DWP Department for Work and Pensions

Evaluation of the Fit for Work Service pilots: first year report

By Jim Hillage with others

Following Dame Carol Black's 2008 review[1] of the health of Britain's working age population, a new *Fit for Work Service* (FFWS) was proposed, to offer support for people in the early stages of sickness absence, particularly for employees working in small and medium-sized enterprises (SMEs). It was envisaged that case-managed and multidisciplinary services would provide personalised help to address both social concerns, such as financial and housing issues, and clinical needs, and as a consequence would keep people in work. Between April and June 2010, Fit for Work Service (FFWS) pilots were launched in 11 areas throughout Great Britain with the intention of testing different approaches to providing the service, and getting people back to work as quickly as possible. From April 2011, seven of the pilots were funded for up to a further two years.

In the first year, the pilots provided a service to people in work with a health condition, including workers on a period of sickness absence from their job (sickness absentees), and those who were attending work but at risk of sickness absence (presentees). In the second year, the seven remaining, pilots were asked to increase their efforts to recruit employees on a period of sickness absence from work, particularly those working in SMEs, in order to test the original policy proposition.

The Department for Work and Pensions (DWP), with the Department of Health (DH), commissioned a consortium involving the Institute for Employment Studies (IES), the Fit for Work Research Group at Liverpool University, the Social Policy Research Unit (SPRU) at the University of York, the National Institute of Economic and Social Research (NIESR), and GfK NOP, to evaluate the pilots. This report presents the findings from the first year of the evaluation and is based on:

- management information (MI) collected in each pilot;
- over 200 interviews with stakeholders, providers and others in each pilot area;
- the first wave of a two-wave telephone survey of over 300 FFWS clients;
- interviews with a panel of 64 FFWS clients drawn from four pilot areas;
- interviews with 30 General Practitioners (GPs) across all pilots.

Pilot take-up

By the end of March 2011, 6,726 people had taken up the service offered by the pilots, which is about 40 per cent of the number that the pilots expected when they formed their original plans. The original expectations may have been over-optimistic and pilots found it difficult to engage with GPs and employers on a large scale.

Nearly all FFWS clients were employed and two-thirds were 'presentees' rather than absentees who were the original policy focus. They broadly reflected the workforce as a whole in terms of age, gender, occupation and size of workplace. Most clients had either a mental health condition or a musculoskeletal disorder and many had both, for example many of those with a musculoskeletal disorder, such as a bad back, also had a common mental health condition such as stress, depression or anxiety.

[1] Black, C. (2008). *Working for a healthier tomorrow: Dame Carol Black's review of the health of Britain's working age population*. London: TSO.

Clients' health issues could be made more complex by non-health issues which deterred them from staying in or returning to work and the wide-ranging nature of client needs supports the original proposal for a biopsychosocial case-managed approach to the service. Over half of FFWS clients had work-related concerns, such as lack of support at work, harassment and bullying, and a fear that they could not cope with work demands. Clients also reported non-work problems such as poor housing, difficult domestic relationships or financial difficulties. The combination of these factors tended to determine the level of complexity of an individual case and affect the speed at which sickness absentees returned to work.

Engagement and referrals

In the first year of the programme, the most common way of accessing the FFWS was by self-referral or GP referral. Most pilots spent considerable efforts trying to secure referrals from GPs but found it much more difficult than expected to:

- gain access to GPs in the first place to explain about the service;
- gain interest from GPs when access was granted;
- ensure GPs had a full understanding of the service;
- sustain interest among GPs and ensure the FFWS remained a prominent option.

A number of ways of engaging with GPs appeared to have been more effective than others. These included:

- adopting a systematic approach, including segmenting the GP population to better target engagement efforts;
- initially engaging with practice managers but trying to meet GPs face-to-face;
- establishing credibility, for example, by working with advocates and champions;
- being persistent and maintaining visibility;
- providing additional value and ensuring GPs received client feedback.

Some pilots specifically aimed to engage with employers, particularly at the outset, using a range of awareness-raising and marketing activities. As with GPs, direct approaches, including telemarketing and targeting specific employers, appeared to work best, but most had difficulties securing interest from smaller employers. In addition, almost one in three FFWS clients had contacted the service directly. However, this appears to be largely as a result of marketing to or through employers and health professionals rather than general public marketing approaches which did little to generate referrals.

The client journey through the service

An individual's first contact with the service generally involved a **screening** process to determine their eligibility and a brief discussion of their circumstances and what was limiting their fitness for work or well-being at work. This process was normally conducted on the telephone.

If eligible, clients were then assigned a case manager who conducted a wide-ranging biopsychosocial **assessment** of the client's health and non-health-related conditions and circumstances. In four, generally larger, pilots this was done on the telephone and in the others it was carried out face-to-face. The main features of an effective assessment appeared to be:

- adopting an holistic approach, covering all relevant aspects of the client's health, work and domestic circumstances;
- ensuring the discussion was client-led but with some kind of framework to prompt discussion about all the key issues;
- case managers who had good listening skills and encouraged clients to open up.

The outcome of the initial assessment was generally a **'return-to-work plan'**, identifying the issues facing the client, setting goals and identifying the support that the service would provide or access. As with the assessment, clients expressed a high level of satisfaction with their action plan.

Case management was a key element of the FFWS. In addition to assessment and goal setting, case managers supported their clients to meet their goals by:

- helping them to monitor their progress;
- providing ongoing support and encouragement;
- providing direct forms of support where appropriate; and
- liaising with all others involved in implementing their client's back-to-work plan.

As part of the role, case managers worked with clients to boost their motivation and confidence and provide general advice and guidance about how to meet their goals. In nearly all pilots they offered support with the client's employment situation, helping them to resolve workplace problems or negotiate a return to work. A critical difference between the pilots appeared to be between those that could offer some form of direct clinical support through case managers and those where support was offered from the wider pilot partnership or beyond.

Where clients required services beyond those provided by the case manager, their role involved accessing **additional support**. These could be provided by partners or by external providers in the health service or wider community.

All pilots offered access to clinical services if required and in addition had made connections with a range of other non-clinical service providers, from anger management classes to advice about welfare benefits, that could offer support to their clients if they needed it.

Finally **discharge** arrangements generally involved clients leaving the service either by mutual agreement when they had met their initial goals or there was nothing more that the service could do for them.

The evaluation found three broad models in operation in the first year of the pilots, based on the key distinctions between the pilots in terms of the form and nature of the initial assessment, the support provided by case managers, and the extent and speed at which clients were referred to additional services:

- **Guidance and Gateway** –the 'standard' form of the service. Case managers assessed their clients and provided them with a range of generally non-clinical support. Access was offered to additional services but clients may have had to refer themselves and had no faster access than if they were not with the service.
- **Guidance Plus and Gateway Plus** – an enhanced model. Case managers offered a wider range of support to their clients, including light-touch clinical support, or a fast-track referral to some clinical services, such as physiotherapy.
- **Guidance Plus and Fast Access** – under this model clients generally received an enhanced support from their case manager and fast-track referrals to either physical or psychological support plus a range of other services.

Outcomes

Respondents to the FFWS client survey were generally positive about their overall experience of the service. The vast majority of respondents agreed that the service had been responsive to their needs, well co-ordinated with other health and employment services, personalised and provided relevant referrals or signposting.

Some 62 per cent of the clients who were supported by the pilots in the first year had been discharged by the end of March 2011 and the remainder were either still with the service or were not yet recorded as having left. Ten per cent of clients who were initially assessed subsequently failed to engage.

The average length of time people stayed with the service was around four months, although some sickness absentees may have returned to work before they were formally discharged. Three-quarters of absentees who joined one of the pilots in the first year and who were discharged before the end of March 2011 were back at work by the time they left. Some 18 per cent were still off work, on sick leave, and eight per cent were unemployed.

Most respondents to the client survey said that they would not have received the support they had without the FFWS. Qualitative evidence from clients indicates that the FFWS provided significant support to return to work. In some cases the return would not have happened at all, in others it was made quicker, easier or more sustained by the intervention of the FFWS. In addition, GPs who used the FFWS, reported several benefits including the saving of GP resources.

The full report of these research findings is published by the Department for Work and Pensions (ISBN 978 1 908523 53 2. Research Report 792. March 2012).

You can download the full report free from: http://research.dwp.gov.uk/asd/asd5/rrs-index.asp

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