Department for Work & Pensions

Research Summary

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Evaluation of the 2010–13 Fit for Work Service pilots: final report

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Following Dame Carol Black's 2008 review of the health of Britain's working-age population, a series of Fit for Work Service pilots was established to offer support for people in the early stage of sickness absence, particularly for employees working in small and medium-sized enterprises (SMEs). A first wave of 11 pilots was launched between April and June 2010 throughout Great Britain, initially for a year. Seven of the pilots were funded for a further two years, to March 2013.

These were proof of concept pilots, testing a variety of different locally determined models, and were not intended to be rolled out nationally. However, learning from the pilots has been fed back to inform the implementation of the new national independent health and work advice and referral service, called 'Fit for Work', launched at the end of 2014.

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 in a variety of locally designed delivery models.

This report pulls together the available evidence about whether the seven pilots achieved their aims and in particular their effect on returning sickness absentees to work. It is based on a range of evidence including: management information about the clients and the costs of each pilot; and an analysis of the time taken for clients to return to work compared with local controls. These data are supplemented by qualitative and survey evidence gathered as part of the first year evaluation and pilot summaries edited by the pilots themselves.

A first evaluation report covering the 11 first wave pilots' experience in their first year was published in 2012[1].

Key findings

- At least 70 per cent of the clients in each pilot were sickness absentees in Years 2 and 3, but most pilots found it difficult to attract clients from SMEs.

[1] Hillage, J. *et al.* (2012). *Evaluation of the Fit for Work Service pilots: first year report,* Research Report No. 792, Department for Work and Pensions, March 2012.

- Nearly all the pilot clients had either a musculoskeletal condition or a common mental health condition often compounded by non-health problems.
- The pilots operated a range of different models, varying the mode of assessment (telephone or face-to face), the role of the Case Manager, and the provision of additional services. Key elements of pilot service included:
  - **a biopsychosocial assessment resulting in a return to work plan**;
  - **case management** – by a trained member of the pilot staff;
  - **access to additional clinical or non-clinical services** – beyond those provided by the case manager.
- On average clients spent around 10 to 12 weeks with the service. Seventy-two per cent of clients absent from work on entering the service had returned to work by the time they had left.
- Nine in ten clients were satisfied with the service they received. Around half the clients thought that the pilots had helped them return to work sooner. Clients' self-assessed health also improved over the duration of the pilots.
- In two out of the three pilots involved in a separate impact study, clients had shorter certified sickness absence periods than their equivalent local average. However, this may be due to differences between pilot clients and the local employed population. The pilots were generally more effective for clients with musculoskeletal conditions than for clients with mental health conditions.
- The average cost of providing the pilots was around £1,000 per client, but costs varied from around £500 to over £2,000, depending on the mode of assessment and the extent of in-house support.
- Based purely on costs directly incurred by the pilots and estimates of the cost of sickness absence, the results suggest that low cost pilots were cost effective, whereas higher cost pilots were not cost effective.

Participation

The pilots supported 5,300 clients in Years 2 and 3. This was lower than the numbers engaged in Year 1 when there were both more pilots and the focus was not so strongly placed on recruiting sickness absentees from SMEs.

Following the change of focus, at least 70 per cent of the clients in every pilot were sickness absentees. However, most pilots continued to find it difficult to attract clients from SMEs and only one pilot, Scotland, attracted more than 40 per cent of their clients from SMEs. Attempts to market to SMEs directly were generally unsuccessful, not least because for most SMEs long-term sickness absence was not perceived to be a current issue and many GPs or others who referred clients to the pilots did not distinguish between employees from large or small workplaces.

Nearly all the pilot participants were suffering from either a musculoskeletal condition (50 per cent) or a common mental health condition (45 per cent). In addition, clients also reported a number of non-work problems such as poor housing, difficult domestic relationships or financial difficulties which compounded their health condition(s).

Marketing and referrals

In Years 2 and 3 there was a greater emphasis on receiving referrals from General Practitioners (GPs) as this was likely to be the first port of call for those on a sickness absence from work. Twenty-one per cent of clients were directly referred by GPs, and 29 per cent by Improving Access to Psychological Therapies (IAPT) and other healthcare services. Thirty-six per cent were self-referred, however, many first heard of

the service through their healthcare services. Healthcare services were therefore a significant source of information that prompted a self-referral. Throughout the length of the pilots, only three per cent of clients were referred directly by employers.

Assessment and support

After initial screening, eligible clients were assigned a Case Manager who conducted a wide-ranging biopsychosocial assessment of the client's health and non-health-related conditions and circumstances. Whilst telephone-based assessments by the pilots were thought to be more resource efficient, preserve client anonymity and help focus the discussion, meeting the client face-to-face enabled the Case Manager to more easily establish a relationship and delve into issues in more detail.

Case management was a key element of the pilots. Case Managers with a health background were able to provide clinical support (e.g. cognitive behavioural therapy (CBT)) to clients themselves and were able to liaise with other health services, including GPs. On the other hand it was argued, by some of the pilots, that employing non-clinical staff, overseen by a clinical professional could reduce costs whilst maintaining the quality of service.

There was consensus among the pilots that the biopsychosocial approach and 'demedicalising' the problems faced by clients was crucial to identifying and addressing the barriers to return to work and therefore underpinned successful case management.

Where clients required specialist help (for example, clinical such as physio- or psychotherapy, or non-clinical such as help with debt management or housing), the Case Manager accessed additional support from elsewhere within the in-house team, in the wider partnership or by referring or signposting to external agencies. The pilots that had in-house additional support or fast access to external providers valued the ability to provide interventions without delay and argued that this approach had enabled a quicker return to work.

Client satisfaction

Responses to the client survey showed that most respondents (72 per cent) were very satisfied with the service they had received from the pilots. Clients also generally agreed that the service had offered a personalised (78 per cent), and responsive service that had been able to refer or signpost them to relevant support (75 per cent). Most clients (70 per cent) felt that the pilots had helped reduce their sickness absence.

Clients' self-assessed health status improved over the duration of the pilots. However, due to the lack of a control group, this cannot be directly attributed to the pilots.

Impact on return to work

On average clients spent around 10 to 12 weeks with the pilots and seventy-two per cent of clients who were off sick on entering the pilot had returned to work by the time they had left.

A study of the impact of the pilots on length of absence was conducted in three pilot areas. The time taken to return to work by pilot clients was compared with the 'local average or norm' based on fit note data from local employees.The study, however, did not control for differences in observed characteristics between clients and non-participants, for instance demographic or socio-economic variables. The voluntary nature of the pilots means that pilot clients may also have been more motivated to return to work, or alternatively have more serious conditions, than the local employed population. The results should therefore be seen as indicative only.

The results showed that in two out of the three areas on average pilot clients had shorter certified sickness absence period than their equivalent local norm. The pilots were generally more effective for clients with musculoskeletal conditions than for clients with mental health conditions.

The costs of the pilots

The average cost of the pilots per client was around £1,000 per client, but the costs varied from around £500 per case in the two areas operating telephone-based services to over £2,000 per case in the pilots where a range of in-house support services were available to clients.

Cost effectiveness

The average cost of a day's sickness absence is approximately £90. Based purely on costs directly incurred by the pilots and estimates of the cost of sickness absence, the results suggest that low cost pilots can be cost effective, whereas higher cost pilots were not cost effective. It is important to note, however, that return to work is just one of the potential benefits of the pilots, which also include improved health and wellbeing. Moreover, the assessment of cost effectiveness above omits wider costs borne by employers and health service providers, and does not control for differences between pilot clients and non-participants.

Fit for Work

The design of Fit for Work, the new national independent health and work advice and referral service launched at the end of 2014, reflects some of the positive findings contained in the report, including the:

- use of a bio-psychosocial model to ensure a rounded assessment of the issues preventing a return to work;
- use of telephone-based assessments;
- benefit of adopting a case management approach to ensure the employee receives co-ordinated support over a period of time (although the high cost per client of the pilots means that their level of case management is likely to be more extensive than that provided by Fit for Work); and
- provision of musculoskeletal and mental health experts given the prevalence of those conditions.

The full report of these research findings is published by the Department for Work and Pensions (ISBN 978 1 910219 69 0. Research Report 896. June 2015).

You can download the full report free from: https://www.gov.uk/government/organisations/department-for-work-pensions/about/research#research-publications

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