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

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Research Report No 896

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Summary

Eleven pilots were launched throughout Great Britain between April and June 2010, to support employees in ill health to stay in or return to work after a period of sickness absence. Known at the time as the 'Fit for Work Service', these pilots were initially funded for one year by the Department for Work and Pensions (DWP) and the Department of Health (DH). Seven of the pilots were extended for a further two years.

These were intended to be proof of concept pilots, to test a variety of different locally determined models of delivering a service which helped employees to return to work. Although there was no intention to nationally roll out these models, learning around best practice has been fed back from these pilots to inform the implementation of the new national independent health and work advice and referral service (Fit for Work), which was launched at the end of 2014. The pilots subject to this evaluation will therefore be described throughout this report as 'the pilots' to avoid confusion with the new national programme.

This report presents the available evidence on whether the pilots achieved their aims, in particular, whether the Year 2 and 3 pilots succeeded in providing biopsychosocial support to sickness absentees, improving their health, and helping them to return to work. The report shows that:

- At least 70 per cent of the clients in each pilot were sickness absentees in Years 2 and 3; however, most pilots found it difficult to attract clients from SMEs.
- Nearly all pilot clients had 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. However, each pilot included:
 - **Biopsychosocial assessment**, a wide-ranging assessment of the client's health, non-health-related conditions and circumstances; this resulted in a return to work plan;
 - **Case management** by trained members of pilot staff who co-ordinated the support identified in the assessment and return to work plan;
 - **Access to additional clinical or non-clinical services**, either through in house provision, external partnerships or referrals to existing services.
- 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 partly be due to differences between pilot clients and the local employed population.
- Results varied by health condition. 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.

Contents

Acknowledgements	8
The Authors	9
Glossary of terms	10
List of abbreviations.....	11
Executive summary	13
1 Introduction.....	19
1.1 The pilots.....	19
1.1.1 The aims of the pilots.....	20
1.2 The evaluation.....	21
1.2.1 Main evaluation activities.....	21
2 Overview of the pilots	23
2.1 The pilots.....	23
2.2 Models of provision	23
2.2.1 A simple model of the service	23
2.3 Participation.....	24
2.4 Referrals and marketing	26
2.4.1 Marketing to GPs	27
2.4.2 Marketing to employers.....	28
2.5 Client characteristics	29
2.5.1 Health conditions	30
2.6 Assessment and support.....	31
2.6.1 Assessment	31
2.6.2 Case management.....	32
2.6.3 Additional support.....	33
2.6.4 Discharge.....	33
3 Effectiveness of the pilots.....	35
3.1 Employment outcomes.....	35
3.1.1 Satisfaction with the pilots.....	37

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

3.2	Self-assessed health	38
3.3	Impact on return to work.....	40
3.3.1	Health conditions	41
3.3.2	Other characteristics	41
3.4	Evidence from the longitudinal panel	42
4	Costs of the pilots	45
4.1	Costs	45
4.1.1	Costs per client	46
4.2	Cost effectiveness	47
5	Conclusions	49
5.1	What was the impact of the pilots on return to work?.....	49
5.2	Did the pilots focus on absentees from SMEs?.....	50
5.3	What was the contribution to reducing health inequalities?	50
5.4	Did the pilots use a biopsychosocial model of support?.....	50
5.4.1	Were the pilots person-centred and responsive to individuals' needs?.....	51
5.4.2	Did the pilots form an integrated service and demonstrate effective partnership working?.....	51
5.4.3	Did the pilots provide timely, co-ordinated back-to-work interventions?	51
5.5	Were the pilots cost effective?	51
5.6	Fit for Work.....	52
Appendix A	Pilot summaries.....	53
Appendix B	Methodology.....	84
Appendix C	Impact assessment: fit note approach	90
Appendix D	EQ5D health improvement scores	117

List of tables

Table 2.1	Referral routes to the pilots (percentages).....	26
Table 2.2	Source of initial information about the pilot (percentages).....	27
Table 2.3	Proportion of pilot clients from SMEs	29
Table 2.4	Sickness absence status at entry assessment	30
Table 2.5	Gender and age distribution of clients.....	30
Table 2.6	Average length of time between entry and discharge to the pilots	34
Table 3.1	Proportion of absent clients back at work at time of discharge:	35
Table 3.2	Impact of the pilots on return to work among clients in Years 2 and 3 pilots....	36
Table 3.3	Satisfaction with Case Manager’s understanding of client’s situation?.....	38
Table 3.4	Thinking overall about the service you have received from the pilots, to what extent do you agree that it has (per cent).....	38
Table 4.1	Total number of pilot participants, April 2011 to March 2013.....	47
Table 4.2	Cost per client	47
Table A.1	Summary of the pilots	54
Table C.1	Fit note-based patient episodes in Greater Manchester control practices	93
Table C.2	Primary health problems reported by Greater Manchester clients.....	94
Table C.3	Client characteristics and return to work after Greater Manchester intervention.....	95
Table C.4	Primary health problem and return to work (Greater Manchester client episodes).....	96
Table C.5	Period between start of client sickness episode and any return to work: comparison with local diagnosis-related norms (Greater Manchester client episodes)	96
Table C.6	Period between Greater Manchester assessment and any return to work: comparison with local diagnosis-related norms.....	97
Table C.7	Characteristics of Greater Manchester clients returning to work and having sickness episode shorter than local norm	98
Table C.8	Fit note-based patient episodes in North Staffordshire control practices	99
Table C.9	Primary health problems reported by North Staffordshire clients.....	101
Table C.10	Client characteristics and return to work after North Staffordshire intervention.....	102
Table C.11	Primary health problem and return to work (North Staffs client episodes).....	103
Table C.12	Period between start of client sickness episode and any return to work: comparison with local diagnosis-related norms (North Staffs client episodes)	103

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

Table C.13	Period between North Staffordshire assessment and any return to work: comparison with local diagnosis-related norms	104
Table C.14	Characteristics of North Staffordshire clients returning to work and having sickness episode shorter than local norm	104
Table C.15	Fit note-based patient episodes in Leicester control practices	106
Table C.16	Primary health problems reported by Leicester clients	107
Table C.17	Client characteristics and return to work after Leicester intervention.....	108
Table C.18	Primary health problem and return to work (Leics client episodes)	109
Table C.19	Period between start of client sickness episode and any return to work: comparison with local diagnosis-related norms (Leics client episodes).....	109
Table C.20	Period between assessment and any return to work: comparison with local diagnosis- related norms (Leics client episodes)	110
Table C.21	Characteristics of clients returning to work and having sickness episode shorter than local norm.....	110
Table C.22	Pooled data: Client characteristics and return to work after pilot intervention	112
Table C.23	Pooled data: Characteristics of clients returning to work and having sickness episode shorter than local norm	113
Table C.24	Pooled data: Independent association between client characteristics and a return to work after the intervention	115

List of figures

Figure 2.1	Simple model of a pilot service	24
Figure 2.2	Number of new cases by pilot area to April 2011 to March 2013	25
Figure 3.1	Help provided by the pilots.....	37
Figure 3.2	EQ-5D health status on entry and discharge to the pilots: October 2011 to March 2013.....	39
Figure 4.1	Cost breakdown for each pilot 2011–13.....	46

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The Authors

Jim Hillage, Director of Research, Institute for Employment Studies.

Matt Williams, Research Fellow, Institute for Employment Studies.

Rosa Marvell, Research Officer, Institute for Employment Studies.

Chris Shiels, Research Fellow, University of Liverpool.

Mark Gabbay, Professor of General Practice, University of Liverpool.

Kath Weston, Research Fellow, Social Policy Research Unit, University of York.

Ioan Humphreys, Research Assistant, University of Swansea.

Glossary of terms

Biopsychosocial approach	An approach to treatment which takes into account biological, psychological and social problems to manage the health of an individual.
EQ-5D	EuroQol – 5 dimension – a standardised instrument for use as a measure of health outcomes.
SMEs	Small and medium-sized businesses, i.e. with fewer than 250 employees.

List of abbreviations

BME	Black and Minority Ethnic
CAB	Citizens Advice Bureau
CBT	Cognitive Behavioural Therapy
CLCH	Central London Community Healthcare
CPID	Chartered Institute of Personnel and Development
CMP	Condition Management Programme
COPM	Canadian Occupational Performance Measure
DH	Department of Health
DVSC	Denbigh Voluntary Services Council
DWP	Department for Work and Pensions
EQ-5D	EuroQol – 5 dimension – a measure of health outcome
ESA	Employment and Support Allowance
FTE	Full-time equivalent
GNP	Greater Nottingham Partnership
GP	General Practitioner
HADS	Hospital Anxiety and Depression Scale
HR	Human Resources
IAG	Information, Advice and Guidance
IAPT	Improving Access to Psychological Therapies
IES	Institute for Employment Studies
IS	Income Support
JSA	Jobseeker’s Allowance
MI	Management information
MOI	Memorandum of Information
MSK	Musculoskeletal disorder
MYMOP	Measure Yourself Medical Outcome Profile
NHS	National Health Service

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

OH	Occupational health
PCT	Primary Care Trust
QALY	Quality adjusted life year
RBKC	Royal Borough of Kensington and Chelsea
SMEs	Small and Medium-sized Enterprises
VRCM	Vocational Rehabilitation Case Managers
WHSS	Working Health Services Scotland

Executive summary

Introduction

Following Dame Carol Black's 2008 review 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 stage of sickness absence, particularly for employees working in small and medium-sized enterprises (SMEs). Following a competitive selection process, 11 pilots were launched between April and June 2010 throughout Great Britain, initially for a year, funded by the Department of Work and Pensions (DWP) and the Department of Health (DH).

These were intended to be proof of concept pilots, to test a variety of different locally determined models of delivering a service which helped employees to return to work. As a result, there was no intention to nationally roll out these models. However, learning around best practice has been fed back from these pilots to inform the implementation of the new national independent health and work advice and referral service (Fit for Work), launched at the end of 2014. The pilots evaluated in this report will simply be described as 'the pilots', to avoid confusion with the new national programme.

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. The pilots were launched with the intention of testing different approaches to providing the service and getting people back to work as quickly as possible.

Seven of the pilots that were deemed to be operating most effectively were extended for a further two years, to March 2013. These include Greater Manchester, Kensington and Chelsea (extended to cover Inner North West (NW) London), Leicestershire and Leicester City, Nottinghamshire, North Staffordshire, Rhyl and Scotland.

This report presents the available evidence on whether the Year 2 and 3 pilots achieved their aims, in particular their effect on supporting sickness absentees to return to work. It is based on a range of evidence across the pilots, including management information on client characteristics, pilot costs, and the time taken for clients to return to work in comparison to the local average (based on data from fit notes collected in three pilot areas). These data are supplemented by qualitative and survey evidence gathered as part of the Year 1 evaluation and pilot summaries edited by the pilots themselves (presented in Appendix A).

A first evaluation report covering the experience of the 11 pilots in Year 1 was published in 2012.¹

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. Available at: www.gov.uk/government/publications/evaluation-of-the-fit-for-work-service-pilots-first-year-report-rr792

Key findings from this report

Participation

In Years 2 and 3 the seven pilots supported 5,300 clients. This was lower than the number of clients supported in Year 1, due to the smaller number of pilots and the focus on sickness absentees from SMEs.

Following the change of focus, at least 70 per cent of the clients in every pilot were sickness absentees (Section 2.4). However, most pilots continued to find it difficult to attract clients from SMEs (Section 2.3.2). With the exception of the Scotland pilot, which was restricted to employees of SMEs, SME employees constituted less than 40 per cent of the clients in all other pilots. Attempts to market to SMEs directly were generally unsuccessful as long-term sickness absence was not perceived to be a current issue by most SMEs, and many General Practitioners (GPs) or other health professionals who referred clients to the pilots did not distinguish between employees from large or small workplaces.

Nearly all the pilot participants were suffering from 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). Most thought their health condition had been made worse by work (Section 2.5.1).

Marketing and referrals

In Years 2 and 3 there was a greater emphasis on receiving referrals from or through GPs, as this was likely to be the first port of call for those on a sickness absence from work. In the first year, just over a quarter (27 per cent) of the users of the service were referred by GPs, and a similar proportion (29 per cent) referred themselves. The rest mainly came through referral from local Improving Access to Psychological Therapies (IAPT) services or other healthcare services.

The pilots pursued a number of strategies to engage with GP practices. Evidence from the pilots suggests that the most effective approaches included:

- Initially engaging with Practice Managers but trying to meet GPs face-to-face as often as possible;
- Establishing credibility, for example, by working with advocates and ‘GP or Practice Manager Champions’;
- Ensuring referral processes were as simple and efficient as possible;
- Providing additional value (for example advice about using the fit note) and ensuring GPs received client feedback.

According to the management information for Year 3 of the pilots, around 21 per cent of clients were directly referred by GPs, 29 per cent by IAPT or other healthcare services, and 41 per cent self-referred. However, a significant proportion of clients (45 per cent) first heard about the service through their GP, and a further 41 per cent heard about the service through their local IAPT or other healthcare service. Healthcare services were therefore a significant source of information that prompted a self-referral. Throughout the duration of the pilots, few clients were referred directly by employers (Section 2.4).

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. Clients expressed a high level of satisfaction with their initial assessment and the main features of an effective assessment appeared to involve adopting a holistic approach, conducting a client-led assessment underpinned by a framework, and Case Managers who had good listening skills. 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 (Section 2.5).

Case management was a key element of the pilots. A critical difference between the different pilots appeared to be between those that could offer some form of direct clinical support through Case Managers (such as providing Cognitive Behavioural Therapy (CBT)) and those where support was offered by the wider pilot partnership or beyond. This reflected the different disciplinary backgrounds of the Case Managers. In Years 2 and 3 the Case Managers in three pilots had a health background, in a further three pilots they had backgrounds in human resource management (or employment services) and in one pilot area, the Case Managers were experienced in vocational rehabilitation. Those with a health background were able to provide clinical support to clients themselves and were able to liaise with other health services, including GPs. On the other hand, some of the pilots argued 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. It was also felt to be important that Case Managers remained impartial, allowing clients to fully disclose the barriers that prevented them from returning to work, particularly if some of those barriers originated in the workplace.

Where clients required services (either clinical such as physio- or psychotherapy, or non-clinical such as help with debt management or housing) beyond those provided by the Case Manager, the Case Manager role involved accessing 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 within a partnership 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, and a further 16 per cent were 'fairly satisfied'. Clients also generally agreed that the service had offered a personalised (78 per cent) and responsive (79 per cent) service that had been able to refer or signpost them to relevant support (75 per cent). Most clients (69 per cent) also thought that the service had been well co-ordinated with other services (Section 3.1.1).

Around half the clients in the survey indicated that they thought the pilots had helped them to manage their health condition, and help them return to work earlier than they would otherwise have done after a period of absence due to ill-health (Section 3.1). On average clients spent

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

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 (Section 2.6.4).

Clients' self-assessed health, measured using an EQ-5D questionnaire, also improved over the duration of the pilots. The percentage of clients reporting problems in mobility, self-care, usual activities, pain or discomfort and anxiety or depression fell significantly between entry to and discharge from the pilots. However, it is worth noting that due to the lack of a control group, this cannot be directly attributed to the pilots.

Impact on returning to work

A study of the impact of the pilots on sickness absence duration was conducted in three pilot areas (Section 3.2). The time taken to return to work by pilot clients was compared with the 'local average or norm' based on all fit note recipients in the same area (who had been absent for at least four weeks, typically the eligibility period for the pilots), for each of the main health problems encountered (common mental health disorders and musculoskeletal disorders (MSKs), including back pain). However, the data on fit notes were drawn from a selection of practices in three of the seven pilot areas (Manchester, Leicester and North Staffordshire) and were not necessarily representative of all clients involved in the pilots. In addition, the study did not control for differences in observed characteristics between clients and non-participants, for instance in demographic or socio-economic variables. The voluntary nature of the pilots mean that pilot clients may have been more motivated to return to work than those who did not volunteer (which may overstate impact), or conversely, their conditions may have been more urgent and/or severe (which may understate impact). The results on the impact of the pilots should therefore be treated with caution.

The results showed that in two out of the three areas, pilot clients had shorter certified sickness absence periods on average than their equivalent local norms. The detailed results varied by health condition between the pilots; but in general, clients with MSKs were more likely to have shorter than average absences than clients with a common mental health condition. One explanation for the variation could be the speed of access to additional support. For example one of the pilot areas, Manchester, had a physiotherapy provider within the pilot partnership to whom clients could be referred quickly, whereas patients with a moderate or severe mental health disorder were referred to the local IAPT service, which could take some time.

There was some variation in the results from the three areas where the fit note study took place, although the general direction of the findings was similar:

- In Greater Manchester, absence episodes (the length of time from first service contact to return to work) for clients with depression, back and musculoskeletal problems were significantly shorter than the length of a comparable episode among the 'local norm'. For all recorded diagnoses the average duration of a sickness absence episode was 3.4 weeks, significantly lower² than the local norm of eight weeks.
- In North Staffordshire, clients' absence episodes tended to be significantly shorter than the comparison group when the health problem was depression or a musculoskeletal condition, but not for other conditions. For all recorded diagnoses the average duration of a sickness absence episode was 3.4 weeks, significantly lower than the local norm of six weeks.

² The difference is statistically significant at the five per cent confidence level, which means that there is less than five per cent probability that the difference is due to chance.

- In Leicester, client absence episodes tended to be shorter than the local norm when the cause of sickness absence was musculoskeletal (but not mental health-related). However, for all recorded diagnoses in Leicester the average duration of a sickness absence episode was 6.9 weeks, slightly longer than the local norm of six weeks, however, this difference was not statistically significant.

Analysing the data from the three pilot areas combined showed that the odds of returning to work sooner than the local average were twice as high for clients with musculoskeletal conditions, than for clients with mental health conditions. The pooled data also indicated that absence episodes tended to be longer when the client had no dependent children, when their referral came from a GP or 'other' health professional, and when the client had spent more than eight weeks off work before their initial assessment – suggesting the importance of an early intervention.

The costs of providing the pilots

The cost of each of the pilots was analysed. These costs covered the direct costs of the pilots funded by the DWP and did not include any costs incurred as a result of the pilot by health service providers (receiving additional referrals from the pilots) or employers (making workplace adjustments to accommodate employees returning to work). The most significant items were staff costs and the amount spent on providing clients with services in addition to those provided in-house. The overall costs of each pilot varied significantly partly due to differences in the number of clients and also due to the different service models offered. For instance, some of the pilots' models provided their client services in-house and others primarily signposted clients to other providers (Section 2.6.3).

The average cost was around £1,000 per client, but the costs varied from around £500 per case in the two areas operating telephone-based services (Greater Manchester and Scotland) to over £2,000 per case in the pilots in Inner NW London, and North Staffordshire where a range of in-house support services were available to clients (Section 4.1).

Covering the cost

The average cost of a day's sickness absence is approximately £90.³ To cover average costs of £1,000 per case, a pilot would need to have reduced clients' sickness absence by an average of 11 working days. To cover the cost of the lower cost pilots, £500 per case, the pilots would need to have reduced clients' sickness absence by an average of five to six working days (Section 4.3).

The cost effectiveness of the three pilots for which an impact study was conducted can be assessed using these estimates. One of the three pilots, Greater Manchester, was highly cost effective, with a net benefit of around £1,500 per client. However, the other two pilots (North Staffordshire and Leicester) were not cost effective, with a net cost of around £1,500 per client each.

³ Chartered Institute for Personnel and Development, 2009 *Absence Management: Annual survey report 2009*.

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

The results of these three pilots suggest that service models based on lower cost pilots, such as Greater Manchester, were cost effective, whereas higher cost pilots were not cost effective. However, it is important to note 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-psycho-social 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.

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.⁴ On this basis, a new **Fit for Work Service** was proposed as a proof of concept pilot, to offer support for people in the early stages of sickness absence and fill the gap in the provision of occupational health (OH) 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. Learning around best practice has been fed back from these pilots to inform the implementation of the new national independent health and work advice and referral service (Fit for Work), launched at the end of 2014.

Between April and June 2010, 11 pilots were launched throughout Great Britain, initially for a year, funded by the Department of Work and Pensions (DWP) and the Department of Health (DH). From April 2011, seven of the pilots were extended for a further two years, up to March 2013.

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), the University of Swansea and GfK NOP to evaluate the pilots.

A report presenting the findings of the first year of the evaluation and the experience of the 11 Year 1 pilots in their first year of operation was published in 2012⁵. This report provides an update on that report, focusing on the seven pilots that were funded for Years 2 and 3, and draws together all the available evidence on the impact of the pilots on the employment and health of those who participated.

1.1 The pilots

The 11 Year 1 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 fewer 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 pilot, and the Scotland-wide pilot (with nearly two and a half million people employed).

The areas covered by the 11 Year 1 pilots were:

- Birmingham, Coventry, Sandwell and Solihull – referred to in this report as the 'Birmingham area' pilot;

⁴ Black, C. (2008). *Working for a healthier tomorrow: Dame Carol Black's review of the health of Britain's working age population*, London: TSO.

⁵ 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. Available at: www.gov.uk/government/publications/evaluation-of-the-fit-for-work-service-pilots-first-year-report-rr792

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

- Eastern and Coastal Kent;
- Dundee and Tayside – referred to in this report as the ‘Dundee’ pilot;
- Greater Manchester;
- Kensington and Chelsea;
- Leicestershire and Leicester City – referred to in this report as the ‘Leicester’ pilot;
- North Staffordshire – referred to in this report as the ‘North Staffs’ pilot;
- Nottinghamshire;
- Rhyl;
- Scotland;
- Wakefield.

In Years 2 and 3, 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 funded further. The pilot in Nottinghamshire continued with a change to the service model to focus on the case managed support for clients, one element of their initial approach. The pilots in Rhyl, and Kensington and Chelsea⁶ were expanded to cover a wider geographical area. All the pilots in Years 2 and 3 were asked to focus on sickness absentees, as opposed to employees with a health condition who remained in work (presentees), and to recruit employees from SMEs. It was recognised that this would affect the number of participants in the pilots as engagement would be focused on a smaller population.

Brief descriptions of each of the seven pilots that operated in Years 2 and 3 are contained in Appendix A.

1.1.1 The aims of the pilots

The original aims and objectives of the pilots were set out in a memorandum of information (MOI)⁷ issued as part of the original pilot selection process and in presentations to potential bidders. 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 from work on health grounds – working in SMEs;
- contribute to tackling health inequalities in their area – for instance by covering areas with greater levels of sickness absence’;

⁶ In Years 2 and 3 the pilot covered the London Boroughs of Kensington and Chelsea, Westminster and Hammersmith and Fulham. In the rest of this report the pilot is referred to as ‘inner North West (NW) London’.

⁷ HM Government (2009). *Fit for Work Service Programme of Piloting: Memorandum of Information*, HM Government.

- 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; and
- provide timely, co-ordinated back-to-work interventions.

1.2 The evaluation

The overall aims of the evaluation were to:

- understand the nature of the programme of piloting and assess the effectiveness of the service being provided. **This aim was largely covered by the first evaluation report, supplemented by evidence presented in this report;**
- identify and disseminate (in collaboration with DH and DWP) the key lessons for ensuring the quality, effectiveness and efficiency of the pilots in the future. **This aim was largely covered by the first evaluation report and subsequent dissemination, supplemented by evidence presented in this report;**
- undertake an economic evaluation of the pilots, including estimating the net impact of the pilots on clients' speed of return to work and flow onto welfare benefits. **This aim is partly covered by this report.**

1.2.1 Main evaluation activities

The evaluation had a number of strands, most of which took place in the first year of the evaluation. The evidence from all aspects of the evaluation including the research conducted in year one, is drawn on in this final evaluation report. The various strands included:

- Management information (MI) collected from the pilots about their clients, including a new MI system introduced by the DWP for the second and third year of the pilots to standardise data collection. However, some of the pilots reported difficulty with updating the MI and expressed concerns that some of the summary data did not tally with their own records;
- interviews with pilot personnel and stakeholders in the first year of the pilots. While there was no additional pilot fieldwork in the second and third year, the descriptions of how the pilots operated published in the first evaluation report⁸ were updated by the pilots themselves and some added information about which aspects of the pilots worked particularly well;

⁸ 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. Available at: www.gov.uk/government/publications/evaluation-of-the-fit-for-work-service-pilots-first-year-report-rr792

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

- three telephone surveys of clients including a two-wave telephone survey of clients in the first year pilots and a third survey of clients in the remaining seven pilots in years two and three. Although the response rates to the surveys were over 50 per cent, the proportion of clients consenting to take part in the surveys varied significantly between pilots and therefore the achieved samples cannot be considered to be representative;
- a longitudinal panel of clients who took part in two waves of in-depth qualitative interviews;
- interviews with GPs, including those actively referring patients to the pilots and some who were not involved;
- a bespoke impact study comparing length of sickness absence among pilot clients who were absent from work with the average among fit note recipients in the local area, using fit note data collected from a selection of GP practices in three pilot areas.

Please see Appendix B for more details of the methodology employed throughout the evaluation.

2 Overview of the pilots

2.1 The pilots

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. In the first year the lead body in most sites was a health service organisation. In Years 2 and 3, most of the pilots were, or had changed to become, led by an independent social enterprise or Community Interest Company, but still retained their partnership approach.

2.2 Models of provision

This section sets out a brief description of the service provided by the pilots and the key distinctions between the pilot models.

2.2.1 A simple model of the service

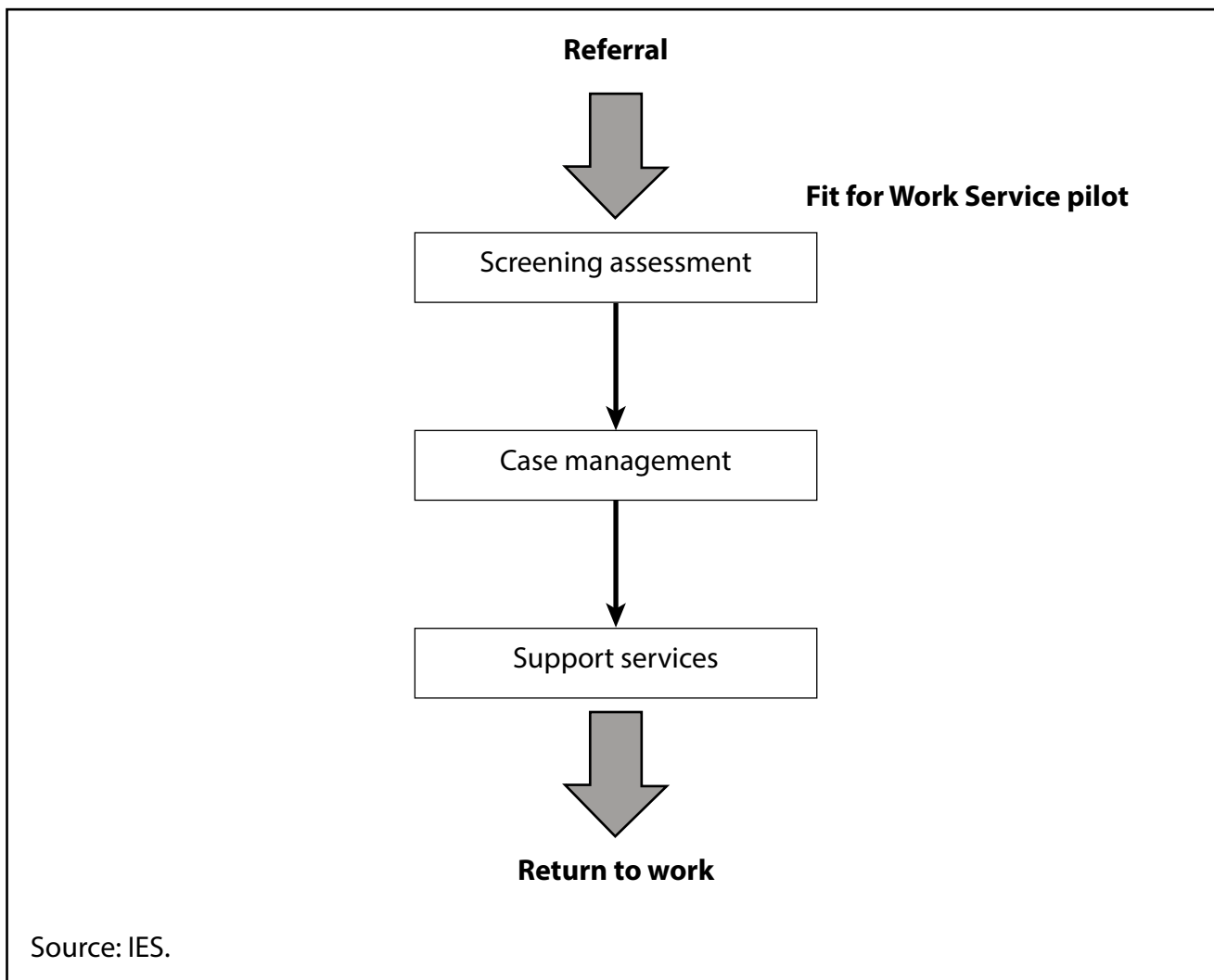
In the evaluation report of the Year 1 pilots it was noted that each pilot had a different way of operating. In all pilots, the client journey included five separate stages (Figure 2.1), but practice at each stage varied from pilot to pilot⁹.

- **Referral** – individuals could access the pilots either by being referred, 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 pilots 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 wellbeing at work. This process was usually 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 by 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. Most pilots 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 in which Case Managers or other in-house staff offered some form of clinical support (such as Cognitive Behavioural Therapy (CBT)) and those that relied solely on clinical interventions from organisations involved in the wider pilot partnership or beyond. Another point of difference was whether such additional support was provided by partners within the local pilot or by external providers in the health service or wider community.

⁹ *ibid.*

- **Discharge** – the pilots usually monitored the client’s progress once discharged from the service, to see whether they had been able to overcome or manage the issues that were affecting their wellbeing at work and to see if they needed any further support.

Figure 2.1 Simple model of a pilot service



The details of each of the individual pilots are summarised in Appendix A. In addition Appendix A includes a summary table which outlines key elements of the pilot models and a range of data about the profile of their clients, how they engaged with the pilots and their outcomes.

2.3 Participation

In Year 1, the 11 pilots provided a case-managed service to 6,726 clients. In Years 2 and 3, the smaller number of pilots and the required tighter focus on the core target group of sickness absentees meant that the pilots catered for fewer numbers, with a total of 2,517 clients in Year 2 and 2,783 clients in Year 3.

As in Year 1, participation varied across the pilots in Years 2 and 3, however, the variation was much smaller in numerical terms, generally reflecting the size of the pilots (Figure 2.2). However as in Year 1, the pilot in Rhyl and surrounding areas which covered a small area continued to recruit a relatively large number of clients. In four of the pilots, Greater Manchester, Inner NW London, Rhyl and Scotland numbers in Year 3 were higher than in Year 2, while in the three other pilots they declined.

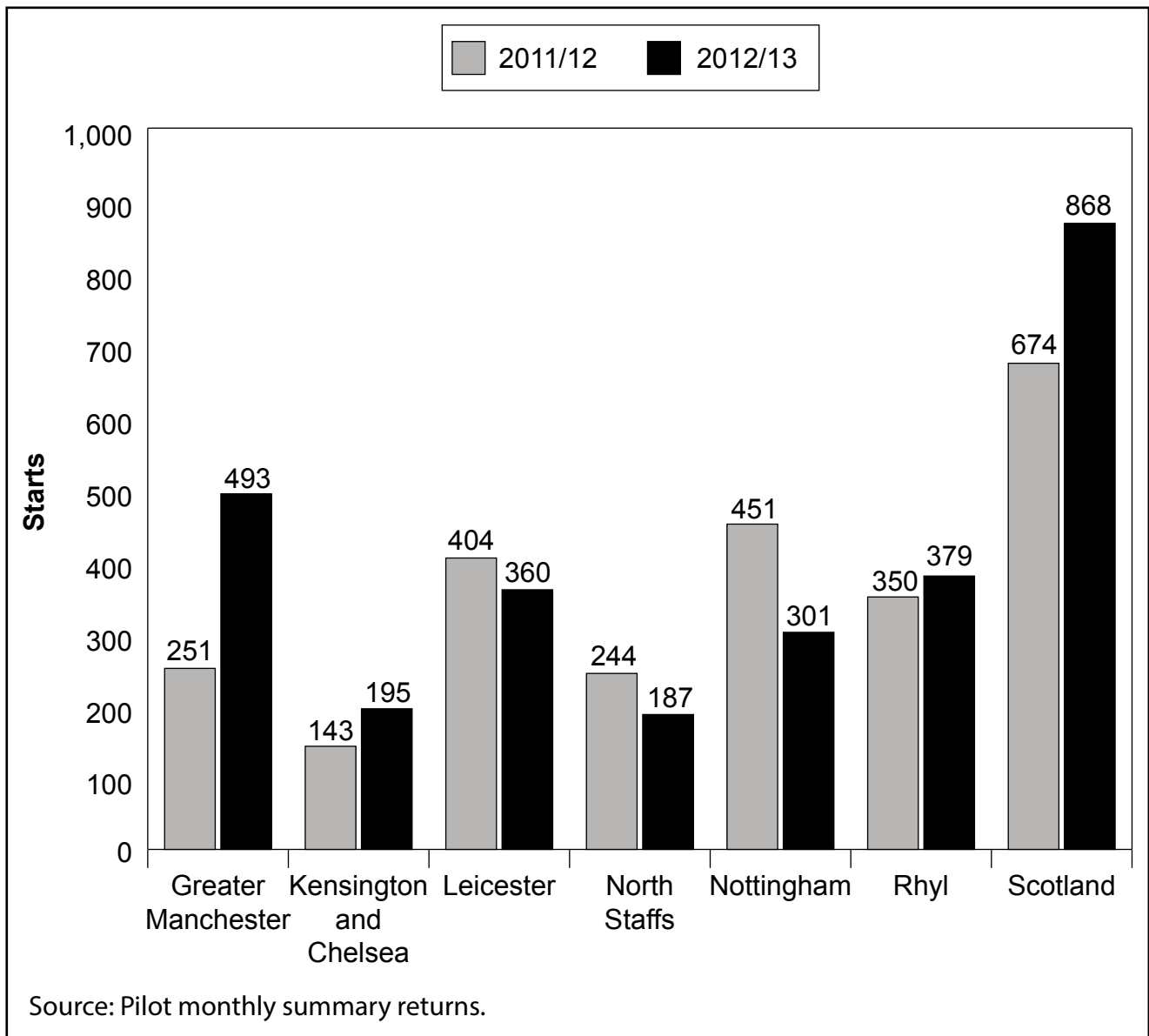
Evaluation of the 2010–13 Fit for Work Service pilots: final report

In Year 1, the pilots attracted significantly fewer clients than they had originally expected. This was attributed to three main reasons:

- 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 GPs and employers); and
- the time taken to learn lessons about the effectiveness of various marketing techniques.

Due to the renewed focus on sickness absentees in Years 2 and 3, the expected number of clients was reduced. In the event, five of the pilots managed to attract more clients than they had expected, according to the profile they submitted to the Department for Work and Pensions (DWP) and three (North Staffordshire, Nottinghamshire and Rhyl) exceeded their targets by around 50 per cent. However, the overall numbers were lower than profiled, mainly due to the Scotland pilot only attracting 1,542 clients against a profile of 2,500. Figure 2.2 shows the number of people who contacted the pilots and arranged to have an initial assessment.

Figure 2.2 Number of new cases by pilot area to April 2011 to March 2013



2.4 Referrals and marketing

In Years 2 and 3 the pilots were encouraged to focus on seeking referrals to the service from GPs as these were the likely first port of call for people on sickness absence from work. In the first year just over a quarter (27 per cent) of the pilot participants were referred by GPs and a similar proportion (29 per cent) referred themselves, probably having been informed about the pilots by their GP. According to the Management Information (MI) for the last year of the pilots around 27 per cent of clients were referred by GPs, while 36 per cent self-referred. Other common referral routes included the Improving Access to Psychological Therapies (IAPT) service (14 per cent) and other healthcare services (15 per cent).

Table 2.1 Referral routes to the pilots (percentages)

Referral route	Greater Manchester	Inner NW London	Leics	North Staffs	Notts	Rhyl	Scotland	All
GP	8	44	65	24	43	36	12	27
IAPT service	34	6	14	19	38	0	0	14
Other healthcare service	32	3	0	2	7	2	23	15
Employer	2	1	0	12	3	7	2	3
Self-referral	22	44	0	34	6	54	59	36
Another service/ route	2	1	21	9	3	1	4	6
<i>Base (N)</i>	637	265	557	292	591	333	1,694	4,369

Note: The MI covered the period October 2011 to March 2013, in Years 2 and 3 of the pilot; however, there may have been some variation across the pilots.

Source: Pilot MI.

A large proportion of clients (49 per cent) first heard about the pilots through their GP (Table 2.2), and a further 38 per cent heard about the pilots through their local IAPT or other healthcare service.

The involvement of GPs as either a direct source of referral, or the provider of information to patients to enable them to self-refer, varied between the pilots. Some such as Leicester, Rhyl (which was based in the same building as a GP surgery) and Inner NW London had close relationships with local GPs reflected in the data in Table 2.1. Others found establishing and sustaining relationships with GPs more difficult and relied more heavily on their relationship with other health organisations (such as IAPT in Greater Manchester).

Overall the involvement of GPs was greater in Years 2 and 3, at least as a prime source of information if not direct referral (i.e. as measured by the data in Table 2.2) but not as high as anticipated.

Table 2.2 Source of initial information about the pilot (percentages)

Route of information	Greater Manchester	Inner NW London	Leics	North Staffs	Notts	Rhyl	Scotland	All
GP	17	82	79	38	43	79	46	49
IAPT/ psychological therapy services	39	8	9	21	41	0	0	15
Other healthcare service	35	6	6	4	7	3	40	23
Employers	3	3	1	17	4	10	5	5
Friend, family or colleague	3	0	1	4	1	4	3	2
Advert, poster or other promotional material	0	0	4	1	0	0	1	0
Other	3	1	1	15	4	4	5	7
<i>Base (N)</i>	<i>635</i>	<i>264</i>	<i>503</i>	<i>293</i>	<i>591</i>	<i>330</i>	<i>1,700</i>	<i>4,316</i>

Note: The MI covered the period October 2011 to March 2013, in Years 2 and 3 of the pilot; however, there may have been some variation across the pilots.

Source: Pilot MI.

2.4.1 Marketing to GPs

In the first year the pilots found it difficult to secure referrals from GPs and in particular 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 pilots; and
- sustain interest among GPs and ensure that the pilots remained a prominent option.

In Years 2 and 3 the pilots spent considerable effort attempting to engage with GP practices in their area to maximise the number of referrals. This could prove a difficult task for those covering wide geographical areas as some of the most effective ways of engaging with GPs were quite labour intensive. Some practices recruited dedicated engagement officers (see, for example, Nottinghamshire), while in other pilots Case Managers spent time engaging with GP practices. Evidence from the Year 1 evaluation, supplemented by feedback from the pilots in Years 2 and 3, suggests that the most effective ways of engaging with GPs included:

- initially engaging with Practice Managers, but trying to meet GPs face-to-face as often as possible;
- establishing credibility, for example, by working with advocates and ‘GP or Practice Manager Champions’ (i.e. local GPs and Practice Managers who were willing to promote the pilots to their colleagues and facilitate access for the pilots);
- ensuring referral processes were as simple and efficient as possible, for example, through referral cards (see Leicester);

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

- providing additional value (for example, advice about using the fit note) and ensuring GPs received client feedback.

2.4.2 Marketing to employers

The other main target for the pilots' marketing activities was employers and particularly small and medium-sized enterprises (SMEs). In every pilot area, SMEs made up 99 per cent of all employers. Again the pilots employed a range of methods including:

- engaging with representatives from intermediaries such as Chambers of Commerce and the Federation of Small Businesses and attending employer events, organising 'business breakfasts';
- telemarketing campaigns targeting small businesses – which were generally reported by the pilots to have achieved limited success; and
- general marketing campaigns (including radio, billboards etc.) aimed at both employees directly and small employers – again with limited success.

In one pilot, North Staffordshire, SME engagement was the responsibility of a specialist employment service which was part of the local pilot partnership. A range of methods was used including: networking events with follow-up phone calls; training sessions; e-zines (small on-line newsletters or magazines); cold-calling and telemarketing to raise awareness. In addition, local radio and transport companies were used for mass-marketing campaigns. In the third year, a marketing company took over this function, and redesigned the publicity material. Exposure was also broadened: SMEs were emailed, shopping centres and billboards were used for outside advertising, and there was also a brief social media campaign. This did not yield any differing results from the previous 'in house' work. The pilot reported that best results (in terms of referrals) occurred from good relationships forged by staff employed by the pilot working on cases with local employers and Human Resources (HR) managers.

Employment profile of pilot clients

Most of the pilots therefore found it difficult to attract clients from SMEs. In six of the pilots, only 30 to 40 per cent of clients came from SMEs (Tables 2.3). The exception was Scotland, where the pilot only accepted sickness absentees from SMEs.

Despite the intensified marketing efforts, there was little difference in the proportion of clients coming from SMEs between the pilots in Year 1 and in Years 2 and 3.

Pilots found it difficult to attract employees from smaller workplaces for two main reasons:

- Long-term sickness absence was not perceived to be a current issue for most small workplaces and so while employers may be interested in general sickness management and/or health and safety advice, they generally did not have employees to refer;
- Most clients came directly or indirectly via health services (for example, GPs and IAPT, see Section 2.4) who having established basic eligibility for the pilots did not tend to ask potential beneficiaries about the size of their employers.

In all pilots, most employees (74 per cent) worked in the private sector, with an additional six per cent in the third sector and the remaining 20 per cent from the public sector. There was a higher level of engagement with the private sector in the pilot in Scotland (86 per cent, with ten per cent from the third sector and four per cent from the public sector).

Table 2.3 Proportion of pilot clients from SMEs

Pilot	%
Greater Manchester	36
Inner NW London	30
Leicester	30
North Staffs	37
Nottinghamshire	30
Rhyl	39
Scotland	99
Total	60
<i>Base (N)</i>	<i>4,115</i>

Note: The MI covered the period October 2011 to March 2013, in Years 2 and 3 of the pilot; however, there may have been some variation across the pilots.

Source: Pilot MI.

Outside Scotland almost two-thirds of clients came from large or medium-sized workplaces, which often had Occupational Health (OH) services. The pilots tended to accept clients from such workplaces where:

- the issue to be resolved proved to be outside the remit of any OH service and/or was not able to support the client;
- the client had not been referred to their OH service by their employer;
- the client did not want to go to the OH service because, for example, it was not felt to be neutral and there could be a potential conflict of interest between the employer and employee; or
- the employee would have to wait too long for the issue to be resolved.

2.5 Client characteristics

The vast majority of the clients supported by the pilots in Years 2 and 3 were on sickness absence from work when they first became involved with the pilots.

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

Table 2.4 **Sickness absence status at entry assessment**

Pilot	Off sick %
Greater Manchester	78
Inner NW London	71
Leicester	77
North Staffs	75
Nottinghamshire	80
Rhyl	89
Scotland	100
Total	88
<i>Base (N)</i>	<i>4,389</i>

Note: The MI covered the period October 2011 to March 2013, in Years 2 and 3 of the pilot; however, there may have been some variation across the pilots.

Source: Pilot MI.

On average, 88 per cent of pilot clients were absentees, compared with just 30 per cent in the Year 1 pilots. The MI data show that the proportion of sickness absentees among the client group as a whole varied between 70 per cent in Inner NW London to 100 per cent in Scotland (Table 2.4). During the first year of the pilot, employees in work at risk of becoming absent were accepted into the Scottish pilot. This stopped in Years 2 and 3, although the Scottish pilot continued to provide support to employees from SMEs who remained in, or were struggling at work, but this was funded separately, via Scottish Government.

As in the Year 1 pilots, just over half the clients (54 per cent) were female. In Year 3, clients tended to be older than in the early years of the pilots, with 67 per cent aged 40 or over, compared with 55 per cent in Year 1 (see Table 2.5).

Table 2.5 **Gender and age distribution of clients**

Gender	%	Age	%
Male	46	16-29	13
Female	54	30-39	21
		40-49	31
		50 plus	35
<i>Base (N)</i>	<i>4,355</i>	<i>Base (N)</i>	<i>4,382</i>

Note: The MI covered the period October 2011 to March 2013, in Years 2 and 3 of the pilot; however, there may have been some variation across the pilots.

Source: Pilot MI.

2.5.1 Health conditions

According to the MI, the main health condition that affected clients at the time of their initial assessment was either a musculoskeletal condition (50 per cent) or a common mental health

condition (45 per cent). The most common musculoskeletal condition was a back problem (23 per cent) followed by an upper limb disorder (15 per cent) or a lower limb disorder (12 per cent). The main mental health conditions presented at initial assessment were: depression (18 per cent); anxiety (13 per cent); and stress (nine per cent).

As in Year 1, clients' health profiles varied by pilot, with a higher proportion of musculoskeletal disorders (MSKs) reported in Scotland (affecting 70 per cent of clients at initial assessment), while 75 per cent of clients supported by the Nottinghamshire pilot had a mental health condition.

The Year 1 evaluation report found that over half of 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. The importance of non-health issues was confirmed by pilots in Years 2 and 3 in their monthly progress reports to DWP.

2.6 Assessment and support

2.6.1 Assessment

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. In two pilots (Greater Manchester and Scotland, both of which had the largest potential eligible populations) this was done on the telephone and in the others it was carried out face-to-face, although in the third year in Leicester, clients with a musculoskeletal problem were assessed over the phone. Assessment interviews generally lasted around an hour and while they were generally conversational in style, some pilots used bespoke or standard assessment tools to collect information about the client. In Years 2 and 3 in all pilots this included asking clients to complete an EQ-5D health questionnaire. Case Managers, interviewed in the first year of the pilots, emphasised that the client assessment did not stop after the initial interview(s) and that some issues were only revealed over time.

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 underpinned by a 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 more resource efficient, preserve client anonymity and help focus the discussion. However, meeting the client face-to-face enabled the Case Manager to more easily establish a relationship and delve into issues in more detail. Although some interviewees in the first year evaluation felt there was potential for sensitive or latent issues to be missed in a telephone assessment, the Scotland pilot 'found no evidence to suggest that the quality of the service (which included telephone-based assessment and case management) compared unfavourably to face-to-face models'.

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 pilots would provide or access.

2.6.2 Case management

Case management was a key element of the pilots. 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 provided 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 (such as providing CBT) and those where support was offered by the wider pilot partnership or beyond.

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. The pilots also concluded that being able to offer an individually tailored package of support was also crucial. One of the pilots, Leicester, found no evidence to suggest that 'a simple client assessment and agreed action plan is enough support for the vast majority of clients'.

In Year 1, Case Managers mostly came from health backgrounds: generally physiotherapy, psychotherapy or occupational therapy, although some had experience in HR management and employment support. In Years 2 and 3 the balance was more even. In Years 2 and 3 the Case Managers in three pilots had a health background, in a further three they had backgrounds in HR management or employment services and in one, (Inner NW London) the Case Managers were experienced in vocational rehabilitation. Two pilots (Leicester and Manchester) felt that Case Managers could be non-clinical as long as they were supported by clinical staff. While another (Nottinghamshire) felt that having NHS-based clinical staff was beneficial in terms of liaison with other health services, including GPs.

One key attribute for Case Managers identified by all pilots, was the ability to win the trust of their clients while remaining impartial between the client and their employer. This allowed clients to fully disclose the barriers that prevented them from returning to work, particularly if some of those barriers originated in the workplace, and mediate between clients and employers if required.

2.6.3 Additional support

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 (such as physiotherapy);
- from elsewhere within the partnership; or
- by referring or signposting to external agencies.

There were differences in the range of support on offer across the pilots; they 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) or ‘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. Some had special funding or contractual arrangements with providers allowing immediate referrals while others relied on standard National Health Service (NHS) referrals to local providers (including IAPT in some areas).

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 accessed ranged from anger management or weight management classes to advice about welfare benefits.

The pilots that had in-house additional support or fast access to external providers within a partnership fed back that they valued the ability to provide interventions without delay and they felt this had enabled a quicker return to work (Appendix A).

A summary of the main key characteristics of the pilots in terms of mode of assessment, Case Manager background and additional support can be found in Table A1.1, Appendix A.

2.6.4 Discharge

Clients were generally discharged from the pilots when they had either completed their intervention programme, when (or soon after) they returned to work, or when no further support was required.

According to the MI for Years 2 and 3, clients spent around 10 to 12 weeks ‘on programme’, i.e. between their entry to the pilot and discharge (see Table 2.6), which is shorter than the estimated length of time in service in Year 1. One pilot explained that during the course of the pilots Case Managers gained a better understanding of what was required to help people back to work as soon as possible and whether potential clients needed interventions to change their mindset prior to them joining the pilot. The variation of duration of involvement between the pilots may also reflect differences in the discharge practices and/or record keeping. In the first year it was apparent that some pilots retained contact with the client after they had returned to work and did not formally discharge them until a few weeks after they returned to work. Meanwhile others would agree a formal discharge before clients returned to work.

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

Table 2.6 Average length of time between entry and discharge to the pilots

Pilot	Mean (weeks)	Median (weeks)	<i>N</i>
Greater Manchester	7.6	5.0	611
Inner NW London	11.6	11.5	250
Leicester	10.7	8.0	500
North Staffs	8.9	8.0	280
Nottinghamshire	12.8	10.0	492
Scotland	18.3	15.0	1,569

Note: The MI covered the period October 2011 to March 2013, in Years 2 and 3 of the pilot; however, there may have been some variation across the pilots. It was not possible to include Rhyl in the above figures, due to data collection issues.

Source: Pilot MI.

3 Effectiveness of the pilots

This chapter reviews the evidence on the effect of the pilots on client satisfaction, self-assessed health and returns to work. It draws on four sets of data: surveys of clients; clients' self-assessed health status; a study of three pilot areas which used fit note data to compare the length of sickness absences between pilot participants and local averages for fit note recipients as a whole; and in-depth interviews with a panel of pilot clients.

3.1 Employment outcomes

Data from the Management Information (MI) indicated that 72 per cent of clients in Years 2 and 3 who were absent from work on entry to the pilots had returned to work by the time of their discharge. The return to work rate for clients in Year 1 was 74 per cent. Employment outcomes varied between the pilots, from 92 per cent being back at work in Rhyl, to 65 per cent in Nottinghamshire and 46 per cent in Leicester (see Table 3.1).

Table 3.1 Proportion of absent clients back at work at time of discharge:

Pilot	%	N
Greater Manchester	75	407
Inner NW London	73	132
Leicester	46	320
North Staffs	66	140
Nottinghamshire	65	209
Rhyl	92	51
Scotland	81	835
All pilots	72	2,094

Note: The MI covered the period October 2011 to March 2013, in Years 2 and 3 of the pilots; however there may have been some variation across the pilots.

Source: Pilot MI.

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

A survey of participants in the seven pilots in Years 2 and 3 asked about the impact of the pilots on return to work.¹⁰ Around three-quarters (76 per cent) of clients surveyed during the second and third years of the pilots said that the pilot had helped them return to work and 22 per cent said it had not. When asked what they thought they would have done in the absence of the pilot (Table 3.2), most said they would have either returned to work later (49 per cent) or not returned at all (ten per cent). Only a few (four per cent) said that going to the pilot had delayed their return to work. However, it should be noted that these are clients' own perceptions rather than objective measures of net impact.

Table 3.2 Impact of the pilots on return to work among clients in Years 2 and 3 pilots

What would have happened in the absence of the service?	%	N
Returned to work later	49	118
Returned to work at about the same time	30	73
Not returned to work	10	25
Returned to work earlier	4	9
None of the above	3	7
Don't know	4	10
Total	100	242

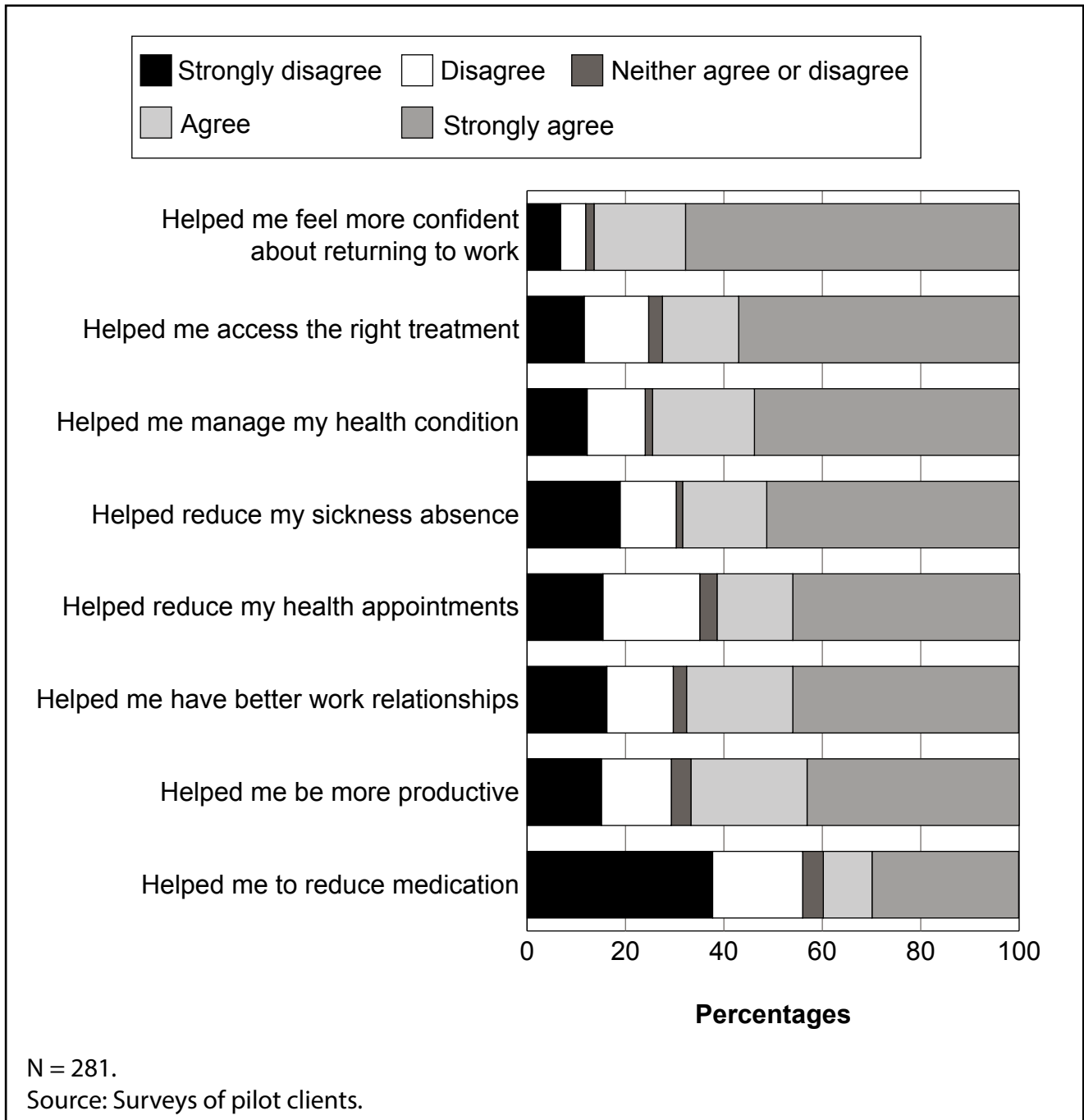
Source: Third survey of pilot clients.

Clients were also asked about whether the service had helped them in a number of specified ways (Figure 3.1). The vast majority (86 per cent) agreed or strongly agreed that their contact with the pilots had helped them to feel more confident about returning to work. Around three-quarters agreed that the pilots had helped them access the right treatment and manage their health condition. Most also thought that engaging with the pilots had enabled them to:

- reduce their number of sickness absences;
- reduce the number of their health appointments;
- improve their working relationships; and
- work more productively.

¹⁰ Although the response rates to the surveys were over 50 per cent, the sample from which they were achieved was not fully representative of the client base as a whole because of the differential consent rate between the pilots. It is therefore important to recognise the limitations of the survey data.

Figure 3.1 Help provided by the pilots



3.1.1 Satisfaction with the pilots

Overall clients strongly appreciated the service they received. The second survey of clients asked respondents about their satisfaction with the levels of service received and 88 per cent were either very satisfied or satisfied with how well their Case Manager understood their situation (Table 3.3). Similar levels of satisfaction were reported by the individual pilots where they had conducted their own surveys.

Table 3.3 Satisfaction with Case Manager’s understanding of client’s situation?

	%	N
Very dissatisfied	5	11
Fairly dissatisfied	3	6
Neither satisfied nor dissatisfied	5	11
Fairly satisfied	16	36
Very satisfied	72	161
Total	100	225

Source: Second survey of pilot clients.

Levels of satisfaction varied with the employment status of the respondent and were highest among those who had returned to work between the two surveys and lowest among those who had remained off sick.

The pilot clients also generally agreed that the service had offered a personalised (78 per cent), and responsive service (79 per cent), that had been able to refer or signpost them to relevant support (75 per cent) (Table 3.4). Most (69 per cent) also thought that the service had been well co-ordinated with other services.

Table 3.4 Thinking overall about the service you have received from the pilots, to what extent do you agree that it has (per cent)

	Disagree strongly	Tend to disagree	Neither	Tend to agree	Agree strongly	N
Offered you a personalised service	8	5	8	19	59	226
Been responsive to your needs	7	6	9	23	56	232
Referred or signposted you to relevant support	8	8	9	24	51	224
Been well co-ordinated with other health and employment advice services	8	8	16	24	45	212

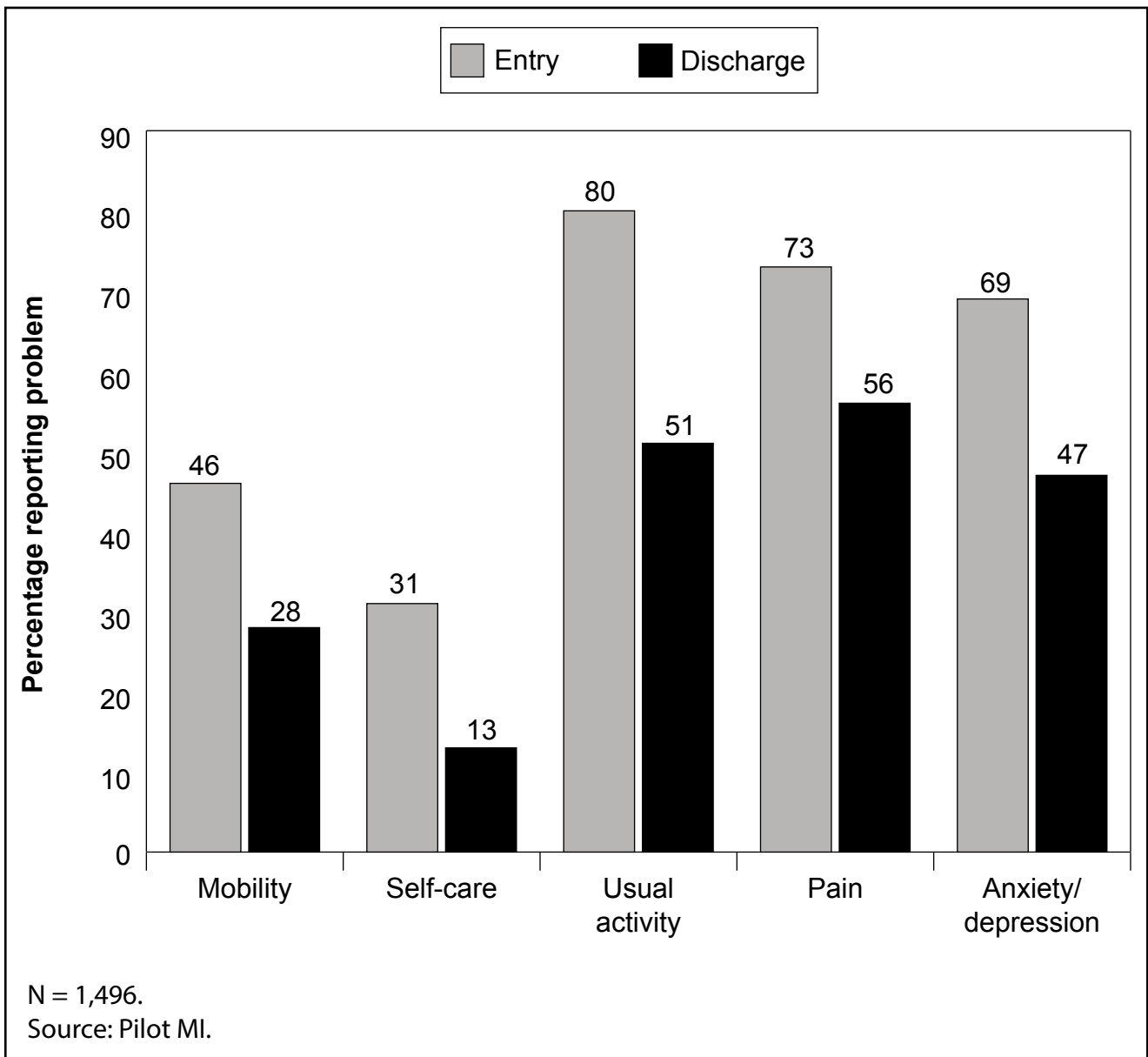
Source: Second survey of pilot clients.

3.2 Self-assessed health

Clients also expressed an improvement in self-assessed health status over the duration of the pilots. Clients completed an EQ-5D questionnaire, a standardised instrument for measuring health outcomes, upon entry to and discharge from the pilots. Respondents are asked to assess their health by reporting whether they experience problems in five areas: mobility, self-care, usual activities, pain/discomfort and anxiety/depression. (A copy of the questionnaire is provided in Appendix B).

The results are presented in Figure 3.2, which shows that in each of the five elements of the EQ-5D, clients felt their health had improved by the time they had left the pilot.

Figure 3.2 EQ-5D health status on entry and discharge to the pilots: October 2011 to March 2013



Unfortunately there is no control group or comparable norms with which to compare these results and enable us to judge the extent to which such improvements can be attributed to the pilots, or may have happened in any case.

The improvement in self-assessed health was greatest for clients who:

- had participated in the Inner NW London or Scotland pilots;
- were male;
- were employed by a small employer (with under 50 employees);
- had a lower limb condition or back problem; and
- did not have access to occupational health (OH) through their employer.

More detailed analysis can be found in Appendix D.

3.3 Impact on return to work

In three of the pilot areas (Greater Manchester, North Staffordshire and Leicester), an impact evaluation was carried out to estimate the causal effect of the pilots. To compare sickness absence durations between pilot clients and the local employed population, 'control' fit note data were collected from four general practices in the Greater Manchester pilot areas, nine in Leicestershire, and six in North Staffordshire. From the fit note data local 'norms' for the average length of a period of certified sickness absence relating to particular diagnoses were established (see Appendix C for details of the methodology).

The fit note data collected from control practices were collapsed into discrete patient absence 'episodes'. These 'episodes' encompassed periods of continuous work incapacity certified by one or more fit notes. Comparable data were collected from pilots' participants through the MI system.

Clients of the pilots typically only accessed the pilots after a certain period of sickness absence, normally after four weeks. As such, the average duration of absence episodes **exceeding four weeks** was estimated from fit note data, to construct an '**adjusted local norm**' for each particular health condition. The assumption is that all patients receiving fit notes with more than four weeks' absence would normally be eligible to participate in the pilots, and could therefore act as a 'control group' for pilot clients. As such, the average length of time it took pilot clients to return to work (following their assessment) could be compared to the adjusted local norm, to provide an estimate of the causal impact of the pilots on returns to work.

However, given the voluntary nature of the pilots, it should be noted that pilot clients were a self-selected group who may not have been representative of the local employed population. For instance, employees on sickness absence who volunteered for the pilots may have been more motivated to return to work than those who did not volunteer (and would have had higher return to work rates than the control group even in the absence of the pilots); conversely, it is conceivable that those who volunteered had more severe or urgent health conditions than those who did not volunteer (and would have had lower return to work rates than the control groups without the pilots). Moreover, the analysis of return to work rates by health condition does not control for observable differences between pilot clients and all fit note recipients, for instance in terms of demographics or socio-demographic variables. Differences in both observable (for example, demographic) and unobservable (for example, motivation) variables between pilot clients and the local employed population may therefore bias the results.

Compared to local norms, average absence episodes were significantly¹¹ shorter for pilot clients in both Greater Manchester and North Staffordshire, by 40 to 60 per cent. In Greater Manchester, the average duration of a client episode was 3.4 weeks compared to an adjusted local norm of eight weeks, and in North Staffordshire, the average duration was 3.4 weeks compared to a norm of six weeks. The impact of the pilots varied substantially across different health conditions. In Leicester, sickness absence durations were slightly longer for

¹¹ Significant at the five per cent level, which means that there is less than five per cent probability that the difference is due to chance. All mentions of statistical significance hereon refer to the five per cent significance level.

pilot clients (6.9 weeks compared to six weeks), however, this difference is not statistically significant.

3.3.1 Health conditions

In **Greater Manchester**, sickness absence episodes (from first service contact to return to work) for clients with depression, back and musculoskeletal problems were significantly shorter than the length of a control episode as represented by the 'adjusted local norm'. The average duration for clients with depression was 3.6 weeks compared to an adjusted local norm of 8.0 weeks; clients with a back problem were off work for an average of 2.1 weeks compared to an adjusted norm of 4.7 weeks. For those with other musculoskeletal problems the client average was 2.6 weeks, also significantly lower than an adjusted norm of 9.3 weeks. On the other hand, there was no statistically significant difference in average sickness absence duration for clients with anxiety or stress. One possible explanation for this difference is that patients in the Greater Manchester pilot with musculoskeletal disorders (MSKs) were able to access physiotherapy/chiropractor support (commissioned through the pilot) within 3.0 days of assessment. Clients with common mental health conditions were provided with support in house, however those with moderate to severe conditions were referred to Improving Access to Psychological Therapies (IAPT) and had to wait longer to receive the intervention.

In **North Staffordshire** client episodes tended to be significantly shorter than the comparison group when the health problem was depression or a musculoskeletal problem or '[an]other health problem'. The average duration for clients with depression was 3.8 weeks compared to an adjusted local norm of 8.0 weeks; clients with a musculoskeletal problem other than a back condition were off work for an average of 2.9 weeks after contacting the pilot, compared to an adjusted local norm of 8.0 weeks. For those with 'another health problem' the respective durations were 3.0 and 6.0 weeks. There were no significant differences in the length of absence for clients with other diagnoses (including anxiety and stress).

In **Leicester** client absence episodes tended to be significantly shorter than the local norm when the problem causing sickness absence was musculoskeletal in nature. Clients with a back problem spent an average of 6.1 weeks with the pilot compared to an adjusted local norm of eight weeks, and those with other musculoskeletal conditions were off work for an average of 3.6 weeks (after their initial assessment) compared to an adjusted local norm of 8.8 weeks. There were no significant differences for clients with common mental health conditions (depression, stress and anxiety), or for clients with 'other' health problems.

3.3.2 Other characteristics

Based on combined data from all three pilots, the probability of returning to work sooner than the local average is significantly higher for employees from small and medium-sized enterprises (SMEs) and medium-sized employers, than for employees from large employers with over 250 employees (see Table A3.23 in Appendix). Restricting analysis to the clients of the three pilots, clients were significantly less likely to return to work after the pilots when:

- The client had no dependent children. The odds of returning to work were 66 per cent higher for clients with dependent children.
- The client was referred by their General Practitioner (GP) or '[an]other healthcare professional'. Compared to clients referred by their employers, the odds of returning to work were 78 per cent lower for clients referred by their GP or 'another healthcare professional'. The difference in odds of returning to work between employer referrals, self-referrals and IAPT referrals is not statistically significant.

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

- The client had spent more than eight weeks off work before their initial assessment. The odds of returning to work were 55 per cent lower for clients who had been absent from work for more than eight weeks before contact with the pilots. The difference in odds of returning to work is not significantly different for clients who had been off work for less than four weeks and those who had been off work for four to eight weeks.

Clients with musculoskeletal conditions are significantly more likely to return to work sooner than the local adjusted norm. Specifically, the odds of returning to work sooner than the local average were twice as high for clients with musculoskeletal conditions compared with clients with common mental health conditions.

3.4 Evidence from the longitudinal panel

As part of the evaluation in-depth face-to-face interviews were conducted with 63 pilot participants, followed up by a further telephone interview six months later. In Year 1 the interviewees explained that they had chosen to engage with the pilots because they hoped it would prove beneficial, they had been encouraged to do so by others, they recalled positive past experiences of similar pilots or of the provider, they were inclined to take up support, or they had been approached directly by pilot staff. There were also people who said they had no choice about being referred to the pilots.¹²

The interviews indicated that engaging with the pilots had made an impact on people where it influenced decisions about returning to or staying in work, helped to stabilise, improve or manage health, played a part in resolving problems with employers, supported progress towards work readiness, and boosted confidence, morale and motivation. The pilots did not make a difference where people had little experience of the service (so far), where the service had failed to contact the client as promised, where support did not match needs or expectations, and where clients found the manner and advice of staff unhelpful.

Respondents tended to end contact with the service because they had returned to work, accessed substantial support from elsewhere, when it became apparent that the service could not do anything to help the individual, or when the service failed to re-establish contact. People who had found the pilots beneficial or who thought it might be useful in the future explained that they would be happy to re-engage with the service if the need arose.

Aside from the pilots, a number of other factors were reported to be important in making decisions about work, including personal motivation to be in work, improving health and management of symptoms, financial considerations, the perceived attitude and behaviour of the employer, and valuable support received from other services or professionals. Barriers to work and perceived risks to sustaining work encompassed ongoing health limitations, problems with employers and concerns about job insecurity, a range of labour market barriers such as a lack of qualifications, responsibilities for childcare, and financial problems.

In the second round of interviews with 55 of the original panel of pilot participants, respondents reported a number of benefits. These included that the pilots had helped them to sustain work, had led to improvements in health or the management of conditions, had facilitated access to external healthcare interventions, or had speeded up a return to work. Respondents views about the pilots making an impact at an earlier stage did not diminish over time and some

¹² This comprised a small group of participants from one of the Year 1 pilots who had been referred to the pilot by their employer without their knowledge.

people attributed greater impact to the pilots on reflection than they had done previously. People who had felt that the pilots had not made an impact during the first interview had not changed their view. Not making a difference was associated with the pilots not meeting individual needs for support or where the pilots had very little contact with clients.

Although some people did not want, or perceive a need for, interaction between the pilots and employers or GPs, there was evidence that this could make a positive impact where clients had requested or permitted it. Where it happened, direct liaison or mediation by the pilots with employers was deemed critical or important for outcomes where it had enabled returns to work, or quicker returns, or returns to more sustainable work.

Interaction between the pilots and with GPs was also reported to have been helpful, where it took place. For instance in some cases the pilots talked to a client's GP about making a referral for the client to health services such as physiotherapy, acupuncture or Cognitive Behavioural Therapy (CBT) and clients felt that the pilots 'carried more weight' than their own requests.

As in the first round, the second round of interviews showed that a variety of factors influenced work trajectories, aside from support from the pilots. Some interviewees had stayed in work or returned to work because of personal motivation and determination, financial need, improved health or better management of conditions, adjustments in the workplace or having a new job, or assistance received from other sources such as employment services or health practitioners. Help from other services included support to clients to retrain and find work, or visits to the employee in work. Although some people in work had no current problems, others continued to struggle with ill health or work problems, suggesting that sustained employment was at risk.

Worsening or non-improving physical or mental health, rather than reasons directly relating to their employment, were the main reasons why people had stopped working or had not worked between the interviews. Whilst some people out of work were acting on plans to rejoin the labour market, others were not focused on work. The most common unmet needs were support to manage or treat chronic or persistent health conditions.

All except two people had ended contact with the pilots before the second interviews. Contact had typically ceased either by mutual agreement or unexpectedly (from the client's perspective, for example, where the pilot stopped operating). The conclusion of contact was mutually agreed where people felt they did not need any more support, where people were no longer focused on returning to work in the local area, where they chose not to continue after their Case Manager changed, and where they felt dissatisfied with the pilots or had found that interventions had been ineffective. An unexpected end to contact was experienced when the pilots failed to recontact the client, for example where the pilot (in this case Birmingham) closed, and where clients were discharged when they were made redundant. In most cases, people who had been happy with the service said they would get in touch again if the need arose in the future, and some were considering doing so because of a new health or work problem.

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

Mostly, overall views about the pilots at the time of the second interview were unchanged from those expressed six months earlier. Particularly positive views emphasised the importance of regular contact with someone supportive and understanding, the non-clinical approach and genuine care of staff, and of support progressing at an appropriate speed and intensity. The pilots' failure to meet individual needs remained at the centre of negative comments. Changes in views over time occurred for some participants, which to some extent mirrored changes in circumstances or changes to the perceived level of support received.

4 Costs of the pilots

Data on the costs of providing the service were sent by the pilots approximately every quarter to the Department for Work and Pensions (DWP). These data have been examined to calculate a cost per client for each of the pilot services and, using the change in health status data from the Management Information (MI), draw some tentative conclusions about the cost effectiveness of the pilots.

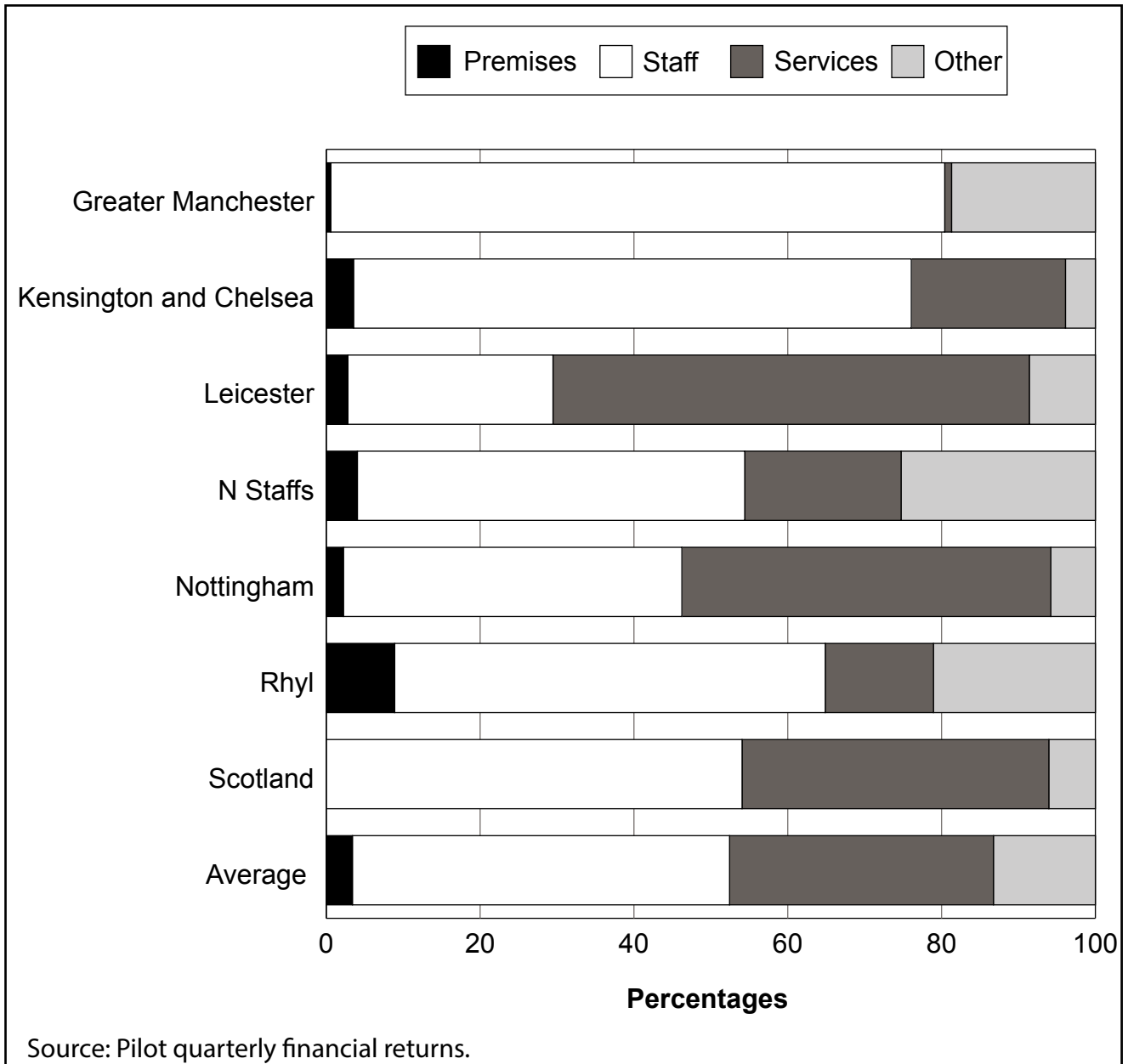
4.1 Costs

The cost data submitted by the pilots in their quarterly returns were broken down into four main headings: premises; staff (employed directly by the pilots); services (commissioned support bought in by the pilots); and other costs (which included marketing, training and general expenses). The breakdown between these costs varied by pilot, but generally the largest component was staff costs (Figure 4.1).

Some of the pilots' models provided their client services in-house and/or primarily signposted clients to other providers and therefore commissioned service costs were minimal (see pilot summaries in Appendix A). Some costs (such as in-house commissioning costs) varied with client numbers, whereas others, such as staff and accommodation were more fixed for the period of the pilot. The Scottish pilot did not have to pay for accommodation and in some of the other cases accommodation and general office costs were to a greater or lesser extent subsidised by a host organisation. However, these costs comprise only a proportion of the overall costs (Figure 4.1). In addition the host organisation of the Manchester pilot provided some additional staff to help the pilot engage with employers (Appendix A), the cost of these staff are also not included.

It should be noted that the data relate to the direct costs of the pilots and, for instance, do not include any costs incurred as a result of the pilot by health service providers (such as Improving Access to Psychological Therapies (IAPT)) to which some pilots such as Manchester referred clients) or employers. The inclusion of these costs would raise the cost of those pilots particularly reliant on externally funded services as well as the overall average.

Figure 4.1 Cost breakdown for each pilot 2011–13



4.1.1 Costs per client

To calculate the cost for each case and provide a basis for comparing the costs of each pilot, the total known costs for each pilot have been divided by the number of clients recorded on the central MI system over the same period. Table 4.1 provides details of the number of clients in Years 2 and 3 and the two years added together.

Table 4.1 Total number of pilot participants, April 2011 to March 2013

	2011/12	2012/13*	2011–13
Greater Manchester	251	346	597
Inner NW London	143	195	338
Leicester	404	360	764
N Staffs	244	187	431
Nottingham	451	301	752
Rhyl	350	379	729
Scotland	674	868	1,542
Total	2,517	2,636	5,153

* April 2012 to March 2013 except for Greater Manchester and Leicester where the data relate to April 2012 to December 2012.

Source: Pilot monthly summary returns.

The costs per client are presented in Table 4.2. The average (mean) cost was around £1,000 per client, but the costs varied significantly from around £500 per client in the two areas operating telephone-based services (Greater Manchester and Scotland) to over £2,000 per client in the pilots in Inner NW London and North Staffordshire, both of which offered intensive in-house services.

Table 4.2 Cost per client

	2011/12 (£)	2012/13 (£)	2011–13 (£)
Greater Manchester	684	510	584
Inner NW London	2,464	1,847	2,108
Leicester	1,438	1,661	1,543
N Staffs	2,638	2,897	2,751
Nottingham	556	1,202	814
Rhyl	929	1,631	1,294
Scotland	527	357	431
Average	1,065	1,067	1,066

Source: Pilot quarterly financial returns and pilot monthly summary returns.

4.2 Cost effectiveness

One way of placing the costs in context is to estimate the net saving in average reduced sickness absence required to recoup the costs of each pilot. While this exercise involves a series of assumptions it is a recognised way of estimating the financial impact of an intervention.

The average cost of a day's sickness absence is approximately £90.¹³ To cover average costs of £1,000 per case, a pilot would need to have reduced clients' sickness absence by an average of 11 working days. To cover the cost of the lower cost pilots, £500 per case,

¹³ Chartered Institute for Personnel and Development, 2009 *Absence Management: Annual survey report 2009*.

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

the pilots would need to have reduced clients' sickness absence by an average of five to six working days.

The cost effectiveness of the three pilots for which an impact study was conducted can be assessed using these estimates. One of the three pilots, Greater Manchester, was highly cost effective, with a net benefit of around £1,500 per client. However, the other two pilots (North Staffordshire and Leicester) were not cost effective, with a net cost of around £1,500 per client each.

The results of these three pilots suggest that service models based on lower costs pilots, such as Greater Manchester, were cost effective, whereas higher cost pilots were not. However, it is important to note 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.

5 Conclusions

The aims of the pilots were set out in Chapter 1 (Section 1.1.1). This final chapter draws together the evidence presented in this report, supplemented by the findings of the first evaluation report¹⁴, about whether the pilots met these aims and the net impact of the pilots.

5.1 What was the impact of the pilots on return to work?

Most (72 per cent) of the clients who were absent from work when they contacted the pilot had returned to work by the time they had been discharged from the service or soon after (Section 3.1). Responses to the client survey shows that clients were generally very satisfied with the service they had received from the pilots. The survey also shows that clients thought that the service had helped them manage their health condition, they felt more confident about returning to work and half of the clients surveyed reported that they would have taken longer to return to work if they had not become involved with the pilot (Section 3.1). Qualitative research with clients also found that the intervention had helped them to sustain or return to work as well as improve their health (Section 3.4).

In terms of impact, the question is whether they did so sooner than they would otherwise have done, if the pilot had not existed. The evidence from the fit note data collection exercise in the Manchester, North Staffordshire and Leicester pilots throws some positive light on this issue. In two out of the three areas, clients returned to work sooner on average than the control group of all fit note recipients in the same area, taking into account a four-week lead time before clients took up the service. It should be noted that these two groups are not matched other than in their initial absence period: the 'fit note population' control group would include a range of people for whom the pilots would not be appropriate, and differences between the two groups (for instance in motivation to work or socio-economic conditions) may account for some of the difference in outcomes.

However, the pattern is broadly similar across the three pilot areas, particularly for people suffering from a back or other musculoskeletal problems. Compared to clients with mental health conditions, clients with a musculoskeletal issue were twice as likely to return to work more quickly than the local average (Section 3.3.1). The analysis of self-assessed health (EQ5D scores) also found that the clients with back or lower limb disorders experienced above average health gains (Section 3.2). This does not mean that the services were not able to help clients suffering from a mental health condition, only that the pilots appeared to make a bigger difference to those suffering from a physical condition. One explanation for the variation in the length of absence between clients with different diagnoses could be the speed of access to additional support. For example, in the Manchester pilot there was a physiotherapy provider within the pilot partnership to whom clients could be referred quickly, whereas patients with a moderate or severe mental health disorder were referred to the local Improving Access to Psychological Therapies (IAPT) service, which could take some time.

¹⁴ 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.

The fit note analysis also found that clients who had been off work for eight weeks or more before their assessment were significantly less likely to return to work (Section 3.3.2), indicating the importance of early intervention – a conclusion echoed by many of the pilots themselves (see Appendix A).

5.2 Did the pilots focus on absentees from SMEs?

In the first year the pilots were focused as much on supporting presentees (from whom they found a ready demand for their services) as from absentees. Following the change of focus in Years 2 and 3, at least 70 per cent of the clients in every pilot were absentees and the average proportion was 88 per cent (Section 2.4.2). However, most pilots found it difficult to attract clients from small and medium-sized enterprises (SMEs) (Section 2.4.2). Attempts to market to SMEs directly were generally unsuccessful, not least because for most SMEs long-term sickness absence was not a current issue and many General Practitioners (GPs) or other healthcare professionals who referred clients to the pilots did not distinguish between employees of large or small workplaces. Indeed the evidence is that the pilots tapped into a demand for their services from employees in large workplaces, even where there was existing occupational health (OH) provision. In these cases employees sought support from the pilots mainly because they had to wait too long to see their occupational service, or their condition was outside the remit of OH or they did not feel OH would be impartial.

5.3 What was the contribution to reducing health inequalities?

Some of the pilots (such as Inner NW London as it then was and Leicester) began in Year 1 by targeting the most deprived localities in their areas. However, this strategy was dropped in Years 2 and 3 as the pilots tried to maximise the number of clients they reached. There is some evidence from the survey of pilot clients in the first evaluation report that the pilots were particularly successful in reaching employees in lower level personal service occupations. However, the majority of clients were employed, generally in larger employers where access to OH support – however effective – was likely to be greater than in smaller workplaces. We therefore cannot conclude that the pilots made a significant contribution to reducing health inequalities.

5.4 Did the pilots use a biopsychosocial model of support?

All the pilots employed a biopsychosocial approach both in their initial assessment of clients' needs and in providing support. This meant addressing both clients' health problems and their non-health problems whether work-related or not. 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 (Section 2.6.2).

5.4.1 Were the pilots person-centred and responsive to individuals' needs?

Three in four pilot clients thought that the service had offered a personalised and responsive service that had been able to refer or signpost them to relevant support (Section 3.1.1). The pilots also concluded that being able to offer an individually tailored package of support was crucial to helping their clients back to work (Section 2.6.2).

5.4.2 Did the pilots form an integrated service and demonstrate effective partnership working?

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. In the first year the lead body in most sites was a health service organisation. In Years 2 and 3, most of the pilots were, or had changed to become, led by an independent social enterprise or Community Interest Company, but still retained their partnership approach (Section 2.1).

The operational models of the pilots varied. While all offered their clients advice and guidance in the form of case management, they differed in the degree to which they offered an integrated service within the pilot itself. Some, such as the Inner North West London pilot and North Staffordshire, offered clients access to both clinical (such as physiotherapy) and non-clinical services (such as debt management) in-house. Others had semi-integrated arrangements based on partnerships with external providers and (for example, Scotland) offered access to commissioned services (including psychotherapy and physiotherapy) and signposted clients to a network of other services, for example, smoking cessation classes available through the NHS or social services support with housing. A third model involved a combination of integrated and networked provision. For example, the Manchester pilot had a partnership with a physiotherapy provider and could provide some in-house support to clients with common mental health conditions, but referred clients with moderate to severe conditions to the local IAPT service.

5.4.3 Did the pilots provide timely, co-ordinated back-to-work interventions?

The pilots which had in-house additional support or fast access to external providers within a partnership valued the ability to provide interventions without delay and felt this had enabled a quicker return to work (Section 2.6.3). Seven out of ten clients across all the pilots thought the services they had received from the pilot had been well co-ordinated with other health and employment advice services.

5.5 Were the pilots cost effective?

Proving their cost effectiveness was not an explicit aim for the pilots. They were selected primarily on the basis of trialling different models. However, the evaluation does provide some insight as to whether the benefits experienced by the pilot participants outweighed the costs of providing the service.

The limited data on the costs of the various pilots indicate that they varied considerably; from under £500 per client to over £2,500. In very broad terms, there were three groups of pilots:

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

- two were relatively low cost (Scotland and Greater Manchester), which both provided a telephone-based assessment service for around £500 per client;
- three mid-cost pilots (Leicester, Nottinghamshire and Rhyl) had costs between £800 and £1,300 per client; and
- two were relatively high cost pilots (Inner NW London and North Staffordshire) at over £2,000 per client, where the models included a significant range of in-house provision.

The variation in costs reflects not just the different nature of the services provided, but also the numbers of clients the pilots were able to reach and the extent to which all costs associated with the pilot were included in the data provided. For instance, the costs involved in referrals to external health services from some of the pilots (for example, where the clients had conditions that could not be treated by in-house services) were not generally included. In addition some pilots had free or subsidised accommodation and other overhead costs which may not always have been included. Furthermore, no account has been taken of any additional costs incurred by employers (for example, in the form of workplace assessments or adaptations). The absence of these costs means that the average figures reported here are probably lower than the full cost of service provision.

One way of looking at the cost effectiveness of the various models is to place a value on the benefit of getting people back to work earlier, in terms of reduced sickness absence. Getting an absentee back to work one and a half weeks sooner than they would otherwise have been would cover the average cost per client of £1,000. The cost of the lower cost pilots (for example, Greater Manchester) at around £500 per client would be covered by getting people back to work just 0.7 weeks sooner. Based on fit note data, the Greater Manchester pilot was highly cost effective, with a net benefit of around £1,500 per client, whilst the other two under evaluation (North Staffordshire and Leicester) were not. This suggests that service models based on lower costs, such as Greater Manchester, can be cost effective.

It is important to recognise that these are fairly crude calculations, based on the available data. In addition to basing the cost of provision largely on the narrow 'Exchequer' cost of setting up and running the pilot, the gains considered in the report are fairly narrowly defined too. For instance, the potential wider gains, for example, improvements in health and wellbeing or reducing the chances of people going on to long-term sickness related benefits, are not taken into account in this calculation of cost effectiveness (see Section 4.2). The caveats around biases to the estimates of impact, due to the voluntary nature of the pilots and the lack of controls for demographics, socio-economics variables etc. also apply (Section 3.3).

5.6 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.

Appendix A

Pilot summaries

Summaries of each of the pilots are set out in this appendix. Summaries of the pilots appeared in the first evaluation report. These were subsequently updated by the pilots themselves. There may be differences in the figures provided by the pilots in the summaries and those covered in the main report; these may be due to different approaches to the analyses and the time periods covered.

Table A.1 provided a very brief summary of some of the features of each pilot model and range of indicators covering the participation and outcomes of each pilot presented in the main report.

54 **Table A.1 Summary of the pilots**

Pilot name	Mode of assessment and initial case management	Case Manager background	Provision of additional support	Proportion of planned number of clients achieved (%)	Proportion of eligible population engaged (2012/13) (%)	Proportion of clients heard of service through GP (%)	Proportion of clients referred by GP (%)	Proportion of clients absent from work at entry assessment (%)	Proportion of clients from SMEs (%)	Average (mean) length of time with service (wks)	Proportion of absent clients back at work at discharge (%)	Cost per pilot (£)
Greater Manchester	Telephone	Human resources	External provision Clients signposted to IAPT and CAB	88	1.0	18	8	78	36	7.6	75	584
Inner NW London	Face-to-face	Vocational rehabilitation	In-house provision including counselling and physiotherapy, plus direct referral to a range of biopsychosocial services	102	2.5	82	44	71	30	11.6	73	2,108
Leicester	Face-to-face	Varied non-clinical	Two local IAPT services provided additionally required clinical treatments, specially contracted musculoskeletal therapy providers	127	2.6	79	65	77	30	10.7	92	1,354
North Staffs	Face-to-face	Multi-professional health backgrounds	In house provision including specialised employment advice, CBT and one-to-one physiotherapy. Onward referrals to community physiotherapy service. Additionally, drug, alcohol and domestic abuse services, IAPT services or Crisis and Early Intervention signposted.	150	2.9	38	24	75	37	8.9	65	2,751
Nottinghamshire	Face-to-face	Occupational therapists	Internal therapeutic support referral to IAPT and physiotherapy	150	1.9	43	43	80	30	12.8	65	814
Rhyl	Face-to-face	Employability and workforce development	Physiotherapy and psychological services provided within partnership. Clients signposted to additional services, for example, debt advice	146	15.9	78	36	89	39	–	92	1,294
Scotland	Telephone	Multi-professional health backgrounds	Physiotherapy, counselling and occupational therapy subcontracted within the partnership and included both NHS and private providers	51	1.1	46	12	100	99	18.3	81	431
All pilots				85	1.6	49	27	87	60	–	78	1,066

Greater Manchester

The Greater Manchester pilot, led by Pathways Community Interest Company (Pathways CIC), covered the Greater Manchester City Region. It was overseen by a steering group whose members include Improving Access to Psychological Therapies (IAPT), New Economy, Bolton Primary care Trust (PCT), National health service (NHS) Manchester, and Tameside and Glossop PCT.

Ownership of the Fit for Work Service (FFWS) contract was moved from the North West Strategic Health Authority to the Combined Authority (the City Region) following proposals to restructure the NHS which would remove strategic health authorities.

The pilot was centred on tackling the range of issues affecting employees in the early stages of sickness absence. Therefore, the pilot aimed to tackle not only health, treatment and employability, but also social concerns such as finance and housing. In addition, its holistic model took a biopsychosocial approach to the causes of absenteeism and aimed to provide support with societal distress, workplace interventions, addictive behaviours, mental wellbeing, back pain etc. Mental health advice for human resources managers was also provided. These aims were achieved through a predominantly telephone-based case management.

Background

The pilot covered the ten local authorities which comprise Greater Manchester, with a working-age population of 2.6 million, and an employed population of just under half of that figure. Whilst the geographical focus of the pilot remained constant over the three years, the direction of the programme changed.

During the first year, there was a mixture of one-third absentees to two-thirds presentees (employees in work but at risk of sickness absence), and the pilot supported those at risk of moving from work onto health-related benefits and acted in a preventative way against sickness absence.

Following the Department for Work and Pensions' (DWP's) policy emphasis on individuals who had been absent for four weeks or more, the target group for Year 2 was 100 per cent absentees. Whilst this provided more focus on the original policy intent, the pilot providers raised concerns over the length of time off sick that some people had to wait before receiving attention. They additionally highlighted that cases lasting four weeks or more could become more complex due to the waiting period.

In Year 3, much of the concerns over the four-week period were addressed through the introduction of additional acceptance criteria. Specifically, clients could be accepted before the four-week period if after two weeks they had a suitable General Practitioner's (GP's) note that indicated they were at risk of a long-term sickness absence or where individuals required an intervention related to bullying or harassment, or where the individual was a significant and necessary asset to an SME. In addition, following changes to employment law concerning the employment rights of employees during the first two years of work are less secure, individuals in this category were also seen as eligible, mitigating against capability issues being raised.

Referral processes to and from the pilot

The split between sources of referrals to the pilot varied over the three phases. Over the first year, most referrals were via self-referral, when GP referrals stood at just under four per cent, and IAPT) at just over 15 per cent. However, there were large rises in both GP and IAPT referrals in Year 2, with IAPT providing over half of the referrals into the pilot, and GP referrals rising from four per cent to nearly 30 per cent. In addition a number of clients who self-referred were signposted to the service by GPs with some GPs using this method, as a therapeutic intervention for mental health clients (as it provided the patient with control rather than the GP). Taking a broader view from December 2011 to February 2013 (the end of the pilot), 20 per cent of overall referrals were self-referrals, just under ten per cent came from GPs, over one-third were from the IAPT programme, just under two per cent came from employers and the rest resulted from other sources. Importantly, the gains made in GP referrals during the second phase dropped starkly for the last year. This was due to the increasing numbers of clients with mental health issues who were being referred, and GPs using supported signposting as the method for entering into the service.

The Greater Manchester pilot took a number of measures to increase referrals from GPs, although found it difficult to cover all 600 plus practices in the area. Measures included meetings with individual practices, locality Practice Managers, primary care trust executives and clinical commissioning groups. In addition, regular bulletins were provided, continual professional development classes and masterclasses were offered, Practice Manager Champions were recruited, and an employment advice line was organised which would respond within 24 hours to requests by GPs.

The pilot set a target for the second year of 69 per cent of referrals to be employees working in small and medium-sized enterprises (SMEs), which was not realised (in fact only 35 per cent of individuals who entered the service were from an SME).

The lead pilot body recognised that the complexity and volume of SMEs in the Greater Manchester region resulted in engagement difficulties and implemented several strategies to maximise SME involvement. This involved targeting SMEs that were known (through telemarketing) to have sickness absence issues, as well as organisations with over ten employees. Furthermore, pilot personnel participated in employment networks and disseminated the business newsletter, and broadcasted links to the service and articles through the Chamber of Commerce and Chartered Institute of Personnel and Development. The core employer target involved SMEs. However, support was also offered to non-SME clients where the issue to be resolved proved to be outside of the remit of any Occupational Health (OH) service, or would pose a conflict of interest between the employer and employee, or the employee would have to wait too long for the issue to be resolved. In addition, pilot personnel raised awareness of the service through attending community events and local mental health events.

Model of provision

The Greater Manchester holistic model meant that both clinical and non-clinical causes of sickness absence were tackled in order to return people to work, and the pilot aimed to achieve this as speedily as possible. The scheme guaranteed to get in contact with individuals within 24 hours of receiving a referral, and to carry out assessment within three days of the referral being activated.

A 'new layer' was introduced in the second phase, where two 'frontline advisers' discussed the issue in depth over the telephone, and collected detailed information prior to people consenting to support. This fulfilled the more detailed 'baseline management information' required, and responded to the complex needs of individuals with long-term absences whilst not using up Case Managers' time. An overview of the service was given at this point, and qualifying clients were informed of the name of their Case Manager. The Case Manager was triaged to ensure that the manager possessed the specific skills that could best deal with the client's needs. If the individual did not qualify, they were signposted to alternative services. The 'activation' of eligible people's referrals – via their confirmation of participation – was sent to the referrer, and if the client did not qualify, the full reasoning was also passed on, along with confirmation of signposting, within 24 hours.

This pilot centred on case management which assisted people back to work through negotiated phases and monitoring progression. The Case Manager addressed personal and occupation obstacles, and operated as an interface between the individual, healthcare and support services, and employers. Collaborating in such a way meant that problems could be actively solved between stakeholders, and there was a higher chance of fostering sustainable communication between employer and employee. The Case Managers functioned in multiple ways: brokering information and referrals to other organisations, providing both general and specific advocacy, casework and support, fostering a relationship on a personal and motivational level with the client, and supporting people to self-determine their return to work. Clients were supported by the Case Manager for over six weeks.

Patients with musculoskeletal disorders (MSKs) were able to access physiotherapy/ chiropractor support which was commissioned through the pilot, within three days of assessment. Clients with common mental health conditions were provided with support in house, however, clients with moderate to severe conditions were referred to IAPT where the lengths of waits adversely affected speed of intervention.

The model of provision was voluntary and impartial, facilitating a neutral platform where people could fully disclose the barriers they experienced in relation to returning to work. This was especially crucial when the Occupation Health service within workplace was perceived as the evidence collector for dismissal, compounded with issues related to bullying, discrimination or stress. The pilot personnel also found that some clients with musculoskeletal or mental health concerns were fearful of the impact on their insurance if the issue was discussed with their GP. The pilot therefore aimed to address both latent non-clinical issues, as well as provide ongoing advice to manage longer-term health concerns to transition clients back to work.

Two broad issues emerged as the most significant in the Greater Manchester pilot, the first being individual and lifestyle factors (addictive behaviours with regard to drugs and alcohol, diet, lack of exercise, poor self-care), and the second being working environment (high demand, low control, perceived poor psychological protection and leadership, lack of work-life balance). In addition, the service saw a significant increase in mental health issues caused by financial difficulties, specifically defaulting on loans, or having taken out payday loans. The pilot dealt with many issues internally with the employer, with healthcare provided, and also signposted to other appropriate services, such as the Citizens Advice Bureau (CAB) for financial advice, or the IAPT for mental health.

Data from the service suggested that a number of employees did not want to return to their previous job, and likewise, the organisation may not have welcomed that individual back. In

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

these circumstances, Case Managers got involved with career planning, CV composition, advising on how to look for jobs and gave trial interviews.

Staffing arrangements

The Case Managers were professional staff qualified in human resource management, but in addition tapped into the knowledge of the Pathways CIC, whose members had expertise in nursing, psychological therapy, nutrition, diet management, staying active and neuro-linguistic programming. This represented the diversification of skills which responded to social needs spurred by the financial crisis.

The Pilot team comprised: one service manager (one full-time equivalent, with two people sharing the job role), five Case Managers (four x 0.42 full-time equivalent, one x full-time equivalent); one administrator (full-time equivalent) and two partnership managers (one x full-time equivalent, one x 0.8 full-time equivalent), recruited in Year two. There were also two front line advisors (one x full-time equivalent, one x 0.8 full-time equivalent). The finance to pay for the new staff recruited came from Pathways CIC. The role of the new staff was to generate more absentee referrals in Years 2 and 3.

Client profile

In total, 637 clients participated in the service. Over the pilot as a whole, 80 per cent of clients were absentees due to the shift of focus onto those who had been absent for at least four weeks.

The main health conditions supported by the services related to MSKs and mental health issues, with 27 per cent of participants reporting back issues, 20 per cent citing depression, and 11 per cent mentioning stress. When looking holistically at the population of the pilot, 98 per cent of clients had either a mental health or a musculoskeletal issue. Eighty per cent were absentees, and the rest were in work.

In relation to the nature of work, the overwhelming majority of individuals (61 per cent) worked in organisations with over 250 employees, two-thirds of clients worked for private firms and almost all of the remainder worked for public sector companies.

Follow-up and discharge arrangements

Goals were set collaboratively between the client and the service, and when it was agreed they had been realised, and when nothing further was to be achieved, Case Managers discharged their clients. Preceding this discharge, an additional 'EQ-5D' – a health observation questionnaire – was carried out, and on leaving the scheme, clients were given a formal summary to see their total progress. This was also passed on to employers/GPs/health professionals providing consent had been given. Individuals were encouraged to contact the service if they felt they may be at risk of leaving work again.

During the first ten days of returning to work, Case Managers tracked their clients, as service personnel were aware this was a fragile time when issues may arise again. This was also a space in which these issues could be collaboratively redressed not only between employee and Case Manager, but also with employer. Following this initial period, over the next six months the person was contacted on a monthly basis to support them to remain in work.

Outcomes and key lessons

- Responding to diversified biopsychosocial needs, the skill set of service personnel was expanded.
- Concerns regarding meeting the four week absentee criteria was addressed by adding in extra referral criteria, for example, enabling patients who were expected by their GP to be off work for four weeks or more to access the service at two weeks.

Challenges

- Despite concerted efforts, levels of referrals of GPs and SMEs did not reach expected targets.
- The economic recession added additional socioeconomic pressures on individuals which affected their ability to return to work.

Successes

- The number of clients who were referred into the service and who would not respond to the service telephone calls/letters, remained at a low level over the course of the service, from as little as two per cent in the first year, rising to ten per cent in the final phase.
- Ninety-eight per cent of clients were back in work at time of discharge in the first phase, falling only to 95 per cent in the second year.
- A high proportion of clients felt the service genuinely assisted people, and valued how the service sped up and supported their return to work, and how it maintained their employment on re-entry.

What worked?

To maximise the reduction in the length of sickness absence the Greater Manchester pilot found the most effective model to be guidance plus early intervention access to either physical or psychological support plus a range of non-clinical services. There was a need for the service to:

- join up the triangle of employers, employees, and GPs/health professionals in tackling sickness absence;
- be impartial in order for clients to fully disclose their return to work barriers/health issues. This was particularly relevant where motivation to return to work was affected by workplace practices such as linking sickness absence procedures with disciplinary procedure;
- provide a seamless service where there was a continuous point of contact, to treat, enable and empower the client, thus supporting early and sustainable return to work;
- utilise evidence based tools within assessment/case management/discharge to demonstrate the fiscal, economic and social value of the service;
- provide an individually tailored package of support, including developing the client's skills, confidence and knowledge to manage their own health, physical treatment, psychological therapies; health condition management, self-care and living skills, relationship support, mediation, employment law advice, employment brokerage services, financial difficulties support and fit note solutions.

Case Managers could be nonclinical as long as they were supported by clinical staff.

Legacy

It was recognised that trying to provide a limited number of referrals across ten boroughs and trying to achieve equal shares across boroughs resulted in marketing inefficiencies. GPs within localities saw their locality numbers as being so small that it was not necessarily a service of choice. The service has been continued above and beyond the pilot however, for example, the numbers of referrals in one of the boroughs, Manchester, is equivalent to that of the pilot programme across the ten boroughs. This has improved GP engagement and enabled effective targeting to take place. The service has been funded by local authority and Clinical Commissioning Group funding.

Inner North West London

Introduction

The FFWS pilot began in the Royal Borough of Kensington and Chelsea (RBKC) in 2010. Kensington and Chelsea Primary Care Trust (PCT) led a partnership of the PCT, RBKC and Central London Community Healthcare NHS Trust (CLCH), forming an FFWS Strategic Group to oversee implementation.

During the period of the pilot, Kensington and Chelsea PCT, Hammersmith PCT and Westminster PCT grouped as a PCT cluster-NHS Inner North West London. Service delivery extended into City of Westminster and London Borough of Hammersmith and Fulham in 2011, for the second and third years of the pilot. The core membership of the Strategic Group remained the same throughout the duration of the pilot with links established to wider strategic partners. The pilot ended in March 2013.

The following organisations were involved as delivery partners (either for a period or for the lifetime of the pilot)- RBKC-Environmental Health and Housing (advice and support for employers relating to workplace health and safety management; housing advice and support for clients in early phase of pilot); CLCH-Employee Health; NOVA and Open Age (Information Advice and Guidance Services offering support to find new jobs and/or access training, the focus of Open Age was over 50 years age group); debt advice, delivered at different periods of time, by Broadway and by Nucleus Legal Advice Centre. An Operational Group of delivery partners was formed and facilitated joint working.

The range of strategic and operational partners involved in the pilot reflected the biopsychosocial model that was adopted for the service.

Background

The three aforementioned boroughs are located in the region of Inner North West London, a densely populated, socio-economically and culturally diverse area with mobile populations. Population structures include large, and young working-age populations. The combined working-age population (for the three boroughs) in 2011, identified from the Annual Population Survey, was 434,500 and the combined number in employment was 279,400. Large numbers commute into the area to work, particularly to Westminster and located within each of the boroughs are a high number of SMEs that employ fewer than ten employees.

Referral processes to and from the pilot

Individuals who wished to access the pilot had to be employed or self-employed and off work sick, a small number of presentees were accepted. Eligibility criteria evolved over the period of the pilot, the main changes included extension of geographical coverage, acceptance of non-residents of the boroughs meaning individuals living and/or working in the three boroughs could access the service, and a change from admitting clients with four or more weeks' sickness absence to those with two to six weeks.

In the early stages of the pilot, the referral process was initially referral from GPs and RBKC Environmental Health Officers visiting small and medium-sized businesses. The referral process subsequently included referrals from GPs within the broader geographical area, direct referrals from employers (with employee agreement) and self-referral.

Over the duration of the pilot (i.e. 2010-2013), GPs were the referral source for 54 per cent of cases and self-referral was 33 per cent. Information from GPs was the way in which almost all participants heard about the FFWS, with self-referrals mainly signposted to the service by GPs.

On receipt of referral, VRCMs implemented the initial screening for pilot eligibility. The VRCMs were also responsible for the next stages of the referral and assessment processes including referral onto other pilot services.

Model of provision

Screening for eligibility was implemented by telephone; if the client was eligible and it was deemed that the pilot could assist, then he/she was invited for an initial face-to-face biopsychosocial needs assessment also implemented by VRCMs. Clients were also asked about their access to workplace OH and their fit note issued by their GP. The needs assessment enabled health and non-health barriers to returning to/remaining in work to be identified. Health and work goals were agreed collaboratively between the client and the VRCM and a return to work plan developed.

A second stage was added to the initial assessment process, clients were seen by a counsellor for a more detailed assessment of their mental health needs, this included use of PHQ9 (a self-administered patient health questionnaire used to monitor severity of depression) and GAD7 (a self administered patient questionnaire used as a screening tool and severity measure for generalised anxiety disorder). This counsellor assessment addressed two key issues: firstly whether short-term counselling provided by the pilot would be suitable, and secondly to identify whether the individual had a level of mental health needs that could not be addressed by the service and required referral to other services.

Wellbeing was measured at the time of initial assessment and again at discharge. This was initially measured through the administration of the MYMOP2 tool, later replaced by EQ-5D (in order to have a nationally consistent outcome measurement used by all the pilots).

Case management was delivered by the core team of VRCMs based within CLCH. Following assessment, clients were then referred by Case Managers to required pilot health/other interventions.

Pilot health interventions included counselling, physiotherapy, acupuncture, osteopathy (in the first year only) and clinical exercise-(supported exercise programmes) provided by CLCH. VRCMs could also refer to the wider group of pilot providers, i.e. those delivering

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

employment advice, information and guidance or debt advice. Additional facets delivered by Case Managers were employer liaison, including negotiation of return to work advice to employers and employees regarding workplace adaptations and also signposting to services not provided directly by the pilot, for example, stopping smoking, weight management services.

Staffing arrangements

A project manager was employed by the PCT to manage the implementation of the pilot; this included contract and performance monitoring, stakeholder engagement, and marketing, overall pilot monitoring and reporting to the FFWS Strategic Group and to DWP.

The core team were employed by CLCH and constituted two VRCMs, later joined by a third, one administrator and one counsellor. (There was an additional counsellor from 2010-11 but this was reduced in April 2011 in response to levels of demand).

Case Managers' backgrounds included vocational rehabilitation (particularly for clients with multiple health and social barriers to returning to and staying in work) and health sciences. There was a broader team of therapy staff who delivered services to the pilot, overall management was provided by CLCH Employee Health Head of Service – an OH nurse.

The other pilot delivery partners internally managed their staff, service reports were submitted to the pilot Project Manager.

Client profile

The service supported 454 individuals during the overall period of the pilot (2010-2013). A review of data for this period identifies, that the client group comprised more females (61 per cent) than males (39 per cent), the majority of clients were aged between 30 and 49 (64 per cent), 27 per cent were known to be from Black and Minority Ethnic (BME) groups, 26 per cent were known to be from white British/white Irish, 26 per cent white other (8 per cent – other and 12 per cent – prefer not to say/unknown).

Around three-quarters (74 per cent) of clients were absentees and 24 per cent presentees. The main health condition was mental health for 57 per cent of clients and musculoskeletal (MSK) for 36 per cent.

Follow-up and discharge arrangements

Clients were discharged from the service when:

- there was a return to current or new job (not all cases were immediately closed on return to work – would depend on whether some needed additional support); or
- the client was looking for new work (but had accessed and completed interventions).

In some cases, clients' plans changed and they subsequently decided to take redundancy or retire and were therefore discharged. Also some clients were discharged when they were unable/chose not to engage with the service at that time.

Outcomes and key lessons

Challenges

- Employer/business engagement proved to be challenging and resource intensive in the early stages of the pilot. The initial eligibility criteria meant that employees not resident in Kensington and Chelsea were unable to access the service and it was thought that this potentially contributed to the low level of engagement from employers. However, when the criteria were amended to enable referrals of individuals living and/or working in the borough (as was also the case in the other boroughs when the pilot extended geographical coverage) coupled with implementation of a wide range of engagement methods including tailored social marketing, referrals from employers/businesses remained low.
- Local reflections on the pilot identified that some SMEs may have a specific interest in supporting presentees.
- In relation to GP referrals, continuous messaging was necessary to ensure eligible referrals were made in order to adhere to the requirements of the FFWS pilot programme.
- With regards to GP assessment of client 'eligibility' and referral, it may be that GPs primarily refer based on a clinical judgement and are less likely to determine employer type or size, and pre-existing access to OH as part of an assessment for referral.

Successes

In addition to early intervention to support sickness absentees successful practical implementation of a biopsychosocial approach, strong case management, co-ordinated services and a person centred approach (all of which were principal elements of the pilot programme), further successes included the following:

- The pilot contributed to national and international research on health and work, through outlets such as featuring in the Occupational Health at Work Journal. It additionally contributed to the Organisation for Economic Co-operation and Development (OECD's) UK work on mental health and work.
- The pilot increased awareness of the link between health and work and through this helped to inform local health and wellbeing and economic development priorities relating to health and employment.
- The Case Management team reached the finals of Personnel Today's 2012 Innovation in Occupational Health Awards.

What worked?

- Targeting sickness absentees was best achieved by referrals from GPs.
- A GP robust engagement strategy was felt to be a key requirement in order to increase awareness amongst GPs of the pilot, influence referral practices and to encourage and facilitate eligible referrals. Face-to-face meetings between GPs and VRCMs was deemed by the pilot to be the most effective means of increasing awareness and understanding of the service with subsequent referrals from some practices. Additional Case Manager time was dedicated to engagement and a GP champion enlisted to increase engagement activity as the pilot extended its coverage to other geographical areas.

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

- Prompt direct referral of clients to ‘in house’ therapy provisions such as counselling and to other closely linked services, alongside strong case management were key features of the pilot enabling early interventions.
- Of the clients who provided related feedback, a high level rated waiting times for appointments as ‘Very Short’. GP feedback on the service included positive commentary on prompt response to referrals, in addition to the comprehensive assessments undertaken by Case Managers, the coherent approach and tailored support provided.
- Bringing together the range of health and other services under the pilot ‘umbrella’ enabled a shared ‘fit for work’ vision and identity, a strong team approach to case management and facilitated VRCMs co-ordination of referrals.
- Vocational rehabilitation was a shared central goal, i.e. the main aim being to assist the individual to return to work and all delivery partners were required to work in close partnership with the VRCMs.
- A local review of self-reported outcome measures indicated health improvement (measured initially using MY MOP 2 then EQ5D) for the majority of those who completed the outcome measures.
- Of those clients who provided service user feedback, the majority rated the service as ‘Very Helpful’ in dealing with health/work issues.
- A local review of service data for clients who were identified as employed/self-employed and on sick leave and who completed case management, identified that there was an average return to work time of six weeks. Early intervention achieved through prompt referrals and appointments, the multidisciplinary co-ordinated approach and the highly personalised service offered to pilot clients potentially had a significant contributory role to play in achieving a quick return to work for this group.

Legacy

In 2013, funding was secured from City of Westminster Work and Skills Board and Kensington and Chelsea Performance Reward Grant for a 12-month Fit for Work provision covering City of Westminster and Royal Borough of Kensington and Chelsea. The eligibility criteria and referral process into this service mirrored the pilot; the service model included case management but not in house therapies. A local evaluation of this provision is being undertaken and will inform a wider programme of work relating to employment and workplace health.

Leicestershire and Leicester City

Introduction

The Leicestershire and Leicester City pilot was originally a consortium project which was officially led by the Leicestershire PCT and Leicester City Council. Other partners involved were Leicestershire City Council, Jobcentre Plus, Leicester City and Leicestershire Learning Partnership.

In May 2011 the structure changed and a not-for-profit company ‘The Fit for Work team’ under a social enterprise banner, limited by guarantee, was incorporated. They delivered the Leicestershire Fit for Work Service (FFWS) contract from July 2011 under the same terms.

These structural changes occurred to meet the terms of the DWP funding, i.e. to become sustainable if possible by the end of the pilot 2013.

The heart of the Leicestershire model was a case managed service which provided a client assessment and day-to-day case management by non-clinical staff, supported by a small clinical team. All referrals were received from GPs or via GPs from IAPT therapists. The pilots were designed to target small/medium-sized organisations, however, GPs did not triage clients based on the size of the organisation or if the organisation had internal occupational health prior to referring into the service. The Case Manager identified the barriers preventing the client returning to work through a discussion and assessment process. The Case Manager and client would agree on any intervention needs, which would form an action plan. The aim of the interventions was to facilitate a quicker return to work. These interventions were fundamental in supporting the client back to work. Case management provided the support and monitoring of progress through the agreed interventions, particularly for clients who were not able or not willing to act on the recommendations of the assessment. These interventions were provided both in house and externally and included advice, guidance and support. Where necessary, clients were referred to other local services for non-clinical interventions (such as debt management) or clinical therapy from musculoskeletal therapy providers or the IAPT programme. This occurred after the client's need had first been discussed with the in-house GP and/or the OH nurse. The Leicester pilot offered an additional service for referring GP's in that it signed the client's fit note on behalf of the referring GP. Fit note signing was done by the in-house GP. Notes were signed as 'fit note surgeries' where progress of the return to work journey was monitored alongside clinical supervision. This was carried out on an iterative basis by a Case Manager and the plan adjusted in discussion with a clinician at frequent intervals. The pilot adopted a process of 'supported signposting' to such services.

Background

The pilot initially received referrals from 40 practices across both city and county. The need to enhance referral numbers led to an expansion of the pilot to cover all city and county practices (including the neighbouring county of Rutland). By the end of the pilot 95 per cent of Leicestershire practices had referred at least one client and 62 per cent had referred five or more clients.

Referral processes to and from the pilot

The Leicestershire pilot used a significant proportion of their funding, to actively explore different ways of engaging GPs, employers and employees in the service. As referrals were only accepted from GPs, the marketing approach to employers and employees focused on encouraging the employee to visit their GP in order that the GP could then refer them to the service. Marketing information leaflets were distributed not only in locations where potential clients would be aware of them, but also passed on to employers. Marketing to employers and employees was less successful than engaging with GPs directly. Increased GP awareness was achieved by attending practice meetings and ensuring the referral process was as easy as possible for the GP. For example, referral cards were designed that required minimal information from GP in order to support the referral. The cards were in the size of a business card and were stamped and signed by the GP. The cards provided information about the service and how the client could access the service. This approach was well received in the majority of GP surgeries. There were regular visits to GP practices throughout the pilot. There were also information and education events targeted at GPs to support the

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

visits. The service was publicised through local and national radio, adverts in newspapers, on local buses and in as many pharmacies as possible. There was limited success with a telemarketing campaign targeted at SMEs.

The vast majority of clients were referred by GPs, and a small number also came via IAPT. There were no other methods of referral to the pilot.

Model of provision

Within 24 hours of the referral, clients were contacted to make an appointment with a Case Manager. Dedicated non-clinical pilot staff delivered case management, and made an initial assessment based on an in-depth interview. The pilot ensured that there was a choice of potential locations for the initial assessment. This was to put the client at ease and more receptive to engage with a return to work plan. Most assessments took place at the pilot office and some at a local GP practice. All assessments adopted a biopsychosocial approach. The *BPS flags framework for musculoskeletal obstacles at the workplace* (developed by Professor Kim Burton from the University of Huddersfield) was adopted and applied to all causes of sickness absence and, over time, a suite of tools for assessment, case management and communication was developed. The outcome of first assessment was an agreed return to work plan, signed by the client and Case Manager.

The assessment and action plan formed the basis for recommending appropriate interventions. The initial assessment and action plan was generally done face-to-face, however, latterly clients with a musculoskeletal problem were assessed over the phone. According to the pilot, this change in approach did not affect the number of successful outcomes. Additional clinical needs assessments which the Case Managers felt were necessary were carried out by the in-house GP or OH Nurse. The Case Managers and the Clinical team carried out regular reviews of all cases. A unique aspect of the service was the signing of fit notes by the in-house GP throughout the return to work journey. This was of particular value to referring GPs. As well as saving time, it saved the practice between two and four appointments for a typical case. GPs frequently used the service for advice on sickness absence management and the use of the fit note.

Following the initial assessment, Case Managers accessed a variety of clinical and non-clinical services. The level of clinical involvement depended on the original reason for referral and the assessment and the subsequent agreed action plan. Wherever possible, the pilots accessed services that had their own funding streams. Typically these were for debt management, family problems, benefits advice and confidence building. There were close links to the city and county local IAPT services that provided psychological therapy when required. Musculoskeletal therapy was provided though a number of musculoskeletal disorder (MSK) providers commissioned directly by the pilot and working to a service specification that put a return to work as the main outcome.

Staffing arrangements

The PCT chose not to employ staff directly into the service but instead commissioned all of the staff from a variety of specialist organisations. This approach was shortlisted for the 2012 BMJ Award for 'partnership working'. However, it did prove to be costly and more expensive than direct employment. Case Manager costs were reduced by half when staff were employed directly. While expensive, this approach did ensure no financial consequences when closing the pilot in 2013

The original project manager was employed on secondment from a local PCT, but later left the pilot. Two OH Nurses job shared a 0.8 full-time equivalent (FTE) position, and were contracted from an external OH provider. A GP, contracted under a sessional rate, supported the whole team, and signed off the clients' fit notes whilst they were within the service. The five non-clinical Case Managers, made up four FTE, and had backgrounds in employment support, financial services, youth work and others, and were all contracted from Advance Housing. Administrative support was commissioned through external agencies and from the Leicester City Council. Leicester City Council acted as the financially accountable body and providing project support, drawing down a management charge for that support.

All Case Managers were non-clinical and came from Information Advice and Guidance (IAG) backgrounds. These IAG skills allowed the Case Managers to quickly build a rapport with clients as well as to maintain a demedicalised approach to the service, in support of the current evidence on biopsychosocial models. Where clients had specific clinical issues Case Managers could discuss the client's issues with either the GP or OH Nurse who would then decide the appropriate course of action. This may have included the client seeing the GP or the OH Nurse. However, all clients' progress was reviewed and discussed with the GP at the time of fit note signing, typically every two weeks. The costs of employment for non-clinical staff as Case Managers was far lower than those of clinical staff and had no detrimental effect on positive client outcomes.

Client profile

Out of the eligible clients that were referred, 82 per cent went for assessment. Just under two-thirds of clients had a mental health condition, and nearly one-third had an MSK as their main reported condition at point of referral. PHQ9 and GAD7 data collected towards the end of the pilot suggests that 80 per cent of clients reached the threshold for a mental health problem that would make them eligible for therapy in the IAPT programme.

Clients were evenly split between men and women. In addition, one-fifth had BME backgrounds, and around two-thirds were aged over 40.

Whilst it might be expected that relying on GP referrals to have led to a representative sample of the workforce entering the pilot, employees from large employers were over represented. There was no full explanation behind the lack of SME referrals, but the service providers suggested that SMEs are less reliant than large companies on GP fit notes to trigger sickness absence procedures, and will often try and resolve the problem without asking for one.

Follow-up and discharge arrangements

A consultation between client, Case Managers and additional team members facilitated discharge, and a report signed by the Clinical Lead was sent to the client's GP. The EQ-5D was used on entry and was again used on exit to assess the client's general wellbeing. At one month and then three months after discharge, clients received follow-up contact. Clients, and employers where appropriate, were sent a questionnaire to report back their views on the service.

Outcomes and key lessons

For clients whose outcomes were recorded, 20 per cent had remained at work (having been in work when entering the service), 40 per cent had returned to work, and a further 20 per cent were off sick. The remaining clients were unemployed, planning to go back to work, had found new employment, or could not be contacted.

- Employer OH can be seen to be on the side of organisation even when it is impartial.
- Clinical case management is not necessary in order to achieve successful outcomes as long as non-clinical cases managers are supported by clinical staff when appropriate.
- Between 65 and 75 per cent of clients who returned to work reported that ‘human interventions’ such as confidence building, support to dialogue or mediation at the workplace as the intervention that had the most impact on facilitating their return. This study won a National Institute for Health and Care Excellence (NICE) Shared Learning Award in May 2012 for ‘demedicalising’ mental health.

Challenges

- Maintaining GP awareness and commitment took a good deal of concerted effort, and the balance between keeping up the profile of the pilot without becoming an irritant proved a difficult balance to strike.
- It proved even more difficult to engage local SMEs despite attempts at direct contact.
- In the Leicestershire pilot, the Case Manager’s role was to also market the service; if referrals numbers were down Case Managers would engage in targeted marketing activity to GP practices; referrals would then increase and the marketing activity would decrease. This pattern would then be repeated with referrals decreasing due to a lack of marketing activity and so the cycle would begin again. This approach maximised the utilisation of Case Managers. Providing the right amount of support to a client, i.e. the length of time within the service and achieving a sustainable outcome, was always a balancing act. Discharge a client too early and clients may have to return the service or return to sickness absence. Hanging on to clients too long resulted in additional unnecessary cost and lack of available referral space.

Successes

- The pilot providers cite the key success of the pilot was that providing early interventions for clients who are off work was successful and had a positive impact for clients and employers alike.
- Marketing activities that were undertaken resulted in a high level of 95 per cent of all GP surgeries in Leicester, Leicestershire and Rutland referring clients to the pilot.
- Relationships and referrals improved considerably over the three-year period.

What worked?

The pilot reported that the following elements of their service underpinned their successes:

- Developing a strong relationship with each GP practice by attending practice meetings.
- Making the referral process easy for GP’s and clients.

- Accessing clients as early as possible in order to start the process of return to work. ‘The longer clients are out of work the less likely they are to return to work.’
- Demedicalising client’s issues and using a biopsychosocial approach to explore not just the traditional clinical issues but also the social issues. ‘The social issues are as important as the clinical ones.’
- Using non-clinical staff to deliver the case management, assessment, and client support providing the service was overseen by a clinical professional could reduce costs whilst maintaining positive client outcomes.
- Case managed interventions are essential to ensure the client can get the support they need to enable them to return to work. The pilot found no evidence to suggest that ‘a simple client assessment and agreed action plan is enough support for the vast majority of clients.’
- Case managed interventions need to be made without delay in order to maintain the momentum and focus of the patient journey. Delays in intervention can exacerbate a client’s depression and anxiety and can lead to a significant delay in returning to work.
- Employing staff directly rather than commissioning them to reduce costs.

Legacy

Leicestershire FFWS continues to be delivered in Leicestershire after being commissioned locally. The service remains as per the original pilot; non-clinical case management supported by clinical staff where appropriate. However, a larger proportion of clients are being assessed over the phone rather than having a face-to-face assessment. Very few members of staff are commissioned by the organisation, most being employed directly. The cost of delivering the local service is far lower than that of the pilot with positive client outcomes remaining high.

The Fit for Work team has become sustainable and provides additional health and employment-related services. The Fit for Work team is part of a group of organisations who formed the Health Work and Wellbeing Group, a company limited by guarantee, in order to share ongoing learning and to provide a mechanism by which the group can access larger national contracts.

North Staffordshire

Introduction

At the start of the pilot, the lead organisation for the pilot was NHS North Staffordshire, but due to organisational change within the NHS, the lead organisation changed to the Staffordshire and Stoke on Trent Partnership Trust. Following this adjustment, the accountable organisation became the Staffordshire Commissioning Cluster. The key partners remained the same: Stoke-on-Trent City Council, Staffordshire County Council and Staffordshire Jobcentre Plus. The pilot developed out of the Condition Management Programme (CMP) in order to fill the gap in provision for employed people on sickness absence. It was also to provide a co-ordinated approach to addressing health and work issues, in particular empowerment and self-management.

Background

The pilot covered North Staffordshire, including Stoke-on-Trent, which had a working-age population of about 300,000. 207,000 of these individuals were in employment. This area was covered by 300 GPs in 90 practices in the area.

The principle target group were employees who lived or worked within the North Staffordshire area, who had been on sickness absence for four weeks. Presentees were not excluded, but their numbers in the programme remained low throughout.

Over the three phases of the pilot, although marketing became more targeted, the coverage and eligibility since the start of the pilot did not change.

Referral processes to and from the pilot

Preceding admission to the pilot, referrals were screened for basic criteria such as address and employment by the Service Administration team. GP recommendation was the highest reported source of information about the pilot, although this was via signposting as the majority of referrals were self-referral. Just over 20 per cent of both sources and referrals respectively were represented by the IAPT programme. Self-referrals were explained by word of mouth recommendations and advertising, and employer referrals were seen as stemming from advertising campaigns and attendance at networking events.

In the beginning, the pilot was responsible for GP engagement, and GPs were informed of both their patients' engagement and outcomes from the service. The forms of GP engagement included one-to-one contact, presentations to practice meetings, broadcasting service updates and feedback through Local Medical Committee newsletters and Sharepoints, and local medical business and education events were attended. Introduced in the third phase, a GP was hired on a short-term contract to act as a GP Champion, which had a direct positive effect on referral rates.

There was a change in marketing focus over the pilot. When the funding was extended after the initial period, the service directed its marketing solely at SMEs. However, if individuals from large private and public sector organisations were referred, they continued to be accepted. This was done if either they had not been referred to their own OH services, or if such services were not addressing the workplace issues.

The Specialist Employment Service was originally responsible for SME engagement, contracted to the pilot. A range of methods was used: networking events with follow-up phone calls, training sessions, e-zines, cold-calling and telemarketing to raise awareness. In addition, local radio and transport companies were used for mass-marketing campaigns. In the third phase, a marketing company took over this function, and redesigned the publicity material. Exposure was also broadened: SMEs were emailed, shopping centres and billboards were used for outside advertising, and there was also a brief social media campaign. This did not yield any differing results from the previous 'in house' work. The best results occurred from good relationships forged by pilot personnel working on cases with local employers and HR managers.

Model of provision

When clients were deemed eligible, they were referred to a geographically-assigned Case Manager who carried out an initial face-to-face assessment. This usually took place within the participant's GP surgery and followed the biopsychosocial model. However, it also

included assessment for suitability of the service, signed informed consent was obtained and questionnaires were completed which provided standardised clinical assessment and service evaluation.

The clinician delivering the initial assessment had the final decision as to whether the pilot was appropriate to assist the individual at that time. At this point an Action Plan was developed, and onward referrals identified. This was collated and passed on to the client's GP for comment on any conditions or factors that would present as reasons to withhold certain medical treatments.

During the second phase, a common database commissioned by the DWP replaced the previous, regional CMP service for storing client records electronically. Both clinical practitioners – Work Facilitators, Case Managers – and Specialist Employment Advisers worked in the same office, and both used this database, albeit with restricted medical content. This ensured a comprehensive, contemporaneous and coherent client record.

The service resolved cases through both in-house and outsourced skills sets, and through additional direct onward referrals. In-house interventions included: individualised case management, specialised employment advice such as CV writing and job searching, debt and finance advice, cognitive behavioural therapy (CBT), self-management workshops and one-to-one physiotherapy. Onward referrals were made to a community physiotherapy service for non-complex musculoskeletal conditions, and magnetic resonance imaging (MRI) scans and pain-relieving epidural and joint injections were given for complex or inconclusive musculoskeletal issues. Additionally, drug, alcohol and domestic abuse services were signposted, and for those with long-standing or complex mental health needs, either local IAPT services or Crisis and Early Intervention teams were suggested.

The outcomes of each intervention were co-ordinated by the Case Manager, as was the entire process, in order to ensure that the plan was progressing and remained joined up. Throughout the intervention period, the client received regular contact from the Case Manager, who also took responsibility for the final client discharge.

Staffing arrangements

During the first phase, North Staffordshire the pilot was delivered by a full-time team lead, three (0.6 WTE) Work Facilitators – Case Managers – from multi-professional health backgrounds, a full-time project support worker and two full-time administrative assistants. At this period, project management was from the CMP Management team.

When the CMP closed after this time, a further 1.8 (WTE) Joint Project Leads were transferred to the pilot.

The Aspire Group Ltd, to whom the Specialist Employment Service was contracted, provided two (WTE) Employment Advisors, which reduced to 1.6 (WTE) in the second year. They were co-located within the Pilot team.

Client profile

All in all, 293 people participated in the North Staffordshire pilot. Taking the figures from October 2011 to February 2013, just under two-thirds of the clients were female, around 40 per cent of clients were aged over 50 and approximately a further 40 per cent were aged between 35 and 49. Just under two-thirds of individuals worked for companies with over 250 staff members, and an additional fifth worked in organisations either between 50 and 249

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

employees. Just under two-thirds worked in private firms, and another third worked in the public sector.

Over the whole project, one-third of participants reported anxiety as their main health condition, a further fifth cited depression.

Follow-up and discharge arrangements

Clients were discharged during a face-to-face appointment if at all possible, which usually occurred after four weeks. However, after returning to work, clients often proved quite elusive, and thus the discussion took place over the telephone. At this point, an outcome form, satisfaction surveys and repeat standardised questionnaires were completed. If the assessment took place via the telephone, these were completed and sent via post.

After clients returned to work, case workers maintained contact to ensure that the person remained in employment. According to the individual needs and contactability, the length of this time varied.

Three months after discharge, progress was checked via a follow-up phone call. Of the reviews carried out, 97 per cent of those who had gone back to work had remained there.

All those discharged were encouraged to re-refer if there was a problem.

Outcomes and key lessons

Seventy-five per cent of those who engaged with the service returned to work within three months. The drop-out rate of the programme was 17.5 per cent. The pilot provider's view is that the service developed its case management knowledge and expertise well, although GP engagement and referral numbers remained below where they would have liked them to be.

- Appointing a GP Champion from the start date would ensure best GP engagement.
- Gaining a high level of support at Trust Board level improved the commissioning position.
- Having a combination of different work-related issues had a greater impact on sickness absence than one single primary health condition.
- Having a common database from the start would have ensured that data retrieval was coherent and contemporaneous, and there would have been total reporting reliability.
- The pilot providers recommended independent local evaluation.

Challenges

- Increasing GP engagement proved to be difficult to sustain.
- Engaging employers was additionally tricky, and an outside marketing company made negligible difference to their rates of referral.
- Referral numbers did not reach the levels originally calculated.

Successes

- Many Key Performance Indicators were achieved:
- The number of given cases was exceeded.
- Three-quarters of participants were on sickness absence.

- Over two-thirds of cases were returned to or maintained in work on discharge.
- The average duration to return to work was seven weeks, and the average duration with the service was ten weeks.
- Two-thirds of clients presented with common mental health conditions.
- There were improvements of 55 per cent in pre and post intervention scores for both depression and anxiety, as well as in SF12 and EQ-5D scores.
- Ninety seven per cent of cases followed up after three months were in work.

Nottinghamshire

Introduction

The Greater Nottingham Partnership (GNP), a strategic sub-regional regeneration partnership, was the original pilot lead for the period 2010–2011 and provided project management and overall direction. The GNP commissioned three parts to the FFWS through an open tender process, which comprised of the ‘Work Survival Programme’, ‘Support in Work’ and ‘Working for Health’.

- Work Survival Programme comprised up to six, three-hour-long workshops for those who were struggling to maintain their health but were still in work, either a group of individuals or run for a single employer on employer premises. This was run by a national Welfare to Work provider who provided Pathways to Work locally.
- Support in Work – which involved individual case management for clients with complex needs, which was delivered by NHS-based occupational therapists.
- Working for Health – an online health check for SMEs, which was followed by an in-person assessment with an employment law specialist. This was designed to formulate a response to problems with absence management.

These three strands followed a preceding earlier programme called the Fit for Work Project, which started in Nottingham 18 months before the national pilots. The previous scheme, commissioned through the City Strategy Programme, was run by a partnership consisting of the NHS, Jobcentre Plus and the local Employment and Skills Board. From the outset, collaborating with employers was seen as crucial, and Support in Work was founded alongside the local IAPT service to deliver workplace interventions. The Work Survival Programme was the only new initiative for Nottingham in their national pilot participation.

Following changes to regeneration structures, after April 2011 an independent social enterprise and registered charity, Enable, took over leadership of the service and the Accountable Body role. As of this period, only individual case management support was provided for clients and in Years 2 and 3, the pilot focused on the Support in Work element of the original programme.

Background

Initially, the pilot covered Nottingham City, Mansfield and Ashfield, with the central focus on areas where long-term worklessness and health inequality was most pronounced. At a later point, in order not to exclude beneficiaries or employers from just outside the city boundary, the pilot was expanded to cover all of Nottinghamshire. The county had a working-age

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

population of half a million, with 374,000 in employment.

From August 2010, the case management service Support in Work was also expanded over the county and larger GP practices were targeted to make them aware of the service. From the second year, when the priority was to increase the proportion of absentees accessing the service and volume of GP referrals, attempts were made to contact practices across the city and county and, engagement with GP structures was stepped up.

Referral processes to and from the pilot

From Year 2 there was an increase in GP referrals from just two per cent in the first phase, to over 40 per cent from October 2011 to March 2013. This elevation was explained by the success of investment in a dedicated Outreach and Engagement Officer. This officer's focus was on liaising with GPs, attending their Protected Learning Time events, practice meetings, distributing dedicated literature, plus basing client clinics in GP premises. These efforts added to marketing drives of utilising leaflets and posters in practices, as well as speaking to GPs, receptionists and nurses. Ongoing GP engagement was imperative and GPs were kept informed of referral rates through a monthly practice newsletter. The newsletter also featured case studies and updates on health and work developments.

The other large share of referrals resulted from the local City and County IAPT service, also responsible for just under 40 per cent. The close working relationship with the IAPT service was built on the local service origins and was facilitated via practical measures such as co-location of Support in Work Case Managers alongside IAPT delivery teams within Primary Care Services.

In the early stages of the pilot, employer referrals were an important source, especially for the Work Survival Programme. Telemarketing ultimately proved successful in generating interest in the specialist SME focused support of Working for Health. This later success came after less success with a business broker and working with organisations such as Business Link and the Federation of Small Businesses. However, from April 2012 to March 2013, employees from SMEs accounted for 35 per cent of all clients, which was lower than the providers hoped for. This was despite extensive marketing activity via a range of SME business networks, including the Chamber of Commerce and Industry and the Federation of Small Business, and the use of telemarketing.

Model of provision

From the beginning of the pilot, access to support began with a short telephone screening process. During this call initial monitoring data were collected and the eligibility of both referred and self-referred clients was checked. Unemployed individuals and 'presentees' from large employers, not deemed eligible, were signposted to other sources of advice and support.

Those that did qualify were allocated to a clinical Case Manager who managed their contact with the service. A much more detailed face-to-face assessment was then carried out by the Case Manager, who produced a set of agreed action points with the client. This included providing therapeutic support or referrals onto other services such as debt counselling, IAPT or physiotherapy where appropriate. Case Managers used their contacts with other NHS health professionals, including GPs, to ensure that clients received the treatment they required to support a return to work. GPs were contacted and given advice on fit note completion in such a way that they could be of value to both employee and employer. With

client consent, Case Managers also liaised directly with their employer to increase the likelihood of the employee being able to return to work and met with employer and employee to facilitate this.

Staffing arrangements

The Case Managers for Support in Work were NHS-employed occupational therapists, and across the city and county there were seven full-time equivalent staff. These clinical staff were employed by Nottinghamshire Healthcare NHS Trust. All were experienced in vocational rehabilitation and had a range of specialisms, including mental health, ergonomics, and substance misuse.

The Central team was made up of a part-time project manager, an outreach and engagement officer, administration support plus part-time support with marketing, communications and business engagement. The project manager was experienced in working with a practice-based commissioning cluster and was a former non-executive director of a PCT. Additionally, strategic leadership was provided via a director from the local Employment and Skills Board, who was originally employed by GNP, and then Enable.

Following the removal of two of the three service strands – the Work Survival Programme and Working for Health – the total number of staff working for the service was lowered from the first phase, as the focus became solely case management.

Client profile

From December 2011 until the end of the project in March 2013, 592 individuals participated in the case management programme. Just under 60 per cent of clients were female, around 40 per cent of the total population were aged between 35 and 49, and just over one-third were aged over 50. Reflecting the difficulties in recruiting from SMEs, nearly 70 per cent of individuals worked for companies with more than 250 employees, and two-thirds of participants worked for private sector firms.

In contrast to other pilots, there were lower amounts of MSKs – ten per cent had back issues – and over two-thirds reported depression or anxiety. This reflects the service's close working relationship with, and proportion of referrals from, the local IAPT services. These individuals with mental health problems tended to be supported by Case Managers for longer periods and, in many instances, received ongoing support after they had returned to work.

Follow-up and discharge arrangements

The action points produced at the initial client face-to-face assessment provided the framework for deciding what follow-up was required and timeframes were tailored on a personal basis. Some clients required more time to complete a therapy course or time was required for the Case Manager to liaise with their employer. Other individuals had weekly meetings with their Case Manager to facilitate progress.

For a significant number of clients, discharge from the service did not take place until after they had returned to work, with case workers maintaining contact to ensure that the person sustained in employment, particularly those with mental health issues.

Outcomes and key lessons

- Supporting those with mental health problems to return to and sustain in work generally takes longer than those with MSKs.
- Helping individuals back to work did not necessarily mean back into the same job or back to the same employer.
- Whilst many people had access to an OH service, this was often limited to telephone support and not an 'early intervention' due to internal employer referral processes.
- Many individuals contacted the service to access practical, impartial advice.

Challenges

- Engaging SMEs to increase referrals was tough, and they remained a lower share of the proportion of overall clients supported.
- Some of those referred to the service did not actually choose to engage with it.
- There were concerns from the pilot providers that limiting the service after the first phase would be less cost effective, as it would narrow the opportunity for early, low-level interventions.

Successes

- Over the second phase of the pilot, the service helped two-thirds of clients on sickness absence back to work, including a significant proportion of those suffering with mental health problems.
- Employers valued the service, and the vast majority were happy to engage with Case Managers about individual employees and how they could retain staff with health problems.
- The use of experienced occupational therapists as Case Managers was an important factor in ensuring clients could maintain employment.
- Using a dedicated Outreach and Engagement Officer in the second phase to engage GPs resulted in the service being valued to the extent that it has been commissioned post pilot by two Clinical Commissioning Groups and a Public Health Service.

What worked?

- Consistent support from an experienced Case Manager worked well for individuals.
- The ability to provide therapeutic support through experienced clinical Case Managers.
- The use of the knowledge and expertise of experienced Case Managers to provide appropriate referrals onto other specialist services to support a return to work.
- The use of NHS-based clinical staff was beneficial in terms of liaison with other health services, including GP's.
- GP's appreciated the fact that the service was a multidisciplinary approach.
- Employers valued the impartiality of the service and the support with the interpretation of fit notes.

Legacy

Since the end of the pilot phase, Nottinghamshire Fit for Work Service has been commissioned by two Clinical Commissioning Groups – Nottingham City and Mansfield and Ashfield – and by Nottingham City Public Health in 2013/14 and 2014/15. This has been to provide both case management and group support through the Support in Work service. The client group has broadened to now cover sickness absentees, presentees and the unemployed for whom health is their primary barrier to active job seeking and help continues to be provided to both those with physical and mental health conditions. The service has been commissioned in the context of priorities set out in local Joint Strategic Needs Assessments and in particular, mental health strategies. Close working relationships have been developed with both primary care and secondary care health providers to support the delivery of this service.

In addition, the service has delivered a local contract to help the long-term unemployed with mental health problems to manage their health and actively job seek. Building on the early concepts of the Work Survival programme, the service has also worked with a number of local employers to deliver organisational development support to manage sickness absence and support employees with health conditions more effectively.

The service has also worked closely with the other remaining organisations that delivered the Fit for Work pilots to develop a national approach through the Health, Work and Wellbeing Group.

Rhyl

Introduction

The lead organisation involved in the pilot was the Rhyl City Strategy Community Interest Company. The other organisations involved were 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 sat on the board and steering group. The pilot operated 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

The pilot originally covered Rhyl in Denbighshire, as well as the Glyn and Abergele/Pensarn wards in Conwy, but was expanded to include the entirety of both counties. The initial area was one of high deprivation and unemployment, with high levels of drug and alcohol addiction. Additionally, the pilot covered an area that lacked services for employed people, and it sought to enhance socioeconomic regeneration and wellbeing. The pilot added value to existing services because it was the only system for employed people in the locality.

The pilot was originally intended for SMEs, but following an influx of referrals from larger companies, the advisory group suggested altering the remit to include these as well. Despite continuing with SME engagement, the pilot providers discovered local practical difficulties, including the fact that many of the SMEs were micro businesses, and that there were fewer medium-sized SMEs than was first estimated.

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

Across all phases, the service took referrals for both employed and self-employed clients, but in the second phase the focus changed to an emphasis on recruiting absentees. From April 2011, the target was to have a maximum of 30 per cent presentees. Eligibility covered sickness absentees off work for two to four weeks, captured at four to six weeks, individuals waiting for specialist health input and those with no OH access. There were additional criteria of employees returning to sickness benefit having recently returned to work, employed presentees – but only if they were self-employed – and longer-term sickness absentees who had repeat or extended sick leave.

Referral processes to and from the pilot

Although GPs only counted for just over one-third of direct referrals to the service, this does not reflect that a much greater majority of participants were signposted to the pilot by their GP – three-quarters. Through their GP engagement drive, the Rhyl pilot ended up with 120 GPs referring into the service. Self-referrals and direct employer referrals were at a much lower level. Onward referrals were made as necessary to various services, particularly physiotherapy and a variety of psychological talking therapies.

Model of provision

Within a week of referral – and often within forty eight hours – Case Managers directly contacted the client and arranged a one-hour meeting. Case Managers also travelled to see participants where necessary, or gave advice and guidance over the phone. At this initial stage, the client registered, completed a data protection form, and with their Case Manager, drew up an action plan.

The delivery partners for clients with musculoskeletal and mental health concerns were psychological therapists and NHS Physiotherapy at Glan Clwyd Hospital. As required, additionally services were introduced such as neuro-linguistic programming therapy, osteopathy and life coaching. Private counsellors were needed to provide additionally psychological services to fill the gap left by the decommissioned MIND Wrexham and MINDS Vale of Clwyd providers.

Clients were signposted to the expert patient programme, debt advice, benefits advice and career services. Frequently, Case Managers knew people within these services, so were able to help clients quickly get assistance.

Staffing arrangements

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

Client profile

Three hundred and forty individuals took part in the pilot, and just under two-thirds were female. Almost all reported either an MSK – primarily back and lower limbs – or mental health concerns – the majority being depression and anxiety – or both. Under two-thirds worked for companies with more than 250 employees; however, the Rhyl pilot exhibited a greater number of participants from much smaller companies compared to other regions in the national pilot.

Around 40 per cent of clients were between 35 and 49-years-old and about one-third were aged over 50.

Follow-up and discharge arrangements

Client need dictated the nature of follow-up and discharge arrangements. Some clients reported a significant improvement after four weeks contact with the service, whereas others were monitored for longer periods. This ensured that there was no recurrence of problems following return to work. As circumstances improve, client contact reduced so as to give participants a sense of 'ownership'. Evaluation questionnaires were administered post-discharge, and clients were contacted at three and six months after discharge.

Outcomes and key lessons

- The pilot decommissioned services that did not communicate well, and made provision to buy in services from different service providers.
- A GP Champion was planned to help the pilot get the message out to GP networks.

Challenges

- The pilot providers made strenuous efforts to engage with SMEs when it became apparent that they had too many referrals from large companies. Larger amounts of SME engagement still proved hard to achieve.

Successes

- An 'agreement' form for clients to sign was introduced to reduce incidence of failure to attend onward referral appointments.
- GP recruitment drives resulted in a greater number of GPs referring to the service.
- Case Managers intimate knowledge of external advice and guidance services helped pilot clients gain support faster.

Scotland

Introduction

The Scottish pilot, known as Working Health Services Scotland (WHSS), covered the whole of Scotland,

The pilot comprised mainly telephone-based case management operating within a biopsychosocial delivery model. The personalised service centred on early assessment, deconstruction of complex problems and rapid access to local therapeutic interventions

Service performance, management information provision, financial and data governance were the responsibility of Salus Occupational Health and Safety, a 'social enterprise' within NHS Lanarkshire. Salus had considerable experience of running case management-based services for different groups of clients, and this experience informed the development of the pilot.

Representatives from Jobcentre Plus, the Scottish Government and other key stakeholders formed the senior management group to whom SALUS reported on a quarterly basis.

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

The formation of the service necessitated significant strategic and partnership working, taking into account the disparate urban, rural and remote regions covered. This began with developing a commonly agreed delivery model amongst 14 regional health boards, latterly reduced to 11. A bespoke web-based data system was developed, which enabled all activity to be recorded and accessed centrally. Regional based staff required training to deliver the pilot locally.

Background

Scotland has a working population of approximately 3,400,000, of whom 2,400,000 are in employment. To be eligible for the service, in Years 2 and 3 of the pilot, clients must:

- have been employed by an SME (fewer than 250 employees),
- not have access to full OH support through their work; and
- have been absent from work

During the first year of the pilot, employees in work at risk of becoming absent were accepted into the service. This stopped in Years 2 and 3, although WHSS continued to provide support to employees from SME's who remained in, or were struggling at work but this was funded separately, via Scottish Government.

Referral processes to and from the pilot

Referrals to the WHSS could be made by a GP or other health professional, or via self-referral. Referrals from employers, with the employee's consent, were also accepted by the service in the first year. Initially the service was marketed to GPs, other health professionals (particularly physiotherapists) as well as SMEs. As the majority of referrals came from GPs signposting clients, the bulk of marketing attention was redirected to this area alone. Additionally, Case Managers and their line managers promoted the service among relevant audiences of health professionals, employers and via the activities of other health and work initiatives.

Referrals were received via a dedicated telephone number. During the first call clients were screened for eligibility and basic health details, as well as being asked to provide demographic and contact information. Providing eligibility criteria were met and the client wished to engage, the case was forwarded electronically to the appropriate health board; all support was provided in the client's local region. Within two working days of enrolment, clients were contacted to arrange a telephone assessment, which was to be completed within five working days of enrolment. Clients requiring clinical intervention were seen within ten working days of that assessment.

Model of provision

Each client's personalised support plan was developed from the telephone-based biopsychosocial assessment, which is performed by a Case Manager. The assessment focused not only on health problems and type of work, but also involved other issues such as family, relationships, debt, substance use and housing. A battery of standardised tools were used at baseline: the EQ-5D (EuroQol-Vas) was employed for all clients, the Hospital Anxiety and Depression Scale (HADS), and the Canadian Occupational Performance Measure (COPM) could be employed at the Case Manager's discretion. In the first year, a typical initial telephone assessment lasted an hour; however, as Case Managers gained experience

this duration decreased. Following the assessment the health issues and barriers to work were identified.

Subsequently, each client was assigned a Case Manager who maintained regular one-to-one telephone contact throughout the client's engagement with the service. Advice, support and mentoring were offered. The Case Manager's role included orchestrating the process at a suitable pace, as well as co-ordinating contact with client and services to ensure satisfactory progression. Clients were also supported through local Working Health Service teams. Support may have included early access to locally delivered interventions such as physiotherapy, occupational therapy and counselling. Additional NHS services may also have been offered, such as smoking cessation, help with eating disorders and addiction, podiatry and help with pain. Further interventions were also available such as wider social services information and guidance about housing, debt and skills advice.

Commissioned services in the form of physiotherapy, counselling and occupational therapy were all subcontracted and included both NHS and private providers, depending upon the specific region. Payment of services also varied, with some block purchasing or payment upon completion. Since the commencement of WHSS, a total of 12,991 client interventions were recorded of which 80 per cent used physiotherapy, ten per cent engaged in counselling and one per cent used OH services. Clients could receive more than one type of intervention.

Staffing arrangements

At the outset of the service, the initial call handling was managed by the lead organisation, via the existing Scottish Centre for Healthy Working Lives advice line. Case management covered all health boards, with some remote or sparsely populated regions sharing a dedicated Case Manager. All Case Managers were NHS staff, many seconded from other roles, employed by their regional NHS and line managed locally.

Client profile

The gender mix was evenly split, with just under half of clients being female (48 per cent). Two-thirds of clients worked on a full-time basis. The mean age of clients was 44 years, and ranged from 16 to 89. Forty-five per cent of clients worked within micro organisations with ten or fewer employees, 30 per cent worked in small workplaces with between 11 and 50 employees, and 25 per cent worked within organisations with more than 50 employees. Clients were generally low paid; with 64 per cent earning less than £20,000 per year and nearly 90 per cent earning less than £30,000 per year.

Follow-up and discharge arrangements

Upon completion of the programme the Case Manager contacted the client to both review their progress and discuss return to work plans. The same standardised questionnaire tools that were administered at the initial assessment were repeated at this point. Each client was followed up at three and six month intervals after programme completion to obtain a health update and ascertain work status.

Outcomes and key lessons

On programme exit:

- 78 per cent of clients reported that their health condition had been fully or partially resolved;
- 80 per cent of clients stated WHSS had helped them remain at, or return to, work;
- 45 per cent no longer required medication and 14 per cent required less medication;
- 91 per cent per cent stated that on considering their health status at discharge, they would still be able to do their job within the next six-month period;
- 99 per cent stated the service was good or excellent;
- based upon the EQ5D, one per cent of those presenting with an MSK problem reported no pain at assessment. This rose to 40 per cent at discharge. Only two per cent reported they had no problems completing 'usual daily activities' at assessment; this rose to 60 per cent on discharge;
- of those presenting with a mental health problem, seven per cent stated they had no anxiety on assessment; this rose to 65 per cent on discharge. 25 per cent stated they were not depressed at assessment, this rose to 81 per cent on discharge.

Challenges

- The primary challenge was to increase service uptake of absentees.
- Various marketing strategies were employed to increase awareness of the service. These included national and local radio advertisements and bus and subway poster displays. These were judged to be expensive and of limited effectiveness.
- Healthcare professionals working within mainstream services could benefit from awareness raising session(s) or training to increase their understanding and the importance of the health and work relationship.

Successes

- The service was structured to include the administration of standardised psychometric tests both at pre and post intervention. This enabled the identification of any change in the client's physical or mental wellbeing. Clients' opinions of the service were also obtained through the use of a Client Satisfaction Questionnaire. All measures have consistently shown that clients' health status improves following intervention.
- The service now contributes to the Scottish MSK Framework. WHSS is a recognised referral pathway for those absent from work with an MSK problem which impacts negatively upon their work situation.
- WHSS delivered entirely within the pilot key performance criteria and reported solely on absentees from small to medium-sized enterprises.
- The Scottish pilot delivered services to 64 per cent of individuals who earned less than £20,000 per year.
- Client self-referral route was mainly due to GP signposting; therefore 71 per cent of referrals were the result of GP referral processes.

What worked?

- Commissioned Treatments – Analysis of the number of commissioned physiotherapy treatments attended, against before – and after – improvements in clients' health status as measured by the EQ5D, suggests that, in general there was no benefit in the client attending more than four treatment sessions. This is in accordance with NHS MSK framework guidelines. Additional sessions could be provided on an individual basis if, in the opinion of the clinician, these would provide significant improvement and prevent onward referral to mainstream NHS services. Economies of Scale – All initial referrals from across Scotland are received at a central hub. There is no duplication of administrative infrastructure.
- Telephone Based model – The potential client population exceeded two million, and while some client interactions were face to face, the majority were telephone-based. Telephone-based services have been employed within Salus extensively, and it has found no evidence to suggest that the quality of the service compared unfavourably with face-to-face models.

Legacy

WHSS continues to be funded by Scottish Government.

Eligibility criteria within the Scottish Government-funded model include both absentees and presentees employed by SME's, in recognition that early appropriate interventions can prevent absenteeism. This may be of particular benefit to sole traders and employees of micro organisations who are more likely to remain in, and struggle at, work with a health condition.

Appendix B

Methodology

The evaluation had a number of strands; the evidence from all aspects of the evaluation including the research conducted in Year 1, is drawn on in this final evaluation report. The various strands included:

- Management information (MI) collected from the pilots about their clients, including a new MI system introduced by the Department for Work and Pensions (DWP) for **Years 2 and 3** of the pilots. Some of the pilots reported difficulty with updating the MI through the life course of the pilot, and pointed out that some of the summary data did not tally with their own records. Checks have been made to verify the data wherever possible and this revealed that differences tended to be relatively small. The differences reported, may be due to differences in the time periods covered and in the approach to the analysis (including the data cleaning process) pilots may have also continued to collect and update their MI.
- Interviews with pilot personnel and stakeholders in Year 1 of the pilots. While there was no additional pilot fieldwork in Years 2 and 3, the descriptions of how the pilots operated published in the first evaluation report¹⁵ were updated by the pilots themselves and some added information about which aspects of the service worked particularly well.
- Three telephone surveys of pilot clients including a two-wave telephone survey of clients in the first year pilots and a third survey of clients in the remaining seven pilots in Years 2 and 3. Although the response rates to the surveys were over 50 per cent, the proportion of clients consenting to take part in the surveys varied significantly between pilots and therefore the achieved samples cannot be considered to be representative.
- A longitudinal panel of clients who took part in two waves of in-depth qualitative interviews.
- Interviews with General Practitioners (GPs), including those actively referring patients to the service and some who were not involved with the pilots.
- A bespoke impact study comparing length of sickness absence among clients who were absent from work with the average among fit note recipients in the local area, using fit note data collected from a selection of GP practices in three pilot areas.

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

Management information

In the evaluation of the Year 1 pilots each of the 11 pilots submitted aggregate data about their clients to the Institute for Employment Studies (IES) Evaluation team and the results were reported monthly to enable the DWP, Department of Health (DH) and others to monitor the participation of services both across the programme as a whole and for individual pilots.

In Years 2 and 3 the DWP designed a new MI system which involved collecting data on

¹⁵ 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.

individual clients from each of the seven remaining pilots. The data covered:

- 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;
- date of entry and exit to the service;
- an EQ-5D health status questionnaire, completed by the client on entry and exit to the service (see separate section on EQ-5D analysis).

The new management information data was collected by the DWP directly between October 2011 and March 2013, although data collection for some pilots did not start until December 2011 and finished as early as January 2013 for others. The data collection periods of the data reported in this report therefore vary by pilot but generally cover October 2011 to March 2013.

EQ-5D data

Data on the health status of clients were collected by the pilots as clients entered the service and when they left. The data were collected using the EQ-5D questionnaire, set out below.

EQ-5D Health Questionnaire

Under each heading, please tick the ONE box that best describes your health TODAY

MOBILITY

- I have no problems in walking about
- I have slight problems in walking about
- I have moderate problems in walking about
- I have severe problems in walking about
- I am unable to walk about

SELF-CARE

- I have no problems washing or dressing myself
- I have slight problems washing or dressing myself
- I have moderate problems washing or dressing myself
- I have severe problems washing or dressing myself
- I am unable to wash or dress myself

USUAL ACTIVITIES (*eg work, study, housework, family or leisure activities*)

- I have no problems doing my usual activities

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

I have slight problems doing my usual activities	<input type="checkbox"/>
I have moderate problems doing my usual activities	<input type="checkbox"/>
I have severe problems doing my usual activities	<input type="checkbox"/>
I am unable to do my usual activities	<input type="checkbox"/>
PAIN / DISCOMFORT	
I have no pain or discomfort	<input type="checkbox"/>
I have slight pain or discomfort	<input type="checkbox"/>
I have moderate pain or discomfort	<input type="checkbox"/>
I have severe pain or discomfort	<input type="checkbox"/>
I have extreme pain or discomfort	<input type="checkbox"/>
ANXIETY / DEPRESSION	
I am not anxious or depressed	<input type="checkbox"/>
I am slightly anxious or depressed	<input type="checkbox"/>
I am moderately anxious or depressed	<input type="checkbox"/>
I am severely anxious or depressed	<input type="checkbox"/>
I am extremely anxious or depressed	<input type="checkbox"/>
© 1990 EuroQol Group. EQ-5D™ is a trade mark of the EuroQol Group	

EQ-5D data can be used to calculate the health improvement in terms of quality-adjusted life years (QALYs). A QALY is used in health economics to measure the number of extra years (or parts of years) of life that would be added by an intervention. Each year is assigned a value of between 1 (perfect health) and 0 (death). If the extra years would not be lived in full health, for example, if the person would lose a limb, or be otherwise debilitated in some way, then the extra life-years are given a value between 0 and 1 to account for this and then this improvement is applied to the average costs of the service to calculate how much the service costs per QALY.

The results from the EQ-5D data were analysed by researchers at the University of Cardiff who converted the improvement recorded into QALYs. In conducting their analysis the following assumptions were made:

- in the absence of a counterfactual, the health gain reported by clients between entry and discharge from the service was a net gain – i.e. they would not have experienced any gain if they had not entered the service;
- there was no further health gain following discharge, as no data were collected to suggest that this might be the case; and
- the average cost of the service was the net additional cost of providing the service – i.e. there were no other costs incurred by the health service, employers or other parties. Again no data were collected to suggest otherwise, however, it is acknowledged that they could be both wider costs and also wider benefits.

Additional data

In addition the pilots submitted monthly reports which included details of the number of new client cases that month, the number of cases expected and the proportion of clients who were absentees.

Pilots also submitted quarterly financial returns outlining the amounts spent in the preceding three months itemised under a number of categories.

Data limitations

DWP researchers collected and analysed these data. For the final evaluation report the evaluators were given:

- summary tables covering aspects of the client data;
- the monthly reports of client numbers; and
- the quarterly financial returns.

The pilots reported a number of concerns with the accuracy of the MI data including a lack of clarity about some of the data variables (such as client start date) and not all the fields were completed for every client. In addition some of the pilots reported that the data in the summary tables provided by the DWP were different to the data in their own records. However, in the absence of another data source, the available MI data are presented in this report and the limitations acknowledged.

Research with the pilots and stakeholders

In their first year, researchers from the Evaluation team visited each of the then 11 pilots and conducted interviews in two waves, between October and December 2010 and June and July 2011, with:

- pilot managers and directors;
- members of steering groups and project boards;
- Case Managers and other members of the Pilot Core teams;
- other providers of 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.

In all 214 interviews were conducted, which explored:

- the models operated by the pilots;
- their experiences of, and any barriers to, setting up the pilot;
- 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;

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

- reflections on what had gone well in the first months of operation and what had been the key challenges.

A brief description of the operation of each pilot was written by the Research team and checked for accuracy by each pilot. The summaries were published in the first year evaluation report¹⁶.

There were no further interviews with pilot personnel or stakeholders in Years 2 and 3. For the final evaluation report, pilots were asked to update their summaries by the DWP and some provided additional information about the aspects of their pilots that had worked particularly well in their view.

Surveys of pilot clients

Three separate surveys of Fit for Work Service (FFWS) clients were conducted by researchers from IES and GfK NOP. In the original evaluation plan it was envisaged that a two-wave survey of clients in all 11 pilot areas would be conducted over the first year. However, this plan was changed due to the lower than expected participation in the service and the low rate of participant consent to take part in the survey in some areas. 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 clients was available for interview.

As a result the first survey and its subsequent follow-up had a smaller sample than originally planned. To fill the gap, a third survey of participants in the seven Year 2 and 3 pilots was commissioned.

The first survey took place between February 2011 and July 2011 and 311 interviews were conducted, a response rate of 54 per cent. However, the balance of the sample varied across the pilots, 69 per cent of respondents were 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 second survey was a follow-up to the first and respondents were recontacted six months after their initial survey. Fieldwork therefore took place between September 2011 and January 2012 and 225 interviews were conducted, a response rate of 75 per cent. The achieved sample broadly reflected the balance of responses from across the pilots in the first survey. This survey was designed to focus on the experiences since they had left the service and the impact they thought the service had had on their health and working lives

The third survey took place among clients of the seven remaining pilots between May 2012 and the end of November 2012, and was designed to collect respondents' views of the pilots and whether the service had had an effect on whether and when they returned to work. Some 323 interviews were conducted, a response rate of 53 per cent, of whom 242 were absent from work when they first came into contact with the service and had subsequently returned to work. Again the consent rate varied considerably between the pilots (from eight per cent in Scotland to 82 per cent in Inner North West London) and therefore the balance of the achieved sample varied across the pilots.

¹⁶ Op. cit.

Although the response rates to the surveys were over 50 per cent, the sample from which they were achieved was not fully representative of the client base as a whole because of the differential consent rate between the pilots. It is therefore important to recognise the limitations of the survey data.

Longitudinal panel of pilot clients

A further element of the evaluation involved two waves of qualitative interviews with clients in four of the original pilot areas 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 was to gain an in-depth understanding of clients' reasons for approaching the pilot, their experience of the service and their subsequent health and labour market experiences and the views on the impact of the service.

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 telephone survey. The four were:

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

The first wave of 63 interviews took place face-to-face between March and June 2011. The second wave of fieldwork was conducted by telephone with 55 of 63 people who took part in the first wave of interviews and took place between September and December 2011.

Study of GP involvement in the pilots

Another aspect of the evaluation involved telephone interviews with 31 GPs, including those actively referring patients to the service and some who were not involved with the pilots, in the first year of the service. This study was conducted by researchers from the Social Policy Research Unit at the University of York. Fieldwork took place in the spring of 2011 and the interviews covered: the GPs' knowledge and views about the usefulness of the pilot; how they learned about the service in their area; their reasons for, and experiences of, using the service; how patients have been helped by the pilot; and their suggestions for improving the pilot/communication with GPs.

Impact assessment

A bespoke study to assess the impact of the service on return to work times was undertaken in three pilot areas (Greater Manchester, Leicester and North Staffordshire) using data collected from fit notes. Details of the method involved in this aspect of the evaluation and the full results are set out in Appendix C.

Appendix C

Impact assessment: fit note approach

Pilots included in assessment

Three pilots were selected for the impact assessment component of the national evaluation: Greater Manchester, Leicester and North Staffordshire. The sites were chosen to represent a cross-section of the seven second and third year pilots where it proved possible to engage General Practitioner (GP) practices in the research. Having three pilots enabled an analysis of the impact of different models of service provision.

Method

Hypotheses

The impact assessment involved testing three hypotheses relating to the effectiveness of the pilots:

- 1 Specific characteristics of the client and their sickness episode significantly increased the likelihood of a return to work.
- 2 Where a client did return to work, the duration of the certified sickness episode was shorter than the average length of episode for the same diagnosis in the local area.
- 3 Below-average periods of certified sickness were associated with characteristics of the client.

Hypotheses were tested by (i) analysing data within each pilot area and (ii) using a ‘pooled’ client dataset from all three areas.

Collection of ‘control’ data

In order to compare the sickness certification outcomes of the client with those in the local area patient population, ‘control’ fit note data was collected from a number of practices in each of the three pilot areas (four general practices in Greater Manchester, nine in Leicester and six in North Staffordshire).

At each of the control practices, ‘carbonised’ pads of fit notes were used by GPs for a period of approximately 12 months (September 2011 to September 2012). Such specialised pads enabled a duplicate copy of the fit note issued to the patient to be retained. Details on each duplicate copy were anonymised and entered into a spreadsheet by a member of practice staff, and the spreadsheet was submitted to a secure project web site at the start of each month. Using this method the details of every fit note issued at each practice in the 12-month period should have been recorded. The fields in the final database included all information on each fit note (including date of issue, the health problem causing work incapacity and the

period of certification). In addition, for each fit note, a number of items were collected from the individual patient medical record. These included the patient number on the practice register (to allow the tracking of patients receiving more than one fit note).

Construction of local ‘norms’

The collection of such detailed data enabled the construction of local ‘norms’, in terms of the average period of certified sickness for specific health conditions. The fit note data collected from control practices was collapsed into discrete patient ‘episodes’ (period of continuous work incapacity certified by one or more fit notes). For each of the three pilot areas, Greater Manchester, Leicester and North Staffordshire, it was possible to estimate the average duration of episodes associated with a specific diagnostic cause of incapacity.

Two measures of these diagnosis-specific episode norms were used in the testing of hypotheses 2 and 3, cited above.

- Firstly, an **unadjusted** ‘complete episode’ norm was used in comparing the total length of a client sickness absence episode, with the average length of a similar sickness episode in the local area.
- An **adjusted** local episode norm was calculated on the basis of the assumption that all patients receiving fit notes in the control practices would usually be eligible for a pilot intervention after four weeks of sickness absence. Hence, all control episodes of a period exceeding four weeks in duration were used in the calculation of a new average: the ‘adjusted local norm’. This local adjusted episode’ was used as a type of control group to evaluate the impact on return work (i.e. from period of first contact with the service to any return to work).

Pilot client data

Details of all clients formally discharged by the three pilots in 2012 (1 January to 31 December) were downloaded from the respective service databases. Two entry criteria were applied in order to select client episodes for the impact assessment:

- Only clients on sick leave from their paid employment were included. ‘Presentees’, who were assisted by the pilot to remain in employment, were excluded.
- Only client episodes with recorded information on the employment outcome of the pilot intervention (i.e. returned to work or not after intervention) were included. Episodes where the client was not able to be contacted at follow-up, or where this data was missing from the service database, were excluded from analysis.

Analysis

Associations between a range of client characteristics and various return to work outcomes were investigated. Potential client-based explanatory factors included gender, age, marital status, ethnicity, having dependent children, the agency referring client to the service, the size of client’s employer and the period of certified sickness before first contact.

Client outcomes included (i) any return to work after pilot intervention (ii) for clients returning to work, the length of the total sickness episode, which would include any absence before the pilot referral and (iii) the length of the ‘partial’ episode after initial assessment (i.e. the duration of sickness absence between assessment and return to work). The third outcome, referred to as a ‘partial episode’ was considered particularly relevant to measuring the impact

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

of the intervention itself, i.e. whether a client receiving the intervention returned to work sooner than a sickness absentee not using the service.

Three binary outcomes were computed for each client episode: any return to work after the intervention (no/yes); if returning to work, a total client sickness episode shorter than the 'unadjusted' local norm (no/yes); and a 'partial' client episode shorter than the 'adjusted' local norm (no/yes).

At the univariate level of analysis, the significance of association between client categorical variables and binary outcomes was tested using the chi-square test. For comparing the significance of differences between the median length of client sickness episodes and the median duration of episodes for a similar diagnosis computed from the control data ('local norm' and 'adjusted local norm'), the Wilcoxon signed-rank test was deemed appropriate.

These analyses were conducted separately for each of the three pilots in the assessment.

Finally all data were 'pooled' and logistic regression models were developed and run in order to identify the independent effects of client characteristics on return-to-work outcomes. For each covariate in the models the odds ratio (adjusted for other covariates), 95 per cent confidence interval and associated p-value are reported.

For all tests, univariate and multivariate, a conventional criterion of statistical significance ($P < 0.05$) was assumed. This implies that there is less than five per cent probability that the estimated effects were due to chance.

The results

Greater Manchester

'Completeness' of data

Of 239 client episodes downloaded from the service Management information (MI) database, a total of 172 client (72 per cent) episodes met the criteria (involved absence from normal work and included return to work information) for inclusion in the analysis for the impact assessment. Of those episodes included in the assessment, the client's primary health problem was not known for seven episodes (4.1 per cent) and the information required to compute the duration of the client's certified sickness before the first contact was not available in 23 cases (13.4 per cent).

Of the 102 cases where it was reported that the client had returned to work after the intervention, missing data prevented the computation of the length of a complete episode (onset of sickness absence to return to work) for nine episodes (8.8 per cent). The period from initial assessment to return-to-work could not be computed for two episodes (two per cent).

'Control' fit note episodes

Over the 12-month data collection period at the four general practices in Greater Manchester, information relating to 4,638 fit notes, issued to 1,657 patients, was recorded. A total of 2,181 discrete patient episodes were identified, and allocated to diagnostic categories. Allocation of an episode to a category was based on the type of diagnosis on the majority of fit notes within the episode.

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

Nearly 35 per cent of episodes were due to common mental health conditions (depression 18.6 per cent, stress 6.4 per cent, anxiety 4.5 per cent) (Table C.1). Over nine per cent of episodes were caused by back pain. In terms of the average duration of episodes, patient episodes for depression had a median length of 8.6 weeks, anxiety 4.8 weeks, stress and back problem, both four weeks.

Table C.1 Fit note-based patient episodes in Greater Manchester control practices

Diagnostic category of episode	Certified sickness episodes in category		Median duration
	N	Col %	(weeks) of episode
Mild-moderate mental disorders			
Anxiety	98	4.5	4.8
Depression	405	18.6	8.6
Stress	140	6.4	4.0
Other	112	5.1	8.0
Severe mental disorder	25	1.1	12.7
Back problem	203	9.3	4.0
Other musculoskeletal	74	3.4	8.0
Bone fracture	46	2.1	4.3
Other injury	116	5.3	3.0
Causes of injury	22	1.0	2.0
Infectious/parasitic	63	2.9	1.0
Neoplasm	16	0.7	9.5
Endocrine/nutrition/metabolic	8	0.4	17.6
Haematological	7	0.3	3.7
Nervous system/sense organ	55	2.5	4.0
Circulatory	73	3.3	8.7
Respiratory	161	7.4	1.0
Digestive	70	3.2	1.4
Genitourinary	24	1.1	1.4
Pregnancy/childbirth	47	2.2	2.4
Skin	11	0.5	1.0
Congenital	7	0.3	8.0
Symptoms (without diagnosis)	218	9.9	2.9
Procedures/investigations/treatments	15	0.7	6.0
Post op recovery	161	7.4	4.0
Unclassified	6	0.3	1.9
Total	2,181	100	4.0

Source: Pilot MI and fit note database, 2011 to 2012.

Characteristics of clients in Greater Manchester sample

Of the client episodes included in the assessment, 59 per cent (99/168) were experienced by females, 62 per cent (107/172) by clients aged over 40, 91 per cent (149/163) by those classifying themselves as 'white', 62 per cent (86/138) who were married or cohabiting and 32 per cent (48/149) having one or more children. Nearly 71 per cent (109/155) of the

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

contacts involved clients working for larger (250+ employees) employers. Over 47 per cent (81/172) and 25 per cent (43/172) of episodes were initiated by the Improving Access to Psychological Therapies (IAPT) and a GP respectively. In 49 per cent (74/149) of episodes the client had been absent from normal employment for more than eight weeks before the first contact.

Only 165 client episodes could be allocated to a diagnostic category (Table C.2). Over 32 per cent (n=53) of the sickness absence episodes were due to depression, 19 per cent (n=32) to anxiety, 13 per cent (n=21) to stress and over 20 per cent (n=34) were due to the client being off work with a back or other musculoskeletal problem.

Table C.2 Primary health problems reported by Greater Manchester clients

Category of primary health problem	N	Col %
Mild-moderate mental disorders		
Anxiety	32	19.4
Depression	53	32.1
Stress	21	12.7
Other	4	2.4
Severe mental disorder	1	0.6
Back problem	24	14.5
Other musculoskeletal	10	6.1
Bone fracture	2	1.2
Other injury	3	1.8
Infectious/parasitic	3	1.8
Neoplasm	1	0.6
Endocrine/nutrition/metabolic	1	0.6
Haematological	1	0.6
Nervous system/sense organ	3	1.8
Circulatory	1	0.6
Respiratory	1	0.6
Symptoms (without diagnosis)	4	2.4
Total	165*	100

* Primary health problem not recorded for seven clients.

Source: Pilot MI and fit note database, 2011 to 2013.

Return to work

Overall, 59.3 per cent (102/172) of Greater Manchester client episodes led to a return to work after the intervention. Higher rates of return to work were found when the client was female, aged 40 or under, white, married (or cohabiting), had a dependent child, was referred to the service by a GP or other health professional and worked in a smaller company (Table C.3).

Table C.3 Client characteristics and return to work after Greater Manchester intervention

Client characteristic	No. (%) returning to work after using the pilot	P
Gender		
Male (n=69)	40 (58.0)	0.83
Female (n=99)	59 (59.6)	
Age		
40 or under (n=65)	43 (66.2)	0.15
Over 40 (n=107)	59 (55.1)	
Ethnicity		
White (n=149)	90 (60.4)	0.81
Other (n=14)	8 (57.1)	
Marital status		
Married/cohabiting (n=86)	58 (67.4)	0.4
Single (n=38)	23 (60.5)	
Other (n=14)	7 (50.0)	
Dependent children		
No (n=101)	56 (55.4)	0.12
Yes (n=48)	33 (68.8)	
Agency referring to the pilot		
IAPT (n=81)	44 (54.3)	0.09
GP/other health professional (n=43)	33 (76.7)	
Employer (n=8)	3 (37.5)	
Client self-referral (n=38)	21 (55.3)	
Size of employer		
Under 50 employees (n=19)	14 (73.7)	0.28
50-249 employees (n=27)	14 (51.9)	
250 or over (n=109)	71 (65.1)	
Time between start of current sickness episode and pilot assessment		
Less than 4 weeks (n=47)	38 (80.9)	<0.001
4-8 weeks ((n=28)	19 (67.9)	
Over 8 weeks (n=74)	34 (45.9)	

Source: Pilot MI and fit note database, 2011 to 2013.

However, the only statistically significant association with a return-to-work outcome was for the episode being over eight weeks in duration when the client was first assessed by the pilot. Clients with a longer period of sickness absence prior to contact with the pilot were less likely to return to work after the service intervention. Only 46 per cent of episodes where the client had been absent from work for over eight weeks prior to contact were reported to have resulted in return to work, compared to 76 per cent of those where the client had been off work for a shorter period ($P < 0.001$).

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

In relation to specific client health problems, return to work was highest within the back problem category. Three-quarters of client episodes in this category (18/25) were reported to have a return-to-work outcome for the client (Table C.4).

Table C.4 Primary health problem and return to work (Greater Manchester client episodes)

Category of primary health problem	N	No. (%) reporting a return to work
Anxiety	32	18 (56.2)
Depression	53	34 (64.2)
Stress	21	12 (57.1)
Back problem	24	18 (75.0)
Other musculoskeletal	10	6 (60.0)
Other health problem	25	13 (52.0)

Source: Pilot MI and fit note database, 2011 to 2013.

Length of client sickness episodes

The length of sickness episodes reported by clients who returned to work tended to be considerably longer than those represented by local ‘norms’ generated from the fit note data collected at the four ‘control’ practices. For episodes of anxiety, depression and stress, the differences were statistically significant (Table C.5). It should be noted that in Table C.5 and subsequent tables some of the sample sizes for individual conditions are very small and therefore should be treated with caution.

Table C.5 Period between start of client sickness episode and any return to work: comparison with local diagnosis-related norms (Greater Manchester client episodes)

Category of primary health problem	N returning to work	Duration of total client episode (median weeks)	Local ‘norm’ (median weeks)	P
Anxiety	18	9.3	4.8	0.007
Depression	34	13.0	8.6	0.006
Stress	12	11.8	4.0	0.02
Back problem	18	7.1	4.0	0.07
Other musculoskeletal	6	11.0	8.0	0.79
Other health problem	13	5.8	3.7	0.34
All recorded diagnoses	101	10.8	4.8	0.001

Source: Pilot MI and fit note database, 2011 to 2013.

When considering only the partial episode remaining after the initial assessment by the pilot, residual episodes for depression, back and musculoskeletal problems were significantly shorter than the length of a control episode as represented by the ‘adjusted local norm’ (Table C.6).

Table C.6 Period between Greater Manchester assessment and any return to work: comparison with local diagnosis-related norms

Category of primary health problem	N returning to work	Duration of client episode after pilot assessment (median weeks)	Adjusted local 'norm' (median weeks)	P
Anxiety	18	7.7	9.1	0.81
Depression	34	3.6	8.0	0.03
Stress	12	4.9	6.6	0.88
Back problem	18	2.1	4.7	0.01
Other musculoskeletal	6	2.6	9.3	0.04
Other health problem	13	8.1	8.0	0.82
All recorded diagnoses	101	3.4	8.0	0.03

Source: Pilot MI and fit note database, 2011 to 2013.

Association between client characteristics and early return to work

Of those clients returning to work after the intervention, 28 per cent (26/93) of sickness absence episodes had had a total duration shorter than that of the 'local norm' for a similar diagnosis. When considering only the part of the episode after the initial contact, and comparing it with 'adjusted local norm', the proportion rises to 70 per cent (70/100).

Three client characteristics were significantly associated with the likelihood of a total episode being shorter than the norm (Table C.7):

- Episodes of clients referred to the service by a GP or other health professional were more likely to result in a prompter return to work (49 per cent, compared to 16 per cent of cases referred to the pilot by another agency, $P=0.001$).
- Clients working in smaller organisations who returned to work were more likely to have had an episode shorter than the local norm (77 per cent of episodes experienced by clients returning to work, and working in an organisation with less than 50 employees, were shorter than the local norm, compared to approximately 20 per cent of the episodes of other clients, $P=0.001$).
- Not surprisingly, only one episode that had lasted over four weeks before initial client contact with the pilot, resulted in a return to work prompter than the norm.

Clients working in smaller workplaces and those who had eight or fewer weeks off work prior to their pilot assessment were also had partial episodes that were shorter than the adjusted local norm:

- Only 63 per cent of episodes of clients returning to work to larger organisations (over 250 employers) were shorter than the adjusted norm compared to 86 per cent of other episodes ($P=0.04$).
- Only half of episodes where the client was off work for more than eight weeks before assessment resulted in the partial episode being shorter than the local average duration for the same health problem (compared to 80 per cent of other episodes, $P=0.008$).

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

Table C.7 Characteristics of Greater Manchester clients returning to work and having sickness episode shorter than local norm

Client characteristic	% (n/N) with total episode shorter than local norm for same health problem	p	% (n/N) with partial episode shorter than adjusted local norm for same health problem	p
Gender				
Male	31.6 (12/38)		65.0 (26/40)	
Female	26.9 (14/52)	0.63	73.7 (42/57)	0.36
Age				
40 or under	24.1 (13/54)		70.7 (41/58)	
Over 40	33.3 (13/39)	0.33	69.0 (29/42)	0.86
Ethnicity				
White	30.1 (25/83)		72.7 (64/88)	
Other	16.7 (1/6)	0.48	50.0 (4/8)	0.18
Marital status				
Married/cohabiting	27.8 (15/54)		70.2 (40/57)	
Single	42.9 (9/21)		78.3 (18/23)	
Other	28.6 (2/7)	0.44	71.4 (5/7)	0.76
Dependent children				
No	32.7 (17/52)		72.7 (40/55)	
Yes	22.6 (7/31)	0.33	69.7 (23/33)	0.76
Agency referring to the pilot				
IAPT	7.7 (3/39)		63.6 (28/44)	
GP/other health professional	48.5 (16/33)		78.8 (26/33)	
Employer	0 (0/3)		33.3 (1/3)	
Client self-referral	38.9 (7/18)	0.001	73.7 (14/19)	0.34
Size of employer				
Under 50 employees	76.9 (10/13)		85.7 (12/14)	
50-249 employees	61.5 (8/13)		85.7 (12/14)	
250 or over	12.1 (8/66)	0.001	63.4 (45/71)	0.04
Time between start of current sickness episode and pilot assessment				
Less than 4 weeks	63.2 (24/38)		78.9 (30/38)	
4-8 weeks	5.3 (1/19)		84.2 (16/19)	
Over 8 weeks	0 (0/34)	0.001	50.0 (17/34)	0.008

Source: Pilot MI and fit note database, 2011 to 2013.

North Staffordshire

‘Completeness’ of data

Details of 239 client episodes were downloaded from the service MI database, with 221 (92 per cent) meeting the criteria (involved absence from normal work and included return to work information) for inclusion in the analysis for the impact assessment. Of those episodes included in the assessment, the client’s primary health problem was not known for 11 episodes (5.0 per cent) and the information required to compute the duration of the client’s certified sickness before the first contact was not available in 30 cases (13.6 per cent).

Of the 142 cases where it was reported that the client returned to work after the intervention, missing data prevented the computation of the length of a complete episode (onset of sickness absence to return to work) for six episodes (4.2 per cent). The period from initial assessment to return to work could not be computed for 35 episodes (24.6 per cent).

‘Control’ fit note episodes

Details of 5,591 fit notes (issued to 2,304 patients) were recorded at the six North Staffordshire ‘control’ practices in the 12-month data collection period. A total of 2,865 discrete patient episodes were identified (Table C.8). The highest proportion (29 per cent) related to sickness certification for common mental health conditions: (Depression 13 per cent; Stress ten per cent; Anxiety five per cent). Back and other musculoskeletal problems accounted for nearly 14 per cent of total episodes.

The average (median) length of a depression episode was eight weeks. For anxiety episodes, it was 4.3 weeks, stress three weeks, back problem four weeks and for other musculoskeletal episodes the median duration was 6.6 weeks.

Table C.8 Fit note-based patient episodes in North Staffordshire control practices

Diagnostic category of episode	Certified sickness episodes in category		Median duration (weeks) of episode
	N	Col %	
Mild-moderate mental disorders			
Anxiety	143	5	4.3
Depression	366	12.8	8
Stress	279	9.7	3
Other	49	1.7	8
Severe mental disorder	24	0.8	16.4
Back problem	272	9.5	4
Other musculoskeletal	124	4.3	6.6
Bone fracture	84	2.9	4
Other injury	145	5.1	2
Causes of injury	14	0.5	3
Infectious/parasitic	84	2.9	2
Neoplasm	35	1.2	12
Endocrine/nutrition/metabolic	21	0.7	2.1

Continued

Table C.8 Continued

Diagnostic category of episode	Certified sickness episodes in category		Median duration (weeks) of episode
	N	Col %	
Congenital	12	0.4	12
Symptoms (without diagnosis)	325	11.3	3.4
Procedures/investigations/treatments	30	1	3.1
Post op recovery	250	8.7	4
Unclassified	6	0.2	1.8
Total	2,865	100	4

Source: Pilot MI and fit note database, 2011 to 2013.

Characteristics of clients in North Staffordshire sample

Over 57 per cent (126/221) of episodes were experienced by females, 64 per cent (139/216) by clients aged over 40, 94 per cent (187/199) by those classifying themselves as 'white', 54 per cent (82/151) who were married or cohabiting and 37 per cent (71/193) having one or more children. Nearly 64 per cent (127/200) of the contacts were for clients working for larger (250+ employees) employers. In over 36 per cent (80/221) of cases the client was referred to the service by a GP or other health professional, and in 32 per cent (70/221) of episodes the client referred themselves. In 41 per cent (79/191) of episodes the client had been absent from normal employment for more than eight weeks before the first contact.

Of the 210 episodes where there was information about the client's main health problem, over 32 per cent (n=65) reported that anxiety was the major reason for sickness absence from employment (Table C.9). Depression was cited in 20 per cent (n=42) of cases, and stress in seven per cent (n=14). Musculoskeletal problems (including back problems) accounted for over 20 per cent (n=44) of recorded client episodes.

Table C.9 Primary health problems reported by North Staffordshire clients

Category of primary health problem	N	Col %
Mild-moderate mental disorders		
Anxiety	65	32.1
Depression	42	20.2
Stress	14	6.9
Other	3	1.4
Severe mental disorder	2	0.9
Back problem	23	10.6
Other musculoskeletal	21	9.6
Bone fracture	2	0.9
Other injury	5	2.3
Infectious/parasitic	1	0.5
Endocrine/nutrition/metabolic	1	0.5
Nervous system/sense organ	6	2.8
Circulatory	5	2.3
Digestive	5	2.3
Recovering from operation	4	1.8
Symptoms (without diagnosis)	11	5.0
Total	210*	100

* Primary health problem not recorded for 11 clients.

Source: Pilot MI and fit note database, 2011 to 2013.

Return to work

Over 64 per cent (142/221) of North Staffs client sickness episodes resulted in a return to work after the intervention. Return to work was more likely if the client was female, aged over 40, married (or cohabiting), had a dependent child, was referred to the service by their employer or worked in a larger company (Table C.10).

However, only the period the client had been off work before contact had a statistically significant association with a return to work outcome. Only 54 per cent of episodes where the client had been absent from work for over eight weeks prior to assessment were reported to have resulted in return to work, compared to 72 per cent of those where the client had been off work for a shorter period ($P=0.03$).

In relation to specific client health problems, return to work was highest when the client had been suffering from anxiety. Over 72 per cent of client episodes in this category (47/65) were reported to have a return to work outcome for the client (Table C.11).

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

Table C.10 Client characteristics and return to work after North Staffordshire intervention

Client characteristic	No. (%) returning to work after using the pilot	P
Gender		
Male (n=94)	54 (57.4)	
Female (n=126)	88 (69.8)	0.06
Age		
40 or under (n=77)	44 (57.1)	
Over 40 (n=139)	94 (67.6)	0.12
Ethnicity		
White (n=187)	123 (65.8)	
Other (n=12)	8 (66.7)	0.95
Marital status		
Married/cohabiting (n=82)	58 (70.7)	
Single (n=42)	27 (64.3)	
Other (n=27)	18 (66.7)	0.75
Dependent children		
No (n=122)	75 (61.5)	
Yes (n=71)	52 (73.2)	0.1
Agency referring to the pilot		
IAPT (n=42)	29 (69.0)	
GP/other health professional (n=80)	49 (61.2)	
Employer (n=29)	23 (79.3)	
Client self-referral (n=70)	41 (58.6)	0.21
Size of employer		
Under 50 employees (n=29)	18 (62.1)	
50-249 employees (n=44)	26 (59.1)	
250 or over (n=127)	92 (72.4)	0.2
Time between start of current sickness episode and assessment		
Less than 4 weeks (n=64)	44 (68.8)	
4-8 weeks ((n=48)	37 (77.1)	
Over 8 weeks (n=79)	43 (54.4)	0.03

Source: Pilot MI and fit note database, 2011 to 2013.

Table C.11 Primary health problem and return to work (North Staffs client episodes)

Category of primary health problem	N	N (%) reporting a return to work
Anxiety	65	47 (72.3)
Depression	42	25 (59.5)
Stress	14	8 (57.1)
Back problem	23	16 (69.6)
Other musculoskeletal	21	13 (61.9)
Other health problem	45	30 (66.7)

Source: Pilot MI and fit note database, 2011 to 2013.

Length of client sickness episodes

The length of sickness episodes reported by clients who returned to work tended to be considerably longer than those represented by local ‘norms’ generated from the fit note data collected at the four ‘control’ practices. For all categories of mental health and musculoskeletal problems, the differences were statistically significant (Table C.12).

Compared to average episode length represented by adjusted local norms, partial client episodes (from first service contact to return to work) tended to be significantly shorter when the health problem was depression or a musculoskeletal problem (other than back) (Table C.13).

Association between client characteristics and early return to work

Of those clients returning to work after the intervention, 14 per cent (19/134) of episodes had had a total duration shorter than that of the ‘local norm’ for a similar diagnosis. When considering only the partial episode (after assessment) and the adjusted local norm as a comparator, the proportion rises to 67 per cent (72/107).

Table C.12 Period between start of client sickness episode and any return to work: comparison with local diagnosis-related norms (North Staffs client episodes)

Category of primary health problem	N returning to work	Duration of total client episode (median weeks)	Local ‘norm’ (median weeks)	P
Anxiety	47	12.0	4.4	<0.001
Depression	25	14.5	8.0	<0.001
Stress	8	9.1	3.0	0.02
Back problem	16	10.4	4.0	<0.001
Other musculoskeletal	13	9.0	6.5	0.006
Other health problem	30	8.9	3.4	<0.001
All recoded diagnoses	139	11.1	4.4	<0.001

Source: Pilot MI and fit note database, 2011 to 2013.

Table C.13 Period between North Staffordshire assessment and any return to work: comparison with local diagnosis-related norms

Category of primary health problem	N returning to work	Duration of client episode after assessment (median weeks)	Adjusted local 'norm' (median weeks)	P
Anxiety	47	3.6	4.1	0.56
Depression	25	3.8	8.0	0.03
Stress	8	3.1	5.6	0.11
Back problem	16	3.7	8.0	0.09
Other musculoskeletal	13	2.9	8.0	0.04
Other health problem	30	3.0	6.0	0.02
All recorded diagnoses	139	3.4	6.0	0.02

Source: Pilot MI and fit note database, 2011 to 2013.

Two client characteristics were significantly associated with the likelihood of a total episode being shorter than the norm (Table C.14). Single clients returning to work were likely to return sooner than clients with another marital status. Nearly 35 per cent of single client episodes were shorter than the local norm compared to 11 per cent of the episodes of other clients returning to work ($P=0.02$). The length of the period the client was off work before contact was associated with returning to work sooner. Those episodes where the client had been absent from work for less than four weeks before the pilot tended to be shorter than the norm (24 per cent, compared to five per cent of episodes where the pre-pilot period had been longer).

However, none of the measured client characteristics had any independent significant association with the likelihood of the partial episode (after initial assessment) being shorter than the local adjusted norm.

Table C.14 Characteristics of North Staffordshire clients returning to work and having sickness episode shorter than local norm

Client characteristic	% (n/N) with total episode shorter than local norm for same health problem	p	% (n/N) with partial episode shorter than adjusted local norm for same health problem	p
Gender				
Male	17.6 (9/51)		64.1 (25/39)	
Female	12.0 (10/83)	0.37	69.1 (47/68)	0.56
Age				
40 or under	13.3 (12/90)		64.0 (48/75)	
Over 40	16.7 (7/42)	0.61	73.3 (22/30)	0.36
Ethnicity				
White	12.7 (15/118)		68.1 (64/94)	
Other	42.9 (3/7)	0.09	80.0 (4/5)	0.58

Continued

Table C.14 Continued

Client characteristic	% (n/N) with total episode shorter than local norm for same health problem	p	% (n/N) with partial episode shorter than adjusted local norm for same health problem	p
Marital status				
Married/cohabiting	8.9 (5/56)		63.8 (30/47)	
Single	34.8 (8/23)		72.2 (13/18)	
Other	17.6 (3/17)	0.02	75.0 (9/12)	0.68
Dependent children				
No	19.1 (13/68)		71.2 (37/52)	
Yes	9.6 (5/52)	0.15	59.5 (25/42)	0.24
Agency referring to the pilot				
IAPT	15.4 (4/26)		61.9 (13/21)	
GP/other health professional	14.9 (7/47)		71.8 (28/39)	
Employer	23.8 (5/21)		84.6 (11/13)	
Client self-referral	7.5 (3/40)	0.37	58.8 (20/34)	0.32
Size of employer				
Under 50 employees	6.2 (1/16)		80.0 (8/10)	
50-249 employees	22.7 (5/22)		81.2 (13/16)	
250 or over	12.1 (11/91)	0.28	60.5 (46/76)	0.17
Time between start of current sickness episode and pilot assessment				
Less than 4 weeks	24.4 (10/41)		58.4 (18/31)	
4-8 weeks	11.1 (4/36)		70.0 (21/30)	
Over 8 weeks	0 (0/41)	0.003	68.4 (26/38)	0.56

Source: Pilot MI and fit note database, 2011 to 2013.

Leicester

‘Completeness’ of the data

A sample of 1,337 client episodes was downloaded from the respective service database. Of these 555 (42 per cent) episodes met the criteria (involved absence from normal work and included return to work information) to be included in the analysis for the impact assessment. Of those episodes included in the assessment, the client’s primary health problem was not known for 169 episodes (30.5 per cent) and the information required to compute the duration of the client’s certified sickness before the first contact was not available in 153 cases (27.6 per cent).

Of the 320 cases where it was reported that the client returned to work after the intervention, missing data prevented the computation of the length of a complete episode (onset of sickness absence to return to work) for 165 episodes (51.6 per cent). The period from initial assessment to return to work could not be computed for three episodes (0.9 per cent).

‘Control’ fit note episodes

Eight general practices in Leicestershire collected fit note data for 12 months. Details of 4,638 fit notes, issued to 1,657 patients, were recorded. A total of 2,181 discrete patient episodes were identified, and allocated to diagnostic groups.

Nearly 29 per cent of episodes were due to common mental health disorders (depression 15.1 per cent, stress 9.6 per cent, anxiety 2.4 per cent) (Table C.15). Over ten per cent of episodes were caused by a back problem. In terms of the average duration of episodes, patient episodes for depression had a median length of 6.2 weeks, anxiety 4.4 weeks, stress three weeks and back problem three weeks.

Characteristics of clients in the Leicester sample

Over 52 per cent (282/545) of pilot sickness absence episodes were experienced by females, 64 per cent (343/539) by clients aged over 40, 77 per cent (421/546) by those reporting themselves to be ‘white’, 62 per cent (277/445) who were married or cohabiting and 38 per cent (117/310) reported having one or more children. Over 70 per cent (367/523) of the contacts were for clients working for larger (250+ employees) employers. A GP or other individual health professional referred clients to the service in over 84 per cent (468/555) of cases. In 31 per cent (124/402) of episodes the client had been absent from normal employment for more than eight weeks before the initial assessment.

Of the 386 episodes where the client’s health problem was recorded, nearly 28 per cent (n=106) reported that depression was the main illness causing sickness absence from work. (Table C.16). Stress was cited in 26 per cent (n=99) of cases, and anxiety in eight per cent (n=33). Back and other musculoskeletal problems accounted for 15 per cent (n=58) of recorded client episodes.

Table C.15 Fit note-based patient episodes in Leicester control practices

Diagnostic category of episode	N	Col %	Median duration (weeks) of episode
Anxiety	133	2.4	4.4
Depression	851	15.1	6.2
Stress	542	9.6	3
Other	86	1.5	7.4
Severe mental disorder	54	1	12
Back problem	569	10.1	3
Other musculoskeletal	232	4.1	4.4
Bone fracture	189	3.3	4
Other injury	336	5.9	2
Causes of injury	41	0.7	2
Infectious/parasitic	166	2.9	1
Neoplasm	69	1.2	12
Endocrine/nutrition/metabolic	40	0.7	3.4
Haematological	15	0.3	4
Nervous system/sense organ	158	2.8	3.8
Circulatory	109	1.9	7.9

Continued

Table C.15 Continued

Diagnostic category of episode	N	Col %	Median duration (weeks) of episode
Respiratory	408	7.2	1
Digestive	156	2.8	1.7
Genitourinary	100	1.8	2.1
Pregnancy/childbirth	122	2.2	2.3
Skin	79	1.4	3
Congenital	34	0.6	20
Symptoms (without diagnosis)	535	9.5	2.3
Procedures/investigations/treatments	86	1.5	2.5
Post op recovery	502	8.9	3
Unclassified	39	0.7	2
Total	5,651	100	3.4

Source: Pilot MI and fit note database, 2011 to 2013.

Table C.16 Primary health problems reported by Leicester clients

Category of primary health problem	N	Col %
Mild-moderate mental disorders		
Anxiety	33	8.3
Depression	106	27.6
Stress	99	25.6
Other	1	0.3
Severe mental disorder	2	0.5
Back problem	48	12.4
Other musculoskeletal	10	2.6
Bone fracture	2	0.5
Other injury	24	6.3
Infectious/parasitic	4	1.0
Endocrine/nutrition/metabolic	2	0.5
Nervous system/sense organ	2	0.5
Circulatory	5	1.3
Respiratory	5	1.3
Digestive	1	0.3
Pregnancy-related	1	0.3
Skin	1	0.3
Congenital	1	0.3
Recovering from operation	5	1.0
Symptoms (without diagnosis)	34	8.9
Total	386*	100

* Primary health problem not recorded for 169 clients.

Source: Pilot MI and fit note database, 2011 to 2013.

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

Return to work

Over 58 per cent (320/555) of Leicester client sickness episodes resulted in a return to work after the intervention.

None of the measured characteristics of the client had a statistically significant association with a subsequent return to work (Table C.17).

When considering specific diagnoses, the sub-group of episodes of clients suffering from reported stress had the highest proportion resulting in a return to work (62 of 99 episodes, 62 per cent) (Table C.18).

Table C.17 Client characteristics and return to work after Leicester intervention

Client characteristic	No. (%) returning to work after using the pilot	P
Gender		
Male (n=263)	149 (56.7)	0.78
Female (n=282)	163 (57.8)	
Age		
40 or under (n=196)	114 (58.2)	0.82
Over 40 (n=343)	196 (57.1)	
Ethnicity		
White (n=421)	242 (57.5)	0.73
Other (n=125)	74 (59.2)	
Marital status		
Married/cohabiting (n=277)	163 (58.8)	0.1
Single (n=113)	55 (48.7)	
Other (n=55)	35 (63.6)	
Dependent children		
No (n=193)	111 (57.5)	0.69
Yes (n=117)	70 (59.8)	
Agency referring to the pilot		
IAPT (n=76)	46 (60.5)	0.36
GP/other health professional (n=468)	265 (56.6)	
Employer (n=1)	1	
Client self-referral (n=10)	8 (80.0)	
Size of employer		
Under 50 employees (n=78)	37 (47.4)	0.11
50-249 employees (n=78)	48 (61.5)	
250 or over (n=367)	219 (59.7)	
Time between start of current sickness episode and pilot assessment		
Less than 4 weeks (n=181)	125 (69.1)	0.6
4-8 weeks ((n=97)	71 (73.2)	
Over 8 weeks (n=124)	83 (66.9)	

Source: Pilot MI and fit note database, 2011 to 2013.

Table C.18 Primary health problem and return to work (Leics client episodes)

Category of primary health problem	N	N (%) reporting a return to work
Anxiety	33	18 (54.5)
Depression	106	59 (55.7)
Stress	99	62 (62.5)
Back problem	48	23 (47.9)
Other musculoskeletal	10	4 (40.0)
Other health problem	90	45 (50.6)

Source: Pilot MI and fit note database, 2011 to 2013.

Length of client sickness episodes

The length of sickness episodes reported by pilot clients who returned to work tended to be considerably longer than those represented by local ‘norms’ generated from the fit note data collected at the eight ‘control’ practices. For episodes of anxiety, depression, stress and back problem, the differences were statistically significant (Table C.19).

When comparing the partial episode (remaining after the initial assessment by the pilot) with the length of adjusted control practice episodes, the residual pilot episodes tended to be shorter than the local norm when the problem causing sickness absence was musculoskeletal in nature. (Table C.20).

Table C.19 Period between start of client sickness episode and any return to work: comparison with local diagnosis-related norms (Leics client episodes)

Category of primary health problem	N returning to work	Duration of total client episode (median weeks)	Local ‘norm’ (median weeks)	P
Anxiety	18	8.9	4.4	0.003
Depression	59	12.9	6.2	<0.001
Stress	62	9.0	3.0	<0.001
Back problem	23	7.9	3.0	0.002
Other musculoskeletal	4	9.0	4.4	0.11
Other health problem	45	12.3	2.9	<0.001
All recorded diagnoses	211	10.0	3.0	<0.001

Source: Pilot MI and fit note database, 2011 to 2013.

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

Table C.20 Period between assessment and any return to work: comparison with local diagnosis- related norms (Leics client episodes)

Category of primary health problem	N returning to work	Duration of client episode after assessment (median weeks)	Adjusted local 'norm' (median weeks)	P
Anxiety	18	6.6	6.3	0.59
Depression	59	6.7	8.0	0.32
Stress	62	5.4	4.6	0.06
Back problem	23	6.1	8.0	0.02
Other musculoskeletal	4	3.6	8.8	0.04
Other health problem	45	5.6	6.0	0.86
All recorded diagnoses	211	6.9	6.0	0.89

Source: Pilot MI and fit note database, 2011 to 2013.

Table C.21 Characteristics of clients returning to work and having sickness episode shorter than local norm

Client characteristic	% (n/N) with total episode shorter than local norm for same health problem	p	% (n/N) with partial episode shorter than adjusted local norm for same health problem	p
Gender				
Male	6.8 (5/74)		53.4 (55/103)	
Female	17.9 (14/78)	0.04	56.6 (60/106)	0.64
Age				
40 or under	11.5 (6/52)		57.0 (45/79)	
Over 40	11.6 (11/95)	0.99	50.8 (62/122)	0.39
Ethnicity				
White	14.4 (17/118)		52.7 (88/167)	
Other	6.5 (2/31)	0.24	64.1 (25/39)	0.2
Marital status				
Married/cohabiting	10.8 (10/93)		53.4 (70/131)	
Single	11.1 (3/27)		61.5 (25/39)	
Other	22.7 (5/22)	0.3	62.5 (15/24)	0.54
Dependent children				
No	9.1 (5/55)		49.4 (41/83)	
Yes	14.6 (7/48)	0.39	64.4 (38/59)	0.08

Continued

Table C.21 Continued

Client characteristic	% (n/N) with total episode shorter than local norm for same health problem	p	% (n/N) with partial episode shorter than adjusted local norm for same health problem	p
Agency referring to the pilot				
IAPT	4.0 (1/25)		54.5 (18/33)	
GP/other health professional	14.3 (18/127)	0.34	55.4 (97/177)	0.48
Size of employer				
Under 50 employees	18.8 (3/16)		54.5 (12/22)	
50-249 employees	14.3 (3/21)		62.1 (18/29)	
250 or over	11.4 (12/105)	0.69	53.4 (79/148)	0.69
Time between start of current sickness episode and pilot assessment				
Less than 4 weeks	22.0 (18/82)		55.9 (52/93)	
4-8 weeks	0 (0/31)		53.2 (25/47)	
Over 8 weeks	2.6 (1/39)	0.001	52.6 (30/57)	0.91

Source: Pilot MI and fit note database, 2011 to 2013.

Association between client characteristics and early return to work

Of those clients returning to work after the intervention, 13 per cent (19/152) of sickness absence episodes had had a total duration shorter than that of the 'local norm' for a similar diagnosis. When comparing only the part of the episode after initial contact with the adjusted local norm, the proportion rises to 55 per cent (115/210).

A significantly higher proportion of the episodes of females returning to work were shorter than similar episodes found within the local patient population (18 per cent of female client episodes versus seven per cent of male episodes, $P=0.04$). As may be anticipated, the vast majority of episodes shorter than the norm involved a short (< 4 week) pre-pilot period of sickness absence. However, none of the measured client characteristics had any independent significant association with the likelihood of the partial episode (after initial assessment) being shorter than the local adjusted norm. (Table A3.21).

Pooled data from the three pilots

The final stage of the impact assessment involved pooling the available client data from Greater Manchester ($n=172$), North Staffordshire ($n=221$) and Leicestershire ($n=555$) in order to identify any client characteristics that may be important in achieving positive return to work outcomes (regardless of the model of service delivery).

Any return to work

A significantly higher proportion of clients with dependent children had episodes leading to a subsequent return to work after the intervention (Table C.22). Nearly 66 per cent of episodes of sickness absence experienced by clients with children led to a positive outcome compared to 58 per cent of the episodes of clients with no dependants ($P=0.04$). Higher proportions of client episodes that had not reached eight weeks in duration before initial contact resulted in a return to work (72 per cent, compared to 58 per cent of episodes that had already passed the eight week threshold, $P<0.001$).

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

Table C.22 Pooled data: Client characteristics and return to work after pilot intervention

Client characteristic	No (%) returning to work after using the pilot	P
Gender		
Male (n=426)	243 (57.0)	
Female (n=507)	310 (61.1)	0.2
Age		
40 or under (n=442)	267 (60.4)	
Over 40 (n=485)	283 (58.4)	0.52
Ethnicity		
White (n=757)	455 (60.1)	
Other (n=151)	90 (59.6)	0.91
Marital status		
Married/cohabiting (n=445)	279 (62.7)	
Single (n=193)	105 (54.4)	
Other (n=96)	60 (62.5)	0.13
Dependent children		
No (n=416)	242 (58.2)	
Yes (n=236)	155 (65.7)	0.04
Agency referring to the pilot		
IAPT (n=199)	119 (59.8)	
GP/other health professional (n=593)	348 (58.7)	
Employer (n=38)	27 (71.1)	
Client self-referral (n=118)	70 (59.3)	0.52
Size of employer		
Under 50 employees (n=126)	69 (54.8)	
50-249 employees (n=149)	88 (59.1)	
250 or over (n=603)	382 (63.3)	0.16
Time between start of current sickness episode and pilot assessment		
Less than 4 weeks (n=292)	207 (70.9)	
4-8 weeks ((n=173)	127 (73.4)	
Over 8 weeks (n=277)	160 (57.8)	<0.001

Source: Pilot MI and fit note database, 2011 to 2013.

Return to work episodes shorter than the local norm

For those clients returning to work in the three pilot areas, four facets of the total sickness episode were significantly associated with a return to work sooner than patients in the local control practices (Table C.23). Significantly lower proportions of married (or cohabiting) clients returned to work within the threshold set by the local norm (14 per cent, compared to 26 per cent of clients with another marital status, $P=0.04$). Only nine per cent of episodes where engaged with the pilot was initiated by a IAPT referral led to a relatively prompt return to work, compared to 19 per cent of episodes where referral was by another agency ($P=0.001$). A higher proportion of sickness episodes experienced by clients working in smaller organisations (<250 employees) were shorter than the local norm (27 per cent, compared to 12 per cent of those of clients returning to work in larger organisations, $P=0.001$). The shorter a client had been off work prior to their involvement with the pilot the more likely they were to return to work sooner than the local average. Episodes where the client had been off work for less than four weeks before the assessment were more likely to be shorter than the local norm (32 per cent, compared to three per cent of episodes where the client sickness absence before the pilot had lasted four weeks or more, $P=0.001$).

When considering only the partial episode outcome (period from the pilot assessment to return to work), a significantly lower proportion of episodes of clients working in larger organisations (250 employees or more) were shorter than the adjusted local norm for a similar health problem (nearly 58 per cent, compared to 70 per cent of partial episodes experienced by employees in smaller companies, $P=0.04$).

Table C.23 Pooled data: Characteristics of clients returning to work and having sickness episode shorter than local norm

Client characteristic	(n/N) with total episode shorter than local norm for same health problem	P	% (n/N) with partial episode shorter than adjusted local norm for same health problem	P
Gender				
Male	16.0 (26/163)		58.2 (106/182)	
Female	17.8 (38/213)	0.63	64.5 (149/231)	0.19
Age				
40 or under	15.8 (31/196)		63.2 (134/212)	
Over 40	17.6 (31/176)	0.64	58.2 (113/194)	0.31
Ethnicity				
White	17.9 (57/319)		61.9 (216/349)	
Other	13.6 (6/44)	0.49	63.5 (33/52)	0.83
Marital status				
Married/cohabiting	14.8 (30/203)		59.6 (140/235)	
Single	28.2 (20/71)		68.8 (55/80)	
Other	21.7 (10/46)	0.04	67.4 (29/43)	0.27
Dependent children				
No	20.5 (35/175)		62.1 (118/190)	
Yes	14.5 (19/131)	0.21	64.2 (86/134)	0.7

Continued

Table C.23 Continued

Client characteristic	(n/N) with total episode shorter than local norm for same health problem	P	% (n/N) with partial episode shorter than adjusted local norm for same health problem	P
Agency referring to the pilot				
IAPT	8.9 (8/90)		60.2 (59/98)	
GP/other health professional	19.9 (41/206)		61.1 (151/248)	
Employer	20.0 (5/25)		70.6 (12/17)	
Client self-referral	17.2 (10/58)	0.001	63.0 (34/54)	0.85
Size of employer				
Under 50 employees	31.1 (14/55)		69.6 (32/46)	
50-249 employees	28.6 (16/56)		72.9 (43/59)	
250 or over	11.8 (31/262)	0.001	57.6 (170/295)	0.04
Time between start of current sickness episode and pilot assessment				
Less than 4 weeks	32.3 (52/161)		61.7(100/162)	
4-8 weeks	5.8 (5/86)		64.6 (62/96)	
Over 8 weeks	0.9 (1/114)	0.001	56.6 (73/129)	0.45

Source: Pilot MI and fit note database, 2011 to 2013.

Logistic regression: Independent effects of client characteristics

Three logistic regression models were run in order to estimate the independent effects of the range of client episode characteristics on outcome (ie controlling for all other covariates in the respective model). (Table C.24).

Based on combined data from all three pilots, the probability of returning to work sooner than the local average is significantly higher for employees from small and medium-sized enterprises (SMEs) and medium-sized employers, than for employees from large employers with over 250 employees (see Table C.23). Restricting analysis to the clients of the three pilots, clients were significantly less likely to return to work after the pilots when:

- The client had no dependent children. The odds of returning to work were 66 per cent higher for clients with dependent children.
- The client was referred by their GP or '[an]other healthcare professional'. Compared to clients referred by their employers, the odds of returning to work were 78 per cent lower for clients referred by their GP or 'another healthcare professional'. The difference in odds of returning to work between employer referrals, self-referrals and IAPT referrals is not statistically significant.
- The client had spent more than eight weeks off work before their initial assessment. The odds of returning to work were 55 per cent lower for clients who had been absent from work for more than eight weeks before contact with the pilots. The difference in odds of returning to work is not significantly different for clients who had been off work for less than four weeks and those who had been off work for four to eight weeks.

When the client had returned to work, the odds of the total period of sickness absence being shorter (than that of patients in local control practices) was lower when the client was a worker in a larger organisation. Compared to the reference category (organisations of less than 50 employees), the odds of the total episodes of clients working in larger companies (>250 employees) being shorter than the local norm were significantly lower (OR=0.33, P=0.03). Longer periods of pre-pilot sickness absence significantly reduced the odds of the total episode being shorter than the local norm for a similar diagnosis.

Clients with musculoskeletal conditions are significantly more likely to return to work sooner than the local adjusted norm. Specifically, the odds of returning to work sooner than the local average were twice as high for clients with musculoskeletal conditions compared with clients with common mental health conditions.

Table C.24 Pooled data: Independent association between client characteristics and a return to work after the intervention

Client characteristic	Clients returning to work					
	Any return to work OR (95 % CI)	P	Total episode shorter than local norm OR (95 % CI)	P	Partial episode shorter than adjusted local norm OR (95 % CI)	P
Type of health problem						
Mental health	1	0.82	1		1	
Musculoskeletal	0.94 (0.52-1.68)		1.09 (0.40-3.0)	0.87	2.11 (1.01-4.82)	0.04
Other	0.92 (0.50-1.69)	0.79	0.72 (0.12-4.46)	0.72	0.70 (0.27-1.79)	0.45
Gender						
Male	1		1		1	
Female	1.32 (0.85-2.03)	0.22	1.86 (0.79-4.38)	0.16	1.45 (0.82-2.54)	0.2
Age						
40 or under	1		1		1	
Over 40	0.85 (0.60-1.22)	0.38	0.48 (0.21-1.12)	0.09	0.89 (0.51-1.57)	0.7
Ethnicity						
Non-White	1		1		1	
White	1.56 (0.81-3.01)	0.18	0.66 (0.16-2.71)	0.57	1.48 (0.57-3.85)	0.42
Marital status						
Married/cohabiting	1		1		1	
Single	0.89 (0.52-1.54)	0.68	2.29 (0.86-6.15)	0.1	1.29 (0.64-2.62)	0.48
Other	1.18 (0.61-2.28)	0.62	1.38 (0.47-4.04)	0.56	1.52 (0.65-3.53)	0.33

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

Table C.24 Continued

Client characteristic	Clients returning to work					
	Any return to work OR (95 % CI)	P	Total episode shorter than local norm OR (95 % CI)	P	Partial episode shorter than adjusted local norm OR (95 % CI)	P
Dependent children						
No	1		1		1	
Yes	1.66 (1.05-2.65)	0.03	0.58 (0.25-1.36)	0.21	1.41 (0.78-2.23)	0.25
Agency referring to the pilot						
Employer	1		1		1	
Self-referral	0.23 (0.05-1.18)	0.08	2.19 (0.19-24.6)	0.53	0.76 (0.12-4.86)	0.77
IAPT	0.21 (0.04-1.09)	0.06	0.66 (0.05-8.75)	0.75	0.57 (0.09-3.64)	0.57
GP/other health professional	0.22 (0.05-0.99)	0.04	1.99 (0.19-20.6)	0.57	0.59 (0.10-3.52)	0.56
Size of employer						
Under 50 employees	1		1		1	
50-249 employees	0.89 (0.42-1.93)	0.78	1.75 (0.48-6.38)	0.4	1.36 (0.45-4.12)	0.59
250 or over	1.08 (0.57-2.02)	0.82	0.33 (0.12-0.92)	0.03	0.58 (0.25-1.39)	0.22
Time between start of sickness episode and pilot assessment						
Less than 4 weeks	1		1		1	
4-8 weeks	0.92 (0.52-1.65)	0.78	0.16 (0.05-0.52)	0.002	1.15 (0.56-2.39)	0.69
Over 8 weeks	0.45 (0.27-0.73)	0.001	0.03 (0.01-0.21)	0.001	0.60 (0.31-1.16)	0.14

Source: Pilot MI and fit note database, 2011 to 2013.

Appendix D

EQ5D health improvement scores*

Area	Mean difference in EQ-5D 5L Score	Std. Deviation	N
Greater Manchester	0.125	0.199	563
Inner North West London	0.238	0.296	75
Leicester	0.233	0.303	636
North Staffs	0.176	0.243	115
Nottinghamshire	0.137	0.243	72
Scotland	0.331	0.282	514
Total	0.221	0.277	1,975
Gender			
Male	0.232	0.283	880
Female	0.213	0.271	1,070
Total	0.221	0.277	1,950
Size of employer			
<10	0.296	0.289	279
10 to 49	0.270	0.268	279
50 to 249	0.244	0.277	385
250+	0.179	0.266	941
Don't know	0.164	0.299	48
Missing	0.195	0.286	41
Total	0.221	0.277	1,973
Health condition at entry assessment			
Depression	0.158	0.251	256
Anxiety	0.181	0.254	222
Stress	0.229	0.260	233
Other mental health condition	0.164	0.226	19
Back	0.270	0.301	372
Lower limb	0.307	0.269	170
Upper limb/neck	0.249	0.270	214
Chronic Fatigue/ME/Fibromyalgia	0.021	0.258	23
Neurological condition	0.134	0.239	20
Other condition	0.137	0.285	80
Total	0.217	0.263	1,647
Access to Occupational Health			
No	0.254	0.276	821
Yes	0.160	0.230	466
Total	0.219	0.265	1,287

* Average difference between EQ5D score on entry and score on discharge.