor working conditions, physically demanding jobs, organisations with no formal return to work policies or practices to encourage rehabilitation and disclosure, poor manager communication, high job demands, few opportunities to make work adjustments, low supervisory support, poor wages.	Hogelund J, 2001; Trades Union Congress, 2002; Nieuwenhuijsen et al 2003,2004; Jansen et al, 2003; Aan et al, 2005; Johansson et al, 2006, Munir et al, 2007; Baanders et al, 2001.
Back pain	Poor working conditions, physically demanding jobs, organisations that do not have any formal return to work policies or practices to encourage rehabilitation, low job satisfaction, lack of flexibility over working time, poor perceptions of work safety.	Ekberg & Wildhagen, 1996; Fishbain et al, 1999; Main & Burton, 2000; van der Giezen et al, 2000; Hogelund J, 2001.
Heart disease	Poor working conditions, physically demanding jobs, organisations that do not have any formal return to work policies or practices to encourage rehabilitation, low social support and social isolation, lack of control over work.	Berkman, 1992; Strauss, 1992; Hogelund J, 2001; Sykes, 2004.
Cancer	Poor working conditions, organisations that do not have any formal return to work policies or practices to encourage rehabilitation, high physical demands of the job, poor relationships with/ lack of support from colleagues and superiors, lack of discussion with health professionals on return to work issues, poor control of work hours and amount of work, perceived discrimination of employer, working with carcinogens eg. Asbestos.	Maunsell et al, 1999; Hogelund J, 2001; Spelten et al, 2002; Verbeek et al, 2003; Bouknight et al, 2006; Pryce et al, 2007; Fantoni et al, 2009.

## **Project aims**

This research project aims to:

1. Identify the specific competencies required by line managers to encourage and support the return to work of employees following a period of long term sickness absence due to stress, anxiety and depression, back pain, heart disease or cancer
2. Build a model of the competencies required by line managers to support an effective return to work
3. Test the validity of the Competency Framework for Managers to Support Return to Work, and through doing so, develop a Competency Measure for Managers to Support Return to Work, to test a) the test re-test reliability of the competency framework to determine the stability of behaviours over time; and b) the predictive validity of the competency framework
4. Develop practical guidance and tools for employers, Occupational Health/Human Resource professionals and line managers that specify the competencies required for effective rehabilitation

## 2. RESEARCH METHODS

### Overview of methodology

A combined qualitative and quantitative approach was used to identify manager behaviours and develop a Competency Framework for Managers to Support Return to Work following long term sickness absence due to anxiety and depression, back pain, heart disease or cancer. Data was accumulated from a range of professionals (employees, line managers, HR and OH), in key sectors (Education, Healthcare, Central Government, Local Government, Finance, Manufacturing and Transport) using a combined qualitative and quantitative approach including focus groups, semi structured one-to-one interviews and a questionnaire survey completed by employees and managers at two time points six months apart. This multi-method, multi-perspective approach has been successfully employed previously to develop performance-based competency frameworks (Patterson et al, 2000; Robinson et al, 2005), and more recently to develop a framework for managers to prevent and reduce work stress (HSE, 2007). Furthermore, this approach allows for triangulation and preliminary validation of the findings. The flowchart below outlines the methodology.

**Figure (2.1): Flow chart of the methodology**

#### STAGE 1:

**Identifying the manager's behaviours:** 5 x ½ day workshops with HR and OH professionals and 46 semi structured interviews with managers and employees experienced in the return to work processes. Data was analysed using content analysis and an independent theme sort was used to identify themes and develop the preliminary Competency Framework

#### STAGE 2:

**Developing the Competency Measure for Managers to Support Return to Work:** Questionnaire developed using facet theory drawing from the pool of management behaviours extracted from the focus groups, and interviews with managers and employees.

#### STAGE 3:

**Trial and refinement of the Competency Framework and Measure for Managers to Support Return to Work: Questionnaire Time 1:** Distribution of questionnaire to 186 managers and 359 employees. Analysis of the results and reduction of management behaviours following factor analysis

#### STAGE 4:

**Follow up survey:** Refined questionnaire sent back to the original employees and managers after a period of 6 months. Analysis to examine the reliability and validity of the competency framework over time.

#### STAGE 5:

**Research and practical outputs:** Including a model of the competencies required by line managers to support effective return to work, a Management Competency Indicator Tool and quick view advice leaflets and guidance for employers, employees, OH and HR.

## **STAGE 1: Identifying the manager's behaviours: Workshops and interviews**

Two qualitative approaches were used to identify the behaviours required by managers to support return to work: workshops with professionals and interviews with employees and managers. In total, the perspectives of 78 OH professionals, 64 HR professionals, 26 employees and 20 line managers were gathered.

### **Workshops**

Occupational Health and Human Resource professionals were invited to attend one of five half day workshops sponsored by the Chartered Institute of Personnel and Development (CIPD), the Health and Safety Executive (HSE), Loughborough University and Healthy Working Lives.

The workshops aimed to:

- Gather HR and OH perspectives on the line manager's role in return to work and particularly the effective and ineffective management competencies using a focus group approach;
- Ensure a wide sample of employee and management experiences were captured in the data collection;
- Raise awareness of the manager's role in supporting employees through the return to work process; and
- Provide a platform for recruiting managers and employees for Stage 2 and 3 data collection.

### *Recruitment*

OH and HR professionals were recruited through a variety of channels. The vast majority of the participants were recruited through existing contacts of the researchers and the CIPD, HSE and Healthy Working Lives. Articles placed in relevant publications such as People Management and Occupational Health Journal helped to generate further interest. To ensure key sectors were represented, personal invitations to attend the free workshop and contribute to the research programme were sent out. Participants were also recruited using professional interest emails and web groups. Finally, further contacts were made in meetings with stakeholders and through networking at conferences, seminars and training sessions.

The workshops were advertised as a chance for the OH and HR professionals to network, up-skill and learn more about current research on long term absence management, as well as discuss the important issues surrounding return to work. Workshop bookings were monitored to ensure equal representation from sectors and organisations were encouraged to only send one delegate to optimise the number of participating organisations.

### *Approach*

Workshop delegates were asked to consider one case they had been involved with and to note the positive and negative behaviours the manager had demonstrated throughout the process. In small groups, they were asked to identify common themes and consider what line manager behaviours facilitate or represent barriers to employee return-to-work following long term sickness absence due to anxiety and depression, back pain, heart disease or cancer. 1.

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<sup>1</sup> A comprehensive review of the workshops see Yarker, J., Hicks, B., Donaldson-Feilder, E., & Munir, F. (2009). Line managers and return to work. Report on workshop discussions held on behalf of the British Occupational Health Research Foundation.

## **Interviews**

Semi-structured interviews were carried out with line managers and employees, who had been through the return-to-work process following long term sickness absence. The interviews were transcribed and content analysis was used to identify important themes.

The interviews aimed to:

- Identify the behaviours shown by managers during a period of absence and through the return to work process as perceived by 26 employees and 20 managers;
- Assess the usability of the return to work competencies and to identify what type of management framework, tools, guidance and resources would be most beneficial.

### *Recruitment*

Workshop delegates (OH and HR professionals) were asked to seek interest from managers who had managed employees' return, or employees who had returned to work following a period of sickness absence from one of the four conditions. 26 employees and 20 managers took part in a telephone interview lasting approximately 40 minutes. Although more people came forward for interview, it was felt that data saturation had been reached, all of the four major health conditions had been sufficiently covered and the requirements of the study design had been met. There were a total of 31 successful return-to-work scenarios and 15 unsuccessful return-to-work scenarios. Interviewee demographics for the employee and the manager are shown in appendix 1.1 and 1.2 respectively.

### *Interview proformas*

Two interview proformas were designed; one for managers and one for employees. These were developed to elicit information regarding specific positive and negative managerial competencies relevant to supporting return to work.

For all interviews, a critical incident technique was used (Flanagan, 1954). This technique is advantageous in that it facilitates the revelation of issues which are of critical importance and enables issues to be viewed in their context. It also places a focus on observable incidence, and therefore a useful approach in identifying specific manager behaviours shown in the return to work process. As many of the incidents occurred some years previously, it was recognised that the recollection of these events may not be entirely accurate. To partially counter this, participants were emailed two days before the interview and encouraged to reflect upon the specific episode and in particular their manager's behaviours and actions throughout their absence and subsequent return to work.

Interviewees were asked to consider five separate stages of their absence and return: the point they were initially diagnosed; when they first went off; during their absence from work; their subsequent return to work; and finally their current situation now they were back at work (if applicable).

Interview proformas were piloted with two managers and two employees. As a result of these examinations, minor improvements were made. To view both the manager and the employee interview proformas see appendix 2.1 and 2.2 respectively

### *Analysis*

Interviews were recorded and fully transcribed. Transcripts were held on an NVivo data management system for ease of storage and analysis. Behaviours were then extracted from the transcripts on the basis of the definition 'all managerial behaviours (positive and negative) associated with the management of an employee's return to work following sickness absence.' This was performed using content analysis (Miles & Huberman, 1984). This is a technique used to quantify the interviewees' statements or behavioural indicators and

generate frequencies; a process widely used in qualitative research (Narayan et al, 1999; Dasborough, 2006; HSE, 2007).

In order to evaluate the extent of agreement between raters on what constituted a behaviour, two employee and two manager interviews were chosen at random. Two researchers then independently highlighted behaviours from the transcript using the definition mentioned above. A high level of agreement between the researchers was achieved and behaviours were independently identified by the two researchers from a further 20 randomly selected transcripts (10 managers and 10 employees). The behaviours from the 20 transcripts were placed onto cards (one card per behaviour) in preparation for the card sort. A total of 348 behaviours were ascertained from these transcripts.

Two impartial observers, blinded to the aims of the study (Dasborough, 2006), were asked to sort the behaviours into themes. The preliminary card sort identified 10 broad themes. Two researchers then discussed the emerging themes. From this, a further two themes were created which encompassed those behaviours which previously did not aptly fit with the originally formulated themes. The secondary card sort identified a total of 12 themes. This process is in accordance with other published research (Patterson et al, 2000) in which the project researchers (rather than objective observers) conducted the secondary card sort (HSE, 2007). Having established the themes, the remaining transcripts were analysed using content analysis and each behaviour coded according to the theme which was most befitting. No differences in behavioural indicators were found between themes reported by employees or managers or between sectors and therefore the same coding framework was applied to all data.

The analysis of this data was compared to the themes identified from the professional workshops for accordance. A further two behaviours were added with regard to both the employee's and manager's knowledge of the legal requirements regarding the return to work procedure. Once agreed, these 12 themes and 75 behaviours then constituted the preliminary Competency Framework for Managers to Support Return to Work. This preliminary framework was used to develop the Competency Measure for Managers to Support Return to Work.

#### *Data protection*

Throughout the workshops and the interviews data protection was consistent with the Data Protection Act. All participants were made aware of their confidentiality rights. All interviewees were assured that their participation was voluntary and that their organisation would not be made aware of whether they had participated or not. It was emphasised that no one at their organisation or outside the research team would be made aware of their responses. All written data from both the workshops and the interviews would be anonymised, coded and securely stored at Goldsmiths, University of London with only the research team being granted access to it. Before any interviews began, this procedure was reemphasised to the interviewees and they were assured that they could stop the tape at any point throughout the interview without question. Only when the participant had understood and agreed to these terms, did the interview begin.

### **STAGE 2: Developing the Competency Measure for Managers to Support Return to Work**

A Measure for Managers to Support Return to Work was developed for three reasons: first, to refine and test the reliability and validity of the Competency Framework for Managers to Support Return to Work, and second, to measure employees ratings of manager behaviour and compare these ratings to return to work outcomes, and third, to develop a self-report tool for managers to rate their own behaviour as a development aid.

Once the preliminary behaviours had been established, the behaviours were converted into questionnaire format using an approach called Facet Theory (Donald, 1995). Facet Theory requires the statements to i) overall cover all 12 themes, ii) each to reflect a single theme, iii) include an active verb iv) refer to an observable or inferable behaviour. Although Facet Theory suggests that each question is phrased positively it was decided that negative manager behaviour may be more than the absence of positive manager behaviour due to the phrasing of the original behaviours and so therefore both positively and negatively phrased statements were included. This is consistent with good practice in psychometric scale development (Coolican, 2004). All ambiguous, double-barrelled or leading statements were re-written or deleted. All statements were the same for both the employee and manager framework.

The statements in the employee framework were prefixed by 'My manager...' and those in the manager framework were prefixed by 'I.' All scores were rated on a five point Likert scale from 'Strongly Agree' to 'Strongly Disagree' with an additional response option of 'No opportunity to observe'. The initial measure consisted of 75 items. The framework was distributed for comments to the British Occupational Health Research Foundation steering group as well as a number of employees and managers who had been through the return to work experience. It was agreed that all statements were relevant, easy to comprehend and were void of jargon and ambiguity. Once the preliminary measure had been developed it was added to the start of both the manager and employee questionnaires which aimed to explore other aspects of return to work following long term sickness absence.

### **STAGE 3:**

#### **Trial and refinement of the Competency Framework and Measure for Managers to Support Return to Work: Questionnaire Time 1**

A quantitative questionnaire-based approach was used to trial and refine the Competency Framework for Managers to Support Return to Work. Two questionnaires were developed: one for the employees and the other for their managers, and distributed via participating organisations and charities.

This stage aimed to:

- Trial and refine the Competency Framework for Managers to Support Return to Work, and in doing so,
- Refine the Competency Measure for Managers to Support Return to Work (i.e. develop a robust, reliable and valid measure of manager behaviour), and
- Examine the associations between manager behaviour and a range of return to work outcomes thereby identifying whether some manager behaviours are more important in the return to work process than others.

## *Recruitment*

Occupational Health and Human Resource professionals who attended the Stage One workshops were asked to seek interest from managers and employees meeting the study criteria. Uptake was significantly lower than expected, particularly given the participation in and response to the workshops. The questionnaire release coincided with two major events: the onset of the recession and the outbreak of swine flu. The implications for these are addressed further in the discussion under limitations of the study section. In an attempt to address this, recruitment was expanded to a range of relevant charities and support networks. A total of 359 employees and 186 managers responded to the survey. From this figure, 264 employees were recruited through organisations and contacts and the remaining 95 were recruited through charities. For managers, 151 were recruited through organisations and contacts and the remaining 35 were recruited through charities. While the target of 250 managers was not achieved due to recruitment challenges, it was agreed on consultation with the advisory group that the sample of 186 managers would not detract from the power of the study findings as the original targets had been drawn on conservative estimates. Further participant details are reported in the results section.

## *Procedure*

The questionnaire was placed online using Survey Monkey. The web link to the survey was sent out to:

- managers who had recently managed or were about to manage an employee returning to work following long term absence due to anxiety and depression, back pain, heart disease or cancer; and
- employees who had recently returned or were about to return to work following the same health conditions.

## *Employee questionnaire*

- Competency Measure for Managers to Support Return to Work (Preliminary 75 item version)
- Socio-demographic and illness specific information on age, gender, education, occupation, type of employment (part time or full time), size of the employing organisation and union activity, illness diagnosis, treatment schedule and illness self-management strategies, health status and current or recent absence.
- Well being using the 12 item General Health Questionnaire (Goldberg, 1972). This measure consisted of 12 items which gathered information on how the employee had been feeling over the past month e.g 'Have you recently lost much sleep over worry?' Likert scoring was used where each item was scored from 0 (not at all) to 3 (much more than usual). Negative items were reversed scored. The GHQ-12 has been found to be a valid and reliable measure of well being (e.g. Gilbreath & Benson, 2004).
- Psychological stress using the MOS Health Distress Scale (Stewart & Ware, 1992). This was a 4 item scale which asked questions such as 'Are you discouraged by your health problems?' This was scored on a 6 point Likert scale ranging from 'None of the time'(1) to 'All of the time' (6).
- Functional limitations using the 8 item Work Limitations Questionnaire (Lerner et al, 1998). This is designed to assess how much impact the employee's health condition has had on their work in the past 2 weeks. The questionnaire is measured on a 5 point Likert Scale ranging from 'Difficult none of the time' (1) to 'Difficult all of the time' (5).
- Job satisfaction scale (Nagy, 2002). This scale asks how satisfied the employee was with their job before their absence and how satisfied they are with it now. It is measured on a 7 point Likert scale ranging from 'extremely dissatisfied' (1) to 'extremely satisfied' (7).

- Self rated job performance scale (Bond & Bunce, 2001). This scale asks the employee to rate their performance before their absence and then rate it at the present time. This is scored on a 7 point Likert scale ranging from 'very poorly'(1) to 'extremely well'(7).

### *Manager questionnaire*

In addition to the competency measure the questionnaire included the following measures:

- Socio-demographic information similar to that of the employee.
- General Health Questionnaire (Goldberg, 1972).
- The managers awareness of Occupational Health and Human Resource issues including sickness absence, sources of workplace support, employer work adjustments and intervention.
- Experience of and attitudes towards managing employees returning to work following a period of long term sickness absence.
- Prior training and development in returning employees to work.

### *Reduction of the Competency Framework and Measure for Managers to Support Return to Work*

The preliminary version of the Competency Measure for Managers to Support Return to Work was comprised of 75 questions, each describing a behaviour identified from the interviews and focus groups. In order to develop a robust measure of behaviour, it was necessary to conduct a procedure of reliability analysis and factor analysis. Reliability analysis assesses whether the questions offer a consistent measure of behaviour i.e. is the question measuring the same thing each time? Factor analysis examines the underlying structure of the questions: do they all measure the same thing, or do they measure slightly different concepts? These steps ensured that only those questions that differentiated between responses and meaningfully measured behaviour were kept in the questionnaire.

Data was analysed using a process of reliability analysis, as described by Rust and Golombok (1999). Items were removed if they i) had a facility index equal to or approaching either extreme score, ii) had a good facility index but low standard deviation, iii) had item-total correlations below 0.2, iv) had inter-item correlations above 0.9 and v) had low squared multiple correlations. Finally items where 30% of the data was missing were removed. All of these measures were carried out on both the employee and manager data.

Before a factor analysis was carried out on the remaining 62 items from the employee competency framework, responses of 'no opportunity to observe' were re-coded to 'missing data' to avoid a negative skew, and negatively phrased questions were reverse coded. Following pre-analysis checks on the data to ensure that a stable factor structure could emerge, that the items were properly scaled and free from bias, and that the data set satisfied all necessary multivariate assumptions (e.g. normality, linearity, and homoscedascity) a factor analysis was conducted. Items were factor analysed using an oblique criterion and a direct oblimin rotation. Questions related to the manager's behaviours while the employee was absent from the workplace were separated from the rest of the behaviours which were more concerned with when the employee had returned to the workplace. The decision for this was twofold. Firstly, conceptually the behaviours are very different, with one set relating to manager's behaviours while the employee is absent and the other relating to behaviours once the employee has returned to work. Secondly, whilst the information given from the interviews and the workshops described these behaviours as separate, when conducting the factor analysis some important and relevant behaviours associated with the period once the employee has returned to work may have been clouded and lost in place of those behaviours concerned with when the employee was absent from the workplace. It therefore seemed logical to remove these behaviours and separate the return to work into two separate time periods; 'while the employee was absent' and 'once

they returned to work.’ Application of a scree test (Ferguson & Cox, 1993) suggested three factors should be rotated. Items loading at or above 0.4 were regarded as significant and items which loaded significantly onto more than one factor were either excluded where the difference was less than 0.2 or allowed to remain where the difference was over 0.2, in which case they were assumed to load onto the factor with the highest loading. The analysis was re-run until the final pattern matrix satisfied these criteria.

The final measure contained 42 items across four sub-scales: a scale comprised of 10 items associated with ‘while the employee was absent from the workplace’ ( $\alpha$  .93); and three factors (factor 1: 7 items,  $\alpha$  .91; factor 2: 5 items,  $\alpha$  .89; factor 3: 20 items,  $\alpha$  .98). All of the alpha coefficients ranged above the minimum of 0.70 recommended by Nunally (1967). Following the successful completion of the factor analysis on the employee data, the structure was reviewed in the manager sample. A factor analysis was conducted on the manager data to see if any different factors emerged which were not present in the employee data i.e., the employee would not have known if the manager was carrying out some actions when they may well be behind the scenes. From this analysis it was shown that no other significant factors became apparent.

The competency framework including the four sub-scales was sent to the BOHRF steering group in order to define the names of the factors and any sub-clusters within each factor that may be apparent.

#### *Analysis of associations between manager behaviour and return to work outcomes*

A correlation analysis was conducted to explore the associations between demographic variables and return to work outcomes, and the four line manager behaviour competencies. A series of separate stepwise regression analyses were run to examine each return to work outcome: First, each return to work outcome (Time 1) was examined for the total sample; Second, each return to work outcome (Time 1) was examined separately for each of the four illness conditions; Third, each return to work outcome (Time 1) was examined for the whole sample omitting the competency ‘While the employee is off’.

For each set of analyses, the demographic variables that correlated with the return to work outcome being tested were included in step one, so as to control for variance in the outcome attributed by the employee demographics; the four line manager behaviour competencies were entered in step two.

A regression analysis was also conducted on the manager demographics and their scores on the manager competencies. This was to assess whether any external factors play a role in improving their line manager competency scores.

#### **STAGE 4:**

##### **Questionnaires Time 2: Follow up survey**

This final stage of data collection and analysis aimed to examine the associations between the Competency Measure for Managers to Support Return to Work and return to work outcomes over time.

Questionnaires were administered following a six month gap to all those employees and managers who had indicated their willingness to participate in Time 2. The Time 2 questionnaire included the refined Competency Framework for Managers to Support Return to Work and the same outcome measures as measured in Time 1.

The data analysis strategy used in Time 1 was applied.

### **3. RESULTS**

The results are presented in four parts:

Part 1: Sample demographics and sickness absence patterns

Part 2: The Competency Framework and Measure for Managers to Support Return to Work

Part 3: The relationship between the Competency Framework for Managers to Support Return to Work and return to work outcomes

Part 4: Key issues associated with return to work

Data collected from the interviews and workshops were used to develop the Competency Measure for Managers to Support Return to Work. Qualitative data is not presented here but can be found in appendix 3. The information illustrated presents responses from Time 1 questionnaire unless stated otherwise. Time 2 data is presented where appropriate and discussed in relation to any change or stability when compared to Time 1 responses. Data has been summarised in this section, however full statistical findings can be observed in appendix 4-16.

#### **Part 1: Sample demographics**

##### **Employee characteristics**

A total of 359 employees responded to the Time 1 questionnaire of which 347 were suitable for further analysis. Questionnaires were deemed suitable for further analysis if the respondent had completed over 80% of the Competency Measure for Managers to Support Return to Work section at the beginning of the questionnaire. The sample was balanced in terms of gender (147 females (52%) and 135 males (48%)), with a mean average age of 45 years old (sd: 9.7). 14% of employees held vocational qualifications, while the majority of the sample held qualifications above GCSE or equivalent (GCSE: 28%, A level: 22%, Degree: 24%, Post Graduate: 12%).

The majority of respondents were employed within IT (34%), Telecommunication (26%), Education (10%), Retail (8%) and Healthcare (6%). Employees' average length of tenure was 17 years (sd: 11.3). A substantial proportion of the employees worked within large organisations of over 5000 people (75%) with smaller organisations (between 1-249 personnel) being represented by only 8% of the employees who responded. The majority of employees worked regular 9am-5pm hours (85%) as opposed to shift hours (15%) and 77% were part of a Union. 44% of the employees earned between £7,000 and £28,000 a year, 38% earned between £29,000 and £41,000, 15% earned between £42,000 and £62,000 and 3% earned between £63,000 and £76,000 a year.

##### *Time 2 employees' characteristics:*

A total of 115 employees responded to the T2 questionnaire of which 111 were usable. The sample composition was comparable to that of Time 1.

##### **Manager characteristics**

A total of 186 managers responded to the questionnaire of which 177 questionnaires were usable. 57 females (55%) and 47 (45%) males responded to the questionnaire with a mean age of 45 years old (sd 7.8). 9% of managers held a vocational qualification, with the majority holding qualifications above GCSE level or equivalent (GCSE 28%, A level 13%, Degree 27%, 23% Post graduate. The sample reflected a number of sectors; Telecommunication (20%), IT industries (15%), Healthcare (14%), Retail (11%) and Central Government (11%). Managers' average length of tenure was 18 years (sd: 10.2). 48% of the managers worked within organisations of over 5000 employees and only 11% were employed in smaller organisations of between 1-249 employees. 83% of managers worked regular hours (83%) as opposed to shift hours and 69% were part of a Union. 16% of managers earned between £7,000 and £28,000 a year, 45% earned between £29,000 and £41,000,

29% earned between £42,000 and £62,000 and 8% earned between £62,000 and £76,000 a year and 2% earned over £76,000 a year.

Only 31 managers answered the questionnaire at Time 2, despite three attempts to follow-up and the offer of incentives in the form of 'prize vouchers'. Unfortunately this figure was insufficient to conduct any meaningful analyses. The consequences of this low response rate were two fold: firstly, we were unable to examine whether managers perceived their behaviours on the competencies to change or remain stable over time, and secondly, we were unable to examine those manager characteristics (e.g. demographics, training) that predicted self-reported behaviour on the Measure to Support Return to Work. While this is disappointing, it does not detract from the main objectives of this study as it is the employees rating of their managers' behaviour, and the links between these ratings and the employees return to work outcomes, that provide key information about the validity (both test re-test and predictive validity) of the framework. A summary of descriptive findings can be found in appendix 8.

### Sickness absence patterns

Table 3: Sickness absence of employees (Time 1 data)

Chronic Illness	Total		Female		Age		Time since diagnosis (mean, months)		length of absence in the last 2 years (days)	
	No.	%	No.	%	No.	sd	No.	sd	No.	sd
Stress, anxiety and depression	207	58	98	53	44	9.5	46	77.3	103	71.2
Back pain	56	16	23	52	42	9.1	98	101.6	78	51.5
Heart disease	30	8	3	13	54	5.6	49	134.1	92	67.8
Cancer	46	13	25	69	47	8.8	26	24.3	165	111.6
All employees	347	100	147	52	45	7.8	51	85.3	105	78.2

*\*It is noted that the condition of stress, anxiety and depression is over represented in this sample. This may reflect a response style which is specific to this group, such that those with stress, anxiety and depression are more willing to respond to questionnaires relating to their line manager and the improvement of the return to work process than those employees with other health conditions.*

Table 3 shows the responses across illness conditions. Heart disease was the only condition reported by more men (87%) than women (13%). On average, employees with back pain reported that they had their condition the longest (mean 98 months), while those with cancer reported longer periods of sickness absence. A comparable sample composition was reported at Time 2.

Managers reported that they had managed employees returning to work following stress, anxiety and depression (69%), cancer (16%), back pain (9%) and heart (6%) respectively.

*Table 4: Time since the employee returned to work following long term sickness absence (Time 1 data)*

Group	Returned less than 3 months		Returned longer than 3 months		Number of people who have relapsed at least once
	No.	%	No.	%	
Stress, anxiety and depression	108	59	75	41	62 (30%)
Back pain	21	50	21	50	15 (28%)
Heart	14	61	9	39	2 (7%)
Cancer	16	46	19	54	9 (20%)
All employees	161	57	122	43	88 (31%)

Table 4 shows the length of time employees had been back at work on completing the questionnaire. 'Time since returning to work' was categorised into those who had returned to work for 3 or less months, and those who had returned longer than 3 months. Those who were absent due to stress, anxiety and depression and backpain were more likely to experience relapse, and take a further period of sickness absence, than those with heart disease or cancer. Employees reported that their relapse was attributed to a variety of factors: for some the absence was attributed to their primary illness, for others a secondary illness was reported (e.g. stress) to be the cause of their second period of absence.

## Part 2: The Competency Framework for Managers to Support Return to Work

The final Competency Framework for Managers to Support Return to Work was comprised of four competencies. The framework and example behaviours are shown in Table 5.

Table 5: The Competency Framework for Managers to Support Return to Work

Competency	Sub-competency	Do (✓) / Don't (✗)	Examples of manager behaviour
While the employee is off		✓	<p>During the employee's absence, the manager...</p> <ul style="list-style-type: none"> <li>Regularly communicates with the individual via telephone or email</li> <li>Regularly communicates work issues with the individual to keep them in the loop</li> <li>Focuses conversations more on the individual's wellbeing</li> <li>Is in touch with the individual's close colleagues with regards to their health</li> <li>Encourages work colleagues and other members of the organisation to keep in touch with the individual</li> <li>Relays positive messages through family or friends</li> <li>Makes it clear that the individual should not rush back to work</li> <li>Makes it clear that the company will support the individual during their absence</li> <li>Reassures the individual that their job will be there for them when they return</li> <li>Prevents the individual from pushing him/herself too much to return to work</li> </ul>
The initial return to work		✓	<p>On the employee's return, the manager...</p> <ul style="list-style-type: none"> <li>Gives the individual lighter duties/ different jobs during their initial return to work</li> <li>Incorporates a phased return to work for the individual</li> <li>Remains objective when discussing return to work adaptations for the individual</li> <li>Explains the return to work process/procedures to the individual before they return</li> <li>Explains any changes to the individual's role, responsibilities and work practices</li> <li>Meets the individual on their first day back</li> <li>Makes the individual's first weeks back at work as low stress as possible</li> </ul>
Negative behaviours		✗	<ul style="list-style-type: none"> <li>Loses patience with the individual when things become difficult</li> <li>Displays aggressive actions</li> <li>Questions the individual's every move</li> <li>Goes against the individual's requests for certain adjustments to be made to their work</li> <li>Makes the individual feel like a nuisance for adding extra work to their schedule</li> </ul>
General behaviour	Managing the team	✓	<ul style="list-style-type: none"> <li>Asks the individual's permission to keep the team informed on their condition</li> <li>Makes the individual feel like they were missed by the organisation</li> <li>Encourages colleagues to help in the individual's rehabilitation process</li> <li>Promotes a positive team spirit</li> <li>Regularly communicates with HR/OH and keeps the individual informed</li> </ul>
	Open and sensitive approach	✓	<ul style="list-style-type: none"> <li>Is proactive in arranging regular meetings to discuss the individual's condition and the possible impact on their work</li> <li>Communicates openly</li> <li>Listens to the individual's concerns</li> <li>Understands that, despite looking fine, the individual is still ill</li> <li>Appreciates the individual's wishes</li> <li>Has an open door policy so the individual can always approach them with any concerns</li> <li>Adapts their approach to be more sensitive towards the individual</li> <li>Allows the individual to maintain a certain level of normality</li> <li>Is quick to respond to the individual via email or telephone when they have a concern</li> <li>Takes responsibility for the individual's rehabilitation</li> <li>Acknowledges the impact the individual's illness has on them</li> <li>Remains positive with the individual throughout their rehabilitation</li> </ul>
	Legal and procedural knowledge	✓	<ul style="list-style-type: none"> <li>Shows awareness of their relevant legal responsibilities</li> <li>Understands the need to make reasonable adjustments by law</li> <li>Follows the correct organisational procedures</li> </ul>

The final Competency Measure comprised of 42 questions, across the four competencies for Managers to Support Return to Work. The questions included in the measure are shown in Table 6. All responses were rated on a 5-point likert scale 'Strongly disagree' (1 point) to 'Strongly agree' (5 points). There is also the option to answer 'No opportunity to observe.' The 'Negative behaviours' competency is reverse coded; 'Strongly disagree' (5 points) and 'Strongly agree' (1 point).

*Table 6: Competency Measure for Managers to Support Return to Work*

Competency	Item
	<b>'During my absence my manager.....'</b>
While the employee is off	1 Regularly communicated with me via telephone or email 2 Regularly communicated work issues with me to keep me in the loop 3 Focussed conversations more on my wellbeing 4 Was in touch with my close colleagues with regards to my health 5 Encouraged work colleagues and other members of the organisation to keep in touch with me 6 Relayed positive messages through family or friends 7 Made it clear that I should not rush back to work 8 Made it clear that the company would support me during my absence 9 Reassured me that my job would be there for me when I returned 10 Prevented me from pushing myself too much to return to work
	<b>'My manager.....'</b>
The initial return to work	11 Gave me lighter duties/ different jobs during my initial return to work 12 Incorporated a phased return to work for me 13 Remained objective when discussing return to work adaptations for me 14 Explained the return to work process/procedures to me before I returned 15 Explained any changes to my role, responsibilities and work practices 16 Met me on my first day back 17 Made my first weeks back at work as low stress as possible
Negative behaviours	18 Lost patience with me when things became difficult 19 Displayed aggressive actions 20 Questioned my every move 21 Went against my requests for certain adjustments to be made to my work 22 Made me feel like a nuisance for adding extra work to their schedule
General behaviour Managing the team	23 Asked my permission to keep the team informed on my condition 24 Made me feel like I had been missed by the organisation 25 Encouraged colleagues to help in my rehabilitation process 26 Promoted a positive team spirit 27 Regularly communicated with HR/OH and kept me informed
Open and sensitive approach	28 Was proactive in arranging regular meetings to discuss my condition and the possible impact on my work 29 Communicated openly 30 Listened to my concerns 31 Understood that despite looking fine, I was still ill 32 Appreciated my wishes 33 Had an open door policy so I could always approach them with any concerns 34 Adapted their approach to be more sensitive towards me 35 Allowed me to maintain a certain level of normality 36 Was quick to respond to me via email or telephone when I had a concern 37 Took responsibility for my rehabilitation 38 Acknowledged the impact my illness had on me 39 Remained positive with me throughout my rehabilitation
Legal and procedural knowledge	40 Showed awareness of their relevant legal responsibilities 41 Understood the need to make reasonable adjustments by law 42 Followed the correct organisational procedures

### Reliability of the Competency Measure for Managers to Support Return to Work

Following the factor analysis, the internal reliability or consistency of the measure was calculated. A reliability of 0.70 or higher is usually considered 'acceptable' (Nunnally, 1967). Table 7 illustrates that there is a high internal reliability between the questions that make up each of the four competencies.

*Table 7: Internal reliability of the Competency Measure for Managers to Support Return to Work*

Return to work line manager competency	Number of questions	Cronbach's Alpha Reliability
While the employee is off	10	0.93
The initial return to work	7	0.91
Negative behaviours	5	0.89
General behaviours	20	0.98

### Stability of the Competency Measure for Managers to Support Return to Work across employee characteristics

A series of analyses were conducted to examine differences in responses to the Competency Measure across a range of employee characteristics. An independent t-test showed that non-union members reported their managers' behaviour to be significantly better on the Competency Measure than union members. Non union members ( $M = 3.7$ ,  $s = 0.87$ ) and the union members ( $M = 3.3$ ,  $s = 0.92$ ),  $t(279) = 2.802$ ,  $p = .005$ ,  $\alpha = .05$ ). No significant differences on the Competency Measure were found for gender, age, salary, size of organisation and length of tenure.

*Table 8: The stability of the Competency Measure across conditions*

Competencies	Stress, anxiety and depression (mean)	Back pain (mean)	Heart disease (mean)	Cancer (mean)
While the employee is off	28.5	28.8	36.8	35.9
The initial return to work	22.7	22.5	26.8	25.5
Negative behaviours	19.6	20.5	22.6	22.6
General behaviours	60.1	62.9	76.6	72.5

*\*Please note that the 'Negative behaviours' competency was reversed coded and therefore high manager scores on this competency relate to better avoidance of the negative behaviours by the manager.*

A series of analyses were conducted to examine differences in responses to the Competency Measure across the chronic illness conditions. A series of one way ANOVAs showed significant differences between conditions to the Competency Measures: employees with stress, anxiety and depression and back pain rated their manager significantly lower than those with heart disease and cancer on the competencies 'While the employee is off', 'Negative behaviours' and 'General behaviours'; and employees with stress, anxiety and depression, and back pain rated their manager significantly lower than those with heart disease on the competency 'Initial return to work'.

### **Stability of the Competency Measure for Managers to Support Return to Work over time**

A sub-sample of employees completed the questionnaire at two time points, with a six month interval. The employees' rating of their managers on the overall framework and each of the four competencies over time was analysed using a number of paired samples T-tests. It was found that employees rated their manager significantly lower (poorer) on the Competency Framework at Time 2 than they did at Time 1: specifically, differences were found for ratings on three of the four competencies: 'While the employee is off,' 'The initial return to work,' 'General manager behaviours'. No significant change in rating was found for the competency 'Negative behaviours'.

### **Line manager characteristics associated with responses on the Competency Measure for Managers to Support Return to Work**

The line manager data was examined to identify any characteristics, experience or training events associated with their self-rated responses on the Competency Measure for Managers to Support Return to Work. A regression analysis indicated that attendance on a relevant training course and past experience of managing employees back to work, and their self-rated behaviour on the competencies 'Initial return to work' and 'General Managers' Behaviours'. Furthermore, the sector in which managers worked was significantly associated with the managers' scores on the competency 'While employee is off'.

### Part 3: The relationship between the Competency Measure for Managers to Support Return to Work and the Return to Work outcomes

The Competency Measure for Managers to Support Return to Work was found to be associated with a range of return to work outcomes. An initial bivariate correlation analysis was used to examine the relationship between the return to work outcomes and employee demographics. Those variables that correlated with the return to work outcomes were controlled for in subsequent analysis. A series of stepwise regression analyses were then used to examine the associations between the Competency Measure and return to work outcomes. A summary of analyses are presented in the tables that follow, full regression tables can be found in Appendix 5-7.

Table 9: Line manager behaviour and return to work outcomes for the total sample (Time 1)

RTW line manager competency	Length absence	Well being	Psych distress	Work limitations					PA	NA	Job perf	Job sat
				P	T	M	O	OP				
Controls: Gender Age Salary Education Type of organisation Employees in org	**	**  *	**	**	**	**		**	**	**	*	**   **
While the employee is off		*		***	***				***	**	**	
Initial RTW	*									*		
Negative behaviours		*	***			***	***		***	**		
General behaviours	**											***

Key: (PA) Positive Affect, (NA) Negative Affect, Work limitations including Time Management (T), their Physical Capacity (P), their Mental Capacity (M), their Output Demands (O) and their Overall Production lost (OP); \* p>.05, \*\*p>.01, \*\*\*p>.001

A further series of analyses were carried to examine any differences between each of the four illness conditions. Different models were found for each illness condition, with the measure for managers to support return to work playing the most significant role for those employees with stress, anxiety and depression.

### *Stress, anxiety and depression*

Employees who rated their manager highly on the competency 'While the employee is off' reported greater job performance and positive mood states, lower negative affect, greater well being, lower psychological distress, lower sickness absence and with having less perceived impact on their time management and mental workload.

Employees who rated their manager highly on the competency 'Initial return to work', reported greater negative affect and psychological distress and as having a greater impact on their perceived mental workload. Although this appears counter intuitive, it may be a reflection on the employees' general make-up, as this relationship is only present within employees suffering from stress, anxiety and depression. Those employees who are naturally higher on negative affect and psychological distress scales are more likely to be absent from work through stress, anxiety and depression.

Employees who rated their managers as demonstrating higher levels of 'Negative behaviours' also reported greater negative affect, and a greater impact of their illness on their physical and output capacities and their overall production lost.

Employees who rated their manager highly on the competency 'General manager behaviour' reported greater employee job satisfaction.

### *Back pain*

For employees with back pain conditions, those who rated their manager higher on the 'While the employee is off' competency reported their illness having a less negative impact on their physical capacities. Employees who rated their manager as demonstrating higher levels of 'Negative behaviours' reported a greater impact of their illness on their time management capacities. The 'Initial return to work' and the 'General manager behaviours' competencies were not significantly correlated with any of the return to work outcomes.

### *Heart disease*

For employees with heart disease conditions, those who rated their manager higher on the 'While employee is off' competency reported lower lengths of absence. Employees who rated their manager as demonstrating higher levels of 'Negative behaviours' experienced greater negative affect and perceived a greater impact on their physical, mental, time, output capacities and perceived overall loss in production. 'General manager behaviours' competency was not significantly correlated with any employee return to work outcomes.

### *Cancer*

For employees with cancer, those who rated their manager higher on the 'While employee is off' competency were significantly correlated with higher job satisfaction scores. Those who rated their manager higher on the 'Initial return to work' competency were significantly correlated with higher job performance scores and well being scales as well as lower scores on the negative affect. They were also correlated with having less perceived impact on their physical capacities. Employees who rated their manager as demonstrating fewer 'Negative behaviours' reported less perceived impact on their output capacities and perceived overall production lost. Finally, employees who rated their manager higher on the 'General manager behaviours' competency reported less impact on their time management capacities.

Table 10: Line manager behaviours (excluding the 'While employee is off' competency) and return to work outcomes for the total sample (Time 1)

RTW line manager competency	Length absence	Well being	Psych distress	Work limitations					PA	NA	Job perf	Job satis
				P	T	M	O	OP				
Controls: 1. Gender 2. Age 3. Salary 4. Education 5. Type of organisation	**	**  *	* *	**	**	**		**	**	** *	** **	
Initial RTW	*											
Negative behaviours		***	***	***	***	***	***	***		***		
General behaviours	**							***		***	***	

As the competency 'While the employee is off' played such a significant role in predicting each of the return to work outcomes at Time 1, the analyses were re-run omitting this competency to establish the order of importance of competencies required once the employee returned.

Employees who reported their manager demonstrating higher levels of 'Negative behaviours' reported lower well being, greater psychological distress and negative affectivity and greater work limitations. Those who rated their manager higher on the competency 'General manager behaviours' reported greater job performance and job satisfaction, higher positive affect and lower lengths of absence. Surprisingly, higher ratings on the 'Initial return to work' competency were associated with longer lengths of absence. This suggests that the longer an employee is absent then the more effort a manager shows when the employee initially returns to work.

A further regression analysis was carried out on the return to work outcomes for each specific employee condition taking into account the significantly correlated demographic controls.

#### *Stress, anxiety and depression*

For employees with stress, anxiety and depression those who rated their managers higher on the 'General manager behaviours' reported better job satisfaction, positive affect, lower lengths of absence, and reported fewer limitations on their time management capacities. Employees who reported their manager demonstrating higher levels of 'Negative behaviours' reported higher levels of negative affect, greater psychological distress, lower well being and greater work limitations. Again, the 'Initial return to work' competency was associated with greater lengths of sickness absence.

#### *Back pain and heart disease*

For employees with back pain conditions and heart disease there were no significant correlations between the three manager competencies and any return to work outcomes.

#### *Cancer*

For employees with cancer, those who rated their manager higher on the 'Initial return to work' competency reported lower negative affect, higher well being, and fewer perceived limitations on their physical capacities. Those who reported their manager demonstrated

lower levels of 'Negative behaviours' reported less perceived production lost and output demand capacities. Those who rated their manager higher on 'General manager behaviours' reported less perceived limitations on their time management capacities.

### The relationship between the Competency Measure for Managers to Support Return to Work and the Return to Work outcomes: Over Time

The relationship between the Competency Measure for Managers to Support Return to Work and the return to work outcomes were examined over time. Employees completed the questionnaire at two time points, with a six month interval. Data was analysed to examine whether manager behaviour predicted return to work outcomes over time.

Table 11: Line manager behaviour and return to work outcomes for the total sample (Time 2)

RTW line manager competency	Well being	Psych distress	Work limitations					PA	NA	Job perf	Job satis
			P	T	M	O	OP				
Controls: Salary Employees in org	**	**	*	*	*	**	*	***	*		
While the employee is off											
Initial RTW			**	**	*	*	**				
Negative behaviours	**	*							**		***
General behaviours											

The competencies 'While the employee is off' and 'General behaviours' competencies were not associated with any of the return to work outcomes measured at Time 2. However, the competencies 'Initial return to work' and 'Negative behaviours' played more of a role explaining return to work outcomes than at Time 1.

Due to the smaller sample size of Time 2, data was analysed as one group containing the four health conditions. While it was not possible to examine whether the specific models of manager behaviour identified at Time 1 were replicated at Time 2, the analysis over time using the full sample including employees from all four illness groups, showed that variations in manager behaviour predicted across a range of return to work outcomes.

Table 12: Time 1 line manager behaviour and return to work outcomes of employees at Time 2

RTW line manager competency	Well being	Psych distress	Work limitations					PA	NA	Job perf	Job satis
			P	T	M	O	OP				
Controls: Salary Employees in org	***	**	*	**	*	**	*	***	**		
While the employee is off											**
Initial RTW											
Negative behaviours	*		*								
General behaviours											

- *When well being was entered into a regression with no controls then it significantly correlated with 'Negative behaviours.' Those employees who rated their manager better at avoiding 'Negative behaviours' reported better well being*

To examine whether line manager behaviour at Time 1 predicted return to work outcomes at a later date, a series of analyses were conducted to examine associations between Time 1 manager behaviour and Time 2 return to work outcomes. The competencies 'Initial return to work' and the 'General behaviours' did not significantly predict any of the return to work outcomes measured at Time 2. Higher manager scores on the 'While the employee is off' competency predicted employee job satisfaction at Time 2. Lower levels of 'Negative behaviours' predicted better employee well-being and less perceived impact on the employees' physical capabilities.

The data was analysed removing the competency 'While the employee is off'. Again, Managers rated as demonstrating high levels of 'Negative behaviours' predicted lower employee well being and greater physical limitations at Time 2. Higher scores on the 'General behaviours' competency predicted higher levels of job satisfaction at Time 2. The 'Initial return to work' competency was not correlated with any of the return to work outcomes at Time 2.

A Paired-Samples T-Test was carried out to assess any changes in the ratings of return to work outcomes over the six month period. There were no significant differences between the means at Time 1 and Time 2 for the employees return to work outcomes, suggesting that in general employees' perceptions of the outcomes remained stable across the study period.

#### Part 4: Key issues associated with returning to work

While the focus of this study was to identify the Manager Competencies for Managers to Support Return to Work, the questionnaire captured broader information about the employees' and managers' experiences of the return to work. Key issues associated with returning to work are noted below:

Table 13: Responsibility for return to work

Person	Employee response		Manager response	
	No.	%	No.	%
Employee	156	52	15	12
Line manager	65	22	97	81
HR	18	6	2	2
OH	31	10	2	2
Other (e.g. combination,GP)	30	10	3	3

Employees and managers were asked to state who they believed was the main person responsible for the return to work of an employee following long term sickness absence. Table 13 shows that the majority of employees viewed themselves as the main person responsible for their own return to work (52%). In contrast, managers considered themselves to be the main person responsible for the employees' return to work (81%). Analysis of the same employees at Time 2, indicated a slight change in views on responsibility. 64% of employees stated themselves to be the main person responsible for their return to work followed by the line manager (17%).

Table 14: Reasons for return to work

Reasons	Employee response count	%
Regain a sense of normality	216	62
An eagerness to work again	140	41
Financial	102	30
Pressure from the org/manager to return	78	23
Boredom	58	17
Other	9	7
Their responsibility to return	7	2

Table 14 shows that the majority of employees wished to return back to work in order to regain a sense of normality (62%) and this was coupled with a genuine eagerness to work again (41%). These reasons were seen to be more important than the financial aspect of returning to work (30%). When employees responded in the 'other' category the reasons given were usually in regard to their sickness records and the potential disciplinarys they may face or fear of scrutiny from their work colleagues. The reasons for returning to work continued to be prioritised in the same way six months later by employees responding to the Time 2 questionnaire.

Table 15: Barriers to return to work

Reasons	Employee response count	%
Overcoming own anxiety of returning to work	202	60
Lack of understanding and support from the manager/organisation	104	31
Lack of motivation	88	27
Poor communication between all parties involved in the return to work process	72	22
Lack of advice on how condition may affect work and health	70	21
None/insufficient workplace adjustments	67	20
Lack of understanding from work colleagues	50	15
Other	13	4
Fatigue from work or travel	10	3

Employees were asked to state what the biggest barriers or greatest challenges they faced were when returning back to work. As shown in Table 15, an overwhelming majority of employees stated that their biggest challenge was overcoming their own anxieties of returning to work (60%). The second biggest barrier was a lack of understanding and support from managers and organisations (31%). The barriers to returning to work continued to be prioritised in the same way six months later by employees responding to the Time 2 questionnaire.

Table 16: Description of the return to work

Description of the return to work	Employee response		Manager response	
	No.	%	No.	%
Very successful	65	22	45	39
Mostly successful	83	28	35	30
Fairly successful	97	32	30	25
Fairly unsuccessful	18	6	4	3
Mostly unsuccessful	11	4	1	1
Very unsuccessful	23	8	2	2

This table displays both employees' and managers' responses on how they viewed the return to work. A Mann-Whitney test on the data indicated that there was a significant difference between employees and managers responses ( $p < 0.00$ ) with managers tending to rate the return more successful than employees. There was no difference between employees' ratings of the success of the return to work at Time 1 and Time 2, indicating that employees' perception of the return to work remained stable over the six month period.

## **4. DISCUSSION**

### **Summary of research findings**

#### ***The development of the Competency Framework and Measure for Managers to Support Return to Work***

- A competency model was identified using a multi-method, multi-perspective approach, which was comprised of four competencies:
  - While the employee is off work
  - The initial return
  - Negative behaviours; and
  - General behaviours.
- The Competency Measure for Managers to Support Return to Work was developed using factor analysis. The final measure included 42 questions, divided into four sub-scales that measured the four competencies.
- The measure showed high internal reliability and no significant differences in responses were found between gender, age, organisation type or tenure. Employees who were members of a union reported poorer behaviour from their line manager than those who were not union members.
- Differences were found between employees with different illness conditions in their reports of their line managers' behaviour. Employees with stress, anxiety and depression, and back pain, typically rated their manager lower than those with heart disease or cancer.
- When comparing Time One and Time Two responses taken six months apart, employees rated their line managers lower on the same behaviours, suggesting that as time goes on they perceive their line manager to behave less positively.

#### ***Associations between the Competency Measure for Managers to support return to work and return to work outcomes***

- The competency measure was associated with a number of return to work outcomes, after controlling for a range of demographic and illness variables. It was found that different aspects of the competency model were associated with different return to work outcomes including: absence, general well being, psychological distress, work limitations, negative and positive affect, and job performance and satisfaction. This indicates that at different points on the return process and for different reasons, each of the four competencies play an important role in supporting the employees' return to work.
- The competency 'While the employee is off' was most frequently associated with return to work outcomes. When data was analysed using only those behaviours shown once the employee returns, all three of the remaining competencies were found to be associated with a range of return to work outcomes.
- The competency measure was most strongly associated with return to work outcomes for employees with stress, anxiety and depression. The smaller sample sizes for the remaining conditions may account for this difference and further research is warranted to better understand how the model works for other illness conditions.
- When examining return to work outcomes at Time Two, the line manager competencies predicted fewer of the return to work outcomes than demonstrated in the cross-sectional associations at Time One. However, the competencies 'Initial Return to work' and 'Negative behaviours' played a more significant role. Weak associations over time are often found between line manager behaviour and health outcomes in organisational research due to the wide number of factors that can influence health and health behaviour over time (Nielsen et al 2008).

### ***Absence patterns and absence behaviour***

- Employees reported a high relapse rate (indicated by more than one period of long-term absence). Those with stress, anxiety and depression, and back pain, reported higher relapse rates (30% and 28% respectively) than those with cancer (20%) or heart disease (7%).
- Employees perceived themselves to be primarily responsible for their own return, while line managers also perceived themselves to be responsible for the employees return.
- Returning to normality, being eager to return to work and for financial gain were the most frequently cited reasons for returning to work.
- Employees cited overcoming their own anxiety as the most significant barrier to returning to work (60%), this was followed by a lack of understanding and support from their line manager/ organisation (31%) and nearly a quarter reported that there was a lack of advice on how their health condition affected their work, poor communication between all parties involved and insufficient workplace adjustments.
- Very few employees cited their medical condition, or their ability to manage their illness at work, as a barrier to returning to work suggesting that it may be the organisational and social factors associated with returning that pose the largest problem to return to work, rather than the illness itself.
- Managers and employees hold different definitions of a successful return to work; managers tended to rate the return as more successful than the employee. This may be because the managers' focus is on getting the employee back into the workplace and return equates to success, whereas employees use more complex or subtle factors (such as a sense of reintegration or return to full functioning) to evaluate the process.

### **Strengths and potential biases in the research**

This research drew from multiple perspectives and combined qualitative and quantitative approaches taken at two time points in an attempt to address traditional research biases such as common-method variance. Furthermore, attempts were made to limit bias in the techniques used. For example, while critical incident approach (used during the interviews; stage one data collection) is seen as advantageous in many respects as it allows for the revelation of issues which are of critical importance to the person, it has been challenged because of the reliance on accuracy of recall of events (Chell, 1998) and the potential impact of Affective Events Theory, in that employees are more likely to recall negative events rather than positive ones (Dasborough, 2006). In order to limit these effects, interviewees were emailed two days before their interview and asked to think about and recall specific line manager behaviours and incidents in preparation for the interviews.

However, the study was not without limitations. Recruitment for this project was very challenging and a number of factors may have affected this. Firstly, a large number of the professionals who attended the workshops were unable to support the recruitment of employees and managers for either the interviews or questionnaires. Secondly, the project coincided with two significant events: the recession and the outbreak of swine flu. The economic climate placed a lot of pressure on organisations and employees. A number of the original contacts had been made redundant by the time of the first wave of questionnaires, and many, understandably, felt it inappropriate to distribute questionnaires within their organisation at a time of such uncertainty and pressure. Furthermore, the swine flu epidemic meant that OH resources were redirected to manage this issue, leading to a further drop in the original pool of Occupational Health professionals able to support the recruitment for this project. Thirdly, a number of organisations were supportive of the project, but had other ongoing manager initiatives in health and well-being training and did not want to overburden their line managers. Finally, due to the issues faced recruiting through organisations, a number of relevant charities were approached. While these were supportive, the delay in

progressing through the administrative process and the distribution of their materials (for example, many newsletters go out quarterly) had an impact on the number of responses achieved through charitable sources. Consequently, while the total number of employees at Time 1 was greater than expected, the distribution across planned industry sectors (for example, finance and government were under-represented) and illness conditions could not be achieved. The original target of 250 employees and managers was a conservative estimate, and the sample of 186 managers participating at Time 1 allowed for small to medium effect sizes to be examined. Unfortunately, this lower than anticipated manager response at Time 1 had a significant impact on the ability to collect meaningful Time 2 data, with a reduced sample of 31 managers. The consequences of this were two fold: it was not possible to examine whether managers rated their behaviour consistently across the six month period; and it was not possible to examine which manager characteristics predicted manager behaviour on the Measure to Support Return to Work. While disappointing, the employee and manager data examined at Time 1 demonstrated good levels of reliability and validity, with the data from the employees at Time 2 demonstrating the predictive validity of the measure (i.e. line managers' behaviour at Time 1 was associated with a range of return to work outcomes at Time 2). Subsequently, the criteria for measure development have been met using established principles of measure development (Rust & Golombok, 99).

This study purposely recruited managers and employees from a variety of organisations so as to capture a breadth of return to work experiences. However, in doing so it was beyond the scope of the study to account for variations in the absence policy, or the way in which absence policy translated into practice within the respondent's organisation. Further research is required to understand the extent to which manager behaviour is governed by organisational policy and practice.

Finally, the research was conducted prior to the introduction of the 'fit note'. Rather than describe whether or not an individual is fit to work, the new 'fit note' aims to provide more information on how the employees' condition affects what they do and how they may be able to return to work. As such, the 'fit note' will place greater responsibility on the line manager, requiring them to consider more fully their employees' ability to return and the possible adjustments required, and to support an early return. It is likely that some new behaviours regarding the managers' response to, and management of, the 'fit note' will become important in supporting return to work. As the framework has been developed using a bottom-up approach, whereby only behaviours identified as relevant by key stakeholders have been included in the measure, it would not be appropriate to add new behaviours retrospectively. Further research is required in the future to examine any additional behaviours required by the line manager specific to the introduction of the 'fit note'. If any behaviours are identified, these behaviours could then be integrated into the existing framework.

### **Need for further research**

There is a need to understand better how the Competency Framework for Managers to Support Return to Work operates for different illness conditions. The findings suggest that the behaviours are highly relevant for those returning with stress, anxiety and depression. Further research could examine subtle differences across a variety of conditions such as recurring medical conditions or work-related injuries. Furthermore, it may be that these behaviours are relevant for employees returning due to absences from work due to other reasons, for example, taking maternity leave, sabbatical etc.

Following the identification of these behaviours and a measure to assess a manager's behaviour on the four competencies, interventions can be designed to help managers to develop effective behaviours to support employees in returning to work following sickness absence.

Research from the leadership literature suggests this relationship plays an important role in the psychological health of the employee (e.g. Van Dyne et al, 2002; Harris and Kacmar, 2005.). It may be that the relationship between the line manager and employee prior to the absence plays an important role in how the line manager behaves towards the employee while they are off, and how the employee perceives the line managers' behaviour once they return. This area would benefit from further investigation.

This research found employees from the four illness groups experienced differences in manager behaviour, with employees with cancer and heart disease reporting more positive behaviours from their managers. It may be that managers adopt different, more positive behaviours, for those employees with cancer or heart disease as they believe the cause of, and recovery from, the illness is less within the control of the individual. Further research is needed to understand the drivers of manager behaviour, in particular how managers' perceptions of the illness influence their interaction with the returning employee.

### **Implications for the line manager**

- The introduction of the 'fit note' to replace the old 'sick note' system will put greater responsibility on line managers to support an early return to work for those on long-term sick leave. In order to fulfil this role, managers need to be aware of the behaviours that are important to support employees who are returning to work, as set out in the Competency Framework for Managers to Support Return to Work. The new Fit for Work services, or the Scottish Working Health Services could be used by managers who wish to seek extra support when managing a returning employee.
- A range of behaviours is important to support employees to return to work following long-term sick-leave: there is no one behaviour or competency needed. It is likely that different behaviours are important at different times and for different employees, depending on the illness conditions involved.
- The Competency Framework for Managers to Support Return to Work provides clear and specific behaviours that line managers can refer to when managing an employee's return. Furthermore, managers can use the framework or measure to identify their strengths and where they may require additional support, guidance or training.
- To be effective at supporting an employee in returning to work, a manager does not necessarily have to be knowledgeable about their illness condition. It is more important that they show good people management skills, including effective communication, sensitivity to and understanding of the individual and awareness of the context.
- Managers are most likely to be in a good position to support an employee returning to work if they have established a good relationship with the individual prior to their absence. Thus part of good sickness absence is about on-going good people management and establishing good relationships with all employees.
- Line managers are often hesitant to contact employees while they are off work: however, our findings suggest that maintaining contact with the employee during their sickness absence is both welcomed by the employee and is associated with a range of positive return to work outcomes. Furthermore, contact at this stage may also help to relieve the employees' anxiety regarding return to work, therefore addressing one of the barriers to return to work as reported by employees.
- There is need to continue displaying the behaviours relevant to supporting return to work well beyond the initial return. Our findings suggest that there can be a tendency to return to business-as-usual following the employee's return; however the returning employee may need ongoing support for some months following their initial return.
- Line managers should look to Occupational Health and/or Human Resources for support as it is likely that they will be able to provide information about the process, illness condition and work adjustments to help manage the absent or returning employee, and be available to discuss any concerns arising throughout the process.

## Implications for Organisations

- The introduction of the 'fit note' to replace the old 'sick note' system will put greater responsibility on employers, and line managers in particular, to support early return to work for those on long-term sick leave. It will therefore be important for organisations to find ways to support line managers in shouldering this responsibility. The Competency Framework for Managers to Support Return to Work provides a way of doing this.
- The Competency Framework puts the management of return to work into a format and language that is easily accessible, particularly as competency frameworks underpin selection, performance management and training in many organisations. In doing so, it provides a common language to facilitate discussions between HR, OH and the line manager.
- The Competency Framework specifies a number of behaviours, all of which are important for different reasons and for different illness conditions. It is important that line managers are supported in their use and development of these competencies. While some line managers may use a number of the relevant behaviours, it is likely that many managers are either unaware of the importance of the behaviours, or do not know how best to show them. Organisations need to support managers by raising awareness of the line manager competencies for managing return to work, and providing guidance, support and/or training for the line manager to help them develop the skills required.
- Managers are most likely to be in a good position to support an employee returning to work if they have established a good relationship with the individual prior to their absence. Organisations can therefore enhance their absence management by setting a positive people management culture and providing appropriate management training and development to emphasise good people management skills for all line managers.
- Many line managers are reluctant to contact an employee while they are off work. Our findings suggest that contact, if it is kept informal and focused on non-work issues, is important to the employee. There is need for OH/ HR to encourage the line manager to maintain contact, and support them in their efforts to do so.
- If the employee perceives their line manager to have been part of the cause of their long term sickness absence (for example, due to work-related stress) then the organisation needs to find another person to help with the return to work or another line manager which the employee gets on better with.

## Implications for policy makers

- The introduction of the 'fit note' to replace the old 'sick note' system will put greater responsibility on employers, and line managers in particular, to support early return to work for those on long-term sick leave. National policy needs to encourage organisations and their line managers to consider how they fulfil this responsibility: this should include promotion of the Competency Framework for Managers to Support Return to Work as a mechanism for enhancing the skills of managers.
- More generally, national bodies need to improve the availability of guidance for line managers on return to work and absence management; this needs to include raising awareness of the line manager behaviours to support return to work.
- More accessible training is needed for line managers in this area. Management development providers need to be encouraged to include return to work issues, and particularly the line manager behaviours to support return to work, in their programmes. Wherever possible, opportunities for training in this area need to be provided to managers working in small and medium sized organisations.
- National policy needs to raise the profile of a multidisciplinary approach to return to work which engages the line manager, occupational health, human resources, general practitioner and other healthcare specialists to support the returning employee.

## **5. REFERENCES**

- Aas RW, Ellingsen KJ, Lindoe P, Moller A (2008). Leadership Qualities in the Return to Work Process: A Content Analysis. *Journal of Occupational Rehabilitation*, 18; 335-346.
- Baanders AN, Andries F, Rijken PM, Dekker J (2001). Work adjustments among the chronically ill. *International Journal of Rehabilitation Research*, 24, 7-14
- Berkman LF, Leo-Summers L, & Horowitz RI. (1992). Emotional support and survival following myocardial infarction: A prospective population-based study of the elderly. *Annals of Internal Medicine*, 117, 1003-1009.
- Bevan S (2003). *Attendance Management*. The Work Foundation.
- Bevan, S & Hayday (2001) *Costing sickness absence in the UK*, IES report 382, Brighton
- Black C (2008) *Working for a Healthier tomorrow*. London:TSO
- Bond FW & Bunce D (2001). Job control mediates change in a work reorganization intervention for stress reduction. *Journal of Occupational Health Psychology*. Vol 6; 290-302
- Boudrez, H, de Backer, G, Comhaire, B (1994). Return to work after myocardial infarction: results of a longitudinal population based study. *European Heart Journal*; 15, pp32-36.
- Bouknight RR, Bradley CJ, Luo Z (2006) Correlates of return to work for breast cancer survivors. *J Clin Oncol* **24**(3): 345–353.
- Boyatzis RE (1982). *The competent manager: A model for effective performance*. Chichester: John Wiley and Sons
- Bupa (2009) *Healthy Work Challenges and Opportunities to 2030*. London
- CBI (2004) *Room for improvement: CBI absence and labour turnover survey 2004*. London: CBI.
- CBI/AXA (2008) *CBI/AXA absence and labour turnover survey 2008*. London:CBI
- Cherniss C (1995). *Beyond burnout: Helping teachers, nurses, therapists & lawyers recover from stress and disillusionment*. NY: Routledge.
- Coolican, H. (1994). *Research Methods and Statistics in Psychology*. Hodder and Staughton: London.
- Chartered Institute of Personnel Development (2009) *Absence Management: Annual survey report 2009*
- Currie SR & Wang JL. (2004). Chronic back pain and major depression in the general Canadian Population. *Pain*, 107, 54-60.
- Dasborough MT (2006). Cognitive asymmetry in employee emotional reactions to leadership behaviours. *The Leadership Quarterly*, 17, 163-178
- de Boer, A, Verbeek, J, Spelten, E, Uitterhoeve, A, Ansink, A, Reijke, T, Kammeijer, M, Sprangers, M, Van Dijk, F (2008). Work ability and return to work in cancer patients. *British Journal of Cancer*; 98, 1342-1347.

- Department of Health (2004) *'Choosing health: making healthier choices easier.'* London: DH
- Donald, I. (1995). Facet Theory: Defining Research Domains. In G. M. Breakwell, S. Hammond & C. Fife-Shaw, *Research Methods in Psychology*. London: Sage.
- Diffley C. (2003). *Managing Mental Health: Research into the Management of Mental Health Problems in the Workplace*. The Work Foundation/Mindout.
- Dionne CE, Bourbonnias R, Fremont P, Rossignol M, Stock SR, Nowen A, Laroque I, Demers E. (2007). Determinants of 'return to work in good health' among workers with back pain who consult in primary care settings: a 2-year prospective study. *European Spine Journal*, 16, 641-655.
- Ekbladh E, Haglund L, Thorell LH (2004) The worker role interview – preliminary data on the predictive validity of return to work of clients after an insurance medicine investigation. *J Occup Rehabil* 14: 131–141
- Ekberg K, Wildhagen I.(1996) Long-term sickness absence due to musculoskeletal disorders: the necessary intervention of work conditions. *Scand J Rehabil Med*;28:39–47.
- European Commission (2003). *Social Situation in the European Union*. Luxembourg Office for Official Publications of the European Communities. Statistical Office of the European Communities.
- Fantoni, S, Peugniez, C, Duhamel, A, Skrzypczak, J, Frimat, P, Leroyer, A (2009). Factors related to return to work by women with Breast Cancer in Northern France. *Journal of Occupational Rehabilitation*; 20, 49-58
- Fishbain, D, Cutler, R, Rosomoff, H, Khalil, T, Abdel-Moty, E, Steele-Rosomoff, R (1999). Validity of the dictionary of Occupational Titles Residual Functional Capacity Battery. *The Clinical Journal of Pain*; 15, 102-110
- Flanagan JC (1954). The critical incident technique. *Psychological bulletin*, 51, 327-358
- Ferguson, E. & Cox, T. (1993). Exploratory Factor Analysis: A user's guide. *International Journal of Selection and Assessment*, 1, 84-94.
- Gilbreath, B., & Benson, P. G., (2004). The contribution of supervisor behaviour to employee psychological well-being. *Work & Stress*, 18, 255-266.
- Goldberg, D. (1978). *GHQ-12*. London: NFER-Nelson
- Health & Safety Executive (2006). *Self-reported work-related illness 2006/07. Results from the labour force survey*. <http://www.hse.gov.uk/statistics>
- Health and Safety Executive (2004). *Self-reported work-related illness 2003/2004*. <http://www.hse.gov.uk/statistics>
- Health and Safety Executive (2007). Management Competencies for preventing and reducing stress at work. <http://www.hse.gov.uk/research/rrpdf/rr553.pdf>
- Health, Work and Wellbeing Programme (2008) Dame Carol Black's review of the health of Britain's working age population. *Working for a healthier tomorrow*. London: The Stationary Office
- Henderson M, Glozier N & Elliot KH (2005). Long term sickness absence. *British Medical Journal*, 330, 802-803

Hogelund J. (2001). *Work incapacity and reintegration: a literature review*. The Danish National Institute of Social Research.

Holmgren K, Ivanoff SD.(2007) Supervisors' views on employer responsibility in the return to work process. A focus group study. *Journal of Occupational Rehabilitation*. 17:93–106.

IRS (2009). Managing long-term sickness absence: the 2009 IRS survey

Janssen N, van den Heuvel WP, Beurskens AJ, Nijhuis FJ, Schroer CA, van Eijk JT. (2003). The demand-control-support model as a predictor of return to work. *International Journal of Rehabilitation Research*, 26, 1-9.

Johansson G, Lundberg O, Lundberg I. (2006). Return to work and adjustment latitude among employees on long-term sickness absence. *Journal of Occupational Rehabilitation*, 16, 185-195.

Joling, C, Janssen, PPM, Groot, W (2004). Modelling return to work intervention strategies: A method to help target interventions. *Journal of Occupational Rehabilitation*, 14, 43-60.

Karasek R (1985). *Job Content Questionnaire and User's guide revision 1.1*. Los Angeles: Department of Industrial and Systems Engineering, University of Southern Los Angeles.

Kuijjer W, Groothoff JW, Brouwer S, Geertzen JHB, & Dijkstra PU. (2006). Prediction of sickness absence in patients with chronic low back pain: A systematic review. *Journal of Occupational Rehabilitation*, 16, 439-467.

Labriola M, Christensen KB, Lund T, Nielsen ML, Diderichsen F.(2006) Multilevel analysis of workplace and individual risk factors for longterm sickness absence. *Journal of Occupational Environmental Medicine* 48(9):923–9.

Lerner D, Amick iii B & Glaxo Welcome (1998). *Work Limitations Questionnaire*. The Health Institute. Tufts-New England Medical Center, Boston.

Linton, S & Hallden K (1998) Can We Screen for Problematic Back Pain? A Screening Questionnaire for Predicting Outcome in Acute and Subacute Back Pain. *The Clinical Journal of Pain* 14 . pp 209-215

Main CJ, Burton AK (2000). Economic and occupational influences on pain and disability. In *Pain Management. An Interdisciplinary Approach* (Ed Main CJ, Spanswick CC):63–87. Churchill Livingstone, Glasgow.

Maunsell E, Brisson C, Dubois L, Lauzier S, & Franser A. (1999). Work problems after breast cancer: An exploratory qualitative study. *Psycho-Oncology* 8, 467-473

McMillan Cancer (2010) <http://www.macmillan.org.uk/Home.aspx>

Meijer, E., Sluiter, J., Heyma, A., Sadiraj, K. and Frings-Dresen, M. (2006). Cost-effectiveness of multidisciplinary treatment in sick-listed patients with upper extremity musculoskeletal disorders: A randomised, controlled trial with one-year follow-up. *International Archives of Occupational and Environmental Health*, 79(8), 654–664

Mental Health Foundation (2009). *Returning to work: The role of depression*. <http://www.mentalhealth.org.uk/publications/?entryid=67533>

- Miles MB & Huberman AM (1984). *Qualitative data analysis: A sourcebook of new methods*. Beverly Hills: SAGE
- Mind (2005). *Stress and mental health in the workplace*. London: Mind publications.
- Munir, F., McKay, C., Yarker, J., Haslam, C., Kazi, A., & Cooper, L. (2008). Back, but not better. Ongoing mental health hampers return to work outcomes. *Occupational Health at Work*. February 2009.
- Munir, F, Jones, D, Leka, S & Griffiths, A (2005a). Work limitations and employer adjustments for employees with chronic illness. *International Journal of Rehabilitation Research*, 28, 112-117
- Munir, F, Haslam, C, Long H, Griffiths A, Cox S, & Leka S (2005b). Managing chronic illness at work: exploring effective strategies for employees and organisations. University of Nottingham Report produced for the European Social Fund.
- Narayanan L, Menon S & Spector PE (1999). Stress in the workplace: A comparison of gender and occupations. *Journal of Organizational Behaviour*, 20, 63-73
- Nagy, M.S. (2002). Using a single-item approach to measure facet job satisfaction. *Journal of Occupational and Organizational Psychology*, 75, 77-86.
- NHS Information Centre (2008) Health Survey for England 2006: CVD and risk factors adults, obesity and risk factors children
- Nielsen, K., Randall, R., Yarker, J. & Brenner, S-O. (2008). The effects of transformational leadership on followers' perceived work characteristics and well-being: A longitudinal study. *Work and Stress*, 22, 16-32.
- Nieuwenhuijsen K, Verbeek J, Siemerink JC, Tummers-Nijssen D. (2003). Quality of rehabilitation among workers with adjustment disorders according to practice guidelines; a retrospective cohort study. *Occupational Environmental Medicine*, 60, S121-S125.
- Nunnally, J.C. (1967). *Psychometric Methods*. New York: McGraw Hill.
- Patterson F, Ferguson E, Lane P, Farrell K, Martlew J & Wells A (2000). A competency model for general practice: implications for selection, training and development. *British Journal of General Practice*, 50, 188-193
- Petrie, K, Weinman, J, Sharpe, N, Buckley, J (1996). Role of patients' view of their illness in predicting return to work and functioning after myocardial infarction: a longitudinal study. *British Medical Journal*, 312; 1191-1194
- Pransky J, Shaw W, Loisel P, Hong QN, Desorcy B (2009). Development and Validation of Competencies for Return to Work Coordinators. *Journal for Occupational Rehabilitation*
- Pryce J, Munir F, & Haslam C. (2007). Cancer survivorship and work: symptoms, supervisor response, co-workers disclosure and work adjustments. *Journal of Occupational Rehabilitation*, 17, 83-92.
- Rankin N (2004). *The new prescription for performance: the eleventh competency benchmarking survey*. *Competency & Emotional Intelligence Benchmarking Supplement 2004/2005*. London: IRS

Reiso H, Nygard JF, Jorgensen GS, Holanger R, Soldal D, Bruusgaard D (2003) Back to work: predictors of return to work among patients with back disorders certified as sick: a two-year follow-up study. *Spine* **28**: 1468–1473

Rick J & Thompson L (2004). *Managers' roles in rehabilitation for work-related stress*. Proceedings of the Division of Occupational Psychology Conference 2004

Robinson MA, Sparrow PR, Clegg C & Birdi K (2005). Design engineering competencies: future requirements and predicted changes for the forthcoming decade. *Design studies*, 26, 123-153

Rust, J., & Golombok, S. (1999). *Modern Psychometrics: The science of psychological assessment*. Routledge: Taylor Francis Group.

Saksvik PO, Nytro K, Dahl-Jorgensen C, & Mikkelsen A (2002). A process evaluation of individual and organisational occupational stress and health interventions. *Work & Stress*, 16, 37-57

Sainsbury Center for Mental Health (2007) Policy Paper 8- Mental Health at Work. Developing the business case

Sanders, S. H. (1995). Risk factors for the occurrence of low back pain and chronic disability. *APS Bulletin*, 5, 1-5.

Schleifer SJ, Macari-Hinson MM, Coyle DA, Slater WR, Kahn M, Gorlin R, & Zucker HD. (1989). The nature and course of depression following myocardial infarction. *Archives of Internal Medicine*, 149, 1785-1789.

Sjoberg, A., & Sverke, M. (2000). The interactive effect of job involvement and organizational commitment on job turnover revisited: A note on the mediating role of turnover intention. *Scandinavian Journal of Psychology*, 41, 247-252.

Snook SH. (2004). Self-care guidelines for the management of non-specific low back pain. *Journal of Occupational Rehabilitation*, 14, 243-253.

Soderman E, Lisspers J & Sundin O. (2003). Depression as a predictor of return to work in patients with coronary artery disease. *Social Science & Medicine*, 56, 193-202.

Stewart A & Ware J (1992). *Measuring functioning and wellbeing: the medical outcomes study approach* (pp.373-403). Durham, NC: Duke University Press, 1992.

Strauss B, Paulsen G, Strenge H, Graetz S, Regensburger D, & Speidel H. (1992). Preoperative and late post-operative psychosocial state following coronary artery bypass surgery. *Thoracic and Cardiovascular Surgeon*, 40, 56-64.

Sykes D, Hanley M, Boyle D, & Higginson J. (2000). Work-strain and the post discharge adjustment of patients following a heart attack. *Psychology & Health*, 15, 609-623.

Tepper BJ (2000). Consequences of abusive supervision. *Academy of Management Journal*, 43, 178-190

The Work Foundation (2009). *Fit for work? Musculoskeletal Disorders in the European Workforce*.

<http://www.theworkfoundation.com/Assets/Docs/Fit%20for%20Work%20panEuropean%20report.pdf>

Trades Union Congress (2002). *Rehabilitation and retention: the workplace view*. Labour Research Department, Trades Union Congress.

Turner JA, Franklin G, Fulton-Kehoe D, Sheppard L, Wickizer TM, Wu R, Gluck JV, Egan K (2006) Worker recovery expectations and fear-avoidance predict work disability in a population-based workers' compensation back pain sample. *Spine* **31**: 682–689

Vaananen A, Toppinen-Tanner S, Kalimo R, Mutanen P, Vahtera J, Peiro JM. (2003) Job characteristics, physical and psychological symptoms, and social support as antecedents of sickness absence among men and women in the private industrial sector. *Soc Sci Med*. 57(5):807–24.

Van Dierendonck D, Haynes C, Borrill C & Stride C (2004). Leadership behaviour and subordinate well-being. *Journal of Occupational Health Psychology*, 9, 165-175

van der Guizen AM, Bouter LM, Nijhuis FJN (2000). Prediction of return to work in low back pain patients sick-listed for 3–4 months. *Pain*;87:285–94.

Verbeek J, Spelten E, Kammeijer M, & Sprangers M. (2003). Return to work of cancer survivors: a prospective cohort study into the quality of rehabilitation by occupational physicians. *Occupational Environmental Medicine*, 60, 352-357.

Verbeek JH (2006) How can doctors help their patients to return to work? *PLoS Med* **3**: e88

Waddell, G. and Burton A.K. (2006). *Is work good for your health and well-being?* London:TSO