

Research report

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

by Jim Hillage with others

Department for Work and Pensions

Research Report No 792

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Jim Hillage with others

A report of research carried out by the Institute for Employment Studies, the Fit for Work Research Group at Liverpool University, the Social Policy Research Unit at the University of York, the National Institute of Economic and Social Research and GfK NOP on behalf of the Department for Work and Pensions

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First published 2012.

ISBN 978 1 908523 53 2

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

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Acknowledgements

The Evaluation Team are extremely grateful for all the help they have received from those engaged in delivering the Fit for Work Service pilots. We are also grateful for the advice and guidance we have had from Bola Akinwale, the project manager at the Department for Work and Pensions (DWP), and her DWP and Department of Health colleagues.

The Authors

This report is the work of a large number of people across the evaluation team who conducted the fieldwork, collected the management information, helped analyse the results and wrote the pilot summaries. These include: Heather Rolfe and Helen Bewley at NIESR; Mark Gabbay, Paula Byrne, Suzanne Edwards, Chris Shiels, Joanna Thomas, Ryan Woolridge and Anne Rannard at the University of Liverpool; Annie Irvine, Jacqueline Davidson, Kath Weston and Roy Sainsbury at SPRU; Richard Glendinning, Chris Holmes and Anna Silk at GfK NOP; and Gill Brown, Sara Dewson, Dan Lucy, Rose Martin, Claire Tyers, Helen Stevens and Sally Wilson at IES. However, any errors or omissions in this report are the responsibility of the primary author: Jim Hillage.

Abbreviations

CAB	Citizens Advice Bureau
CBT	Cognitive behavioural therapy
CMP	Condition Management Programme
COPM	Canadian Occupational Performance Measure
EQ-5D	A standardised instrument for use as a measure of health outcome
ESA	Employment and Support Allowance
FFWS	Fit for Work Service
FTE	Full-time equivalent
GP	General Practitioner
IAPT	Improving Access to Psychological Therapies
IES	Institute for Employment Studies
IS	Income Support
JSA	Jobseeker's Allowance
MI	Management information
MSD	Musculoskeletal disorder
MYMOP	Measure Yourself Medical Outcome Profile
NIESR	National Institute for Economic and Social Research
OH	Occupational health
OT	Occupational therapy
PCT	Primary Care Trust
SMEs	Small and Medium-sized Enterprises
SPRU	Social Policy Research Unit (at the University of York)

Main messages

- In March 2010, 11 pilot Fit for Work Services (FFWS) were established to provide personalised, case-managed support for workers in the early stages of sickness absence or ill-health in order to expedite return to work and support job retention.
- Over the first year of the programme, most of the pilots successfully established a wide-ranging service using a biopsychosocial approach. Though service models varied, all services provided clinical and non-clinical support to help workers experiencing a period of ill-health to keep attending work or to resume work after a period of absence. The services were well-liked by clients and stakeholders and appeared to be a meeting genuine need for this type of service.
- Both the volume and profile of clients were not in line with expectations. Take-up was significantly lower than expected by local partners and the 6,700 clients helped by services in the first year were much more likely to be people struggling at work with a health condition rather than the primary target group of people on a period of sickness absence from work. All services had difficulties securing the volume of referrals they had expected from GPs and small and medium-sized employers and had little success in pursuing general marketing exercises to reach clients in other ways.
- Most clients had multiple needs. In addition to health conditions, most clients had other problems or concerns, which together presented significant risks to staying in work. Particularly complex cases involved combinations of multiple health conditions, personal difficulties and problems with their employer. The wide-ranging nature of clients' needs provides support for the original proposal to use a biopsychosocial case-managed approach to the service.
- In line with the original policy proposal, each pilot had its own way of operating. Key distinctions were between: 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.
- At this stage, evidence on the impact of the pilots in helping sickness absentees back to sustained work is largely based on the perceptions of service providers and individual clients. There is some qualitative evidence that most clients would not have received the interventions they had without the support of the FFWS and that the service helped people get back to work more quickly or more easily than they would otherwise have done.
- The evidence from service providers and clients suggests that a successful approach to helping sickness absentees back to work includes:
 - quick access to an holistic initial assessment;
 - ongoing case management to identify latent concerns (often non-medical) and maintain momentum towards a return to work goal;
 - fast access to physiotherapy or psychotherapy if required;
 - facilitating better communication between employee and employer and providing advice for return to work options; and
 - advice to improve and manage longer-term health conditions.

Summary

Introduction

Following Dame Carol Black's 2008 review¹ 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 a 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, 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. Pilots were formed by partnerships of health, employment and local community organisations, and offered biopsychosocial assessments of need and case-managed support to aid a quick return to work. From April 2011, seven of the pilots were funded for up to a further two years.

The pilots

In the first year, the pilots covered 11 diverse areas of Great Britain, from the area around Rhyl in North Wales to the whole of Scotland. They 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). Clients were working in a range of organisation types, both small and large. 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 first year evaluation report

In September 2010, 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 in aggregate form across a number of core indicators;
- over 200 interviews with stakeholders, providers and others involved in the delivery of services in each pilot;
- 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 GPs across all pilots including those who had referred patients to the FFWS and those who had not.

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.

The report primarily focuses on the first year of operation across all 11 pilots but, where relevant, identifies the main changes that have occurred in the first few months of the second year.

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 take-up of the pilots varied, and while some attracted numbers close to their original plans, most fell well short. Two of the smaller pilots had a significantly higher penetration rate (defined as number of cases divided by the employed population) than the other pilots.

The main reasons for the lower than expected take-up were:

- the size of the core client population of long-term sickness absentees may have been overestimated;
- difficulties in generating the expected level of referrals from General Practitioners (GPs) and employers.

Client profile

In the first year, nearly all FFWS clients were employed and two-thirds were 'presentees' rather than absentees who were the original policy focus. Among the absentees fewer than 30 per cent had been off work for between four and 12 weeks – the prime target group.

The pilots recruited presentees for three main reasons:

- they were easier to reach;
- they had problems that could be helped;
- the pilots believed they were providing an early intervention that could prevent subsequent absence.

FFWS clients broadly reflected the workforce as a whole in terms of age, gender and occupation and size of workplace. Most clients of the Scottish pilot worked in SMEs, while most clients from the other pilots in England and Wales worked in large organisations.

Most clients had either a mental health condition or a musculoskeletal disorder. In the two pilots in Scotland, three-quarters had a musculoskeletal condition. In most of the other pilots, mental health conditions were the most commonly reported type of health condition. Most clients had more than one health condition, 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.

In addition, health issues could be made more complex by non-health issues which deterred employees from staying in or returning to work. 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. Most thought their health condition had been made worse by work.

Clients, therefore, varied in the extent to which:

- they had single or multiple health conditions or non-health problems;
- their conditions were apparent on initial assessment or were latent and only emerged over time;
- they were keen or more reluctant to get back to work.

The combination of all these factors tended to determine the level of complexity of an individual case and is likely to have affected the speed at which sickness absentees were able to return 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. A few pilots focused almost exclusively on referrals through GPs. At the opposite end of the scale, three pilots had very few direct referrals from GPs. However, it is likely that the data underplay the importance of GPs in directing individuals to the service – for example, some GPs may have told a patient about the service who then self-referred.

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.

Engaging employers

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.

Engaging individuals

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

Following referral, the client journey included a number of stages but practice at each stage varied from pilot to pilot. The key stages are described below.

Screening

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.

Assessment

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. Assessment interviews generally lasted around an hour and were conversational in style, based around an interview guide or assessment form. Case managers emphasised that the client assessment did not stop after the initial interview(s) and that some issues were only revealed over time.

Clients expressed a high level of satisfaction with their initial assessment and 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.

Telephone-based assessments were thought to be time efficient, preserve client anonymity and help focus the discussion, but could miss sensitive or latent issues. Meeting the client face-to-face enabled the case manager to more easily establish a relationship and delve into issues in more detail.

Return-to-work plans

The outcome of the initial assessment was generally an action or '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

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:

- from elsewhere within the in-house team, for instance from colleagues with other specialist roles or backgrounds;

- from elsewhere within the partnership; or
- by referring or signposting to external agencies.

Finally, case managers were involved in discharging their clients from the service and subsequent follow-up.

In most pilots the case managers came from medical backgrounds. In two pilots the case managers had non-medical backgrounds with experience in either workforce development or human resource management. In the rest, there was a mix of experience across the team. A mixed team had the advantage of having the experience or skills to deal with most conditions and circumstances encountered.

Additional support

Where clients required additional support and case managers acted as a gateway to additional support services, these could be provided by partners within the local FFWS pilot or by external providers in the health service or wider community.

There were differences in the range of support on offer and pilots also varied in:

- **The process of accessing support** – with a distinction between **referrals** (whereby case managers contacted the third party to make an appointment for their client) and **signposting** (information on how to contact the third party was passed to clients who then made their own appointments).
- **The speed of access** they offered clients particularly to clinical services such as psychological therapy or physiotherapy services (through special funding or contractual arrangements) and those which relied on standard NHS referrals to local providers (including Improving Access to Psychological Therapies (IAPT) in some areas). Most (seven) of the pilots had the ability to fast-track their clients to at least some clinical services.

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

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, there were three broad models in operation in the first year of the pilots:

- **Guidance and Gateway** – this was 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** – in this enhanced model, case managers offered a wider range of support to their clients, including light-touch clinical support, or they were offered 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.

Our assessment of the services’ impact is ongoing and, as yet, does not allow us to draw conclusions on the effectiveness of each of these models.

Discharge

Clients generally left the service by mutual agreement when they had met their initial goals or there was nothing more that the service could do for them. Some clients left the service early because they felt they had received all the support they wanted or found support elsewhere. In most pilots, case managers kept in touch with their clients after they were formally discharged from the service to ensure they did not experience any further problems.

Satisfied clients

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.

Outcomes

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. Just over ten per cent of clients who were initially assessed subsequently failed to engage.

The average length of time people stayed with the service appears to be around four months, although some sickness absentees may have returned to work before they were formally discharged.

Data from the management information indicate that 74 per cent 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 of the respondents to the client survey said that would not have received the interventions they had without the support of the FFWS. Qualitative evidence from the clients interviewed in the panel indicates that the FFWS provided significant support to return to work, without which the return would not have happened. Others said that the service had helped by:

- accelerating a return to work;
- easing or supporting a return to work;
- sustaining employment after a return to work.

Nearly all the clients who were at work when they were first supported by the pilots, and who left the pilot during the first year, remained employed.

GPs who used the FFWS reported several benefits from their perspective including:

- the holistic assessment of patients' capabilities;
- the provision of expert workplace assessments;
- the saving of GP resources.

1 Introduction

Dame Carol Black's 2008 review of the health of Britain's working age population highlighted evidence suggesting that early intervention can help to prevent employees' short-term sickness absence from progressing to longer-term absence or worklessness.² On this basis, a new Fit for Work Service (FFWS) was proposed, to offer support for people in the early stages of sickness absence and fill the gap in the provision of occupational health services, particularly for employees working in small and medium-sized workplaces. It was envisaged that case-managed and multidisciplinary services would address both social concerns, such as financial and housing issues, and clinical needs, and as a consequence would keep people in work and reduce flows onto long-term sickness benefits.

Between April and June 2010, FFWS pilots were launched in 11 sites throughout Great Britain, initially for a year, funded by the Department of Work and Pensions (DWP) and the Department of Health (DH). In February 2011, additional funding was made available and the pilots were asked to submit plans for up to a further two years (to March 2013).³

In September 2010, DWP and 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 draws together the findings of the first year of the evaluation and is primarily focused on the experience of the 11 pilots in their first year of operation.

1.1 The pilots

The 11 initial pilots covered diverse areas and regions of Great Britain, varying in the size and characteristics of their populations and the structure and nature of employment. Some pilots covered relatively small geographical areas and populations, such as the area around Rhyl where there are less than 10,000 people in employment. Some covered large mainly urban areas, such as Greater Manchester (with an employed population of over a million). Others included a mixture of urban and rural areas, such as the Leicester and Leicestershire pilot, and the Scotland-wide pilot (with nearly two and a half million people employed).

The areas covered by the initial pilots were:

- Birmingham, Coventry, Sandwell and Solihull – referred to in this report as the 'Birmingham area' pilot;
- Eastern and Coastal Kent;
- Dundee and Tayside – referred to in this report as the 'Dundee' pilot;
- Greater Manchester;
- Kensington and Chelsea;
- Leicester and Leicestershire – referred to in this report as the 'Leicestershire' pilot;
- North Staffordshire;

² Black, C. (2008). *Working for a healthier tomorrow: Dame Carol Black's review of the health of Britain's working age population*. London: TSO.

³ <http://www.dwp.gov.uk/newsroom/press-releases/2011/feb-2011/dwp022-11.shtml>

- Nottinghamshire;
- Rhyl;
- Scotland;
- Wakefield.

In the second year, the Dundee pilot was absorbed into the Scotland-wide pilot and the pilots in the Birmingham area, Eastern and Coastal Kent, and Wakefield were not further funded. The pilot in Nottinghamshire is continuing with a change to the service model to focus on the case managed support for clients, one element of the initial approach. The pilots in Rhyl, and Kensington and Chelsea were expanded to cover a wider geographical area. All the pilots in the second year were asked to focus on sickness absentees as opposed to employees with a health condition who remained in work (i.e. presentees) and on employees from small and medium-sized enterprises (SMEs).

The pilots were all formed by partnerships or partnership organisations which included local health organisations, local authorities, employment service providers (such as Jobcentre Plus) and other community organisations. Pilots were given a fixed amount of funding to deliver an agreed business plan. In most pilot areas (seven) the lead body was a health service organisation. In most pilot areas the FFWS pilot represented a completely new form of provision.

Brief descriptions of each of the pilots and their operation in the first year are contained in Appendix A.

1.1.1 The aims of the pilots

The aims and objectives of the pilots during the first year were set out in a memorandum of information (MOI)⁴ issued as part of the pilot selection process and in presentations to potential bidders.⁵ The main aim of the pilots was to provide a personalised back-to-work package of support that helped sickness absentees to:

- return to sustained work sooner than they would have otherwise done; and thereby
- reduce the flow onto welfare benefits.

To meet this aim the pilots were asked to:

- focus primarily on sickness absentees – defined as people off sick from work on health grounds – working in SMEs;
- contribute to tackling health inequalities – for instance by covering less well-off areas where there is the most significant potential to prevent worklessness arising from ill-health;
- effectively combine support for health conditions with a wider set of employment and community-related services to form a biopsychosocial model of support;
- be person-centred and responsive to individuals' needs;
- join up appropriate local services – existing or new – to form an integrated health and work service providing holistic support;
- demonstrate effective partnership working;
- provide timely, coordinated back-to-work interventions.

⁴ HM Government (2009). Fit for Work Service programme of piloting: memorandum of information. HM Government.

⁵ <http://www.dwp.gov.uk/docs/hwwb-plenary-edinburgh.pdf>

The intention in the first year was to test a range of delivery models across the pilots based on existing or innovative approaches to identify which had the greatest potential for success.

1.2 The evaluation

The aims of the evaluation were to:

- understand the nature of the FFWS programme of piloting and assess the effectiveness of the service being provided;
- identify and disseminate (in collaboration with DH and DWP) the key lessons for ensuring the quality, effectiveness and efficiency of the FFWS in the future;
- undertake an economic evaluation of the FFWS, including estimating the net impact of the service on clients' speed of return to work and flow onto welfare benefits.

Specific objectives for the evaluation included examining:

- the take-up of the pilots and specifically the routes by which people accessed the service, why they wanted to use the service and any barriers they faced;
- the characteristics of people who accessed the service and, where possible, exploration of the characteristics of people who were eligible for the service but did not take it up;
- the nature of services provided by the FFWS, including looking at to whom they were provided and how they differed to provision prior to the pilots;
- the different models of service provision between the pilots;
- the views of FFWS participants and stakeholders, including General Practitioners (GPs) and employers, about the services provided; and
- the key costs involved in delivering the service.

1.2.1 Main evaluation activities

During the first year of the evaluation the following activities were undertaken:

- A process for collecting management information (MI) about users of the service was developed. During the first year management information was collected in each pilot in aggregate form across a number of core indicators. A new management information requirement was implemented for the second year of the pilots to improve information collected at an individual level.
- Over 200 semi-structured qualitative interviews with stakeholders, providers and others involved in the delivery of the pilot services were carried out. Interviews took place in all pilot areas in two waves: in October and November 2010 and June and July 2011.
- A two-wave quantitative telephone survey of FFWS clients was designed and the first wave conducted between February and July 2011 with follow-up interviews conducted around six months later.⁶ The number of interviews conducted in the first wave (311) was fewer than originally planned due to the lower than expected number of contact details available.
- A panel of 70 FFWS clients, drawn from four pilot areas, was established to take part in a qualitative (two-wave) longitudinal study. The first round of semi-structured interviews was undertaken in April to June 2011 with follow-up interviews planned with the same respondents six months later.

⁶ Second-wave telephone survey interviews with clients were conducted at the time of writing and are, therefore, not reported in the present report.

- Semi-structured qualitative interviews were conducted with 30 GPs across all pilots, including both those who had referred patients to the FFWS and those who had not. These interviews also took place between April and June 2011.

Details of the methodology used in each of these elements of the evaluation are provided in Appendix B.

In addition, and not reported here, the evaluation team is conducting an ongoing impact study based on data from fit notes detailing the sickness absence durations of eligible people from GP practices participating in the pilots and comparable non-participating GP practices in three pilot areas. This element of the evaluation, when completed, will be able to provide a quantitative estimate of the net impact of the service on clients' speed of return to work.

1.3 This report

This report is based on the data gathered from the management information, the interviews with pilot personnel and stakeholders, the first wave of the client telephone survey, the first wave of qualitative interviews with longitudinal panel of FFWS clients, and the interviews with GPs. The report aims to provide those responsible for developing and delivering the policy with an understanding about how the pilots work in practice and how they are testing the original concept. It also provides some initial insights into what works well, and less well, in delivering a short sharp early intervention to help people in danger of a long absence from work due to ill-health get back to work sooner. In so doing, it relies on a mix of evidence sources, most of which are qualitative and are based on the perceptions of the pilots from the individual respondent's perspective. At this interim stage definitive conclusions about the pilots are difficult to draw. The most reliable evidence is that which is consistent across a range of sources.

The report primarily focuses on the first year of operation across all 11 pilots but, where relevant, identifies the main changes that have occurred in the first few months of the second year. It examines the level and nature of participation in each of the pilots and the characteristics of the clients with whom the pilots have engaged. It describes the way the pilots have operated and the type of services provided, and examines the initial evidence on what elements of those services have been more or less effective and why, based on the reflections of those involved in delivering the pilots and the clients who received the service on offer.

In the rest of this report:

- Chapter 2 provides an overview of pilot services and identifies the main models of provision.
- Chapter 3 looks at the process through which clients accessed the FFWS.
- Chapter 4 follows the client journey through the FFWS.
- Chapter 5 looks at outcomes and the numbers leaving the service in the first year.
- Chapter 6 draws together the conclusions from the first year of the evaluation.

A summary description of each pilot is included in Appendix A and details of the methods used in the evaluation activities reported here are provided in Appendix B.

2 Overview of the pilots

This chapter provides an overview of the services provided by the pilots and identifies the main models of provision. It looks at the number and the characteristics of participants during the first year of operation. It also examines why people got in contact with the service and their motivations and expectations of the service they would receive.

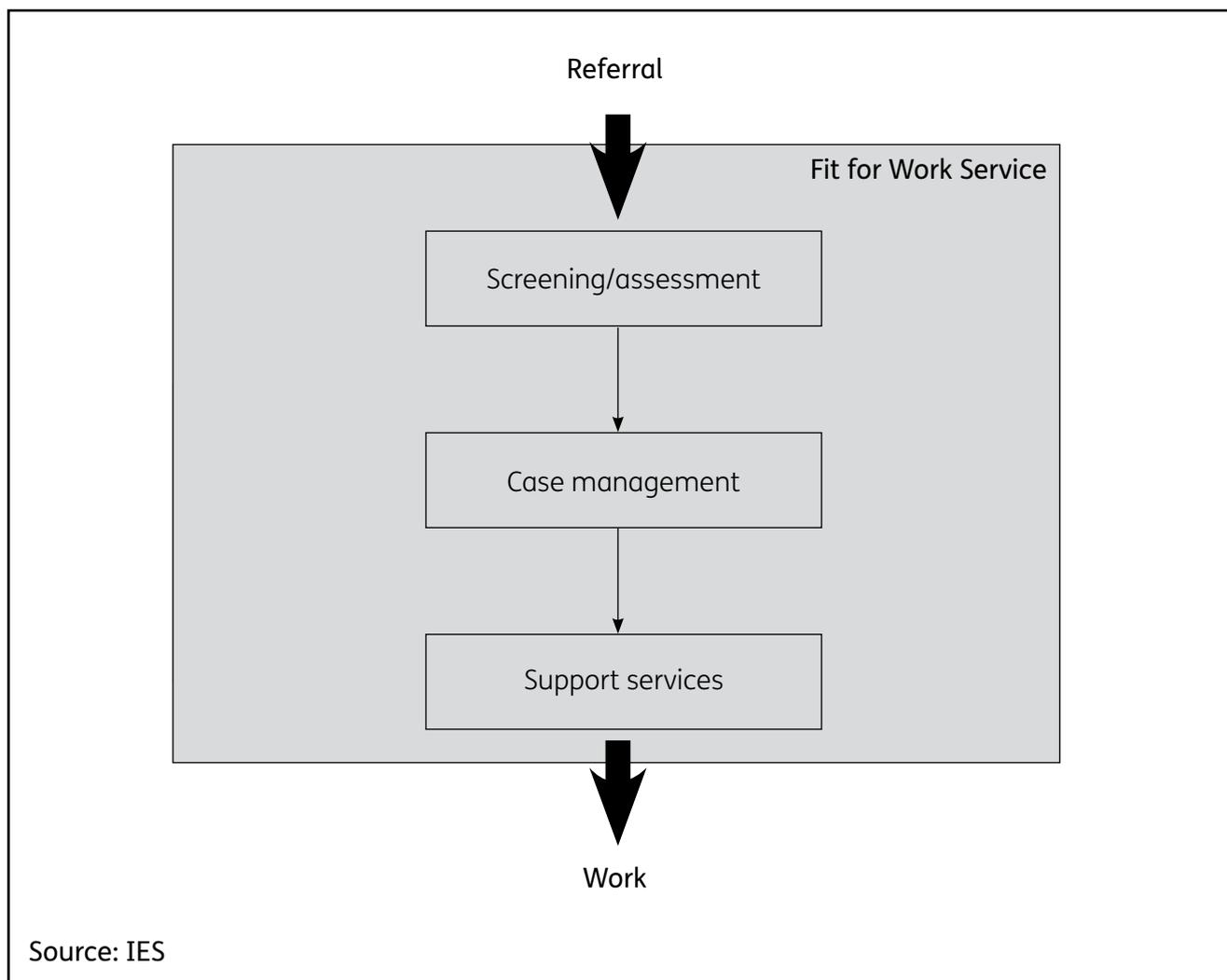
2.1 Models of provision

To provide an initial introduction to the concept of the Fit for Work Service (FFWS) and a context to the information about its clients, this section sets out a brief description of the service provided by the pilots and the key distinctions between the pilot models.

2.1.1 A simple model of the service

Each pilot had a different way of operating. In all pilots, the client journey included five separate stages (Figure 2.1), but practice at each stage varied from pilot to pilot.

- **Referral** – individuals could access FFWS either by being referred, for example, by their General Practitioner (GP) or other health service providers, or by contacting the pilot themselves having seen publicity about the service or having been told about it by their GP or employer.
- **Screening** – individuals' first contact with the service generally involved a screening process to determine their eligibility and suitability for the service 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.
- **Assessment and case management** – if eligible, clients were then assigned a case manager who usually conducted a more thorough assessment of the client's circumstances, helped them to draw up a 'back-to-work plan' and provided them with support to fulfil the goals set out in the plan. One major difference between the pilots was whether the assessment and subsequent case management was conducted via telephone or face-to-face.
- **Support** – case managers offered support with goal setting and monitoring progress as well as confidence-building and motivation and other forms of assistance. Nearly all pilots offered support with the client's employment situation, helping them resolve workplace problems or negotiate a return to work. A critical difference between the pilots appeared to be between those which offered some form of clinical support and those that relied solely on clinical interventions from organisations involved in the wider pilot partnership or beyond. Where clients required additional support, case managers acted as a gateway – signposting or referring clients to additional support services provided by partners within the local FFWS pilot or by external providers in the health service or wider community.
- **Discharge** – the service usually monitored the progress of individual clients once they had been discharged from the service, to see whether they had been able to overcome or manage the issues that were affecting their well-being at work and to see if they needed any further support, including from the service.

Figure 2.1 Simple model of a Fit for Work Service

2.2 Numbers and profile of participants

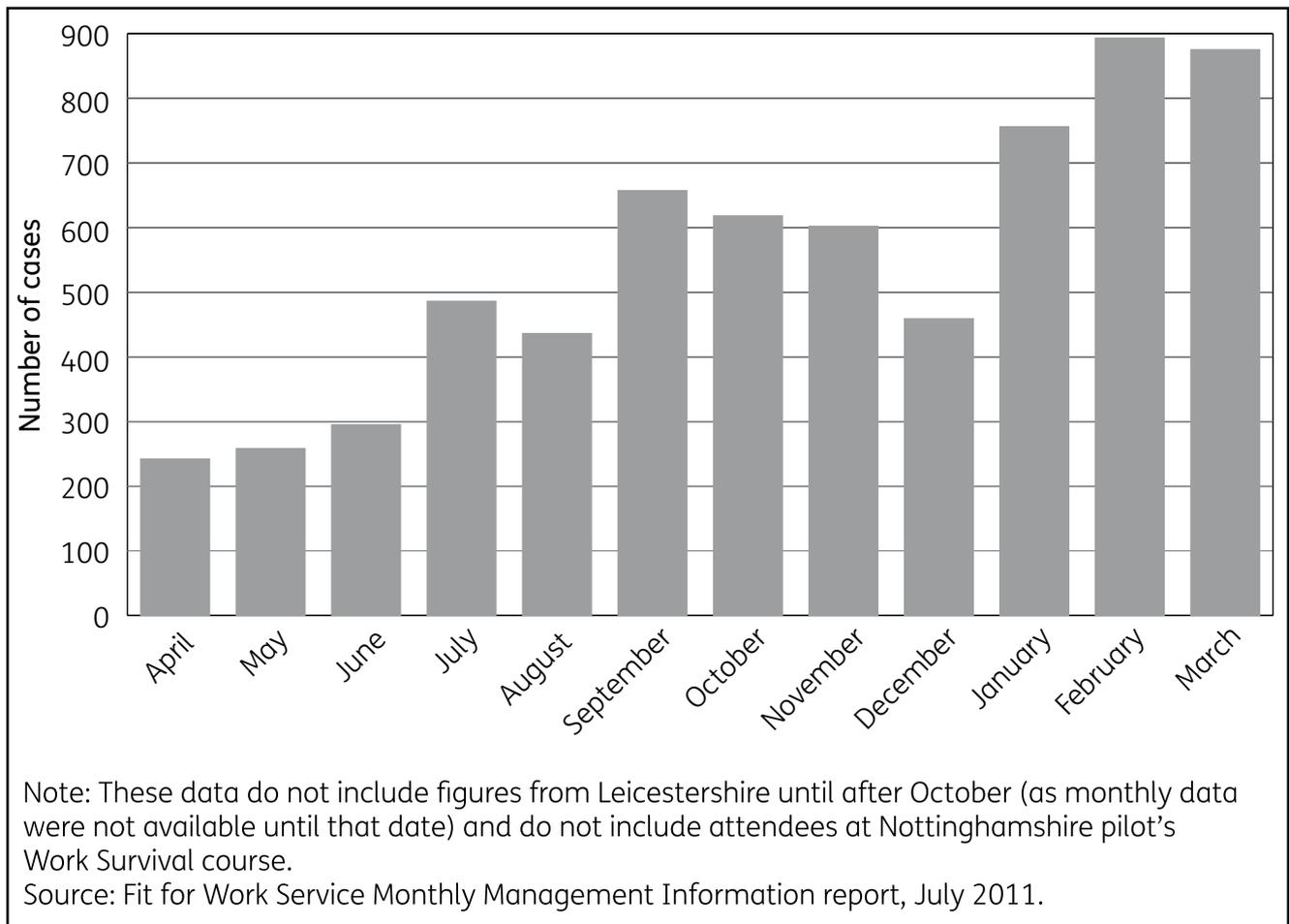
By the end of March 2011, a year after most of the pilots started, a total of 9,624 people had been referred to the FFWS pilots for support⁷, of whom 7,133 had been referred to a case management service. Some of them were ineligible for support from the pilot and 6,726 eligible clients took up a case-managed service.⁸ In the first year the pilots set their own eligibility criteria consistent with the model in their bid for funding. In most pilots the service was restricted to employed or self-employed individuals, although some admitted unemployed people and some focused more on sickness absentees than others (see Section 2.3.1).

⁷ This number includes 2,491 people referred to the Nottinghamshire pilot's Work Survival course. In the first year, the Nottinghamshire pilot has three elements: the Work Survival Programme – workshops for employees in work; Support in Work – individual case-management service for sickness absentees; and Working for Health – an online health check for small employers. There may be some overlap of individuals using both the Support in Work and the Work Survival programmes in Nottinghamshire. For details of these services please see the summary of the Nottinghamshire pilot in Appendix A.

⁸ 2,367 people were referred to the Nottingham Work Survival course which did not include case management.

The numbers of people taking up the service increased steadily during the course of the first year of the pilot programme. In their first six months, the 11 pilots were recruiting new cases at an average of 400 a month. In the second six months the monthly average had increased to 700 a month and to 840 a month over the last three months (from January to March 2011) (Figure 2.2).

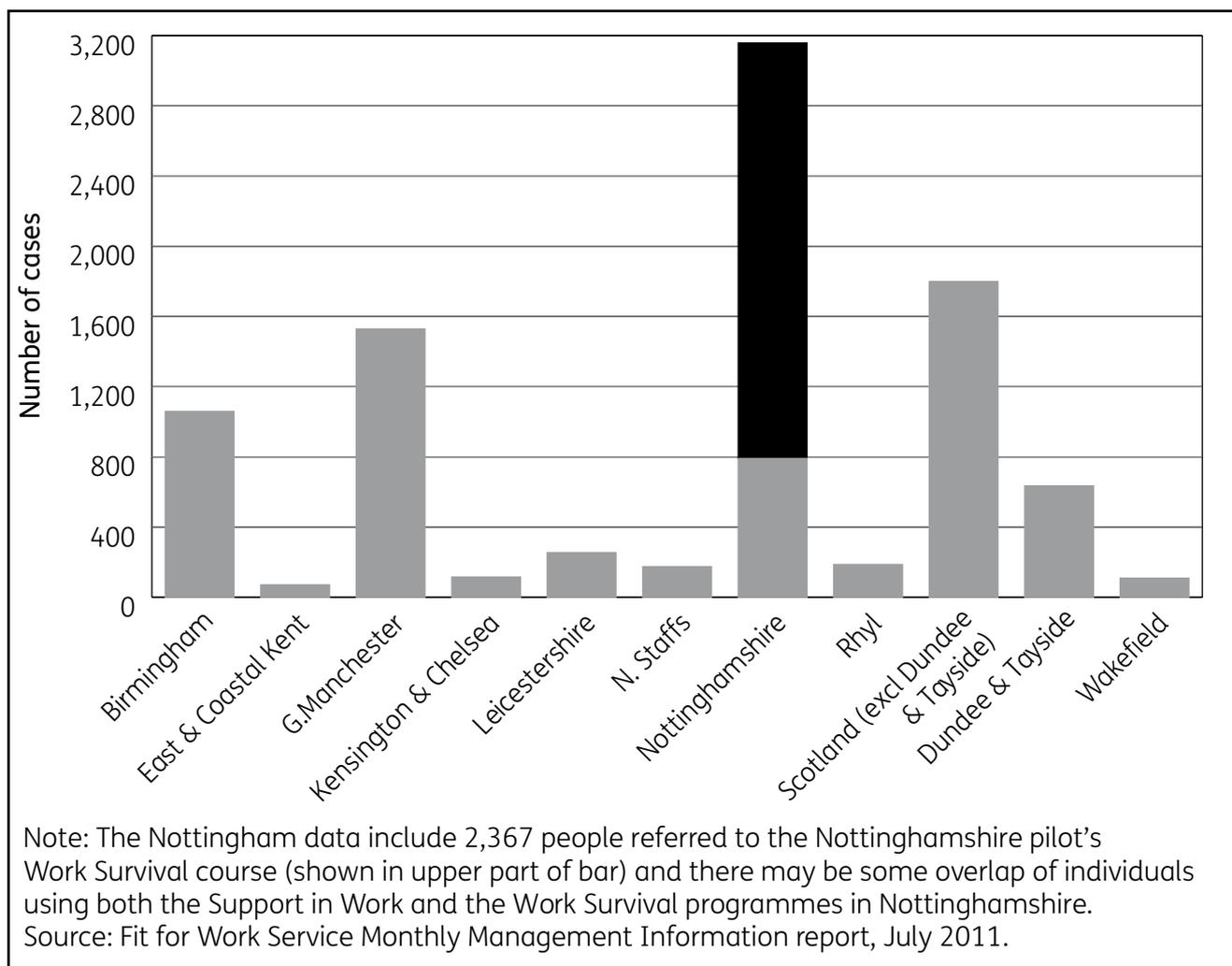
Figure 2.2 Number of new FFWS cases per month, to March 2011



Take-up of the service by individual pilot varied enormously (Figure 2.3). Three of the pilots, Eastern and Coastal Kent, Wakefield, and Kensington and Chelsea, had around 100 participants during their first year.⁹ At the other end of the scale the pilots in the Birmingham area, Greater Manchester and Scotland had over 1,000 participants and the pilot in Nottinghamshire recruited 791 people to its case management service and a further 2,367 to its Work Survival Programme.

The difference in take-up partly reflects the size of the pilot site's geographical area (and therefore, the number of potential clients), their general strategy towards recruitment – including the extent to which they focused primarily on absentees – and the success of their marketing campaigns and other attempts to engage with potential recruits.

⁹ Eastern and Coastal Kent recruited a further 16 cases and Wakefield added a further eight cases before they closed at the beginning of June 2011.

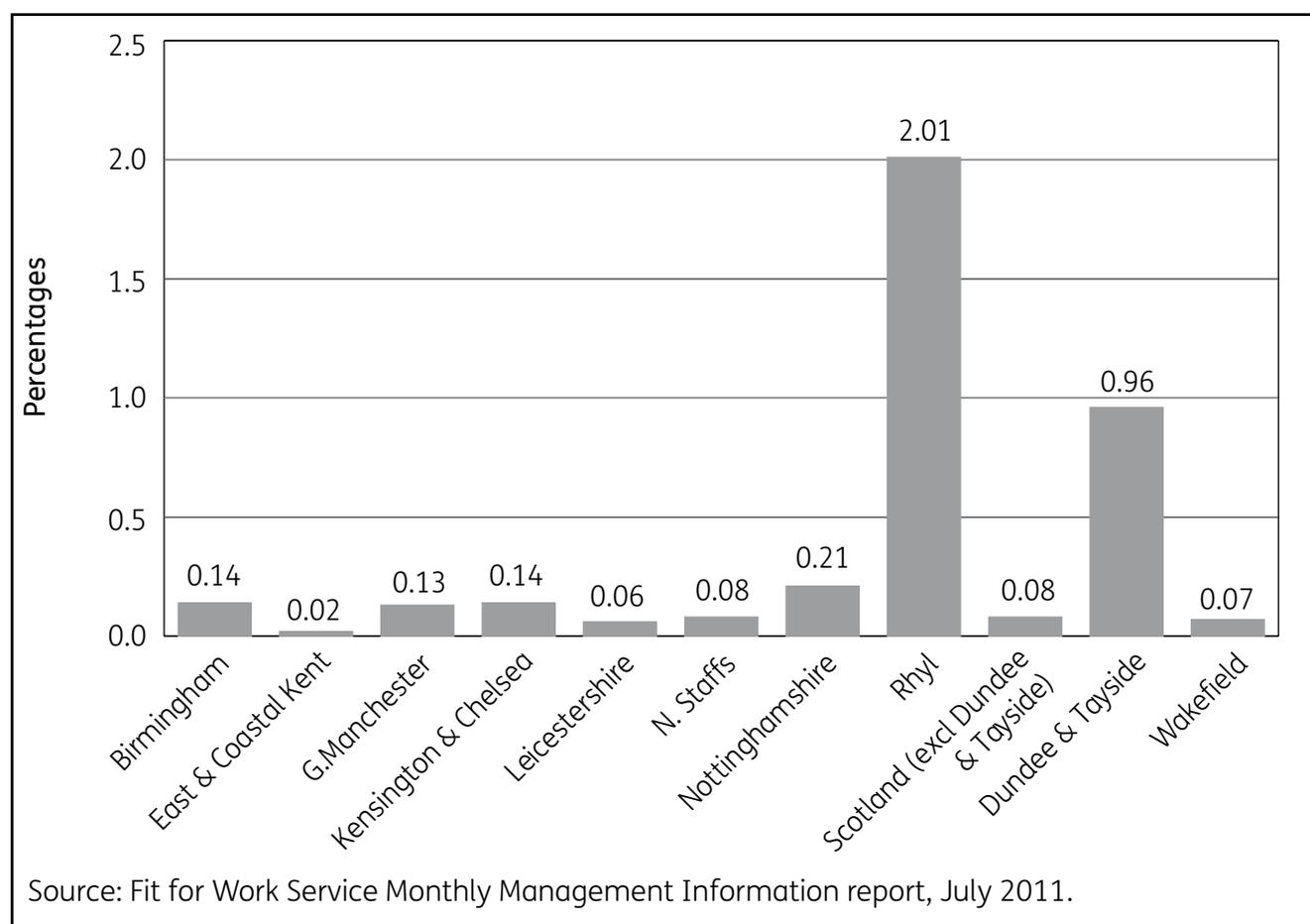
Figure 2.3 Number of FFWS cases, by pilot, March 2011

To control for the size of the pilot area, we have divided the total number of clients in each pilot (at the end of March 2011) by the size of the employed population¹⁰ (see Figure 2.4). It is recognised that the base includes many people who are beyond the scope of the pilots, but there are no accurate or consistent data on the 'eligible population' for each of the pilots. On average around two to three per cent of the employed population are on sick leave at any one time and of those around a quarter will be off work for over four weeks, implying a long-term sickness absentee population at any one time of under 100 in a small area such as Rhyl and over 7,000 in Scotland. However, in practice, the actual number of sickness absentees will reflect the local occupational and sectoral structure of employment in the pilot area as well as demographic factors such as age and gender.

Not surprisingly, the number of FFWS clients represents a very small proportion of the total employed population in the area – generally around 0.1 per cent. However, the data do show that the smaller pilots (such as Dundee and Rhyl) have a significantly higher penetration rate than the other pilots, with, respectively, one per cent and two per cent of the employed population receiving services from the pilot.

¹⁰ Taken from the ONS Annual Population Survey July 2009 to June 2010, which serves as a baseline for the programme of piloting.

Figure 2.4 Participants in FFWS case-managed service as a proportion of employed population, March 2011



2.2.1 How many people did the pilots expect to attract?

When they submitted their original bids, pilots estimated the number of people who would take part in the service they were offering. The estimates were based on different assumptions about the level of long-term sickness absence in their area and the likely number of referrals. They varied significantly as a proportion of the employed population in their area.

In total the pilots expected to have had over 17,000 participants by March 2011. Take-up was, therefore, significantly lower than expected at less than 40 per cent of the original plans. Although the rate of participation picked up over the course of the year, even if the rate achieved over the last three months of Year 1 had been realised over the whole year, the pilots would have only achieved a take-up of only about 60 per cent of the original plan.

The main reasons for the lower than expected take-up were:

- the size of the core client population of long-term sickness absentees (that is employees off work with a health condition for longer than four weeks) may have been over-estimated by some pilots. For example, using the assumptions outlined above, the initial annual targets range from 20 per cent to over 900 per cent of the estimated size of the core client group at any one time;
- difficulties in generating the expected level of referrals from GPs and employers (see Section 3.2.1); and
- the time taken to learn lessons about the effectiveness of various marketing techniques.

Although some of the pilots started up later than originally planned, this only had a temporary effect.

2.2.2 Participation in Year 2

Seven of the pilots continued into the second year. Most continued to operate on the same basis as before, but some were required to focus their efforts more on recruiting employees on sick leave and from small and medium-sized enterprises (SMEs). All the pilots provided new estimates of the number of cases they expected to achieve. As a result of the change in focus and more realistic expectations borne out of their experience of the first year of piloting, the projected numbers of cases were considerably lower than during the first year of operation.

As at the end of July 2011, 784 employees had been or were being supported by the pilots. This figure is broadly in line with the revised expectations.

2.3 Client profile

In this section we look at the profile of the clients who took up the service in Year 1 and highlight the main changes in the first four months of Year 2. It is important to note that when looking at the profile of FFWS clients as a whole, the pattern is largely determined by the characteristics of clients in the larger services, notably Scotland. Where relevant the breakdown by pilot area is, therefore, shown.

2.3.1 Absentees or presentees?

In the first year, some 95 per cent of FFWS clients were employed, nearly all of whom were employees rather than self-employed. Among the employees 30 per cent were sickness absentees and two-thirds were attending work at the point they came in contact with the service, whom we refer to as 'presentees' (Table 2.1). In practice, the presentee group broadly included individuals who were employed and attending work and had a health or behavioural condition that affected or could affect their ability to work productively, including being at risk of sickness absence.

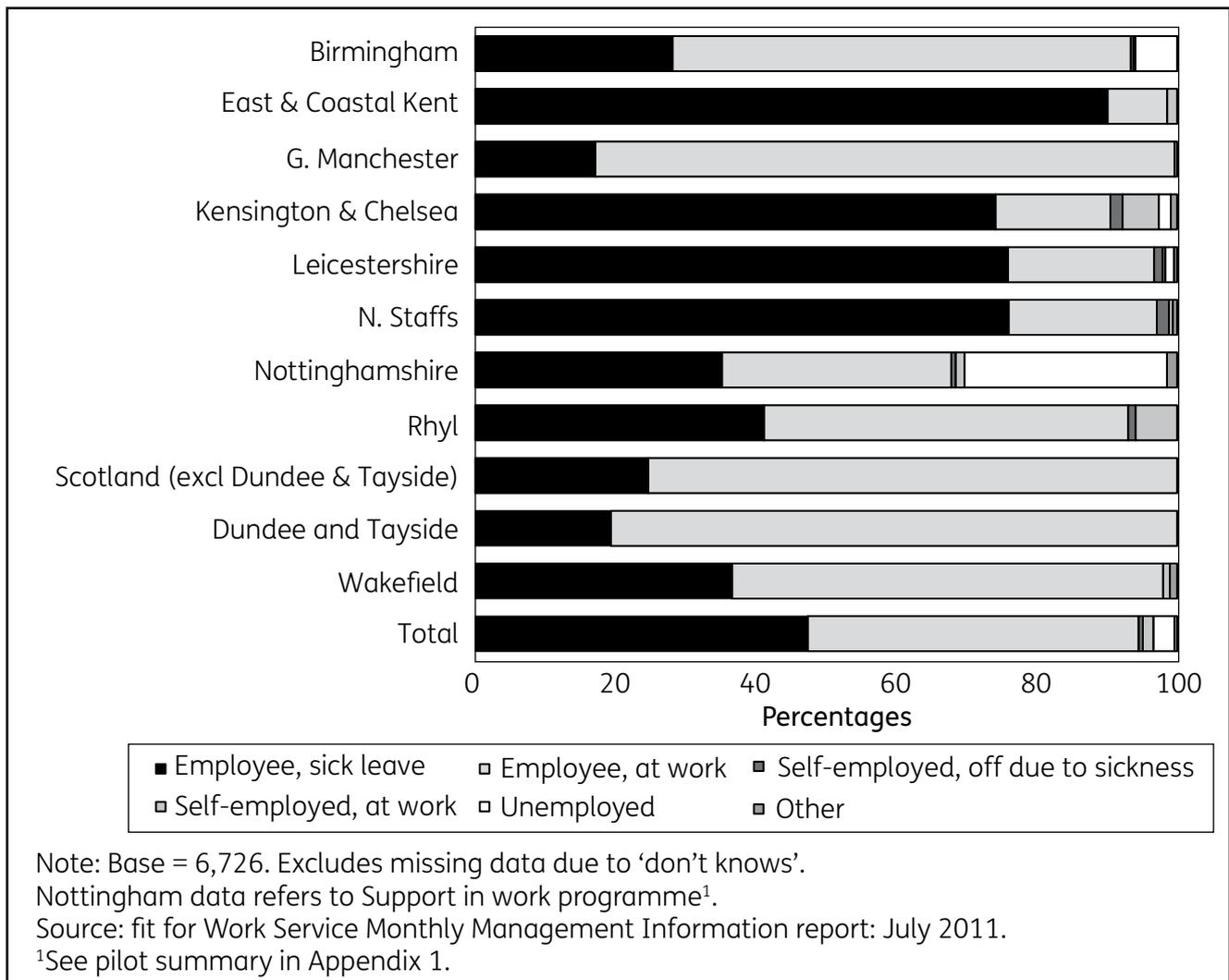
Table 2.1 FFWS client profile: work status, March 2011

Employment status	Column %
Employee, attending work	65.6
Employee, sick leave	29.5
Unemployed or economically inactive	3.8
Self-employed, attending work	0.6
Self-employed, off due to sickness	0.3
Other	0.2
<i>Base (N = 100%)</i>	<i>6,517*</i>

* Excludes don't knows.

Source: Fit for Work Service Monthly Management Information report: July 2011.

The proportion of employees on sick leave in the first year varied by pilot – from around 20 per cent in Greater Manchester, Scotland (two of the larger pilots) and Dundee, to around 75 per cent in Eastern and Coastal Kent, Kensington and Chelsea, Leicestershire and North Staffordshire (Figure 2.5). Presentees were the majority overall because they dominated take-up in pilots with the most participants.

Figure 2.5 Work status by pilot, March 2011

Some pilots had, therefore, focused more attention on employees with health conditions who were still at work, rather than those who were absent from work which was the original policy intent, for three main reasons:

- **Presentees were easy to reach** – some of the pilots found that they were receiving referrals from employers and GPs, as well as self-referrals, from people still at work. In the absence of significant numbers of employees on sick leave they decided to take them on to use the resources they had available and increase their client base. As one case manager explained: *'I think, to be fair, we got to the stage that if we could help anybody, then we weren't going to stick to the criteria.'*
- **Presentees had problems that needed help** – one pilot manager described this group of clients as people with *'general health and well-being related issues that had not yet reached the stage of a diagnosed health condition'*. Such issues included: low confidence, low self-esteem, poor exercise tolerance, harmful health behaviours and poor sitting posture.
- **Pilots believed that providing an early intervention could prevent subsequent absence** – some of the pilot managers argued that by supporting presentees they were providing an early intervention that could help people sustain their subsequent employment. If that could be provided cost effectively, for example, through group sessions, then this would reduce the likelihood of such people incurring the greater costs associated with sickness absence later on.

Changes in Year 2

From April 2011, with the extension of the seven pilots, greater emphasis was given to recruiting absentees and in the four months since April,¹¹ the proportion of absentees in the client group is at least 75 per cent in all the continuing pilots.

Length of time off sick

Among those who were on sick leave in Year 1, 47 per cent had been off work for less than four weeks at the time they entered the FFWS, 29 per cent had been off for between four and 12 weeks and 24 per cent had been absent for over 12 weeks.

Survey data presented as part of the background information about the programme of piloting and other literature suggest that between four and 12 weeks is theoretically the most effective point at which to make an intervention.¹² Only a relatively small minority, around nine per cent, met these criteria (29 per cent of 29.5 per cent from Table 2.1).

2.3.2 Age and gender

The age profile of people using FFWS in Year 1 (Table 2.2) broadly resembled the profile of all employees in employment. However, the gender profile was slightly different. A small majority of the people accessing FFWS in the first year were female (53 per cent), a higher proportion than in the employed labour force as a whole (47 per cent)¹³. Some of the interviewees suggested that the reason for this might be that women were more open to seeking help with health or other problems than men.

The gender and age profiles varied a little between the pilots but there was no significant pattern, and age and gender profiles of the FFWS clientele have been broadly consistent over the months of piloting, including the second year.

¹¹ Each pilot that received further funding agreed that a minimum proportion of their clients would be absentees. The minimum level varied from 60 per cent in Nottinghamshire to 100 per cent in Greater Manchester. The pilot in Scotland continues to provide a service for presentees, funded by the Scottish Government, while the FFWS pilot focuses on absentees (23 per cent of the total clientele in Scotland).

¹² Shiels, C., Gabbay, M.B. and Ford, F.M. (2004). 'Patient factors associated with duration of certified sickness absence and transition to long-term incapacity', *British Journal of General Practice*, 54(499): 86–91.

Hillage, J., Rick, J., Pilgrim, H., Jagger, N., Carroll, C. and Booth, A. (2008). 'Review of the effectiveness and cost effectiveness of interventions, strategies, programmes and policies to reduce the number of employees who move from short-term to long-term sickness absence and to help employees on long-term sickness absence return to work', *Document 4*. London: National Institute for Health and Clinical Excellence.

Campbell, J., Wright, C., Mosely, A., Chilvers, R., Richards, S. and Stabb, L. (2007). 'Avoiding long-term incapacity for work: Developing an early intervention in primary care', Universities of Exeter and Plymouth Peninsula Medical School Report.

¹³ Office of National Statistics data, January 2011.

Table 2.2 Gender and age distribution of FFWS clients

Gender	Column %	Age	Column %
Male	47.0	16–29	18.5
Female	53.0	30–39	23.6
		40–49	29.0
		50 plus	25.5
<i>Base (N = 100%)</i>	6,726	<i>Base (N = 100%)</i>	6,726

Source: Fit for Work Service Monthly Management Information report: July 2011.

2.3.3 Occupation

Data on the occupation of FFWS clients did not form part of the standard aggregate management information collected in Year 1.

In the survey of FFWS clients, just under half (42 per cent) of respondents were from professional and managerial occupations. A further 20 per cent were from administrative or skilled trades occupations and the remaining 37 per cent were process operatives or from personal service, sales or elementary occupations (Table 2.3). This breakdown broadly reflects the occupational structure of Great Britain as a whole, although FFWS clients were more likely to be in personal service or associate professional occupations and less likely to work in a skilled trade or a managerial occupation than average. Other studies have found that employees in personal service occupations tend to have relatively high absence rates and those in managerial positions have the lowest rates.¹⁴

Table 2.3 Occupation of FFWS clients

	FFWS clients column %	GB employed population column %
Managers and senior officials	11	16
Professional occupations	12	14
Associate professional and technical occupations	19	15
Administrative and secretarial occupations	14	11
Skilled trades occupations	6	10
Personal service occupations	15	9
Sales and customer service occupations	6	7
Process, plant and machine operatives	6	7
Elementary occupations	10	11
Total	100	100
<i>Base</i>	<i>(311)</i>	

Source: Fit for Work Service User survey (Wave 1) and ONS.

¹⁴ For example, Barham, C. and Leonard, J. (2002), 'Trends and sources of data on sickness absence', *Labour Market Trends*, April, pp. 177–185.

2.3.4 Health and other conditions affecting FFWS clients

According to the management information, the main health condition affecting around 80 per cent of the FFWS clients during the first year of piloting was either a mental health or a musculoskeletal disorder (Table 2.4). In the two pilots in Scotland, most of the clients (over 75 per cent) had a musculoskeletal condition, primarily due to the way the service was marketed to GPs and other health practitioners (including physiotherapists) in the first year. In most of the other pilots, mental health conditions were the most commonly reported condition.

Table 2.4 Main health condition of FFWS clients, March 2011

Health condition	Column %
Mental health	36.5
Musculoskeletal	37.5
Cardiovascular	1.3
Respiratory	1.0
Injury	0.6
Other	22.0
<i>Base (N = 100%)</i>	6,726

Source: Fit for Work Service Monthly Management Information report: July 2011.

In the second year, 33 per cent of clients are reported to have a mental health condition, 60 per cent have a musculoskeletal disorder and fewer than five per cent are classified as having an ‘other’ health condition.¹⁵

There was no a consistent pattern across the pilots in the proportion of people recorded as having health condition in the residual ‘other’ category, which could suggest that the data in this category could be more influenced by the way they were compiled at local level than actual differences in the client profile. For example, in both the Birmingham and Manchester area pilots, over 40 per cent of clients were reported to have ‘other’ conditions, whereas in the other pilots the figure was generally around ten per cent.

In the pilot in the Birmingham area, clients with ‘other’ conditions included people with diabetes; neurological conditions (for example, transient ischaemic attacks, multiple sclerosis, epilepsy); general health and well-being issues (such as poor exercise tolerance, weight issues, diet and general lifestyle issues); women’s health; psychological issues (such as low self-confidence, motivational issues, routine problems, assertiveness). In the Greater Manchester pilot, clients with ‘other’ conditions included people in work who were concerned about their future employability, for instance due to alcohol or drug dependency or other aspects of their fitness for work. Clients with such behavioural disorders could be classified differently in other pilots.

The survey of FFWS participants also found that most users of the service reported that their main health condition was either musculoskeletal (49 per cent, including back pain, a neck or upper limb condition including arthritis, or some other physical disorder) or a common mental health condition (40 per cent) such as stress, depression or anxiety. A further two per cent said they had a serious mental health condition such as manic depression or schizophrenia.

¹⁵ However, these figures are significantly affected by the data from the Scotland pilot which in this instance include support for presentees funded by the Scottish Parliament. Eighty per cent of all Scottish cases have a musculoskeletal disorder.

In the survey, absentees were significantly more likely to report a mental health condition as opposed to a musculoskeletal health condition, whereas the opposite was true among presentees.

Nine per cent of survey respondents reported an ‘other’ condition such as:

- other respiratory conditions (such as asthma, chronic obstructive pulmonary disease, bronchitis, pneumonia);
- other gastrointestinal conditions (such as irritable bowel syndrome, haemorrhoids, bowel cancer, stomach ulcer);
- headaches and migraines;
- heart, blood pressure and circulation conditions;
- eye, ear, nose and mouth, or dental conditions (including sinusitis and toothache);
- diabetes.

These data relate to a client’s main health condition but many FFWS clients have multiple health conditions. In the survey, 73 per cent of respondents reported more than one health condition. Most respondents with a musculoskeletal disorder also reported a second musculoskeletal condition: for example, people with back pain also reported neck and upper limb conditions and vice versa. Some 44 per cent of respondents with multiple conditions, who reported that their main condition was a musculoskeletal disorder, also said that they had a common mental health condition such as stress, depression or anxiety. Similarly, 26 per cent of those with multiple conditions who said their main condition concerned their mental health said they also had back pain (Table 2.5).

Table 2.5 Additional health conditions at time of first contact with the service by main reported health condition

Additional health condition	Main health condition	
	Musculoskeletal conditions	Mental health condition
Common mental health conditions	44	:
Back pain	:	26
Neck and upper limb conditions	:	20
Other musculoskeletal conditions		26
Genito-urinary conditions	:	12
Eye, ear, nose, mouth or dental conditions	:	17
Headaches and migraine	27	63
Minor illnesses	18	26
Heart, blood pressure and circulatory conditions	21	17
Gastro-intestinal conditions	11	21

Note: Multiple response question, does not sum to 100 per cent.

Source: Fit for Work Service User survey (Wave 1).

Other commonly reported secondary conditions were:

- headaches and migraines (41 per cent of respondents with multiple health conditions);
- minor illnesses such as colds, flu and sickness (20 per cent);
- heart, blood pressure and circulation conditions (17 per cent).

The responses to the survey reflected the experience of case managers who reported that in some cases mental health issues compounded a physical health condition. For example:

‘[For] my clients it’s mostly musculoskeletal issues, more physical issues, but there again I think after a long period of time of suffering from those conditions, they do start to present themselves with stress and quite possibly bordering on things of depression. As well, I find more of the employed group who do go off work maybe due to a physical condition, they tend to present themselves at a later date with anxiety at the thought of going back to work.’

Health issues could be compounded by non-health issues which deterred employees from staying in or returning to work. In the survey, 43 per cent of absentees identified a non-health barrier that was keeping them from returning to work in addition to their health condition. Absentees with a mental health condition were more likely than those with a musculoskeletal disorder to report a non-health barrier. The most common barriers were work-related and included lack of support at work, harassment and bullying, and a fear that they could not cope with work demands. In addition, FFWS clients also had concerns that were not related to work, which could further confound their situation.

In Kensington and Chelsea one of the case managers had reviewed all the cases that she and her colleagues were currently dealing with and found *‘six non-health components that can complicate a client’s condition which affected 35 of our 40 open cases’*.

The factors were:

- Housing. *‘If you haven’t got a roof over your head or you don’t know where you are going to live, that is a basic human need. You are not even going to worry about work.’*
- Finances. *‘So if you cannot even make a phone call, how are you going back to work? People that are struggling with bus passes, basics.’*
- Work-based conflicts. *‘Any conflicts like work place bullying to the fact that there’s potentially a court case or just tension between employees and the clients. That complicates returning to work.’*
- Social support. *‘We have got a lot of clients that don’t, are not from the area and they have families overseas so often when they are off work or they are struggling they go back home or they just have no support because people who don’t have much social support are more vulnerable and it’s harder for us to assist them.’*
- Return-to-work goal. *‘When they first see us we don’t know what the return-to-work goal will be. For example, we don’t know whether they are going to go back to the same job or new job or we don’t even know whether they are going to go back to work at all which we see quite a lot of in the beginning. That complicates it because you’re almost not sure where to go. If the return to work goal is the new job we already know it’s going to take longer because of the fact they are going to retrain and find a new job.’*
- Legal issues. *‘For example, whether there’s a court case pending because as a case manager you need to be aware that’s in the background because you need to watch what you say. You know there’s going to be tension or you know the employer’s going to be much more uptight because there’s a court case.’*

Other case managers that we interviewed referred to cases that involved one or more of the above factors or which displayed other underlying issues that the case manager had to uncover and then help their client with in developing a solution. For example, another case manager talked about:

‘A site manager for a construction company, worked for many years for them, and his GP had referred him with anxiety and stress. When I was actually speaking to him, he was actually saying that he is suffering from anxiety and stress at the moment because his employers have been informed that he requires a certain standard of fire certificate on health and safety and he’s not very good at reading and writing he tells me and the course they want him to go on, is a four-day course and it involves reading and writing and that totally freaked him out. But when we actually saw him and we looked at the nature of the course it looked like it didn’t mean that everyone at that level had to go, only certain people had to go. So when we actually contacted the course provider and checked into the legislation about it, that was the case, not everyone had to go, only a certain number and at a certain level. So when we spoke to the employer and he had a meeting with them as well, he didn’t have to go on it. So straight away he is back into work, he is a happy chappie.’

Duration of health condition

Half the survey respondents said that their main health condition had lasted for less than six months prior to their first contact with the FFWS and the other half had had their condition for at least six months or more. Some 21 per cent of respondents had had their condition for three years or more and therefore, may not have been the ideal candidates for the early, short sharp intervention it was originally envisaged that the pilots would provide.

Relationship between health and work

According to the client survey, absentees were significantly more likely than presentees to say that their health condition had either been caused or made worse by work – 22 per cent of absentees said that their condition was unrelated to their work, compared with 46 per cent of presentees (Table 2.5).

Table 2.6 Relationship between health and work

	Absentees column %	Presentees column %	All respondents column %
Health condition caused by work	53	16	37
Health condition made worse by work	62	47	55
Health condition unrelated to work	22	46	33
Don’t know	5	7	6
<i>Base</i>	171	136	307

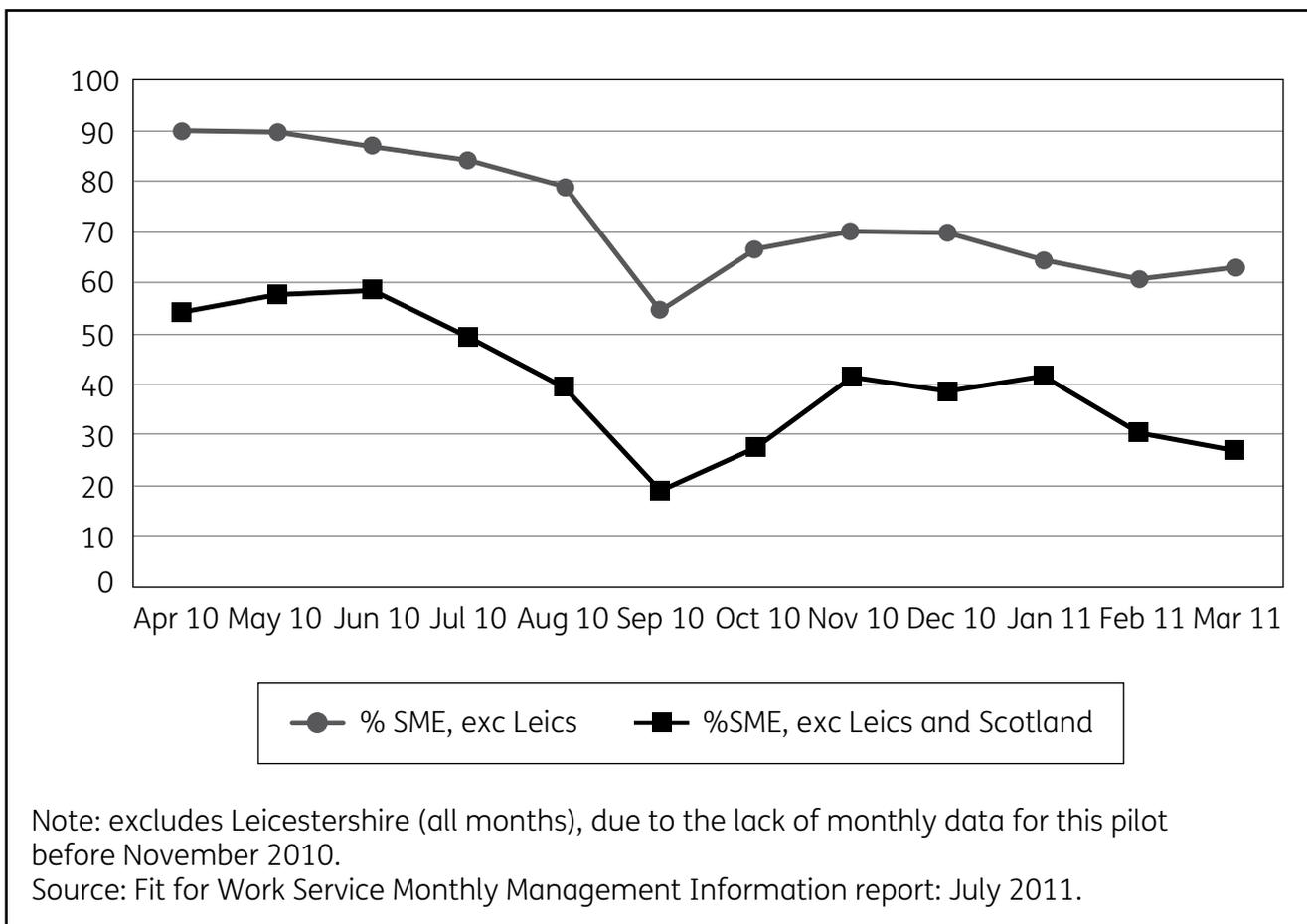
Note: respondents could make multiple responses, therefore, columns do not total 100.

Source: Fit for Work Service Monthly Management Information report: July 2011.

2.4 Employer characteristics

Most (67 per cent) of the clients, who were employed, worked in small or medium-sized workplaces (with under 250 employees). However, the profile is again particularly affected by the two pilots in Scotland which focused in particular on smaller businesses. Across the other pilots, the position was almost exactly reversed and most (two-thirds) of the clients worked for large employers. Figure 2.7 shows the proportion of the monthly intake by employees in smaller workplaces, across all 11 pilots during the first year of the pilots (excluding Leicestershire and with and without Scotland).

Figure 2.6 Proportion of FFWS clients coming from SMEs and from larger employers, to the end of March 2011



The original policy intention was that pilots should concentrate on workers on sick leave from SMEs. Combining the data in Table 2.1 and Figure 2.6 show that in the first year of the pilots around 14 per cent of clients were people working for SMEs and on a period of sickness absence from work – a large proportion of whom were from Scotland. Over the first four months of Year 2, the proportion has increased to 21 per cent.

2.4.1 Type of employer

According to the survey, the largest proportion of respondents worked in the health and social work sector (26 per cent), followed by education (12 per cent), wholesale and retail (11 per cent), and manufacturing (ten per cent). Around half (53 per cent of respondents) worked in the private sector.

2.5 Did the client profile match expectations?

As identified above, the pilots generally found they were treating more people still in work than they had initially expected and also fewer employees from SMEs. In addition, they reported that their clients were more likely than expected to:

- be employed by public sector organisations;
- present with mental health conditions either as a primary or secondary condition;
- have a complex set of problems, for example, involving drug and alcohol abuse, housing, finance, family breakdown issues, or difficulties with their employer – although this is perhaps surprising as it was the original policy proposition that many clients would be facing multiple issues.

However, the qualitative evidence from the pilots supported by the panel interviews suggests that most of the clients were motivated to return to or stay in work. One case manager said that she had expected to see more serious cases, including more people who did not want to return to work, and in her experience most clients had '*regular day-to-day occupational health issues*'. In this way the clientele of the service probably reflects the fact that GPs and other referrers were inclined to put forward people who they felt could most benefit from the service and make the most of the short-term interventions on offer, as found in interviews with GPs.

2.6 Overview of the client group

While all clients had some form of health condition, they varied in the degree to which:

- They had a single issue which was affecting their ability to attend work, or multiple health or other concerns were at play.
 - Some clients had a specific health condition or other concern that needed specific treatment or support. One of the main reasons given by GPs for referring patients to the FFWS was to give them quicker access to medical services (for example, physiotherapy or psychological therapy) than they would have otherwise received as such services were in short supply in the area.
 - Others had several concerns which combined to form a significant risk to continuing to attend their jobs or returning to work. This group included people who had multiple health conditions; those who had difficulties with their employer about how best to attend work given a health condition; and people for whom the combination of a health condition and difficult personal circumstances (for example, with their relationships or finances) affected their capacity to attend work. Particularly complex cases had combinations of all of the above.
- Their conditions were apparent on initial assessment or latent and only emerged over time.
- They were keen to attend work or more reluctant. In the longitudinal panel and the study of GPs it was possible to distinguish between:
 - clients who felt ready for work or that their health condition was not significantly affecting their ability to stay in or return to work but needed support to help them activate their work goals. The GPs interviewed were generally more likely to refer patients who they perceived were motivated to get back to work (see Section 3.2.1); and
 - a smaller group of clients who did not feel work-ready or felt that their health impinged on their ability to stay in or return to work and therefore, possibly needed more significant help to enable them to regain or retain active employment.

The combination of all these factors tended to determine the complexity of an individual case and in turn is likely to have affected the speed at which they were able to return to work. That said, evidence from the qualitative longitudinal panel suggests that clients were generally a proactive group, having generally taken steps to access the service and improve the situation in which they found themselves.

2.7 What did clients want from the Fit for Work Service?

The first wave of interviews with the longitudinal panel of FFWS clients explored their hopes and expectations of the service. Clients commonly talked about having recognised a problem with their health or their job and thinking that the FFWS could help resolve it, or benefit them in some way, to enable them to keep going to work or return to their job as soon as possible. General hopes were

centred on employment prospects, health outcomes and the ways in which the service would be delivered. These included:

- help to return to work, to stay in work, or to resolve problems with an employer;
- assistance to improve a health condition, such as depression or musculoskeletal pain;
- that the service would be delivered by qualified professionals (where treatment was expected) and would be trustworthy;
- that involvement in the FFWS would remain confidential;
- direct links to relevant support (without having to go through a GP).

Further to these general hopes and expectations, some interviewees explained how they had hoped for certain kinds of support or expected specific support because they had been informed that they would be available. For example, in an area offering fast access to treatment, this was the main motivation for seeking assistance from FFWS where people were aware of this offer. The specific forms of support that were hoped for or expected included:

- mediation with the employer;
- legal advice;
- financial advice;
- (quick) access to treatment, such as physiotherapy and or psychological therapy, or complementary therapies;
- job-search assistance (including identifying suitable posts and CV preparation);
- suggestions for workplace adaptations and reasonable adjustments;
- moral or personal support, someone to talk to;
- condition management advice regarding stress or fatigue.

A number of panel study participants said that they had no expectations prior to their first FFWS appointment. These people had learned very little if anything about the service when they were first informed about it, through either their GP or when filling in a questionnaire in the GP surgery.

3 Engagement and referrals

This chapter looks at the process through which clients accessed the service and the ways in which the service was marketed to General Practitioners (GPs), employers and individuals.

3.1 Referral to the service

Clients accessed the service through a number of routes. Data from the pilots' management information (Table 3.1) indicate that across the pilots in the first year, the most common way of accessing the Fit for Work Service (FFWS) was by clients contacting the service themselves (29 per cent of cases). In addition, 27 per cent were referred by their GP, 14.5 per cent came through the local Improving Access to Psychological Therapies (IAPT) service and 11 per cent from employers. Around 18 per cent came through other sources which included health service organisations other than the GP or IAPT, Jobcentre Plus, housing authorities or other community organisations such as the Citizens Advice Bureau.

Table 3.1 Referral sources, March 2011

Source of referral	Column %
Self-referral	28.9
GP	27.1
IAPT	14.5
Employer	11.1
Other	18.0
Don't know	0.4
<i>Base (N = 100%)</i>	6,726

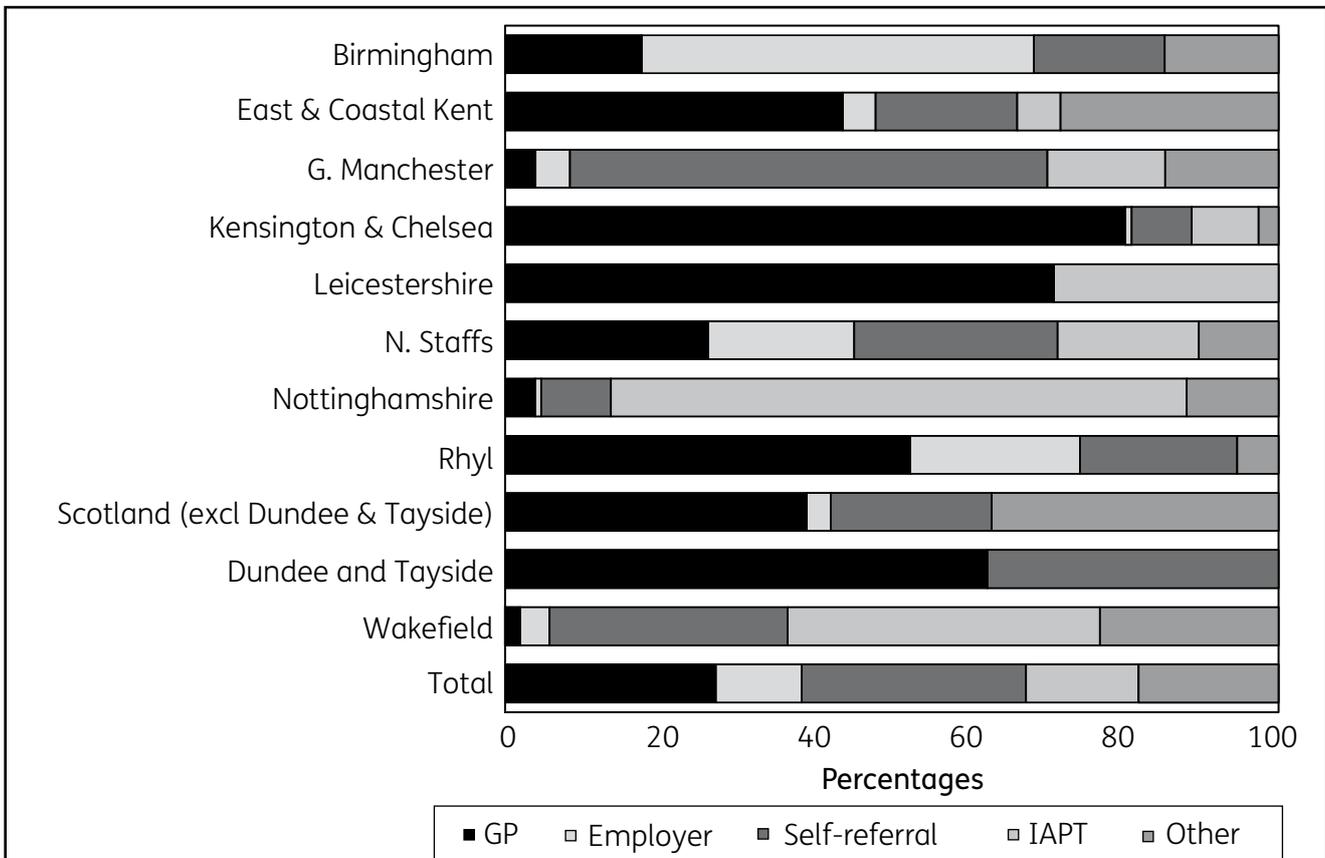
Source: Fit for Work Service Monthly Management Information report: July 2011.

The most common referral sources varied significantly between the pilots (Figure 3.1), reflecting both differences in the model that the pilots were operating and also the effect of local marketing approaches. There appear to be at least three different patterns of referrals.

In two pilots, Leicestershire, and Kensington and Chelsea, the majority of clients came through GPs. In both cases, the pilot had a policy, of focusing exclusively on referrals through GPs¹⁶ – although, as the management information data suggest, they also found clients through other routes.

At the opposite end of the scale, in three pilots, there were very few referrals directly from GPs. Wakefield struggled to secure any engagement from their local GPs, while in both Greater Manchester and Nottinghamshire GPs were much slower to engage with the service than expected (pilot profiles in Appendix A). However, in these pilots a significant proportion of clients were referred to the service via the local IAPT service.

¹⁶ In the Leicestershire pilot all FFWS clients saw their GP before they accessed the service and the GP made the referral even if other services such as IAPT may have been the initial source of information about FFWS as reflected in Figure 3.1.

Figure 3.1 Referral sources by pilot site, March 2011

Note: Base = 6,726. Excludes missing data due to 'don't knows'.

Nottingham data refers to Support in work programme¹.

Source: Fit for Work Service Monthly Management Information report: July 2011.

¹The Nottinghamshire pilot has three elements: The Work Survival Programme - workshops for employees in work; Support in Work - individual case-management service for sickness absentees; and Working for Health - an online health check for small employers (see pilot summary in Appendix 1).

In the other pilots, referral routes were more mixed with broadly similar proportions of referrals from GPs, employers and from individual clients themselves. Some of these pilots, such as Birmingham and North Staffordshire placed a growing emphasis on recruiting through employers over the first year, partly because their efforts with GPs proved less successful than originally envisaged (Appendix A).

Representatives from the pilots reported that many of the individuals who self-referred, were originally 'signposted' to the service by their GP, while others heard about the service through their employer, general publicity (such as leaflets left by the service in GP surgeries), more wide-ranging marketing and by word of mouth from family or friends.

In the client survey, 54 per cent of respondents said they had first heard about the FFWS via their GP. Of these, 72 per cent were referred directly by their GP and 21 per cent contacted the service themselves. The rest were referred by another health professional or contacted directly by the service, for example, by being recruited by a pilot representative while waiting in GP surgeries, such as in the Birmingham area pilot.

There is a range of evidence to suggest that the programme management information almost certainly underplays the importance of GPs in directing individuals to the service. While some of the

interviewees in the longitudinal panel had been referred by their GP or another health practitioner, others said that they had first heard about the service from their GP, or in a few cases from information provided with their fit note, and had contacted the service themselves. In the GP study, a number of respondents said that the FFWS in their area asked for patients to self-refer. Some GPs reported that they would provide patients with contact details and literature for and about the service and leave it to the patient to get in touch.

Some GPs were happy with patients referring themselves to the service as it cut down on time devoted to administrative tasks. There was also the feeling that self-referring patients were taking more responsibility for themselves and that this allowed patients who were ‘*well motivated*’ to refer themselves for treatment. However, there were also thought to be some downsides to patients referring themselves, in that the GP did not necessarily get any feedback from the FFWS and did not feel particularly involved in the patient’s treatment.

The management information may also not fully reflect the importance of employers as a source of referrals. Some of the employers interviewed reported that they had told an employee about their local FFWS, but had left it up to them to make the contact (which would be recorded as a self-referral). For example, two employers from two different pilot areas told us:

‘We don’t refer them to Fit for Work we give them the contact details and advise them to contact Fit for Work so we leave it with them to do it but we basically advertise it ... I know that some have made contact.’

‘I spoke to the individual and said is this something that they might be interested in and I gave them the leaflet with the information and then I think they made contact themselves.’

Some individuals using the service had not actually been involved in making the initial contact. The longitudinal panel included two people whose employer contacted the FFWS without their knowledge.

The location of the pilot premises also seemed to be an important explanation for some of the referral patterns. For example, some of the pilots were located in the same building as IAPT and other primary care services and therefore, had made good connections with them. Another pilot was based in the same building as a large GP practice and this was reported to have facilitated the development of a good relationship and therefore, referrals.

3.1.1 Changes in Year 2

In the second year of operation, to increase the proportion of clients who were on a period of sickness absence from work when they began using the service, the pilots were asked to place greater emphasis on referrals from GPs and the proportion of clients referred by GPs between April and July 2011 increased to 48 per cent. Over the same period, the proportion coming through employers and from other routes dropped to three per cent and nine per cent respectively.

3.2 Marketing

The marketing strategies adopted by the pilots followed their overall participant recruitment strategy and reflected the routes through which they intended to engage with potential clients. As the pilots progressed, and referrals proved lower than expected, the pilots reviewed and adapted their marketing approaches to try to increase take-up.

Some pilots had designated personnel whose main role was to market the service to referral sources such as GPs and employers, but in most cases responsibility for marketing was shared between pilot managers and case managers.

3.2.1 Engaging GPs

All of the pilots have attempted to engage with most, if not all, of the GP practices in their area through a combination of:

- initial emails and letters to GPs and practice managers;
- follow-up phone calls and visits to surgeries to speak with GPs;
- attending practice meetings or GP learning events;
- attending other events in the wider community at which GPs were present;
- handing out questionnaires and leaflets in GP surgeries – to generate patient interest and self-referrals;
- providing promotional materials such as posters, leaflets, stamps for fit notes, holders for fit notes and pens, and advertising on the Life Channel, which broadcasts in practice waiting rooms.

Barriers to engagement

In all pilots, engaging with GPs proved to be much more difficult than expected for a range of reasons:

- **Gaining access to GPs** in the first place to explain about the service. A lot of organisations and agencies compete to attract GPs' attention and email or paper correspondence on its own often failed to have any effect. One GP explained that *'we get an awful lot of emails and they ... go in and out of our attention span fairly quickly'*.
- **Gaining interest from GPs when access was achieved** – one area estimated that around one-third of the GPs in their area did not engage with occupational health issues in general and therefore, were not interested in services such as FFWS. None of the GPs interviewed in our study who had not referred patients to the FFWS said they would not consider using the service and most thought it could be a good idea (but knew little about it). However, a number of the pilot interviewees said they had encountered resistance from some GPs who felt it was not their role to discuss work with their patient.
- **Ensuring GPs had a full understanding of the service** including at whom it was aimed and what it could offer. Most of the GPs interviewed who had not engaged with the FFWS in their area had a very limited understanding or had a mistaken understanding about what it could provide and for whom. The launch of the Fit for Work Service so soon after the introduction of the Employment Support Allowance and the Work Capability Assessment (in 2008) to assess Incapacity Benefit recipients' 'fitness for work', was felt by some interviewees to add to the confusion about what the FFWS was about. This confusion is illustrated by one project leader:

'It would have been helpful if the Government's [work capability assessment] fit for work assessment had been called something different because I think our pilot started first. We'd established the name, the Fit for Work Service, so you would have thought they would have called it something slightly different.'

Even some of those GPs who had sent patients to the service misunderstood at whom the service was aimed. For example, some interviewees thought the service was aimed at unemployed people who were looking to get back to paid work and one GP thought that the FFWS was aimed at people with 'borderline' medical problems which did not preclude them from doing any work.

- **Sustaining interest among GPs and ensuring the FFWS remained a prominent option** – some of the GPs interviewed said that the FFWS was not always at the forefront of their mind and could, therefore, be forgotten if they did not see eligible patients on a regular basis. *‘I have so many things on my plate that I don’t always think about it ... I’m pretty sure I could be referring ... more people. It’s a case of ... remembering’*. Forgetting about the service because they were busy could also be compounded by incomplete knowledge of the FFWS: *‘there are points where I could have probably introduced it earlier or you know, mentioned it and I’ve missed the boat a little bit ... you’re taken up with everything else and ... you forget, and also I’m ... not maybe a hundred per cent clear on exactly who could be referred and the criteria and whatever’*.
- **Relevance to patients** – some GPs interviewed did not refer anyone whom they considered had chronic and incurable health problems or *‘sufficient medical problems that actually being able to work is going to be problematical’*. Other GPs mentioned specific conditions patients might have and which they would not refer to the FFWS: neurological conditions; psychotic patients who were supported elsewhere; cancer patients; people waiting for treatment or surgery; and people who had recently had a heart attack. Other GPs did not refer people who they perceived would only be off work for very short periods of time with health conditions that would resolve themselves without intervention. One GP also thought that it was challenging to assess when someone was ready to return to work: *‘knowing when they’re about to be able to work, I suppose, has been a bit more of a challenge than I imagined’*. A number of GPs reported that they were unlikely to tell patients about, or refer patients to, the FFWS if they thought that the patient was not motivated to return to employment. Similarly, some GPs said that it was difficult to refer patients who did not want to go to the FFWS. One GP explained that this was because such patients were unlikely to buy into the service and turn up for appointments or to engage with the service if they did turn up, which would be a waste of the FFWS’ time. As one GP put it: *‘I would only refer to it if I felt they were actually keen to pursue it ... if I sense that they’re motivated’*.
- **Initial one-year nature of the pilot** – some GPs did not want to sign up to a service that was only going to be available for one year. In one area (Leicestershire) an email announcing the extension of the service for a further two years was reported to have resulted in an increase in referrals.

The difficulties in engaging with GPs were summarised by one case manager who went to a practice managers’ meeting where the attendees were all aware of the pilot from promotional events and visits but few of their GPs were referring to the pilot:

‘I said well, we are not getting enough referrals numbers, why? ... And the practice manager said look GPs forget. They’ve got a lot going on. They’ve got people bombarding them all the time to say refer this, refer that and the GP, the practice manager said just keep promoting yourselves, just keep going back to talk to them and that’s one response, one factor that perhaps could explain it. Another one interestingly, we had this last week, was I went to a meeting and there was a senior GP there that represented a lot of GP organisations and his response was I think he’s saying he didn’t feel it was the GP’s role to have these discussions with their patients about work.’

Overcoming the barriers: effective practice in engaging with GPs

From our interviews and discussions with project staff and interviews with GPs, a number of ways of engaging with GPs appear to have been more effective than others. These include:

- **Adopting a systematic approach** – this could involve the pilot having someone directly responsible for GP engagement; segmenting the market to concentrate on those GPs and practices where a positive response was most likely; adopting customer-relationship management techniques – including developing a system for keeping track of contacts and their involvement with the service, such as the number of subsequent referrals; and ensuring a consistent message was promoted across a range of activities.

- **Initially engaging with practice managers** – a number of pilots had found that initially contacting the practice managers was an effective way of first approaching a practice and gaining access to GPs.
- **Meeting GPs face-to-face** – face-to-face meetings with GPs were felt to be the best way of getting the message across about the services that the pilots could provide. One GP told us that a face-to-face meeting to hear about the FFWS *‘was a way of having my undivided attention, so that always is better than hoping I’ll read something’*.
- **Establishing credibility** – it is also important that the people meeting with GPs have a good understanding of the service and of the clientele, so they could relate more directly to the audience and answer detailed questions. An interviewee from one pilot told us that: *‘what the team found was the message [to GPs] was better coming from the case managers than perhaps the project manager of the team because they could talk about current caseloads and results in terms of referrals as well’*.
- **Working with advocates and champions** – some of the pilots worked with particularly enthusiastic GPs who were willing to promote the service to their colleagues and facilitate access for the pilots and get their message across. Such GPs are sometimes referred to as ‘GP champions’.
- **Being persistent** – it often took a number of contacts in various forms to engage effectively with GPs. GPs have a lot of calls on their time with numerous agencies and companies wanting to talk to them, so *‘getting through the door’* could be difficult. Once engaged, GPs often needed reminders in the form of promotional material to maintain a level of referrals.
- **Maintaining visibility** – for example, some pilots found that using spare rooms in GP surgeries to assess or meet with clients was a good way of keeping GPs aware of the existence of the service and what it could offer.
- **Providing additional value** – providing additional related information and advice to GPs about developments such as the fit note and changes to the Incapacity Benefit regime and the Employment and Support Allowance was a means of gaining and maintaining access to GPs.
- **Providing GPs with client feedback** – with the client’s permission, letting GPs know the support the service had provided and what had happened as a result was felt to be a good way of sustaining GPs involvement. Some of the GPs interviewed would have liked more feedback about the appropriateness of the referrals they had made and what the service was doing for those patients who had been referred.
- **Demonstrating the value of the service** – through developing and disseminating case studies which demonstrate the benefits of the service to both the patients and GPs (for example, in the form of reduced patient time). Demonstrating the link between the FFWS and the fit note, and that a referral to the FFWS could help their patients secure a partial return to work, was another way of illustrating the value of the pilots, according to some interviewees.

The experiences of the FFWS pilots echoed those of other pilots. For example, the Job Rehabilitation and Retention Pilots (JRRP) also found it difficult to engage with GPs and the evaluation concluded that general marketing approaches, such as writing to GPs or speaking at GPs’ conferences, were ineffective. The approaches that seemed to work best for these pilots included:

- GP champions; and
- using branded sick notes – so that patients received information about the pilot and self-referred.¹⁷

¹⁷ Stratford, N., Taylor, R., Legard, R., Natarajan, L., Purdon, S. and Shaw, A. (2005). *The Job Retention and Rehabilitation Pilot: reflections on running a randomised controlled trial*. Research Report No. 305. London: DWP.

Changes for Year 2

All the continuing pilots are trying to place greater emphasis on GP referrals in their second year of operation and most have reviewed their strategy and adopted one or more of the approaches outlined above. For example, the Nottinghamshire pilot has been ensuring that GPs receive more regular and comprehensive feedback about any patients they have referred to the service and has been thinking more about *'how we get a two way communication going so that when a GP does refer a patient they understand the outcome of that referral and the impact that referral is having'*. Kensington and Chelsea appointed a GP champion in June 2011 arguing that *'If you've got somebody with that clinical credibility sitting on your team, who is able to present at the GP-facing event, for example, it might make more of an impact'*.

Perhaps the most radical change is in the Greater Manchester pilot where service level agreements have been put in place with six GP practices. The practices are contracted to provide a minimum of four referrals every month and receive a payment of £5 per referral to cover administration costs.

3.2.2 Engaging employers

Not all pilots specifically aimed to engage with employers particularly at the outset, as they were aiming to get referrals from other sources such as GPs. However, a number began to focus more attention on employers both as a source of referrals and a means of accessing employees directly. This became more of a priority for some pilots over the course of the first year as they tried to increase the number of referrals.

The approaches adopted included:

- general awareness-raising activities;
- telemarketing;
- targeting specific employers.

Awareness raising

The pilots that were looking for referrals, directly or indirectly from employers, tried to raise awareness about their services through meetings of employer networks, especially when public health issues were on the agenda. Examples include local chambers of commerce, the Federation of Small Businesses and the Chartered Institute of Personnel and Development. However, these efforts were reported by employers to have had limited success. A number of pilots had organised mass mailings to local employers but to little effect.

A few of the pilots hosted their own events for employers and one had run a series of workshops for smaller employers to help them develop their own absence-management procedures and through this publicise their services. Another offered free health checks to employees and received a number of self-referrals from employees who had health-related concerns but were not absent from work. One pilot site ran a seminar for local employment lawyers and had received one referral (via an employer), which was instigated by an employment lawyer who suggested that the employer use the service to prevent the situation in question escalating to a tribunal.

Telemarketing

Two of the pilots contacted external organisations to provide a telemarketing campaign with employers in their area, which they both felt had been successful in raising awareness about the pilot generally and securing direct or indirect referrals. The success was felt to be due in one area to the professional approach adopted. This included focusing on employers known to have an interest in health and work, providing clear messages about what the pilot had to offer, and using a professional company to make the approaches.

Targeting specific employers

Some of the pilots found more success targeting larger employers, including those in the public sector, although these employers were beyond the intended target of the pilots.

In these cases a direct, face-to-face approach appeared to be particularly successful in either getting the support of the employer or in being able to approach employees directly. For instance in one site we were told:

‘What we have done is try to target some bigger employers and go and sit in their coffee room and chat to their staff. If they can put a name to a face it encourages them to use us. We even take referrals there and then from people.’

However, another pilot had found it difficult to get some of the local large employers to refer potential clients, even though the employers sat on their steering group. Some large employers with their own occupational health provision were reported to think that the FFWS was not relevant for them, although others saw the merit of an impartial service that offered a wide range of support. A number of case managers said that in their experience some employees did not ‘trust’ their occupational health department. For example:

‘What we found is occupational health may be there but it could be that employees don’t want to talk to [them] because although occupational health is a neutral thing for bigger businesses, some managers have been known to use it like a punishment. “Oh right, you have been off work three separate occasions, you need to go to occupational health.” So their view of occupational health is more negative than positive and they could be worried about whatever they discuss with occupational health will go back to their manager.’

Overcoming the barriers

The main barriers faced by the pilots in marketing their service to employers were:

- Accessing sufficient numbers of smaller workplaces particularly in the current business climate.
- Convincing smaller employers of the value of the service as, for example, many had little direct experience of employees on long-term sick leave.

No clear picture emerged over the first year about the best way to engage employers with the service. What appeared to be a successful approach in some areas was reported to be less effective in others. As with GPs, direct approaches rather than general approaches, such as mailshots, appeared to work best. Otherwise, success appeared to depend as much on how well the activity was carried out, and whether it was targeted and sustained, than on the nature of the activity itself.

Changes in Year 2

The continuing pilots are placing a greater emphasis on marketing to smaller employers. For example, Greater Manchester has undertaken a mailshot to all small and medium-sized enterprises (SMEs) in their area and has linked in to a local good employer charter entitled ‘Good Work: Good Health’.

3.2.3 Engaging individuals

Almost one in three of 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.

A number of the pilots used general marketing campaigns with the aim of getting individuals to self-refer to the service. Approaches included radio advertising; posters on public transport; leaflets distributed through pharmacies, to workplaces and GP surgeries; and distributing leaflets at public events and in shopping centres. However, the consensus is that, with a few exceptions, such approaches may have raised the general level of awareness and profile of the services but have done little to generate referrals.

Some pilots had targeted potential clients by marketing their services in GP surgeries. In the Birmingham area pilot, for instance, case managers had distributed short questionnaires and information about the service to patients waiting in GP surgeries. The Nottinghamshire pilot ran an advert on the Life Channel in practices in Mansfield and Ashfield, placed an A5 leaflet for potential service users in surgeries and spoke to practice staff, such as receptionists and nurses, who came into contact with people who might have a need to use the service. In both cases the approach was felt to be successful in generating referrals.

The more that methods were targeted, for example, in GP surgeries or within workplaces, and involved direct contact with individuals, the more successful they appeared to be in encouraging people to refer themselves to the service. In Scotland, where the service offers a fast-track service to physiotherapy or counselling, case managers and service providers have had access to NHS waiting lists to identify people who would be eligible to come more quickly through the FFWS route. This was reported to have had a significant effect on increasing referrals.

4 The client journey

This chapter describes a client's journey through the Fit for Work Service (FFWS), from referral and the initial screening and assessment, through the provision of case management and other services, to what happens when clients leave the service. It includes data from the client survey and interviews about what they thought of the service.

4.1 The process of referral

Most pilots were flexible about the way they receive referrals and accepted telephone, email, letter or fax referrals. Some pilots, such as Rhyl, designed a referral form for referrers such as GPs to complete which asked for basic details about the person being referred. However, it was reported that these were not always fully completed or the information provided did not necessarily correspond with clients' accounts during assessments. Other pilots had decided not to use formal processes so as to make it as easy as possible to refer to the service.

The GPs interviewed who were engaged with their local FFWS were mainly happy with the referral process, although one who was asked to fax through a letter of referral said that it would have been preferable to have had a standard form to fill in with the information that the service needed.

Generally, the key pieces of information that the pilots required on referral were contact details and some information about the individual's circumstances and conditions.

4.2 Screening and assessment

In most pilots, people who were referred or referred themselves to the service were initially screened, usually by an administrator. The initial screening was carried out primarily to ensure a client's eligibility and to collect sufficient information to allocate eligible clients to a case manager. In Scotland, this preliminary screening was conducted by a call centre. In the first year in a few pilots, the case manager conducted the preliminary screening and the subsequent assessment at the same time. However, in Year 2, a screening process has been introduced in some instances, for example, in Nottinghamshire and Greater Manchester, to check eligibility and to collect basic management information about the client.

4.2.1 Inappropriate referrals

Some people who were referred to the service were identified at the screening stage as ineligible or as having a condition with which the service could not help. There are no systematic data on the number of inappropriate referrals, but the pilot interviewees generally reported they were few in number (generally between five and ten per cent, although much higher in some of the smaller pilots) and tended to:

- be unemployed – and therefore, not eligible for those pilots aimed solely at those in employment;
- work for a large employer – where the pilot only accepts employees from small and medium-sized enterprises (SMEs);
- have a chronic or severe mental health or physical condition which could not be treated by the services available to the pilot.

The numbers of inappropriate or ineligible referrals were reported to have declined over time as General Practitioners (GPs) and other referrers learnt more about the type of people the pilot services were aimed at. When pilots received a referral for someone they could not help, they generally referred them to a more appropriate agency or back to the original source of referral. For example, in the Leicestershire pilot, where individuals are not eligible to receive the service if they are on benefits and do not have an employer, they are passed onto a local service serving this type of client called the Multi Access Centres (MACs).

4.2.2 Assignment of cases

Clients were generally allocated to case managers on the basis of:

- Geography – some pilots have regional teams such as Scotland or case managers who look after particular localities.
- Health condition and client need – in some pilots (for example, the pilots in the Birmingham area, Eastern and Coastal Kent, and Wakefield), some case managers specialised in providing support to people with physical health conditions while others looked after those with mental health conditions. In Greater Manchester, where case managers do not have a clinical background, clients are allocated to the case manager with the skills that can best deal with the client needs.
- Capacity – to distribute caseloads evenly within the team, taking account of case-manager availability, and the size and balance of their caseload.

4.2.3 Assessment

Practice varied across the pilots as to how the initial assessment was conducted:

- In four pilots – Birmingham area, Greater Manchester, Scotland and Dundee – the assessment was normally carried out by telephone, although case managers would meet the client face-to-face if that was felt to be better.
- In remaining pilots the assessment was normally conducted face-to-face. In one pilot area (Eastern and Coastal Kent) the discussion normally took place in the client's home, in another it was generally at a GP practice or health centre, while in the others the venue varied, depending on the circumstances.

The assessment varied considerably in its length and coverage from around 20 minutes (for example, when carried out by telephone in Dundee), to up to two hours (conducted face-to-face by two staff in Eastern and Coastal Kent). Most pilots allocated around one hour for the initial client assessment.

Telephone assessments tended to be shorter than those conducted face-to-face. Case managers who conducted telephone assessments generally thought they worked well, and that clients seemed to feel safe, liked the comparative anonymity and talked about themselves more openly and frankly than if the interview was conducted face-to-face. However, some were concerned that an assessment over the telephone could miss something that could have been identified if the assessment had taken place in person, and found that some clients preferred to speak to them in person (in which circumstances the case managers generally resumed the discussion face-to-face). Some of the clients interviewed in the longitudinal panel also said they would have preferred face-to-face meetings in order to establish rapport.

Most pilots have set themselves a standard of arranging the initial assessment within 48 hours of receiving a referral and carrying it out within five days. One case manager explained:

'I do try to deal with things as quickly as possible, because if somebody has got up their courage to ring and ask for help I think the worst thing you can do is to let them go off the boil.'

However, in one pilot area there could be as long as a month between a telephone-based screening and a face-to-face assessment at times of peak workload, which did not seem to be in accordance with the short sharp intervention as intended by the policy.

The case managers interviewed in all the pilots said that they conducted an ‘holistic’ biopsychosocial assessment, covering medical and non-medical issues. Case managers generally tried to keep the style of the interview informal, based around an interview guide or assessment form. In some pilots, assessments were further informed by detailed clinical assessments if required and the use of standardised measurement tools.

One case manager described the assessment process as follows:

‘Once the client has been referred in, whether they refer themselves in or their employers or the GP refers them in, we make an appointment within a couple of days and go out and have a one hour assessment with them, where we fill in all the questionnaires, we talk to them about their job, what their problems are, and a lot of the times when you actually meet the person they might be off work ... say with a bad knee but then there is other contributing factors to that problem, when we get there which you know might be stress, depression, home life problems so you really need to take a whole holistic view of it.’

Looking at the process in more detail, the assessment interviews largely followed a semi-structured format and were deliberately conversational in style. Most pilots provided their case managers with a discussion guide or list of topics to cover, which generally included health, work, and any other barriers to returning to or staying in work. For instance in the Birmingham area pilot, each assessment had to cover education (are clients well-informed about the issues that they have), self-management (are they managing their health effectively) and work status (are they absent/ how is work impacted by the health condition). In some pilots the case manager completed a comprehensive assessment form, but even in these cases they tried to retain a conversational style to the interview.

Similarly case managers in Scotland reported that they adopted a conversational approach to elicit information from their clients to complete a web-based entry-assessment questionnaire covering medical and non-medical issues. In Wakefield, the case managers took brief notes during the assessment with their client and completed their pro forma after the interview. In another area a case manager explained that:

‘We’ve actually got our own client assessment form that takes all the details and some things we can transfer from the referral form anyway such as name and address. Particularly if it is a GP referral then they like to know what we’re doing with their patient so we need those details to refer back to the GP to let them know, then the assessment is quite detailed and we’ve got where we can collect some qualitative data just writing what the background information of this case is and then drill down to exactly what the work issue is and what’s the problem.’

One of the more structured assessment processes took place in the Kensington and Chelsea pilot. The case manager carried out a range of assessments, for which pro formas were used to ensure that all areas of biopsychosocial need were covered and recorded in a standard format. Client needs were identified largely through the use of open questions and in-depth discussion aimed at obtaining a complete picture of issues affecting clients’ ability to return to work. The initial-assessment pro forma covered details of sickness absence, whether the client felt that their job had contributed to their medical condition, the treatment they had received before referral to FFWS, their physical symptoms, concerns of a non-medical nature including debt and family, and their psychological and emotional wellbeing. Other areas of questioning included social support, finances, medical conditions, details of their job and the potential for the service to liaise with the employer.

One of the case managers explained that:

‘People forget about other issues so we have a question that asks about any other problems, housing problems, any financial worries and we ask about relationships. It’s just really active listening and picking up from what people are saying and not saying in non-verbal communication. It’s basically the skill of the case manager.’

In a number of pilot areas additional clinical assessments were also undertaken. In Kensington and Chelsea, most clients have a separate session with a counsellor as part of the initial assessment, to identify any psychological health needs which are more difficult to identify. The counsellor assessment was introduced once it was realised that some clients with physical health conditions were not progressing because of unmet psychological needs, as one case manager explained:

‘As case managers we’re not experts in the mental health field and when the case manager sees clients for an hour we’re quite generalistic in our assessment and we wouldn’t have the clinical expertise to dig in. It wouldn’t be appropriate for us to do that, whereas the counsellor can do that and she can pick up on different cues.’

Health and well-being measures

Case managers also used measurement tools or standard assessment measures to assess an individual’s health or well-being and track their progress during their time with the service. The tools used included:

- MYMOP – ‘Measure Yourself Medical Outcome Profile’ – a patient-generated instrument to measure health outcomes.
- EQ5D – a self-reported generic preference-based measure of health outcomes, developed by the EuroQol Group.
- COPM – ‘Canadian Occupational Performance Measure’ developed by the Canadian Association of Occupational Therapists to measure an individual’s self-perception of their performance at work.¹⁸
- GHQ-12 – a short form of a self-administered general health questionnaire which assesses a person’s ability to carry out normal functions and psychological well-being.¹⁹
- PHQ9 – a self-administered patient health questionnaire which is used as a diagnostic instrument for common mental health conditions.²⁰
- SF12 – a short form survey with 12 questions (based on the SF-36 Health Survey) which assess mental and physical functioning and overall health-related quality of life.²¹
- GAD7 – Generalised Anxiety Disorder Assessment based on seven questions designed to measure an individual’s mental health.²²

Continued

¹⁸ <http://www.caot.ca/copm/index.htm>

¹⁹ Goldberg, D. and Williams, P. (1988). *A users guide to the GHQ*. London: Institute of Psychiatry.

²⁰ Kroenke, K., Spitzer, R.L. and Williams, J.B.W. (2001). ‘The PHQ-9: validity of a brief depression severity measure’, *Journal of General Internal Medicine*, 16: 606–613.

²¹ <http://www.sf-36.org/tools/sf12.shtml>

²² Spitzer, R.L., Kroenke, K., Williams, J.B. and Löwe, B. (2006). ‘A brief measure for assessing generalized anxiety disorder: the GAD-7’, *Archives of Internal Medicine*, May 22, 166(10):1092–7.

- HADS – Hospital Anxiety and Depression Scale which measures anxiety and depression on a 10-point scale.²³
- BDI – Beck Depression Inventory is a 21-question multiple-choice self-report inventory, used for measuring the severity of depression.

Some case managers felt that purely relying on assessments using standard screening instruments could be misleading, but most thought they could be helpful if used in conjunction with more qualitative information gathering techniques.

In the Leicestershire pilot, case managers generally referred all medical cases to an occupational health nurse to conduct a further assessment (by telephone or face-to-face) or to a GP/occupational health physician when necessary for a further assessment. The pilot management team believes that having non-clinical and clinical staff working together was an important part of the process of biopsychosocial assessment, as they were able to discuss each case and the different options for moving forward.

In North Staffordshire, musculoskeletal cases could be referred for a specialised assessment conducted by clinicians, and in other areas additional assessments were carried out by the specialist services to which a client was referred. One pilot manager told us:

‘There’ll be a general assessment by the case manager to clarify what their barriers to work and what their general health problems are. Obviously it will go into more depth if they go into a counselling session or a debt management session; they will do their own assessments.’

At the outset, some case managers were concerned that clients with, for example, a physical condition, might not be keen on discussing more psychosocial issues. In the event, most found that clients were happy to talk about work-related issues, although some tended to be less forthcoming about domestic or personal matters. Case managers tried to explain to clients the reason for conducting such a comprehensive assessment and the need to collect such a range of data.

During the assessments a number of pilots use a psychosocial flag system²⁴ to identify the risks attached to a client or their likelihood of returning to work. For instance in Eastern and Coastal Kent, the outcome of the assessment process was a series of RAG (red/amber/green) ratings around barriers to work (for example, practical barriers such as access to healthcare, transport, debt; worker identity and motivation to return to work; issues with work and the workplace, etc.). Based on the number of red, amber or greens, a score was calculated denoting the complexity of the case.

Assessment is an ongoing process

A number of case managers emphasised that the client assessment did not stop after the initial interview(s) and that some issues only came to the surface over time. For example, in one area, the case managers felt that clients were relatively open about their work situation, but less willing to divulge problems with debt, alcohol or their home lives at the outset. These are issues that the case managers felt often needed to be uncovered over time, as the trust between client and

²³ Snait, P.R. (2003). ‘The Hospital Anxiety And Depression Scale’, online: <http://archinte.ama-assn.org/cgi/content/full/166/10/1092>

²⁴ For example, one based on Kendall, N.A.S., Burton, A.K., Main, C.J. and Watson, P.J. (2009). *Tackling musculoskeletal problems: a guide for the clinic and workplace – identifying obstacles using the psychosocial flags framework*. London: The Stationery Office.

case manager developed. One case manager highlighted how it can take a number of weeks and discussions with the employer, as well as the individual, to really understand some complex problems and to separate client perception about their situation from the reality. Another said that:

‘Assessment can be part of the ongoing process because it might be that you do a piece of work, it might not quite work or there might be parts of it so you reassess again. So it’s pretty much an ongoing tool that we use.’

4.2.4 What works?

In the survey, clients expressed a high level of satisfaction with their initial assessment, with 72 per cent saying they were very satisfied and 21 per cent saying they were satisfied. Only three per cent expressed dissatisfaction with this element of the service.

From the interviews with case managers, the main features of an effective assessment appear to be:

- An holistic approach, covering all relevant aspects of the client’s health, work and domestic circumstances.
- Ensuring the discussion is client-led but with some kind of framework to prompt discussion about all the key issues, but which does not restrict discussion of the salient circumstances and issues for the individual.
- Case managers who have good listening skills and encourage clients to open up.

There were felt to be advantages and disadvantages associated with both telephone-based and face-to-face interviews. The former were thought to be time efficient, preserve client anonymity and help focus the discussion, but could miss sensitive or latent issues. Meeting the client face-to-face enabled the case manager to more easily establish a relationship and delve into issues in more detail. However, meeting clients in person could take more time. Having two people to conduct an assessment could add to the information collected but was felt to be particularly resource intensive and some interviewees questioned whether such an approach added sufficient value.

4.2.5 Return to work plans

The outcome of the initial assessment was generally an action or ‘return-to-work’ plan. From our interviews with case managers it appears that there was no standard format for such a plan across the Year 1 pilots. In some pilots they were fairly detailed working documents. They tended to identify the issues facing the client, set goals, identify the support that the service would provide the client and indicate additional services that could help the client meet their goals. In these pilots, for example, Greater Manchester, the action plans were reported to be fairly active documents regularly reviewed and updated in subsequent meetings between the case manager and the client.

In other pilots the action plans were said to form a less central element of the case manager/client relationship. In Leicestershire, for example, although the initial action plan was seen as a form of ‘contract’ between the client and the service, setting out their mutual obligations to each other, it was seen as more of an initial engagement tool and rarely reviewed and updated. In Eastern and Coastal Kent the plan was described as a ‘goal’ rather than an ‘action’ plan and was felt to be too broad to have significant ongoing value.

In Scotland, where case management was provided by telephone, action plans were agreed verbally and did not exist in documentary form. Case managers maintained notes of actions on their client file.

Around two-thirds (67 per cent) of respondents to the FFWS client survey said that their **first meeting** with the FFWS had included ‘the development of an action plan to help you stay in or return to work’ or that they had subsequently been provided with a plan (Table 4.1). The responses varied by pilot area from 83 per cent in North Staffordshire to 59 per cent in Scotland.

Table 4.1 Proportion of FFWS clients with an action plan by pilot site

	Column %	Base
North Staffordshire	83	(35)
Leicestershire	65	(51)
Rhyl	64	(90)
Greater Manchester	61	(23)
Eastern and Coastal Kent	60	(25)
Scotland	59	(37)
Total	67	(311)

Note: results for individual pilots are only included when the number of responses exceeds 20 as below that level the results are likely to be statistically unreliable.

Source: Fit for Work Service User survey (Wave 1).

However, this result is likely to reflect the nature of the service provided and the actual wording of the question asked, as respondents in a telephone-based service, such as Scotland or Greater Manchester, were not likely to have actually ‘met’ their case manager at the assessment stage.

In most cases (89 per cent) respondents reported in the survey that their case manager was involved in drawing up the action plan. A further 30 per cent said that a health professional (other than their GP, such as a physiotherapist, mental health nurse or counsellor) was involved in drawing up the plan and this percentage rose to 75 per cent in Scotland. In 15 per cent of cases respondents reported that their employer was involved and this was most common in North Staffordshire (24 per cent of cases), and ten per cent of respondents said their personal GP was involved (29 per cent in Greater Manchester).

In most pilots, case managers stressed the importance of the client ‘owning’ the plan and being responsible for its contents. In at least a couple of pilots, with the consent of the client, action plans were sent to their GP or other referrer.

The plans covered a range of actions according to the client survey (Table 4.2). In most cases (89 per cent) respondents said that their action plan included actions to improve their health (including help with managing a health condition or lifestyle changes to improve health condition). Over half (57 per cent) of the respondents reported that their action plan included help with their work (such as phased return to work, mediation with employer or ergonomic assessment at work).

Table 4.2 Content of FFWS action plans

	Column %
Physical therapy or treatment (such as physiotherapy or therapeutic exercise)	50
Phased return to work	43
Help with managing a health condition	42
Help with stress or mental health issues (such as psychotherapy or counselling)	40
Lifestyle changes to improve your health condition (such as diet and exercise)	31
Mediation with employer	30
Provision of careers information, advice or guidance (IAG) including advice on training or qualifications	19
Ergonomic assessment at work such as sitting position, posture, repetitive movements and work speed	14
Getting advice on debt or financial issues	12
Other (including personal goal planning)	4
None of these	1
Not stated	1
<i>Base</i>	<i>(207)</i>

Note: Multiple response question, does not sum to 100 per cent.

Source: Fit for Work Service User survey (Wave 1).

A number of pilots held regular team conferences (weekly or fortnightly) to discuss particular cases and coordinate delivery of the service.

Client satisfaction

As with the assessment, clients expressed a high level of satisfaction with their action plan in the survey. Nearly three-quarters (72 per cent) said they were very satisfied and 23 per cent said they were satisfied. Only four per cent said they were dissatisfied.

4.2.6 Changes for Year 2

The main changes to the screening and assessment process in the continuing pilots appear to be among those that have introduced a screening stage to:

- check on client eligibility – with the greater emphasis placed on recruiting employees on sick leave;
- collect a standard set of data from each client across all the pilots as part of a revised management information requirements – which involve administering the EQ5D questionnaire.

In one pilot, Rhyl, a client agreement was introduced as part of the action plan which set out the costs to the pilots of services provided free at point of delivery with the aim of reducing the number of clients who did not show up for therapy sessions. There was some evidence, described by interviewees as ‘anecdotal’, that this change was having a beneficial effect in reducing the number of ‘no shows’.

4.3 Case management in practice

Case managers performed a crucial role in the provision of the service, although the nature of the role varied across the pilots. At a minimum, it involved assessing and managing individual cases and organising access to the necessary support, although the way in which cases were managed and support provided varied. In some pilots case managers were more actively involved in providing support to clients themselves, for example, in the form of low-intensity talking or physical therapies. In most pilots the case managers provided some form of employment support.

Most case management was provided in-house. In three pilots the role of case manager was contracted out to an external agency. In one of these, there were significant tensions between the delivery organisation and the pilot management about the roles and responsibilities of those involved in delivering the service as a whole. Two of these three pilots have not been funded for a second year.

4.3.1 Marketing

In most pilots the case managers were involved in marketing the service to GPs and other potential referral sources. This has mostly been an opportunistic role made necessary and possible by the lower than expected number of clients – see Section 2.3.

4.3.2 Assessment and goal setting

In all the pilots case managers were responsible for making the initial detailed assessment of client needs and working with the client to draw up an action plan and set goals, for example, about returning to work (see Section 4.2.5).

4.3.3 Client support

Once an action plan was drawn up, case managers supported their client to reach the goal that had been set by helping them to monitor their progress, providing ongoing support and encouragement, providing direct forms of support where appropriate, and liaising with all the other parties identified in the plan. This element of the role was described by one case manager as follows:

‘It is about that motivation and that urging the person on and just being able to communicate between the different people that are all taking part in this plan of care for the individual.’

Most of the case managers interviewed stressed the importance of clients taking responsibility for developing and meeting the goals themselves. One case manager described this process as being *‘supporting rather than suffocating’*. They also tended to stress that their role was not to be an advocate for their client and that they had to be willing to challenge them and adopt an impartial stance in mediating with employers.

Goal monitoring and ongoing contact

In all pilots, case managers generally remained in active contact with their client during their time with the service. Contact could be face-to-face, by telephone, text or email and varied in frequency depending on the situation, although most case managers said they tried to keep in contact with their clients on a weekly basis at least. In a number of pilots, for example, Dundee, client progress was monitored at regular case team meetings or case conferences.

4.3.4 Provision of direct support

As part of the role, case managers would work with their client to boost their motivation and confidence and provide general advice. In most cases, if required, they would support their client in talking to their employer. In addition, in some areas case managers provided low-level clinical support.

Employment support

In nearly all the pilots, case management involved liaising between the client and their employer about issues affecting their work, and helping to negotiate any modifications or adaptations to work patterns, duties or surroundings that could help with their health condition. This could take the form of preparing their client to talk to their employer or talking to the employer directly. In two pilots it was estimated that such support was required in around 50 per cent of cases.

One case manager described this aspect of the role as:

‘Trying to find a match between what the client can do, based on feedback from the therapist and the client and then trying to match it with what the job demands are, and bearing in mind that we need to please employers as well. So it’s kind of balancing business need with the client’s rehab need, and it’s like a little dance.’

In some pilots, such as Eastern and Coastal Kent, this form of support was provided by a specialist member of the in-house case management team. In one pilot, North Staffordshire, employment support was provided by a specialist agency which was part of the delivery partnership.

Low-intensity clinical support

In six of the pilots, members of the case management team also provided low-level clinical support to clients, for example, in the form of pain and anxiety management, providing guidance on posture improvement and relaxation techniques, low-level cognitive behavioural therapy, or neuro-linguistic programming.

For example, in one pilot, case managers were trained to help clients with either physical or mental health conditions; clients were allocated accordingly. The role of the case managers working with people with physical problems was to educate people about their symptoms and conditions’ likely trajectories, particularly how to manage conditions (for example, through pain management). Other case managers were trained to work with people with anxiety, depression and work-related stress, and they used various therapeutic techniques to educate clients and help clients manage symptoms and problems. They were delivering a form of talking therapy drawing on various recognised approaches.

In another site, the case managers were able to provide (low intensity) support with physical health conditions which included verbal advice about exercises rather than physical therapies, while mental health interventions could consist of an activity-focused action plan and self-management rather than talking therapies such as cognitive behavioural therapy (CBT).

In one site we found that some of the specialist providers involved in delivering additional services were concerned about the potential confusion or worse that could be caused by the case manager and a specialist therapist giving a client conflicting advice. This suggests the importance of good communication between case managers and specialist providers about the support provided to clients.

4.3.5 Access to other services

Where clients required services beyond what the case manager could provide, their role involved accessing additional support:

- from elsewhere within the in-house team, for instance from colleagues with other specialist roles of backgrounds;
- from elsewhere within the partnership; or
- through referring or signposting to external agencies.

Case managers were usually responsible for onward referral or signposting to specialist provision, but in one pilot onward medical referrals were made by an in-house team of occupational health nurses. Case managers coordinated the client's journey through the onward services to which they were referred or signposted (see Section 4.4).

4.3.6 Sign off and follow up

Finally, case managers were involved in discharging their clients from the service and subsequent follow-up (see Section 4.5).

4.3.7 Case managers' backgrounds

In most pilots the case managers came from medical backgrounds: most commonly physiotherapy, psychotherapy or occupational therapy. In some of these pilots, there was a mix of experience across the team, for example, with some case managers trained in mental health and others with a background in physical therapy. In one site, Kensington and Chelsea, the team was drawn from people trained in rehabilitation counselling and human movement with a background in vocational rehabilitation and in another area the case managers were trained occupational therapists.

In two pilots, Rhyl and Greater Manchester, the case managers had non-medical backgrounds with experience in either workforce development or human resource management. In a further two pilots, the case managers came from a mix of medical and non-medical backgrounds. In Wakefield the case managers had nursing, employment advice, marketing and training backgrounds. In the other, Leicester City and Leicestershire, the case managers (who included a trained nurse and people with experience of employment support) worked alongside two occupational support coaches.

Interviewees from the pilots identified a number of advantages in case managers having a clinical background including establishing credibility with GPs and other health professionals who referred clients to the service, and the provision of some forms of clinical support. However, in some pilots, interviewees thought that their pilot was too clinically focused, as there was often an issue with the client's work or employer, and there was usually a need to at least talk to the employer. One case manager (from an employment service background) told us that:

'I'm not sure whoever thought up the project had quite understood how many work related issues there might be. I think ... by the time we get involved with people even though it's four to 12 weeks quite often it isn't the first time they've been off so this is a repeating pattern and from the time we get involved there are quite a lot of employment issues as well and I think the balance in the team hasn't been right to reflect that.'

Key competences for a case manager

Case managers and others working with them were asked what they thought were the key competences required for the role. The main skill identified was:

- Communication – and in particular the ability to connect with their clients which involved a combination of listening skills, empathy, the ability to influence people as well as deal with a range of other people.

One case manager explained that:

‘You need excellent communication skills both verbally and written because as a case manager it is quite communication heavy. You’re on the phone all the time liaising with difficult clients but also employers so you have to be persuasive, you have to change communication style depending on the response you get from employers because it can be quite hostile, can be quite tricky because the environment we’re coming into there’s often a claim between the employer and the employee or there’s some tension and you’re trying to get someone back to work to the same job.’

Some stressed the ability to identify key issues affecting clients’ health and well-being, which could require a clinical background.

The other key skills and competences that were highlighted include:

- adaptability and flexibility;
- mediation skills to liaise with employers;
- organisational skills;
- teamworking skills;
- understanding what services were available for clients in their area.

In addition to induction training and familiarisation with their site’s systems and processes, some of the case managers had received training in motivational skills, mediation, dealing with alcohol and drug dependence, dealing with anxiety, and vocational rehabilitation.

However, not all case managers felt they had the full set of skills required and some interviewees identified some further training needs. For instance one case manager said that they could benefit from *‘some training on how to negotiate with difficult employers, or just some negotiating training, because that’s actually something that I think is probably quite new to me as a clinician’*.

4.3.8 Caseloads

The number of clients looked after by a case manager at any one time varied, partly with the type of model in operation and to an extent the level of take-up of the pilot, as most were operating at below full capacity.

In the pilots offering a face-to-face case management service, caseloads were around 20 and most generally felt they could cope with more. In two pilots the caseload – based simply on the number of clients who had passed through the service divided by the number of case managers – seemed considerably higher. In the pilots providing the telephone-based service, caseloads were generally two or three times higher. One case manager in a telephone-based service had 43 cases at the time they were interviewed which they thought was *‘completely manageable’*. The available evidence suggests that case managers could cope with higher caseloads if demand increased.

4.3.9 Client satisfaction with case management

Respondents to the client survey were generally happy with their case manager, with 76 per cent saying they were very satisfied with the service they had received and a further 17 per cent saying they were satisfied. Only six per cent expressed dissatisfaction with case management.

4.3.10 Models of provision

In all the pilots, case managers offered **guidance** to their clients and a **gateway** to other services if required (see Section 4.4). However, the form of guidance offered by case managers varied. In all pilots the case managers offered support with goal setting and monitoring as well as confidence building and motivation. In nearly all they offered support with the client's employment situation, helping them 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. This distinction could be characterised as the difference between offering 'guidance' and 'guidance plus'.

4.4 Additional services

Most FFWS clients needed forms of advice, support or treatment beyond that provided by the core case management service, and all the pilots provided their clients with a gateway to additional services either within their delivery partnership or wider. There were differences in the range of support on offer and pilots also varied in:

- **The process of accessing support** – with a distinction between direct **referrals** (where case managers contact the third party to make an appointment for their client) or **signposting** (where information on how to contact the third party is passed to clients who then make their own appointments or go back to their GP for them to make the referral).
- **The speed of access** they offered clients particularly to clinical services such as psychological therapy or physiotherapy services (through special funding or contractual arrangements, sometimes with non-NHS providers such as MIND) and those which relied on standard NHS referrals to local providers, including Improving Access to Psychological Therapies (IAPT) in some areas. Most (seven) of the pilots had the ability to fast-track their clients to at least some clinical services by, in effect, buying additional capacity. Four pilots, Kensington and Chelsea, Rhyl and the two Scottish pilots, could provide fast-track referrals for their clients to either physiotherapy or psychotherapy and clients could also be fast-tracked to occupational therapy in Scotland. The Leicestershire and North Staffordshire pilots could fast-track clients to physiotherapy but not to psychotherapy which was provided on the usual basis by local IAPT services. In the Birmingham area pilot it was reported that their fast-track facility had been little used as in-house services had generally met their clients' needs.

Pilots without fast-track arrangements, such as the Eastern and Coastal Kent and Nottinghamshire pilots, could refer clients to clinical services but on the basis of normal NHS arrangements. In Wakefield, clients could be referred directly to the local IAPT service, but for physiotherapy clients had to go back to their GP for a referral. In Greater Manchester, clients were signposted to clinical services rather than referred.

All the pilots had made connections with a range of other non-clinical service providers in their area that could offer support to their clients if they needed it. In most cases clients were signposted to these types of services, but some of the pilots had additional arrangements with such providers to supply their clients with quick access to services such as debt advice or information advice and guidance.

4.4.1 Internal or external provision

Additional clinical and non-clinical services were provided by organisations who were either part of the local pilot partnership, or that had a direct contractual relationship with the pilot to provide services but were not involved in the pilot itself or part of the wider community. The advantages of having direct partnership or contractual relationship were felt to be:

- It could facilitate fast access – fast-track arrangements were usually made through some form of contract or service agreement.
- It enabled a good exchange of information – case managers could provide the service provider with information about the client, and providers could be requested to provide feedback on the clients who had been referred.

In some pilots, changes to the arrangements with direct-service providers had been made during the course of the pilot. For example, two pilots had changed the method of payment from a block provision to paying on a case-by-case basis, as the number of referrals had been less than expected. In one pilot the contract with one of the service providers involved in the first year was not continued, because case managers were dissatisfied with the quality and frequency of the feedback information received about their clients.

4.4.2 Non-clinical provision

Most pilots developed comprehensive databases or directories of local services to help case managers identify sources of external support. Examples of the non-clinical services that clients had accessed include advice and support with:

- anger management;
- business creation and development;
- changing career and job search (including CV preparation and interview practice);
- debt management and counselling, and financial support;
- employment law (for example, through the Advisory Conciliation and Arbitration Service (Acas) or Citizens Advice Bureau);
- housing;
- job skills training (including vocational skills, basic skills and English for Speakers of Other Languages (ESOL));
- making workplace adaptations (Access to Work);
- nutrition and diet;
- pain management;
- physical health and lifestyle, including help with substance abuse and smoking cessation;
- self-harm;
- welfare benefits.

A few gaps in local provision were identified, including help with anger management and eating disorders in some pilots, and some reported the need for more higher-intensity psychological therapy services in areas without IAPT. In some of the wider-ranging areas, access to IAPT was felt to be ‘patchy’ and case managers said they would have benefited from a more uniform provision.

Aggregate management information reported by pilots provides information about the additional services (in addition to case management) to which clients are referred. Such services could be provided by organisations within the delivery partnership or outside. Leaving aside case management and the support directly provided by case managers, the most common service to which clients were referred in Year 1 was physiotherapy (29 per cent of cases), followed by psychological therapies (12 per cent), specialist employment advice (ten per cent) and occupational therapy (8.5 per cent) (Table 4.3).

Table 4.3 Services used by FFWS clients, all pilots, year to March 2011

Service	Percentage of clients	N
Physiotherapy	29.3	1,970
Psychological therapies	12.0	808
Specialist employment advice (support finding a new job)	9.9	669
Occupational therapy	8.5	570
Employment mediation	4.5	304
Occupational health	3.7	247
Debt advice	3.5	234
Learning and skills advice	1.9	129
Other types of treatment for musculoskeletal conditions	1.2	81
Legal advice	1.1	77
Advice about alcohol/drug misuse	1.1	75
Housing advice	0.7	49
Relationship advice	0.2	16
Other	12.0	806
<i>Base (total number of clients)</i>		6,726

Source: FFWS management information report, July 2011.

The data from the FFWS client survey shows a broadly similar pattern, despite the fact that the survey sample has a different composition to the client population as a whole. Some 41 per cent of respondents had been referred or recommended to contact a physical therapy service and 27 per cent had been referred to some form of psychotherapy provider (Table 4.4). In addition, at least ten per cent of clients had been referred to services to do with their current job such as an ergonomist; advice to improve general health, such as smoking cessation; and other work-related support services such as training or careers advice.

The survey also asked respondents who had been referred to a particular service whether they would have contacted that service in any event. Only 31 per cent of clients who went to physiotherapy said they would not have contacted the service without the intervention of the pilot and therefore, implicitly most would have gone to physiotherapy in any event. The pilots appear to have had more of an impact, at least among survey respondents, in enabling clients to access other, mainly non-health related, services. For example, over 70 per cent of respondents said they would not have got in touch with an ergonomic assessment type service without the help of the FFWS.

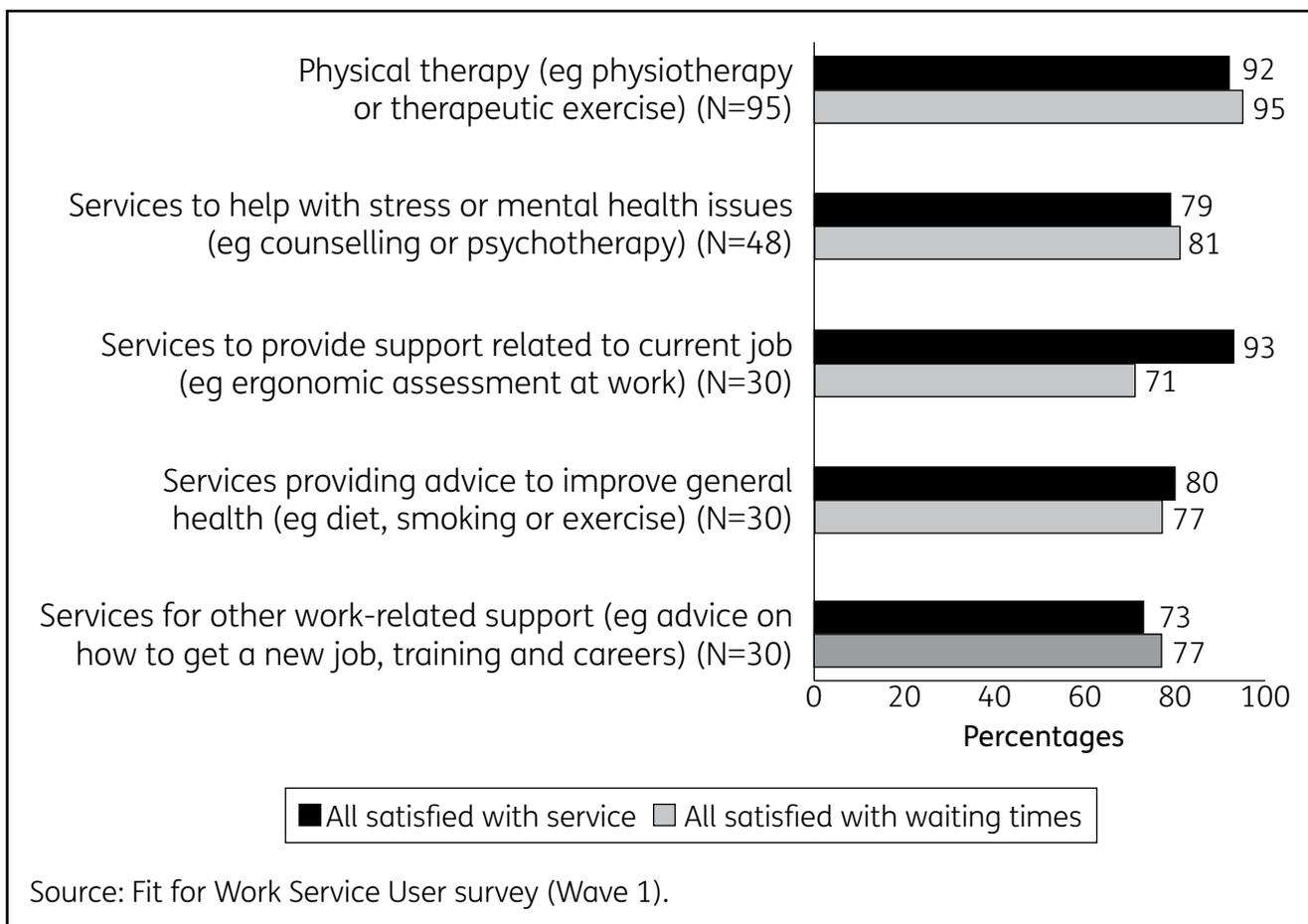
Table 4.4 Services to which FFWS clients are referred and whether they would have gone anyway

	Referred to or recommended to contact the service (column %)	Would NOT have contacted the service anyway (row %)	N
Physical therapy	41	31	127
Services to help with stress or mental health issues	27	47	83
Support services related to your current job (ergonomic assessment)	15	71	48
Advice to improve your general health (such as diet, smoking or exercise)	15	63	48
Other work-related support services (such as training and careers advice)	14	56	43
Other health-related referral	9	62	29
Other advice services not related to work or health (such as debt, financial, relationship)	9	62	29
None	20		
<i>Base (total number of respondents)</i>			311

Note: multiple responses allowed.

Source: Fit for Work Service User survey (Wave 1).

In the survey, clients were generally satisfied with the service they received and the time they had to wait to access the service. Respondents who went to a physiotherapist were particularly satisfied with the speed of referral and the service they received. Over 90 per cent said they were very or fairly satisfied with their experience (Figure 4.1). Clients were less satisfied, but still positive, about the waiting times for psychological therapies and the service they received from work-related supported services, for example, about changing their job or career.

Figure 4.1 Satisfaction levels with referral services and waiting times (%)²⁵

Changes in Year 2

Some of the pilots had rearranged elements of their partnership in the second year and had, for example, dropped service providers for whom it transpired there was very little demand or with whom the pilot was not happy about the level of service received.

4.5 Leaving the service

According to case managers, clients generally left the service when they had met their initial goal or there was nothing more that the service could do for them. The point of discharge was generally set by mutual agreement, although in one pilot the aim was to discharge clients two weeks after they returned to work. Another pilot set a target maximum length of time with the service of 12 weeks, although this could be exceeded in some circumstances.

In most pilots, case managers kept in touch with their clients after they were formally discharged from the service, to ensure they did not experience any further problems. Most got in touch again after three months and a few after six months as well, at which point they administered further health assessments (such as EQ-5D) to measure clients' progress.

²⁵ Clients were asked to express their satisfaction on a five-point scale: very satisfied; fairly satisfied; neither satisfied nor dissatisfied; fairly dissatisfied; very dissatisfied.

In large part, interviewees in the longitudinal panel who said contact had ended knew in advance that they were being discharged and had no outstanding need for support from the FFWS. However, feeling vulnerable in work or wanting FFWS contact to last longer was described by some people who said that support from the FFWS was not available once they had returned to work.

In some cases, contact ended when the service was not able to help a client make progress. People in this situation included absentees who were recovering from an operation or had a chronic disease. There were also people who had found that the case manager lacked empathy and did not want further support or perceived that the case manager thought they did not want to work. There was also a client whose musculoskeletal problem did not improve with FFWS physiotherapy and whose contact ended after FFWS referred them for hospital tests.

While some clients had received or expected further contact after being discharged from the service, in other cases contact appeared to end rather abruptly, as one interviewee described:

'... the service was really good and then, all of a sudden, I haven't heard anything and I don't know why, because, up until that point, I mean, I don't know whether she's left ... or whether I came to the end of my time, I don't know. It was, kind of, just left a bit ...'

4.5.1 Expectations about future contact

Many people were aware that they were welcome to re-contact the service should the need have arisen in the future. Some people did not see a need to renew contact with the FFWS, particularly in cases where health or employment problems had been resolved or where the client had retired from paid employment. Furthermore, people who had been disappointed with the FFWS did not expect to contact the service again.

However, some people expressed intentions to seek further support from the FFWS after being discharged or losing contact with the service if their health or employment circumstances changed and they thought the service could help them again.

Finding that the service had been beneficial was important in people's thinking about the likelihood of returning to the service. However, one interviewee, referred by a GP, was uncertain of how to access the service again and this was a potential barrier to them going back for further help if they thought they needed it.

'Bounce backs'

In some pilots case managers found that a few of their clients came back to the service for more support some time after they had been discharged. There were a range of reasons why some clients 'bounced back', including where a return to work was expected but didn't happen, a repeat flare-up of the original health condition, or a newly emerged health issue. Some clients were re-referred to the FFWS by their GPs following a period of no contact with the service (despite repeated attempts by the pilots to engage with the clients).

4.6 Clients' views of the service

Respondents to the FFWS client survey were generally positive about their overall experience of the service. They were asked to think about the overall service they had received from the FFWS and say how much they agreed or disagreed that the service had been: responsive to their needs; well coordinated with other health and employment services; offered a personalised service; and referred or signposted then to relevant support. The vast majority of respondents agreed or strongly agreed on all four counts (Table 4.5).

Table 4.5 Overall opinions of the FFWS

	Responsive	Coordinated	Personalised	Relevant referrals
Strongly agree	75	63	73	64
Agree	13	19	16	19
Neither agree nor disagree	5	7	3	5
All disagree	7	11	8	12
Total	100	100	100	100
<i>Base</i>	<i>(309)</i>	<i>(274)</i>	<i>(305)</i>	<i>(282)</i>

Excludes don't knows and not applicable.

Total may not sum to 100 per cent due to rounding error.

Source: Fit for Work Service User survey (Wave 1).

The survey respondents who expressed disagreement with at least one of the statements about various aspects of the service were more likely to have a mental health condition than a musculoskeletal condition. They were also more likely to think that the FFWS had not helped them to stay in work and report poor general health at the time of the survey.

Among the interviewees in the longitudinal panel positive views centred on:

- The fact that individual needs had been met and interventions had been beneficial. For example, one client said:

'As an intermediary, they obviously offered something that no one else did. The GP didn't offer this service, they just treat your illness or whatever, but this, kind of, went beyond the illness and dealt with the circumstances around ... they offered a service that I'm not aware of can be offered elsewhere.'

- The competence of the staff who were described as knowledgeable, approachable and understanding. One client commented that:

'I do remember just crying and feeling so relieved, somebody you know, somebody understands a bit about it and she was very nice.'

- The quality of service delivery which was variously felt to be reliable, quick, flexible, in depth, impartial, confidential, seamless and focused. Another client explained:

'... what they have been able to do for me in say two months would probably have taken 12 months with the GP putting you in queues and everything.'

In contrast, negative views were expressed when the client thought that:

- their needs had not been met;
- the service had not been reliable about keeping in touch and meeting appointments;
- staff did not seem competent and sympathetic; and
- there was a lack of flexibility in aspects of service delivery.

Contact ending abruptly without warning was also confusing for people who were expecting further contact, even if they did not need further help.

5 Client outcomes

This chapter looks at client outcomes and the numbers of clients leaving the service in the first year, the proportion of absentees who returned to work and the proportion of presentees who remained in work. It also looks at the evidence from the longitudinal panel and client survey on how the support provided by the pilots helped clients regain or retain employment and the benefits that General Practitioners (GPs) saw from the service.

5.1 Number of clients leaving the service

Of the 6,417 clients who were supported by the pilots in the first year, and for whom data are available, 4,022 had been discharged and the remaining 2,035 were either still with the service or not yet recorded as having left at the end of March 2011 (Figure 5.1).

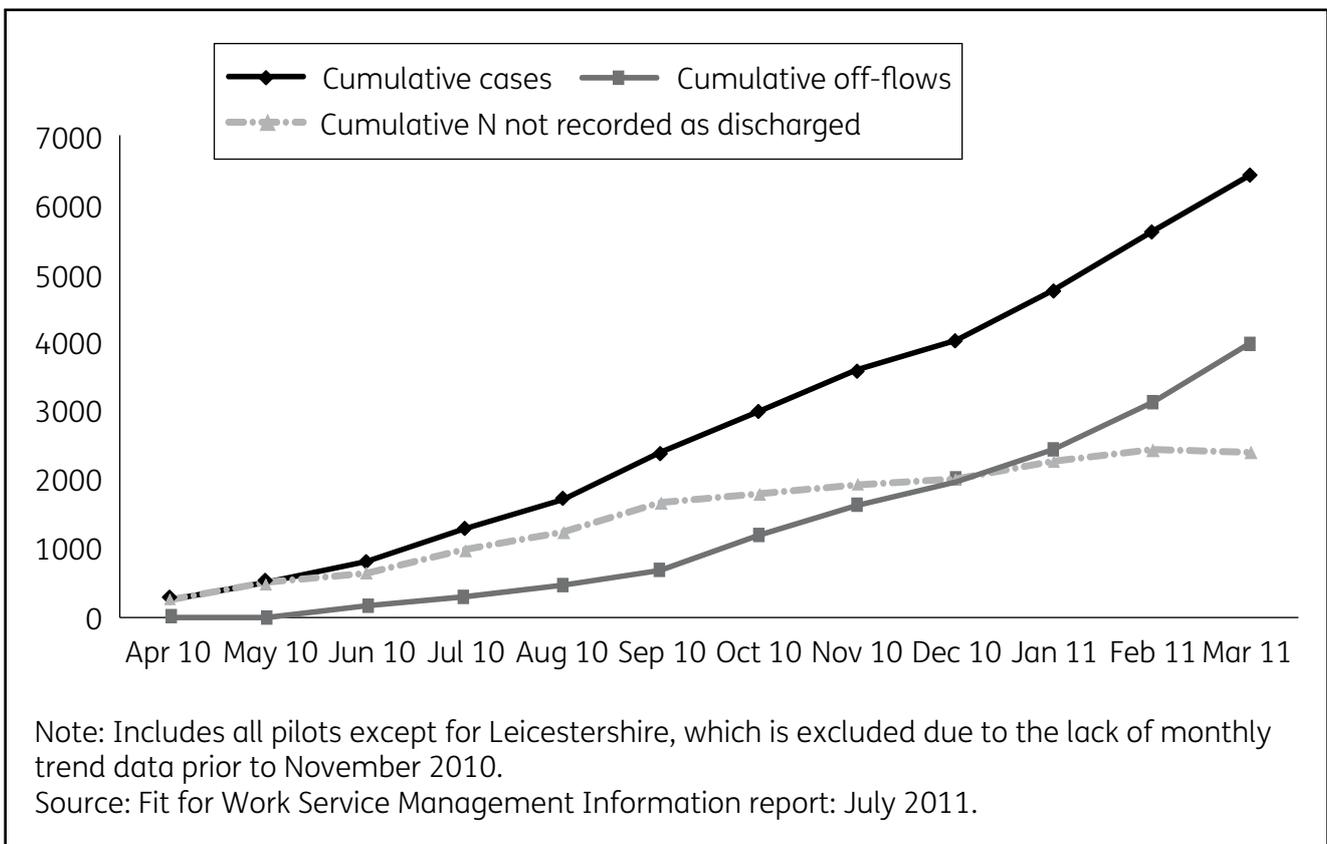
5.1.1 Length of time in service

Initial analysis of the detailed client datasets in a selection of pilots involved looking at the number of 'days on programme' in three pilots (North Staffordshire, Kensington and Chelsea, and Dundee), covering a total of 556 clients. The average length of time between assessment and discharge varied between 11 weeks and 19 weeks, with an average across the three pilots of 17 weeks. It should be noted that the length of time in the service using this measure will depend on how a pilot defines a discharge and the way the date of discharge is recorded. It also should be noted that these data include presentees and absentees, and the latter could be discharged some weeks after they returned to work.

One case manager told us that:

'What I personally do is it's a couple of weeks before I actually think about discharging them that I say you know you are doing really well, you are in week 2 or week 3 of your phased return we will be thinking about discharge in a few weeks time. Just so that they are aware and if there is any issues you know within those couple of weeks that they can raise them and we can iron out then. Then there is a discharge pro forma that we actually go through, and we repeat [the measurements of health outcome].'

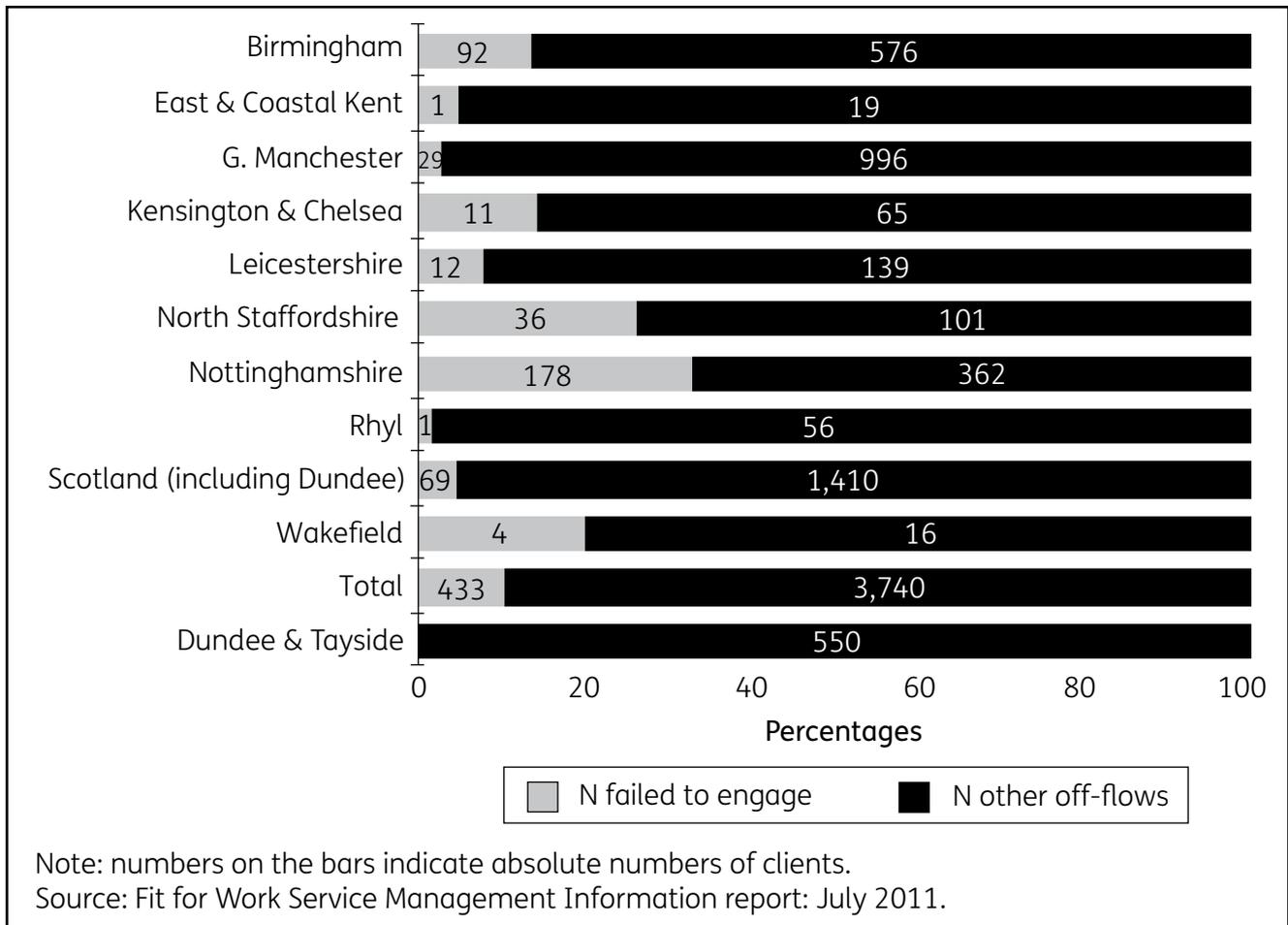
Figure 5.1 Cumulative cases, cumulative off-flows and net numbers in the service, start of pilot to end March 2011



5.1.2 Clients who failed to engage

People who leave the service are formally discharged, drop-out of it, or never really engage with it. The balance between these exit routes varied between pilots in the first year, although this could be as much a reflection of the way the data are collected or recorded as of clients' experience of the service (Figure 5.2). Considering all pilots together, around 11 per cent of clients failed to engage with or dropped out of the service having received an initial assessment. In the Nottinghamshire and North Staffordshire pilots over 20 per cent of clients fall into this category (referred to as 'failed to engage' in Figure 5.2), while the proportion was less than five per cent in Greater Manchester, Rhyll and Scotland (including Dundee).

Figure 5.2 Off-flows recorded as ‘failed to engage’, by pilot site, as at end March 2011



Some clients left the service early because they felt they had received all the support they wanted or found support elsewhere. One case manager referred to a client who had not liked the advice provided by the case manager about the level of their alcohol consumption.

In the rest of this chapter we describe what we know about main groups of clients who were discharged from the service:

- Clients who were absent from work with a health condition when they first became involved with the service.
- Clients who were at work with a health condition when they first became involved with the service.

5.2 Absentees

Data from the management information indicate that 74 per cent 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 (Table 5.1). Some 18 per cent were still off work, on sick leave, and eight per cent were unemployed.

Table 5.1 Outcomes of those who were off sick on entry to the FFWS, end of March 2011

	Column %	Base
Back at work	74.0	
Still off sick	17.9	
Unemployed	8.0	
Total	100.0	747

Source: Fit for Work Service (FFWS) management information report, August 2011.

There is a range of evidence about the role of the pilots in helping people back to work. For some of the absentees in the longitudinal panel, the FFWS was reported to have helped by:

- providing significant support to return to work, without which the return would not have occurred;
- accelerating a return to work;
- easing or supporting a return to work;
- sustaining employment after a return to work.

The key role that the FFWS played in these cases included helping clients to:

- stabilise and improve health through interventions such as physiotherapy or psychological therapy;
- learn to manage symptoms better through advice about medication, workplace routines or equipment, or healthier lifestyles;
- resolve or lessen problems with employers by liaising directly with them, advising employees about effective ways of negotiating with their employer, or signposting to effective specialist support (such as legal advice);
- make progress towards work by identifying alternative more suitable job opportunities;
- helping people 'take control' of their situation by liaising with other parties on the client's behalf, or guiding people to appropriate sources of help;
- boost confidence, morale and motivation.

5.2.1 Providing significant support

A number of interviewees in the longitudinal panel felt that the service had already played a significant role in helping them return to work, which would not have occurred in the absence of the services' help. Such support included the service providing access, that clients would not otherwise of been able to have, to clinical or other support to help with their condition or help with agreeing adaptations to their working regime or workplace. The support and advice provided by the service meant that clients were more physically or mentally confident about resuming work.

5.2.2 Accelerating return to work

A number of people from all four pilots in which clients were interviewed for the longitudinal panel said that, in their opinion, the input from the FFWS had enabled them to return to work sooner than they would have done otherwise. Seeing their physical or mental health improve through physiotherapy or psychological therapy, that had been accessed through the FFWS more quickly than through the NHS, led them to believe that they were able to return to work more rapidly as a result. Some people who thought they had returned to work more quickly than they would have done without support from the FFWS, indicated that assistance focused on their employer had been instrumental.

5.2.3 Easing or supporting return to work

One view was that returning to work had been easier than expected after the FFWS ‘took control’ by contacting their employer and negotiating a detailed plan for a phased return. From the client’s perspective, contact from the FFWS prompted an immediate change in the employer’s attitude, with the employer becoming more understanding and supportive from then on. A number of people also talked about feeling supported by the FFWS throughout their return to work even though they would have returned without this help. This support was described as feeling reassured that they were doing and saying the right things with their employer, being helped to feel more confident about getting back to work, or as just having someone there if needed, to listen and give advice:

‘Mainly it has just been a confidence thing, with me. It’s just been that little bit of bolstering to help me get back.’

5.2.4 Sustaining return to work

Among people who said they might have returned to work without the FFWS, one view was that the FFWS had made an impact by helping to make their return sustainable. In many cases, people did not recover completely from health conditions before returning to work and some with chronic and recurring conditions expected their health to fluctuate. The FFWS helped to make return to work longer-lasting in a number of ways including:

- advising the client to increase their work hours and take tasks at a slower pace than they would have chosen to do;
- encouraging the client to think in new ways about situations or about balancing work with other aspects of life;
- educating the client about ways of managing their health in work;
- helping the client to be more assertive in discussions with managers, particularly regarding the number of hours they were expected to work.

Negotiations with employers could also lead to a change in role, workplace adaptations or a permanent reduction of hours, which clients felt increased their chances of staying in work with ongoing health limitations. There were also examples of people receiving valuable support when in work, which they perceived as an aid to sustaining work. This support included negotiation with a line manager to insist on adhering to the plan for a phased return, or help to identify times for rest for someone who was feeling more fatigued in work.

5.2.5 Nature of assistance provided to help people back to work

The pilots undertook a range of activity to help people back to work, which could play a role in enabling or accelerating a return to work, or in easing the transition and sustaining it.

- **Supporting clients to negotiate changes to working patterns or workplace adjustments with employers** – in some cases, the FFWS had contacted an employer on their client's behalf to explain their circumstances and negotiate, for example, alternative working hours. In other cases the service had supported clients to work with another intermediary or make their own case with their employer. For example, case managers signposted clients to legal services or supported the client to assert their own case in discussions with the employer, for example, about a phased return. In another example, a small and medium-sized enterprise (SME) employee did not want the FFWS to have direct contact with their employer, but assistance was provided through a suggestion that the client ask their GP to advise reduced hours and lighter duties when issuing a fit note.
- **Supporting clients to find new employment** – for example, in one case where the client had been off sick with depression caused by workplace bullying, help from the FFWS to alter negative thinking and improve mental health was sufficient to renew confidence to 'take control' of the situation, to resign from their job and to find a new one.
- **Offering multiple forms of support** – for some people the support from the FFWS that had been critical in returning to work was multi-faceted, including both help to improve health (through physiotherapy) or to educate about a condition, and assistance to negotiate a return with the employer (for example, suggesting a phased return and home-working). Therefore, meeting multiple needs was important where people came to the service with multiple problems, such as musculoskeletal pain and feeling that the employer was looking to dismiss them from their job.
- **Providing advice about return to work options** – for example, advice on return to work options, such as a phased return, was important for an employee who had not been aware of such options previously and who was then able to suggest a phased return to their employer. In another case, an occupational therapist's report suggesting workplace adaptations prompted an employer to purchase new equipment and the employee hoped that, as a result, the employer would be more likely to make further changes to working conditions. In these cases, support that centred on workplace arrangements was augmented by advice to improve and manage conditions (such as anxiety, insomnia and musculoskeletal pain), which was also found to be valuable.

It is important to note that this is qualitative evidence only, from the first wave on the panel study, based on the perception of the interviewees. Quantitative evidence, based on a comparison of fit note data from FFWS participants and non-participants will be available in due course which could provide more robust evidence on the net impact of the service.

5.2.6 Importance of workplace adaptations

The responses to the client survey also indicate the importance of adaptations to working patterns or duties to facilitate a return to work. Nearly three-quarters (73 per cent) of the survey respondents who had been absent from work on entry to the service but had subsequently returned did so with some change to their working patterns or duties. The most common adaptations involved changes to working hours, patterns of work, work tasks or workload (Table 5.2). Five per cent said that they had changed employers.

Table 5.2 Has your return to work involved any of the following (%)

	Column %*
Changed hours of work (such as to the number of days or hours worked)	50
A changed pattern of work (such as a later start, an earlier finish, or allowing short breaks throughout)	45
Changed duties (such as alternative tasks or providing work in another part of the organisation)	42
A reduced workload (such as sharing deadlines or reallocation of work to others)	41
Moving to a different job with same employer	14
Adaptations to premises or equipment (such as moving tasks to an area accessible to you or providing work in another part of the organisation)	11
Working at home or at a work premises closer to your home to avoid travel	5
Moving to a different employer	5
Something else (specify)	2
None of these	27
<i>Base</i>	64

*Multiple response question, does not sum to 100 per cent.

Base: all respondents who were absentees at first contact with service, who are working at time of Wave 1 survey.

Source: Fit for Work Service User survey (Wave 1).

Apart from health and workplace issues, the longitudinal panel interviews identified a number of other related factors which contributed to an employee returning to work after a period of sickness absence, in addition to the support provided by the FFWS. These included:

- personal motivation to be in work, or determination not to be absent;
- improving health and ability to manage conditions in work;
- financial considerations;
- the perceived attitude and behaviour of the employer, including their readiness to support flexible work arrangements;
- valuable support received from other services or professionals, including health services, family, trade unions and voluntary organisations.

5.3 Presentees

Nearly all the clients who were at work when they were first supported by the pilots, and who left the pilot during the first year, remained employed. Around two per cent were off sick at the time of their discharge and a further two per cent were unemployed (Table 5.3).

Table 5.3 Outcomes of those who were in work on entry to the FFWS, as at end of March 2011

	Column %	Base
Still in work	95.7	
Now off sick	2.5	
Unemployed	1.8	
Total	100.0	2,336

Source: FFWS management information report, August 2011.

Some presentees perceived that the FFWS had helped to prevent sickness absence or had minimised the impact of their health condition at work.

In one example, direct contact between the FFWS and an employer about adjusting the hours worked had helped someone with a chronic health problem to stay in work without reducing their contractual hours. Advice about medication had also been significant in feeling able to keep working. Also reducing musculoskeletal pain through physiotherapy and learning exercises that helped to manage a condition led to feeling that work was more manageable or that sickness absence had been prevented. There was also evidence that experience of support was mixed such that, for example, physiotherapy made no impression on musculoskeletal pain, but the recommendations of an occupational therapist for changes to a workstation helped to improve posture and minimise pain in work. Aside from tangible impacts on their employment prospects, some people also recognised that the FFWS had helped them to feel supported and more informed about their employment rights.

Where people had not perceived their health as impinging on their employment, the FFWS had still made an impact on health, morale and finances. By the time of the research interviews some people had already noticed reduced pain through physiotherapy exercises and advice about using painkillers. People also talked about the FFWS equipping them with techniques for managing pain, through information about exercises and good posture.

‘I now know what to do when I start to feel the pain, so as the pain doesn’t get worse, ‘cause I didn’t know what to do before.’

Advice about healthier lifestyle choices and managing stressful situations at work was also found to be beneficial. Even where no changes to health had been observed, some interviewees suggested that the FFWS had made a difference by prompting them to seek medical support for the first time, or by enabling them to access treatment more quickly than through referral to an NHS service. Improved morale was noted by a participant who was hopeful that their health would get better more quickly now that they were engaged in the FFWS. Financial savings were also perceived by a few FFWS users who would otherwise have paid for rapid access to private physiotherapy.

In the survey, most respondents (52 per cent) who were in work when they were in first contact with the service and were still in work at the time of the survey, said that they had not had any changes to their working patterns or duties. However, 20 per cent had changed their hours and over ten per cent had experienced at least one of: a changed pattern to their work, reduced workload, workplace adaptations or changed duties (Table 5.4).

Table 5.4 Has staying in work involved any of the following (%)

	Column %
Changed hours of work (such as to the number of days or hours worked)	20
A changed pattern of work (such as a later start, an earlier finish, or allowing short breaks throughout)	16
A reduced workload (such as sharing deadlines or reallocation of work to others)	16
Adaptations to premises or equipment (such as moving tasks to an area accessible to you or providing equipment to allow work to continue)	13
Changed duties (such as alternative tasks or providing work in another part of the organisation)	11
Working at home or at a work premises closer to your home to avoid travel	2
Moving to a different job with same employer (if an employee)	2
Something else (specify)	2
*Moving to a different employer	1
None of these	52
<i>Base</i>	<i>(133)</i>

*Multiple-response question, does not sum to 100 per cent.

Base: all respondents who were presentees at first contact with service, who were still in work at time of Wave 1 survey.

Source: Fit for Work Service User survey (Wave 1).

5.4 Where the pilots had not influenced clients' outcomes

The FFWS did not make a reported difference to some interviewees in the longitudinal panel including where:

- the individuals had little experience of the service (so far);
- the service had failed to contact the client as promised;
- the service did not provide support to match the client's needs or expectations;
- clients found the approach taken by staff unhelpful or upsetting, or the advice inappropriate.

5.5 The benefits for General Practitioners

GPs who had used the FFWS reported several benefits for them including:

- the holistic assessment of patients' capabilities;
- the provision of expert workplace assessments;
- the saving of GP resources.

Some GPs reported that the FFWS was better able to assess holistically whether a patient was able to return to their workplace on reduced duties because they could have access to the patient's employer and working conditions: *'I can't give specifics on my fit notes, whereas I think that the FFWS people could go and make it more specific so the patient knew what they were expecting or asking and the employer could, there could be dialogue'*. As one GP said, *'if my patient's health generally, mental and physical, improves because he goes back to work ... I've done my job'*.

Other GPs similarly said that they did not have the time in a ten minute consultation with a patient to give them the amount of support they might need with workplace issues.

Saving GPs time in repeat appointments with patients on sick leave was also seen as a benefit: *'I don't have to keep ... reviewing them frequently, and trying my best to help organise or manage their care back to work. So, it takes that group away from us for a period of time. Reduces my workload'*. Some GPs said that the FFWS might also prevent patients from going onto long-term sick leave in the first place and in this way it was seen as a constructive way to help GPs who were sometimes criticised for issuing sick notes.

One GP thought that the FFWS also had the potential to reduce spending on their budgets by cutting the amount of drugs and referrals for patients on sick leave. Similarly, the FFWS was seen to have the potential to prevent patients developing chronic conditions if they were able to access services in a timely manner.

6 Conclusions

Over the first year most of the 11 pilots successfully established a wide-ranging Fit for Work Service (FFWS) operating a biopsychosocial model by providing clinical and non-clinical support to help employees retain or resume their employment after a period of ill-health.

The evaluation has learnt a lot about how the pilots operate and the clients they have been able to reach. The remainder of the evaluation will focus more intensively on the impact of the service and will try to identify what aspects or forms of delivery appear to be most effective and for whom.

In the first year, take-up of the FFWS was significantly lower than expected and focused more on people struggling at work with a health condition (presentees) than the primary target group of people on sickness absence from work (absentees). All the pilots had difficulties securing the volume of referrals they had expected from General Practitioners (GPs) and small employers, and had little success in pursuing general marketing exercises to reach clients in other ways. They also found a strong demand for their service from employees still at work, and a number believed they were operating within the spirit, if not the letter, of the overall policy by providing (very) early interventions that helped sustain people in employment.

Significant lessons have been learnt in the first year about the best ways of engaging with GPs, who remain the most likely route through which FFWS will attract clients from the target group. All the remaining pilots are concentrating on increasing their referrals from GPs and taking a more systematic and professional approach to securing their involvement. Effective engagement strategies involved:

- initially engaging with practice managers but trying to meet GPs face-to-face to get the message across;
- establishing credibility by, for example, working with advocates and champions;
- being persistent and maintaining visibility by, for example, meeting clients in GP surgeries;
- providing additional value and ensuring GPs received client feedback;
- demonstrating the value of the service to GPs generally as well as their patients.

In the second year of the pilots the volume of take-up is lower – as some pilots such as Greater Manchester have stopped taking presentees altogether – and overall the proportion of absentees is higher, over 75 per cent in all pilots.

Attracting employees from smaller workplaces remains a particular challenge. In the first year the pilots found a demand for their services among employees and employers in larger workplaces, including in the public sector, who felt the service supplemented or enhanced the provision of occupational health schemes. This reflects concerns some employees, and indeed managers, had about the independence or effectiveness of their organisations' occupational health provision but it is not a gap that public policy was intending to fill. The original intent was to provide a service to employees for whom occupational health was not available, such as those working for small businesses, rather than supplementing existing provision provided by large employers. At any one time the vast majority of small employers will not have any employees with serious health conditions and therefore, will not have the motivation, let alone the capacity to become engaged. This serves to underline the importance of targeting individuals at the point when their need for help first arises – in other words when they go to their GP to be signed off work. Just over half of all employees work in small and medium-sized enterprises (SMEs). The proportion rises to nearly 60 per cent if the self-employed are included. If the pilots can recruit clients who are representative

of employees as a whole, then around half should be working in SMEs. To do better than that, and target those in need without access to occupational health, remains a key challenge for the service.

The clients who accessed the service in the first year were a broad cross section of the workforce in terms of age, gender and occupation. While some presented with particular conditions or circumstances that needed a specific form of treatment or support, most appeared to have multiple conditions or circumstances which could combine to form a significant risk to staying in or returning to work. This group included people with multiple health conditions often compounded by difficulties agreeing with their employer how to best work with their condition, or difficulties with their personal circumstances, including relationships and finance, affecting their capacity to work. Nearly half of the clients in the survey reported non-health-related barriers keeping them from returning to work and most thought their health condition had been made worse by work. Particularly complex cases involved combinations of all three circumstances: people with multiple health conditions, personal difficulties and problems with their employer.

In addition, the pilots worked with clients with latent conditions or circumstances, who posed another layer of complexity by presenting with one condition but also having underlying barriers to work which took time to come to the surface.

Whatever their condition, clients were generally motivated to get back to work and looking for support – either having selected themselves or been identified by their GP as someone who might benefit from the service. The pilots were, therefore, probably not working with a true cross section of long-term sickness absentees and, in particular, those who were not interested in returning to work. However, it is worth noting that 20 per cent of FFWS clients (according to the survey) had long-term health conditions and it is unclear whether the service was best designed to meet their particular needs.

All of the pilots varied in the detail of what they provided and how. However, the key distinctions appeared to be between:

- **Whether a client's assessment was conducted face-to-face or on the telephone and the depth of the assessment.** Telephone-based assessments were thought to be time efficient, preserve client anonymity and help focus the discussion, but could miss sensitive or latent issues. Meeting the client face-to-face enabled the case manager to establish a relationship more easily and delve into issues in more detail. Key to a successful 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; and having case managers who had good listening skills and encouraged clients to open up.
- **The extent of support provided by case managers** and in particular whether that extended to providing low-level clinical support as well as general guidance and employment support. Having a mixed team of case managers with backgrounds and experience of working with employers and with clinical backgrounds seemed to offer the greatest level of flexibility to meet clients' needs.
- **Whether clients were referred to additional services** beyond those provided by case managers or whether they were signposted and responsible for making contact themselves. The pilots created a wide-ranging network of additional services, particularly to meet clients' non-medical needs. However, there was some evidence from the survey that clients were more satisfied with the support they received with health – particularly physical – conditions than with any additional non-health barriers to work.
- **Whether clients had fast access to additional services**, in particular clinical support through fast-track service provision.

Combining these four criteria suggests there were three models in operation in the first year of the pilots:

- **Guidance and Gateway** – this was the ‘standard’ form of the service. Case managers assessed their clients’ needs 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** – in this enhanced model, case managers offered a wider range of support to their clients including light-touch clinical support or clients were offered 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.

These three models can be seen as points on a continuum. No one pilot fitted any of the separate models exactly but during the first year all displayed most of the features of one of the categories.

At this stage the evidence on effectiveness is largely based on the perceptions of providers and clients. On this basis the key elements of a successful approach include:

- quick access to a wide-ranging initial assessment covering medical and non-medical issues;
- ongoing case management to identify latent concerns (often non-medical) and maintain momentum towards a return-to-work goal;
- fast access to physiotherapy for those with a musculoskeletal disorder and to psychotherapy for those with a mental health condition;
- facilitating better communication between employee and employers and providing advice for return-to-work options, such as a phased return, changes to hours or work pattern, etc or to relieve workplace pressures that cause or exacerbate a health condition;
- advice to improve and manage conditions (such as anxiety, insomnia and musculoskeletal pain).

These points largely mirror the key elements of a FFWS envisaged in Dame Carol Black’s 2008 review.²⁶

It is still unclear whether the pilots were helping their clients get back to work quicker than they would otherwise have done. There is always the danger that by providing a range of services to support employees, they will wait until they have had their ‘treatment’ before returning to the workplace, and this could mean that it takes longer than if they had been left to their own devices. However, such a return may be more sustained if the issues causing or exacerbating the absence have been resolved. The survey evidence suggests that most clients would not have received the interventions they had without the support of the FFWS and qualitative evidence from the panel interviews indicates that the service helped people get back to work quicker or easier than they would otherwise have done.

Most of the pilots in the first year, were certainly geared up to help their absent clients make a quick return to work. However, this could be made more difficult by the absence of a fast-track referral system. Pilots also generally followed up their clients after they left the service and there was evidence that clients would return for additional support if they needed it. However, the low levels of re-engagement in the first year implied that clients in fact had little need of further help.

²⁶ Black, C. (2008). *Working for a healthier tomorrow: Dame Carol Black’s review of the health of Britain’s working age population*. London: TSO.

Seven pilots have received funding to extend their operations for at least a second year. A number of questions have emerged from the first year of the evaluation which might help to test the success of the original policy model. These include:

- Is engaging with GPs the best way of accessing workers on a period of sickness absence from smaller firms? If so how can this best be done?
- How can GPs be encouraged to refer patients who are not particularly proactive about seeking help but would benefit from the FFWS support?
- How can the pilots focus on health inequalities and, for example, increase the proportion of employees from more disadvantaged occupational groups?
- Four in ten FFWS absentees identified a non-health barrier that was keeping them from work in addition to their health condition. What lessons can be learnt for best practice in addressing non-health-related barriers to returning to work? Do case managers have the appropriate skill set for liaising with employers?
- The evidence on how long clients spend with the service is not comprehensive but suggests that it is over three months; is this consistent with providing a short sharp intervention as originally envisaged or do clients need longer-term support?

In the evaluation of the second and subsequent years of the pilots it will be important to focus on impact and the effect the pilots have on sustained employment and reducing the flow onto out-of-work benefits. In so doing, the evaluation should examine:

- The relationship between inputs and outcomes and in particular the relationship between:
 - how clients are brought into the service, their characteristics and their appropriateness for the service;
 - clients' assessments and the understanding the service has of their needs;
 - the interventions provided and the extent to which the services provided meet clients' needs;
 - clients' health and employment outcomes, and the speed and the sustainability of their return to work.
- The role of employers in assisting return to work and the issues the service faces in helping employees negotiate a return.
- The costs of the service and its cost effectiveness, taking into account the nature of the intervention and the financial benefits stemming from the outcomes.

Appendix A

Pilot summaries

Birmingham, Coventry, Sandwell and Solihull

Introduction

The lead organisation for this pilot is Birmingham, Coventry, Sandwell and Solihull Fit for Work Commissioning Partnership which represents 13 organisations, including six Primary Care Trusts (PCTs) (Birmingham East and North (BEN) PCT, Coventry PCT, Heart of Birmingham PCT, Sandwell PCT, Solihull PCT and South Birmingham PCT), and various local and national government partners.

The various partner organisations who form this commissioning partnership, have established a management board to oversee the establishment and operation of the pilot Fit for Work Service (FFWS). The day-to-day management of the pilot is the responsibility of an appointed programme manager, who reports to the management board. A third-party private provider is responsible for delivery of the case management service, selected following a tendering process.

A decision was made by the commissioners to follow a clinically-driven pilot model, as they felt this would be easier for General Practitioners (GPs) to engage with, work with and understand, and for other health professionals to interact with.

Background

Since the original proposal the area served by the pilot has increased in size. It originally covered parts of each of the six PCTs, identified on the basis of levels of worklessness and types of employment; measures of health inequalities; potential interest and take up by local GPs. The coverage of the pilot area was subsequently expanded to include all of the postcodes in the Birmingham area (with a working age population of 1.8 million and an employed population of around 740,000).

Referral routes to the service

Data to the end of March 2011 show that referrals came to the service from three main sources: employers (50 per cent), GPs (18 per cent) and individuals self-referring (17 per cent), with some other referrals coming in through other health professionals and specialist services such as Improving Access to Psychological Therapies (IAPT).

A range of outreach activities have taken place, including cold-calling practice managers, and organising mailshots and mailouts to GPs. Outreach activities have also focused on physiotherapy departments, health trainers, IAPT and cardiac rehabilitation services.

An outreach worker has attended Protected Learning Time (PLT)²⁷ events and cluster meetings across the Birmingham area to promote the service to GPs. They have also handed out questionnaires to people waiting in GP surgeries to determine eligibility and generate self-referrals, hosted GP events, and based case managers in GP surgeries.

²⁷ Time that is set aside during the working day to allow a member of staff the opportunity to participate in a training/learning/development event as part of Continuing Professional Development (CPD), or Personal Development.

Employers have been engaged through offering them access to the FFWS case managers onsite, to assess employees' general health and well-being, and delivering assessment and screening for various common conditions such as stress, low mood/depression, musculoskeletal disorders and other physical related issues.

Model of provision

A third-party private sector provider is responsible for delivery of the core service of case management.

An initial screening process determines eligibility. At that point a decision is made as to whether it would be more appropriate for the client to see a physical or mental health practitioner. Following this the case manager would conduct an assessment either face-to-face or over the phone and agree an action plan with the client.

The case managers are all health professionals and generally only refer where treatment needs go beyond the interventions they can offer. Because their delivery model does not enable fast-tracking they would normally encourage clients to self-refer or go via their GP to obtain further support. They have signposted to various services specialising in issues such as employment and debt advice.

Each case manager is responsible for reviewing and coordinating a bespoke action plan with the client. When this has been completed or no further needs have been identified, a decision will normally be made to discharge them from the service. Follow-up contact is normally maintained allowing the client to re-engage with the service at any stage.

Staffing arrangements

The programme manager manages the contract with the third-party provider. The original provider team consisted of a manager, senior case manager, two case managers with a physiotherapy background, two case managers with a mental health background and an administrator. An outreach worker was recruited subsequently. A PCT worker assisted in engaging with GPs and practice managers but was only available to the FFWS pilot for a short duration (two to three months).

Since the end of March 2011, the service has been wound down. Fixed-term contracts for most of their case managers were terminated at the end of April; only the most senior case manager remains from the original case manager team. The pilot also retained their outreach and engagement consultant and an administrator.

Specialist adviser staff working on other welfare-to-work Ingeus contracts were redeployed from Pathways to work from April to June to the Fit for Work team to work as case managers in order to cover the remaining caseload.

Follow-up and discharge arrangements

The action plan would form the basis of the discharge process. Once a client was seen to be independently managing all of their actions on their plan, a decision would be made to discharge them. Clients would be made aware they could re-engage with the service if they encountered any further difficulties.

Client profile

As at the end of March 2011, the pilot was working or had worked with 1,059 cases. Clients had been referred from a range of sources and mainly comprised employees at risk of sickness absence (i.e. presentees) (see Table A.1).

Table A.1 Client profile to end March 2011: Birmingham area pilot

Referral source	%	Employment status	%	Health condition	%
GP	18	Employee, sick leave	28	Mental health	30
Employer	50	Employee, at work	64	Musculoskeletal	18
Self-referral	17	Self-employed, off due to sickness	*	Cardiovascular	2
IAPT	0	Self-employed, at work	*	Respiratory	1
Other	15	Unemployed	6	Injury	1
Don't know	1	Other	0	Other	48
		Don't know	1	Don't know	1
N =	1,059		1,059		1,059

* indicates percentage less than 0.5 but greater than zero.

Percentages may sum to more or less than 100 due to rounding.

Source: FFWS Management Information report, July 2011.

Case managers viewed that phased return to work, particularly for absentees with mental health issues, had been particularly effective in helping to get people back into work earlier.

Case managers also viewed the general health and well-being of the presentee clients they had seen as 'quite poor' and believed that putting simple measures in place (such as provision of advice about maintaining good health) had proved effective with these service users.

Clients in the group that had been moved from Employment and Support Allowance (ESA) to Jobseeker's Allowance (JSA) tended to be harder to help, particularly when their health problems had a long history.

Key lessons from the first year

A key challenge for this pilot was to obtain a higher proportion of GP referrals. A project worker at a partner PCT was available to assist the Ingeus team on GP engagement for a two to three month period only.

Regarding employers, the service provider identified a greater willingness among employers to refer 'in work' employees to the service as opposed to absentees. Their experience has been that credibility with individual employers needed to be built in order to obtain access to people off work.

Eastern and Coastal Kent

Introduction

The eligible partnership (The Triple Aim Partnership) which submitted the original bid for the pilot comprises:

- NHS Eastern and Coastal Kent PCT;
- Thanet District Council;
- Kent County Council.

Due to an expansion of the pilot's geographical coverage beyond two deprived wards, governance of the project moved to the Finance Committee of NHS Eastern and Coastal Kent PCT around the autumn of 2010.

NHS Eastern and Coastal Kent were the lead partners in the pilot until December 2010/January 2011. From this date, the Director of Public Health at Kent County Council (KCC) assumed responsibility for the pilot. As part of this change, a new steering group for the project was established and oversight of the project moved from NHS Eastern and Coastal Kent PCT.

The pilot is NHS-based and was set up to provide holistic support in helping sickness absentees off work for between four and 12 weeks to return to work. The pilot's eligibility criteria have since been expanded to include presentees. The team is comprised of case managers, referred to as Return-to-Work Coordinators (RTW), from a predominantly clinical background working alongside employment specialists seconded from a third-party provider. The core delivery team makes an holistic assessment of client needs, liaises between the client, their GP, employer and other parties (for example, the client's family), and signposts or facilitates access to other services (both within and outside the NHS).

Background

The original geographical focus for the pilot was the two electoral wards of Margate Central and Cliftonville West. Both were identified as highly deprived wards. Across these two wards, there are six primary care practices (about 26 GPs) serving a total population of 40,210 people.

Since the commencement of the pilot in June 2010, the geographical coverage has been expanded twice in response to low referral numbers. The first expansion represented a threefold increase in the area covered by the pilot. This took place in September 2010. The second expansion took place in October 2010 to enable the pilot to cover the entire PCT (NHS Eastern and Coastal Kent). This covers 125 GP practices and is the sixth largest PCT in the country, with a working-age population of 455,000 of whom 335,100 are employed.

The pilot initially focused exclusively on sickness absentees. At the start of the pilot, individuals were eligible for the service if they had been absent from work due to ill-health for between four and six weeks. In June, the eligibility criteria were adjusted so that individuals off sick from work for between four and 12 weeks were eligible for treatment. From December 2010/January 2011, the pilot also provided a service to presentees.

Referral processes to and from FFWS

The pilot initially only accepted referrals from primary care services, including GPs and other services such as Increasing Access to Psychological Therapies (IAPT). Referrals originating from other sources (such as employers) were directed to contact their GPs to access the pilot service. Since December 2010/January 2011, the pilot has accepted referrals directly from employers.

Figures from the aggregate management information show that from the start of the pilot (from June 2010) until the end of March 2011, 31 (44 per cent) eligible referrals to the pilot originated from GPs; three (four per cent) originated from employers; 13 (18 per cent) were recorded as self-referrals; four (six per cent) were referred by the local IAPT provider; and 20 (28 per cent) came from an 'other' source. Anecdotal evidence suggests that many of these referrals came from local NHS services such as Chronic Pain, Physiotherapy and Occupational Therapy.

With low referral numbers and caseloads, roughly 60–70 per cent of staff time has been spent on marketing efforts. All staff have been involved in this effort. Marketing efforts initially focused on meeting practice managers, GPs and representatives from other health services face-to-face. With the expansion of the pilot to cover the entire PCT, a direct face-to-face approach was not possible. Promotional material was sent to all the GP practices in the new areas, with the intention of face-to-face contact with those practices that showed an interest. From November 2010, the pilot actively

marketed to employers. This included cold calling of local employers by employment specialists. With the change in pilot leadership in December 2010/January 2011, a steering group was established incorporating representatives from local business associations (Chamber of Commerce, Federation of Small Businesses). In addition, specialist marketing expertise from within the eligible partnership was engaged and new promotional materials produced. Marketing to GPs was reviewed and a new GP information pack produced and presentations made to GPCC (General Practice Commissioning Consortia) locality leads.

Model of provision

The pilot is a public, private and voluntary sector partnership. There are three main organisations involved in delivering the service: NHS Eastern and Coastal Kent; a local-based charity with knowledge and experience of programmes to help people sustain their employment, as well as supporting individuals who are at risk of losing their employment; and a private sector provider specialising in psychological health and well-being services.

Employment specialists seconded from the charity work alongside return-to-work coordinators (case managers) from the NHS. The role of the employment specialists is to support the return-to-work coordinators in working with employers to achieve a return to work. The private provider provides fortnightly supervision for the team (return-to-work coordinators/employment specialists).

The model of provision is based on the ‘participation in work framework’,²⁸ and involves a ‘hub and spoke’ approach, with the return-to-work coordinator acting as the ‘hub’, working collaboratively with employers, healthcare professionals and the client to facilitate a safe and timely return to work. The ‘spokes’ refer to a wider range of services that the return-to-work coordinator may access to help the client achieve a return to work. Wider services include those available through the NHS (including physiotherapy, IAPT), and third-party providers.

The model of provision includes a one to two hour client assessment carried out by two staff (one a return-to-work coordinator and one a return-to-work coordinator or employment specialist). One of these is designated as the lead on the case, the other as the second. Up until December 2010/January 2011, the lead was always a return-to-work coordinator. From that time onwards, the lead could also be an employment specialist. The assessment typically takes place in the clients’ own home, although the pilot has access to other locations if necessary. In cases where there are clearly workplace problems evident from the initial referral or phone contact with the client, an employment specialist will attend the initial assessment.

The outcome of the initial assessment is a RAG (red, amber, green) rating for the complexity of the client’s problems, and an agreed goal for the client to work towards. A letter summarising the discussion and the plan going forward is then sent to the employee and their GP. Further contact with the client is on a case-by-case basis, but may involve one or two more home visits along with telephone and email contact. Where possible, contact with the employer is made.

Up until December 2010/January 2011, clients were assigned a lead case manager on the basis of the information received in the initial referral or phone call. From that date, all referrals received direct from an employer were allocated to an employment specialist as lead.

Case management involved liaising with the client, their GP, employer and other interested parties (family, other health professionals and service providers). It also involved identifying and helping client’s access relevant services.

²⁸ Ross, J. (2008). ‘The participation in work framework: an occupation-focused perspective of rehabilitation for work’ paper presented at the 8th European Congress of the Council of Occupational Therapists for the European Countries (COTEC), Hamburg, Germany, May.

Staffing arrangements

The pilot was initially managed by an experienced occupational therapist (OT) working one day per week on the project and employed by NHS Eastern and Coastal Kent. From December 2010, a new full-time project manager was appointed from KCC.

Otherwise, the pilot team has remained the same throughout the project and is as below:

- three day per week project coordinator employed by NHS Eastern and Coastal Kent;
- a full-time team leader (an experienced band 7 OT) with day-to-day responsibility for managing the core team;
- just over five full-time equivalent (FTE) return-to-work coordinators, primarily from an OT background. One coordinator is a recent psychology graduate, and another comes from a social care and nursing background. Two of the coordinators from an OT background are newly qualified.

In addition, there are 1.6 FTE employment specialists seconded from the local charity and a team administrator.

Client profile

In the period between June 2010 and the end of March 2011, the pilot had received 93 eligible referrals and 71 of these had received an initial assessment. Table A.2 outlines the profile of these 71 clients, and how they were referred into the service.

Table A.2 Client profile to end March 2011: Eastern and Coastal Kent pilot

Referral source	%	Employment status	%	Health condition	%
GP	44	Employee, sick leave	90	Mental health	44
Employer	4	Employee, at work	8	Musculoskeletal	34
Self-referral	18	Self-employed, off due to sickness	0	Cardiovascular	7
IAPT	6	Self-employed, at work	1	Respiratory	0
Other	28	Unemployed	0	Injury	1
Don't know	0	Other	0	Other	14
		Don't know	0	Don't know	
N =	71		71		71

Source: FFWS Management Information report, July 2011.

Follow up and discharge arrangements

The decision on when to discharge a client is taken on a case-by-case basis. Clients are discharged if they become unemployed and need to find a new job. They are also discharged when the view of the FFWS team is that they have provided all the advice and support they can.

Outcomes

From the management information to the end of March 2011, and looking at clients who were off sick due to ill-health on entry to the service, 74 per cent were recorded as back in work on discharge from the service.

Key lessons from the first year

- Effective stakeholder engagement and the engagement of specialist marketing expertise early on in the project may have been beneficial in generating a higher number of referrals. Engaging GPs is a challenge, takes time and considerable effort, and may have been aided by a GP champion.
- Home assessments of clients were thought to work well and provide a useful way of gaining an holistic sense of client needs.
- Clients had more complex needs than anticipated and a more experienced team may have been beneficial. In particular, greater expertise or knowledge around mental health issues may have been useful.
- The successful opening up of a dialogue between employer and employee appears to have been perceived as key in a number of cases by staff. The skills and experience of employment specialists appear to have been important in this respect.
- The service may have benefited from clearer guidelines, processes and timeframes for working with clients. Knowing when to discharge clients appears to have been difficult. The service provided appears quite different to the short sharp intervention envisaged in the bid.

Greater Manchester

Introduction

The area covered by the pilot is the Greater Manchester City Region and the lead body is Pathways Community Interest Company.

The pilot contract was held by the North West Strategic Health Authority but responsibility for the FFWS contract has now been taken on by the Combined Authority (i.e. City Region) in response to the proposed structural reorganisation of the NHS, which aims to abolish strategic health authorities.

The Pathways Community Interest Company delivers the service. It is overseen by a steering group that includes members from IAPT, New Economy, Bolton PCT, NHS Manchester, and Tameside and Glossop PCT.

The FFWS delivers a predominantly telephone-based intervention using a social medical empowerment model, with emphasis on the social dimension. An holistic, biopsychosocial approach is used to assess each client.

Background

The pilot covers the whole of Greater Manchester (ten local authorities), with a working-age population of 2.6 million and an employed population of 1,150,000. There was no change to the geographical area covered by the pilot in phase two. During phase one, two-thirds of clients were presentees and one-third absentees. During phase two of the pilot, the target group is 100 per cent absentees. Changes to target group occurred following the Department for Work and Pension's (DWP's) policy emphasis on targeting those individuals absent from work for four weeks or more (absenteeism). Efforts will now focus on supporting absentees to return to work.

Referral processes to and from FFWS

In the first two months of phase two, the main referral routes have been IAPT therapists (around half), GPs/practices (approximately a quarter) and the remainder are employers and self-referrals. In phase one, most referrals were via self-referrals. Greater Manchester FFWS has a target of 69

per cent referrals from small and medium-sized enterprises (SMEs) in phase two. The Partnership Manager engages with all IAPT sites. Primary Care Advisers engage with the primary care sector (such as practice managers). FFWS personnel attend community events, local mental health events and meet with service commissioners to raise awareness of the service. Mailshots, 'ring arounds' and face-to-face contacts with SME employers are also carried out by FFWS team members.

Model of provision

A 'new layer' has been inserted into the screening and assessment process since Round 1. As previously, the Service Administrator continues to take initial referrals/contact information. This information is forwarded to the 'new layer' of two 'frontline advisers' who deal with the 'front calls'. This first stage contact enables the client to have an in-depth discussion about the service prior to consenting to have support and enables the advisers to collect detailed information about the client's employment and health condition, including detailed information around the fit note, the type of fit note, the start date, end date and what is written on the fit note. The advisers also go through a 'European health questionnaire' with clients, which covers issues such as mobility, self-care, mental well-being and a 'barometer of how they feel on that day' in regard to their health. This first stage aspect of the process is designed to gather all the 'baseline management information' that is now required by DWP.

The reason for introducing this new layer is that the first stage now takes longer due to the extra information required by DWP and as a result would absorb too much of the case managers' available time. In addition, absentees off sick for four weeks or more can be complex cases, which will take more time for case managers to resolve. After the first stage, the operational service manager triages each case to the appropriate case manager, who in turn continues with the assessment of the client through a telephone intervention, identifying actions and work goals to enable the client to effectively return to work. Triage is important as the client needs to be passed to the most appropriate case manager (with specific skills that can best deal with the client's needs).

Case managers assess a client's needs over the telephone, a process lasting between 30–45 minutes. Based on this conversation an action plan is drawn up. A copy of the action plan is sent to the GP. Action plans are regularly reviewed and updated. Interventions can include assisting with employer and employee advocacy, liaising with HR departments and occupational health, working with trade unions, and helping people to find alternative employment. Clients are supported by the case manager for six weeks or longer, usually with follow-up telephone contact, although face-to-face meetings can be arranged if required.

Client support or advice relating to workplace/employment issues can mainly be dealt with internally. Many housing and social problems can also be dealt with by FFWS staff. FFWS also works with employment solicitors. FFWS also signposts to debt advice networks for financial issues and the CAB for welfare/benefits and other advice. The service also has close links with IAPT to which clients can be signposted. Clients can be signposted to any relevant service that can support them.

Staffing arrangements

The FFWS team comprise one service manager (one FTE with two people sharing the job role), five case managers (four x 0.42 FTE, one full-time); one administrator (full-time), partnership managers (one full-time, one x 0.8 FTE), and two front-line advisers (one full-time, one x 0.8 FTE). The finance to pay for the new staff recruited (such as Partnership Managers) has come from Pathways CIC. The role of the new staff is to generate more referrals now that the new target referral source in phase two is 100 per cent absenteeism.

The staff team have a diverse range of backgrounds and professional skills. Originally the team were HR focused but now staff have been recruited with a more diverse skills set. For instance there are HR specialists, two staff with a social work backgrounds and ‘lifestyle advisers’ (dealing with social, personal and well-being issues).

The staff team has diversified as the economy has declined ‘to bring in [people who have knowledge of] ... the social economic aspects of case management.’ The team now has a different range of skills to respond to economic and social change resulting from the recession. For instance, more clients are contacting the service due to stress or other conditions resulting from the fear of redundancy/restructuring of their organisations, or as a result of facing more pressure and greater workloads due to cutbacks.

The staff and the organisation are now much more experienced after the initial 12 months of the pilot, so they are performing more proficiently and effectively – they have a better understanding of their job roles and client needs.

Client profile

Referral source of clients is mainly from IAPT therapists and as time goes on increasingly clients will be absentees. The aim is that GPs and employers will become the other main sources of referrals in phase two.

Table A.3 Client profile to end March 2011: Greater Manchester pilot

Referral source	%	Employment status	%	Health condition	%
GP*	4	Employee, sick leave	17	Mental health	48
Employer	4	Employee, at work	83	Musculoskeletal	4
Self-referral	62	Self-employed, off due to sickness	0	Cardiovascular	0
IAPT	15	Self-employed, at work	0	Respiratory	3
Other	15	Unemployed	0	Injury	0
Don't know	0	Other	0	Other	45
		Don't know	0	Don't know	0
N =	1,529		1,529		1,529

* GP referrals cannot be separated out from referrals from other health professionals.
Source: FFWS Management Information report, July 2011.

In the first four months of the second year a further 59 clients had entered the service (Table A.4).

Table A.4 Client profile April to July 2011: Greater Manchester pilot

Referral source	%	Employment status	%	Health condition	%
GP*	31	Employee, sick leave	98	Mental health	69
Employer	5	Employee, at work	0	Musculoskeletal	17
Self-referral	12	Self-employed, off due to sickness	2	Cardiovascular	0
IAPT	51	Self-employed, at work	0	Respiratory	0
Other	2	Unemployed	0	Injury	0
Don't know	0	Other	0	Other	14
		Don't know	0	Don't know	0
N =	59		59		59

* GP referrals cannot be separated out from referrals from other health professionals.
Source: FFWS Management Information report, August 2011.

Follow-up and discharge arrangements

Case managers review client's progress over an approximate six-week period. Once clients have returned to work from sickness absence or, in the case of presentees, have addressed their work issues, case managers complete a final review with clients, write to them and summarise actions, so that clients can see the distance they have travelled.

Following intervention closure, clients receive a text message or phone call from the service administrator at set intervals of two weeks, six weeks, 14 weeks and 22 weeks, to check on their progress. If there are any problems identified at this stage, the client can be passed back to a case manager for additional support. If there are no problems reported, the case is closed and the client discharged from the service.

Outcomes

Positive views were expressed on client outcomes, in particular keeping people in employment. It was reported that clients 'rarely' drop-out from the service.

Key lessons from the first year

Telephone interventions have been found to be effective as they 'focus people on moving forward' and it avoids the 'comfort zone' of people 'chatting' and having 'coffee', a problem that can occur during face-to-face assessments. Greater Manchester has changed their approach to GP referrals. Despite considerable efforts to market the service to GPs, FFWS was still receiving a relatively small number of referrals. Greater Manchester has now put in place a service level agreement (SLA) with six GP practices. The SLA addresses concerns GPs have had about referring to FFWS (such as data protection). The SLA also stipulates that there needs to be a minimum of four referrals every month. Greater Manchester is also paying £5 per referral from GP practices to cover their administration costs. The finance for these incentive payments is provided by Pathways CIC, in the hope that referrals will increase from GPs. Having a team with a diverse skill set and professional experience is important in dealing with the wide range of client needs.

Staff are now more knowledgeable, experienced, confident and skilled, and as a result they are able to provide a better and more effective service.

Kensington and Chelsea

Introduction

The lead organisation is the Kensington and Chelsea PCT, with delivery partners drawn from Central London Community Healthcare Trust (CLCH), the Royal Borough of Kensington and Chelsea (RBK&C) (Environmental Health and Housing), and partners from the third sector: Broadway Debt Counselling Service and Information Advice and Guidance (IAG) services NOVA and Open Age (over 50s). With the extension of the pilot from April to June 2011 and two-year renewal to 2013, some delivery partners have been changed: the debt service is being delivered by Nucleus Legal Advice Centre and the role of the RBK&C as a delivery partner is discontinuing.

The model was designed to be close to Dame Carol Black's vision of the FFWS as meeting biopsychosocial needs.²⁹ Case management is delivered by the core team within CLCH followed by referral to specific interventions. Health interventions are delivered by CLCH and include counselling, physiotherapy, acupuncture, osteopathy and clinical exercise. The service also offers advice on debt and employment/careers delivered by partners in the third sector. The case manager also carries out employer liaison work for around 50 per cent of clients. During the final months of the first pilot phase, a social marketing company was hired to assist with employer engagement. A GP champion, from a practice within the borough, has been hired to assist with GP engagement.

Background

The pilot area covers the London Borough of Kensington and Chelsea, which has a working-age population of around 119,000 and employed population of 85,700. As the pilot enters the next phase, it is extending to cover the neighbouring boroughs of Hammersmith and Fulham, and Westminster, increasing the total population covered by the pilot to around 570,000.

Individuals wishing to access the FFWS must have been signed off sick for two to six weeks (although exceptions are sometimes made) with mild to moderate mental health problems, musculoskeletal or work-related ill-health. Original eligibility was absence of at least four weeks and the service was targeted at GPs and residents in the borough's deprived wards, which are mainly located in the north of Kensington and Chelsea. After initial slow take up, eligibility was extended to allow referral by all GPs in the borough, including the affluent southern wards. It was also extended to allow self-referrals and referrals via employers, including a small proportion of presentees (from November 2010), although GP referrals make up the great majority of referrals. Eligibility was also extended to non-residents working for employers in the borough. With the extension of the pilot to the two neighbouring boroughs, residents and employees of the three boroughs will be eligible to access the service, if they meet the sickness absence criteria.

Referral routes to the service

The main referral route is through GPs, and these account for almost all referrals, but clients can also self-refer. Referrals have been lower than anticipated, with non-referring GPs saying their patients do not fit the criteria. Delivery partners and consultancy support tried to engage employers, including through training offers, but take up remained limited.

Marketing has focused on GP surgeries where meetings have been arranged to raise awareness of the FFWS. Other publicity materials have been produced to increase the number of self-referrals. The service has found it necessary to carry out more publicity and marketing work than it had originally anticipated and has involved delivery partners in this work. Pilot leaders have found that the involvement of case managers in GP recruitment has been particularly effective, and a case manager is to devote significant time to this work in the next phase of the pilot. A GP champion has been hired to facilitate this work, which will be crucial in determining the successful expansion of the pilot to the two new boroughs.

Model of provision

The case manager assesses client eligibility based on a form returned by GP, or ideally by contacting clients by phone. Then, if deemed eligible, they are invited for assessment and then become a case if accepted by the FFWS.

²⁹ 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 are assessed at a face-to-face initial needs assessment and then assisted in drawing up a Return to Work Plan which involves discussions about their barriers to work, their health problems and what kind of services they believe will benefit them. Changes in clients' wellbeing are measured by administering the MYMOP2 tool immediately after clients' initial assessment and at discharge. The use of MYMOP2 is being discontinued, and the EQ5D will be used in its place, as this is being used in all pilots for consistency in measuring outcomes across the programme. A second stage has been added to the initial assessment meeting with the case manager: all clients are seen by a counsellor as an additional, and more detailed, assessment of any psychological needs. This was introduced so that a brief clinical assessment of mental health needs can be performed by a trained therapist in order to determine suitability of short term counselling provided by the service. Also, any concerns or serious mental health issues can be picked up and managed accordingly. Two further checks are carried out by the case manager: first, whether clients have access to Occupational Health, although this is not used to screen clients out of the service; and secondly, clients are asked about the fit note written by their GP.

Following assessment, clients are referred to FFWS provision and have appointments made on their behalf by the case manager using an online calendar. Case managers also deliver employer liaison services, negotiating return to work, adjustments and suchlike, with clients who give permission for such contact to be made. Clients are also signposted to services which are not offered by the FFWS. A key feature of the Kensington and Chelsea model has been direct referral to contracted services. This is considered effective because of the ability to track clients' use of services, how they progress within the FFW service, and the ability to quality assure the services offered.

The case managers have built up their awareness of many services available locally, to enable signposting for health and other needs not met by FFWS. These have included weight management, smoking cessation and legal support, for example.

Decisions to exit the service are made between the case manager and client. This is once they have achieved their goals in relation to rehabilitation, usually having returned to work. Clients are always encouraged to return to work. However, if one of the clients' goals is to eventually secure new work, the client may be discharged before they have done so, if they are actively job seeking or training and have completed other interventions. Providers also follow-up clients and report case closures to the case managers. A small proportion of cases are closed because clients fail to engage.

Staffing arrangements

The project manager and a senior public manager, who works part time on the project, are employed by the PCT. The rest of the team comprises two case managers, one full-time administrator, and two counsellors employed by CLCH. From April 2011, the number of counsellors was reduced to one. The project manager has a background in regeneration, and social and economic inclusion. The case managers are qualified and experienced in vocational rehabilitation, specialising in working with clients with multiple health and non-health barriers to return to and stay at work. They also hold relevant clinical/health qualifications in health science. The case manager role has involved designing all documentation, initial assessment, referrals and case loading. Stakeholder (GP) recruitment, employer liaison, general networking, awareness raising and pilot reporting are carried out by the project manager and case managers. The project manager also commissions services. With the extension of the pilot to the neighbouring boroughs, the project is to recruit an additional full-time case manager.

Client profile

As at the end of March 2011, Kensington and Chelsea FFWS had 151 referrals and 116 cases. Most absentees had been off sick for less than four weeks, which is higher than the proportion within the FFWS service as a whole. Around 60 per cent of clients were women and more than three-quarters

(78 per cent) aged under 50. The main conditions reported by clients were mental health (50 per cent) and musculoskeletal (43 per cent). In terms of employment status, 76 per cent were on sick leave and 22 per cent were at work. There were a very small number of unemployed clients (two).

The pilot service was targeted at employees from SMEs. To make the referral criteria simple and encourage referrals, GPs were not asked to distinguish potential clients by employer size, and more than two-thirds of clients came from larger employers. However, this is not regarded as problematic, particularly in view of the finding that many such clients have not had access to occupational health support. Clients have a mix of physical ailments, mental health problems and stress at work. Many are experiencing disputes or bullying and harassment at work. Of the physical ailments, many are back and musculoskeletal problems (see Table A.5). The average return-to-work period is 40 working days from the assessment date. The profile of clients has been close to expected, although most clients have been employed by large organisations rather than SMEs. However, these have generally had little OH support and have been in need of FFW services. Many clients have complex needs and have required more intensive help than had been originally anticipated. A number have been identified as having mental health needs requiring more specialist treatment than can be provided within FFW.

Table A.5 Client profile to end March 2011: Kensington and Chelsea pilot

Referral source	%	Employment status	%	Health condition	%
GP	80	Employee, sick leave	74	Mental health	50
Employer	1	Employee, at work	16	Musculoskeletal	43
Self-referral	8	Self-employed, off due to sickness	2	Cardiovascular	0
IAPT	9	Self-employed, at work	5	Respiratory	0
Other	3	Unemployed	2	Injury	1
Don't know	0	Other	1	Other	6
		Don't know	0	Don't know	0
N =	116		116		116

Source: FFWS Management Information report, July 2011.

In the first four months of the second year a further 28 clients had entered the service (Table A.6).

Table A.6 Client profile April to July 2011: Kensington and Chelsea pilot

Referral source	%	Employment status	%	Health condition	%
GP	64	Employee, sick leave	79	Mental health	64
Employer	0	Employee, at work	14	Musculoskeletal	36
Self-referral	21	Self-employed, off due to sickness	0	Cardiovascular	0
IAPT	14	Self-employed, at work	4	Respiratory	0
Other	0	Unemployed	0	Injury	0
Don't know	0	Other	4	Other	0
		Don't know	0	Don't know	0
N =	28		28		28

Source: FFWS Management Information report, August 2011.

Drop out rates from the service are reported to be minimal.

Key lessons from the first year

At the time of the first pilot visits in Autumn 2010, the pilot reported experiencing challenges in recruiting GPs and in engaging employers. A GP-engagement strategy has been successful in involving this key stakeholder group in the pilot. As the pilot enters the next phase, and expands to the two neighbouring boroughs of Hammersmith and Fulham, and Westminster, a strategy is in place to do this work. This includes the input of a GP champion and additional case manager time. A key lesson from the pilot has, therefore, been the importance of devoting time and expertise to GP engagement.

A second challenge to the pilot has been in engaging employers, particularly SMEs. It had been thought that employers were deterred by initial eligibility rules which excluded non-residents of the borough. However, although this was changed and additional resources were devoted to this work, employers were not attracted to the pilot. Reasons for this may include the current economic climate leading to employees being fearful of losing their jobs and reluctant to have a period of sickness absence, or this may reflect SMEs' attitudes towards well-being and sickness absence.

Some services offered by FFWS had initially low rates of use, but these picked up during the course of the pilot, with the exception of housing services and environmental health services to employers. These services will not be included in the next stage of the pilot on a direct referral basis, but by signposting.

The key successes of the pilot are considered to be strong case management and delivery of a wide range of biopsychosocial services through direct referral. The service now includes a full psychological assessment by a trained counsellor as part of the initial assessment. Clients are fast-tracked to services and referral times are short. Managers, case managers and service managers share the same vision of FFWS and are strongly committed to its success. The pilot has strong leadership from the project manager who is seen as giving the project momentum and clarity of vision.

Summary of successes and challenges

- FFWS Kensington and Chelsea has achieved strong strategic partnership and good working relationships with providers.
- Case management is highly organised and effective in both direct delivery and client referral.
- Clients' progress is well documented and their journeys are closely tracked.
- Delivery partners, as well as project leaders and managers, are highly committed to the pilot model and its emphasis on addressing biopsychosocial needs.
- Delivery partners have benefited through raised awareness of their own services, closer links between health, employment and other services, and extension of their own workforce skills.
- The main challenge to the project has been in engaging GPs.
- Difficulties have been encountered in engaging employers.
- Some delivery partners experienced difficulties in dealing first with lower than expected referrals or with fluctuations in demand.

Leicester City and Leicestershire

Introduction

The Leicester and Leicestershire pilot was originally a consortium project officially led by the Primary Care Trust and Leicester City Council. The other partners also involved were Leicestershire County Council, Job Centre Plus, Chamber of Commerce, Leicester City and Leicestershire Learning Partnership. The governance structure is in transition and a number of these original partners have now formed a not-for-profit company, limited by guarantee, under a social enterprise banner.

The model is based on GP referrals. A case management service staffed by non-clinical staff and supported by a small clinical team is provided by a core FFWS team. Case managers are trained in providing guidance and support. Where necessary they refer onto existing free local services for non-clinical issues or to contracted musculoskeletal providers and IAPT services for clinical issues having first discussed the clients' need and the clinical strategy with the in-house GP and occupational health nurse.

Background

Originally, the pilot established links to 40 practices across areas of the city and county. Expansion, driven by the need to enhance referral numbers, has led to the whole of the city and county now being covered, as well as the neighbouring county of Rutland. The pilot has received referrals from 111 of the 145 practices across Leicestershire. The vast majority of clients are employed but off sick from work. The pilot also supports clients, as assessed by their GP, at risk of going off sick. However, in the first year of operation presentees accounted for only 20 per cent of clients who had an initial assessment. (In the four months following April 2011, presentees accounted for 23 per cent of those who had an initial assessment.)

Referral processes to and from FFWS

The vast majority of clients are referred by GPs, with a small number coming through IAPT. The pilot has conducted additional marketing to encourage employees to talk to their own GP about being referred to the service and to raise awareness among local employers. The hope is that they will also encourage individuals to visit their GP to be referred into the service.

To help this process the information leaflets provided to employees also double as a 'self-referral' form which can be completed and taken to a GP appointment; this form informs the GP about the service and how they can refer their patient. It is hoped that more people will request referrals while sitting across from their GPs over time.

Face-to-face visits have been made too, and events have been held for GPs in the area to alert them to the service and encourage them to use it. FFWS-branded fit note holders have been specially designed and given to GPs to use. The main marketing activities have, therefore, focused on GPs, although work has also taken place with IAPT counsellors to encourage them to refer onto the service. Mailouts and sessions involving employers and employment lawyers have also taken place, and the service has been invited onto local radio and used local newspaper adverts.

The main delivery mechanism is through the case managers who are able to access a variety of non-clinical and clinical services. Some of the services are not funded by the pilot (such as debt advice, confidence building). If required, clinical treatments are provided by two local IAPT services and specially contracted MSK providers who are paid on a case-by-case basis. After the initial face-to-face meeting case managers generally remain in contact with their client by phone in order to check on progress. This contact is to maintain the relationship and ensure that the return to work plan is being followed, clients are progressing and that any additional support is being provided.

Model of provision

Clients are contacted by case managers within 24 hours of them entering the service. Case management is conducted by dedicated FFWS staff, who make an initial assessment based on an in-depth initial interview. The case managers go out to meet clients in an environment in which the client feels comfortable. In the city centre this is generally a central location, but in the county this will generally take place in a local GP practice. The assessment process involves discussion of the client's health, work and personal situation, and the flags system is used to aid assessment. The in-house GP and OH nurses will discuss the findings of the in-depth interview with the case managers. The in-house GP or OH nurses may then feel that the client needs an additional clinical-needs assessment which they carry out, and they may then make clinical referrals, which the case manager will be informed of. The clinical team is always available and meet regularly with the case managers. A particularly important part of the service is the fit note signing which is undertaken by the in-house GP. He runs weekly fit note surgeries where case managers present and discuss cases in detail if required. The level of clinical involvement is dependent on the original reasons for the clients' absence.

There has been little change to the assessment and staffing model since the start, although as the case managers' experience develops they are increasingly taking over responsibility for the client journey from, and with the approval of, the clinical staff.

Staffing arrangements

Pilot staff work for a number of different organisations. The original project manager was employed by a local PCT and was on secondment, but she has now left the pilot. Her replacement will ultimately be employed directly by Fit for Work. There is a clinical team of two OH nurses (equivalent to one FTE) who are contracted from an established local OH provider. The whole team has the support of a GP who signs off the fit notes for clients while they are part of the service. The five case managers (four FTE) have experience in employment support, and have backgrounds in financial services, youth work, etc. The case managers are contracted from Advance Housing.

Client profile

At the end of March 2011, 62 per cent of clients had a mental health condition and 26 per cent had a musculoskeletal disorder as their main condition. Many clients have needs related to non-clinical personal issues (such as debt, housing, confidence skills) or the nature of their work. These needs are met via a network of existing local providers without cost to FFWS.

Table A.7 Client profile to end March 2011: Leicestershire pilot

Referral source	%	Employment status	%	Health condition	%
GP	71	Employee, sick leave	73	Mental health	62
Employer	0	Employee, at work	20	Musculoskeletal	26
Self-referral	0	Self-employed, off due to sickness	1	Cardiovascular	1
IAPT	29	Self-employed, at work	*	Respiratory	0
Other	0	Unemployed	1	Injury	0
Don't know	0	Other	*	Other	11
		Don't know	4	Don't know	0
N =	255		255		255

* indicates percentage less than 0.5 but greater than zero.

Percentages may sum to more or less than 100 due to rounding.

Source: FFWS Management Information report, July 2011.

In the first four months of the second year a further 82 clients had entered the service (Table A.8).

Table A.8 Client profile April to July 2011: Leicestershire pilot

Referral source	%	Employment status	%	Health condition	%
GP	76	Employee, sick leave	70	Mental health	57
Employer	0	Employee, at work	27	Musculoskeletal	26
Self-referral	0	Self-employed, off due to sickness	1	Cardiovascular	2
IAPT	24	Self-employed, at work	1	Respiratory	0
Other	0	Unemployed	1	Injury	0
Don't know	0	Other	0	Other	15
		Don't know	0	Don't know	0
N =	82		82		82

Source: FFWS Management Information report, August 2011.

Follow-up and discharge arrangements

Discharge/exit decisions are made in consultation between the case manager and other team members. Official follow up occurs at three and six months. The EQ5D is used on entry to and exiting from the service. Clients are also sent a questionnaire on discharge to ask for their views on the service.

Outcomes

The pilot estimates that around 60 to 65 per cent of their clients return to work, with around ten per cent heading towards new employment. Just under a quarter of clients exit the service without a return-to-work outcome.

In the year ending March 2011, eight per cent of clients recorded as having been discharged were said to have ‘failed to engage’ with the service.

Looking within clients for whom outcomes are known, just under three-quarters of those who were off sick on entry returned to work.

Key lessons from the first year

Although the pilot has been successful in engaging GPs, it has been a key challenge to maintain GP awareness and commitment. The pilot is now focused on understanding what mechanisms are most effective at raising and maintaining the profile of the organisation with GPs without becoming an irritant; it is hoped this will boost low user numbers.

The pilot has found it more challenging to engage local SMEs despite a number of attempts to write to or engage them directly (although as of July 2011, Leicestershire had the highest proportion of absentee clients working for SMEs of any of the pilots). What this demonstrates is that while reliance on GP referrals might be expected to lead to a representative sample of the workforce entering the pilot, in fact larger employers are over represented. This may well be due to lack of formal structures within SMEs, meaning that they are less reliant on the fit note to trigger procedures related to sickness absence (and hence their employees are less likely to ask for fit notes). Whether this or other reasons are behind the lack of SME referrals, however, remains a key question for the service.

Finally, working with two different IAPTs to establish a consistent approach to referrals has been challenging, although relationships and referrals are now working better.

North Staffordshire

Introduction

The lead organisation is NHS North Staffordshire. Key partners include NHS Stoke-on-Trent, Stoke-on-Trent City Council, Staffordshire County Council and Staffordshire Jobcentre Plus. The pilot was developed out of the Condition Management Programme (CMP) to fill the gap in provision for employed people who were absent sick and provides a co-ordinated approach to addressing health and work issues focused on empowering clients and self-management. The service offers support in the form of: case management (including CBT); employment and skills advice, and physiotherapy advice for mild musculoskeletal conditions. There is also access to an enhanced MSK service and to IAPT.

Background

The pilot covers North Staffordshire and Stoke-on-Trent, with a working age population of around 300,000 of whom some 207,000 are in employment. There are around 500 GPs in 180 separate practices in the area.

The principle target group is employees who live or work in the North Staffordshire area and who have been off sick from work for at least four weeks. Presentees are also eligible for the service but referrals are lower for this group.

There have been no changes to coverage or eligibility since the start of the pilot.

Referral processes to and from FFWS

Referrals to the service are screened by the service administrator for eligibility, for instance to ensure they work or live in the area. GP recommendation is still the biggest source, followed by self-referrals, employers and IAPT. There is a change in marketing focus since the first year. Radio and transport advertising has been replaced by increased engagement with GP consortia, local business groups, press and journal advertising, and free employer training advertised on the Acas website.

Model of provision

Eligible clients are referred directly to case manager for a face-to-face initial appointment (90 minutes), which usually takes place at a GP surgery or health centre. Case managers are assigned to geographical area and pick-up clients within that area. Data management has changed from an inefficient handwritten paper-based system to a computerised system. All work facilitators and employment advisers now access a common database to enter client details and update client case notes.

A back-to-work plan is developed at the initial assessment and discussed with the client at follow-up meetings. The emphasis is on the client developing the plans themselves; getting them to discuss their problems and helping them find solutions. The service tries to resolve cases by using the skills of case managers (who can provide low-level CBT), the employment and skills advisors (contracted out to an external provider) and the Specialist Musculoskeletal Assessment and Intervention Service (also contracted out). Or it refers on to:

- primary care/community providers for low-level physiotherapy – i.e. that which does not require immediate, high-intensity support of physiotherapy; or
- IAPT service for high-level counselling/CBT – i.e. that which is not resolved with the three-day counselling workshops undertaken by case managers in stress, anxiety and depression.

Advice on financial problems, domestic violence, drug and alcohol addiction and housing is available from organisations FFWS refer to.

The intervention ends when clients return to work. Regular telephone contact is maintained during phased return and clients are usually discharged after four weeks and followed up at three months. All those discharged are encouraged to re-refer if there is problem.

Staffing arrangements

In the first year the North Staffs FFWS service comprised a FTE team lead, 3.6 FTE work facilitators from nursing/AHP professional backgrounds, one FTE project support worker, two FTE specialist employment advisers (Aspire Group), one FTE business support manager and two FTE administrative assistants.

Client profile

As of the end March 2011 there were 175 referrals which became cases, 26 per cent GP recommendations, 26 per cent self-referrals, 19 per cent employer referrals, 18 per cent IAPT referrals, ten per cent 'other'. Mental health conditions were highest at 61 per cent, musculoskeletal 23 per cent and the rest were neuro, cardiovascular and diabetes. A reported 76 per cent were sickness absentees and 21 per cent presentees (including both employees and the self-employed in these numbers).

Table A.9 Client profile to end March 2011: North Staffordshire pilot

Referral source	%	Employment status	%	Health condition	%
GP	26	Employee, sick leave	76	Mental health	61
Employer	19	Employee, at work	21	Musculoskeletal	23
Self-referral	26	Self-employed, off due to sickness	2	Cardiovascular	*
IAPT	18	Self-employed, at work	1	Respiratory	1
Other	10	Unemployed	0	Injury	6
Don't know	0	Other	1	Other	9
		Don't know	0	Don't know	0

Source: FFWS Management Information report, July 2011.

In the first four months of the second year a further 53 clients had entered the service (Table A.10).

Table A.10 Client profile April to July 2011: North Staffordshire pilot

Referral source	%	Employment status	%	Health condition	%
GP	25	Employee, sick leave	81	Mental health	62
Employer	17	Employee, at work	17	Musculoskeletal	23
Self-referral	30	Self-employed, off due to sickness	0	Cardiovascular	4
IAPT	26	Self-employed, at work	0	Respiratory	0
Other	2	Unemployed	0	Injury	2
Don't know	0	Other	2	Other	9
		Don't know	0	Don't know	0
N =	53		53		53

Source: FFWS Management Information report, August 2011.

Follow-up and discharge arrangements

When clients return to work, the work facilitator will meet them after approximately two weeks to complete questionnaires again and to also collect a client feedback form. At three months, every client receives a follow-up phone call from FFWS to check progress and complete a satisfaction questionnaire.

Outcomes

Seventy-five per cent of those who engage with the service return to work within three months. Taking end of June 2011 figures this equates to 193 out of 257 people. Dropout rate (for FFWS cases) is 17.5 per cent. Pilot provider's view is that the service is developing its knowledge and expertise in case management but is still below where it would like to be in terms of GP engagement and referral numbers.

Key lessons from the first year

Referral numbers were considerably lower than originally calculated. Radio and transport advertising didn't work well and so the marketing strategy was adjusted to target more private sector SME employers, to market training packages to those employers and to continue and strengthen involvement/marketing to GP consortia and local business organisations.

Nottinghamshire

Introduction

The Nottinghamshire pilot was originally led by Greater Nottingham Partnership (GNP), who commissioned three service strands through an open and competitive tendering process. The role of GNP was to provide project management and overall pilot direction. From 31 March 2011, Enable (an independent social enterprise and registered charity) took over the leadership of the service.

The original model consisted of three strands:

- **The Work Survival Programme** – up to six, three-hour-long workshops for those in work but struggling to manage their health (either a group of individuals, or run for a single employer on employer premises) – run by a national Welfare to Work provider who provided Pathways to Work locally.

- **Support in Work** – individual case management and treatment for clients with more complex needs, provided by occupational therapists.
- **Working for Health** – an online health check for SMEs, followed by a face-to-face consultation from an employment law specialist designed to identify problems with absence management and help formulate a response.

Nottingham started running a scheme that they called the ‘Fit for Work project’ around 18 months before the national pilots. This was run as a partnership between the NHS, Jobcentre Plus and the local Employment and Skills Board and was commissioned through the City Strategy Programme. Working with employers was seen as important from the outset and Support in Work was originally set up alongside IAPT to assist with workplace assessments and workplace interventions. Both the Support in Work and Working for Health strands existed as pilot schemes before the national FFWS pilots, but the Work Survival Programme was a new initiative.

Changes in DWP funding for the pilot in Nottinghamshire meant that the Work Survival Programme and Working for Health were dropped from the FFWS in the second year of piloting, although the law firm providing the Working for Health strand decided to continue offering a similar service on a paid-for basis.

Background

Initially the pilot area covered Nottingham City, Mansfield and Ashfield, the aim being to target areas where long-term worklessness was greatest and health inequality most pronounced. The pilot was later expanded to cover the whole county, to avoid turning away individual beneficiaries and employers from just outside the city boundary. Nottinghamshire has an adult population of working age of around 500,000, of whom 374,000 are in employment.

From August 2010, Support in Work was extended to a county location, as well as continuing to run in the city. However, the priority areas were unchanged and the service was targeted at larger GP practices, concentrated in Mansfield and Ashfield. During the second year of the pilots, funding was contingent on increasing the number of GP referrals and so attempts were being made to make contact with all practices within Nottingham City and Nottinghamshire. Customers are entitled to use the service if they live or work in the pilot area.

Referral routes to and from the service

The main sources of referrals into the service have been large employers, health professionals and self-referrals. At the outset, it was expected that a greater proportion of referrals would come from GPs and the service had appointed a GP champion to promote the service to them. Advertisements were placed on the Life Channel in practices in Mansfield and Ashfield, and the service was marketed through an A5 leaflet for potential service users in practices, an A5 folder and leaflet for GPs, and through speaking to GPs and practice staff, such as receptionists and nurses. During the second year of piloting, GP engagement was being increased by informing GPs that their patients were using the service and keeping them updated on progress, as well as running clinics and drop-in sessions within practices.

Large employers were identified as an important source of referrals to the Work Survival courses in particular. The Work Survival strand employed two outreach engagement consultants to promote the service to the health and employment communities.

A high proportion of referrals came from IAPT staff who were co-located alongside the Support in Work strand within Primary Care Services. Referrals to Working for Health came through the business broker and organisations such as Business Link and the Federation of Small Businesses, but the low numbers of referrals from these sources resulted in a decision to fund a telemarketing campaign. This was funded by the provider of the Working for Health strand and was said to be very successful in increasing the number of SMEs using the service.

Model of provision

Since the start of the pilots, a short screening interview (usually done by telephone) has been introduced to collect data required by DWP and to check that clients referred to the service (or who have contacted the service directly) are eligible to use the service. Those who are deemed ineligible (for example, because they are unemployed) are offered information on other sources of advice and support. Eligible clients are allocated to a case manager who then oversees the rest of their contact with the service. This case manager carries out a detailed face-to-face assessment and agrees action points with the client, which may include the case manager working with them to provide therapies, or make referrals on to other services such as debt counselling, IAPT or physiotherapy, as appropriate. Case managers are able to use their contacts with other primary health professions to ensure that clients receive the treatment that they require more quickly where this is likely to affect whether they are able to return to work or not. Case managers also typically liaise with the employer over action that could be taken to increase the likelihood of the employee being able to work, for example, how the role could be adapted to allow the employee to return to work. They also work with GPs to ensure that the fit note is completed in a way which increases the chances of the employee being able to maintain their employment.

Staffing arrangements

Support in Work case workers are occupational therapists, with five people working across the city and county areas, now employed by Nottinghamshire Healthcare Trust. There were a further three vacancies for case workers at the time of fieldwork.

The central team consisted of a project manager who worked eight days a month and a director from the Employment and Skills Board (but employed by the Greater Nottinghamshire Partnership and later Enable). Two further part-time members of staff assisted with marketing, communications and business engagement. The project manager had experience of working with a practice-based commissioning cluster and as a former non-executive director of a Primary Care Trust.

The total number of staff working for the service in the second year of piloting was lower than the number involved during the first year due to the removal of two of the three strands to the service (the Work Survival Programme and Working for Health).

Client profile

At the end of March 2011, 791 clients had worked with or were working with the Support in Work programme. Almost three-quarters (73 per cent) of those who completed the initial assessment were referred to the service by IAPT and more than one-fifth (21 per cent) of cases came from self-referrals and other sources. Less than one in twenty (four per cent) service users were referred to the service by GPs. Nearly one-third (28 per cent) of service users were absent from work, but more than a quarter (26 per cent) were presentees and just under one-quarter (23 per cent) were unemployed. Given the high proportion of referrals from IAPT, it is unsurprising that the main health condition of more than two-thirds (68 per cent) of clients concerned their mental health.

**Table A.11 Support in Work - client profile to end March 2011:
Nottinghamshire pilot**

Referral source	%	Employment status	%	Health condition	%
GP	4	Employee, sick leave	28	Mental health	68
Employer	1	Employee, at work	26	Musculoskeletal	11
Self-referral	9	Self-employed, off due to sickness	1	Cardiovascular	2
IAPT	73	Self-employed, at work	1	Respiratory	1
Other	12	Unemployed	23	Injury	1
Don't know	2	Other	1	Other	13
		Don't know	20	Don't know	4
N =	791		791		791

Source: FFWS Management Information, July 2011.

In the first four months of the second year a further 105 clients had entered the service (Table A.12).

**Table A.12 Support in Work - client profile April to July 2011:
Nottinghamshire pilot.**

Referral source	%	Employment status	%	Health condition	%
GP	2	Employee, sick leave	48	Mental health	72
Employer	0	Employee, at work	30	Musculoskeletal	16
Self-referral	12	Self-employed, off due to sickness	4	Cardiovascular	2
IAPT	60	Self-employed, at work	0	Respiratory	0
Other	26	Unemployed	16	Injury	1
Don't know	0	Other	1	Other	8
		Don't know	1	Don't know	1
N =	105		105		105

Source: FFWS Management Information, August 2011.

Follow-up and discharge arrangements

The action points arising from the detailed assessment provided a framework for deciding when any follow-up meetings should be held. In some cases weekly meetings might be required to discuss progress, whereas other clients might need longer to complete a course of therapy, or to allow time for the case manager to speak to the employer. Therefore, the timetable for follow-up meetings was agreed on an individual basis with clients.

The initial intention was that outcomes were to be monitored three and six months after discharge. However, the timing of discharge varied from client to client, depending on the length of treatment required and the complexity of people's needs. This approach was thought to increase the proportion of clients who stayed in work. It also depended on whether the client informed them that they were returning to work.

Outcomes

It was felt that the service was able to help a large proportion of clients to return to work, although this was not always in the same job or with the same employer. It was also felt that the service was welcomed by employers and that the vast majority were happy to speak to case managers about how they could retain staff with health problems. However, it was apparent that some of those referred to the service did not actually choose to engage with it and a relatively high proportion of those referred to the service were unemployed and had no further contact with it. Also, there were concerns that the more limited service offered over the second year of piloting would be less cost effective due to the lack of opportunities for early, low-level interventions.

Key lessons from the first year

The quality of the service, due to the use of experienced occupational therapists as case managers, appeared to be an important factor in ensuring that the service was effective in helping clients to maintain employment. Initial attempts to market the service to GPs were relatively unsuccessful and the decision to instead market the service directly to potential clients and through building on existing links with IAPT services and other clinical services, appeared to work better in terms of generating referrals. Efforts to market the service to GPs in the second year have been refocused to promoting the service to the emerging GP clinical commissioning groups, including their practice manager structures, with a greater emphasis on providing the service from GP premises.

There is also a renewed focus on sickness absentees being supported through the service.

Rhyl

Introduction

The lead organisation involved in the pilot is the Rhyl City Strategy Community Interest Company. The other organisations involved in the pilot are Betsi Cadwaladr University Health Board and Public Health Wales. Representatives from SERCO probation services, Welsh government, Careers Wales, Denbigh Voluntary Services Council (DVSC), the private sector, police, Federation for Small Businesses, and the Local Health Board sit on the board and steering group. The pilot operates a psychosocial model, using an holistic approach to provide a support service to employed people in the area. The pilot operates from a large medical centre in Rhyl.

Background

Originally covering Rhyl in Denbighshire, Glyn and Abergele/Pensarn wards in Conwy, the pilot area now extends to cover Prestatyn, St. Asaph, Kinnel Bay and all of Colwyn Bay. The service takes referrals for employed clients either in work or off sick; but in the second year they have a new emphasis to recruit absentees. The new target is maximum 30 per cent presentees. They are concerned to help self-employed clients, who rarely take sick leave. Accordingly, they plan to only accept presentees if they are self-employed. The service is based in one GP medical centre. Other practices are also on board and they have now engaged 38 GPs who refer into the service. There are approximately 60 GPs in the geographical area. The area is one of high deprivation and unemployment with high levels of drug and alcohol addiction. The employed tend to work for large public sector organisations. The pilot covers an area that lacks services for employed people and seeks to enhance socioeconomic regeneration and well-being. Eligibility criteria for the service cover

sickness absentees off work for two to four weeks, captured at four to six weeks; those waiting for specialist health input; those with no access to work-based OH; employees returning to sickness benefit having recently returned to work; employed presentees – but only if self-employed; longer-term sickness absentees who have repeat/extended sick leave.

The rationale was to provide a service for employed people in an area of high unemployment that already had a range of employability services for those out of work. The FFWS adds value to existing services by providing the only support service in the area for employed people. Originally intended for SMEs, an excess of referrals coming from larger companies in the area stimulated the advisory group to expand the FFWS remit to accommodate these. The focus continues to engage with SMEs but there are practical difficulties as many SMEs in the locality are micro businesses, and there are less medium-sized enterprises than they realised.

Referral processes to and from the service

Referrals are predominately from GPs, with self-referrals and employer referrals much lower. The FFWS believe the majority of self-referrals are signposted by GPs. Onward referrals are made to various services as necessary, in particular MIND and physiotherapy.

Model of provision

Case managers make contact with the client and arrange a one-hour meeting with them in the FFWS offices within a week of referral (often within 48 hours). Case managers will also travel to see clients where necessary or give advice and guidance over the phone. A registration form and data protection form is completed with the client and an action plan drawn up.

FFWS Rhyl use MIND Aberconwy and NHS Physiotherapy at Glan Clwyd Hospital as their delivery partners for clients with common mental health problems and musculoskeletal problems. Additional psychological services are purchased from local private counsellors, to fill the gap left by decommissioned MIND Wrexham and MIND Vale of Clwyd service providers. Other services that are bought in as required are neuro-linguistic programming therapy, osteopathy and life coaching.

Clients are signposted to the expert patient programme, debt advice, benefits advice and career services. Very often case managers know people in these other agencies and are able to help FFWS clients get support quickly.

Staffing arrangements

The staff comprise one service manager, three case managers, one partnership development manager and an administrator. The original service manager had left the organisation and Rhyl City Strategy's project manager was on fostering leave for the second round of process visits. All case managers come from employability or workforce development backgrounds.

Client profile

At the end of March 2011, the pilot was working with, or had worked with, 187 active cases, of which 57 had an off-flow record. The client base in the first year of operation was varied; approximately 50 per cent employed by large organisations and 50 per cent from SMEs.

Table A.13 Client profile to end March 2011: Rhyl pilot

Referral source	%	Employment status	%	Health condition	%
GP	52	Employee, sick leave	41	Mental health	42
Employer	22	Employee, at work	52	Musculoskeletal	48
Self-referral	20	Self-employed, off due to sickness	1	Cardiovascular	*
IAPT	0	Self-employed, at work	6	Respiratory	0
Other	5	Unemployed	0	Injury	2
Don't know	0	Other	0	Other	9
		Don't know	0	Don't know	0
N =	187		187		187

* indicates percentage less than 0.5 but greater than zero.

Percentages may sum to more or less than 100 due to rounding.

Source: FFWS Management Information, July 2011.

In the first four months of the second year a further 111 clients had entered the service (Table A.14).

Table A.14 Client profile April to July 2011: Rhyl pilot

Referral source	%	Employment status	%	Health condition	%
GP	75	Employee, sick leave	48	Mental health	45
Employer	10	Employee, at work	46	Musculoskeletal	52
Self-referral	13	Self-employed, off due to sickness	2	Cardiovascular	1
IAPT	0	Self-employed, at work	5	Respiratory	0
Other	2	Unemployed	0	Injury	0
Don't know	1	Other	0	Other	2
		Don't know	0	Don't know	0
N =	111		111		111

Source: FFWS Management Information report, August 2011.

Follow-up and discharge arrangements

Discharge is dictated by client need; there is a variation, with some clients reporting a significant improvement after four weeks contact with the service. Others are monitored for longer periods to ensure that problems do not reoccur following return to work. Client contact with the service tends to be reduced as their circumstances improve to give them a sense of 'ownership'. Follow-up/evaluation questionnaires are administered three months post-discharge.

Key lessons from the first year

The pilot has decommissioned services that were not communicating well with them, and has made provision to buy in services from different service providers.

They made strenuous efforts to engage with SMEs when it became apparent that they had too many referrals from large organisations.

They are planning to engage a GP to champion the service to help them get the message out to GP networks.

They have introduced an 'agreement' form for clients to sign to reduce incidence of failure to attend onward referral appointments.

Scotland

Introduction

This pilot, known as Working Health Services Scotland covers the whole of Scotland and the lead body is SALUS Occupational Health & Safety.

The service operates a ‘hub and spoke’ model. Referrals come in by telephone to a central call-handling centre where basic client details are taken. Case management and onward referrals are delivered regionally by teams based within Scotland’s regional health boards.

The case management service operates primarily by telephone. Case managers perform an initial telephone assessment (lasting around an hour) and make onward referrals to third-party providers as appropriate. The three main services offered in most regions are physiotherapy, counselling and occupational therapy. Case managers will also signpost clients as appropriate to other organisations offering advice and support on a range of wider issues.

This large-scale pilot has involved significant strategic and partnership working, involving the agreement of a delivery model between 14 regional health boards, designing a web-based data system, securing Scottish government support, coverage of urban, rural and remote regions, and training a number of regionally-based staff. The pilot receives some funding from Scottish government and is overseen by a senior management group that includes representatives of Scottish government, Jobcentre Plus and other key stakeholders. The service manager reports to this group quarterly.

Background

The service covers the whole of Scotland, with a working-age population of 3,400,000, of whom some 2,400,000 are in employment. Eligible clients are people employed by SMEs (with fewer than 250 employees) who do not have access to occupational health through their employer. Clients must be in employment but can be in work or off sick from their job. There have been no changes to the geographical area or eligible population since the start of the pilot. The FFWS pilot builds on three previous pilot services that have operated on a similar model in Scotland in recent years and are perceived to have been effective.

The Dundee FFWS pilot has recently been amalgamated into the Scotland-wide pilot.

Referral routes to and from the service

The service accepts self-referrals, referrals from GPs and other health professionals and more recently has also begun to accept referrals from employers. To date, most clients have been self-referrals who have been ‘signposted’ (that is, told about the FFWS) by their GP.

The service has been marketed to GPs, a range of other health professionals (particularly physiotherapists) and also to SMEs. The lead organisation allocated a marketing budget of £35,000, approximately 1.4 per cent of the overall budget and a variety of marketing and promotional approaches (including leaflets, business cards, and rubber stamps for GPs to print onto fit notes, radio and poster advertising) was tried in the different health board areas. This was not found to be particularly effective. While there are challenges in engaging GPs, this has been found to be the most productive source of referrals and the bulk of marketing efforts are now being targeted at GPs. Case managers and their line managers also take up various opportunities to promote the service among relevant audiences of health professionals, employers and via the activities of other health and work initiatives.

In some health board regions, a ‘triage’ system has been introduced, whereby clinicians or case managers will examine NHS waiting lists to identify patients who may be eligible to access services (more quickly) via the FFWS. To date, this system is primarily being used in physiotherapy services and is contributing to increased numbers of referrals to the FFWS for musculoskeletal conditions.

The lack of a high profile national launch of the Scotland-wide service, due to embargo preceding the 2010 General Election, is felt to have hindered promotion and referral rates.

Model of provision

Using the service’s ‘hub and spoke’ model, assignment of clients to case managers is done by geographical region – usually based on where the client lives, but in some cases according to where they work.

The case management service operates predominantly by telephone. Case managers perform an initial ‘entry assessment’, based on the biopsychosocial model. This looks not only at health problems and type of work, but also holistically at things like family, relationships, debt, substance use and housing. With each client, the following standardised tools are completed at baseline (and again at discharge): Hospital Anxiety and Depression Scale (HADS), EQ-5D (EuroQol-Vas) and the Canadian Occupational Performance Measure (COPM). The HADS has replaced the previously used GHQ-12 and is found to be more user-friendly and informative.

The initial telephone assessment lasts up to an hour, but case managers are finding that they can complete the assessment more quickly and more ‘conversationally’ as they gain in experience.

The case manager’s role is to bring the person back to work. They are the main point of contact, coordinate all the services in relation to the person and make onward referrals to subcontracted providers as deemed appropriate for that client. The three main services offered in most regions are physiotherapy, counselling and occupational therapy. These are all subcontracted and include NHS and private providers. Specific contractual arrangements differ by region. Case managers make onward referrals as appropriate, with the agreement of their clients. To date, physiotherapy has been the most frequently used service, followed by counselling, with most limited use of occupational therapy. Regions differ in their use of NHS and private providers and whether services are block purchased or paid on completion. Case managers will also signpost clients as appropriate to other organisations offering advice and support on a range of wider issues. The role includes orchestrating the process at a suitable pace, and maintaining contact with the client and with the services accessed to ensure that things are progressing well.

Staffing arrangements

The initial call handling is managed by the lead organisation, via the existing Scottish Centre for Healthy Working Lives advice line. There is case manager coverage for all 14 health boards, but some (for example, sparsely populated or remote regions) do not currently have a dedicated case manager, with some case managers, therefore, covering more than one health board. There has been some staff turnover among case managers, influenced by wider changes/uncertainties within the NHS. However, overall staffing numbers have been maintained and there is capacity to provide the service to clients in all health board regions.

All case managers are NHS staff, many seconded to this role from other roles. Case managers are employed by their regional NHS and line managed locally. In many cases, case managers were originally placed alongside CMP teams. With the disestablishment of CMP, some case managers have relocated or had changes in line-management arrangements.

Case managers' professional backgrounds include nursing, midwifery, health visiting, NHS24, CMP, occupational therapy, public health and physiotherapy. Most have some kind of health background. There is a senior case manager based with the lead organisation, overseeing all of the case managers.

Client profile

As at the end of March 2011, the pilot had worked with or was working with 2,434 clients. To date, the majority of clients have approached FFWS with musculoskeletal problems, though there are also a number of mental health cases. Most clients are still at work (in other words, presentees). Clients are perceived to have a strong commitment to work and are motivated to engage with FFWS in order to avoid or minimise sickness absence.

Table A.15 Client profile to end March 2011: Scotland-wide pilot

Referral source	%	Employment status	%	Health condition	%
GP	45	Employee, sick leave	23	Mental health	15
Employer	2	Employee, at work	76	Musculoskeletal	78
Self-referral	25	Self-employed, off due to sickness	0	Cardiovascular	2
IAPT	0	Self-employed, at work	0	Respiratory	*
Other	27	Unemployed	0	Injury	0
Don't know	0	Other	0	Other	4
		Don't know	1	Don't know	1
N =	2,434		2,434		2,434

* indicates percentage less than 0.5 but greater than zero.

NB: Figures include Dundee and Tayside.

Source: FFWS Management Information report, July 2011.

In the first four months of the second year a further 661 clients had entered the service (Table A.16). The pilot in Scotland continues to provide a service for presentees, funded by the Scottish Government. The FFWS element of the pilot focuses on clients who are sickness absentees (23 per cent of clients in the first four months of the second year).

Table A.16 Client profile April to July 2011: Scotland-wide pilot

Referral source	%	Employment status	%	Health condition	%
GP	52	Employee, sick leave	23	Mental health	15
Employer	2	Employee, at work	77	Musculoskeletal	80
Self-referral	35	Self-employed, off due to sickness	0	Cardiovascular	1
IAPT	0	Self-employed, at work	0	Respiratory	*
Other	10	Unemployed	0	Injury	0
Don't know	1	Other	0	Other	3
		Don't know	*	Don't know	*
N =	661		661		661

* indicates percentage less than 0.5 but greater than zero.

NB Figures include Dundee and Tayside.

Source: FFWS Management Information report, August 2011.

Follow-up and discharge arrangements

Engagement with the case management service typically lasts around 10-12 weeks and in most cases, it will be self-evident to the client and the case manager when the time is right to disengage. At discharge, there is an exit interview and the three standard measures (HADS, EQ-5D and COPM) are repeated. GPs are provided with a copy of the discharge report. The intention is to follow up clients at three and six months, but it is not always possible to make contact with clients at these points.

Outcomes

The majority of clients are perceived to achieve positive outcomes, either staying in work or returning more quickly from absence. Early disengagement rates are very low.

The management information data indicates that 11 people who started out in work or off sick from their job when they entered the service became unemployed, however, follow-up contact reveal all have found subsequent employment. Also, some case managers and service providers have supported clients to look into alternative forms of work or retraining if it appears that a return to their previous type of work would be incompatible with their health.

Key lessons so far

Overall, the service is perceived to be working very well for those people who have accessed it. Client feedback is almost universally positive. Key aspects of effectiveness are early intervention, rapid access to health services (primarily physiotherapy or counselling) and the use of a biopsychosocial approach. The case management approach, providing continuity and coordination of support, is also an important aspect of the model. The centralised and web-based data systems implemented in the Scotland-wide pilot are also felt to have worked very well.

While client numbers have picked up over the first year of operation, a key challenge continues to be promoting the service in order to generate referrals. The extent of stakeholder engagement and client take-up of the service also differs between health boards. It is now believed that the most productive approach is to focus heavily on promoting the service to GPs and to try to establish an 'automatic' link between the issuing of a fit note and a referral being made to the FFWS. In the second year of operation, there will also be a renewed focus on bringing more absentees into the service. Linking the service more strongly to the fit note should help in this respect.

The timing of the implementation of the service (coinciding with the General Election) was felt to hinder marketing. The lack of a national launch of the service has been a barrier to more effective promotion and more could have been done to coordinate promotion of FFWS alongside the launch of fit notes.

Although progress is being made, there is still a perceived need to do more work with senior officials in health boards, in order to change attitudes towards the health and work agenda and to increase understanding of the importance of the health and work relationship and the value of the FFWS.

Dundee and Tayside

Introduction

The Dundee pilot was not given funding by DWP to continue in its own right beyond April 2011 and is now funded as part of the Scotland-wide FFWS pilot. However, this has not meant any significant changes to the actual working of the FFWS in Dundee apart from having been asked to get more referrals for mental health conditions and from absentees (previously the pilot had attracted lots of musculoskeletal conditions and presentees).

The FFWS service in Dundee is run by Dundee Community Health Partnership (NHS Tayside) and provides vocational rehabilitation to employees in SMEs. The service is delivered in house by an integrated team of physiotherapists, counsellors, case managers and an occupational therapist who all work together to provide a fast intervention for clients. The model was designed to offer a range of person-centred and holistic support which takes account of a client's (work and social) life situation. Case managers signpost to all service providers (where appropriate), coordinate service provision and liaise with employers.

Background

The service has been operating since October 2008 in the Dundee city area (including Broughty Ferry and Monifieth). This covers approximately 4,000 firms; 64 GP practices (across Tayside) and a working-age population of 94,000, 66,000 of whom are in employment). Dundee has experienced industrial shifts from traditional manufacturing industries to the service sector (retail, customer service, etc). Such jobs are often low paid and correlate to poorer health outcomes.

To be eligible people need to be employed, live or work in the Dundee area and work for an SME. The broad target client groups are:

- Employed – off sick from work in SMEs (sickness absentees – no minimum number of weeks off sick).
- Employed – not off sick from work in SMEs (presentees).

There have been no changes in eligibility or coverage since the start of the pilot but there will be an increased focus on increasing referrals from people with mental health conditions and people who are absent from work (off sick) as a result of being funded from the Scotland-wide pilot.

Referral processes to the service

The service in Dundee operates on the basis of self-referral. All referrals are initially conducted by case managers over the telephone. The case manager may request a face-to-face meeting for clients with cases they consider to be complex. Clients were thought to hear about the service from a number of sources including GPs, employers, word of mouth and advertising. There were also thought to be some repeat referrals. The pilot collects data on where clients had heard about the service. Most people had heard about the service via their/a GP, followed by their employer and 'other sources' respectively.

Some GPs embrace the service and recommend it to their patients. One GP acted as a champion for the service and promoted it in the national media. Some local employers were also recommending the service to their staff and provided staff with details of how to access the service and also arranged for FFWS staff to come to the workplace and inform staff about the service. The service was thought to be helpful to SMEs who did not have access to OH departments.

Model of provision

Clients are mostly screened and assessed over the telephone by a case manager. Telephone enrolment takes anything from 15 minutes and increased slightly with the recent addition of the HADS questionnaire (see below) to better identify people with mental health conditions (as requested by Salus). The case manager may also invite clients with more complex cases in for a face-to-face enrolment interview. Assessment tools to measure health and work-related performance are EQ-5D, COPM and HADS. Clients are given an appointment time with a clinician in this first contact.

Case managers are assigned to the clients they happen to receive initial enrolment calls from. Case managers' roles depend on the client. They may have only limited contact (enrolment and discharge) with some clients who, for example, are present in work and assessed as needing a set number of physiotherapy sessions only. For clients with more complex needs (for example, mental ill health and who are absent from work) then the case manager will have a greater role to play.

The case managers have a background in mental ill health and, as well as their case management role, they have increasingly provided clinical interventions to some clients (to cover for the reduced hours of one in-house counsellor) and will work with some clients on a one-to-one basis. They will also refer clients either to services in house (for example, physiotherapy or counselling or occupational therapy, benefits advice) and outside the service (for example, to financial services or Jobcentre Plus).

Clients are discharged by case managers once their treatment is thought to be complete. At this stage they are given a feedback form to complete and the same outcome measures (COPM, EQ-5D and HADS) are completed as at enrolment to see what improvement there has been. After discharge, clients are followed up three and six months afterwards to see if they need any help/if things are continuing to improve. GPs are sent a discharge summary letter.

Staffing arrangements

Pilot staff are seconded from the NHS and have a mix of skills. The service manager (seconded from DWP, with an employment/marketing background) manages a team of eight: two physiotherapists (there were previously three but one had left the NHS); an occupational therapist; a counsellor, two case managers (both with backgrounds in mental health and who have taken an increasingly clinical role to cover reduced hours of an in-house counsellor) and an administrative assistant.

Client profile

Table A.17 Client profile to end March 2011: Dundee and Tayside pilot

Referral source	%	Employment status	%	Health condition	%
GP	62	Employee, sick leave	19	Mental health	14
Employer	0	Employee, at work	80	Musculoskeletal	84
Self-referral	38	Self-employed, off due to sickness	0	Cardiovascular	0
IAPT	0	Self-employed, at work	0	Respiratory	0
Other	0	Unemployed	0	Injury	0
Don't know	0	Other	0	Other	2
		Don't know	1	Don't know	1
N =	635		635		635

Source: FFWS Management Information report, July 2011.

Management information data at the end of March 2011 showed:

- All clients accessed the service by self-referral, but 62 per cent were signposted to the programme by their GP (and other sources of information included employers and returners).
- 100 per cent of clients worked for SMEs.
- 55 per cent of clients were male and 45 per cent were female.
- 14 per cent were aged 16–29; 24 per cent were aged 30–39; 29 per cent were aged 40–49 and 34 per cent were 50 or over.
- 84 per cent presented with musculoskeletal conditions and 14 per cent with mental health conditions.
- 79 per cent of absentees had been absent from work for less than four weeks (80 per cent were presentees; 19 per cent were absent from work).

Follow-up and discharge arrangements

Clients are discharged from the FFWS by telephone, when they complete the same standardised questionnaires they were assessed with to measure progress. Clients are then followed up at three and six months post-discharge by the FFWS administrator who asks them questions about whether they are still in work and whether they have been off sick in the interim.

Outcomes

A successful client outcome was thought to be where a client felt better; remained in work (where using the service as a presentee) or went back to work (even if this meant them getting a new job) if they were off sick, and so were prevented from going onto benefits.

The service was thought to work really well for clients because it provided rapid access to services and it was tailored to the needs of the individual.

Key lessons

In the second process visit the following points were given:

- The FFWS was thought to be an holistic, speedy and responsive service that was client centred and geared towards what people wanted and needed. Clients were listened to.
- The service provided a link between health, work and well-being and was the only service in the area to fast-track people in work for treatment.
- Relatively speaking the service had managed to engage GPs in telling patients about the FFWS.
- More use could be made of NHS to refer to the FFWS (A&E departments and out-of-hours GPs could refer on).
- Because of the geographical remoteness of some of the area covered by the FFWS some people could end up doing long round trips to access the service.
- Marketing the FFWS had initially been more difficult than anticipated with some feeling that marketing might be more strategic and less ad hoc.

Wakefield

Introduction

The lead organisation is Wakefield Metropolitan District Council (who took over from Wakefield PCT who submitted the bid for the pilot). A steering group comprising the Council, PCT, the social housing provider (Wakefield District Housing) and Jobcentre Plus oversees the pilot.

The service is sub-contracted fully to an employment service provider. They employ a multidisciplinary team of case managers to provide support to clients, signpost clients to other free-to-access services, and maintain regular contact with clients to review progress.

Background

The pilot covers anyone living or working in Wakefield (postcodes WF1 to WF11) (which has a working-age population of 211,000, of whom 149,000 are in employment) or registered to one of the 42 GP practices operating as part of NHS Wakefield District (which, in addition to Wakefield, encompasses some postcodes in Leeds, Doncaster, Barnsley and Huddersfield). People must have a contract of employment on the day of referral and must either have been on sick leave for at least four weeks or still be working. The area has high levels of ESA claims and the pilot was intended to help stem the flow of people claiming benefits by working with people at an early stage. There have been no changes to target areas or eligibility.

Referral routes to the service

A free phone helpline and email address have been set up to take referrals or self-referrals. Referring services/employers can also use a referral form which can be sent/emailed. Referrals can come from Jobcentre Plus, various health workers and services (including IAPT), the district social housing provider, employers, GPs, and any local statutory or voluntary service providers. Most referrals are self-referrals. Case managers call back within 48 hours of receiving the referral for a quick discussion to see if the service is suitable for the individual. If so, an assessment meeting must be arranged within ten days.

The delivery team have continued a strategy of ‘mass marketing’, using a variety of opportunities for promotion such as through radio, newspaper articles and adverts, magazines, meet and greet events, health conventions, and handing out leaflets in a shopping centre.

Referral numbers increased towards the end of the first year, though not significantly enough to meet targets. A focus on GP engagement from January to March yielded referrals. Face-to-face meetings, repeated contact and FFWS Post-it notes were thought to be particularly helpful in engaging GPs and producing referrals. IAPT have continued to make a significant contribution to referral numbers. Links with public health initiatives (such as Health Means Business) have proved useful, with services promoting and referring to each other. It took time to negotiate referral arrangements with large employers (including the council). A change in personnel and greater understanding of the complementary role of FFWS alongside OH has led to a greater number of referrals over time from the council. Efforts to engage SME employers have been largely unsuccessful.

Model of provision

The FFWS is sub-contracted to an external employment services provider – they conduct case management and try to meet client needs as far as possible. If they cannot meet all needs they signpost/refer to external organisations.

One case manager works with clients with mental health problems and one with people whose primary condition is physical. They use basic information about health, taken at the time of referral, to allocate clients before the initial assessment. During the initial, holistic assessment case managers discuss client circumstances and barriers to work, and draw up a goal plan setting out what clients hope to achieve, which is reviewed over time. Case management includes information and advice about health conditions and management techniques (such as pain management, anxiety management), plus help to improve readiness for work/job search (such as CV writing, job searching, interview techniques), and any help case managers feel they can give to remove barriers to work. Access to healthcare services is through GP referral, except IAPT for which they are able to refer clients directly. There is no fast-tracking or spot purchasing.

Case managers signpost or refer to other services when they feel it would be appropriate and beneficial. Services include mental health (including IAPT), physical health and lifestyle (including NHS Health Trainers, Expert Patient Programme, pain management clinics, national charities for specific conditions such as British Heart Foundation), workplace adaptations (Access to Work), sensory impairments, learning disabilities and autism, substance abuse, debt, domestic violence, business creation and development, job skills training, relationships and sexuality, families with young children and employment law advice (Acas).

The number, frequency or venue for client meetings is not set – they tailor service provision to client needs as far as possible.

Staffing arrangements

There have been changes in staffing over the course of the pilot. The original project manager was replaced by the Senior Occupational Support Coach for West Yorkshire in late 2010. The three case managers remain the same, with their duties largely unchanged: two have caseloads; the other is primarily responsible for marketing activity though has taken on a small caseload in recent months. The team also has an Occupational Support Coach who works part time on the pilot as a case manager and has a caseload. The new project manager is a qualified learning disabilities nurse with experience in mental health. The two main case managers have backgrounds in general nursing, or care services (specialising in mental health) and employment advice services. The case manager taking a lead on promotional work has a background in marketing, financial services and training.

Client profile

At the end of March 2011 the pilot had worked with 109 clients after receiving 235 referrals.

Table A.18 Client profile to end March 2011: Wakefield pilot

Referral source	%	Employment status	%	Health condition	%
GP	2	Employee, sick leave	34	Mental health	52
Employer	4	Employee, at work	57	Musculoskeletal	17
Self-referral	29	Self-employed, off due to sickness	0	Cardiovascular	4
IAPT	39	Self-employed, at work	1	Respiratory	1
Other	22	Unemployed	0	Injury	1
Don't know	5	Other	1	Other	19
		Don't know	7	Don't know	6
N =	109		109		109

Source: FFWS Management Information report, June 2011.

Among people still working the most common problem is work-related anxiety and stress. Prevalent health conditions are work-related stress, anxiety and depression, and musculoskeletal problems (mostly back injuries and arthritis).

Follow-up and discharge arrangements

On average, clients have four to five appointments before being discharged, which equates to one or two months of time spent actively engaging with the service. It is usually self-evident to case managers when the time is right for discharge and this follows agreement between case managers and clients that there are no outstanding needs to be addressed. There is a feedback form for clients to complete. Each client is supplied with contact details and told they can get in touch if they need more support. Case managers carry out a follow-up phone call with clients three months after discharge, unless the client says that further support will not be needed. Some clients do 'bounce back', seeking help from FFWS when problems arise in employment. This was perceived as an indication that FFWS is useful and remembered as a valuable service by former clients.

Client outcomes

In large part the pilot was thought to have achieved good outcomes, with clients returning to work quickly, finding a new job or staying in work. One hundred per cent of presentees have remained in work. Non-work outcomes included, for example, enrolling on training courses, increased confidence, learning to manage the effects of health conditions. Another outcome perceived as important was linking clients with local service provision, which clients may not have been aware of previously and which could provide ongoing support.

Key lessons from the first year

There are no plans to continue the FFWS in Wakefield after DWP/DH funding ceases at the end of June 2011. The key lessons learned are as follows:

- FFWS has been successful in the work done and outcomes achieved with individual clients. In particular the use of a multidisciplinary team, who were committed to the aims of the service, efficient delivery, and effective signposting to local provision were thought to be important aspects of FFWS's success.
- Partnership working has been strengthened among public sector organisations and understanding of shared agendas has been developed.
- Engaging various stakeholders was the most significant challenge of the pilot. The overall number of referrals remains below expectations, despite multiple concerted efforts to promote FFWS.
- Relationships between the steering group and delivery team were strained at times, though problems were largely resolved following a change in project manager.
- There were views that if the project had been led by the PCT, there would have been more ownership at a strategic level and it may have been easier to engage GPs.
- There were doubts about whether FFWS met local needs because there are significant numbers of people out of work who were not eligible for the service. In contrast, however, another view was that FFWS filled a gap by providing impartial advice and support specifically focused on employment.

Appendix B

Methodology

The data used in this report comes from five main sources:

- management information collected from the pilots;
- interviews with pilot personnel and stakeholders;
- the first wave of a two-wave survey of Fit for Work Service (FFWS) clients;
- the first wave of interviews with the longitudinal panel of clients;
- interviews with General Practitioners (GPs), including those actively referring patients to the service and some who were not involved with the pilots.

The methodology involved in each of these elements is described below.

Management information

Every month information about the clients engaged with pilots is compiled from submissions of aggregate data made by each of the 11 pilots using a standard template or pro forma designed collaboratively by Department for Work and Pensions (DWP)/Department of Health (DH) and Institute for Employment Studies (IES). The data have been reported monthly to enable the DWP, DH and others to monitor the take-up of services both across the programme as a whole and for individual pilots.

The data cover:

- the numbers of referrals to the service and the numbers of active clients (defined as people who complete an initial assessment);
- client characteristics, including demographics, health condition and work and absence status;
- the characteristics of their employers;
- referral sources;
- services used by FFWS clients;
- the numbers leaving the service and their subsequent work and absence status.

Interviews with the pilots and stakeholders

A separate researcher from the evaluation team was allocated to each pilot area to be primarily responsible for coordinating and conducting interviews with pilot personnel and their stakeholders. All researchers had extensive experience in social research from a range of disciplinary backgrounds. Three came from IES, three from Social Policy Research Unit (SPRU), two from National Institute for Economic and Social Research (NIESR) and three from the University of Liverpool. Two waves of fieldwork were carried out. Between October and December 2010, researchers from the evaluation team visited each of the pilots and conducted interviews with:

- pilot managers and directors;
- members of FFWS steering groups and project boards;
- case managers and other members of the FFWS core teams;
- other providers of FFWS services within the pilot partnership;
- providers of the services outside the pilot to whom the pilot refers or signposts clients;
- GPs involved with local pilots;
- employers involved with local pilots.

A subsequent visit took place between June and July 2011 and follow-up interviews conducted with many of the interviewees in the first round of interviews supplemented by additional interviews as required, focusing on those involved in directing, managing and delivering the pilot services.

The overall aims of the interviews were to explore:

- the FFWS models operated by the pilots;
- their experiences of, and any barriers to, setting up the FFWS;
- their marketing and promotion plans, and the results of these activities during the first few months, including service take-up by different types of client, and the success of different referral routes;
- the role of case managers including their skills and background;
- reflections on what had gone well in the first months of operation and what had been the key challenges.

In total, 118 interviews were conducted in the first and 96 in the second set of visits. In nearly all cases they were face-to-face, following a set of topic guides agreed with the DWP and DH. The number of interviews in each area varied between eight and 16 in the first round and between five and 14 in the second. The interviews were recorded and transcribed. In addition, in some pilot researchers attended steering group meetings and reviewed documentary evidence from the pilots including their original bids, business plans, progress reports and minutes of steering group meetings.

The evaluation team met twice in November 2010 and July 2011 to review the emerging themes from the interviews under a set of headings covering the broad client journey: target groups and eligibility; routes into the pilot and referrals; assessment and entry; case management; access to services; and outflows and follow-up.

Following each workshop, researchers reviewed the content of the interviews and identified the key points to emerge from their pilot and wrote a summary of their pilot following an agreed structure:

- background;
- model of provision;
- staffing arrangements and case manager role;
- referral processes to FFWS;
- referral processes from FFWS onwards;
- service monitoring;

- role of delivery partners;
- role of stakeholders;
- working with clients;
- overall reflections and views on the service.

Responses from interviews were cross-checked and validated where possible with the documentary evidence. In some cases further information or clarification was sought, usually from the pilot managers.

In addition, a workshop was held with representatives from most of the pilots in December 2010 which included a discussion of the emerging findings and their views on:

- accessing clients and referral processes;
- service delivery;
- sign off and discharge from the service.

Finally, researchers wrote a brief description of the key features of each of their pilots and this was checked for accuracy with the pilots.

Survey of Fit for Work Service clients

The survey of FFWS clients was conducted by researchers from IES and GfK NOP. In the original evaluation plan it was envisaged that a two-wave survey of FFWS clients would be conducted over the first year. The plan was to survey clients by telephone within six weeks of their initial assessment over a period of six months with contact details of all new clients agreeing to take part in the survey passed from each pilot to the evaluation team on a monthly basis. The second wave of the survey would follow up interviewees six months after the first interview to collect data on their health and subsequent employment experience and their reflections on the service.

In the event the original plans were changed. The start of the first survey was delayed until February 2011 partly due to low initial take-up among the pilots. To increase the potential sample it was decided to increase the threshold for interview from six to ten weeks after a client had had an assessment. The rate of consent to participate in the survey varied significantly between the pilots. In the period between December 2010 and May 2011, in three pilot areas over 75 per cent of clients consented to have their contact details passed to the survey team. However, in another four, including some of the largest pilots in terms of client numbers, the 'consent rate' was less than ten per cent. This meant that only a small proportion (18 per cent) of all the FFWS clients were available for interview. The total sample received was 647.

In 11 per cent of cases the telephone number provided was incorrect, the respondent had moved or was found to be ineligible (for instance was not aware of the FFWS).

Of the remaining sample:

- ten per cent of FFWS clients who were telephoned declined to take part in the interview;
- in 33 per cent of cases the maximum ten week since the client's assessment had been exceeded before an interview could be arranged;
- three per cent of the sample remained available for interview by the time fieldwork closed on 17 July 2011.

Therefore, 54 per cent of the clients consenting and available for interview took part in the survey, producing 311 interviews.

Table B.1 FFWS client survey response rate

Status	Number	Unadjusted %	Adjusted %
Completes	311	48	54
Samples still live when fieldwork ended	17	3	3
Refusals	60	9	10
Screening failures (respondent not eligible)	20	3	n/a
Respondent moved	7	1	n/a
Ten-week target date expired	187	29	33
Wrong number	45	7	n/a
Total sample loaded	647	100	100

Source: Fit for Work Service User survey (Wave 1).

All respondents had their initial assessment between 7 December 2010 and 10 June 2011 (and the survey interviews took place between 11 February and 17 July 2011 (11 February 2011 and 17 July 2011)). On average 40 days had elapsed between respondents initial Fit for Work assessment and the survey interview and the number of days elapsed ranged from a minimum of 11 to a maximum of 70.

Respondent profile

Sixty-nine per cent of respondents are from just four of the pilots, with the largest numbers from Rhyl (29 per cent), followed by Leicestershire (16 per cent), Scotland (12 per cent) and North Staffordshire (11 per cent).

The following table compares the proportion of respondents across the pilots with the proportion of FFWS clients as at March 2011 (using the data in the April management information report). It can be seen that respondents from areas such as Rhyl and Leicestershire are over represented and those from Nottinghamshire, Birmingham, Scotland and Greater Manchester are under-represented. This imbalance needs to be taken into account interpreting the survey results.

Table B.2 Proportion of Wave 1 survey respondents from each pilot site and management information data by pilot site (%)

	FFWS client wave 1 survey %	<i>Base</i>	Management information	<i>Base as at March 2011</i>
Birmingham area	4	(11)	13	(1,007)
Dundee	4	(12)	*	*
Eastern and Coastal Kent	8	(25)	1	(71)
Greater Manchester	7	(23)	20	(1,529)
Kensington & Chelsea	5	(16)	2	(116)
Leicestershire	16	(51)	4	(249)
North Staffordshire	11	(35)	3	(175)
Nottinghamshire	0	(1)	11	(791)
Rhyl	29	(90)	4	(187)
Scotland	12	(37)	39	(2,345)
Wakefield	3	(10)	1	(109)
Total	100	(311)	100	(6,579)

* included in Scotland totals.

Source: Fit for Work Service User survey (Wave 1).

In other respects the achieved sample also differs from the overall client profile recorded on the management information database. The respondents are more likely to be female, older and a sickness absentee and work for a large employer than the client population as a whole, although their health conditions are broadly similar (see the following table).

Table B.3 Summary table comparing key demographic characteristics of Wave 1 survey respondents with management information data (%)

	Survey data	Management information data
Gender		
Male	37	46
Female	63	52
Don't know	0	2
Total	100	100
<i>Base</i>	<i>(311)</i>	<i>(6,579)</i>
Age		
16 to 29	8	18
30 to 39	28	24
40 to 49	28	29
50+	36	26
Not stated	1	3
Total	100	100
<i>Base</i>	<i>(311)</i>	<i>(6,579)</i>
Main health condition		
Musculoskeletal	49	37
Mental Health	42	38
Other	9	25
Don't know	0	1
Total	100	100
<i>Base*</i>	<i>(307)</i>	<i>(6,579)</i>
Work status at first contact		
Absentee	55	29
Presentee	45	64
Other	0	7
Total	100	100
<i>Base</i>	<i>(311)</i>	<i>(6,579)</i>
Size of Employer*		
SME (<250)	29	56
Large (>250)	66	39
Don't know	5	5
Total	100	100
<i>Base</i>	<i>(286)</i>	<i>(6,579)</i>

Source: Fit for Work Service User survey (Wave 1).

Survey content

In the first Wave the survey covered the following areas:

- Respondents' demographic and employment characteristics.
- Respondents' barriers to staying in or returning to work prior to becoming involved with FFWS.
- Respondents' health condition.
- How respondents first came into contact with the service.
- Respondents' experience of the service.
- Respondents' satisfaction with the service.
- Respondents' overall opinions of the service.
- Respondents' views on the impact of the service.

Wave 2

The follow-up survey of respondents to Wave 1 started in October 2011.

Longitudinal panel of FFWS clients

This element of the evaluation is being conducted by researchers from the Social Policy Research Unit at the University of York and at the Fit for Work Research Group at the University of Liverpool.

The overall aim of this element of the evaluation is to gain an in-depth understanding of clients' experience of the FFWS through two waves of qualitative interviews. The initial aim was to recruit 80 FFWS clients in total; 20 from four pilots. Further to this, the aim was to construct two parallel panels in each site:

- **Panel A:** People who are recent recruits to a FFWS.
- **Panel B:** People who have recently returned to work after engagement with a FFWS.

The first panel was expected to produce findings about the experience of engaging with a FFWS, including what was useful and what was not, regardless of the outcome of engagement. This first panel would include both absentees and presentees. The second panel was designed to produce more focused findings about how a return to work was achieved and, in follow up interviews, whether and how the return to work was sustained. By definition this panel would only include people who had been absent from work at some stage during their engagement with the FFWS.

The four pilots chosen for the panel study reflected diversity in service models and had relatively high caseloads at the time the project was set up, which allowed for enough people to be recruited to the panel study without any crossover with the survey. The four were:

- Birmingham;
- Dundee;
- Greater Manchester;
- North Staffordshire.

Each participant was to be interviewed twice, first in a face-to-face interview in March and April 2011 and again by telephone six months later in September/October 2011.

Participant recruitment

The research team liaised with the service provider in each site to transfer securely contact details for clients who had consented to be contacted for the purposes of research, and who met the criteria of being either a new recruit or recently returned to work. A letter was sent to these clients, explaining the study and informing them that a researcher may be in touch to invite them to take part. An opt-out reply slip and envelope was provided to enable people who did not want to take part to notify the researchers. Two weeks after the letter was sent researchers started recruiting participants by telephone.

Recruitment was not straightforward and it proved difficult to achieve 20 participants in each pilot site. Recruitment was hampered first when it became apparent that the number of clients giving consent to be contacted was much less than expected in some areas. Further to this the quality of the data supplied was questioned when it appeared that some people in Birmingham and Manchester had very little knowledge or recollection of contact with a FFWS, or did not perceive that they were recruited to the service. Examples of the latter included people who had contacted the service to refer an employee, had made an initial enquiry but chose not to take it further, or had received a workplace assessment when FFWS staff visited their workplace but who had not sought help from the FFWS for a particular health problem. To mitigate the deficit in recruitment as far as possible, recruitment in Birmingham surpassed the target of 20 and a second round of recruitment took place in North Staffordshire after the provider supplied a further list of clients. These unanticipated problems and extra recruitment activities resulted in delays to fieldwork.

Fieldwork

Semi-structured topic guides were developed to use in the interviews, with separate guides for people who had returned to work and for people who were new recruits. Most people chose to be interviewed face-to-face in their home, workplace or a public place such as a café. However, some people were interviewed over the telephone in accordance with their preferences. Before commencing the interview written consent was obtained from each person; oral consent was attained and recorded where the interview was conducted over the phone. The large majority of interviews were digitally recorded with the participant's permission and professionally transcribed. Notes were taken contemporaneously where the participant declined to be recorded. Each participant was offered a gift of £20 for the first interview; £15 will be offered for the second interview. Following data collection, the Framework approach was used to extract and analyse the data using a set of thematic charts.

Characteristics of the achieved study group

Table B.4 shows the main characteristics of the achieved study group.

Table B.4 Longitudinal panel: sample characteristics

Study group characteristics	Number of people
Area	
Birmingham	23
Dundee	12
Greater Manchester	10
North Staffordshire	19
Sex	
Male	31
Female	33
Age	
18–30	8
31–49	31
50+	24
Not known	1
Primary health condition	
Physical	24
Mental	24
Both	15
None	1
Work status at the time of the research interview	
Returned to work	36
Absent	13
Present	10
Unemployed	5
Total	64

Study of General Practitioner involvement in Fit for Work Service

This study was conducted by researchers from the Social Policy Research Unit at the University of York.

It was originally proposed to carry out qualitative interviews with 50 GPs by telephone. To this end each pilot site was asked for a database of all of the GPs they had informed about FFWS and to indicate which of these GP practices had referred patients onto, or had told patients about the service. In the first instance, ten practices that had, and had not, used the FFWS in all but one³⁰ of the FFWS areas, were contacted. Practice managers were sent an invitation letter and an information sheet about the study and were asked to pass these on to the GPs in their practice. GPs were offered a £50 honorarium for participating in the study.

³⁰ At the time of asking for details of GPs contacted, one area reported that they had not long targeted GPs and felt that it was too soon to contact them for research purposes.

These letters were followed up by the researchers by telephone in the subsequent weeks. Recruiting GPs proved to be time consuming and difficult, partly because there were a range of ‘gatekeepers’ to go through. Practice managers had to be accessed via practice receptionists and were not always available to speak with when the researchers phoned the surgery. Sometimes practice managers dismissed GP involvement in the research without consulting GPs, giving reasons such as they were currently ‘too busy’. Other practice managers could take some weeks to speak with and this added to delays in reaching GPs. A further reason for the difficulty and delay in access was that often when the researcher did speak with the practice manager, they had little recall about having seen the information that had been sent to them or had not yet passed it onto GPs (often waiting for a practice meeting to bring the research to their attention). This meant that the information needed to be sent a second time.

Some of the practice managers reported back that the GPs had said they were too busy to take part in any research, that they were already helping with other research studies or that they were not interested in taking part in the research.

Seventeen GPs were recruited from the first mailout, and once all of the practices had been contacted by telephone it was decided to send out a second mail. This time 140 letters were sent out in all but one of the FFWS pilot areas. The same difficulties were encountered and this mailout ultimately yielded 14 GPs.

Because of the difficulties in accessing GPs it was decided in consultation with DWP to revise the target number to 30 (although 31 interviews were eventually achieved). The study group are described in Table B.5.

Table B.5 Characteristics of sample

Total number of GPs recruited	31
GPs who had engaged with the FFWS	22
GPs who had not engaged with the FFWS	9
Size of practice: number of health care professionals*	
1-5	13
5-10	6
Over 10	12

* This includes GPs, practice nurses and health care assistants.

All but one of the telephone interviews were, with permission, digitally recorded and transcribed professionally for analysis. The Framework approach was used to order and synthesise the qualitative data³¹.

The research was conducted in accordance with the Data Protection Act. All data including personal details were held securely in SPRU.

³¹ Ritchie, J., Lewis, J. and Elam, G. (2003). Designing and selecting samples. In Jane Ritchie & Jane Lewis (Eds.), *Qualitative research practice. A guide for social science students and researchers* (pp.77-108) Thousand Oaks, CA: Sage.

Following Dame Carol Black's 2008 review of the health of Britain's working age population, 11 Fit for Work Service (FFWS) pilots were launched throughout Great Britain with the intention of testing different approaches to supporting people in the early stages of sickness absence to get back to work as quickly as possible.

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.

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DWP Department for
Work and Pensions

Published by the
Department for Work and Pensions
March 2012
www.dwp.gov.uk
Research report no. 792
ISBN 978-1-908523-53-2