Health, Work and Well-being: Attitudes of GPs, line managers and the general public

DWP Communications

Research Report 1

DWP Department for Work and Pensions

© Crown copyright 2011.

You may re-use this document/publication (not including logos) free of charge in any format or medium, under the terms of the Open Government Licence. To view this licence, visit http://www.nationalarchives.gov.uk/doc/open-government-licence or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or e-mail: psi@nationalarchives.gsi.gov.uk.

This document/publication is also available on our website at:
http://www.dwp.gov.uk/comms-ci-research

Any enquiries regarding this document/publication should be sent to us at:
COMMS.RESEARCHANDEVALUATION@DWP.GSI.GOV.UK

First Published 2011

ISBN 978-1-84947-592-1

Views expressed in this report are not necessarily those of the Department for Work and Pensions or any other Government Department.

Executive summary

Background and methodology

Dame Carol Black's review of the health of Britain's working age population was published in 2008[1]. Recommendations included implementing a range of initiatives to work towards creating new perspectives on health and work, recognising that good work is good for health, improving work and workplaces, and supporting people into work. The Government's response, Improving health and work: changing lives, was published in November 2008. The response included a commitment to develop a social marketing strategy supporting the Government's health, work and well-being initiatives to achieve attitude and behaviour change across a range of audiences based on an understanding of the role of 'good' work in improving and maintaining health.

Andrew Irving Associates (AIA) – part of Optimisa Research – was commissioned to undertake exploratory qualitative research to develop insights for attitudinal and behavioural change about health and work among the key target audiences - GPs, line managers and the general public.

Research was conducted across GB in a range of locations including rural (Surrey, Ashby-de-la-Zouch, Coalville, Caernarfon, Bridge of Weir), sub-urban (Radlett, High Wycombe, Walsall, Nottingham, Oldham, Newcastle, Sheffield, Port Talbot, Edinburgh) and inner city locations (London, Birmingham, Manchester, Cardiff, Glasgow) with different economic and social advantages to explore whether issues raised on health and work such as access to employment or services differed because of regional economic factors and social dimensions.

Work was conducted with GPs (six mini-focus groups and eight one-to-one depth interviews), Allied Health Professionals (three mini-groups and four practice manager in-depth interviews), employers and line managers (six groups and 20 one-to-one interviews), and the general public split into three broad categories according to work and health status: working, not currently on sickness absence (six focus groups and six one-to-one interviews), working, but currently off on sickness absence (three mini-groups, three 'Mr & Mrs' interviews, three one-to-one interviews), and those not working and claiming Incapacity Benefit – or Employment and Support Allowance for health reasons (nine mini-focus groups and nine 'Mr & Mrs' interviews – see page 12). In addition, a deliberative workshop was conducted in Central London with all key audiences to enable them to work together to identify insightful ideas for interventions on health and work.

[1] Black, Dame Carol, National Director for Health and Work (2008). *Working for a Healthier Tomorrow.* London TSO

Purpose of the research

Key to the research was exploring the various audiences' motivators and barriers to changing attitudes towards health and work to maintain a healthy workforce and aid return to work. It was also important to explore their views on what should be the key drivers for change.

Overall themes from the research

Some key overarching themes emerged from the research that should be borne in mind when developing future awareness-raising or potential social marketing interventions:

1. ***"Work is good for health"*** – this basic principle was expressed across all audiences, with work being seen to provide self-esteem, sense of purpose and value. In this research, only a minority of respondents with particularly poor experiences of working life (e.g. bullied, signed off through work stress) held a less positive view about the benefits of work.
2. ***All audiences see the need to address perceived systemic issues*** – in particular, they felt there may be a need for financial incentives (and even penalties) to motivate behaviour and attitude change regarding getting (back) into work. Participants across the sample also expressed the view that changing the rules of benefit systems/legislation might also encourage others to change their behaviour e.g. provide financial incentives to come off IB/ESA, and tax breaks on workplace health and well-being services/measures.
3. ***Family and colleagues had a role to play*** in terms of being able to support and ideally facilitate behaviour change. The concept of mutual support and encouragement is very important, for example in setting each other short term goals for change.
4. ***Those on IB/ESA (and some whose sickness absence has been 'poorly managed') needed a significant degree of help to get back into work*** – they often felt isolated and lacked confidence to take control in changing their behaviour. Many lacked the self-belief to be proactive themselves and approach health or employment authorities. A perceived lack of proactive contact from health or employment authorities could also reinforce a perception that they cannot change their situation.
5. ***Size of company and company culture are crucial factors impacting on attitudes towards health and work***. In this research, typically larger companies were more likely to have resources for and access to health and well-being related schemes such as occupational health, sickness absence policies and monitoring; in contrast, smaller employers relied on team bonding, shared responsibility and mutual support to manage sickness absence. Medium sized

employers tended to be the companies most frequently looking for advice/guidance on maintaining a healthy workforce and effective implementation of return to work strategies have more issues due to dilution of key factors – they lacked resources of large organisations or the 'team ethic' observed in smaller firms.

6. ***"Happy workers are less likely to go off sick"*** – this is a widely held view, but differences emerged in how line managers/employers tackled this. Employees and line managers both expressed the view that small changes in the workplace could make a big difference with gestures such as a thank you, a team lunch or an away day helping to make staff feel part of a close-knit and supportive team. This was also reflected in the attitudes of those currently on sickness absence – those that wanted to return to work more quickly felt more supported and valued when they had been at work.
7. ***Fostering a 'team within a team' is important for health maintenance*** – establishing the natural defence against sickness absence that a small team ethic observed in the research can achieve via collective responsibility and mutual support.
8. ***Having information that employees and employers can access will not actually facilitate change*** – there was a need for more proactive engagement, possibly involving (neutral) intermediaries or advocates.
9. ***GPs feel they lack the skills required to make effective fitness for work decisions*** – and they were reluctant to have deeper relationships or more active engagement with employers; GP's advice on return to work could be driven by the need to keep patients on the books and protect their patients' wishes.

Brief overview of findings by audience

General Public

For the **general public, working and not on sickness absence**, key drivers for changing their own behaviour were effective early intervention and better access to intermediaries to aid health maintenance such as therapists, consultants and trainers on various facets of everyday mental and physical health. In addition, they needed a better understanding that work could help with recovery and efforts need to focus on raising awareness of and credibility that you do not have to be 100% fit for work. In smaller organisations it was observed that there was a requirement to address the tension between the theory that work can aid recovery and the practical obstacles to achieving this (i.e. the difficulty of finding a role for someone unable to perform their usual duties within a small team).

Major disincentives to changing their behaviours included the impact of workplace culture, such as a lack of personal encouragement or facilitation of change from employers/line managers, the negative impact of inflexible sickness absence policies that can exacerbate rather than help aid recovery from illness/sickness and currently, the negative impact of the economic climate (which they believed led to longer working hours, accepting pay cuts, less time to exercise, and less reward for hard work).

For the **general public, working and currently on sickness absence**, attitudes towards health and work reflected reasons for being off in the first place. The type of illness/injury impacted on likely imminence of recovery and ability to return to their former duties in the near future (e.g. they were more confident of achieving return to work in a specified time period if they had a broken leg as opposed to depression). The attitude of their line managers or employers towards their sickness absence also had a big impact on their views on health and work, and whether or not work was the root cause of their absence. There were mixed views about contact from employers when off sick. Type, source and regularity of contact with work could be key to influencing attitudes towards an early return to work. Again, they believed that you had to be 100% fit before returning to work which could be reinforced by the actions of GPs and employers advising them to stay off work until absolutely sure they could return to former duties. Effective early intervention and access to intermediaries (for independent advice and access to services) and tackling perceptions of fitness for work were key issues to address in interventions with this group.

For the **general public on health related benefits (IB/ESA)**, attitudes towards health and work were more mixed. Some were keen to express that they believed work benefited their mental health and well-being, and its absence meant a lack of routine and purpose to their daily lives. For others, work was seen as a having a key detrimental impact on their well-being, caused by feeling unappreciated or overworked by line managers or employers.

Motivators to change attitudes towards health and work typically were less top of mind than barriers to returning to work or barriers to daily activity/role. For the longer term unemployed, there was a greater sense of isolation from positive influencers of change (e.g. initiatives aimed at helping people back to work and improving their mental and physical fitness for work) and it was harder for them to envisage what could help change their situation. Most wanted more proactive intermediary facilitation to get back to work, with access to rehabilitation (health, life skills and employment skills) and return to work service providers top of mind. They also echoed sentiments of those signed off work sick, who wanted their GPs to signpost them more effectively towards services to help improve health, life and employment skills. In addition, support and encouragement from friends and family (particularly noted at the 'Mr & Mrs Interviews') was an important factor in encouraging a change in attitude and behaviour towards health and work.

Employers and Line Managers observed that a motivated and happy workforce was less likely to go off work sick. However, there was frequently a gap between theory and company practice because of what they saw as competing priorities such as day-to-day targets and ‘getting the job done’. Employers felt health and well-being would take too much time and did not see it as an integral part of day to day working. In medium sized organisations (where, as noted, they can lack resources of large organisations or the ‘team ethic’ observed in smaller firms) employers said that they might seek concrete evidence of return on investment to justify dedicating more resources and time to well-being. Key drivers for future interventions were seen as access to more targeted and directly applicable advice and guidance on how to *facilitate* positive change to health and well-being practices rather than government and other practitioners conveying guidance through published/web based Information (which was largely seen as too generic to spend time investing in understanding and digesting it). In particular, they wanted to be made more aware of and have greater access to advice via neutral intermediary services on issues such as: how to effectively manage sickness absence, timescales for realistic return to work, assessing employees’ fitness for work, how to access relevant support and guidance services (and when).

GPs, Allied Health Professionals and Practice Managers largely supported the positive connection between health and work, both in their professional capacity and as employees/employers themselves. In principle, they were happy to signpost patients towards services and to recommend that their patients’ talk to their employer. However, they saw their primary role as the patient’s advocate, and felt this meant that they should respect their patients’ wishes and/or protect them, especially if work had a role in the on-set of the patient’s condition. Central to GPs views was their desire to protect GP-patient confidentiality, and they thought discussing work could meet with resistance in some instances and jeopardise their relationship with their patient. Ideally, they wanted intermediary or independent arbitration and assessment in the area of fitness for work.

In addition they were seeking:

- increased clarity/understanding about services available that they could signpost patients towards
- more consistency by area/region regarding the availability of rehabilitation, employment and retraining services (there was some perception that this was something of a postcode lottery)
- consideration of the perceived systemic issues that they thought were: a lack of financial incentive to get off health benefits; the amount of time a GP can sign a patient off for and the length of time between fitness for work assessments for those on IB/ESA.

Suggestions from findings for consideration in social marketing strategy development

As part of the research, the target audiences were asked for their ideas on what might lead them to change behaviour/attitudes. They generated considerable lists, mostly in embryonic form, of ideas for 'ideal world solutions' to maintain health in work and aid return to work (when not necessarily 100% fit). A number of ideas could have a role in backing up or enhancing current initiatives that are either not well known or currently being piloted.

The insight suggested it would be helpful to establish better links between (and identifying communication possibilities across) several initiatives currently working on providing guidance to target audiences, and sufficient funding/support to ensure these initiatives last.

Key implications of findings for future activity amongst the **general public** were:

- the desire for more holistic services providing a range of help and advice (from financial, lifestyle, health and employment) to be more widely available; ideally packaged and delivered within a nationally identifiable initiative;
- aiding and encouraging self-referral to these services through raising awareness of services (possibly through advertising/marketing activity);
- enhancing understanding the notion that you do not have to be 100% fit to work; however, it is questionable whether the term '100% fit to work' might be misleading to all audiences as this phrase focuses too heavily on 'perfect' fitness; understanding this idea however will aid acceptance of GP intervention in the fitness to work agenda, especially with the introduction of the Statement of Fitness for Work or 'fit note'.

Key implications of the findings for future activity amongst **employers/line managers** were:

- providing motivation and proof of return on investment to encourage employers to take time out to access targeted information already out there (e.g. Workplace Wellbeing Tool, ACAS information, etc.); helping to narrow the gap between information provision and a fuller understanding of why this should be acted on;
- promoting key messages coming out of the research:
  - benefits of more 'give and take' (i.e. flexible working) in the employer/ employee relationship which can positively impact on well-being *and* profits;
  - explore how to maximise impact of statistics on cost to economy to encourage employers to act and their employees to seek changes (i.e. rather then enormous 'headline' costs to the economy generally, making statistics more meaningful to the individual employer and making the financial costs/implications more relevant to the employee's income);

- small *and* medium sized businesses should be considered key targets for occupational health advice interventions rather than focusing on companies with 0-49 employees;
- encouraging more links between existing intermediary activity which is being funded and delivered at a local level and any centrally funded Government pilot services under the HWWB agenda; providing more joined up service provision for employers and the general public.

Key implications for future activity amongst **GPs/AHPs** were:

- GPs (and possibly the general public) will need to be persuaded of the value of the fit note; provision of guidance and continued efforts to persuade GPs of the importance of their role in this area is likely to be important and necessary;
- possible advantages of expanding on existing pilot services (e.g. advisers in GP surgeries) – services that appear to address a range of issues observed;
- consideration of how practice nurses, in particular, can take a more prominent role in motivating and facilitating change in behaviour regarding return to work or improving health and well-being (taking pressure off GPs and potentially offering provision of free activities).

Acknowledgements

This research was commissioned by the Cross-Government Health, Work and Well-being Strategy Unit (HWWB).

The authors (Ian Sparham, Nicky Spicer and Dorothy Chang) would like to thank Laura Smethurst and Beth Simmons in the Cross-Government Health, Work and Well-being Strategy Unit for their help and support throughout the research and in the writing and preparation of this report.

We would also like to thank Shuba Krishnan, Jon Arthurs and Martin Dewhurst from COI for their input and help with the set-up and conduct of the project. In addition, we appreciate the input in the analysis phase from James Farnham and the Strategic Consultancy team at COI.

Thanks are also due to the GPs, Allied Health Professionals, employers and their staff and members of the public who took part in the research for giving up their time.

Finally, the authors would like to acknowledge the contribution of other members of the Andrew Irving Associates (AIA) and wider Optimisa Research team, including Oliver Bonnington, Julie Walker, Hayley Connolly, Anna Ponomarenko, Andrew Irving and David Waring for their help in arranging interviews, conducting a proportion of the fieldwork and input into analysis and reporting.

Glossary of Terms

Depth Interviews – a face-to-face one-to-one interview

Focus Group – a group discussion consisting of between six and eight respondents

Mini-Group – a group discussion consisting of between three and five respondents

'Mr & Mrs' interviews – in-home interviews with co-habiting couples that involves two moderators attending and simultaneously conducting one-to-one interviews with both partners before bringing them back together to explore and compare any differences in opinion on an issue expressed by each individual when spoken to separately (e.g. experience of being out of work and what interventions may help them get back into work)

Social marketing – application of commercial marketing concepts, knowledge and techniques to non-commercial ends for society's welfare

Abbreviations

AHP	Allied Health Professionals
ESA	Employment and Support Allowance
IB	Incapacity Benefit
HR	Human Resources
HWWB	Health, Work and Well-being Strategy Unit
GP	General Practitioners
MSD	Musculo-Skeletal Disorder
OH	Occupational Health
RSI	Repetitive Strain Injury
SSP	Statutory Sick Pay

Contents

Executive summary 3
Background and methodology 3
Purpose of the research 4
Overall themes from the research 4
Brief overview of findings by audience 5
General Public 5
Acknowledgements 10
Glossary of Terms 11
Abbreviations 12
Contents 13
1 Introduction 15
1.1 Background and purpose 15
1.2 Research objectives 16
1.3 Method and sample 16
1.3.1 Methodology 16
1.3.2 The samples 19
1.4 Background information on audience generated ideas 24
2 Overview of findings for each audience 26
2.1 The General Public: working, not currently on sickness absence 26
2.1.1 Current beliefs and behaviours about health and work 26
2.1.2 Factors that motivate change in attitude and/or behaviour 30
2.1.3 Barriers and disincentives to change attitudes/behaviours 33
2.1.4 Audience generated ideas for interventions 35
2.1.5 What should drive intervention ideas? 36
2.2 The General Public: Working, currently on sickness absence 39
2.2.1 Patterns of absence amongst the sample 39
2.2.2 Current beliefs and behaviours about health and work 39
2.2.3 Factors that motivate change in attitude and/or behaviour 43
2.2.4 Barriers and disincentives to change attitudes/behaviours 45
2.2.5 Audience generated ideas for interventions 47

2.2.6 What should drive intervention ideas? 48
2.3 The General Public: On Incapacity Benefit/Employment and Support Allowance 51
2.3.1 Current state of health 51
2.3.2 Current beliefs and behaviours about health and work 52
2.3.3 Factors that motivate change in attitude and/or behaviour 56
2.3.4 Barriers and disincentives to change attitudes/behaviours 57
2.3.5 Audience generated ideas for interventions 61
2.3.6 What should drive intervention ideas? 62
2.4 Employers and Line Managers 64
2.4.1 Introduction 64
2.4.2 Current beliefs and behaviours about health and work 65
2.4.3 Factors that motivate change in attitude and/or behaviour 68
2.4.4 Barriers and disincentives to change attitudes/ behaviours 70
2.4.5 Audience generated ideas for interventions 73
2.4.6 What should drive intervention ideas? 74
2.5 GPs and Allied Health Professionals 76
2.5.1 Introduction 76
2.5.2 Current beliefs and behaviours about health and work 78
2.5.3 Factors that motivate change in attitude and/or behaviour 81
2.5.4 Barriers and disincentives to change attitudes/ behaviours 83
2.5.5 Audience generated ideas for interventions 86
2.5.6 What should drive intervention ideas? 87
3 Interaction between the audiences and its impact on Behaviour Change 90
3.1 Current levels of interaction and the key tensions in the interaction 90
3.2 Audience synergies (deliberative workshop) 92
Appendix A: The Long Lists – Audience generated ideas 96
Appendix B: Research Sample Frames 103
Appendix C: Topic guides 106

1 Introduction

AIA Research (aka Andrew Irving Associates), part of Optimisa Research, was commissioned by COI on behalf of the Cross-Government Health Work and Well-being Strategy Unit to carry out qualitative research exploring attitudes and behaviours related to health and work. The research was designed to develop key insights on the key target audiences' attitudes and behaviours that would help develop social marketing intervention activity to promote attitudinal and behaviour change and the role of 'good' work in improving and maintaining health.

This report outlines findings from this qualitative study amongst the core target audiences of:

- GPs, allied health professionals and practice managers
- line managers and employers and
- three general public audiences: those in work and not on sickness absence; those in work but currently on sickness absence; and those not working because of a health condition and on incapacity benefit/employment support allowance.

The report highlights potential motivators for and barriers to change in attitudes and behaviour related to health and work amongst these audiences. It also explores the respondents' opinions on drivers for change and ideas for solutions that each audience would like to see implemented or facilitated. Where possible, an understanding of the possible synergies between the audiences' views and experiences is highlighted. For example, the way in which behaviour change in GPs and line managers may be received by or influence the general public more widely.

This research also highlights the key systemic barriers that all audiences feel act as barriers to behaviour change.

1.1 Background and purpose

Dame Carol Black's review of the health of Britain's working age population was published in March 2008[2]. Recommendations made in this review included implementing a range of initiatives to work towards creating new perspectives on health and work, recognising that good work is good for health, improving work and workplaces, and supporting people into work. The Government's response to the Black review, *Improving health and work: changing lives*, was published in November 2008[3].

[2] Black, Dame Carol, National Director for Health and Work (2008). *Working for a Healthier Tomorrow.* London TSO

[3] Improving health and work: changing lives (2009) The Government's Response to Dame Carol Black's Review of the health of Britain's working-age population London TSO

This report sets out the findings of the exploratory depth research with key audiences conducted during September and October 2009.

1.2 Research objectives

This research was commissioned to examine attitudes, behaviour and propensity for future change in attitudes and behaviour in the area of health and work amongst each of the key audiences; general public, employers and line managers and GPs, Allied Health Professionals (practice nurses, counsellors and mental health professionals, dieticians, physiotherapists, podiatrists, community nursing teams) and GP surgery Practice Managers. In this respect, for *each audience* the following areas are explored:

- Background observations on the sample;
- Current beliefs and behaviours about health and work;
- Insight from each of the audiences on factors that would or could motivate change in attitude or behaviour;
- Barriers and disincentives to change in attitudes and behaviour;
- What should drive any potential social marketing interventions;
- Audience generated ideas for interventions.

The report will also focus on current levels of interaction between the audiences and how this impacts on potential for behaviour change and implications of research for Social Marketing and Communications going forward.

The report also explores how findings of the research can be mapped onto current HWWB activity and identifies ways in which existing or planned activities could be enhanced.

1.3 Method and sample

1.3.1 Methodology

Qualitative research was seen as an appropriate and effective methodology for addressing the exploratory nature of the research objectives and a combination of depth interviews and group discussions were used.

A combination of focus groups, depth interviews and ‘Mr & Mrs/Partner’ Interviews were used across the research.

The focus groups provided a lively forum for debate about the issues around health and work for all audiences; in addition, a group forum offers a mutually supportive environment for discussing current circumstances and a more dynamic environment for generating ideas for improvements to health and work practice. Complementing

this, the depth interviews offered an opportunity to tackle issues in more depth with all audiences, or for the general public samples the more sensitive or personal individual stories in an appropriately private setting. In particular, mental health or serious physical illness/injuries (where there are mobility issues) were best approached as a one-to-one interview at the participant's home.

One of the key objectives of the research amongst the general public was to establish what the influencers are on current behaviour and attitudes towards health and work. We conducted interviews with couples to understand the impact of 'the family unit' on attitudes/behaviours regarding health and work. We conducted a series of 'Mr & Mrs/partner Interviews' which involved two moderators each separately interviewing a partner within a relationship, ideally at their home and exploring reasons for their viewpoints. The last part of the interview was spent with the respondents back together as a pair 'summing up' their feelings about health and work and what might help return to work. In particular, we felt this methodology would be useful to exploring the impact of ill health and ability to work and how these were interpreted differently or similarly by partners. We conducted interviews with couples where at least one partner were currently off work sick (receiving SSP or occupational sick pay) and interviews with couples where at least one partner was longer-term sick and no longer in employment (in receipt of Incapacity Benefit or Employment and Support Allowance).

Deliberative Workshop – In addition to depth interviews and audience specific groups, an extended deliberative workshop (three hours) was conducted in Central London on 8th October to facilitate discussions between all key audiences (six GPs, six Line Managers, six 'working public, not sick' and seven either on SSP or on IB/ESA). This was useful sounding board for exploring ideas, testing emerging propositions generated in the audience specific research and framing development of propositions which work for all parties.

The deliberative workshop involved:

- Splitting participants into groups by target audience – to discuss the issues, respond to ideas and work together to come up with propositions that work for them.
- Then splitting participants into 'convergent mini-groups' (a foursome comprising a health professional, employer, working general public and those on SSP or IB/ESA) to discuss and establish core commonalities, differentials and possible synergies.

See section 3.2 for more detailed discussion of this session. Fieldwork was carried out across England, Scotland and Wales between 7th September and 8th October 2009.

The sample was recruited across a range of locations including rural, sub-urban, urban and inner city locations and regions with different economic and social advantages to explore whether issues raised on health and work such as access to employment or services differed because of regional economic factors and social dimensions. The table below highlights the areas visited to achieve this regional and population density split:

Country	Regions	Location of Interviews		
		Inner City	Urban/Suburban	Rural
England	South	London	Radlett High Wycombe	Surrey
	West Midlands	Birmingham	Walsall	
	East Midlands		Nottingham	Ashby-de-la-Zouch Coalville
	North West	Manchester	Oldham	
	Northern & Yorkshire		Newcastle Sheffield	
Wales	Vale of Glamorgan, Neath Port Talbot and Gwynedd	Cardiff	Port Talbot	Caernarfon
Scotland	Lanarkshire, Renfrewshire and Midlothian	Glasgow	Edinburgh	Bridge of Weir

Samples for the interviews were recruited via standard ‘free-find’ methods, using experienced market research recruiters based in the regions visited. ‘Free-find’ methods rely on sourcing the participants without using lists provided by clients. This involved a combination of:

- Official HWWB headed letters to GP surgeries (for the GP, Practice Manager and AHP samples)
- On-street questioning, networking and snowballing (i.e. ‘do you know anyone who…’) in areas local to recruiters, using a recruitment questionnaire designed to screen for potential participant’s eligibility (see appendices for recruitment screeners).

1.3.2 The samples

Our sample ensured coverage of the three core samples identified in Stage 1 scoping research:

1. The General Public (split into those working and not on sickness absence, those in work and currently on sickness absence and those claiming Incapacity Benefit/Employment and Support Allowance for health reasons);
2. Employers (Board Directors, Human Resources, Occupational Health and Staff Welfare, Line Managers); and
3. Health Professionals (GPs and Allied Health Professionals, Practice Managers).

The General Public

The key general public audiences for the research were:

- Working people who are not currently on sickness absence
- Working people who are currently on sickness absences (receiving either Statutory Sick Pay or Occupational Sick pay)
- Those not working and on Health Related Benefits (claiming Incapacity Benefit or Employment and Support Allowance due to ill health).

Working, not currently on sickness absence: six focus groups, three depths (see appendix for breakdown)

This group was sampled to incorporate people at different 'lifestages'. The lifestages broadly reflect the Healthy Foundations segmentation model[4] to explore the impact that age, and family responsibilities could have on attitudes towards health and work and to understand what impact relationship status could have on the attitudes towards health and work (and perceptions of their 'family responsibilities'):

- pre-family a mix of freedom years (young workers) and younger settlers (cohabiting couples) aged 18-39
- for family a mix of younger and older jugglers (with dependents), including single parents aged 25-59
- for older a mix of alone again (empty nesters, second time singles without dependents in household) and older settlers (no dependents) – ages 40+.

Quotas were also applied across the sample to ensure that sample picked up a range of experiences of previous spells of sickness absence, including no sickness absence in last 12 months, three-plus spells of one to seven days absence in last 12 months, at least one spell of four weeks+ unplanned sickness absence in last 24 months, planned sickness absence of three weeks or more in last 24 months. Therefore, the sample included some people in work with previous history of

[4] http://www.healthylivingnorthwest.org.uk/resource/309.

sickness absence for mental health issues (e.g. anxiety and depression), physical illness (e.g. cancer and heart problems) and chronic pain (e.g. bad backs and RSI). Many more had had periods off work in the recent past with short-term illnesses or injuries such as flu or broken bones.

The working and not on sickness absence sample was drawn from a range of sectors, including a mix of white collar roles: working in education, finance/banking, central government, local government, sales, web development, environmental health and dentistry; and grey and blue collar roles such as retail, social care, the police, catering and construction.

Other quotas included:

- Gender*:* mix of male and female
- Size of company*:* range from under 50 – 250+ employees.

The sample included a range of levels of seniority within organisations, although the majority were low-mid level managers or in non-managerial roles. We also ensured inclusion of some self-employed respondents across the sample (including an accountant, a consultant, and various builders/labourers).

Working, on sickness absence: three mini-groups, three Mr & Mrs, three depths (see appendix for breakdown)

Instead of splitting these samples by life stage, they were split by the different types of sickness absence currently experienced to explore any differences that could be detected by length of time off sick and whether or not the period of sickness was ‘planned for’ or not (e.g. operations or intensive therapy vs. unexpected and sudden illness). In terms of nature of the condition, minimum quotas of primary mental health conditions and musculo-skeletal disorders were also applied across the sample.

A spread of lifestages was recruited but rather than issuing quotas, this fell out naturally across this sample.

People were recruited from a range of sectors including finance, utilities, IT, recruitment, social care, retail (including charity shops), education, health and safety, transport and administration. The sample included people with a range of seniority from company owners or senior managers through to non-managerial employees. There was a broad mix of health conditions observed in the sample including:

- Mental health issues: stress, breakdown at work, depression, anxiety;
- Musculo-skeletal disorders: back problems, RSI, broken femur, leg and spinal injuries, heart problems, operations (e.g. gall bladder, hip replacement).

Other criteria included:

- Gender*:* mix of male and female

- Size of company*:* range from under 50 – 250 + employees (including representation of self-employed).

Not working and on health related benefits: nine mini-groups, nine Mr and Mrs (see appendix for breakdown)

For the mini-groups we retained the lifestage split for at least some of the groups to help understanding of how lifestage (and family responsibilities) impacts on views of those not working and on health related benefits. However, it was also important to ensure the nature of their condition was accounted for. In particular, it was valuable to look at those suffering from mental health conditions as a discrete group in terms of analysis but also recruited as separate focus groups to be sensitive to their condition (rather than mixing them up with those with physical conditions whose issues were often very different, requiring a different tone and discussion flow).

Satisfying these two requirements (condition and lifestage) within the existing nine mini-group structure necessitated some compromise. Groups were primarily structured by length of time claiming IB/ESA. We conducted three groups amongst those with mental health conditions but mixed the lifestages. The remaining six mini-groups were amongst those with mixed physical conditions and mental health conditions but also took into account lifestage.

Therefore, the sample was recruited to include:

- minimum of 10 respondents across the sample suffering from MSD
- 12-15 respondents across the sample suffering with mental health conditions
- a broad balance with regard previous work experience (including occupational area and size of company).

In this sample, there were widespread levels of work experience and previous achievement in their working lives. This ranged from highly skilled senior IT consultants through to low skilled manual labour (e.g. builders' assistants and cleaners). The sample covered the following occupational areas:

- White collar: IT consultant, recruitment, finance, shop owner, accountant, HR Manager;
- Grey/Blue collar: construction, cleaning (environmental health), transport, electricians, plant operatives, Armed Forces.

Employers and Line Managers

20 one-to-one depths with managerial and welfare staff and six groups with line managers (see appendix for breakdown).

A spread in the sample was ensured in terms of role in the organisation*,* from influencing organisational culture (i.e. board directors) through specialist

knowledge/responsibility (e.g. occupational health/HR managers) to day-to-day management of sickness absence (line management).

Both private and public sector organisations and a small sample of third sector organisations were included. To some extent, sectors represented were also determined by company size (for example, public sector organisations tended to be 250+ employees).

In terms of methodology, a mixture of face to face depth interviews with staff in a range of roles were conducted alongside mini-groups with line managers. Overall, the aim was to get a balance of the rich 'individual' company view from the one-to-ones and the idea generation creativity and dynamics from group discussions.

The benefit of depth interviews was that it allowed more senior or specialist staff to express their views and opinions fully and frankly. It was also more practical logistically to arrange the depths at their convenience to limit refusals/drop-out from the sample. However, for day-to-day managers, mini-groups provided a suitable environment for generating proposition ideas (i.e. they more happy expressing their views in an open forum).

The Line Managers sample was weighted towards those dealing with teams of employees and therefore with the frequent day-to-day dealings with staff where well-being, sickness absence and prevention issues may arise. Sectors represented included manufacturing, catering, construction, the rescues services, local government, banking/insurance and education.

Human resources (HR) managers and those designated with staff welfare responsibilities often had multiple roles within their organisations, including:

- company policy and procedures;
- grievance issues;
- training and recruitment;
- health and safety;
- staff benefits.

Sectors represented included: retail, hospitality, accountancy and manufacturing.

Occupational health experts included representatives from the following sectors: utilities, transport, construction and finance. A couple of participants were outsourced from the NHS and worked in multiple organisations (and helped SMEs), whereas the others were employed full-time by their organisation.

CEOs/board directors were also from a broad spectrum of industries. Sectors represented included: construction, finance, engineering, retail, education and hospitality.

The distinction in managerial roles was unlikely to be clear for employees in smaller sized organisations (<50 employees) and the balance of the depth sample was adjusted to take account of the multiple roles held by senior individuals in smaller firms.

GPs and AHPs

GPs: six mini-groups and eight depths (see appendix for breakdown)

Whilst in theory depth interviews provide the best and most practical way of uncovering GPs' views. Previous experience had suggested that in the company of other GPs doctors can be more willing to open up about the subject of health and work and address the issues in a frank manner[5]. Our experience is that groups can add a creative dynamic, especially for developing and debating workable ideas for addressing sickness absence. We ensured groups included GPs from various sized practices. We also felt it was important that a range of experience was represented in the GP sample to understand how number of years practicing impacts on viewpoints on health and work.

In addition, across the GP sample recruitment ensured that:

- **different size of practice were represented**: single GP practices, practices with 2-5 GPs and practices with 6+ GPs to assess if/how level of patient choice and GP professional support impact on incidence of sickness absence and attitudes to health and work.
- **A variety of location of practices was included**: practices operated in a mix of inner city/large city, urban/suburban and rural areas to gauge how differences in catchment area (e.g. population densities, average socio-economic classifications, levels of unemployment) might impact on attitudes and behaviours towards health and work. Areas with medium-high levels of unemployment were purposively selected on the grounds that issues of health, work and well-being were likely to be more salient in such areas.

Allied Health Professionals: three mini-groups and four depths (see appendix for breakdown)

A cross section of surgery based staff who had some level of interactions with patients were also consulted.

Practice managers were spoken to separately from other allied health professionals on the grounds of having a practice 'managerial' viewpoint as opposed to health professional view on issues of health and work. Practice manager depths were tied in with four of the GP depths in the larger practices. These were conducted either before or after the GP depth (to generate a 'case study' of individual practices).

[5] http://www.optimisaresearch.com/wp-content/uploads/2009/01/evaluation-of-the-gp-education-pilot.pdf

Mini-group discussions were held with the other allied health professionals who had contact with patients and who could play a role in influencing behaviour. We ensured representation of the following: counsellors and mental health professionals, dieticians, physiotherapists, practice nurses, podiatrists, community nursing teams and smoking cessation workers. We wrote to the practice managers at larger practices in an area and asked for volunteers to take part in the research. From this pool of responses we recruited the sample.

1.4 Background information on audience generated ideas

The research invited participants to provide ideas for ideal solutions to improve either their own, their staff's or their patients' health and well-being either to maintain health and keep them in work or to improve their chances of imminent return to working life.

Across the research, respondents generated a list of approximately 85-90 ideas (see appendix A for detailed list), mostly in embryonic form, and some much more personal and niche than others. Although not all ideas were new or feasible initiatives, these were unknown and novel solutions to the person who generated them. It was clear from this process that a number of ideas backed the aims of current initiatives being piloted across GB (see www.dwp.gov.uk/health-work-and-well-being for current initiatives in the Health, Work and Well-Being arena), but that these initiatives were not well known or widely available. In addition, some ideas were much more concerned with workplace led intervention rather than being government-led ideas.

From this, all audiences' ideas could be split broadly into return to work ideas, preventative ideas, and ideas to challenge systemic issues:

- Return to work ideas, focusing on social and vocational rehabilitation for those off work sick or long-term sick included:
  - Improvements in conditions for return to work;
  - Facilitation of return to work (GP, Employer and Independent);
  - Self-help issues;
  - independent / intermediary support/advice
- Preventative ideas, for keeping people from going off work sick and maintaining general health and well-being included:
  - changes to management practice;
  - changes to working practice to improve health and well-being;
  - improvement in on-site provision;
  - employers encouraging non-work related activity;
  - improvements in staff benefits;

  - independent / intermediary support/advice;
- Systemic and fundamental policy issues that needed exploring, discussing and challenging). Ideas included:
  - Enforcing labour rights;
  - Changes to wages, the benefit system, the tax system, health care & services;
  - Changes in GP process.

2 Overview of findings for each audience

In this chapter, for each audience the following areas are explored:

- Current beliefs and behaviours about health and work;
- Factors that would or could motivate change in attitude or behaviour;
- Barriers and disincentives to change in attitudes and behaviour;
- What should drive any potential social marketing interventions;
- Audience generated ideas for interventions.

2.1 The General Public: working, not currently on sickness absence

2.1.1 Current beliefs and behaviours about health and work

Most of the working population in our sample were fairly unaware of the formal links between health, work and well-being; it was not something they consciously considered unless they had experience of having been off work sick themselves for any considerable period of time.

> "Well-being? Sounds very government. I don't think they'd use that sort of word at my work."
>
> (General public, working, not on sickness absence, London)

There was, however, widespread evidence of respondents understanding the link between health and work insofar as:

- people happiest in work reported feeling the most motivated and generally had less time off sick. They claimed to be more fulfilled by work and better rewarded, valued, appreciated by the employer/team they worked with;
- people who tended to take regular periods of sickness absence often felt the converse: feeling under appreciated by their employer and/or line manager, perceiving themselves as being treated as 'just a number'.

There was a general consensus amongst the working population who were not currently off work through sickness absence that at the core of maintaining health and well-being was feeling valued and appreciated within the workplace. Across the sample, there were indications or claims of line managers lacking basic manners, showing little interest in staff or only communicating when there was a problem that

needed solving. Broadly, attitudes to health and work related to levels of job satisfaction and how well managed they were regarding:

- whether they felt valued, appreciated and respected by both management and colleagues;
- an overall sense of autonomy or control over their workload, including perceptions of how flexible they felt their working hours were;
- the level of reward, achievement and fulfilment attained within the workplace;
- presence or absence of a notable 'team ethic' and cultivation of collective responsibility within work;
- overall manageability of workload and ability to delegate and/or keep on top of their work flow.

> "Just saying 'thank you' is a big thing. Feeling what you're doing is being noticed and appreciated. It's amazing how much that means."
>
> (General public, working not on sickness absence, Newcastle)
>
> "Feeling you're on top of things, and that work understand if you start a bit late and leave a bit late. That sort of give and take you get from a good employer."
>
> (General public, working not on sickness absence, Surrey)
>
> "I think flexi time if a good thing…one of my friends works flexi time and it's really good, there's some morning you can start as early as 7.00, finish at 4.00, do that for a few weeks and get an extra day or two days off at the end of the month."
>
> (General public, working not on sickness absence, Cardiff)

It was clear that informal methods of communicating with employees could also play a key role in making people feel valued and appreciated (e.g. employers simply having a coffee / lunch with staff or asking their views on particular issues, etc.).

> "A little thing my work does is we all have lunch together. We sit around the table and talk about anything other than work, if we can. It's not compulsory, some people don't bother. But it's a good thing."
>
> (General public, working not sick, London)

Feeling part of a supportive team – across all sectors – was seen as a key factor influencing attitudes towards health and well-being and sickness absence.

In this research, size of organisation impacted on willingness to encourage supportive, small team ethics. Although health and well-being were not often 'formally' on the agenda, small companies frequently employed simple but effective tactics to promote goodwill and foster loyalty amongst their staff (regardless of sector).

> "I'm one of two, I'm in a specialist team, we're smaller, we're more cohesive, we support each other. I do feel that we do that, whereas the other team they must have about 20 odd members of staff, admin and all the rest of it included and the politics that end and the bitching is ridiculous."
>
> (General public, working not on sickness absence, Birmingham)

In contrast, larger companies were more likely to report having schemes in place both for health maintenance (sickness prevention) and rehabilitation when staff did go off work sick e.g. return to work strategies, occupational health and health and well-being schemes aimed at maintaining well-being at work.

> "[Regarding health and well-being], masseurs come in and those that take telephone calls get a massage for 10 minutes or a hand massage and maybe back. … 18 months ago there was a pack that was created, 'the health and well-being pack'. It was just an internal publication, it may have been in conjunction with someone else but it was pretty much every week you'd get something, so whether it be alcohol units that you should stick to each week, leading up to Christmas time and just a different subject every week."
>
> (General public, working not on sickness absence, Edinburgh)

However, respondents from larger organisations also indicated that their organisations were more likely to have issues with staff feeling less of a sense of *personal* responsibility, compared to small firms. This was due to staff feeling that they worked for an amorphous organisation and consequently they did not appreciate how their absence would impact on colleagues' workloads. This attitude was more prevalent amongst those newer to working life with fewer responsibilities in the workplace and often with less family responsibilities.

Typically, respondents indicated there were higher historic incidents of sickness absence in 'high stress' occupations such as finance, social care, transport, catering and the emergency services. Within the sample there were also a few who confessed to taking regular days of sickness absence when not ill. These respondents tended to treat these days as 'additional holiday'; most worked for larger firms.

> "I throw 'sickies'. I sometimes just get up and think 'can I be bothered with another day listening to those two talking to me on the fish counter?' and I just think 'sod it, I'll stay here and watch Jeremy Kyle, you know!'"
>
> (General Public, working not on sickness absence, Feltham)

In this sample, those who were most inclined to take a sick day when not ill were either living at their family home still or renting with friends, which possibly reflected this lack of personal responsibilities or sense of responsibilities for others. However,

these respondents also claimed not to enjoy their work, feeling unappreciated by their superiors or bored by the monotony of their role.

There were indications that sickness policies can exacerbate sickness absence amongst the working population and/or encourage protracted periods of absence, rather than aid early return to work. In particular, rigidly enforcing a 'three periods of sickness leading to a disciplinary' rule prevalent in many larger organisations could have a detrimental impact:

- encouraging employees to take longer periods of time off (rather than risk returning too early only to go off again, counting as two 'sick periods');
- encouraging employees to come into work when sick to avoid a disciplinary procedure (and potentially spreading illness or exacerbating the individual's illness).

> "I got a nasty, nasty germ just after Christmas and they all come in coughing and spluttering, spluttering and coughing week in, week out and I said "why don't you go home?" "No, can't go home because we score a sickness …" Well blow the sickness! In the end it caught up with me and I was in a right state, so that's how it happens."
>
> (General public, working not on sickness absence, Birmingham)
>
> "If I've been really ill and I've just needed the one day off, I've ended up taking 3 or 4 days so it doesn't look made up."
>
> (General public, working not on sickness absence, Cardiff)

The self-employed in our sample took a far more pragmatic, day-to-day approach to health and work; when faced with a health problem, they admitted to being tempted to return to work as quickly as possible, no matter what the illness/injury was. Respondents explained that this was because they were anxious about losing money, leaving work unfinished and subsequent damage to their reputation.

> "I just don't take time off unless I'm half dead. It's just not a good idea. Someone else could take the work, and I lose money and reputation. … You just do what you can."
>
> (General Public, working not on sickness absence, self employed, Walsall)

That said, there were examples of the self-employed in manual roles easing themselves back into work to control pain (e.g. doing fewer hours or less days work when suffering from pain associated with a bad back) and assessing what was possible on a day-to-day basis. Working for themselves, they were able to weigh up the relative risk of loss of income against what they felt capable of doing. A few admitted they would take a holiday if they felt that was the way to recover (e.g. if stressed/feeling over-worked).

There was evidence that employees did not necessarily make the connection between healthy lifestyle choices and general well-being at work. Employees often admitted to having poor diets; they could be inclined to make injudicious choices regarding food consumed at work, and were lacking regular (or any) exercise. Although the onus was seen to be on them to maintain a healthy lifestyle, many claimed little/no *real* encouragement or, more critically, little facilitation from management to achieve this.

There were, however, examples of progressive employers who were encouraging health and well-being through workplace schemes/incentives. This included cycle schemes, free or subsidised gym membership, regular team sports days and providing recreational diversions in work such as pool tables and table football. This was particularly popular in high stress, long-hour, in-door working environments such as call centres and sales.

> "We do a pedal cycle. We have a thing where a percentage of salary can go towards things, like education and pedal cycles is one of them where they'll encourage you pedal to work…. they have a scheme where you can buy the bikes cheap and say if the bike cost £300, they might do 30 months and just take £10 a month out of your salary until you pay it off."
>
> (General public, working not on sickness absence, Birmingham)
>
> "I would think that the vast majority of people that work in the call centre have got a really good experience at work; there's three pool tables there, for example, and you get a 15-minute break morning and afternoon, you know, there's a great selection of food".
>
> (General public, working not on sickness absence, Edinburgh)
>
> "Well, I was supposed to be off for almost 6 months but I went back early because my boss picked me up and took me home. It really made me feel wanted."
>
> (General public, working not on sickness absence, London)

2.1.2 Factors that motivate change in attitude and/or behaviour

The working public often cited two key areas that would motivate a change in their attitudes and behaviours regarding health and work:

- changes to work-based practice to encourage a greater sense of well-being in the workplace;
- changes to lifestyle (facilitated by work) to encourage maintaining everyday health.

Changes to work-based practice that employees felt would motivate a positive change included regularly reinforcing employee contributions or actions. This could

mean relatively small changes such as more appreciation or politeness from line managers, or increased recognition for their work or contribution. This was often felt more keenly in organisations where line managers or bosses were less visible on a day-to-day basis and where line managers had too large a team to manage one-to-one mentoring on any regular basis.

> "I think just taking an interest, you know, asking how you are, would make a big difference. My boss just doesn't do it."
>
> (General public, working not on sickness absence, London)

A common motivating factor for change was the desire for increased managerial approachability and accessibility. The benefits were seen as better communication and the ability to share and discuss issues and seek solutions more easily before problems arose e.g. dealing with a repetitive strain before it became a chronic pain problem or seeking variety in task/responsibility before workplace lethargy leads to sickness absence.

> "I'd just like to see our boss. He's never there, and he doesn't know what any of us think about work. We can't discuss anything with him. It's not good."
>
> (General Public, working not on sickness absence, Leeds)

Shared responsibility on challenging tasks (having a 'buddy') and workloads was seen as a particular strength of effective small teams. The research indicates that the collective responsibility discussed by respondents who had worked in small teams within medium-large sized organisations, was seen as important in fostering an improvement in attitudes and behaviours. Aligned with this was a desire for more flexible attitude towards working practices (such as working hours/breaks, etc.) and a less hierarchical approach to team structures and management practices.

> "When you're working in a small team you naturally look out for each other. It helps to know there's support there."
>
> (General public, working not on sickness absence, Birmingham)

Early access to medical services and/or therapies whilst still in work (e.g. access to an on-site pharmacy or in-house therapy) was also cited as a way of facilitating behaviour change and a way for employers to demonstrate they cared about their employees and wanted to actively support them. This lack of access to occupational health was noted more by employees in small-medium sized organisations, and particularly acutely in blue collar occupations such as construction.

> "I think going out of their way to have available any services to help if you're feeling upset or unwell is a sign of a good employer … it makes you want to work for them."
>
> (General public, working not on sickness absence, London)

In terms of changes to health, incentives to improve lifestyle were seen as important factors in motivating change: 'what's in it for me?' On a day-to-day basis, it is questionable whether the working public regularly considers the impact of health choices. Although all claimed they 'knew the theory' that they should exercise regularly and eat healthily, choices were dependent on accessibility, affordability and encouragement to utilise both:

- healthy food and drink choices – dependent on what the company canteen served and the work fridge stocked
- fitness and well-being classes/sessions – was there a convenient local gym near to work and any encouragement to use these facilities?

> "I know mates whose companies have gym membership. One pays a bit, but not much, it's like £10 a month or something. I'd love it if my company did that."
>
> (General Public, working not on sickness absence, Greater London)

Again, there was anecdotal evidence of the positive impact of 'buddying up' to improve health (i.e. co-worker encouragement) and setting short term goals. A positive example of health facilitation both by employers and fellow employees was work sponsored sporting challenges e.g. running a marathon (or a 10-kilometre run) as a team with work paying for sponsorship/entry - this acted as an incentive to keep going (and provided good PR publicity for the company).

> "My work paid for people to do the marathon a couple of years ago. It sorted out the sponsorship money, and a couple of us did it. … someone else doing it helped, sharing the pain!"
>
> (General public, working not on sickness absence, Surrey)

Finally, respondents suggested that another key motivator for change was experience of regular or unplanned sickness absence, whether personally or through close colleagues, friends or family. In particular, experiencing lethargy or boredom when not working, or the guilt about the workload impact on others within their team or through their absence (or worry about work remaining uncompleted), could act as reasons to avoid sickness absence where possible.

> "It's hard when you come back from an illness, or you come back from holiday, nobody's done any work for you, it's waiting for you. The amount of people nowadays who take their laptop on holiday with them so they don't have that workload when they come back is very high!"
>
> (General public, working not on sickness absence, white collar, Glasgow)

2.1.3 Barriers and disincentives to change attitudes/behaviours

The key themes that emerged as barriers or disincentives to change for the working public who were not on sickness absence were:

- impact of culture of the work environment (lack of personal encouragement or facilitation of change);
- negative impact of sickness absence policies (that could encourage rather than discourage periods of absence);
- impact of current economic climate (for example, employer or employee response to fear of unemployment, impact of recession on productivity).

Workplace culture (i.e. the attitudes and behaviours accepted in a place of work) could impact by instilling negative/disengaged views on health and well-being at work. Respondents felt that barriers to change could be due in part to actions of employers such as poor attitudes of line management (e.g. no interest in the well-being of staff), inflexible attitudes towards working hours, lack of rewards for employees and perceived 'draconian' measures with regards sickness absence (e.g. disciplined after three periods off in a working year). Typically, medium sized organisations where a 'macho' culture existed had the least conducive environment for encouraging practices to protect staff well-being. Macho cultures observed by respondents in this research tended to be environments where employees masked their emotions – it was claimed that supporting colleagues was low priority, and feeling overloaded or stressed seen as a sign of weakness. This was particularly prevalent in male dominated workplaces and/or sectors (e.g. construction, manufacturing, financial services and sales).

> "With the Bradford Scale, in fact you're better off and many people do take three days because it counts the same as one day, so you might as well have three days and make yourself completely fine."
>
> (General public, working not on sickness absence, Birmingham)
>
> "At my work you battle through problems. You aren't seen to be ill or to seek help if you're overloaded, otherwise people start saying you 'can't cope'. And that means weakness. It's a bit sad, but it's definitely there."
>
> (General public, working not on sickness absence, London)

Where a positive teamwork ethic was not particularly strong or encouraged by employers, there was also a lack of short or long-term goal setting amongst employees to help each other achieve positive change regarding health and well-being at work. The research implies this could have the knock on effect on employees' health and well-being due to the lack of support/empathy from co-

workers or line managers, and a lack of duty of care when looking out for evidence of mental health or chronic pain conditions.

The lack of a positive work culture (seen as employers or line managers showing an interest in the health and well-being of staff) could mean some employees reported that they felt disengaged, stressed or even depressed by their working environment, and thus inclined to take time off sick or behave in ways that were unlikely to help their own health in work (e.g. regular or high intake of alcohol to unwind at the end of a day). This seemed to be exacerbated in low-skilled work where staff felt:

- low levels of job satisfaction (through a lack of control, support or appreciation);
- bored/unchallenged by repetitive work.

> "About five years ago we had a local inspection. It was all very confidential, tell us what you feel, what you think, so we all did, and then all hell broke loose and next thing we're all called to this meeting and the bigwigs walked in and we were eventually shouted out like five year olds, and told if you don't want your jobs, there's plenty of folk lining up just out now, in other words, keep quiet and just get on with it."
>
> (General public, working not on sickness absence, Glasgow)

Many of those in lower paid jobs or at lower levels within organisations also felt they had insufficient money to afford gym memberships or cycle to work schemes.

Behaviours unlikely to help maintain a healthy lifestyle were more prevalent amongst those without dependents (pre-family or those living alone) who were less inclined to think about their own health or have peers with health problems that could act as a prompt to re-consider their own health behaviours.

Respondents often said that their employer did little to encourage or facilitate change in employee attitude towards their own health. There was little incentive/positive reinforcement to exercise (e.g. no cycle scheme or subsidised gym membership), and canteens or fridges stocked with unhealthy food and drink options.

> "It's a bit hopeless if when you go get a drink there's only Coke or Fanta. You think 'why bother?'"
>
> (General public, working not on sickness absence, Port Talbot)

The current economic climate also meant that staff felt additional stress about the security of their jobs; this could mean making work choices that were likely to have an effect on their health, such as:

- working longer hours;
- accepting pay cuts (less money taken home);
- less rewards for their hard work;
- less time to exercise in the working week.

> "Something that's got to be looked at is working hours. I speak for everybody here. We're working more hours than we've ever worked before. Not getting paid any more for it."
>
> (General public, working not on sickness absence, London)

2.1.4 Audience generated ideas for interventions

For the working public, the key to improving current levels of health and well-being was focusing on sickness absence prevention measures. It was suggested employers should be more proactive in their interventions and should take the initiative in providing the impetus in improving the health of their staff via gestures such as subsidised gym membership, healthy food at work or engendering greater role variation to maintain staff morale.

> "If you were doing something tedious, constantly repetitive, doing the same thing day in, day out, that's not going to motivate you…they should bring in task sharing for a bit of variety and then you can all cover each other, if someone's off then you know how to do each other's jobs. It should benefit the organisation."
>
> (General public, working not on sickness absence, Cardiff)

A few of the working public suggested that employers should have access to independent advisers who could give them guidance on healthy workplace practices.

> "I think you do need independent people there to say to the line manager at the top, "you're not being fair", but I'm not talking about unions because union is too strong a thing, nobody wants to call the union in, hardly anybody … it upsets so many people."
>
> (General public, working not on sickness absence, Birmingham)
>
> "I've wanted these independent assessors around before. A complete fresh pair of eyes going in."
>
> (General public, working not on sickness absence, London)

Employees also recognised that they had a role in being proactive by getting involved and taking up initiatives that would be of benefit to them, such as cycling schemes and work organised sport.

Some thought that a more flexible approach to booking annual leave would help both foster more honesty between employers and employees and help prevent sickness absence.

> "I think 'duvet' or 'personal' days are good as well ... you can ring in and say 'I had too much to drink last night', rather than phoning in sick, you're being honest, you can take a day's holiday. It's about trust."
>
> (General public, working not on sickness absence, Edinburgh)

2.1.5 What should drive intervention ideas?

Overall, the core focus of the suggestions from the working public who were not on sickness absence, on what should drive health and well-being interventions was on efforts to maintain health and keep people in work.

Many suggested that 'health and well-being' was not very high on either their personal agenda, or that of their line managers. For many, understanding of the negative impact of sickness absence was based purely on experience (i.e. reactive) and many recognised that more needed to be done to make people aware of the benefits health and well-being maintenance and potential consequences of potentially avoidable sickness absence. Employees in micro, small and medium sized businesses and the self-employed in particular suggested they were likely to need a better understanding of the benefits and consequences before they would pay to participate in initiatives. It was also suggested by some employees from larger businesses that employers should disseminate good practices to other businesses.

> "The councils and the big companies, like gas and telecoms, should be taking our HR experience and actually spinning it down to the smaller and medium businesses. Telling them what works and what doesn't … explaining why people's health at work is important. It shouldn't be taken for granted."
>
> (General public, working not on sickness absence, Edinburgh)

For respondents, a popular driver for change was employers incentivising and rewarding behaviour change. Unless people are given tangible reasons to change, they are unlikely to make them. In this respect, employees wanted their employers to provide incentives that would demonstrate employers were taking their employees' health and well-being seriously e.g. cycling, discounted gym membership, subsidised healthy food (e.g. free fruit), health checks, access to counselling, on-site medical help. Ideally, they wanted the incentive to be personalised and tailored to their needs or those of the team.

> "Why can't they give us free or discounted gym membership? I think that's really important. I'm sure they'd benefit from that. Health bodies and healthy minds. If I had that and it was near work [the gym], I would go."
>
> (General Public, working not on sickness absence, Birmingham)
>
> "It'd be nice if they took us all to a spa for the day if we hit our targets. That would be great. Perhaps the lads could go hot air ballooning or something. Just something that said 'thanks'."
>
> (General Public, working not on sickness absence, Newcastle)
>
> "I think they should just give us fruit to snack on. Better than crisps in the long term."
>
> (General Public, working not on sickness absence, Feltham)

On a day-to-day level, for many employees simply redressing a sense of being valued or appreciated were top of their minds when discussing what should drive change, especially amongst those working in medium and large sized organisations who had less regular contact with bosses or their line managers. Increasing staff's perceptions of their own empowerment and seeing signs that their managers' care was seen as important and also could help people feel a sense of responsibility and that their input mattered. Many suggested that this could be achieved relatively easily and that managers could make small changes that could potentially make a big difference (e.g. lunch with staff, regular catch up meetings, acknowledging people's contributions, informal sharing of issues).

> "You know, if you're working away and you can work through your lunch hour and no-one will notice, but the minute you leave 10 minutes early, or come in 15 minutes late, everyone's on your back, and I think that can feel quite insulting sometimes. Where's the respect there?"
>
> (General public, working not on sickness absence, Glasgow)
>
> "I think regular meetings or away days are good … I think its just issues and problems and this and that and its great just to get out, have a chat, stay overnight, a few beers and just talk about work and probably nothing else, and you think, 'my God, I'm not the only one, they're having problems as well!'"
>
> (General public, working not on sickness absence, Glasgow)

For those who recognised their own health and well-being could suffer through a lack of stimulation and considerable repetition in their work, especially in lower skilled careers, there was a desire for greater variety in their day-to-day roles, having variable responsibilities and experiences to help keep them motivated and engaged.

More broadly, achieving a sense of collective responsibility within teams in medium and larger companies was seen as important in fostering loyalty and keeping people in work rather than going off sick. A few respondents who worked for large organisations which seemed to be already undertaking some 'good practice' in the area of health and work were keen to point out the efforts that had been made to create 'teams within a team'. They said this involved employers and/or line managers constructing a number of small, tight knit teams within with larger teams, with each individual having key responsibilities. The aim was to encourage nurturing environments providing mutual support and with positive line management under-pinning this it also helped to prevent employees feeling isolated or under-valued.

A few working in public sector roles felt employers could show more interest in staff welfare by improving the quality of their buildings/environments they worked in.

> "The classrooms, there are windows that are broken that are freezing cold in winter, we've had the union, we've had temperature taken in the centre of the room and it's showed 12 and it's got to be 11 before you all walk out."

(General public, working not on sickness absence, Birmingham)

2.2 The General Public: Working, currently on sickness absence

2.2.1 Patterns of absence amongst the sample

Periods of time off work varied from a few days at a time (for example, for recurring back problems) to a few months for more complex prognoses such as stress or spinal injuries. A few respondents had more clear-cut physical conditions (e.g. recovery from operation or broken bones) and were more confident of their imminent return to work.

> "I'm out of action for another two weeks but I know I'm going back. I always knew everything would have healed by October. So [in contrast to others] I've actually quite enjoyed it, other than the operation. The last couple of weeks has actually been relaxing, just putting my feet up."
> (General public, working, on sickness absence, Feltham)

Some illnesses and injuries, including both physical and mental health conditions, were linked to incidents that happened at work and a few respondents mentioned that their employer was typically keener to assist with recovery because of this. Where injury was caused by out of work activities, for example sport or vehicle accident, employees sometimes commented that their manager was more impatient about imminent return to work and not very forthcoming with offers of help to return to work.

Some employees currently on sickness absence thought that employers were more willing to take measures to aid return to work for senior employees or those perceived as business critical. In focus groups, disparity in employer action for both physical and mental health conditions was noted and commented upon by the less senior or non-managerial employees.

> "I just wouldn't get that help (company paid physiotherapy). They obviously care about you getting back to work. My boss doesn't care, I think he's hoping I leave to be honest."
> (General public, working, on sickness absence, Manchester)

2.2.2 Current beliefs and behaviours about health and work

For those employed but currently or regularly taking short periods of time off for sickness, attitudes towards health and work reflected:

- type of illness or injury;
- attitude of their work towards their sickness absence i.e. perceived job security, level and type of contact experienced and help offered;

- role of workplace in sickness absence i.e. whether or not work was the root cause of their absence, or whether 'outside work' factors were key.

Type of illness or injury often had a major impact on understanding of the relationship between health and work. For those with physical injuries which required a prescribed time to heal, there was more certainty about their prognosis and when they would feel back to normal and ready to return to work (e.g. planned operations, broken bones, etc.). Amongst these people, very few were aware that they could, in theory, return to work before they were 100% fit. Although some claimed to be bored or unfulfilled sitting around at home, most were unconcerned about their working prospects in the longer term.

> "It's not going to be long. I'm bored of day time telly, but I know it's not forever."
> (General public, working, on sickness absence, Manchester)

However, for those with mental health conditions, and those with more serious or multiple physical problems (e.g. injuries sustained from car accidents) the prognoses were more complex or uncertain and it was often harder for respondents to predict when they would be ready to return to work. This could exacerbate a sense of concern about future employment prospects in either the short or longer term. It was also apparent that a lack of routine or social interaction could impact on mental health. Some who had been off work for a few months with a physical problem but with no clarity about when they would return claimed to be experiencing signs of mental health conditions. This exacerbated the lack of confidence about imminent return to work, ability to return to former duties and/or holding on to employment.

> "I have my good days and bad days, really. It's better if the sun's shining! Some days I do struggle to get myself going in the mornings, though. I'm not sure whether I'd be able to hold down a job full-time right now."
> (General public, working, on sickness absence, Newcastle)

Related to level of uncertainty about when they would be able to return to work, the attitude of their employer towards sickness absence also impacted on their attitudes and behaviours. This reflected:

- the type of contact they had with work: some were more comfortable with low engagement methods such as texts from colleagues/line managers; others wanted phone calls or face-to-face meetings (either at home, on neutral territory or at work) to discuss their current situation.

> "Two of my managers came round and I always think it's really strange, 'why do you need to come round?' but I think they probably come to see that I'm not decorating or something like that."
>
> (General public, working, on sickness absence, Manchester)

- the regularity of contact with work*:* there was also a fine line between sufficient engagement and feeling pressurized or harassed into trying to return to work.

There were indications that those with mental health conditions were more sensitive to feeling under pressure to return, because they could not 'prove' the current state of their condition (in contrast to many physical injuries). The effect of a co-worker getting the type and regularity of contact wrong was to either make an individual feel undervalued and hence feel not missed at work, or make them feel that work was perhaps unnecessarily intruding into their personal space, which could lead to feelings of anxiety. In both situations the individuals could feel less motivated to return to work.

> "I answered the phone the 12th time they called and just said 'I'm still signed off sick' – because it's a mental illness I think it's difficult for them to see it… I look perfectly fine but I'm not and I think that's quite difficult for them to get their heads around."
> (General public, working, on sickness absence, Feltham)

- what reassurances they had received about their position – whether their line managers had indicated that their job was, theoretically, being held open for them indefinitely or if they perceived they were relatively dispensable (more often the case in lower skilled work). Those who had such reassurances felt more able to take time to convalesce.
- *whether they believed they could return to former duties* and the implications this could have for returning to their former employment. Where individuals felt that they were unable to perform tasks central to their previous roles, they were less inclined to return, especially if the alternative roles available were less skilled.

A minority of our sample viewed the relationship between health and work less favourably. This was felt more acutely where:

- *work was seen as the root cause of their illness*, whether this was an injury or accident at work or more commonly whether this was related to mental health (e.g. stress, burn-out, or breakdown at work); where their mental condition was well known there was a sense of embarrassment and in more extreme cases humiliation about returning to work which made people more wary of how this should/could be managed. A few people suggested that it was questionable whether they were likely to return to their current work because of this;

> "I'm worried about going back. Part of me doesn't want to. I feel humiliated by what happened and the way it happened. I feel like I made a fool of myself in front of everyone … crying in front of work colleagues."
> (General public, working, on sickness absence, Feltham)

- *they were not satisfied with their job or felt under-valued.* Those with a history of short term absenteeism often expressed a lack of satisfaction with their job and some claimed to feel undervalued at work. Some respondents said that this meant that they did not feel guilty about taking time off, believing that work would not care whether they were present or not. Those who were less satisfied at work were also more inclined to take a longer period off work for each sickness absence to ensure

they maximised their 'allowance', whilst avoiding being disciplined for a high number of periods of absence.

For those on sickness absence, experiences of formal health and work initiatives were largely dictated by the size of company. Where available, often in larger organisations, provision of occupational health interventions (e.g. counselling, physiotherapy, etc.) were at the company's request and were warmly received. Respondents who had received these services generally thought that it showed that their employer appreciated them and valued their recovery and return to work. Employees who worked for larger organisations were also more likely to have received support to ease them back into work more formally, through a programme involving shorter hours, greater flexibility of working and/or light duties.

> "Working from home is a good option, if they make you feel like you're contributing something. That's the key, to feel you're actually helping."
> (General public, working, on sickness absence, Port Talbot)

In contrast, in small and medium organisations provision of occupational health or rehabilitation measures were less consistently forthcoming and sometimes driven more by the individual than the company, usually via their GP. That said, in smaller organisations there was a natural determination to return to work early and a greater sense of guilt or personal responsibility for being off work for longer periods and leaving others to pick up the work. This was often exacerbated, intentionally or not, by contact with colleagues when off work.

> "I'm in a team of five people, so I feel pretty bad on my other colleagues that I'm off and I'm just beginning to get a bit of a conscience about it now."
> (General public, working, on sickness absence, Feltham)

> "It makes you feel guilty if you have a certain amount of time off, as if they've got a business to run and stuff like that, it's like a guilt trip, which makes you in your mind want to go back earlier than you probably medically should."
> (Mr & Mrs, working, on sickness absence, Walsall)

The self–employed had a strong desire to return to work as early as they could, even if they thought this may be detrimental in the longer term. This was because they could not turn to anyone else to keep their business operational. As a consequence, some continued to work despite having physical injuries (e.g. a bad back). Moreover, the demands of running a business through ailing health could also induce the build up of stress, as they felt unable to take time off work due to loss of income. This was more evident amongst respondents that worked in more physically laborious occupations such as construction work.

2.2.3 Factors that motivate change in attitude and/or behaviour

The attitudes of those on sickness absence towards health and work depended upon their relationship with their workplace during the absence, both in terms of contact and whether (and how) they were being encouraged to return. Contact and encouragement were therefore key to motivating or de-motivating attitudes towards health and work. Respondents suggested that employers could do more to encourage early return in some capacity, including:

- working from home;
- offering lighter duties/shorter hours;
- flexible working patterns.

In addition, there were calls for more tangible demonstrations of how much they are valued from their employer whilst off work, including:

- the employer taking the lead in sourcing and subsidising occupational health intervention at the earliest opportunity (e.g. counselling or physiotherapy) rather than waiting for help from the GP (and the NHS)

  "Employers need reminding "are you checking on your worker?" Sometimes you go off sick and you're just forgotten. They should be looking to sort a phased return for you or to refer you to occi health so that you get the stuff you need to come back to work, you might need equipment, you might need chairs..."
  (General public, working not sick, Birmingham)

- more of the 'right' sort of contact – to keep them engaged/involved and inclined to feel their opinion mattered, such as off the record chats about work; even a text or email wishing them well was a way of helping them feel positive about their employer.

  "I don't mind them phoning, they're short-staffed. So they're always trying to put a little bit of pressure on you but I don't mind because I want to go back anyway."
  (General public, working, on sickness absence, Manchester)

Boredom and lethargy experienced by many when off work for even a few days was a key motivator to return to work. Those who were off for a few weeks or even months became increasingly frustrated about their lack of interaction with work and were often keen to be engaged in some way to reassure them about their future.

> "I think it'd be nice just to get a call. They know I'm off for a while but I feel really uninvolved. I think it'd be nice to know you're not forgotten."
> (Mr & Mrs, working, on sickness absence, East Midlands)

Respondents suggested that more engagement with employers about the possibilities of lighter duties was also likely to motivate a positive change in attitude and behaviour e.g. seeking the option of doing low grade/low pressure work when off

sick from their regular duties, to keep them engaged in the working world. Some suggested that their line managers were not always engaging with them in any meaningful way about what roles/activities they might be able to do if they were currently unable to perform their usual tasks. SME employees working in specialist skilled or, conversely, lower skilled roles suggested it might be hard for them to be accommodated at work when not 100 percent fit. But many also claimed that they had barely, or never, had a conversation about what they might be able to contribute when convalescing.

> "They just didn't ask. It was 'you do it or you don't'. I'm not sure how I could do anything else. I've driven for 10 years. I don't really know what else I could do."
> (General public, working, on sickness absence, Feltham)

Although smaller companies were sometimes less able to offer flexible roles to encourage earlier return to work, employees tended to indicate feeling more of a sense of guilt when off work, knowing only a few others would be taking on their workload (as opposed to this potentially being spread across the team in larger organisations). This sense of personal responsibility appeared to motivate them to return to work as quickly as possible.

Amongst those with mental health or chronic pain conditions who feared being stigmatised or judged by work colleagues, some thought that being able to meet line managers on a neutral territory away from work colleagues to discuss return to work and keep them involved would help them make an earlier return to work. There were indications that those who felt more self-conscious about being judged by colleagues, were seeking return to work solutions where they might be able to avoid contact with colleagues for a period of time whilst re-adjusting to working life, such as working from home, or antisocial hours.

> "I don't like walking in and seeing everyone, knowing I'm going to go home again. I think they're going 'he looks okay. Why's he not back in?' It'd be easier to meet at Starbucks, or something."
> (General public, working, on sickness absence, Manchester)

> "I'd like to be able to go in at say 7 o'clock and leave at 10 o'clock [in the evening] for a bit. Familiarise yourself and get a bit more used to it without others looking at you."
> (General public, working, on sickness absence, London)

There was also desire for more proactive help from their GPs to aid earlier return to work to counter their frustration at:

- a widespread lack of access to or availability of services – in some regions patients were told they would have to wait months for treatments on the NHS;
- the lack of discussion about how to manage or instigate early return to work and when this was advisable. Some felt their GPs were very cautious about declaring

them fit to return to work in some capacity through not understanding their role, and yet they were seemingly unwilling to engage with their employers[6].

> "I think it'd be motivating if GPs seemed to want to get you back to work. Mine doesn't seem to at the moment. It's a closed discussion as far as they're concerned."
> (General public, working, on sickness absence, Feltham)

Finally, the family unit also played a role in their attitudes towards time off work and return to work. Within this sample, it was apparent that those with family and dependents felt more frustrated and guilty about prolonged periods off work. In a few cases this appeared to impact on their self-esteem and they resented their dependency on their family's income and support.

> "It [being off work sick] does get to me you know, because I just want to be able to support my family, but I can't. I feel like I should be the one going out to work"
> (General public, working, on sickness absence, London)

This was exacerbated where sickness absence impacted on income, as was the case with the self-employed or the few within the sample who had been more than six months absent from work.

> "I mean she's been working whilst I've been laid up, like... I'm just quite impatient to be earning to be honest 'cause she don't really earn that much and we need the money"
> (General public, working, on sickness absence, East Midlands)

2.2.4 Barriers and disincentives to change attitudes/behaviours

The two key broad themes that emerged acting as barriers to attitude/behaviour change regarding health and work were:

- a lack of understanding or appreciation of ability to return to work unless 100% fit;
- whether or not work was the key source of their health problems.

Very few of those working but currently signed off sick were aware that they could, in theory, return to work before they were 100% fit. Only those working for large companies with a more established occupational health function, or those in more senior roles across the sample were more likely to have experience of being encouraged to return early in some capacity. This lack of awareness of the possibility of returning to work when not fully fit was reinforced by the actions of GPs and

[6] Although believed by many respondents in the sample, a GP does not need to sign someone as fit for work before they can return to work from a period of sickness absence. The medical certificate is advice to the patient to share with their employer about their functional ability and whether they should refrain from work.

employers advising them to stay off work until they were absolutely sure they could return to their former duties without risk to themselves or others. This was especially emphasised if the role was physically laborious. The duration of work abstinence stated on sick note was often taken as read/not questioned.

> "I can't go back until the doctor's happy. I feel okay, you know. But he's saying I need to be careful as it could easily go again [back]. So I'll listen to him."
> (General public, working, on sickness absence, Caernarfon)

The perceived grey area surrounding fitness for work meant a few were concerned about attempting to access services that might improve their condition (e.g. for bad backs this included swimming). This was driven by a fear of being judged either by their colleagues or employer as ready to return if they were seen to be doing something constructive. The fear of being seen to take part in constructive activities also impinged or impacted on peoples' social lives, particularly in smaller or close knit communities, where being seen in social situations by colleagues was seen as evidence of their readiness to return to work.

In a few instances, those with mental health conditions working for large organisations felt obliged to stay in and not be seen for a number of months, which was felt to be having a negative impact on their recovery. Such a disposition stemmed from the anticipated and/or experienced negative judgements of others concerning how one should conduct oneself when off work sick.

> "I have to hide! …ever since I came out of hospital, I've taken the decision to be really, really careful, even though I'm signed off sick. I'll sit in the pub and have a drink with my friends, I'm like 'yeah, we'll go out for a drink but we're going into London or we're going to Windsor' because if somebody from work sees me, they'll be like 'she's not been in work for three months but she's having a drink!'"
> (General public, working, on sickness absence, Feltham)

Some had approached their employer about light duties to enable an earlier return to work but found their line manager/employer felt unable to offer them a role until they could return to their former duties. This was more commonly discussed by people who worked in smaller organisations and employees thought this was because it was harder to accommodate phased return strategies if there was no role to be fulfilled.

A few admitted they were reluctant to approach their employer about returning to work, particularly if they were worried they might be unable to do their previous duties. They also feared early return would result in exacerbating problems or worsening relationships with colleagues (i.e. being 'seen as a burden' or getting 'favourable' treatment).

> "I don't want to be treated special. You know, people will treat you fine to your face but you just know that they'll be keeping an eye on you and talking… judging."
> (General public, working, on sickness absence, Caernarfon)

For some, there were indications that work was the source of their health problems and was acting as a barrier to return. This related to:

- the job itself providing low job satisfaction;
- presence of a 'macho' culture and perceived stigma around mental health and chronic pain illnesses;

  "There's a lot of employers who are ignorant about mental illness. Well a lot of people are like that, do you know what I mean like? Because I've been diagnosed with depression and anxiety that doesn't mean I'm going to freak out around the site or nothing does it? I mean they could put me in the site office, the deliveries in, the deliveries out, do you know what I mean? I haven't got to be climbing up towers and whatnot have I?"
  (General public, working, on sickness absence, Newcastle)

- experiencing isolated detrimental incidents (bullying at work, breakdown in front of work colleagues, etc.).

  "What if I go back and it's like it was before? That's what's getting me. I can't imagine it'll change. No one's told me it'll be fine, it'll be different."
  (General public, working, on sickness absence, Feltham)

Some said that a poor experience at work meant they lacked of inclination to return early, including:

- feeling over-worked and under-supported by colleagues – some reported that they took time off regularly, feeling they were 'owed a break'; others reported that the regular absence of other staff meant they had to take on too much of the absentee's workload resulting in them going off sick through stress or burn-out;
- a lack of contact from employers when off work and feeling under-valued;
- sickness policy encouraging them to stay off work (e.g. 'three strikes' rule).

Some of those regularly taking short periods of time off work believed that it would be harder for them to change their attitudes because of the detrimental impact of low job satisfaction. They found it hard to recognise the detrimental impact on their working life that this pattern of sickness absence behaviour was having e.g. lack of reward or recognition for their work due to irregular attendance could perpetuate the cycle of low satisfaction and regular time off.

2.2.5 Audience generated ideas for interventions

While there was cross-over with the ideas of the working public for health maintenance at work, those on sickness absence placed greater emphasis on ideas that maximised their chances of return to work. In particular, greater dialogue between employers and GPs was seen as important to aid trust in prognosis and help to plan a feasible return to work strategy tailored to the individual employee.

Moreover, where it was felt a GP was being unnecessarily cautious and preventing them from returning to work when they felt able to, some would have liked the option of a second opinion. In this way it was hoped that a more proactive outcome could be reached.

> "I'd like it if you could go to another GP after a few months, if you requested it. I feel like mine's stopping me working now, and I want to get another opinion."
> (General public, working, on sickness absence, Manchester)

It was felt that employers could do more to offer scaled down and low pressured work for them to do rather than nothing at all. Where this was not possible, some expressed a desire to see their employers take partial responsibility for their retraining if they were no longer able to offer them any employment.

> "It'd be great if you could do something for work but when you feel up to it. No pressure, like. Say, over a month. So you're keeping yourself involved, but not over doing it."
> (General public, working, on sickness absence, Manchester)

> "Your employer should take more responsibility to ensure you're re-trained if they can't help you and they're going to dump you on the scrap heap. I think it'd be good if your last month of sick pay went towards retraining or something."
> (General public, working, on sickness absence, Feltham)

It was expressed that the voice of the individual off sick should be central to any dialogue between employers and GPs. Not only was it hoped that there could be this three-way dialogue, but that there could be greater employee-employer or patient-GP communication.

> "We all use the internet these days, so just doing a blog or something to let them know how you're feeling. You don't have to be asked questions then, it's you just telling them how you feel."
> (General public, working, on sickness absence, Glasgow)

> "Yeah, a helpline or something like that. I want advice on how to get him motivated. Get him out of this rut."
> (Mr & Mrs, partner of working, on sickness absence, Radlett)

> "Be nice if there were little booths in coffee shops which were meeting rooms. That would be a good place to talk to work, away from work."
> (General public, working, on sickness absence, Glasgow)

2.2.6 What should drive intervention ideas?

Overall, for those working but currently on sickness absence the focus for what should drive health and well-being interventions was on effective early intervention and a better understanding of fitness for work.

Experience of how their employer treated them (and how they felt as a result) during their time off work was key to what those on sickness absence felt should (and could) make a difference.

Early interventions / vocational rehabilitation programmes in this research were mostly limited to much larger organisations, and a few more progressive SME organisations. In this respect, it is our view that it is important to address the knowledge gap amongst SME employers, specifically regarding:

- effective and sensitive line management in the area of health maintenance and rehabilitation;

  "My experience is these people [line managers] are not interested; because managers come across false; they're not really interested in how you are, they're worried about their figures for the month or for the quarter and that's what it's like, 'just go away.'"
  (General public, working, on sickness absence, Manchester)

- awareness of benefits of early intervention and phased return (and understanding when/how to make contact with their employees to keep them in the work loop);
- employers showing a better understanding of mental health and chronic physical conditions and what they could still contribute to work and as a result how work could aid their recovery;
- providing greater opportunities to dip in and out of work as their condition allowed.

There was also a desire for increased awareness of and access to early intervention, particularly for those who had experienced having to wait months for NHS rehabilitation services to be available. They wanted early access to neutral intermediaries or independent advice / access to services to help recovery when their GP or employer was not forthcoming with offers of imminent (or paid for) help.

It was also important to raise awareness (and credibility) that you do not have to be 100% fit to work. In particular, addressing tension between theory and practice when faced with obstacles such as:

- employees thought that smaller organisations found it harder to accommodate 'light duties' or alternative roles;
- the handling of mental health conditions – those on sickness absence thought their employers feared the legal implications of encouraging early return to work or alternative duties if this resulted in the condition worsening;

  "If you have an accident at work and you've been off for a long period of time then the company you're working for and their insurance company will be very concerned about taking you back on and if you do get a job it's going to be a job at the bottom of the ladder, you know."
  (General public, working, on sickness absence, Manchester)

- employees in particular industries felt their employers had an ingrained inflexibility towards fitness to work e.g. stringent health and safety regulations to be mindful

of. Some also had the impression that their employers believed they might struggle with alternative roles owing to limited skill sets;

- some wanted to have the option of a viable second opinion from a medical professional in terms of their prognosis. There were some latent concerns that their GPs could not assess each individual's ability to perform duties at their work.

A few also recognised that a driving factor behind ideas to improve health and well-being should be harnessing (but not exploiting) the personal responsibility evidently felt by members of small, closely knit teams when they were off sick. It was suggested that their guilt at burdening others with their workload was a driver that needed replicating across industries to encourage a culture of early return.

> "It's not a bad thing feeling bad about leaving others clearing up my mess at work."
> (General public, working, on sickness absence, Feltham)

2.3 The General Public: On Incapacity Benefit/Employment and Support Allowance

2.3.1 Current state of health

Typically, those previously in more senior roles tended to have experienced mental health conditions which had stopped them working (described variously as ‘burn-out’, or ‘failure to cope’) and were still feeling the on-going after-effect of this e.g. high levels of stress, anxiety and even agoraphobia. In some cases, being out of work had exacerbated their condition. Although these tended to be respondents from white collar occupations, overall they worked in a range of sectors.

> “I just broke down in the middle of the office in front of everyone. … there were about 30 people in there and I was literally sitting there unable to do anything. I just lost it. I was taken into a meeting room told to go home and rest. Unfortunately, after nine months that was it. I was told the position had been closed down.”
> (General public, not working, on IB/ESA, London)

A few respondents in this sample, with a range of physical and mental health conditions, had barely had any work experience and incapacity had set in at a young age. This included those who had dropped out of training courses or study for professional qualifications and who had never re-started.

There were some clear differences in outlook between those out of work for under a year and those out of work for over 3 years. Those out of work for longer periods typically felt more isolated from society and indicated they enjoyed the process of taking part in this research and having a chance to chat and meet people in the same position as them.

The couple interviews (‘Mr and Mrs’ interviews) highlighted where communication may have broken down about their hopes and desires for rehabilitation and future possible employment. In some instances, the sessions acted as a catalyst for further discussion about how to take steps to start the process of vocational rehabilitation.

> “I won’t say this to her but I look at it that perhaps down at Incapacity, they should really be saying to her “No, that's it now, go and get a job. Keep going to the doctor’s, whatever, get going again, get on with it”. You know what I’m saying? “You're alright”. .”
> (Mr & Mrs, partner of not working, on IB/ESA, Oldham)

Some said that they learnt more about possible rehabilitation and back to work services available to them in their area through the experiences of others in the groups. There were a few regions where respondents appeared to have more awareness and experience of rehabilitation services for those in receipt of health

benefits than others. Respondents in Newcastle, South Wales and Glasgow generally appeared to have a greater knowledge of relevant local services than respondents from other areas.

It also should be noted that the sample of those on IB/ESA in our research may not be representative of the views of all those on IB/ESA. We believe the respondents' in our sample mostly wanted to return to work in some capacity, and were not happy to stay on benefits indefinitely – an accusation they made of incapacity benefit recipients.

> "I just can't sit on my arse all day, I'm not a sponger, you know, I've always worked and I've always been brought up the way that you work – it's not been like 'oh yeah, you can go and claim benefits and do what you like son' (as some do and we know they do), I've always worked and that is so frustrating!"
> (General public, not working, on IB/ESA, Walsall)

2.3.2 Current beliefs and behaviours about health and work

The majority of those receiving IB/ESA could identify the health and well-being benefits of work. These were usually expressed as core elements they felt were missing from their lives, namely:

- social interaction - meeting people and making friends;
- having a routine and keeping active - having a sense of purpose;
- sense of identity and self-worth;
- distraction from 'other aspects' of their lives (e.g. unhappy home lives).

> "I really miss the banter to be honest. Just having a laugh and a giggle…. It means a lot more when you don't have it."
> (General public, not working, on IB/ESA, Newcastle)

> "I'm not one of these people that doesn't want to work. I used to enjoy work because I like a laugh and a bit of a joke and when I was at work we used to play jokes on each other, have a laugh – if you've got a good job it's just like being down the pub, you're not drinking but you're socialising and having a laugh .. just having a laugh with people, that's what I miss."
> (General public, not working, on IB/ESA, Ashby-de-la-Zouch)

This view of the benefits of work was also reflected in a widespread recognition of how mental health could deteriorate the longer they had been out of work.

> "My illness brought on severe depression as well because I was so frustrated I couldn't do anything and that was worse than the ME itself as well."
> (General public, not working, on IB/ESA, Cardiff)

This was particularly highlighted by those receiving IB/ESA because of physical health problems (e.g. car accident or sporting injury) for over a year, who had since developed symptoms of poor mental health (e.g. depression or anxiety). They

thought these symptoms were exacerbated by their often more sedentary and isolated lifestyles. They also reported a lack of confidence in their ability to return to work. Their feelings of isolation and symptoms of anxiety had also led to them question the continued relevance of their skills.

> "It's hard for men because you don't have as many friends as your partner does (women have a lot more friends, they do) and when you're a bloke and you get to your 30s, you sort of say 'goodbye' to all that, you miss your work colleagues and you're not going out socially …I mean, I've been off 6 years and in terms of interviews, you just don't know what to do any more, you lose all track of what you do, it's lack of confidence really."
> (General public, not working, on IB/ESA, Ashby-de-la-Zouch)

> "I'm at home all day with nothing to do with my time. I've started to get idle, started to put weight on, starting to get depressed, do you know what I mean?"
> (General public, not working, on IB/ESA, Oldham)

In contrast, those on IB/ESA for under a year tended to have more determination to get back to work. At this point they did not report as many barriers as intractable as those receiving IB for longer periods did and they were also more confident that their skills were still job-ready.

> "I know that I'm a bit more limited now, I'm obviously rusty, I've been out of HR for nearly a year but if somebody would just give me the chance, I could do it. I know I could."
> (General public, not working, on IB/ESA, Newcastle)

As with those still employed currently on sickness absence, those on IB and ESA who had more positive experiences of work were also more keen to return to work. However, respondents also discussed their experience of long periods without contact with either health or employment professionals and how they felt they lacked support and help to return to work.

A few claimed that they wanted to return to work but were being held back by their GP not endorsing their readiness to work.

> "My GP won't let me come off the sick. I'm desperate too, but he won't let me. Says I'm not well enough yet, that I could go again, you know."
> (General public, not working, on IB/ESA, Newcastle)

Many respondents illustrated a lack of knowledge of or confusion about their eligibility for retraining, work placements or therapeutic treatments. There appeared to be a lack of consistent signposting towards these services from either health professionals or employment advisers, or potentially long waiting lists to access services.

> "I can see the strain on my GP every time I go and see him. He's like, 'I can't do anything, there's nothing I can do, my hands are tied.' In my experience the problem is with the funding and what's available to the NHS."
> (General public, not working, on IB/ESA, Walsall)

Both those unemployed for health reasons for under a year and those longer term unemployed reported a reluctance to visit Jobcentre Plus. Many of those who had higher skills or had previously worked in white collar jobs often suggested that Jobcentre Plus only offered lower skilled, financially unrewarding jobs and attracted a 'work shy' clientele whom they did not wish to be compared to.

> "It's a nasty place … I didn't like the girl at the job centre who said, 'I got 12 people back to work and I've got £300 extra on my wage for doing that.' She doesn't know their circumstances, you don't know what they can do, what they can't do, she'll just stick them in anything."
> (General public, not working, on IB/ESA, Oldham)

> "I wouldn't go to the Job Centre. I associate the Job Centre with people who are on the Dole, which is not being rude or anything, people who don't want to work, people who have no intentions of working, we all have them on our street don't we?"
> (Mr & Mrs, not working, on IB/ESA, Oldham)

Some respondents who reported they were more highly qualified/skilled said that they 'self-excluded' when they were offered options of lower skilled work because they felt it was 'beneath' them.

Others suggested they would prefer to wait until they were 100% fit and could do the job they trained for or wait for a post which they believed offered a wage commensurate with their skills.

> "At the job centre it's like they're not listening to you .. or, then it's like 'oh, they're looking for a cleaner' ... well why should I be a cleaner because I've been sick!? ... why should I be the lady that cleans the toilets!? ... why should I do that sort of job!? ... do they want to go and clean the toilets!?"
> (Mr & Mrs, not working, on IB/ESA, Radlett)

Figure 1 highlights two contrasting examples of the impact of understanding and acceptance of the benefits of returning to work when not feeling 100% 'fit for work'. It also demonstrates how positive contact with intermediaries (such as disability charities) can act as a catalyst to positive change.

Figure 1: Less and more positive 'outlooks' regarding the relationship between health and work amongst those on Incapacity Benefit/Employment and Support Allowance

Less positive 'health and work' example: female, IB/ESA under one year	More positive 'health and work' example: Male, IB/ESA more than three years
• Before suffering bad back due to childbirth was a teacher • Back condition since improved, but not 100% and, therefore, feels unable to return to energetic teacher role • Will not consider lower skilled work (eg working on the checkout at Morrison's) as she feels it would be a waste of her skills • Cannot see herself returning to work for the foreseeable future	• Before suffering a stroke and complete memory loss, he was a successful IT technician • Slowly retrained to a basic level with the help of a disability charity • Set realistic objectives about how much work he could do • Now teaches other people on IB/ESA for two hours a week giving him an enormous sense of purpose and self worth

Where contact was made with employment services, it was often driven by their requirement for fitness to work assessments in order to satisfy welfare benefit requirements. That said, there were some who reported trying to access retraining or work placements but claimed they were either told by these services (e.g. Jobcentre Plus):

- they were not eligible for free training; or
- they were better off staying on Incapacity Benefit rather than taking on low paid work.

> "I think it's [as if] you're classed as going to college for more than a certain amount of hours per week. Then that stops you being able to claim, even though you're still having to pay out of your pocket to go on the course. So you can't train. It's madness."
> (General public, not working, on IB/ESA, Walsall)

Knowledge of the localised impact of the current economic climate (i.e. levels of unemployment) could further dent confidence about their chances of obtaining work. Many respondents on health benefits for a longer period (especially those over a year out of work) said that they believed it would be harder to return to work. Amongst respondents from more rural and/or areas of high levels of deprivation, belief in their prospects of imminent return to work was far lower.

> "You read about all these places closing down, going out of business. I know people who've lost their jobs. Well, they're probably going to get another job

> before me aren't they?! They haven't been out of work for Christ knows how long."
> (General public, not working, on IB/ESA, Newcastle)

Others felt that they had just become unemployable in the eyes of employers owing to a combination of a lack of recent work and multiple health problems.

> "It's alright saying 'go back to work' but there's probably not many employers would want to give me a job .. you know, what do you say 'I've been on Incapacity Benefit for 6 years?', 'what's the matter?', 'I've got mental health problems and a bad back' – they won't give you a job! .. They won't touch ya!"
> (General public, not working, on IB/ESA, Ashby-de-la-Zouch)

> "There's no jobs. I love all this about helping me back into work, when there are far more qualified people than me unable to get work."
> (General public, not working, on IB/ESA, Newcastle)

2.3.3 Factors that motivate change in attitude and/or behaviour

More frequently, respondents on IB/ESA, discussed unprompted the barriers and disincentives to changing their attitudes towards health and work and barriers going back to work than they discussed what would help or motivate them to change their beliefs or return to work. This may have reflected the fact that the longer they were out of work, the more isolated they felt from outside influencers to change their situation. Some reported that it was hard for them to envisage what could help change their situation.

Most respondents reported wanting more positive and proactive intermediary facilitation and access to rehabilitation / back to work service providers. In addition, they echoed the sentiment of those signed off work sick, who wanted their GPs to signpost them more effectively towards services to help improve general health and life skills. Some wanted to be given a plan of things that they could do and clear outcomes.

> "Someone taking their time to talk you through your options and setting a plan."
> (General public, not working, on IB/ESA, Walsall)

In terms of self-motivation, those who had been out of work for under a year typically were more able to suggest things they could do or had tried. They also reported that they believed that they were still job-ready or expressed a determination to keep active. Ideas centred on short-term goals and included:

- more active engagement in hobbies and interests that took them outside their home e.g. swimming, going for walks (for general health) and seeking out free classes (for socialising and interaction);
- offering help to local volunteer groups, to provide some structure to their life and help engage in a routine.

> "I've started going to art classes on a Monday. It's made a real difference. I love it, I lose myself in it. … and it's nice to meet people and have a chat."
> (General public, not working, on IB/ESA, Newcastle)

A few respondents who had young families suggested that the birth of a child had acted as a catalyst to consider their situation and trying to seek a change in their circumstances. Increased family responsibilities and the need for further income could occasionally provide the spark to try to change their circumstances. However, much depended on the severity of the illness or injury and the length of time they had been out of working life.

2.3.4 Barriers and disincentives to change attitudes/behaviours

Respondents who were on IB/ESA suggested the key barriers to returning to work were:

- the impact of their previous (negative) experience of work (boredom; bullying; stress; lack of support) provided a psychological barrier to going back to the world of work;
- their lack of awareness of being able to work when not 100% fit, often reinforced by benefit myths such as: perceptions they would be punished for being seen to be fit for work through accessing volunteering or rehabilitation services or exercising in public places.

> "In bigger companies you were just lost, you wouldn't know who was at the desk next to you."
> (General public, not working, on IB/ESA, Cardiff)

These two barriers were also reported as significant by people who were currently on sickness absence but who had a job to return to.

However, for people who were on IB/ESA two further barriers stood out.

- Firstly, there were barriers they associated with service provision and the welfare system. These included a lack of financial incentive to work with some believing that they would earn less in paid employment, the lack of engagement with health and/or work institutions for lengthy periods of time and an inflexibility of employment and rehabilitation services in terms of a belief that there were no options, or very few, for people who wanted to return to work gradually whilst maintaining the financial security that their benefits afforded them;
- Secondly, there was a lack of confidence or know-how about how to access rehabilitation services.

> "You tell me where these services that will help me are? I've not found any that last. So just when you're getting somewhere, you feel you're getting more confident, then it's not there. Bang. … Then you feel kind of worse. Like you've given it a go for nothing."

(General public, not working, on IB/ESA, Newcastle)

Respondents reported a number of barriers that they attributed to services and the welfare system. This included their belief that there was a lack of financial incentive to seek employment. For many who had previously worked in low paid or low/unskilled work, benefits were seen a more secure proposition than potentially unsustainable low paid work. This was exacerbated by beliefs that current high unemployment levels meant there would be other, more immediately appealing candidates than them to employers for most/all roles.

> "The other thing is, with people like us, you've got to remember, if there are jobs there that we could possibly do, there's other people going for them jobs …"
> (General public, not working, on IB/ESA, Ashby-de-la-Zouch)

Compounding this, there were indications that little (if anything) proactive was being done to encourage their return to work or to retrain or learn new skills. People held a set of beliefs about the support that was available to them which were partly based on experiences but which may also have been influenced by assumptions or the views of others including:

- Many respondents suggested that those on Incapacity Benefit could not access government training services with the same level of choice as those on employment support benefits. Some claimed they had tried to access services but were told they would be ineligible;

  > "I wanted to do this computer skills course but the Jobcentre said I couldn't 'cos I was on Incapacity."
  > (General public, not working, on IB/ESA, Walsall)

  > "We're not on the scrap heap because we want to be; it's because we've been put there; we want to work, we are trying but no one wants to help. … I've tried, but I'm not allowed to train. Not unless I pay, which I can't afford. It's difficult."
  > (General public, not working, on IB/ESA, Cardiff)

- Respondents also reported that Jobcentre Plus advisers sent them to their GP to get signed off sick rather than discussing job opportunities or employment support services, resulting in them feeling excluded and feeling that they were not considered suitable for work;

  > "He [Jobcentre Plus Adviser] just told me to go back to my doctor to get a note and I said that I don't want to get a note I want to work."
  > (General public, not working, on IB/ESA, Glasgow)

- Respondents also reported experience of volunteer placements not being open to them unless they could commit to certain hours (despite their inability to predict 'good' or 'bad' days);

  > "I've tried volunteering, working in Oxfam, but they want you to say how many days and hours you want to do, and I just can't know that in advance."

(General public, not working, on IB/ESA, Cardiff)

- Many said that their GP had advised that they were not ready to consider a return to work yet - fuelling a perception that they do have to be 100% fit to work.

“Although I want to go back to work my doctor just keeps shoving these sick notes at me and I'm saying 'Well when are these sick notes going to wrap in because I want to get back to work' I'm in a corner like, you know what I mean?”
(General public, not working, on IB/ESA, Walsall)

Many on Incapacity Benefit commented that they spent lengthy periods of time without any positive interaction with employment or re-training advisers and services. The longer they had been on health benefits the more likely it was that the only contact with employment advisers came with each fitness for work assessment for benefit receipt every six months. Respondents sometimes thought this could be seen as having a detrimental effect on their confidence/self-belief about future employment prospects, particularly where the assessment process was seen as a formality rather than a true assessment that would help them find a way back into employment.

“I've been on Incapacity for about eighteen months now, I've only had to go into the Jobcentre twice. It's like they fill in your paperwork and that's it, you're filed away and they've no need to worry about you anymore. There's no active involvement or anything that they encourage you. You've got to do it all off your own back and it gets difficult to motivate yourself when you're caught in the same trap every day like.”
(General public, not working, on IB/ESA, Walsall)

In addition to finding themselves increasingly isolated from interaction with employment advice/services, those with mental health conditions (who were more likely to need encouragement and reassurance than those with physical injuries) also appeared to lack access to, and consistent delivery of, one-to-one support from outreach workers. Without outreach, many reported a lack of direction and awareness about how to help themselves out of their situation. This was exacerbated where outreach and intervention services were offered but were hard to locate or did not last.

“There was a sign up in my doctors as well, saying that on Thursday afternoons or something somebody from the Jobcentre was going to come there and you could make an appointment. So I made an appointment and that woman never turned up. … The receptionist said she’s been every week for 12 months or something and then this one week I made an appointment she didn’t turn up. They phoned me up and said sorry, and asked if I wanted to go in the Jobcentre, which was not the point of having seen them in my doctors, in a different environment really.”
(General public, not working, on IB/ESA, Oldham)

In addition, it was noted from the couple depths ('Mr & Mrs' interviews) that communication about one or both partners' situation and how to improve health and well-being had sometimes broken down. They could both harbour frustrations about their situations, but only realised they had different views that they had not previously discussed when they were brought together for the last part of the interview. Some respondents conceded that an absence of a discussion between partners could also have a detrimental impact on each other's health and working life.

> "All they're saying to her is "How do you feel? How do you do this?", and she can say whatever she wants couldn't she if she wants to? … They're asking questions and whatever, it's not like they get her on the machine and make her run, you know what I'm saying?"
> (Mr & Mrs, partner of not working, on IB/ESA, Oldham)

> "It was difficult because my husband wouldn't have left me in the house on my own, and he wouldn't want to run the pub on his own. My illness affected everything."
> (Mrs and Mrs, not working, on IB/ESA, Oldham)

> "To be honest, I didn't know you [not working partner] were talking about those things with your GP."
> (Mr & Mrs, partner of not working, on IB/ESA, Oldham)

> "My partner is unable to work because she suffers from depression, so she's on benefit, and if I earn too much money, because I am registered as living with her, then that also has like a kick-back but luckily (or unluckily!) I don't earn too much money at the moment. Partly because I'm looking after her. It's a vicious circle."
> (Mr and Mrs, partner of not working, on IB/ESA, Radlett)

Even those who were more open to the idea of returning to work indicated they lacked confidence and self-belief about their ability to return to work:

- they either anticipated or believed they actually had experienced discrimination when applying for work – either because they had been on health-related benefits for so long or because of the (mental) health condition they had been diagnosed with;

> "I think if they see the word like depression or anxiety like they think, aye, aye, he ain't right in the head, kind of thing."
> (General public, not working, on IB/ESA, Walsall)

- they felt they lacked sufficient skills or recent experience and that they would not be of value to an employer;

> "It is scary now for me – I haven't been for a job interview now for it's got to be at least 14/15 months and the idea of going to an interview terrifies me…I couldn't do it, in my heart I no longer feel that I could do the job that I was doing, I'm not sure I've got it in me any more."
> (General public, not working, on IB/ESA, Cardiff)

- they felt that they might not be able to hold down a job for long and feared they would be unable to get back the financial security of their current benefits.

> "Look, if I get some job, say in a shop tomorrow. I'm working there for like a couple of months and then all of a sudden I just can't do it any more, because of the anxiety, what then? It's just gonna be a real mess trying to get back on the benefit... it's a risk."
> (General public, not working, on IB/ESA, Glasgow)

Age also impacted on attitudes, with those over 50 years in receipt of health related benefits more likely to report feeling less optimistic about future employment prospects than those in their 20s and 30s. Again, this was exacerbated by the current economic climate and was perceived to lower their future employment prospects even further.

> "I'm sorry but hey, I'm not getting any younger, they're [other respondents in the group] not getting any younger. There's discrimination, you see? If you're not 25 then they [employer] don't want to know."
> (General public, not working, on IB/ESA, Glasgow)

2.3.5 Audience generated ideas for interventions

Those on IB/ESA primarily wanted help from independent sources of support. For many, the ideal goal was to build confidence, having short-term goals that they could come to an agreement on with their support worker to improve their situation that did not sacrifice their current levels of benefit until they were ready to return to meaningful employment.

It was anticipated that this help needed to be better signposted by their GP, who was often seen as a gateway to further interventions. Permitted free rein to devise their ideal interventions, they anticipated others (rather than themselves) taking the lead in sourcing interventions and wanted these to be tailored to meet their individual needs.

> "In some workplaces they could have somebody physically assigned to you, so if you're struggling with something and you can't do it, then they can just take over and finish it off while you have a rest."
> (General public, not working, on IB/ESA, Ashby-de-la-Zouch)

> "I'd like to be able to try and work from home, I think. So that, I didn't have the pressure of going to work, for me, for my situation, so that if I didn't want to get dressed today that's alright but I can still maybe do a bit of work if I feel like it."
> (General public, not working, on IB/ESA, Oldham)

> "I always used to think I'd like to be a florist, but like I think now at 36 I wouldn't go about that, and I could never afford to do it and I might be crap at it. But if somebody said to me, "Right there's a free course here, do you think that you could do it?" You'd get up to do it."
> (General public, not working, on IB/ESA, Oldham)

"It would be good to have a Jobcentre equivalent just for the people who have been off sick. I think you would have to have met a standard of requirements to be able to be eligible to use the centre, so you can't just be any guy off the street."
(General public, not working, on IB/ESA, Walsall)

"Maybe a confidence boosting course would be a good idea before you start going for job interviews. Maybe that would be an idea first, a 'confidence' course, something to make you feel good about yourself because I think you do sink into a sort of state of affairs where you do, you feel you're being victimised by the unemployment people."
(Mrs & Mrs, not working, on IB/ESA, Radlett)

"Maybe if big companies or small employers would each give you a trial of a day or half a day, so 5 different companies, where you just work for a little bit and then at the end of the week you get to say "right I really like that one" and then get the chance to do it."

(Mrs and Mrs, not working, on IB/ESA, Sheffield)

"It might be, even something as simple as, every time you go back [to Jobcentre Plus] you see the same person would make you feel so much more confident in the system. But when every time you go back you see somebody who's never met you before, they have to spend the first twenty minutes sitting in front of you, flicking through your file and stuff, it's a bit disheartening."
(General public, not working, on IB/ESA, Walsall)

2.3.6 What should drive intervention ideas?

The focus of health and well-being interventions for those on IB/ESA was improving availability and access to services or initiatives to help regain the confidence and skills to return to work. There was also some need to support the wider family and foster greater family interaction.

The majority of people on IB/ESA wanted interventions to acknowledge that they understood the health and well-being benefits of working and that they should therefore not be treated in the same way as those who had no intention of working; their experiences of being out of work reinforced how much work provided structure, routine, a sense of self-worth and social support. Without this structure, this audience's lack of confidence and self-belief hindered their ability to take the reins in change. In this respect they wanted intervention to offer them the chance to prove their credibility as a potential employee.

"You need something to stir you back into doing something productive, where you don't just feel like you're shoved on a production line of these brickie qualifications that aren't actually real qualifications. They won't even get you anywhere on a building site, they're just something the Jobcentre do to tick a box."
(General public, not working, on IB/ESA, Walsall)

> "When they gave me my job for just two hours a week, I didn't know whether to hug my boss, kiss her, cry or run screaming out of the building! It was like I'd won the lottery (you know, the hairs on my neck still go, you know) and what a boost; I was no longer on the scrap heap, I know I'm only doing two hours a week but it's just such a massive thing."
> (General public, not working, on IB/ESA, Cardiff)

Therefore, those on IB/ESA, particularly those out of work for many years, wanted interventions to facilitate (i.e. guide and hand-hold) a change in their circumstances, not just encourage them to seek/discover services. They wanted more effective signposting to and flexibility of training, employment advice and volunteering opportunities (via GPs and other key intermediaries). There was also a desire to see a change in attitudes of employers, GPs and other intermediaries towards mental health and chronic pain.

> "It's no good saying that there are services out there, I don't know what I'm looking for. … more worryingly I don't think my doctor knows either. He doesn't seem to, anyway."
> (General public, not working, on IB/ESA, Walsall)

Crucial to uptake was the need to bundle services together in a place where users would locate them and in an environment they would feel comfortable. In this respect, services offered at or near GP surgeries were likely to be a key interaction point.

> "One place to go would be good. Somewhere that isn't the Jobcentre!"
> (General public, not working, on IB/ESA, Newcastle)

A final key driver was providing a financial incentive to (return to) work rather than remain on benefits: those on IB needed or sought some security of long-term income if they 'tried out' work, reducing the perceived gamble to come off benefits.

> "I've got to have a word with somebody about doing some kind of courses or something along those lines, as long as I can get the same money .. that's what bothers me; that I am still able to get the money and that I can make a switch or find something where I'm no worse off."
> (General public, not working, on IB/ESA, Ashby-de-la-Zouch)

> "What if I can't do it, you know what I mean, I can only do a couple of days and what if they think I can do it and I can't do it, will I lose my benefits? You just don't know what to do, you just don't, I don't know what to do. I don't know who to ring."
> (General public, not working, on IB/ESA, Oldham)

2.4 Employers and Line Managers

2.4.1 Introduction

Our core focus for the employer sample was on line managers with day-to-day responsibilities for staff. Their views on health and work were often more aligned to those of the working public than those of senior management. Most were responsible for teams of up to 20 people, and all had some experience of dealing with sickness absence and/or grievance issues. Those working in larger firms and/or with larger teams tended to have more direct experience of problems with staff bullying.

Human resources (HR) managers (usually present only in mid-large sized organisations, approximately 30+ staff) and those with designated staff welfare responsibilities often had multiple roles within their organisations, including:

- company policy and procedures;
- grievance issues;
- training and recruitment;
- health and safety;
- staff benefits.

Welfare was just one of their roles and many felt they could be offered more guidance in dealing with particularly difficult sickness cases, usually related to mental health disorders and chronic pain injuries. This was a concern both for those on short and long-term absence and those in work with enduring conditions. HR managers were often concerned with the legal implications of failed return to work initiatives (e.g. staff returning too early and having longer term consequences). In larger companies across business sectors, HR managers claimed to have had less day-to-day involvement in health and work issues than senior managers in small companies who fulfilled multiple functions.

> “Being a small business we need everyone, within realistic terms, to be able to fulfil lots of different positions as well. The directors muck in on everything too.” (Line managers, <50 employees, Birmingham)

Those who most frequently dealt with well-being at work issues were occupational health experts. Responsibilities included:

- management/monitoring of sickness issues, absence and return to work;
- surveying health and well-being across the organisation;
- suggesting improvements to working practice to maintain a healthy workforce (from nutrition to exercise).

CEOs/board directors’ knowledge and interest in the area of health and work often seemed to relate to the size of company they ran. In larger firms this was influenced by the views of HR and occupational health (if there was such a function). CEO and

Board directors' views on health and work frequently appeared to be driven by economic concerns, i.e. lost days to sickness absence. That said, personal experience could play a role in shaping their views. For example, one CEO from a medium sized business who had experienced very poor health said she was more attuned to her staff's needs and welfare than she had been prior to her illness.

2.4.2 Current beliefs and behaviours about health and work

Corroborating the working public view that they were less likely to take time off sick if they were satisfied at work, employers from CEO or board director level through to line managers widely acknowledged the notion that a motivated and happy workforce was less likely to go off work sick. This maxim was recognised irrespective of sector or size of company.

> "I think everyone's goal is in part to feel part of a happy workforce. We all want that."
> (CEO/Board Director, 50-249 employees, Newcastle)

However, it was also widely agreed that there was often a gap between theory and company practice with regards health and work behaviours. Many line managers and those up to board director level felt that 'getting the job done' was the priority and that in pursuing this goal this did not always leave sufficient time or resources to invest in health and well-being activities and monitoring. This position was more frequently voiced during times of cost-cutting, coincidentally when stress levels typically were higher and job uncertainty was at its greatest. Many board directors, particularly in small and medium sized firms, suggested they were worried about economic survival during the recession and explained that some of the well-being benefits were currently viewed as unaffordable luxuries e.g. at-desk massage, team away days, etc.

> "It's finding reliable people, it's difficult in the economic climate to pay everyone want they want to be paid basically and to win enough good quality jobs. My job's to make sure that the business is profitable and to keep everyone happy and to find the right people who are going to be team players and want to get their heads down and work."
> (CEO/Board Director, <50 employees, London)

Senior directors also felt that a friendly approachable management style was important on a day to day level, and that line managers and senior managers being more consistent in this regard was probably more important for staff welfare than more expensive one-off gestures such as away days.

In larger organisations, HR Managers and occupational health/staff welfare advisers suggested that senior managers understood the importance of resources and schemes being in place to maintain health and rehabilitate staff (e.g. occupational health, sickness absence policies and monitoring, access to counselling, health care

schemes), although they often claimed that they needed to understand the return on investment to devote more time/money to potential benefits of health and work initiatives. There were indications that for those trained in health and well-being practices, it could be a struggle to engage senior management in the potential benefits of further investment.

Senior managers claimed to feel bombarded by information about various 'best practice' methods and initiatives and suggested that it was hard to select what required further attention or could be ignored.

In comparison to employers at larger firms, some employers at smaller firms had differing views on what health and well-being meant, equating it to potential investment in health and lifestyle initiatives (e.g. gym membership). For them, well-being was generated by everyday interpersonal contact.

Employers at smaller and even some medium-sized companies felt that they had 'natural' preventative measures to guard against sickness absence, such as the team bond and shared responsibility and support. This was aided by evidence of a flatter company structure and clearer, more frequent demonstrations of staff appreciation. As a consequence, some managers experienced very low levels of sickness absence.

> "Health and well-being isn't a topic of discussion in small companies. It's something you just create between yourselves. It's not something the boss talks about, it's more something that just happens; looking out for each other."
> (Line Manager, <50 employees, Manchester)

> "I really can't believe that there's a problem with small companies in the private sector through absenteeism. I really can't believe that to be honest … In small companies no-one's ever off sick. I don't know if anyone else finds that. I think especially if there's twenty and below."
> (Line managers, <50 employees, Birmingham)

> "We have to pull together; in a big team somebody could quite easily become anonymous, slack in their work, turning up late and getting away with it on the odd occasions; when there's only 5 of us you are a name, not a number and you feel more part of the team."
> (Line Manager, 50-249 employees, Manchester)

However, employers who had more recent firsthand experience of how employee sickness absence could have a significant impact on their business took health and well-being initiatives more seriously, particularly where sickness absence had problematic or complicated consequences, such as:

- a few staff taking on a much bigger workload resulting in stress and burn out. In relation to this, where sickness absence was at short notice rather than planned and it was also more difficult to react to workload issues;

- frustration at the lack of interaction with and guidance from GPs about implications of particular health conditions/expected timescales for return (especially for mental health conditions and chronic pain).

  "It's obviously easier when people go on sick leave when it's planned, from a business point of view, then we can make contingency plans and decide how we're going to spread the work around. … when it isn't planned it means everyone taking the flak at short notice. That's tough."
  (Line managers, <50 employees, Newcastle)

Industry and company culture were also important determining factors in terms of attitudes towards health/well-being. In particular:

- whether or not staff were seen as an asset or could be easily replaced by others and not valued as individuals. In some cases employers indicated staff at certain levels (often lower skilled) were seen as easily replaceable and therefore they questioned the need to invest time and effort in their welfare beyond minimal requirements. This was mentioned more frequently in sectors such as manufacturing, transport and construction. That said, skill-level was not always indicative of value or treatment. In some organisations, employers seemed at pains to make all staff feel valued and appreciated to keep them on-board and content, taking action such as ensuring they made time to get to know all their staff, including cleaners and casuals, addressing everyone by their first name;
- where being fit to work meant being 100% fit. There was a widely held belief that employees needed to be 100% fit to be at work. This was particularly the case in labour intensive, health and safety conscious industries (e.g. construction and manufacturing). Consequently, employers were not knowledgeable about how to manage flexible return to work for partially fit employees (and how small changes could make a big difference to engaging those currently off work sick);
- where workplaces were dominated by either a macho attitude or individuated ways of working. Where staff welfare was low on their agenda, management and other staff were more likely to view illness as a sign of weakness. It was suggested that this sometimes resulted in staff concealing diagnoses or their experiences of illness. This was especially the case in workplaces where there were 'macho' cultures, which were largely intolerant of and ignorant towards stigmatised illnesses, such as psychiatric and chronic pain disorders. A few believed that health was solely the responsibility of the individual employee rather than any onus being on the company to maintain workforce health.

  "We've had no complaints from anyone that they are under too much pressure; on the contrary, people always tell us that it's far better when we're really busy".
  (Line manager, 50-249 employees, Cardiff)

In workplaces where a macho culture was prevalent, the stigma of mental illness was quite apparent. Managers sometimes expressed a view that they did not have the time to understand individuals' mental health problems, nor how they could be

accommodated in the workplace and this sometimes led to accusations of employment discrimination against this group of people.

> "[Mental health conditions] would definitely be a turn off, If we were interviewing other people of equal ability then we would pick them over someone who had been on long term incapacity. I think there's a stigma attached to it, isn't there, and there's a lot of question marks that would need to be answered and a lot of understanding of the reasons for the circumstances I guess and, to be quite honest, when you're in a small business and you've got limited hours in the day and limited time and you're employing people, if there is alternatives then I guess they would probably be taken, that's probably not right."
> (Line manager, 50-249 employees, Cardiff)

A few senior managers commented that they had been working longer hours, often including weekends. This was mainly put down to wider economic pressures. Consequently, they questioned whether they were really setting a good example to their staff in terms of hours worked, a work-life balance and generally promoting healthy working practices.

The final belief about health and well-being raised by employers and line managers was that whilst they acknowledged a personal responsibility to take care of their staff, they were dependent on workers letting them know how they were feeling. From their perspective, health and well-being was an interpersonal responsibility.

> "I think employers, the bosses, have definitely got the responsibility to actively keep an eye on their employees with regard to keeping them healthy and keeping them in employment and not infecting other members of staff. I can't control that without their support."
> (Line manager, 50-249 employees, Surrey)

2.4.3 Factors that motivate change in attitude and/or behaviour

As a rule, most mid- and senior level managers expressed a desire to keep staff happy and motivated to come to work. There was widespread acceptance that happy staff were more likely to be productive. However, senior managers could have a fairly reactive approach to health and work. Those companies who had experienced the detrimental impact of sickness absence more regularly, or had experienced the absence of key personnel, were more motivated to find ways to maintain health at work due to:

- the knock-on impact on other staff (i.e. taking on more responsibilities and related stress/demands);
- cost and time taken to find cover;
- difficulties and costs associated with rehabilitation and (phased) return to work.

> "If you'd been through the time and effort of a key member of staff being off. Getting them well, getting cover in, helping them back to work. It's a bloody

nightmare, and they were off with stress, and probably due to work. That's avoidable."
(CEO/Board Director, 50-249 employees, Newcastle)

Figure 2 highlights two contrasting cultures of SME business owners - in this case a hotelier and a construction company – and the ways this impacts on attitudes towards health and well-being initiatives.

Figure 2: impact of culture - contrasting attitudes towards health and work

Example: health and work exemplar employer – SME hotelier	Example: health and work high-risk employer – SME construction company
• CEO took personal interest in alternative therapies • Appreciated staff could be tired, stressed within workplace – wanted to reduce turnover, encourage caring attitude towards staff • Arranged facilitators of yoga, Reiki, relaxation and meditation to come in • Encouraged staff to participate by subsidising their sessions • Notable improvement in staff well-being, more relaxed • Idea rolled out across hotel group	• Man management low on agenda – little evidence of staff being appreciated and rewarded • Little attempt to create a 'team' feel (no team activities, rewards/incentives) • Staff treated as dispensable/easily replaceable (low skill) • 'Macho' attitudes to health: illness is a sign of weakness; little experience of handling mental health conditions • Unwilling to let staff back to work unless they can 'do their job' • Health seen as the responsibility of employee rather than the company – 'Why should I pay? • Training focused solely on elements of job, not staff welfare

Figure 2 contrasts the views of employers from different perspectives on the value of health and well-being in the workplace.

The hotelier realised that staff stress was leading to sickness absence and ultimately poor hotel performance (and income). As a consequence he acted to eradicate the problem and help improve working conditions by arranging, and part funding, various relaxation activities for staff.

In contrast, the construction company owner's pre-occupation with making sufficient money to stay in business meant staff welfare was of low importance, particularly when low or unskilled labour was perceived as easy to come by. Staff were individuated, rather than team focussed and he made it clear that if they were ill it was a sign to him that they did not want to work.

The owner had never had a business case made to him about the benefits of maintaining low staff turnover through a few well-being measures. Given the levels of current high unemployment in his sector, he felt even less inclined to change his strategy as he perceived that there was a sizeable supply of labour available. However, he did suggest that the time spent on replacing staff and the necessary recruitment and training was still a drain on management time.

There was a general acceptance across this audience that more needed to be done to publicise the financial impact of sickness absence on the economy and the social consequences of long-term sickness. Employers and line managers hoped that this might persuade more business owners of the need to invest more heavily in health and well-being maintenance for staff, rather than troubleshooting problems as and when they arose.

> "Putting those facts up brings it home. It's a big problem, no doubt."
>
> (Line manager, <50 employees, Birmingham)

In addition, increasing the cost effectiveness of health and welfare initiatives for staff (e.g. through tax breaks and subsidies) was more likely to motivate positive change.

2.4.4 Barriers and disincentives to change attitudes/ behaviours

The key barriers for employers/line managers to changing attitudes towards health and well-being at work, particularly in SME businesses, were issues of education and awareness-raising and these were sometimes linked to existing industry or company culture. These included:

- not understanding the short and long-term benefits of health and well-being initiatives and therefore to invest further in them. More fundamentally, though, some did not understand that little changes in attitudes and behaviours could make a big difference, despite recognising that happier staff were generally more healthy and productive;
- lack of awareness of the benefits of early intervention (and the consequences of remaining on sickness absence for long periods);
- line managers feeling inadequately trained to deal with sickness absence and health and well-being issues.

Many employers, regardless of company size, believed that there was too much emphasis placed on them having to seek out information as opposed to being given it by an external source. This was especially a concern as they felt they had more pressing business issues to contend with and was felt more acutely higher up the management hierarchy. Furthermore, many were unaware of any financial and emotional benefits of maintaining health and well-being, though this was more of an issue for SME employers who wanted to understand *why* resources should be directed towards this.

> "When you hear about the insurance companies, you know, with the call centres ... they have policies and 'duvet days' and things like that and I think that's meant to eliminate a lot of these problems. I think with us, we're a small business and the thought of allowing 'duvet days' is completely ridiculous; we don't have

excess staff. I'm not rejecting all this, I just want to understand how it works in small businesses."

(Line Manager, 50-249 employees, Cardiff)

For many SME employers, no one had challenged the widely held belief that you did need to be 100% fit to return to work, particularly in labour intensive, health and safety conscious industries (e.g. construction and manufacturing). Employers were also uncertain about the legal/insurance implications of encouraging people to return to work as early as possible, particularly in physically laborious employment.

The absence of an appreciation for the merit of partial fitness for work was exacerbated in companies where employers indicated a lack of incentive to invest in lower grade staff's welfare.

"I think they're pretty much ten a penny when they get to the assistant level, you know, bottom of the rung. I'll be honest, they'd know and I know that they can't do anything else. I'm not going to get them in to sit in the office to help do the admin. What would they do, make tea?"
(CEO/Board Director, under 50 employees, Birmingham)

"If it's a call centre job and they're morbidly obese then they don't have to be 100% fit because they're sitting in a chair answering the phone all day I guess. If it's a sign installer on the high street then they need to be physically fit and capable of getting up and down access equipment and they need good eyesight and they need to be at least 99% fit. Surely?"
(Line manager, 50-249 employees, Port Talbot)

"If it's a low skilled job, it's a boring job, there's less motivational reward .. 'what am I going to miss if I phone in today?' The fact that it's low skilled surely means that it's down the lower end of the pay scale as well and so there's less to lose especially in the private sector. Ultimately employees need to perform and there's a fine line between how far you push and dropping them."
(Line managers, 250+ employees, Cardiff)

A few line managers also worried about patronising more skilled staff off sick by offering light duties (e.g. basic or menial tasks) as a way of encouraging early return.

"There's plenty of less stressful aspects of the job that this employee could do to encourage her back, but the difficulty with that is that we're talking very menial tasks for somebody who's quite experienced."
(Line manager, <50 employees, Cardiff)

In addition, line managers said that they were not trained in how to manage sickness absence and well-being issues effectively (e.g. stress at work). This resulted in cases of mis-management of staff both in work and off-sick that might have been avoidable, including line managers not treating issues with required sensitivity. This was particularly rife in work places where managers lacked understanding about mental health conditions and chronic pain. Some employers and line managers reported that they thought taking a concern for their staff was 'nannying'. These

people believed that their staff would not be appreciative of initiatives such as away days or team bonding exercises. This culture was not sector specific and was evident in white, blue and grey collar organisations.

A recurring issue was the impact of the current economic conditions on attitudes of employers and line managers with regards:

- *not being able to reward staff:* most employers were considering freezing pay, not giving out bonuses and perks and cutting team days/activities. All of which it was believed could dent staff morale;
- *budgets for health/well-being adjustments being cut*: restricted on canteen food (healthy options were seen as comparatively expensive), lack of funds to incentivise healthy living (e.g. gym memberships). The emphasis placed on this related to the beliefs of some employers that health and well-being at work equated to expenditure on initiatives, rather than a focus on less costly daily interpersonal interaction;
- *staff workloads going up due to redundancies*: poor work-life balance meant that there was a lack of time to improve health and well-being. Again, this linked to the idea that health and well-being could only be improved through financial means;
- *lack of top-down 'example setting'*: it was questionable whether management was setting a good example in terms of hours worked, work-life balance, promoting healthy working practices, etc.

Amongst the senior and mid-level managers in medium sized companies (with roughly 30-149 staff) interviewed, most were keen for guidance on health and work initiatives. This was because they were more likely to lack the resources for a health and work programme that might be justifiable in larger organisations. Moreover, through growth, some indicated that they had suffered a dilution of the effective 'natural' small team ethic evident in smaller firms.

> "I think it's an area we struggle in, when people go off, especially with things like stress which you don't know much about, or how long that will be. It's the lack of planning, and the inability to work out when they're going to be back, or what we can do to help them."
>
> (HR Manager, 50-249 employees, Birmingham)

The final key issue raised by employers and line managers, irrespective of company size, was that line managers often felt they were not adequately trained to deal with sickness absence and health / well-being issues.

In small and medium sized companies, in particular, there was a lack of clarity about when and how to get involved in return to work interventions – particularly because it was not a situation they had to deal with very regularly and therefore training in this area was minimal or non-existent. HR and staff welfare in larger organisations acknowledged that this problem also applied to their organisations; although training was more consistently provided on managing sickness absence (i.e. level of contact,

type of contact and phased return), there was a lack of formal training programmes addressing 'manners' and 'common courtesy' often amongst line managers. There were requests that training should focus on knowing how to treat staff well to get the best out of them day-to-day and help effective engagement to prevent these problems arising in the first place.

> "The MD goes to lots of seminars and meetings that get put on by the various agencies that we use and they have people speaking and trying to educate us on the right way to handle various issues and he stays current on legislation and things like that, so he's pretty good on those sorts of things but yeah, absolutely. We're not at that level and size of business where we can employ someone full time to handle these issues."
> (Line managers, <50 employees, Birmingham)

2.4.5 Audience generated ideas for interventions

There was some overlap between employers/line managers and the working public (both in work and off-sick) in terms of ideas generated. This was especially with regards to seeking the advice of an independent body about workplace best practice for health and well-being.

There were also a minority of employers more willing to consider the mutual benefits of taking on the longer-term sick in return for re-skilling or re-training, provided the conditions were favourable. It was suggested that the employer would benefit from having an extra worker and the person who had been out of work for a long time would benefit from updating their workplace skills, however the employer would like to have a degree of control both over determining the suitability of the candidate and whether there would be any pay arrangement.

> "There's nothing worse than being rejected in any walk of life, so to finally feel physically or mentally able to come back to work but not be able to because you're being rejected, I can't think of anything worse! It is a vicious circle, isn't it, and I really don't know whether the government should incentivise companies to take people in that situation back on."
> (Line manager, <50 employees, Cardiff)

> "I think a lot of companies would be quite happy to jump on board with that [work placements for those on IB/ESA] as long as the people weren't just one day on IB and the next day thrown into work, it would have to be a transition in terms of training – because you can't really rely on the employer to provide that level of support because you'd have to provide that level of support to everybody, otherwise then you'd have resentment in the workplace and that makes it even worse."
> (Line manager, <50 employees, Newcastle)

Employers focused on what outside help they needed or wanted to achieve change to their working practices to improve staff health. This involved greater dialogue with health experts such as GPs.

> "I don't think I've ever had a doctor's letter saying to turn up for a health check. I've never had anything like that. So I think they could do that in general."
> (Line managers, <50 employees, Birmingham)

Most wanted tax breaks but ideally would also like someone to come and talk them through and audit what they need. Multi-role senior managers in SMEs suggested that they needed broader education on the benefits of well-being initiatives for both short and longer-term gains.

In addition, most recognised the need to do more themselves to understand staff health needs and desires in order to maintain a healthier workforce.

> "We had stress spotters. So what their duty was, was to go out in the workplace and really just keep an eye out and sort of look in certain areas just to check whether anybody was under stress or was acting oddly, you know than what they would normally be. … It worked at some level but I wouldn't claim it was rigorously enforced."
> (Staff Welfare and HR, 50-249 employees, Birmingham)

Some line managers and occupational health workers suggested that more could be done to encourage employers to take an interest in staff exercise and nutrition. Simple things such as providing fruit bowls or arranging for healthy eating vendors to come into workplaces on a daily basis were seen a positive steps, as was setting up company sports teams.

> "It's doing more of the good things I've already seen companies do. They all got into 5-a-side football and the company provided them all with t-shirts and things like that and they joined a league and stuff. … It's good PR as well. … And we sponsor the graphics of a charity yacht and we went out on it in the Channel for a day and took all of the staff, as a team building exercise, which was good."
> (Line managers, <50 employees, Birmingham)

The ability to offer attainable goals and rewards to staff was also important, including more novel suggestions such as short paid holidays or alleviating the stress of booking holidays as reward for a sustained period of long hours and hard work.

> "I think the Australian system is an excellent idea; they have so many sick days that are allowed and if they don't take them over a period of twelve months they get a percentage of those days added onto their holiday for the next year."
> (Line manager, 50-249 employees, Oldham)

2.4.6 What should drive intervention ideas?

Key to driving intervention with employers/line managers, especially in SME companies, appeared to be the need for practical assistance to help facilitate change (possibly via intermediaries/advocates) rather than simply putting information out there and hoping it is utilised.

Employers suggested that putting health and well-being higher on their work agenda was key to driving interventions. However they thought that this would be more likely to be achieved through proactively guiding employers on the benefits of:

- Keeping staff happy and motivated (so they do not want to go off and stay off work) – if employers could see that certain paid-for health and well-being initiatives could keep staff motivated they may be more inclined to try them out; fostering loyalty of staff by encouraging the development of a strong team ethic, even within large organisations – “a team within a team”; managers also required guidance on deciding whether an employee coming into work when not 100% could be productive or counter-productive in terms of their long-term motivation for the role;
- Early return to work - challenging the failure to appreciate or lack of knowledge about the benefits of early intervention;
- Overall company financial stability as a consequence of maintaining staff health and well-being – reduction in staff turnover, reduction in work-related stress which may lead to time off work or inefficient working, potential increase in staff loyalty;
- Reviewing the impact of their sickness absence policy – especially if this could be contributing to rather than decreasing short and long term sickness absence.

Employers and HR views on guidance and information already available suggests that there may be a need to increase awareness of and access to advice from intermediaries or advisers (i.e. outside/neutral experts) on:

- how to manage sickness absence (and review policy);
- how to manage flexible return to work (and how small changes could make a big difference to engaging those currently off work sick);
- the broader benefits of health/well-being initiatives in the workplace (especially in small-medium sized companies);
- understanding of particular illnesses (e.g. mental health conditions) on ability to work as well as likely timescales for return to work;
- assessing an individual’s fitness/capacity for work;
- how to access occupational health / other relevant services.

Equally, findings suggest that another important driver for change is successfully transferring knowledge/practices employees had gained from other businesses into their new place of work and/or business to business network and knowledge transfer. Currently line managers and employers, especially in SME businesses, suggested that not enough was done to explore and use knowledge already in the business that could help improve staff health and well-being.

> “I’ve been in places where rewards for staff are a bit more personal, and I want to take that idea to this place. At the moment I’ve not been asked about it, but I know my team and I know they love gardening. It’d be great to have a little

allotment; something we could all use at lunchtimes. I'm sure they'd enjoy it. A challenge and a hobby in work time."

(Line manager, <50 employees, Newcastle)

Many employers also wanted government to help businesses prioritise this issue by providing resources and/or tax breaks to enable investment in health and well-being initiatives. This was expressed more strongly by small and medium sized businesses who said that they did not have resources and know-how for a health and well-being strategy.

"Incentives always help, don't they. Taxable benefits. That said, these things can be so convoluted and difficult to administer… the one we did briefly seemed to be a typical government scheme where they dangle the carrot and then make it so difficult to claim that you just kind of give up. That said, if we can have tax breaks, that'll be a help."
(Line manager, 250+ employees, Cardiff)

2.5 GPs and Allied Health Professionals

2.5.1 Introduction

The GPs in the sample were purposively selected to get a mix of those who worked in surgeries in more deprived and more affluent areas. GPs whose practices had a higher proportion of minority ethnic patients reported issuing a relatively larger number of sickness certificates (Med3), however, they were unable to comment as to why this might be the case. Some GPs were signing as few as 15 Med3 certificates a week, others were signing around 50 a week. The level issued typically related to the total number of patients registered with them.

However, the policy of a particular surgery or the attitude of an individual GP also had an impact on the number issued. Some GPs took a default position of trying not to issue sick notes unless there was a very salient clinical reason why an individual should abstain. Others were less stringent and would often sanction a sick note without too much assessment owing to time constraints. A feeling amongst some GPs was that if they did not give a patient a Med3 certificate, then they would make appointments with different GPs at the surgery until they were signed off.

In larger practices, GP practice meetings were usually used to discuss practicalities and practice business. Discussing individual patient cases tended to be more informal and ad hoc between colleagues, and unlikely to take place in the more open forum of a practice meeting. One or two GPs held inter-GP sessions to discuss clinical issues, although these sessions tended to be fairly sporadic and impromptu.

Allied Health Professionals (AHPs) are professionals with health training, employed in a clinical capacity at surgeries. This disparate group mainly included practice nurses, but also counsellors, nurse practitioners, mental health professionals,

dieticians, physiotherapists, podiatrists and members of community nursing teams. Practice nurses and community nurses saw themselves as fulfilling a primarily supportive role to GPs. In some surgeries, practice nurses took on a triage function, especially when the surgery was busy and there were no free appointments with the GPs. They would make a judgement on how severe a patient's condition was and the appropriate action which needed to be taken (e.g. see a doctor as soon as possible, be treated by a practice nurse). A few practice nurses were nurse practitioners which meant they could deal with certain presenting symptoms and prescribe for them.

> "If patients are coming in and there's no doctor's appointments then it's my job to decide if I can treat them or if they need to be seen by a GP and if it's an urgent problem then obviously that's my decision and where I fit them in as well."
>
> (Practice Nurse, Sheffield)

AHPs were running various clinics, e.g. diabetes, smoking cessation, healthy eating/diet, from their surgeries. In smaller practices or in surgeries where there were staff shortages, GPs also took these. Some of these clinics were funded by the Department of Health. There were high levels of awareness of both adult and childhood obesity and health issues concerned with lifestyle across the sample. However, some GPs reported that their surgeries saw particularly high numbers of patients with lifestyle-related health disorders.

> "I had a child who was clinically obese and I asked the mother what she puts in his lunchbox and it's usually a bar of chocolate and biscuits and crisps and a sticky drink, and you say what about an apple instead of the chocolate, and she says he doesn't like fruit, he likes his chocolate, it's not doing him any harm a small bar of chocolate. At that point I gave up."
>
> (GP, Glasgow)

A minority of GPs were somewhat cynical about the overall effect of these various clinics. There was a feeling that making people more aware of the risk factors for poorer health may have inadvertently and maybe unnecessarily raised concerns and levels of anxiety which, consequently, added to GPs' workloads.

> "We've created a breed of hypochondriacs through no fault of their own by having people who previously wouldn't have seen their doctor from one year to the next, to come in to have their cholesterols checked and their diabetes levels checked."
>
> (GP, High Wycombe)

Apart from the AHPs and GPs, other surgery staff, including practice managers and receptionists, were also consulted. Practice managers are responsible for the overall running of general practices, including financial responsibilities and keeping GPs abreast of practice issues. In comparison with the AHPs and GPs, they had purely

administrative, non-clinical roles and were not qualified in healthcare. Receptionist had greater contact with patients compared to practice managers.

2.5.2 Current beliefs and behaviours about health and work

In general, GPs believed that there was a positive connection between health and work. By and large, they suggested that being at work was good for people's health and well-being, assuming that work itself was not the root cause for being off sick. Some recalled how they had encouraged their patients to take advantage of any services offered by employers, e.g. occupational health schemes, and had suggested to patients who were already off sick that they should explore with their employers the possibility of phased return to work or workplace modifications. Most remarked that they would suggest these options if they felt that they were relevant to an individual patient.

All GPs were willing to signpost or refer patients to available, relevant services that might facilitate return to work. Where there was knowledge of such things, some GPs mentioned local initiatives such as Tomorrow's People[7] which provided an employment adviser for people who were off sick, IB/ESA claimants and the unemployed. However, there were frequent complaints about such initiatives often being relatively short-lived and closing for lack of funding, and a lack of joined-up access to services which could help their patients return to work. As such, most GPs felt that health and work initiatives were a good idea and were able to take some of the burden of responsibility away from themselves, but some (in rural practices) were not always aware of current schemes.

GPs saw their primary role as the patient's advocate. If they felt it appropriate, they would promote the benefits of work to their patients' health however, they were sensitive to the individual's medical needs first and foremost. They felt a need to respect their patients' wishes and/or protect them, especially if work was part of the reason for their health problem. Several GPs acknowledged that they had written out 'compassionate' sick notes for patients who were not clinically ill but who needed time to sort out a short-term personal problem.

> "I know there's other things going on. Things at home. You try to be understanding and see it from their point of view. I don't have an issue in the short-term signing someone off in that situation."
>
> (GP, Surrey)

Others said that it could be hard to refuse to write sick notes and had given patients a sick note 'for the sake of a quiet life'. There were also instances of GPs writing out

[7] www.tomorrows-people.org.uk - Tomorrow's People is a charity that provides one-to-one support to long-term unemployed people to help them return to work. It also works together with employers to find suitable candidates.

sick notes to avoid confrontation or physical aggression from patients. GPs recounted instances of patients becoming tearful or verbally abusive, threatening to break furniture, even in a few extreme cases, threatening the GP with physical violence.

> "One girl she stands out. I said I can't do that, plus the fact you'd be in a stronger position to stay at work and look for another job rather than being sick. So all that stuff, I'm still trying to be your pal, managed to get out the room without a sick line and she got her mother down an hour later. She was 30 years old this girl, she got her mother down, she was phoning me, they were waiting for me outside my room, they couldn't believe I hadn't given in."
>
> (GP, Cardiff)

Some GPs said that they were under time pressures for each consultation and, especially if they were running late, it was often simpler to sign a sick note. GPs also admitted that, in order to 'protect' their patients' interests, they had written out fairly anodyne reasons rather than give the clinical diagnosis. Owing to the stigma attached to mental illness, GPs and their patients felt that disclosure of even minor mental health problems may have negative repercussions in the workplace. For example, GPs explained that it could potentially jeopardise a patient's employment and/or lead to them being socially shunned by other colleagues and friends. It was believed that such consequences might further exacerbate the mental health of the patient and lead to even greater periods off work. GPs and their patients therefore often decided on an alternative health condition to put on the medical certificate.

> "A lot of people don't like you writing that [stress] down, because it's an admission of failure and not coping with whatever they've been thrown at in work... There is an art to writing meaningless sick notes."
>
> (GP, Nottingham)

When probed, GPs and AHPs acknowledged that patients, especially those who were looking to get signed off sick, knew which GPs in a practice were more and less likely to give them a sick note. A few GPs and AHPs claimed that those GPs who took a harder line about issuing sick notes tended to have shorter patient lists as a consequence.

All GPs explained that they were reluctant to get too heavily involved with employers. All GPs said they would not communicate with any employer without the patient's written consent. They were concerned about issues of patient confidentiality and any legal or professional repercussions for breaching this. GPs also believed that a proportion of people who were off sick were very unlikely ever to get back to work, due to the severity of their health problems.

For this minority of individuals with severe and enduring conditions, GPs felt that their returning to previously held employment was not going to be of benefit to their health. Where a patient's health problem was chronic and they had not been able to hold down a succession of jobs due to it, some GPs felt that they should not be

suggesting they seek work, especially if it was deemed that work was interfering with the management of the condition.

Most GPs observed that they were not adequately trained in occupational health issues, although a few younger GPs had developed an ‘extra-curricular’ interest in occupational health. Overall, however, there was consensus that a GP’s role was primarily that of a clinician and to treat a patient according to their clinical assessment. Consequently, they did not feel that they were equipped to judge whether someone was ‘fit to work’, nor did they feel qualified to suggest phased returns to work or workplace modifications. This was particularly so when the GP did not have (or was unlikely to have) any detailed knowledge of the patient’s workplace beyond what the patient divulged.

A GP typically knew a patient’s working status and, if they were not working, what their most recent occupation had been. Owing to confidentiality and not wanting to overstep the boundaries of their roles, GPs could only go on what patients told them and would not, for instance, contact their employer unless sanctioned to by the patient. Only one or two GPs mentioned making referrals for Functional Capability Assessments by third parties, which would assess an individual’s capabilities rather than limitations to work.

> “I know whether my patient is clinically fit to go back to work in the sense that there is no medical reason why he should not go back to work. What I don’t know is whether the conditions of his work mean that it’s OK for him to go back to work. Will he injure himself, will he get stressed, will he have a heart attack? I don’t know and I can’t say because I don’t know.”
> (GP, Glasgow)

> “I don’t like it, I don’t like being the judge or the person that, as a doctor, has got this power, or I have to make the decision about whether they’re fit enough for work. I don’t like it, I think it’s daft, I don’t know what their job is, I find it very annoying.”
> (GP, Sheffield)

For AHPs, the importance of preventing illness was key with regard to health, work and well-being. Prevention included early detection and screening for illness, but also educating patients about the need to monitor their health and to stick to their prescribed treatment plans. The risks associated with failure to take these preventative steps were spelt out to patients in terms of both potential health problems and ability to work in the future. For example, some patients erroneously believed that they only needed to be taking medication to treat high blood pressure in the short term, rather needing to continually take it to control the condition over the longer time.

AHPs, whilst broadly acknowledging that people were better in work than off sick, felt they had little influence on patients returning to work beyond encouragement. During

appointments, some nurses would informally talk to patients about their work and give them advice such as talking to their employers to see if they could be accommodated in some capacity in the workplace. However, they felt that workplace modifications and return to work plans were best left to occupational health therapists.

Those AHPs who saw patients for mental health reasons (such as counsellors, but including nurses) believed that work could greatly enhance an individual's well-being, However the stance taken, depended largely upon the individual; they suggested that it was best practice to find out exactly what the nature of the problem for the patient was before making recommendations about returning or staying in work. Furthermore, they suggested that unless getting back into work was a main goal for the patient, it would rarely be discussed in therapy.

Receptionists and practice managers felt that health and work issues were outside their remit with regard to the general public. Practice managers, however, were responsible for their own workplace well-being. As such, they monitored staff workloads and illness. Most practice managers commented that they never had any problem with staff absence. This was mainly put down to highly motivated, small staff sizes. Motivation for work amongst receptionists was put down to such things as camaraderie and flexibility about working arrangements (e.g. taking time off to drop children at school). Motivation amongst GPs was attributed to their salary and at times rewarding work, although it was suggested that their work was also highly stressful. One practice manager had taken the step to send a GP home as they were in physical agony, such was their commitment to being at work. Both practice managers and receptionist observed workplace well-being and report any concerns to the GPs in weekly meetings.

Interestingly, both receptionists and practice managers tended to look at health and work issues very much from an employee viewpoint, in that they were seeking ways of improving working environments to benefit their well-being.

2.5.3 Factors that motivate change in attitude and/or behaviour

Under the current sick note system, GPs were being asked to assess medical condition and whether the patient should refrain from work, i.e. the reasons why a patient is not fit to work[8]. Thus, they felt that a major factor that could motivate change in their behaviour was access to information and training to enable them to assess fitness to work. GPs also needed to feel that, in the context of the health, work and well-being agenda, they had more of a role to play than feeling as though

[8] The Statement of Fitness for Work or 'Fit Note' came in to use on 6 April 2010. The research reported on here was undertaken before this.

they were simply acting as 'gatekeepers' to the benefit system. Although this was not their role, they felt like this because of their experiences of processing some patients in this way. Whilst some acknowledged that applications for benefit did not necessarily have to come through a GP, they nonetheless felt that they were part of the process.

Given that many GPs did not see themselves as having particular expertise in occupational health, they appreciated being able to refer an employee who was off sick to an independent occupational health specialist. Referrals were most often made when a patient had been off work for several months. Also, one or two GPs suggested that employers could sometimes pressurise patients into asking for a referral to be made, but they stressed that the final decision would be left to the GP. This meant the patient's return to work would be managed by someone with the relevant expertise. Overall, GPs felt that a key motivator for change in their behaviour and attitude was better education and training with regard to health and well-being at work, and the management of sickness absence. However, that having been said, it needs to be noted that GPs are reluctant to change.

A few GPs suggested that surgeries should run 'sick note clinics' once a week, ideally with a GP who was known to take a tougher line on issuing sick notes in charge. It was thought that this could give continuity of care to those who were (genuinely) off sick and might deter those who were opportunistically looking for a sick note. It was suggested that these GPs might take a tougher line with patients from the outset as it was observed that once a patient had been issued a sick note for the first time, it could be problematic trying to get a patient to return to work. For example, where a GP tried to stop the re-issuing of a certificate, a patient would argue that their ailments had not improved and therefore nothing should change with regard to their absence from work. In smaller practices, especially where GPs had been working together for a long time, they would try to adopt the same approach to issuing sick notes in order to provide consistency and continuity of care if a patient's usual GP was unavailable. Where practices were larger, or where GPs in a practice had not worked together for a long time, there was greater inconsistency. Some GPs and AHPs suggested that certain GPs could take a 'softer' approach, but this was just attributed to an individual's mentality.

Other factors which could influence changes in GPs' attitude and behaviour largely reflect a perceived need for systemic change. GPs claimed that stricter time periods for return to work would necessarily impact on the way they managed sickness absence. There was some feeling that the benefit system almost required them to continue issuing sick notes. In this context, several GPs talked about the usefulness of the RM7 form[9] for referring on 'difficult' patients who they thought might be malingering; there was some regret that the RM7 had been discontinued.

[9] The RM7 form was used by a GP to request that a patient underwent independent assessment by the DWP earlier than might otherwise be the case under normal procedures.

Other factors which might influence a change in attitudes included:

- DWP or DH reviewing GPs who gave out a disproportionate number of sick notes in order to name and shame them;
- inviting Jobcentre Plus/Remploy into surgeries to talk to GPs about the impact of issuing sick notes; and
- providing more training for locum GPs about the impact of issuing sick notes. Some GPs suggested that locums were more willing to administer sick notes and that further down the line it had been difficult to get the patient to return to work.

2.5.4 Barriers and disincentives to change attitudes/ behaviours

Despite endorsing the notion that 'work is good for your health', the key disincentives to behaviour change amongst GPs related to:

- *their reluctance to disrupt the relationship with the patient by challenging their claim to need a sick note*. The GP-patient relationship was seen as the central concern to the GP. Most GPs felt that they needed to think about how the relationship with the patient might be affected in the long-term. It was felt that a refusal to issue a sick note could be taken by the patient as a sign of a lack of sympathy and trust. Thinking about this long-term relationship meant that issuing a sick note was sometimes the best option, and therefore it represented a disincentive to change.
- *their reluctance to break patient confidentiality by engaging more directly with employers to facilitate return to work*. It was felt that this engagement required the GP to be highly tactful, but was fraught with the possibility of the trust between them and their patient being undermined. Hence, most felt that they did not want to engage with employers anymore than they really needed to, as commanded by the patient.
- *their belief that they are not adequately trained in the area of occupational health*. From a professional point of view they felt that they were not trained enough in this area to make such crucial decisions. The disincentive to change was therefore the potential of damage to their professional reputation by making a wrong decision.
- *their dislike about being asked to judge whether or not someone is fit enough to return to work.* Related to the previous points, they felt that this was not something they were adequately trained in and they felt that this may jeopardise the intimate relationship between them and their patients.

GPs were also reluctant to adopt a course of action which was likely to increase or expand their workload. They believed that having to contact employers and perform the role of occupational health worker would be too time consuming. They already felt under pressure with regard to the time allowed for consultations. GP partners also commented on the amount of paperwork they had to fill in.

> “Your day is, in theory, 8 till 6, although it usually doesn’t finish up until nearer till 8 till 8, but during the course of that day, there’s a level of pressure and demands way in excess of what it was. When I started I used to go home at lunchtime, which is not very far, to take my dog out for a walk, have a sandwich, read the paper and go back to work. Now you don’t stop for lunch. There’s always piles of stuff to do.”
> (GP, London)

> “There is a 10-minute consultation, about six or seven minutes is taken up with what I need to do to you before you're even allowed to tell me what you’ve come there for. I need to check this, that and the other and all the rest.”
> (GP, Sheffield)

GPs also complained about limited or inconsistent access to suitable return to work services for their patients. There was a feeling that initiatives were set up and just as they were getting established, they were closed for lack of funding or because they were only a pilot project which had run its course. GPs found this very frustrating because it meant they were never quite sure of what was available for their patients or for how long it would be available.

> “There have been a few places round here, in the centre of town, that have come and gone. I used to send some of my more abler patients to one... [but] to be honest I’ve lost track of what’s available.”
> (GP, Glasgow)

Other disincentives to change related to factors which were often felt to be beyond the GPs’ control or influence, such as local economic conditions which were not favourable to encouraging patients to return to work and the benefits system which they felt did not encourage people (back) into work.

> “Let’s face it, there are some people who are never going to get back into work because there isn’t any work for them or they’re too old or their condition is chronic. So what is the point of pointing them in the direction of some re-training scheme, putting them on to some scheme which may or may not last, teaching them how to use computers, make raffia baskets, whatever. What do you do? You write them a sick note.”
> (GP, Cardiff)

> “Why risk getting a job that might be too much for you if you haven’t worked for years, when it will mean household income actually goes down. They might as well as stay on benefits as things stand.”
> (GP, London)

As previously noted, the fact that RM7 forms had been discontinued left GPs with little alternative action if they felt that a patient was persistently and unwarrantedly seeking a sick note.

More specifically, one or two mentioned the barrier presented by a GP being unavailable to see their patient because they were off work sick or on annual leave. In this scenario, continuity of care could be disrupted by locum GPs signing patients off long-term without knowing the case or understanding the nuances of the GP-patient relationship.

Despite emphasising the negative impact on work of some lifestyle habits, such as drinking alcohol and smoking, some AHPs felt that it was sometimes difficult to get patients to change their behaviours. For example, although nurses and dieticians gave patients smoking cessation advice, they felt that the patients knew the risks involved with smoking anyway. Where AHPs repeatedly saw the same patients for reasons unrelated to their smoking, after a while they stopped giving them smoking cessation advice. This was because they felt they needed to educate the patient, but not to the extent that the patient became irritated by the advice. Some AHPs suggested that if they continued 'lecturing' it might both lower patients' self-esteem and prevent them from seeking help for other health concerns.

> "They [the patient] come in and it automatically flashes up on the computer that they smoke and so you've got to say 'and do you smoke?' and then offer smoking cessation advice and I think you've got to be quite realistic that a lot of smokers come in and they know they shouldn't smoke and they don't want to feel like they're getting a lecture every time that they come in."
> (Nurse Practitioner, Birmingham)

Where patients had expressed a desire to return to work in appointments with AHPs, the AHPs (e.g. practice nurses and community nurses) were reluctant to tell them to return to work, or advise them to speak with their employer about the prospect, but instead suggested that they see their GP who could make a formal assessment. Interestingly, these occurrences were sometimes not reported to the patient's GP as the AHP felt that it was a matter that the patient and GP needed to discuss without their interference. For some AHPs the reluctance to tell a patient that they were fit to work was due to a fear of being culpable if the patient subsequently had a work-related relapse. In this context, a few AHPs felt that the imminent introduction of the fit note would enable them to more confidently suggest to patients that they could go back to work in some capacity.

> I get a lot of patients ask me, 'oh, when do you think I can go back to work, nurse?', but I always say to them 'if you feel you're well enough, you should go and speak to your GP and see what they say', because if I tell them 'oh yeah, you can go back to work', then it's on my head be it, you know?"
>
> (Community Nurse, Birmingham)

AHPs making home visits (e.g. practice counsellors) remarked that they only talked to patients about work if the patient brought the topic up. This was because the AHP felt there was insufficient time to talk to the patient about work when they also needed to ascertain such things as whether the patient needed any extra support,

whether they needed any adaptations made to their home if physically ill, what the patient's family situation was like, and what was happening in their wider social environment.

Like GPs, AHPs and practice managers sometimes expressed strong feelings that claiming benefits was too easy (and financially attractive) and allowed patients the option of not working. Indeed some felt that patients used the fact that they were going to see a therapist as a reason for not working, regardless of whether they were able to work or not.

> "It's an excuse, patients think 'well, I'm under a counsellor', or 'I'm under a physio', you know, 'I can't possibly go to work!'"
>
> (AHP, Cardiff)

AHPs felt that there were other barriers outside their control which had a negative impact on the well-being of the general public and their subsequent ability to work. Many patients of working age had told AHPs that they felt isolated. Those AHPs making home visits, especially, commented that there was a high incidence of people living alone, who lacked social networks. Patients also spoke to AHPs about how their workplaces could feel lonely and that there was a lack of team togetherness. In some respects, the absence of cohesion at the community level and within companies was thought to be having a negative influence on the mental health of some patients and hence their ability to be happy in the workplace.

Another factor that was perceived to be outside their control for some nurse practitioners was that the 10-minute consultation time was sometimes insufficient to ask patients all they needed to about their work.

Some AHPs suggested that they were equally as reluctant as GPs to get too involved with employers because of the tricky situation it might place them in with their patients. They were reliant on patients telling them what their jobs entailed, but they had little way of validating the information unless the patient gave them permission to talk to their employer.

Receptionists remarked that through their observations and word of mouth they believed certain patients, whom they saw regularly, were malingering. They speculated that particular GPs were too soft in giving them sick notes. However, they felt it was neither their place to interfere with the GP/patient relationship nor formally discuss it with the practice manager.

2.5.5 Audience generated ideas for interventions

From the GP's and AHP's perspective, emphasis for ideas generated was placed on systemic change and/or making their role more manageable. There was also considerable importance placed on the employer taking health maintenance measures more seriously. GPs widely focused their ideal solutions on prevention of

poor health and well-being which they perceived were easier to implement and more likely to succeed.

> "Because there's such a high demand for sick notes in the area we have a 'sick paper clinic' and we run it every week and we don't give sick papers out any other day. … So that they get continuity of care, number one, me and another doctor."
> (GP, Port Talbot)
> "Maybe a system where the Government employed [IB claimants] and they were seconded to your establishment, and that way you didn't have responsibility of maintaining them if they turn out to be of no use and that you aren't the ones who are doing going to end up in a tribunal."
> (GP, Glasgow)

> "You could have a pot of money, which, if you had so many employees [still in work, not sick] you'd get so much, so many employees you'd get so much and guidelines on how to spend it to improve employee health. A fun fund, or something!"
> (Allied Health Professional, Practice nurse, Sheffield)

> "I've said to people before they should walk a dog for exercise! .. 'have you got a dog? .. do you walk it? .. walk it for an extra 10 minutes a day! .. you can borrow my dog!' (nobody's took me up on that one yet!)"
> (Allied Health Professional, Practice manager, Glasgow)

2.5.6 What should drive intervention ideas?

For GPs and AHPs, central to what should drive interventions was their desire to protect patient confidentiality, and avoid jeopardising their patient relationships. Ideally, they wanted intermediary / independent arbitration in the area of fitness for work.

In order to drive intervention ideas amongst GPs, it should perhaps be borne in mind that they do not feel adequately trained in occupational health issues. Furthermore, they also have little desire to engage further with employers because they do not want to risk compromising their relationship with the patient and/or patient confidentiality; rather, they look for an independent assessment of individuals' 'fitness to work'.

However, GPs could be encouraged to engage more actively with intervention ideas by ways which include:

- devising a means of stimulating or encouraging dialogue between employers and employees who are off sick which do not disrupt, or interfere with GP/patient confidentiality; and
- making sure GPs are aware of services and initiatives, ideally local, to help patients stay in/return to work to which they can signpost or refer patients.

That said, there was a strong sense from this target audience that the system itself needed an overhaul.

Under the current system, long-term sick patients were likely to get caught in the ‘benefits trap’ and there was little financial incentive for them to get back to work. For many GPs, continuing to sign sick notes ensured the patient had access to benefits (hence the frequent complaint by GPs about feeling like they were ‘gatekeepers to the benefit system’). Indeed, there was anecdotal evidence of patients being directed by the local Jobcentre Plus to get a sick note from their GP. This routine issuing of sick notes irked many GPs who saw it as adding to the time pressures they already felt themselves to be under and their workload and having little to do with their role as clinicians.

For patients with longer term health conditions, the current system also allowed GPs to issue a sick note for a considerable period of time[10]. Together with the length of time to the fitness for work assessment for those on ESA/IB, GPs felt a patient could spend quite a long time away from the world of work which could make it harder to rehabilitate him/her back into work.

Most AHPs felt that people with mental health problems needed early access to support services, such as counsellors, to help them remain in employment or facilitate early and flexible return to work. This was because many felt that the longer someone with mental health problems was off work, the less likely they were to return to employment in general.

Several AHPs suggested that such early intervention needed to be seen as part of a holistic provision which had an accent on illness prevention. Therefore, although many AHPs were already promoting healthy lifestyles with the aid of leaflets, some felt that more money could be channelled to such health promotion campaigns.

Many AHPs felt that there was a disconnection between employers, unwell employees and GPs. Consequently, they suggested that there was a need of an independent body which could unite the three parties. They believed such a service was particularly necessary for small-medium sized companies that did not have occupational health functions.

> “In big companies there would be the occupational health adviser but for little/small companies, then it’s between us and the employer, and it would be great, to have somebody who could go and assess them [the patient] and their workplace.”
>
> (AHP, Cardiff)
>
> “If you think about it, a GP signs somebody off sick and they only see them for 7.5-10 minutes and that might be once a week or once a fortnight, so they only get 7.5-10 minutes of what that patient’s like and yet they’re signing them off

---

[10] up to six months within the first six months of the illness/incapacity; after the first six months for any period including ‘indefinite’

> sick .. so I think if we had more information and somebody had gone out and got more of an assessment then that would definitely help."
>
> (Practice Nurse, Glasgow)

Several AHPs commented that where a patient was unable to work because of a long-term health problem, this often led to further mental and physical health problems. For these patients, AHPs suggested that there needed to be some kind of service that concentrated on gradually building up their confidence whilst developing workplace skills, so that they could eventually return to work.

> "If somebody can't work and they are off work for a long time, then I think that impacts on their overall physical and mental health and everything... they need confidence building, so that they could feel more confident to go back to a work environment .. I mean, they could have worked there for 20 years and they've been off sick for a year and then everything's changed"
>
> (Practice Nurse, Sheffield)

In addition, a few AHPs felt that to ease the perceived burden on GPs, they ought to be able to help provide more support to the practitioners in the area of health and well-being and better signposting to alternative sources of advice and occupational health.

3 Interaction between the audiences and its impact on Behaviour Change

This chapter will focus on current levels of interaction between the audiences and its impact on behaviour change. This includes exploration of the tensions between the audiences that are acting as a barrier to reducing sickness absence and improving workplace health and well-being.

3.1 Current levels of interaction and the key tensions in the interaction

The research findings indicate that there are a lot of tensions between the key audiences that can act as barriers to reducing sickness absence and improving workplace health and well-being. This can result in the following cycle of attrition and non-communication between the audiences:

Figure 3: Key tensions between the audiences

GPs	**Employers**
Key tension: Duty of care to patient vs aiding early intervention/return to work	Key tension: Desire to retain healthy workforce vs inclination to invest time/resource in health and well-being (What's in it for me?)
Employees Key tension: Might not feel able to talk to employer about problems Do not want GP to write mental health conditions as a reason for sickness	**On IB/ESA** Key tension: Lack of incentive to come off IB No regular or positive contact with 'authorities' Lack of opportunities to re-train or re-skill

In this cycle, each audience has key tensions with other audiences which are acting as barriers to positive change.

For **GPs**, a key tension is their resistance to working more closely with *employers* because of concerns over breach of patient-GP confidentiality, and a perceived lack of time or inclination to get involved in individual cases.

Likewise, a tension GPs experience *with patients* is that they feel they can only suggest and encourage their patients to talk to their employers, and they do not wish to do anything to confrontational that may jeopardise the GP-patient relationship.

For **employers**, the key tension *with GPs* is the limited or non-existent contact which means a lack of clarity on their employee's condition (which hinders personnel planning). This also exacerbates the employer's inability to facilitate any early intervention, if they do not know whether it is necessary.

- The key tension employers have *with employees with regard health maintenance* is a desire to have a healthy workforce balanced against:
- an unwillingness to spend resources on achieving a more healthy workforce without concrete evidence of return on investment (and tax incentives);
- a perceived lack of time to introduce health and well-being schemes represented a barrier.

Likewise, the tension employers have with *employees with regards return to work* is the desire to see them return to work as soon as possible, but balanced against:

- a lack of tax incentives for occupational health;
- a fear of the legal consequences of ill-advised early return to work,
- a lack of education about the potential return on investment.

For employees, both at work and on sickness absence, the key tension in the health and work agenda *with GPs* includes being advised to stay off work for longer than they think necessary. For some, there were claims that GPs also offered a lack of encouragement with regards to early return to work.

The key tension employees have *with employers* is often if they have issues at work or any condition that is deemed to stem from work itself (whether that relates to culture or individuals). This may reduce inclination to return to work quickly or require more delicate handling of return to work procedures. There can also be tensions with employers with regards the lack of time dedicated to staff welfare, the lack of flexibility about phased return if off-sick (and willingness to consider and comply with any suggested or requested workplace adjustment) and in some instances the lack of workplace cultural empathy about mental health/chronic pain issues.

For those **on health related benefits (IB/ESA)**, the key tension *with GPs* is being signed off with little or no signposting towards services that may aid return to work. A key tension *with (potential or previous) employers* is a lack of contact or exposure to work colleagues or working life, resulting in increased feelings of isolation or lack of employability. There are also tensions with potential future employment, due to the perceived lack of flexibility with regards possible placements. For example, where

the voluntary sector organisation stuck rigidly to set working hours or where Jobcentre Plus (or equivalent employment services) have not enabled change or even actively advised them not to try to change their circumstances.

In light of the tensions between audiences and apparent conflict of interests, it was important to explore where the synergies were between the audience ideas and find ways of getting the audiences to work together towards workable solutions. We sought to explore this via the deliberative workshop session with all audiences.

3.2 Audience synergies (deliberative workshop)

The research included a workshop with six simultaneously conducted mini-groups consisting of a GP, a line manager, an employee (not sick) and someone currently not-working for health reasons (either on sickness absence or Incapacity Benefit/Employment and Support Allowance). These sessions enabled us to 'triangulate' views of GPs, employers and the general public (working and non-working) and try to address some of the tensions found in the other fieldwork. We were seeking to generate practical solutions to the problem of sickness absence, return to work and perceptions of fitness to work that all audiences felt were workable.

Encouragingly, the deliberative sessions confirmed that all audiences held the view that there was a link between workplace culture and maintaining health and well-being in the workplace. Broadly, they all believed the message that good work was good for health. All indicated the importance of the small team ethic and collective responsibility to maintain well-being and encourage positive change. Regulatory changes to enable greater flexibility in workplace practice (e.g. hours, working from home) were seen as increasingly important to encourage where practical.

Unsurprisingly, however, when faced with problems to solve as a group (examples used were high levels of sickness absence, early return to work when not 100% fit, and return to work after a long time out of work), the convergent group sessions initially highlighted how the perceived problems with the current system are currently interweaved and act as key hurdles that need addressing to progress the health and work agenda. Instinctively, all parties looked for incentives to change current behaviour from their perspective, adopting a 'what's in it for me?' attitude.

However, employers, employees and those off sick were able to work together to produce solutions to the problems they were presented with at the workshop. The key goals for each audience which were identified by themselves were:

- *Employers:* getting the most out of employees and reducing occurrences of sickness absence
- *Employees:* feeling valued, appreciated and rewarded by work

- *People working, on sickness absence:* seeking demonstrations of appreciation and respect through more flexibility regarding phased return and a general urgency about getting them back into work
- *People who were not working, on health related benefits*: wanting some encouragement from the government / public bodies to get back into work (e.g. through 'public' education on mental health conditions, financial incentives for both them and potential employers).

The sessions seemed to enable GPs to view situations from both their professional perspective and as an employer. They appeared to understand the problems faced by employers, namely wanting to get the maximum out of their employees whilst acknowledging the employee's need to feel they are treated fairly. However, from a professional perspecitve the GPs' viewpoint and motivations for change remained somewhat distinct to the rest of the group; they believed any change in procedure would mean more work for them and were resistant to anything that could threaten patient-GP confidentiality/duty of care (i.e. they did not want a more hands on role advising employers on phased return, etc.). The GPs tended to focus on the need for systemic changes that would not directly affect them/their role, e.g. changes to state benefits to make this a less attractive proposition i.e. that there is financial gain rather than loss to returning to some sort of employment.

In one or two instances, there were particular issues raised between the GP and those on health related benefits about the role of the GP in assessing fitness for work. One or two people on health related benefits felt GPs were acting as 'clearing stations' (i.e. simply signing people off without taking account of the individual circumstances) and were not seen to be demonstrating any interest in rehabilitation per se. In assessing fitness for work, GPs argued it was very difficult to tell who were genuine cases and the small percentage of patients who were not. Some GPs and those on health related benefits did agree on the need to provide a way out of the benefits system for generations of families who lacked a financial incentive to seek employment. For those with a genuine health issue it was demoralising to be positioned as potential malingerers living off benefits and all parties agreed that this image problem needed addressing and this would be partly achieved by improving understanding of, and reducing the stigma of mental health and chronic pain conditions.

It was evident from the discussions that there was a demand for an intermediary role linking the audiences and helping them to work together to move the HWWB agenda forward. This was demonstrated by the sessions helping to improve understanding between employers and the working public (employees) about mental health / chronic pain conditions simply by listening to the other side of the story. For employers, speaking first hand to those off sick with previous employment histories and adaptable skills opened their eyes to the possible role they could play in rehabilitation and helping re-develop CVs through short-term placements. This

pointed toward a barrier being lack of communication between employers and employees and its attendant solution being the facilitation of discussion. However, it was suggested by the respondents that a more useful solution would be if all parties could access an intermediary who acted as an advocate and adviser. Consequently, there may be mutual benefits for all concerned, namely:

- *Employers:* access to a pool of (potentially free) talent that could be tapped into
- *GPs:* a service to signpost those off work sick or longer-term sick towards re-training/rehabilitation (i.e. not provide the training, but suggest which organisations could)
- *General public:* a service that could help link rehabilitation, employment re-training/re-skilling and social/lifestyle advice.

It was also widely discussed how local employers could get more involved in funding community and voluntary schemes (e.g. sponsoring) to help keep schemes going, gain positive PR and improve the future employment prospects of those not working on health grounds.

Other solutions/ideas generated from the sessions mostly reflected those raised in other sessions. In terms of **maintaining health in the workplace**, ideas included:

- greater role variety/job swaps for employees – to appreciate how others work (agreed between more progressive employers (i.e. those more willing to see that employee roles were not necessarily fixed), employees and those off-work sick)
- better training for line managers re: bullying/stress in the workplace (agreed by all parties, education in this area was seen as sketchy and rarely refreshed)
- sufficient access to holistic and independent occupational health services for small/medium sized businesses (agreed by all parties; it was widely acknowledge that smaller companies lacked the funds to accommodate certain adjustments or offer alternative roles)
- encourage broad understanding of the ethic of smaller team working across all companies (agreed by all, and seen as a simple measure, but one that needed better utilisation).

In terms of **return to work**, ideas included:

- greater availability of work placements for people on health-related benefits or subsidising the employer to take on long-term sick. This was agreed by all in theory, although there were high levels of uncertainty about how this would work in practice and whether it would be ethically viable. For example, how flexible would the arrangement have to be, especially given some of those on incapacity benefit/ESA may not know from one day to the next whether they would be able to work. Additionally, it was unclear whether employers should pay a wage or whether it was sufficient that labour was exchanged for work-ready skills;

- education to combat stigma of mental illness (agreed by all, particularly in light of frank discussions between the GP and those either off work sick or on health related benefits about being tarnished as malingerers). Those with psychiatric diagnoses felt that there was widespread ignorance about the nature of mental illnesses and had experienced colleagues intimating that their condition was unreal. As a result, few had chosen to openly discuss their health issues for fear of being prejudiced or discriminated against.
- better 'organised' community and voluntary schemes, in terms of more secure long-term funding and professional leadership (especially interesting to a few employers and the long-term sick; progressive employers were interested in being engaged in community projects for both company PR and the opportunity to pick out potential employees).
- encouraging a more informal and personal outreach between employer and off sick employee by explaining the health benefits to the (potential) employee and the economic benefits to the employer (agreed between those currently off-work sick, those on health related benefits and line managers. In encouraging such a two-way dialogue in workplaces, it was hoped that this might lessen 'bullying' employers' top-down approach to management where pertinent).

There was also widespread discussion of the need for education and greater understanding of how to facilitate early return to work when not 100% fit. Most respondents across the sample felt that they lacked an understanding of how partially fit employees could be incorporated into the workplace. In particular, they highlighted that there was a need for a better grasp of how phased return could be flexibly implemented depending on the size, type and location of the organisation. This issue was agreed upon by all, focusing on education about flexible return for those off work sick and on health related benefits, plus the small-medium sized organisation line managers and employers as priorities.

Amongst those on sickness absence, those on health related benefits and employees there was also a widespread desire for greater investment and increased access to counselling and other non-drug based therapies.

Appendix A: The Long Lists – Audience generated ideas

General Public: Working, not sick

Return To Work	*Audience Generated Idea*
Independent / intermediary support/advice	▪ Independent, personal job finders for those on IB/ESA ▪ More freely available / flexible counselling services ▪ Phased return to work under more stringent GP supervision

Prevention	*Audience Generated Idea*
Changes to management practice:	▪ Compulsory and regularly refreshed people management courses for line managers to ensure employees are managed effectively; more line management training around manners i.e. recognising the importance of acknowledging achievements, common courtesy ▪ Stress management courses for management staff, allowing managers to spot potential stress issues arising in their team/themselves ▪ Greater visibility of management - ensuring better empathy with staff and ensuring staff views are heard / exchanged throughout an organisation ▪ 360° sessions involving employers and employees - entailing a frank and constructive exchange of views on health and well-being issues ▪ Sharing best practice amongst similar organisations - knowledge is pooled and effective working methods replicated
Changes to working practice to improve health and well-being:	▪ Flexible working arrangements, allowing flexi-time and working from home when appropriate/feasible ▪ Time / workload management courses allowing employees to plan their work effectively (reducing stress); or stress visitors – third party visits to talk to staff about how to deal with workloads/manage time effectively. ▪ Ensuring that employees are not covering absent colleagues for an indefinite period ▪ Job swaps throughout an organisation to keep employees fresh and to allow greater understanding of the business and people's responsibilities ▪ Regular, acknowledged breaks in the working day e.g. ensuring staff spend minimum periods away from their computer ▪ Employee training on the importance of communication of ergonomic problems to line managers (rather than waiting for them to cause injury) ▪ Better facilities/environments for improving well-being (breakout areas, using outdoor spaces where possible, etc.) ▪ Exercise built into the working week (e.g. 1 hour a day), with a recognition from employers that this incentive will benefit staff in the long term ▪ More 'buddying up' with colleagues on tasks/sharing work load and encouragement to exercise – more likely to achieve if supported
Improvement in on-site provision:	▪ In-house company childcare provision ▪ Free/heavily subsidised healthy food options at work

Employers encouraging non-work related activity:	▪ Cycle to work schemes, with bikes funded by company ▪ Free gym membership; free physiotherapy/reiki/massage/yoga, etc. ▪ More team sports encouraged by company with subsidies/sponsorship of teams ▪ Creativity courses for staff, encouraging more hobbies/common interests (to help team building) and a healthier work and life balance
Improvement in staff benefits:	▪ Private healthcare provision for staff ▪ Free vaccinations/screening programmes in work places (e.g. blood pressure, cholesterol, bowel cancer, etc.) ▪ Established stress helplines available to employees and easy access to counselling and life-coaching, covering issues such as debt management ▪ Provision of outside work perks e.g. company allotments, event tickets as rewards, work paying for employees to have cleaners at home

Systemic	***Audience Generated Idea***
Enforcing labour rights:	• Limits on weekly working hours in line with EU regulations • More rights for temporary/contracted staff
Changes to wages:	• Pay freezes should still allow changes in line with interest rate
Changes to the health care / services	• Free prescriptions for non-managerial roles • Being allowed more of a role in deciding when you can return to work, rather than it being defined by a sick note • Allowing tax breaks for employees taking out healthcare provision e.g. BUPA
Changes to the tax system:	• Rebate on N.I contributions for not using the NHS • Option to pay N.I or pay into private hospital fund

General Public: Working, on sickness absence

Return To Work	***Audience Generated Idea***
Improvement in conditions for return to work:	• Mandatory adjustments to working practice or offer of re-training after 2 periods of a recurrent problem • Employer obliged to offer re-training after 6 months if unable to return to previous duties • Provision of transport to / from work if necessary to make the process of returning to work easier (short term) • Health blogs (employers and employees) – non-pressured regular interaction for those more comfortable with email/the internet • Better provision and use of 'neutral' meeting places for employees off sick and employers to meet (e.g. private meeting booths in coffee shops) • More task ownership while off-sick – low grade/low pressure tasks to keep engaged in work
Facilitation of return to work (GPs)	• Option of auto referral to alternative GPs and gaining a 2nd opinion after 3 months of absence
Self-help issues:	• Intermediary initiatives aimed at establishing better communication between partners/loved ones/friends about problems or issues to help engage them in meaningful dialogue about return to work • Helping to achieve and maintain active engagement in hobbies/interests

	while out of work to keep themselves motivated/engaged in daily life

Prevention	*Audience Generated Idea*
Improvement in on-site provision:	• Quicker and easier access to occupational health
Changes to management practice:	• Better line management and monitoring of health and well-being • Cultivating a small team ethic (responsibility, value, importance)

Systemic	*Audience Generated Idea*
Changes in GP process:	• Less 'cut and dried' prognosis restricting phased return – having more of a say about when they can return (not defined only by the sick note) • More cooperation and dialogue between GP and employers to enable more trust in GP prognosis • More flexible/shorter periods of time signed off sick • Ability to access occupational health more easily

General Public: Not working, on IB/ESA

Return To Work	*Audience Generated Idea*
Facilitation of return to work (independent):	• Return to work centres, which take a holistic approach – not just rehabilitation, but training, counselling and confidence building • Casual, paid per hour contracts/job shares (drop in and work – no commitment/paid for what you do) • Independent, personalised job finders and "life coaches" - to talk to/act as a mediator with employers / attend interviews; • A dedicated Jobcentre Plus adviser who gets to know the individual and works with them to find suitable employment • Ability to 'taste tester' jobs without losing benefit support • "Confidence-boosting" workshops/courses • Employment advisers based in doctors' surgeries • Courses/events to aid social engagement in non-work environments, (meeting people, making friends) • Outreach offer of flexible training / voluntary work (including taking people to placements) • More access to free health clubs/swimming • Assessment workshops to see if fit to return to work (tested out in work-related scenarios) • Grants / loans / incentives and support for those on IB/ESA wanting to set up businesses

Facilitation of return to work (GPs):	• Health services to aid return to work • Support groups for those who are long-term sick • N.B. 'Fit Notes' seen positively as something which would prove their ability and reliability to an employer
Facilitation of return to work (Employers):	• Employer taking a percentage of wages to cover cost of training on job/ training at weekends • Job shadowing schemes • Active and consistent involvement from Jobcentre (a dedicated adviser who knows the individual) • Employer Incapacity Benefit payment scheme (potential for free help)

Prevention	***Audience Generated Idea***
Improvement in on site provision:	• More company physiotherapists
Changes to management practice:	• Employer offering flexible working pattern
Independent / intermediary support/advice:	• Free government funded gyms

Systemic	***Audience Generated Idea***
Changes to benefit systems:	• Lack of financial incentive to get off IB; prevent it being more financially profitable to remain on benefits than to be in employment (i.e. reduce amount of IB/ESA to make it less attractive to remain not in work • More clarity of opportunities for those on IB/ESA regarding re-training, volunteering, and attending college, etc. • Ability to 'taste tester' jobs without losing benefit support • Reduce the amount of time people wait for IB/ESA assessments (every 2 months, not 6?)
Changes to GP process:	• Fast track those on benefits to medical help so they are experiencing proactive treatment and not spending months getting trapped in the benefits system

Employers and Line Managers

Return To Work	***Audience Generated Idea***

Independent / intermediary support/advice:	• Independent health advisers, assessors or drop-in GPs to advise managers on likely implications of employees' illnesses on the business • Clearer advice on implications for sickness duration e.g. for mental health disorders • More external advisers offering fresh eyes to business approaches • Better access to advisers on managing sickness absence (including cover, legal/insurance concerns and phased return)
Improvements in conditions for return to work:	• Access to independent re-training and re-skilling facilitators to aid early return to work or re-deployment after 6 months of employee being unable to return to previous duties • Give employee lighter duties/alternative roles on return to work after sickness absence • Encourage larger companies to develop schemes to employ those on IB/ESA • Employer takes a percentage of wages to cover cost of training on job/training at weekends • Employer Incapacity Benefit payment scheme – the potential for 'free' or government subsidized help in return for helping to re-skill/re-train those who have been out of work for longer periods

Prevention	***Audience Generated Idea***

Changes to management practice:	• Greater engagement with, and visibility amongst, staff which would aid accountability and make managers more approachable
	• Well-being surveys, taking a holistic approach to your staff's well-being – with a responsibility to action key recommendations
	• Having "well-being mentors" and advocates, which would guide man-management & health and well-being
	• Burnout monitors and designated members of staff to spot emerging stress problems
	• Fostering a 'team within a team' culture ensuring that employees feel responsible towards other team members
	• Activities to promote well-being such as;
	  o Dress down day on Friday
	  o Outdoor activities at work e.g. company allotment and sports days
	  o Team days and activities e.g. team nights out
	  o Incentives for staff rewarding them for undertaking certain hobbies
	  o The company paying for and organizing employee holidays
	• Incentives for non-sickness (e.g. extra holidays and bonuses)
	• Greater outreach services for companies to facilitate change rather than just putting information out there and hope employers will find it; using credible industry 'health advocates'

Improvements in on-site provision:	• Better facilities and an environment for improving well-being e.g. breakout areas, outdoor space and showers for those who run or cycle into work • Reiki / massage / pilates / yoga available for staff • Gym membership or company gym dependent on size of company

	• Free health screening in the work place, such as eye tests and medicals • Emergency childcare facilities near or at work • Wellness centre at work- free medications for minor ailments and open clinic, speaking to someone medically qualified

Systemic	***Audience Generated Idea***
Enforcing labour rights	• Limits on weekly working hours in line with EU regulations
changes to health care & services	• Shorter statutory Sick Pay periods
changes to tax system	• No tax breaks for well-being interventions • Tax-efficient occupational health

GPs and AHPs

Return to work	***Audience Generated Idea***
Facilitation of return to work (GPs and Employers)	• Independent specialist clinicians for those on IB/ESA • Option of auto-referral to alternative GP (second opinion) after 3 months on sickness absence • A government scheme whereby those who are on IB/ESA for 3+ years could be seconded to companies where they receive on the job training (c.f. YTS) • Encourage large companies to develop schemes to employ those on IB
Independent/ intermediary support and advice	• Graded/phased return to work, preferably assessed and monitored by an occupational health specialist • Independent health advisers/assessors/drop-in GPs to advise and help employers plan (e.g. cover) • Scheme to pick up IB/ESA claimants from home and taken them to work or participation in voluntary scheme • Arts and community based projects that people on long term IB/ESA can get involved with • Increased funding for cognitive behaviour therapy (CBT)and counselling

Prevention	***Audience Generated Idea***
Changes to management practice:	• Fostering a small team ethic which involves a sense of responsibility and flexible working hours • Praising and valuing employees

Changes to their working practice to improve health and well-being	• Surgeries run 'sick note clinics' – sick notes only issued on one morning of the week with stricter GPs taking charge (also providing those off-sick a dedicated contact/more continuity of care) • Get Jobcentre Plus/Remploy into GP surgeries to talk to GPs and AHPs about impact of giving out sick notes • Limiting working hours in a week and enforcing it; flexible working hours • Incorporate exercise into working hours • Increase awareness of potential detrimental effects of shift work on health and diet • Credible industry 'health advocates' visiting organisations
Improvement in on site provision:	• Wellness Centre at work – receive free medications for minor ailments (reduce incidents of staff going home 'sick') • Open clinics at work – more ad hoc access to someone medially qualified to speak to • Make healthy food cheaper than junk food available in staff canteen • Greater access to Occupational Health services, especially for those working in smaller companies • Gym at work • Ergonomics at work (furniture/work stations)
Improvement in staff benefits:	• Team building fund to encourage social interaction • Third party stress visitors, who come in to work to talk to staff about managing their workload, time/planning, etc. • Provision of access to a gym

Systemic	***Audience Generated Idea***
Changes in GP process:	• Bring back RM7s for GPs to feel empowered to refer 'difficult' patients / malingerers
Changes to benefit system:	• Reducing financial amount of IB/ESA to make it less attractive to be off work • Curbing the number of IB/ESA appeals by stopping sick pay during the appeal process • Reducing the amount of time patients have to wait for IB/ESA assessment (2 months, rather than 6 months)

Appendix B: Research Sample Frames

General Public: Working, not currently on sickness absence

Focus groups (6-7 respondents)	*TOTAL GROUPS*	*Pre-family*	*Family*	*Older*
Working and not on sickness absence	6	2	2	2

Depth interviews	*TOTAL DEPTHS*	*Pre-family*	*Family*	*Older*
Working and not on sickness absence	3	1	1	1

General Public: Working and on sickness absence

Working and on sickness absence	*Mini-groups (3-4 respondents)*	*Mr and Mrs*	*Depths*
3 or more spells of 1-7 days sickness absence in the last 12 months	1	1	1
At least one spell of 4 weeks or more unplanned sickness in the last 24 months	1	1	1
Planned sickness of 3 weeks or more in the last 24 months	1	1	1
TOTAL	**3**	**3**	**3**

General Public: Not working and on health related benefits

Mini-groups (3-4 respondents) or Mr & Mrs Interviews	*Total*	*Mixed lifestages*	*Pre-family*	*Family*	*Older*
Claiming IB or ESA for under a year, *mental health conditions*	**1**	1	-	-	-
Claiming IB or ESA for under a year, *mixed physical conditions*	**2**	-	1	-	1
Claiming IB for 1 - 2 years, *mental*	**1**	1	-	-	-

health conditions					
Claiming IB for 1 - 2 years, *mixed physical conditions*	**2**	-	1	1	-
Claiming IB for 3+ years, *mental health conditions*	**1**	1	-	-	-
Claiming IB for 3+ years, *mixed physical conditions*	**2**	-	-	1	1
TOTAL	**9**	**3**	**2**	**2**	**2**

Replica sample for 'Mr&Mrs' Interviews (i.e. total of 9 Mr & Mrs)

Employers and Line Managers

Face to Face Depth Interviews	**Total**	**White/prof Collar**			**Blue/Grey Collar**		
		<50	50-249	250+	<50	50-249	250+
CEOs/Board Directors	6	1	1	1	1	1	1
Occupational Health / Staff Welfare Policy	4	-	1	1	-	1	1
HR Managers	4	-	1	1	-	1	1
Line managers (day-to-day responsibility for staff)	6	1	1	1	1	1	1
TOTAL Depths	**20**	**2**	**4**	**4**	**2**	**4**	**4**

Face to Face Groups (5-6 respondents)	**Total**	**White/prof Collar**			**Blue/Grey Collar**		
		<50	50-249	250+	<50	50-249	250+
Line managers (day-to-day responsibility for staff)	6	1	1	1	1	1	1
TOTAL Groups	**6**	**1**	**1**	**1**	**1**	**1**	**1**

GPs and AHPs

GPs: 6x mini-groups and 8x depths

Level of GP Experience	**Total**	**England**	**Scotland**	**Wales**
MINI-GROUPS (3-4 respondents)				
Under 10 years experience	3	1	1	1
Over 10 years	3	1	1	1

TOTAL MINI-GROUPS	6	2	2	2
DEPTHS				
Under 10 years experience	4	2	1	1
Over 10 years	4	2	1	1
TOTAL DEPTHS	**8**	**4**	**2**	**2**

Allied Health Professionals: 3x mini-groups and 4x depths

	Total	England	Scotland	Wales
MINI GROUPS (3-4 respondents)				
Surgery staff & Allied health professionals	**3**	1	1	1
DEPTHS				
Practice Managers	**4**	2	1	1

Appendix C: Topic guides

Topic guide - Working, Not Sick initial group discussions – 1 hour

Introduction: Explain that there are some key topic areas we would like to cover, but that the nature of the discussion is completely informal and that their views are confidential. Ask for permission to audio record the discussion – reassure that audio is used only as part of the research and all views expressed are anonymous/confidential.

(Interviewer goes through rules of group discussion)

- There are no right or wrong answers – we simply wish to explore opinions on the issues
- Allow everyone to have their say, it's important that only person speaks at a time
- Please also be aware that what gets discussed in this room should not be discussed with anyone once we all leave

Ask them to sign the consent form and answer any questions they have before starting the interview.

SECTION A: Introduction

Note: no more than five minutes in total should be spent on introduction discussion.

1. Individual introductions: first name, briefly describe current circumstances re: hobbies, occupation (and role in this organisation).

2. Icebreaker (to all): What does a typical day at work look like for you?

Probe:

- Commuting, hours at work/work patterns?
- What are your key work responsibilities?
- How many people do you work with day to day?

SECTION B - Suggestions for improving and maintaining a healthy workforce.

NOTE: Most important section of interview – recommend up to 50 minutes. Explain that we're going to be looking at the issue of health and work.

3. Use 'Key Facts' to make point about the enormity of the issue

4. Show the Hummer example – explain we want our groups to devise their own 'Hummers'.

5. From your perspectives, what could be changed to really make a difference to improve health and well-being at work?

Probes:

- What do you want?
- What do you want to be different from now?
- How could this happen?
- Also explore what happens at their work at the moment (what have in place and how effective this is)

Ask them to effectively 'play God' and not be restricted by rules/regulation or current practices, but to consider what you would do if you started from scratch… that ideas can be small or large.

Generate list of issues on flip chart.

Now we have these ideas, can we discuss as a group for each idea:

- What are you trying to do with each idea?
- How/Why might it change attitudes/behaviour?
- Who would be involved? What would be their responsibilities?
- What would you do?

6. What would your idea of an 'ideal employer' do to maintain health in the workplace? Generate list of ideas about how a perfect employer would treat them/their team.

Topic guide - Working off sick / Not working initial group discussions – 1 hour

Introduction: Explain that there are some key topic areas we would like to cover, but that the nature of the discussion is completely informal and that their views are confidential. Ask for permission to audio record the discussion – reassure that audio is used only as part of the research and all views expressed are anonymous/confidential.

Interviewer goes through rules of group discussion.

- There are no right or wrong answers – we simply wish to explore opinions on the issues
- Allow everyone to have their say, it's important that only person speaks at a time

- Please also be aware that what gets discussed in this room should not be discussed with anyone once we all leave.

SECTION A: Introduction

Note: no more than five minutes should be spent on introduction discussion.

1. Individual introductions: first name, current circumstances re: family, hobbies, occupation (and role in this organisation)

2. Generally, what a typical day is like for you at the moment, and what sort of things you do?

3. For those ‘working off sick’: can you tell me about when you are at work – what do you do in a typical day at work?

SECTION B: Understanding of health, well-being and work issues

NOTE: this is for context – limit this discussion to no more than 5-10 mins.

4. We are going to be talking about the topic of ‘health and well-being at work’ today. From your perspective, what kinds of issues do you believe this topic might cover?

Generate list of ideas on flip charts.

5. What sorts of things have you been offered to help you get back to work?

Probes:

- What previous experiences of work have you had that affect your views?
- What have you found helpful/not helpful and why?
- Is there anything that could help you get back into work more quickly?
- Is there anything in particular that stops you from wanting to return to work?

SECTION C: Suggestions for improving and maintaining a healthy workforce

NOTE: Most important section of interview – recommend at least 45 minutes.

6. Use ‘Key Facts’ to make point about the enormity of the issue

7. Show the Hummer example – explain we want our groups to devise their own ‘Hummers’.

8. From your perspective, what could be changed to really make a difference to improve your health and well-being?

9 What would your ideal support be to help you back into work?

Probes:

- What do you want?
- What do you want to be different from now?
- How could this happen?

Ask them to effectively 'play God' and not be restricted by rules/regulation or current practices, but to consider what you would do if you started from scratch… that ideas can be small or large. Generate list of issues on flip chart.

10. Now we have these ideas, can we discuss as a group for each idea:

- What are you trying to do with each idea?
- How/Why might it change attitudes/behaviour?
- Who would be involved? What would be their responsibilities?
- What would you do?

Generate list of issues on flip chart.

11. What would your idea of an 'ideal employer' do to help maintain well-being at work?

Generate list of ideas about how a perfect employer would treat them.

Probes:

- What do you want?
- What do you want to be different from now?
- How could this happen?

Topic guide – Allied Health Professionals group interviews

Introduction: Explain that you are from Andrew Irving Associates, an independent market research agency, and that we are conducting a research study on behalf of the Cross-Government Health, Work and Well-being Delivery Unit looking at attitudes and behaviours towards health, work and well-being. The research is being carried out across Great Britain and we are looking to speak to a range of people who will have important views on this subject including those working in surgeries.

Explain that the interview will last up to one and a half hours. Also explain that there are some key topic areas we would like to cover, but that the nature of the discussion is completely informal and that their views are confidential. Interviewer goes through rules of group discussion:

- There are no right or wrong answers - we simply wish to explore opinions on the issues
- Allow everyone to have their say, it's important that only one person speaks at a time
- Please also be aware that what gets discussed in this room should not be discussed with anyone once we all leave.

Explain that, with their permission (and refer them to the consent form they should have already signed prior to starting the interview which lists what they are agreeing to), we would like to audio record the discussion – which is standard practice in research – in case we need to refer back to data; but also reassure that audio is used only as part of the research and all views expressed are anonymous/confidential.

SECTION A: Introduction

Note: no more than 10 minutes should be spent on introduction discussion.

1. Can you each in turn tell me a little bit about your responsibilities in this surgery – and what you do on a day-today basis?

Probes:

- How long have you been working here?
- What are the key day-to-day challenges you face in your job?
- Please tell me a bit about the surgery work in and types of patients you deal with day-to-day?

Prompts where necessary: poverty, housing conditions, unemployment levels, drug/alcohol issues; elderly, working-age, ethnic minorities, children.

2. Icebreaker: what are the things you most enjoy about your job?

3. And can you briefly tell me about the level of interaction you have with the GP(s) and other staff at the surgery?

Probes:

- How many GPs are there at this surgery? How many other Allied Health Professionals? What roles?

SECTION B: Approach to health and work issues

NOTE: this is for background and interpretative context – limit this discussion to no more than 15 mins max.

4. In general, what do you see as your role in the area of health and work?

Probes:

- What role, if anything, do you see yourself having in encouraging patients to get back to work?
- Are there competing 'priority' issues for you in your work?
- Are there any responsibilities you feel you have for patient well-being that would be best placed elsewhere – why and where?
- Are there any conflicting messages you get? If so what are these (explore messages from other sources/organisations)?

5. What kinds of issues do you come across when seeing patients who are currently in work?

Probes:

- Do you discuss work, family issues, financial or other worries as part of your conversations with patients?
- Typically for what conditions are medical certificates issued for people who are currently in work?
- What are the considerations you make in deciding what to recommend in terms of getting people back to work as soon as possible?

6. Are you ever asked for/involved in producing medical reports/statements by patient's employers?

Probes:

- How frequently are you asked for these?
- What sorts of information do you write in these statements?
- Do you see ask the patient about their work before you write the statement?
- Do you talk to the patient's employer about your patient's job before you write the statement?

7. Can you tell me about the issues you generally come across when seeing patients who are unemployed?

Probes:

- Do you discuss work, family issues, financial or other worries as part of your conversations with patients?
- Typically for what conditions are medical certificates issued for people who are currently unemployed?
- What are the considerations you make in deciding what course of treatment to recommend? (relationship with patient, patient's socio-medical history, is it in response to the patient's request for a sick note)

SECTION C: 'What would you do if…' Reaction to Possible 'Health and Work'

Scenarios

NOTE: limit this discussion to no more than 15 mins. Rotate order of showing vignettes.

8. Scenario: What would you do if you were feeling low, overstretched or stressed? (Note: It does not matter where this stress has come from)

Probes:

- What would tend to happen?
- What would you do for yourself?
- What would you differently at home or at work when you are feeling this way (if anything)?
- Who might you turn to/involve? Why/When?

9. Scenario: What would you do if you had a colleague who was feeling upset at work?

Probes:

- What would tend to happen?
- Who might you turn to/involve? Why/When?

SECTION D: Suggestions for improving and maintaining a healthy workforce

NOTE: Most important section of interview – recommend up to 40 minutes. Maybe show key facts.

10. From your own perspective, what could be changed to really make a difference to improve the public's health and well-being? (Ask them to effectively 'play God' and not be restricted by rules/regulation or current practices, but to consider what you would do if you started from scratch… that ideas can be small or large).

Probes:

- What is the goal/outcome you think this would achieve? Why would it make such a difference?
- How would this be achieved? What would need to happen and how?
- Who would be involved? What would be their responsibilities?
- What would you do?

11. From your own perspective, what could be changed to really make a difference to improve your own well-being at work? (Ask them to effectively 'play God' and not be restricted by rules/regulation or current practices, but to consider what you would do if you started from scratch… that ideas can be small or large).

Probes:

- What is the goal/outcome you think this would achieve? Why would it make such a difference?
- How would this be achieved? What would need to happen and how?
- Who would be involved? What would be their responsibilities?
- What would you do?

SECTION E: Statements for change – 'Where we want to get to' stimulus

A few minutes – each on a separate show card (cards are numbered in order and you should prioritise accordingly).

12. Could you tell me what you think about what is said here?

Probes:

- What are the problems with this statement from your perspective?
- Is this relevant to your surgery? Do you think it should be and why?
- What reservations do you have about any of the statements? Why?

13. Now you have seen all these statement do you have any other thoughts or ideas on what could be changed to really make a difference to health and well-being at work?

Consider any ideas/solutions wearing different hats (i.e. thinking about this an employee's perspective, an employers' perspective, greater interaction with GPs/other health professionals). How might this work?

SECTION F: Reactions (briefly) to current/planned initiatives

Spend a few minutes reviewing current/planned initiatives (show board of brief descriptions of initiatives relevant to them).

14. Which of your ideas do you think are more likely to help support these initiatives in changing attitudes to health and work, and why?

Probes:

- What do you like/dislike about the initiatives?
- Are there any aspects/elements included in the planned initiatives that you had not previously considered?

Thank them for their time.

Topic guide - Audiences not working – Group Discussions

Introduction: Explain that you are from Andrew Irving Associates, an independent market research agency, and that we are conducting a research study on behalf of the Cross-Government Health, Work and Well-being Delivery Unit looking at how work could play a role in improving and maintaining health. The research is being carried out across Great Britain and we are looking to speak to a range of people who will have important views on this subject. This is why we have asked to talk to you today.

Explain that there are some key topic areas we would like to cover, but that the nature of the discussion is completely informal and that their views are confidential. Ask for permission to audio record the discussion – reassure that audio is used only as part of the research and all views expressed are anonymous/confidential.

Interviewer goes through rules of group discussion:

- There are no right or wrong answers – we simply wish to explore opinions on the issues
- Allow everyone to have their say, it's important that only person speaks at a time
- Please also be aware that what gets discussed in this room should not be discussed with anyone once we all leave.

Ask them to sign the consent form and answer any questions they have before starting the discussion.

SECTION A: Introduction

Note: no more than 5-10 minutes should be spent on introduction discussion.

1. Introductions: first name, current circumstances re: family (and children), hobbies
2. What is a typical day like for you? What sort of things do you do?
3. And what would you say makes you have a really good day? What does this involve?

SECTION B: Understanding and experience of health and well-being

NOTE: this is for context – limit this discussion to no more than 15 mins max.

3. I would now like to ask you all about your views on 'health and well-being'. What does this sound like its about? What kinds of issues do you believe this topic might cover? Generate list with flip chart.

4. From your perspectives, what could be changed to really make a difference to improve your health and well-being? What would ideally happen to help you back into work?

Probes:

- What do you want?
- What do you want to be different from now?
- How could this happen?

Ask them to effectively 'play God' and not be restricted by rules/regulation or current practices, but to consider what you would do if you started from scratch… that ideas can be small or large. Generate list of issues on flip chart.

SECTION C: Introducing work to the discussion

5.What are your views towards work?

Probes:

- What do you think is good about work?
- What do you think is bad about work?
- What previous experiences of work have you had that affect your views?

SECTION D: Suggestions for improving and maintaining a healthy workforce.

NOTE: Most important section of interview – recommend up to 40 minutes.

6. What would your of ideal support be to help you back into work? Generate list of ideas about how a perfect employer would treat them.

Probes:

- What do you want?
- What do you want to be different from now?
- How could this happen?

Generate list of issues on flip chart.

Now we have all these ideas can we discuss as a group for each idea:

- What is the goal/outcome you think this would achieve? Why would it make such a difference?
- How would this be achieved? What would need to happen and how?
- Who would be involved? What would be their responsibilities?
- What would you do?

SECTION E: Statements for change – 'Where we want to get to' stimulus

Approx 10 minutes – each on a separate show card (cards are numbered in order and you should prioritise accordingly).

7. Could you tell me what you think about what is said here?

Probes:

- What do you think about these statements?
- What are key positives/issues with this statement from your perspective?
- What reservations do you have about any of these statements? Why?

Generate list of issues on flip chart.

8. Now you have seen all these statement do you have any other thoughts or ideas on what could be changed to really make a difference to your health and well-being?

Consider any ideas/solutions wearing different hats (i.e. thinking about this from an employer's perspective, greater interaction with GPs/other health professionals) how might this work? Place any other 'ideal world' ideas that come out of the group after they have seen statements for change up on flipchart.

SECTION F: Reactions (briefly) to current/planned initiatives

Spend five minutes reviewing current/planned initiatives (show board of brief descriptions of initiatives relevant to them).

9. Which of your ideas do you think are likelier to help support these initiatives in changing attitudes to health and work?

Probes:

- What do you like/dislike about the initiatives? Why?

- Which ones do you think may not be helpful and why?

Thank them for their time.

Topic guide - Audiences not working – Mr and Mrs interviews

Introduction: Explain that you are from Andrew Irving Associates, an independent market research agency, and that we are conducting a research study on behalf of the Cross-Government Health, Work and Well-being Delivery Unit looking at how work could play a role in improving and maintaining health. The research is being carried out across Great Britain and we are looking to speak to a range of people who will have important views on this subject. This is why we have asked to speak to you both today.

Explain that there are some key topic areas we would like to cover, but that the nature of the discussion is completely informal and that their views are confidential. Reassure that there are no right or wrong answers – that we simply wish to explore their opinions on the issues and that these are important. Ask for permission to audio record the discussion – reassure that audio is used only as part of the research and all views expressed are anonymous/confidential.

Explain that we would like to speak to both people in the couple separately to get their own views on this topic, and then we will bring them back together towards the end of the interview for a group discussion.

Ask them to sign the consent form and answer any questions they have before starting the interview.

SECTION A – D: Mr and Mrs are split up and interviewed separately. If both partners are not working due to health reasons, ask all questions, otherwise see question splits where relevant between person not working and partner.

SECTION E – F: Mr and Mrs are brought back together.

SECTION A: Introduction

Note: no more than five minutes should be spent on introduction discussion.

1. Introductions: first name, current circumstances re: family (and children), hobbies

If currently not working:

2. What is a typical day like for you?

Probe:

- What sort of things do you do?

If partner:

2. Are you working at the moment?

If yes – Can you tell me a bit about your job? What is a typical day at work like for you.

If no – What is a typical day like for you? What sorts of things do you do?

SECTION B: Current Health Situation

10 minutes – for person not working because of their health:

3.Can you tell me a little bit about your health?

Probes:

- Does your health impact on what you can do in a typical day? If so, how?
- How did the situation arise? How long ago?
- How does the situation impact on home life in terms of roles and responsibilities around the home?
- What's been more / less easy to deal with?
- What support and guidance (if any) was offered to you?
- What have you found helpful/not helpful? Why?
- Has your partner been able to help you, have they been given any support or guidance?

For partner of person:

3. Can you tell me about your partner being off work and how this has affected you both?

Probes:

- How do you feel about the situation?
- How did you feel about the support that your partner gets? Can you tell me about this and how useful it is
- Do you get any support? Can you tell me about this and how useful it is?
- Do you feel you can do anything to help?

SECTION C: Understanding and experience of health and work issues

NOTE: this is for context – limit this discussion to no more than 15 mins max.

4. We are going to be talking about the topic of 'health and well-being' today. From your perspective, what kinds of issues do you believe this topic might cover?

For person not working:

5. What are your current views about work?

Probes:

- Do you feel ready to go back to work? Why?
- What do you think is good/bad about work?
- Would you like to be in work? Why/Why not?
- What would it take to help you back to work?
- Have there been times when you have felt more able to work? If yes what happened?

Ask about support for return to work from Jobcentre plus/employment advisers/GPs/other health professionals.

For partner:

5. Do you think your partner could go back to work?

- When do you think your partner will be ready to go back to work? Why? Is there anything in particular that you think might make your partner not want to return to work just now?
- Is there anything that you think could help your partner get back into work?

Ask about support for return to work from Jobcentre plus/employment advisers/GPs/other health professionals.

SECTION D: Suggestions for improving and maintaining a healthy workforce.

NOTE: Most important section of interview – recommend up to 25 minutes.

Ask all questions to everyone.

6. From your perspective, what could be changed to really make a difference to improve your well-being? (Ask them to effectively 'play God' and not be restricted by rules/regulation or current practices, but to consider what you would do if you started from scratch… that ideas can be small or large).

Probes:

- What is the goal/outcome you think this would achieve? Why would it make such a difference?
- How would this be achieved? Step-by-step: what would need to happen and how?

- Who would be involved? What would be their responsibilities?
- What would you do?

7. From your perspective, what could be changed to really make a difference to improve your partner's well-being? (Ask them to effectively 'play God' and not be restricted by rules/regulation or current practices, but to consider what you would do if you started from scratch… that ideas can be small or large).

Probes:

- What is the goal/outcome you think this would achieve? Why would it make such a difference?
- How would this be achieved? Step-by-step: what would need to happen and how?
- Who would be involved? What would be their responsibilities?
- What would you do?

8. What would your idea of ideal support be to help you/your partner back into work?

Probes:

- What would ideally need to happen
- How would this be achieved? Step-by-step: what would need to happen and how?
- Who would be involved? What would be their responsibilities?
- What would you do?

Bring couple back together.

SECTION E: Compare and Contrast 'Ideal world'

Approx 10 minutes.

9. What ideas did you both come up with for improving the situation? Remind them of question and ask both to explain their ideals and why they would help for questions 6-8 in turn from their personal perspectives probing against each question to encourage them to discuss.

Probes:

- What do you think of each others ideas? Why do you think that things may work? Explore agree/disagreements on each of their views on the way forward.
- Could you take both your ideas to make an ideal situation for both of you? (note: not necessarily looking for agreement between the couple)

SECTION F: Statements for change – 'Where we want to get to' stimulus

Approx five minutes – each on a separate show card (cards are numbered in order and you should prioritise accordingly).

10. Could you tell me what you think about what is said here?

Probes:

- What do you think?
- What are key positives/key concerns you have about this statement?

11. Now you have seen all these statement do you have any other thoughts or ideas on what could be changed to really make a difference to health and well-being?

Consider any ideas/solutions wearing different hats (i.e. thinking about this from your perspective, from your partner's perspective) how might this work?

SECTION F: Reactions (briefly) to current/planned initiatives (if time)

Spend a couple of minutes reviewing current/planned initiatives (show board of brief descriptions of initiatives relevant to them).

12. Which of your ideas do you think are likelier to help support these initiatives in changing attitudes to health and work, and why?

Probes:

- What do you like/dislike about the initiatives?
- Are there any aspects/elements included in the planned initiatives that you don't think will work/think will work and why?

Thank them for their time.

Topic guide - CEO depth interviews

Introduction: Explain that you are from Andrew Irving Associates, an independent market research agency, and that we are conducting a research study on behalf of the Cross-Government Health, Work and Well-being Delivery Unit looking at how work could play a role in improving and maintaining health. The research is being carried out across Great Britain and we are looking to speak to a range of people who will have important views on this subject including those with ultimate responsibility for staff and who influence company policy. This is why we have asked to talk to you today.

Explain that there are some key topic areas we would like to cover, but that the nature of the discussion is completely informal and that their views are confidential. Reassure that there are no right or wrong answers – that we simply wish to explore their opinions on the issues and that these are important. Ask for permission to audio

record the discussion – reassure that audio is used only as part of the research and all views expressed are anonymous/confidential.

Ask them to sign the consent form and answer any questions they have before starting the interview.

SECTION A: Introduction

Note: no more than five minutes should be spent on introduction discussion.

1. What is you role in this organisation, what are your responsibilities?

2. What are the key issues you are dealing with at the moment as board director/CEO for your organisation?

Probes:

- What are the key day-to-day challenges you face in your job?

SECTION B: Organisation's approach to health & work issues

NOTE: this is for background and interpretative context – limit this discussion to no more than 10-15 mins max.

3. I would like to ask you about your views about 'health and well-being at work'.

Probes:

- What does this mean to you?
- Is this something that you/the organisation you work for talks about?
- Have you ever received information or training about this topic? What was this, who provided it?

4. What do you think are the main issues in the management of the health and well-being of staff in this organisation?

Probes:

- Are there competing 'priority' issues that are more/less problematic within your organisation?

5. What is the impact on business of welfare issues, poor health and well-being in this organisation?

Probes:

- Are there any costs to productivity?
- How does sickness absence affect business?

6. What (if anything) does this organisation currently do in terms of health and well-being at work?

Probes:

NOTE: If only focus on health and safety – prompt for well-being examples – eg healthy eating plans, physical exercise, stress management, employee engagement and discussion groups, flexible working arrangements.

- What effect have you seen as a result?
- How involved are you?
- Who else is involved (internal/external help)?
- Are there any responsibilities you feel you have for staff well-being that would be best placed elsewhere – why and where?
- Are there any conflicting messages you get about what you should do? If so what are these (explore messages from HR/Occupational Health and messages from other organisations)?
- Are there areas that the organisation used to address but no longer needs to – why?

SECTION C: 'What would you do if…' Reaction to Possible 'Health and Work'

Scenarios

NOTE limit this discussion to no more than 15 mins.

For each vignette:

7. As CEO/board director, what would you do and why?

Probes:

- When?
- How would you get involved?
- Who else would you involve?

Note for each stage in the scenario reveal – probes are:

- What more information do you need to know? Eg role in company, age, family circumstances, etc?
- What factors, either present in the above scenario or not, would influence your decision making?
- What would you do personally if you had any of the symptoms raised in the above scenario?

SECTION D: Suggestions for improving and maintaining a healthy workforce.

NOTE: Most important section of interview – recommend up to 30 minutes.

8. From your own perspective, what could be changed to really make a difference to improve health and well-being at work? (Ask them to effectively 'play God' and not be restricted by rules/regulation or current practices, but to consider what you would do if you started from scratch… that ideas can be small or large).

Probes:

- What is the goal/outcome you think this would achieve? Why would it make such a difference?
- How would this be achieved? What would need to happen and how?
- Who would be involved? What would be their responsibilities?
- What would you do?

SECTION E: Statements for change – 'Where we want to get to' stimulus

A few minutes – each on a separate show card (cards are numbered in order and you should prioritise accordingly).

9. Could you tell me what you think about what is said here?

Probes:

- What do you think?
- What are the problems with this statement from your perspective?
- Is this relevant to your organisation? Do you think it should be and why?
- What reservations do you have about any of the statements? Why?

10. Now you have seen all these statement do you have any other thoughts or ideas on what could be changed to really make a difference to health and well-being at work?

Consider any ideas/solutions wearing different hats (i.e. thinking about this from an employee's perspective, greater interaction with GPs/other health professionals) how might this work?

SECTION F: Reactions (briefly) to current/planned initiatives

Spend a few minutes reviewing current/planned initiatives (show board of brief descriptions of initiatives relevant to them).

10. Which of your ideas do you think are likelier to help support these initiatives in changing attitudes to health and work, and why?

Probes:

- What do you like/dislike about the initiatives?
- Are there any aspects/elements included in the planned initiatives that you had not previously considered?

Thank them for their time.

Topic guide - GP depth interviews

Introduction: Explain that you are from Andrew Irving Associates, an independent market research agency, and that we are conducting a research study on behalf of the Cross-Government Health, Work and Well-being Delivery Unit looking at attitudes and behaviours towards health, work and well-being. The research is being carried out across Great Britain and we are looking to speak to a range of people who will have important views on this subject including those working in surgeries.

Explain that the interview will last up to one hour. Also explain that there are some key topic areas we would like to cover, but that the nature of the discussion is completely informal and that their views are confidential. Reassure that there are no right or wrong answers – that we simply wish to gather the opinion of a cross section of relevant parties about their perceptions/feelings on the issues raised. Explain that, with their permission we would like to audio record the discussion – which is standard practice in research – in case we need to refer back to data, but also reassure that audio is used only as part of the research and all views expressed are anonymous/confidential. Please be aware this discussion will not require you to disclose information on individual patients.

Ask them to sign the consent form and answer any questions they have before starting the interview.

SECTION A: Introduction

Note: no more than five minutes should be spent on introduction discussion.

1. Can you tell me a little bit about your responsibilities as GP in this surgery – and what you do on a day-to-day basis?

Probes:

- How long have you been working here?
- What are the key day-to-day challenges you face in your job?
- What are the things you most enjoy about your job?

2. Can you tell me about the practices of the team here?

Probes:

- What kind of interaction do you have with other staff at this surgery?
- Do you discuss patient cases?
- When?
- How often? (Ad-hoc where necessary/scheduled weekly team meetings)
- What kinds of patient issues are most regularly discussed between health professionals at your surgery?

3. Can you tell me a little about the local area this surgery is located in?

Probes:

- Prompt poverty, housing conditions, unemployment levels, drug/alcohol issues

4. And can you briefly describe the types of patients you deal with on a day-to-day basis?

Probes:

- Prompts where necessary: Elderly, working-age, ethnic minorities, children

SECTION B: 'What would you do if…' Reaction to Possible 'Health and Work'

Scenarios.

NOTE: limit this discussion to no more than 10 mins. Rotate order of showing vignettes.

For each vignette, ask:

5. As a GP, what would you do and why?

Probes:

- What advice do you give your patient?
- Why?
- Who else would you involve?

Note: for each stage in the scenario reveal – probes are:

- What more information do you need to know?

- What factors, either present in the above scenario or not, would influence you decision making?
- Where/how would you approach differ?

SECTION C: Approach to health and work issues

NOTE: this is for background and interpretative context – limit this discussion to no more than 10-15 mins max.

6. In general, what do you see as your role in the area of health and work?

Probes:

- Is it your role to encourage patients to get back to work?
- Is it your role to engage with the patient's employer to facilitate return to work? If so, what do you do?

7. What kinds of issues do you come across when seeing patients who are currently in work?

Probes:

- Do you discuss work, family issues, financial or other worries as part of your conversations with patients?
- What are the considerations you make in deciding whether to sign people off work?
- What are the considerations you make in deciding for how long to sign people off work? (relationship with patient, patient's socio-medical history, is it in response to the patient's request for a sick note)
- Roughly how many med3 notes do you write each week?
- Typically for what conditions are medical certificates issued for people who are currently in work?
- Are there scenarios where you are more concerned about prescribing medical certificates?

8. Have you ever been asked for a medical certificate when you have thought the patient didn't need one?

Probe:

- What did you do and why?

9. Are you ever asked for medical reports/statements by patient's employers?

Probes:

- How frequently are you asked for these?
- What sorts of information do you write in these statements?

- Do you see ask the patient about their work before you write the statement?
- Do you talk to the patient's employer about your patient's job before you write the statement?

10. Can you tell me about the issues you generally come across when seeing patients who are unemployed?

Probes:

- Do you discuss work, family issues, financial or other worries as part of your conversations with patients?
- Typically for what conditions are medical certificates issued for people who are currently unemployed?
- What are the considerations you make in deciding whether to issue medical certificates? (relationship with patient, patient's socio-medical history, is it in response to the patient's request for a sick note)
- Are there scenarios where you are more concerned about prescribing medical certificates?

SECTION D: Suggestions for improving and maintaining a healthy workforce.

NOTE: Most important section of interview – recommend up to half an hour.

11. From your own perspective, what could be changed to really make a difference to improve your patients' well-being? (Ask them to effectively 'play God' and not be restricted by rules/regulation or current practices, but to consider what you would do if you started from scratch… that ideas can be small or large).

Probes:

- What is the goal/outcome you think this would achieve? Why would it make such a difference?
- How would this be achieved? What would need to happen and how?
- Who would be involved? What would be their responsibilities?
- What would you do?

12. From your own perspective, what could be changed to really make a difference to improve health and well-being at work, and help people to stay well and at work? (Ask them to effectively 'play God' and not be restricted by rules/regulation or current practices, but to consider what you would do if you started from scratch… that ideas can be small or large).

Probes:

- What is the goal/outcome you think this would achieve? Why would it make such a difference?
- How would this be achieved? What would need to happen and how?
- Who would be involved? What would be their responsibilities?
- What would you do?

13. From your own perspective, what could be changed to really make a difference to improve your own well-being at work? (Ask them to effectively ‘play God’ and not be restricted by rules/regulation or current practices, but to consider what you would do if you started from scratch… that ideas can be small or large).

Probes:

- What is the goal/outcome you think this would achieve? Why would it make such a difference?
- How would this be achieved? What would need to happen and how?
- Who would be involved? What would be their responsibilities?
- What would you do?

SECTION E: Statements for change – ‘Where we want to get to’ stimulus

A few minutes – each on a separate show card (cards are numbered in order and you should prioritise accordingly).

14. Could you tell me what you think about what is said here?

Probes:

- What do you think?
- What are the problems with this statement from your perspective?
- Is this relevant to your surgery? Do you think it should be and why?
- What reservations do you have about any of the statements? Why?

15. Now you have seen all these statement do you have any other thoughts or ideas on what could be changed to really make a difference to health and well-being at work?

Consider any ideas/solutions wearing different hats (i.e. thinking about this from an employee’s perspective, an employer’s perspective, greater interaction with other health professionals) how might this work?

SECTION F: Reactions (briefly) to current/planned initiatives

Spend a few minutes reviewing current/planned initiatives (show board of brief descriptions of initiatives relevant to them).

16. Which of your ideas do you think are likelier to help support these initiatives in changing attitudes to health and work, and why?

Probes:

- What do you like/dislike about the initiatives?
- Are there any aspects/elements included in the planned initiatives that you had not previously considered?

Thank them for their time.

Topic guide - GP group interviews

Introduction: Explain that you are from Andrew Irving Associates, an independent market research agency, and that we are conducting a research study on behalf of the Cross-Government Health, Work and Well-being Delivery Unit looking at attitudes and behaviours towards health, work and well-being. The research is being carried out across Great Britain and we are looking to speak to a range of people who will have important views on this subject including those working in surgeries.

Explain that the interview will last up to one and a half hours. Also explain that there are some key topic areas we would like to cover, but that the nature of the discussion is completely informal and that their views are confidential. Interviewer goes through rules of group discussion:

- There are no right or wrong answers - we simply wish to explore opinions on the issues
- Allow everyone to have their say, it’s important that only one person speaks at a time
- Please also be aware that what gets discussed in this room should not be discussed with anyone once we all leave.

Explain that, with their permission (and refer them to the consent form they should have already signed prior to starting the interview which lists what they are agreeing to), we would like to audio record the discussion - which is standard practice in research - in case we need to refer back to data, but also reassure that audio is used only as part of the research and all views expressed are anonymous/confidential.

SECTION A: Introduction

Note: no more than 10 minutes should be spent on introduction discussion.

1. Ask each in turn to give a little flavour of their daily lives at the surgery – can you tell me a little bit about your responsibilities as GP in this surgery – and what you do on a day-to-day basis?

Probes:

- How long have you been working here?
- What are the key day-to-day challenges you face in your job?
- What are the things you most enjoy about your job?
- What kind of interaction do you have with other staff at this surgery? Do you discuss patient cases? When? How often? (Ad-hoc where necessary/scheduled weekly team meetings)
- What kinds of patient issues are most regularly discussed between health professionals at your surgery?

2. Can you tell me a little about the local area this surgery is located in?

Probes:

- Prompt poverty, housing conditions, unemployment levels, drug/alcohol issues

3. And can you briefly describe the types of patients you deal with on a day-to-day basis?

Probes:

- Prompts where necessary: Elderly, working-age, ethnic minorities, children

SECTION B: 'What would you do if…' Reaction to Possible 'Health and Work'

Scenarios.

NOTE: limit this discussion to no more than 15 mins. Rotate order of showing vignettes.

For each vignette, ask:

4. As GPs, what would each of you do and why?

Probes:

- What advice do you give your patient?
- Why?

- Who else would you involve?
- How much do they agree/disagree as a group?

Note: for each stage in the scenario reveal – probes are:

- What more information do you need to know?
- What factors, either present in the above scenario or not, would influence you decision making?
- Where/how would you approach differ?

SECTION C: Approach to health and work issues

NOTE: this is for background and interpretative context – limit this discussion to no more than 10-15 mins max.

5. In general, what do you see as your role in the area of health and work?

Probes:

- What role, if anything, do you see yourself having in encouraging patients to get back to work?
- Is it your role to engage with the patient's employer to facilitate return to work? If so, what do you do?
- Are there competing 'priority' issues for you in your work?
- Are there any responsibilities you feel you have for staff well-being that would be best placed elsewhere – why and where?
- Are there any conflicting messages you get? If so what are these (explore messages from other sources/organisations).

6. What kinds of issues do you come across when seeing patients who are currently in work?

Probes:

- Do you discuss work, family issues, financial or other worries as part of your conversations with patients?
- What are the considerations you make in deciding: Whether to sign people off work? How long to sign people off work? (relationship with patient, patient's socio-medical history, is it in response to the patient's request for a sick note)
- Roughly how many medical (Med3) notes do you write each week?
- Typically for what conditions are medical certificates issued for people who are currently in work?
- Are there scenarios where you are more concerned about prescribing medical certificates?

7. Have you ever been asked for a medical certificate when you have thought the patient didn't need one?

Probes:

- What did you do and why?

8. Are you ever asked for medical reports/statements by patient's employers?

Probes:

- How frequently are you asked for these?
- What sorts of information do you write in these statements?
- Do you see ask the patient about their work before you write the statement?
- Do you talk to the patient's employer about your patient's job before you write the statement?

9. Can you tell me about the issues you generally come across when seeing patients who are unemployed?

Probes:

- Do you discuss work, family issues, financial or other worries as part of your conversations with patients?
- Typically for what conditions are medical certificates issued for people who are currently unemployed?
- What are the considerations you make in deciding whether to issue medical certificates? (relationship with patient, patient's socio-medical history, is it in response to the patient's request for a sick note)
- Are there scenarios where you are more concerned about prescribing medical certificates?

SECTION D: Suggestions for improving and maintaining a healthy workforce.

NOTE: Most important section of interview – recommend up to 40 minutes.

10. From your own perspective, what could be changed to really make a difference to improve your patients' well-being?

11. From your own perspective, what could be changed to really make a difference to improve health and well-being at work, and help people to stay well and at work?

12. From your own perspective, what could be changed to really make a difference to improve your own well-being at work?

For all - ask them to effectively 'play God' and not be restricted by rules/regulation or current practices, but to consider what you would do if you started from scratch… that ideas can be small or large.

For all probes:

What is the goal/outcome you think this would achieve? Why would it make such a difference?

- How would this be achieved? What would need to happen and how?
- Who would be involved? What would be their responsibilities?
- What would you do?

SECTION E: Statements for change – 'Where we want to get to' stimulus

10 minutes – each on a separate show card (cards are numbered in order and you should prioritise accordingly).

13. Could you tell me what you think about what is said here?

Probes:

- What are the problems with this statement from your perspective?
- Is this relevant to your surgery? Do you think it should be and why?
- What reservations do you have about any of the statements? Why?

14. Now you have seen all these statement do you have any other thoughts or ideas on what could be changed to really make a difference to health and well-being at work?

Consider any ideas/solutions wearing different hats (i.e. thinking about this from an employee's perspective, an employers perspective, greater interaction with other health professionals) how might this work?

SECTION F: Reactions (briefly) to current/planned initiatives

Spend a few minutes reviewing current/planned initiatives (show board of brief descriptions of initiatives relevant to them).

15. Which of your ideas do you think are more likely to help support these initiatives in changing attitudes to health and work, and why?

Probes:

- What do you like/dislike about the initiatives?

- Are there any aspects/elements included in the planned initiatives that you had not previously considered?

Thank them for their time.

Topic guide - Occupational Health, HR Managers and Staff Welfare depth interviews

Introduction: Explain that you are from Andrew Irving Associates, an independent market research agency, and that we are conducting a research study on behalf of the Cross-Government Health, Work and Well-being Delivery Unit looking at how work could play a role in improving and maintaining health. The research is being carried out across Great Britain and we are looking to speak to a range of relevant audiences who will have important views on this subject including those in charge of teams of people at work and those who influence company policy on health issues.

Explain that there are some key topic areas we would like to cover but that the nature of the discussion is completely informal and that their views are confidential. Reassure that there are no right or wrong answers – that we simply wish to explore their opinions on the issues and that these are important. Ask for permission to audio record the discussion – reassure that audio is used only as part of the research and all views expressed are anonymous/confidential.

Ask them to sign the consent form and answer any questions they have before starting the interview.

SECTION A: Introduction

Note: no more than five minutes should be spent on introduction discussion

1. What is you role in this organisation, what are your responsibilities?
2. What are the key HR/Welfare issues for your organisation?

Probes:

- How does well-being and staff welfare fit in? How big an issue is this?
- What impact does this have, and why?

3. What are the key day-to-day challenges you face in your job?

Probes:

- How do you manage these?

4. I would like to ask you about your views about 'health and well-being at work'. From your perspective, what kinds of issues does this topic cover?

Probes:

- Is this influenced by specific training or knowledge you have received? From where?

SECTION B: Organisation's approach to health and work issues

NOTE: this is for background and interpretative context – limit this discussion to no more than 10-15 mins max.

5. What (if anything) does this organisation currently do in terms of health and well-being at work and why?

Probes:

- Why is this done?
- What effect have you seen as a result?
- Are there areas that the organisation used to address but no longer needs to – why?
- How involved are you, and who else is involved?
- Is anything specific done to prevent ill-health and poor well-being becoming a problem?

(NOTE: If only focus on health and safety - prompt for well-being examples – eg healthy eating plans, physical exercise, stress management, employee engagement and discussion groups, flexible working arrangements).

Do you have policies and procedures if an employee goes off work sick? Can you briefly explain these? Does the management of circumstances when an employee is off sick vary if this planned or unplanned; short or long term? How and why?

What happens when an employee comes back to work after being off sick? Explore whether use return to work action plans; make adaptations to ways of working – and if so what and in what circumstances.

6. What do you think are the main issues in the management of the health and well-being of staff in this organisation?

Probes:

- Are there competing 'priority' issues that are more/less problematic within your organisation?
- Are there any responsibilities you feel you have for staff well-being that would be best placed elsewhere – why and where?
- Are there any conflicting messages you get? If so what are these (explore messages from CEO/messages from other organisations)
- In your view which of the policies and processes currently work well/not so well?

SECTION C: 'What would you do if…' Reaction to Possible 'Health and Work'

Scenarios.

NOTE: limit this discussion to no more than 15 mins.

For each vignette:

7. As HR/Staff Welfare manager, what would you do and why? When? How would you get involved? Who else would you involve?

Note for each stage in the scenario reveal – probes are:

- What more information do you need to know? Eg role in company, age, family circumstances, etc?
- What factors, either present in the above scenario or not, would influence your decision making?
- What would you do personally if you had any of the symptoms raised in the above scenario?

SECTION D: Suggestions for improving and maintaining a healthy workforce.

NOTE: Most important section of interview – recommend up to half an hour.

8. From your own perspective, what could be changed to really make a difference to improve health and well-being at work? (Ask them to effectively 'play God' and not be restricted by rules/regulation or current practices, but to consider what you would do if you started from scratch… that ideas can be small or large).

Probes:

- What is the goal/outcome you think this would achieve? Why would it make such a difference?
- How would this be achieved? What would need to happen and how?
- Who would be involved? What would be their responsibilities?
- What would you do?

SECTION E: Statements for change – 'Where we want to get to' stimulus

A few minutes – each on a separate show card (cards are numbered in order and you should prioritise accordingly).

9. Could you tell me what you think about what is said here?

Probes:

- What do you think?
- What are the problems with this statement from your perspective?
- Is this relevant to your organisation? Do you think it should be and why?
- What reservations do you have about any of the statements? Why?

10. Now you have seen all these statement do you have any other thoughts or ideas on what could be changed to really make a difference to health and well-being at wok?

Consider any ideas/solutions wearing different hats (i.e. thinking about this from an employee's perspective, greater interaction with GPs/other health professionals) how might this work?

SECTION F: Reactions (briefly) to current/planned initiatives

Spend a few minutes reviewing current/planned initiatives (show board of brief descriptions of initiatives relevant to them).

10. What are the more/less appealing elements/ideas in the initiatives?

Probes:

- What do you like/dislike about the initiatives?
- Are there any aspects/elements included in the planned initiatives that you had not previously considered?

11. How do you think your 'ideal world' idea sits with the planned initiatives?

Probes:

- Which of your ideas do you think are likelier to happen? Which are likelier to succeed?

Thank them for their time.

Topic guide - Line manager depth interviews

Introduction: Explain that you are from Andrew Irving Associates, an independent market research agency, and that we are conducting a research study on behalf of the Cross-Government Health, Work and Well-being Delivery Unit looking at how

work could play a role in improving and maintaining health. The research is being carried out across Great Britain and we are looking to speak to a range of relevant audiences who will have important views on this subject including those with day-to-day responsibility for staff. This is why we have asked to talk to you today.

Explain that there are some key topic areas we would like to cover but that the nature of the discussion is completely informal and that their views are confidential. Reassure that there are no right or wrong answers – that we simply wish to explore their opinions on the issues and that these are important. Ask for permission to audio record the discussion – reassure that audio is used only as part of the research and all views expressed are anonymous/confidential.

Ask them to sign the consent form and answer any questions they have before starting the interview.

SECTION A: Introduction

Note: no more than five minutes should be spent on introduction discussion

1. What is you role in this organisation, what are your responsibilities (how many people are you working with/managing day-to-day)?

2. What does a typical day at work look like for you?

Probes:

- Working patterns/hours?
- What are your key responsibilities?
- What are the key day-to-day challenges you face in your job?
- Are the things you most enjoy about your job?

SECTION B: Organisation's approach to health and work issues

NOTE: this is for background and interpretative context – limit this discussion to no more than 10-15 mins max.

3. I would like to ask you about your views about 'health and well-being at work'.

Probes:

- What does this mean to you?
- Is this something that you/the organisation you work for talks about?
- Have you ever received information or training about this topic? What was this, who provided it?

4. What (if anything) does this organisation currently do in terms of health and well-being at work and why?

(NOTE: If only focus on health and safety – prompt for well-being examples – eg healthy eating plans, physical exercise, stress management, employee engagement and discussion groups, flexible working arrangements)

5. What do you do to help manage the health and well-being of your staff?

Probes:

- What effect have you seen as a result?
- Are there areas that you used to address but no longer need to – why?
- How involved are you?
- Who else do you involve?
- Is anything specific you do to prevent ill-health and poor well-being becoming a problem?
- To what extent do you discuss health and well-being issues with your staff – and at what stage (for example, are they showing early signs of distress at work, or are they already taking time off work)?
- Does your management of circumstances when an employee is off sick vary if this planned or unplanned; short or long term? How and why?
- How/when is responsibility is passed to others?
- What do you do when an employee comes back to work after being off sick? Explore whether use return to work action plans; make adaptations to ways of working – and if so what and in what circumstances.
- How/when responsibility is passed to others?
- Are there any responsibilities you feel you have for staff well-being that would be best placed elsewhere – why and where?
- Are there any conflicting messages you get about what to do? If so what are these (explore messages from CEO/messages from occupational health/staff welfare or messages from other organisations).

SECTION C: ‘What would you do if…’ Reaction to Possible ‘Health and Work’

Scenarios.

NOTE limit this discussion to no more than 15 mins.

For each vignette:

6. As a line manager, what would you do and why? When? How would you get involved? Who else would you involve?

Note for each stage in the scenario reveal – probes are:

- What more information do you need to know? Eg role in company, age, family circumstances, etc?
- What factors, either present in the above scenario or not, would influence your decision making?
- What would you do personally if you had any of the symptoms raised in the above scenario?

SECTION D: Suggestions for improving and maintaining a healthy workforce.

NOTE: Most important section of interview – recommend up to half an hour.

7. From your own perspective, what could be changed to really make a difference to improve health and well-being at work? (Ask them to effectively 'play God' and not be restricted by rules/regulation or current practices, but to consider what you would do if you started from scratch… that ideas can be small or large).

Probes:

- What is the goal/outcome you think this would achieve? Why would it make such a difference?
- How would this be achieved? What would need to happen and how?
- Who would be involved? What would be their responsibilities?
- What would you do?
- What would your idea of an 'ideal employer' do to maintain health in the workplace? Generate list of ideas about how a perfect employer would treat them/their team

SECTION E: Statements for change – 'Where we want to get to' stimulus

A few minutes – each on a separate show card (cards are numbered in order and you should prioritise accordingly).

8. Could you tell me what you think about what is said here?

Probes:

- What do you think?

- What are the problems with this statement from your perspective?
- Is this relevant to your organisation? Do you think it should be and why?
- What reservations do you have about any of the statements? Why?

9. Now you have seen all these statements do you have any other thoughts or ideas on what could be changed to really make a difference to health and well-being at wok?

Consider any ideas/solutions wearing different hats (i.e. thinking about this an employee's perspective, from a company owner perspective, greater interaction with GPs/other health professionals) how might this work?

SECTION F: Reactions (briefly) to current/planned initiatives

Spend a few minutes reviewing current/planned initiatives (show board of brief descriptions of initiatives relevant to them).

10. Which of your ideas do you think are likelier to help support these initiatives in changing attitudes to health and work, and why?

Probes:

- What do you like/dislike about the initiatives?
- Are there any aspects/elements included in the planned initiatives that you had not previously considered?

Thank them for their time.

Topic guide - Line Manager group interviews

Introduction: Explain that you are from Andrew Irving Associates, an independent market research agency, and that we are conducting a research study on behalf of the Cross-Government Health, Work and Well-being Delivery Unit looking at how work could play a role in improving and maintaining health. The research is being carried out across Great Britain and we are looking to speak to a range of relevant audiences who will have important views on this subject including those with day-to-day responsibility for staff, including health issues.

Explain that there are some key topic areas we would like to cover, but that the nature of the discussion is completely informal and that their views are confidential. Ask for permission to audio record the discussion – reassure that audio is used only as part of the research and all views expressed are anonymous/confidential.

Interviewer goes through rules of group discussion:

- There are no right or wrong answers – we simply wish to explore opinions on the issues
- Allow everyone to have their say, it's important that only person speaks at a time
- Please also be aware that what gets discussed in this room should not be discussed with anyone once we all leave.

Ask them to sign the consent form and answer any questions they have before starting the interview.

SECTION A: Introduction

Note: no more than 10 minutes should be spent on introduction discussion.

1. Individual introductions: first name, occupation, and role in this organisation

Probes:

- How many people are you working with/managing day-to-day?

2. Icebreaker: what does a typical day at work look like for you?

Probes:

- Working patterns/hours?
- What are your key responsibilities? What are the key day-to-day challenges you face in your job?
- Are the things you most enjoy about your job?

SECTION B: Organisation's approach to health and work issues

NOTE this is for background and interpretative context - limit this discussion to no more than 15 mins max.

3. We are going to be talking about the topic of 'health and well-being at work' today. From your perspective, what kinds of issues do you believe this topic might cover?

Generate list of issues on flip chart.

Probes:

- Who is more familiar with this terminology (both personally and something that their company/organisation talks about)?
- Is your opinion influenced by specific training or knowledge you have received? From where?

4. What (if anything) do your organisations currently do in terms of health and well-being at work and why? Generate list of issues on flip chart.

Probes:

- Why is this important (or not)?
- As line managers, how clear are your guidelines/responsibilities in dealing with this issue? Conflicting messages? Levels of responsibility/involvement clear?
- What effect have you seen as a result? What has been more/less helpful?
- What is done to prevent ill-health and poor well-being becoming a problem? Generate list of answers/thoughts/ideas.
- (NOTE: If only focus on health and safety - prompt for well-being examples – eg healthy eating plans, physical exercise, stress management, employee engagement and discussion groups, flexible working arrangements).
- What is done by your organisations when people are off sick, to get them back into work?
- Are there policies and procedures if an employee goes off work sick? If so, what? If not, why not?
- How are they involved (if at all)?
- What happens when an employee comes back to work after being off sick? Explore whether use return to work action plans; make adaptations to ways of working – and if so what and in what circumstances?

SECTION C: 'What would you do if…' Reaction to Possible 'Health and Work'

Scenarios.

NOTE limit this discussion to no more than 10 mins.

For each vignette:

6. As a line manager, what would you do and why? When? How would you get involved? Who else would you involve? Generate list of ideas.

Note for each stage in the scenario reveal – probes are:

- What more information do you need to know? Eg role in company, age, family circumstances, etc?
- What factors, either present in the above scenario or not, would influence your decision making?
- What would you do personally if you had any of the symptoms raised in the above scenario?

SECTION D: Suggestions for improving and maintaining a healthy workforce.

NOTE: Most important section of interview – recommend up to 40 minutes. Possibly use key facts to make point about enormity of the issue.

8. From your perspectives, what could be changed to really make a difference to improve health and well-being at work?

Probes:

- What do you want?
- What do you want to be different from now?
- How could this happen?

Ask them to effectively 'play God' and not be restricted by rules/regulation or current practices, but to consider what you would do if you started from scratch… that ideas can be small or large. Generate list of issues on flip chart.

Now we have these ideas, can we discuss as a group for each idea:

- What is the goal/outcome you think this would achieve? Why would it make such a difference?
- How would this be achieved? What would need to happen and how?
- Who would be involved? What would be their responsibilities?
- What would you do?
- What would your idea of an 'ideal employer' do to maintain health in the workplace? Generate list of ideas about how a perfect employer would treat them/their team.

SECTION E: Statements for change – 'Where we want to get to' stimulus

Approx 10 minutes – each on a separate show card (cards are numbered in order and you should prioritise accordingly).

9. Could you tell me what you think about what is said here?

Probes:

- What do they think?
- What are key positives/problems with this statement from your perspective?
- Perceived relevance/importance to their organisations? Why?

Generate list of issues on flip chart.

10. Now you have seen all these statement do you have any other thoughts or ideas on what could be changed to really make a difference to health and well-being at wok? Consider any ideas/solutions wearing different hats (i.e. thinking about this from an employee's perspective, from a company owner perspective, greater interaction with GPs/other health professionals) how might this work? Place any other 'ideal world' ideas that come out of the group after they have seen statements for change up on flipchart.

SECTION F: Reactions (briefly) to current/planned initiatives

Spend five minutes reviewing current/planned initiatives (show board of brief descriptions of initiatives relevant to them).

11. What are the more/less appealing elements/ideas in the initiatives?

Probes:

- What do you like/dislike about the initiatives?
- Are there any aspects/elements included in the planned initiatives that you had not previously considered?

12. How do you think your 'ideal world' idea sits with the planned initiatives?

Probes:

- Which of your ideas do you think are likelier to happen? Which are likelier to succeed?

Thank them for their time.

Topic guide - Practice Manager depth interviews

Introduction: Explain that you are from Andrew Irving Associates, an independent market research agency, and that we are conducting a research study on behalf of the Cross-Government Health, Work and Well-being Delivery Unit looking at attitudes and behaviours towards health, work and well-being. The research is being carried out across Great Britain and we are looking to speak to a range of people who will have important views on this subject including those working in surgeries.

Explain that the interview will last up to one hour. Also explain that there are some key topic areas we would like to cover, but that the nature of the discussion is completely informal and that their views are confidential. Reassure that there are no right or wrong answers – that we simply wish to gather the opinion of a cross section of relevant parties about their perceptions/feelings on the issues raised. Explain that,

with their permission we would like to audio record the discussion – which is standard practice in research – in case we need to refer back to data; but also reassure that audio is used only as part of the research and all views expressed are anonymous/confidential. Ask them to sign the consent form and answer any questions they have before starting the interview.

SECTION A: Introduction

Note: no more than five minutes should be spent on introduction discussion.

1. Can you tell me a little bit about your responsibilities as a Practice Manager in this surgery – and what you do on a day-today basis?

Probes:

- How long have you been working here?
- What are the key day-to-day challenges you face in your job?
- What are the things you most enjoy about your job?

2. Can you tell me a little about the local area this surgery is located in?

Probes:

- Prompt poverty, housing conditions, unemployment levels, drug/alcohol issues

3. And can you describe the types of patients that this surgery deals with on a day-to-day basis?

Probes:

- Prompts where necessary: Elderly, working-age, ethnic minorities, children

4. And can you briefly tell me about any Allied Health Professionals that work at this surgery?

Probes:

- How many AHPs are there at this surgery?
- What are their roles?
- What kind of interaction do you have with AHP staff at this surgery?
- When?
- How often? (Ad-hoc where necessary/scheduled weekly team meetings)

SECTION B: Approach to health and work issues

NOTE this is for background and interpretative context - limit this discussion to no more than 10-15 mins max.

5. I would like to ask you about your views about ‘health and well-being at work’.

Probes:

- What does this mean to you?
- Is this something that you/the surgery you work for talks about?
- Have you ever received information or training about this topic? What was this, who provided it?

6. What do you think are the main issues in the management of the health and well-being of staff in this surgery?

Probes:

- Are there competing ‘priority’ issues that are more/less problematic within this surgery?

7. What (if anything) do you do to help manage the health and well-being of your staff?

Probes:

- What effect have you seen as a result?
- How involved are you?
- Who else do you involve?
- Is anything specific you do to prevent ill-health and poor well-being becoming a problem?
- To what extent do you discuss health and well-being issues with your staff – and at what stage (for example are they showing early signs of distress at work, or are they already taking time off work)?
- Are there any responsibilities you feel you have for staff well-being that would be best placed elsewhere – why and where?
- Are there any conflicting messages you get about what to do? If so what are these?

8. As part of your role, do you engage with patients in the surgery?

Probes:

- Why/Why not?
- How much engagement do you have?
- What sort of engagement do you have with patients?
- Are you required to deal with complaints? How do you find this?

SECTION C: 'What would you do if…' Reaction to Possible 'Health and Work'

Scenarios.

NOTE limit this discussion to no more than 10 mins. Rotate order of showing vignettes.

9. Scenario: What would you do if you were feeling low, overstretched or stressed? (Note: It does not matter where this stress has come from)

Probes:

- What would tend to happen?
- What would you do for yourself?
- What would you differently at home or at work when you are feeling this way (if anything)?
- Who might you turn to/involve? Why/When?

10. Scenario: What would you do if you had a colleague who was feeling upset at work?

Probes:

- What would tend to happen?
- Who might you turn to/involve? Why/When?

SECTION D: Suggestions for improving and maintaining a healthy workforce.

NOTE: Most important section of interview – recommend up to half an hour.

11. From your own perspective, what could be changed to really make a difference to improve the public's health and well-being? (Ask them to effectively 'play God' and not be restricted by rules/regulation or current practices, but to consider what you would do if you started from scratch… that ideas can be small or large).

Probes:

- What is the goal/outcome you think this would achieve? Why would it make such a difference?
- How would this be achieved? What would need to happen and how?
- Who would be involved? What would be their responsibilities?
- What would you do?

12. From your own perspective, what could be changed to really make a difference to improve your own well-being at work? (Ask them to effectively 'play God' and not be

restricted by rules/regulation or current practices, but to consider what you would do if you started from scratch… that ideas can be small or large).

Probes:

- What is the goal/outcome you think this would achieve? Why would it make such a difference?
- How would this be achieved? What would need to happen and how?
- Who would be involved? What would be their responsibilities?
- What would you do?

SECTION E: Statements for change – ‘Where we want to get to’ stimulus

A few minutes – each on a separate show card (cards are numbered in order and you should prioritise accordingly).

13. Could you tell me what you think about what is said here?

Probes:

- What do you think?
- What are the problems with this statement from your perspective?
- Is this relevant to your surgery? Do you think it should be and why?
- What reservations do you have about any of the statements? Why?

14. Now you have seen all these statement do you have any other thoughts or ideas on what could be changed to really make a difference to health and well-being at wok?

Consider any ideas/solutions wearing different hats (i.e. thinking about this from an employee’s perspective, an employers perspective, greater interaction with GPs/other health professionals) how might this work?

SECTION F: Reactions (briefly) to current/planned initiatives

Spend a few minutes reviewing current/planned initiatives (show board of brief descriptions of initiatives relevant to them).

15. Which of your ideas do you think are likelier to help support these initiatives in changing attitudes to health and work, and why?

Probes:

- What do you like/dislike about the initiatives?

- Are there any aspects/elements included in the planned initiatives that you had not previously considered?

Thank them for their time.

Topic guide - Working, not sick depth interviews

Introduction: Explain that you are from Andrew Irving Associates, an independent market research agency, and that we are conducting a research study on behalf of the Cross-Government Health, Work and Well-being Delivery Unit looking at how work could play a role in improving and maintaining health. The research is being carried out across Great Britain and we are looking to speak to a range of people who will have important views on this subject including those currently working. This is why we have asked you to come and discuss the issues with us today.

Explain that there are some key topic areas we would like to cover but that the nature of the discussion is completely informal and that their views are confidential. Reassure that there are no right or wrong answers – that we simply wish to explore their opinions on the issues and that these are important. Ask for permission to audio record the discussion – reassure that audio is used only as part of the research and all views expressed are anonymous/confidential. Ask them to sign the consent form and answer any questions they have before starting the interview.

SECTION A: Introduction

Note: no more than five minutes should be spent on introduction discussion.

1. Introductions: first name, current circumstances re: family (and children), hobbies, occupation (and role in this organisation).

2. What does a typical day at work look like for you?

Probes:

- Commuting, hours at work/work patterns?
- What are your key work responsibilities? How many people do you work with day to day?

SECTION B: Understanding of health and work issues

NOTE this is for background and interpretative context – limit this discussion to no more than 10 mins max.

3. We are going to be talking about the topic of ‘health and well-being at work’ today. From your perspective, what kinds of issues do you believe this topic might cover?

Probes:

- What does it mean to you?
- Is this something that you/the organisation you work for talks about?
- Have you ever received information or training about this topic? What was this, who provided it?

4. How do you currently view your own health?

Probe:

- Does your work affect you health? If so, how?

5. What (if anything) does your organisation currently do in terms of employees’ health and well-being at work and why?

Probes:

- If not mentioned, what about healthy eating plans, physical exercise, stress management, employee engagement and discussion groups, flexible working arrangements, etc.
- Is this important to you (or not)? Why?
- What do you find helpful/not helpful? Why?
- What effect have you seen as a result of changes?

6. Thinking about the last couple of years, what are your personal experiences of sickness absence?

Probes:

- How often, for how long were you off sick
- How/when did your company get involved, if at all?
- What support/guidance were you offered?
- What could have helped you get back to work more quickly? Did anything stop you returning to work more quickly?
- Did you ever take sickness absence when you were not unwell but needed a day off work? Why?

SECTION C: ‘What would you do if…’ Reaction to hypo - scenario:

7. Scenario: What would you do if you were feeling low, overstretched or stressed? (Note: It does not matter where this stress has come from).

Probes:

- What would tend to happen?
- What would you do for yourself?
- What would you differently at home or at work when you are feeling this way (if anything)?
- Who might you turn to/involve? Why/When?

8. Scenario: What would you do if you had a colleague who was feeling upset at work?

Probes:

- What would tend to happen?
- Who might you turn to/involve? Why/When?

SECTION D: Suggestions for improving and maintaining a healthy workforce.

NOTE: Most important section of interview – recommend up to 30 minutes.

9. From your perspectives, what could be changed to really make a difference to improve health and well-being at your workplace? (Ask them to effectively 'play God' and not be restricted by rules/regulation or current practices, but to consider what you would do if you started from scratch… that ideas can be small or large).

Probes:

- What is the goal/outcome you think this would achieve? Why would it make such a difference?
- How would this be achieved? What would need to happen and how?
- Who would be involved? What would be their responsibilities?
- What would you do?

10. What would your idea of an 'ideal employer' do to maintain well-being at your work? Generate list of ideas about how a perfect employer would treat them.

Probes:

- How would this be achieved? What would need to happen and how?
- Who would be involved? What would be their responsibilities?
- What would you do?

SECTION E: Statements for change – 'Where we want to get to' stimulus

Approx five minutes – each on a separate show card (cards are numbered in order and you should prioritise accordingly).

9. Could you tell me what you think about what is said here?

Probes:

- What do you think?
- What are key positives/issues with this statement from your perspective?
- What reservations do you have about any of these statements? Why?

10. Now you have seen all these statement do you have any other thoughts or ideas on what could be changed to really make a difference to health and well-being at your workplace? Consider any ideas/solutions wearing different hats (i.e. thinking about this from an employer's perspective, greater interaction with GPs/other health professionals) how might this work?

SECTION F: Reactions (briefly) to current/planned initiatives

Spend a couple of minutes reviewing current/planned initiatives (show board of brief descriptions of initiatives relevant to them)

11. Which of your ideas do you think are likelier to help support these initiatives in changing attitudes to health and work?

Probes:

- What do you like/dislike about the initiatives? Why?
- Which ones do you think may not be helpful and why?

Thank them for their time.

Topic guide - Working, not sick group interviews

Introduction: Explain that you are from Andrew Irving Associates, an independent market research agency, and that we are conducting a research study on behalf of the Cross-Government Health, Work and Well-being Delivery Unit looking at how work could play a role in improving and maintaining health. The research is being carried out across Great Britain and we are looking to speak to a range of different people. This is why we have asked you to come and discuss the issues with us today.

Explain that there are some key topic areas we would like to cover but that the nature of the discussion is completely informal and that their views are confidential. Ask for

permission to audio record the discussion – reassure that audio is used only as part of the research and all views expressed are anonymous/confidential.

Interviewer goes through rules of group discussion:

- There are no right or wrong answers – we simply wish to explore opinions on the issues
- Allow everyone to have their say, it's important that only person speaks at a time
- Please also be aware that what gets discussed in this room should not be discussed with anyone once we all leave.

Ask them to sign the consent form and answer any questions they have before starting the interview.

SECTION A: Introduction

Note: no more than 10 minutes in total should be spent on introduction discussion

1. Individual introductions: first name, briefly describe current circumstances re: hobbies, occupation (and role in this organisation)

No probe.

2. Icebreaker (to all): What does a typical day at work look like for you?

Probes:

- Commuting, hours at work/work patterns
- What are your key work responsibilities? How many people do you work with day to day?

SECTION B: Understanding of health and work issues

NOTE this is for background and interpretative context – limit this discussion to no more than 15 mins max.

3. We are going to be talking about the topic of 'health and well-being at work' today; From your perspective, what kinds of issues do you believe this topic might cover? Generate list of issues on flip chart - do not probe.

4. What (if anything) do your organisations currently do in terms of supporting your health and well-being at work and why? Generate list of issues on flip chart.

Probes:

- Is this important (or not)? Why?
- Which have you found helpful, if anything, and why/why not?

- (If only focus on health and safety), what about healthy eating plans, physical exercise, stress management, employee engagement and discussion groups, flexible working arrangements, etc?
- What are your personal experiences of sickness absence? What support and guidance was offered to them. What did they find useful and what would they have found useful?
- What happens when an employee comes back to work after being off sick? Are they helped back through gradual return to work? Any adaptations to ways of working – and if so what and in what circumstances?

SECTION C: 'What would you do if…' Reaction to hypo - scenario:

5. Scenario: What would you do if you were feeling overstretched or stressed? (Note: It does not matter where this stress has come from). Generate list of issues on flip chart.

Probes:

- What would tend to happen?
- What would you do for yourself?
- What would you differently at home or at work when you are feeling this way (if anything)?
- Who might you turn to/involve? Why/When?

Then as a group: What ideally would you like to happen when you are feeling this way?

SECTION D: Suggestions for improving and maintaining a healthy workforce.

NOTE: Most important section of interview – recommend up to 40 minutes. Possibly use key facts to make point about the enormity of the issue.

6. From your perspectives, what could be changed to really make a difference to improve health and well-being at work?

Probes:

- What do you want?
- What do you want to be different from now?
- How could this happen?

Ask them to effectively 'play God' and not be restricted by rules/regulation or current practices, but to consider what you would do if you started from scratch… that ideas can be small or large. Generate list of issues on flip chart.

Now we have all these ideas can we discuss as a group for each idea:

- What is the goal/outcome you think this would achieve? Why would it make such a difference?
- How would this be achieved? What would need to happen and how?
- Who would be involved? What would be their responsibilities?
- What would you do?
- What would your idea of an 'ideal employer' do to maintain health in the workplace? Generate list of ideas about how a perfect employer would treat them.

SECTION E: Statements for change – 'Where we want to get to' stimulus

Approx 10 minutes – each on a separate show card (cards are numbered in order and you should prioritise accordingly).

7. Could you tell me what you think about what is said here?

Probes:

- What do they think?
- What are key positives/problems with this statement from your perspective?
- What reservations do you have about any of these statements? Why?

Generate list of issues on flip chart.

8. Now you have seen all these statement do you have any other thoughts or ideas on what could be changed to really make a difference to health and well-being at work?

Consider any ideas/solutions wearing different hats (i.e. thinking about this an employer's perspective, greater interaction with GPs/other health professionals) how might this work?

Place any other 'ideal world' ideas that come out of the group after they have seen statements for change up on flipchart.

SECTION F: Reactions (briefly) to current/planned initiatives

Spend five minutes reviewing current/planned initiatives (show board of brief descriptions of initiatives relevant to them).

9. What are the more/less appealing elements/ideas in the initiatives?

Probe:

- What do you like/dislike about the initiatives?

10. How do you think the groups ‘ideal world’ ideas sits with the planned initiatives? Use all the ideas that have been placed up on the board from previous group discussion to discuss.

Probes:

- Which of your ideas do you think are likelier to help support these initiatives in changing attitudes to health and work, and why?

Thank them for their time.

Topic guide - Working, on sick leave group discussions

Introduction: Explain that you are from Andrew Irving Associates, an independent market research agency, and that we are conducting a research study on behalf of the Cross-Government Health, Work and Well-being Delivery Unit looking at how work could play a role in improving and maintaining health. The research is being carried out across Great Britain and we are looking to speak to a range of people who will have important views on this subject. This is why we have asked you to come and discuss the issues with us today.

Explain that there are some key topic areas we would like to cover but that the nature of the discussion is completely informal and that their views are confidential. Ask for permission to audio record the discussion – reassure that audio is used only as part of the research and all views expressed are anonymous/confidential.

(Interviewer goes through rules of group discussion)

- There are no right or wrong answers – we simply wish to explore opinions on the issues
- Allow everyone to have their say, its important that only one person speaks at a time
- Please be aware that what gets discussed in this room should not be discussed with anyone once we all leave.

Ask them to sign the consent form and answer any questions they have before starting the discussion.

SECTION A: Introduction

Note: no more than five minutes should be spent on introduction discussion

1. Individual introductions: first name, current circumstances re: family (and children), hobbies, occupation (and role in this organisation).

2. Generally, what a typical day is like for you at the moment, and what sort of things you do?

3. And can you tell me about when you are at work – what do you do in a typical day at work?

SECTION B: Understanding of health and work issues

NOTE this is for context – limit this discussion to no more than 20 mins max.

4. We are going to be talking about the topic of 'health and well-being at work' today. From your perspective, what kinds of issues do you believe this topic might cover? Generate list of ideas on flip charts.

5. What sorts of things have you been offered to help you get back to work?

Probes:

- Is there anything that your work has done to help?
- What have you found helpful/not helpful and why?
- Is there anything that could help you get back into work more quickly?
- Is there anything in particular that stops you from wanting to return to work?

SECTION C: Suggestions for improving and maintaining a healthy workforce.

NOTE: Most important section of interview – recommend up to 40 minutes.

6. From your perspectives, what could be changed to really make a difference to improve your health and well-being?

Probes:

- What do you want?
- What do you want to be different from now?
- How could this happen?

Ask them to effectively 'play God' and not be restricted by rules/regulation or current practices, but to consider what you would do if you started from scratch… that ideas can be small or large. Generate list of issues on flip chart.

7. Now we have all these ideas can we discuss as a group for each idea:

- What is the goal/outcome you think this would achieve? Why would it make such a difference?
- How would this be achieved? What would need to happen and how?
- Who would be involved? What would be their responsibilities?
- What would you do?

Generate list of issues on flip chart.

8. What would an ideal employer do if faced with the situations you have been in to help you back into work? Again, list ideas/thoughts on what is wanted.

Probes:

- What do you want?
- What do you want to be different from now?
- How could this happen?

9. Now we have all these ideas can we discuss as a group for each idea:

- What is the goal/outcome you think this would achieve? Why would it make such a difference?
- How would this be achieved? What would need to happen and how?
- Who would be involved? What would be their responsibilities?
- What would you do?

Generate list of issues on flip chart.

10. What would your idea of an ‘ideal employer’ do to help maintain well-being at work?

Generate list of ideas about how a perfect employer would treat them.

Probes:

- What do you want?
- What do you want to be different from now?
- How could this happen?

11. Now we have all these ideas can we discuss as a group for each idea:

- What is the goal/outcome you think this would achieve? Why would it make such a difference?
- How would this be achieved? What would need to happen and how?
- Who would be involved? What would be their responsibilities?
- What would you do?

Generate list of issues on flip chart.

SECTION E: Statements for change – ‘Where we want to get to’ stimulus

Approx 10 minutes - each on a separate show card (cards are numbered in order and you should prioritise accordingly).

12. Could you tell me what you think about what is said here?

Probes:

- What do they think?
- What are key positives/issues with this statement from your perspective? Why?

13. Now you have seen all these statement do you have any other thoughts or ideas on what could be changed to really make a difference to health and well-being? Consider any ideas/solutions wearing different hats (i.e. thinking about this from an employer’s perspective, greater interaction with GPs/other health professionals) how might this work? Generate list of issues on flip chart.

SECTION F: Reactions (briefly) to current/planned initiatives

Spend five minutes reviewing current/planned initiatives (show board of brief descriptions of initiatives relevant to them).

14. Which of your ideas do you think are likelier to help support these initiatives in changing attitudes to health and work?

Probes:

- What do you like/dislike about the initiatives? Why?
- Which ones do you think may not be helpful and why?

Thank them for their time.