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Evaluation of In-Work Support

Final report

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Evaluation of In-Work Support

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Abbreviations

ABMU	Abertawe Bro Morgannwg University Health Board
ARC	Assisting Recovery in the Community
BME	Black and Minority Ethnic
CBT	Cognitive Behavioural Therapy
CCT	Cross-cutting themes
CITB	Construction Industry Training Board
CQFW	Credit and Qualifications Framework for Wales
DWP	Department for Work and Pensions
ESF	European Social Fund
FSB	The Federation of Small Businesses
FfW	Fit for Work
GP	General Practitioner
HR	Human Resources
IES	Institute for Employment Studies
IWS	In-Work Support
JCP	Jobcentre Plus
MSK	Musculoskeletal
NHS	National Health Service
RCS	Rhyl City Strategy
SME	Small and medium sized enterprises
ToC	Theory of Change
WEFO	Welsh European Funding Office
WLHCs	Work-Limiting Health Conditions

1. Introduction

1.1 In-Work Support (IWS) is a Welsh Government and European Social Fund (ESF) funded programme which began in September 2015 and is funded for a three-year period until the end of August 2018. The operation has been allocated £4.4m funding, of which £3.0m is ESF funding and £1.4m is Welsh Government funding.

1.2 The operation's objectives are to tackle poverty and social exclusion in West Wales and the Valleys by reducing sickness absenteeism and presenteeism rates in the workplace. IWS takes a preventative approach that is intended to curb job losses resulting from work-limiting health conditions (WLHCs). The IWS operation supports absentees (participants who have reached or are expected to reach four weeks of sickness absence) and presentees (participants who are at risk of long-term sickness absence) with rapid access to work-focused physical and/or psychological therapies, with support from a case manager. It also provides workshops to General Practitioners (GPs) to help healthcare providers to address patients' work-related health problems. A further strand involves workshops for small and medium sized enterprise (SME) managers and employees to help improve workplace health and wellbeing.

1.3 Abertawe Bro Morgannwg University Health Board (ABMU) delivers IWS across three south Wales local authority areas[1], while Rhyl City Strategy (RCS) is responsible for delivery in four north Wales local authority areas[2].

1.4 In 2017, the Welsh Government appointed OB3 Research and the Institute for Employment Studies (IES) to evaluate the IWS operation.

1.5 The aims of the evaluation are to:

- develop a logic model to assess the relationships between the elements of the programmes and theory of change
- assess fidelity of the project against the business plan and logic model, considering how much of the intervention was delivered, were activities delivered as intended and were there any unintended outcomes
- review routine monitoring data

[1] Swansea, Neath Port Talbot and Bridgend
[2] Anglesey, Gwynedd, Conwy and Denbighshire

- assess and determine how successfully the project followed the strategy laid out in the logic model
- assess the perceived impact of intervention upon participants
- assess progress against cross cutting themes
- identify lessons learnt and offer recommendations for future delivery.

1.6 The evaluation took place in five stages between May 2017 and August 2018. In Stage 1, the research team gathered relevant data and prepared a refined methodological approach, detailed in the Inception Report. Stage 2 involved the development of a Theory of Change (ToC) for IWS, set out in the Theory of Change report[3]. The ToC is designed to test whether IWS' interventions are working in the way that was originally intended and has informed the subsequent phases of the evaluation. Stage 3 to 5 focused on the process evaluation and involved the preparation of research instruments, sampling of beneficiaries to inform the fieldwork as well as a package of fieldwork with stakeholders, staff, participants, employers and GPs.

1.7 This report synthesises the findings of the evaluation. It sets out to address the following objectives:

- to assess and compare the implementation of the operation in two areas, for absentee and presentee participants
- to assess and compare the implementation of the operation in two areas, for professionals, employers, GPs and other local stakeholder organisations
- to assess and compare the project management of the operation in two areas
- to assess perceived impact and usefulness of the services provided.

[3] Welsh Government (2018) Evaluation of In-Work Support (IWS) Theory of Change

Structure of this report

1.8 This report is presented in 11 chapters.

- Chapter one: Introduction to the report
- Chapter two: An outline of the evaluation methodology adopted for the process evaluation and the profile of those who contributed to the fieldwork
- Chapter three: An overview of the IWS operation, drawing upon the findings of the Theory of Change report, and a review of project achievements and performance to date
- Chapter four: An analysis of participant monitoring data
- Chapter five: Fieldwork findings in terms of the underlying rationale and need for IWS
- Chapter six: Fieldwork findings in terms of the implementation models deployed
- Chapter seven: Fieldwork findings in relation to the engagement and recruitment of clients, GPs and employers
- Chapter eight: Fieldwork findings on the services and experiences of clients
- Chapter nine: Findings of the fieldwork on the services and experiences of employers
- Chapter ten: Fieldwork findings relating to IWS's cross-cutting themes objectives
- Chapter eleven: Our conclusions and recommendations.

2. Methodology

2.1 This chapter sets out the method deployed for undertaking the evaluation and offers a view about the strengths and limitations of the approach adopted. The chapter also offers a profile of professionals, clients and employers who contributed to the evaluation.

Method

2.2 The evaluation, which was undertaken between November 2017 and June 2018, encompassed the following elements of work:

- attending an inception meeting with the study Steering Group in November 2017 to confirm the work programme and discuss access to operation level monitoring data and contact data, and confirming this within an updated work programme
- desk based research which included a review of operation level documentation and monitoring data. In the case of RCS, this also involved reviewing a sample of participant files
- preparing research instruments which included semi-structured discussion guides for use with a range of contributors including project staff, therapists, clients, employers as well as local stakeholder organisations including GP practices
- accessing anonymised datasets for participants supported by RCS and ABMU and drawing out a representative sample of participants to be approached for interview
- conducting interviews with 15 individuals involved with the management and delivery of IWS at RCS (including six case co-ordinators and six therapists) mostly on a face to face basis
- conducting face to face interviews with 10 individuals involved with the management and delivery of IWS at ABMU (including six therapists)
- conducting qualitative (mostly) telephone interviews with a total of 53 clients (35 of whom were supported by RCS and 18 by ABMU)
- conducting interviews with a total of 15 employers (11 of whom were supported by RCS and four supported by ABMU)

- interviewing ten representatives from local stakeholder organisations (eight of whom had collaborated with RCS and two who had collaborated with ABMU)
- conducting interviews or obtaining written feedback from a total of 12 representatives from GP and medical practices (eight of whom had collaborated with RCS and four who had collaborated with ABMU)
- synthesising the findings of the fieldwork and desk-based research and preparing this peer-reviewed final evaluation report.

Methodological considerations

2.3 In terms of interviewing clients, 53 interviews were achieved against a target of 60 (35 RCS clients and 25 ABMU clients). In the case of RCS, an initial sample of 70 clients was selected for interview and a further sample of 35 contacts was obtained in order to achieve the target set. The client sample selected was representative of the overall database by local authority (Conwy, Denbighshire, Gwynedd and Anglesey), type (absentee or presentee) and nature of support accessed (counselling or musculoskeletal (MSK) support). The sample was restricted to those participants who had registered with the operation during 2017 on the basis that their recall of the service would be better.

2.4 It proved challenging to achieve the target number of interviews set out for ABMU clients within the evaluation timescale despite first requesting such data in August 2017. The evaluation team was initially informed by the ABMU that the study would require National Health Service (NHS) Research Ethics approval, however it was later agreed that this would not be required. In addition, appropriate information sharing protocols between the Welsh Government and ABMU had to be agreed. Further delays in accessing the data in a timely manner, possibly accounted for by the lack of staff resources, meant that an anonymised dataset was not shared with the evaluation team until December 2017 and contact data for the selected sample of clients to approach for interview (50 in all) only provided in April 2018. The client sample selected was representative of the overall database by local authority (Swansea, Neath Port Talbot, Bridgend and Carmarthenshire), whether they were on sick leave or not and their primary health condition (emotional health, mental health, musculoskeletal issues). As was the case for RCS clients, the sample was restricted to those who had been referred to the operation during 2017. In all, 18

interviews were achieved from this sample and the tight timescales did not allow for a further sample to be identified and approached for interview (as had been the case for RCS). Of the 18 interviews achieved with ABMU clients, eight reported that they had not received any support from the operation. As a result, care needs to be taken when interpreting the views of these interviewees given that the sample of interviewed clients (at 10) who had received the service is very small.

2.5 In terms of fieldwork with representatives from GP and medical practices (including practice managers), only 12 of 24 target interviews were achieved, despite making contact with some 43 practices in all, the majority of whom were contacted on three occasions. The contributions included a small number of individuals who provided written feedback via email. It proved challenging to secure input from this group due to several factors not least due to GP's busy schedule and difficulties making appointments to interview them but also due to their relatively limited involvement with IWS in many instances. Some care needs to be taken when interpreting the views of contributing GPs as it is likely that those who have been most engaged with IWS and attach the greatest value to it have been more inclined to contribute than others.

2.6 Finally, the sample of employers and local stakeholders (other than GP and medical practices) provided by ABMU was limited in number which made it impossible to achieve the target number of employer and local stakeholder interviews agreed. In all for ABMU, contact details were provided for only eight employers and six local stakeholder organisations. Some care should therefore be taken when interpreting the findings from these contributors.

Profile of interviewed clients

2.7 Of the 35 RCS clients interviewed:

- 27 were female and eight were male
- 16 were based in Conwy, five in Denbighshire, seven in Gwynedd and seven in Anglesey
- all but one were recorded as being of white ethnicity and none were recorded as having a disability
- nine recorded their preferred language as Welsh and 26 recorded it as English

- 34 were employed and one was self-employed
- 26 had come to hear of the service via their GP, four via their therapist, two via their employer and two via other methods
- 10 were recorded as absentees and 25 as presentees
- 11 were recorded as having accessed counselling support and 24 as physiotherapy support.

2.8 Of the 18 ABMU clients interviewed:

- 11 were female and eight were male
- three were based in Bridgend, one in Carmarthenshire, six in Neath Port Talbot and eight in Swansea
- all were recorded as being of white ethnicity and none were recorded as having a disability
- all recorded English as being their preferred language
- 17 were employed and one was self-employed
- 12 had come to hear of the service via their GP or another healthcare professional, five via their work or manager and one via word of mouth
- eight were recorded as being inactive (i.e. an absentee) and 10 were recorded as active (i.e. a presentee)
- seven were recorded as being in receipt of emotional health support and 11 in receipt of MSK support.

2.9 The profile of interviewed clients was broadly in line with those supported by the IWS operation when considering their residing local authority, their ethnicity profile and how they had come to hear of the service. In terms of the primary health condition reported by clients and the type of service accessed, the profile of RCS interviewed clients was well aligned with the overall client population whilst the profile of ABMU interviewed clients was over-represented by participants reporting MSK primary health conditions. A higher proportion of female interviewees and a lower proportion of disabled interviewees contributed to the research compared to the overall profile of supported clients.

3. An overview of the IWS operation

3.1 This chapter provides an overview of the IWS operation and summarises some of the key findings of the Theory of Change report. It then considers IWS's achievements and performance to date over its 30-month delivery period since the start of September 2015, drawing upon the outcomes reported to the Welsh European Funding Office (WEFO) as at the end of May 2018.

The IWS operation

3.2 The IWS operation was designed to support a total of 4,232 participants (both employed and self-employed individuals) with a work-limiting health condition or disability. Participants were expected to fall into one of two categories: 'absentees' and 'presentees'. Absentees were defined as participants who had reached or were expected to reach four weeks of sickness absence whist presentees were defined as those who were at risk of long-term sickness absence. In total, it was expected that 1,640 absentees and 2,592 presentees would be supported by the operation.

3.3 It was also expected that half of all absentees supported (820) would return to work and that 65 per cent (533) would remain in work at six months after return, whilst 60 per cent (492) would remain in work at twelve months after return. For presentees, it was expected that half (1,296) would have an improved labour market situation as a result of the intervention and that 70 per cent (907) would remain in work at six months after exiting the programme and that 65 per cent (842) would remain in work at twelve months after intervention.

3.4 The project was designed to focus on participants who were employed (or self-employed) within the private and third sector (76 per cent of participants were anticipated to come from these sectors) as it was assumed that public sector workers were more likely to have access to occupational health provision.

3.5 The IWS operation was also designed to engage with and support SME employers and employees through workshops and programmes to help managers and employees to manage their own and their employee's health and wellbeing more effectively, and to raise awareness of WLHCs or disabilities in the workplace. It was intended that the operation engage with a total of 1,050 SMEs and that 1,950 employees of SME would be supported via this provision. It was expected that half

of these SMEs (525) would implement effective sickness absence and health policies and practices.

Key findings of the Theory of Change report

3.6 The overarching Theory of Change model for IWS is set out in the Theory of Change report[4]. This model describes the key principles that underpins IWS' design, IWS' target participants, the 'levers of change' (activities) and underlying assumptions.

3.7 The report found that the IWS operation had been appropriately informed by the latest policy and research evidence on best practice about work and health, including the work of Waddell and Burton[5], and Dame Carol Black[6], as well as programme delivery evidence, such as Fit for Work and RCS' and ABMU's earlier programmes. On this basis, the IWS operation had been designed so as to:

- allow multiple referral routes for participants to access the service
- provide early or rapid intervention
- deliver work-focused health therapies
- offer flexible and personalised provision according to the needs of participants and informed by a biopsychosocial assessment
- offer a voluntary service for participants who wanted to return or remain in work.

3.8 The report found that the key outcomes which could be expected to be achieved for absentees and presentees accessing the service included:

- employees taking fewer days off sick and returning to work quicker than otherwise possible
- reduced long-term absences (defined as a continuous period of four weeks or more)
- reduced unemployment amongst those with a WLHC

[4] Evaluation of In Work Support Operation: theory of change
[5] Waddell G and Burton KA (2006) Is Work Good for your Health and Well-being and Waddell G and Burton KA (2004) Concepts of Rehabilitation for the Management of Common Health Problems
[6] Black, C (2008) Working for a Healthier Tomorrow - Dame Carol Black's Review of the Health of Britain's Working Age Population

- employees securing improved health, wellbeing and financial circumstances
- reduced demand on NHS and reduced benefit claims
- higher tax receipts.

3.9 However, the report also found that it was difficult to define the outcomes which presentees could be expected to achieve as there was a lack of consistency in terms of how presenteeism was defined and what constituted improved labour market situations for this group.

3.10 Another key finding of the report was that IWS had been designed in a way which allowed GPs to refer participants from Fit for Work (FfW) with a Return-to Work Plan. It was expected that absentees would be identified via this route. However FfW generated few referrals to IWS during its first year of delivery and the operation had to identify other means of generating absentee referrals to the operation.

Performance against funded targets

3.11 The IWS operation had one output and four result indicators to achieve as a condition of its WEFO funding, set out in Table 3.1. As at May 2018, with a final three-month period of delivery remaining, the operation had exceeded one of these by some margin, was slightly underperforming against a second and was severely under-performing against its remaining three indicators.

Table 3.1: IWS operation achievements against WEFO funded outputs and results (May 2018)

	Programme Target	Achieved to Date 31.5.2018	Target achieved as % of programme target
Output indicator			
Employed participants (incl. self-employed) with work-limiting health condition or disability	4,232	3,410	81%
Result indicators			
Supported enterprises having adopted or improved equality and diversity strategies and monitoring systems	525	33	6%
Employed participants (incl. self-employed) with work limiting health condition or disability with an improved labour market situation upon leaving	1,296	2,189	169%
Employed participants (incl. self-employed) with work-limiting health condition or disability returning to work after a period of absence	820	171	21%
Workplace health programmes	130	33	25%

Source: IWS Operation Quarterly Progress Report to WEFO (1 September 2015 to 31 May 2018)

3.12 Despite initial difficulties in generating absentee referrals to the operation as a result of the issues relating to FfW, IWS had achieved 81 per cent of its overall participant engagement target by May 2018. Whilst it would be unrealistic to expect the operation to achieve its overall target for engaging participants during the remaining three-month funding period it would be feasible to expect the operation to achieve approximately 90 per cent of this target by the end of August 2018[7]. The operation does not report upon the overall split of participants by absentee and presentee characteristics to WEFO[8] although the latest quarterly report notes that for 2,884 RCS participants, 79 per cent (2,281) were presentees and 21 per cent (603) were absentees. The split between absentees and presentees of ABMU clients is offered at Chapter 4 of this report and shows that 47 per cent were absentees and 53 per cent were presentees.

3.13 The operation has performed exceptionally well against its target of participants reporting an improved labour market situation upon leaving the intervention. It is noteworthy that 64 per cent of all participants reported an improved labour market

[7] On the basis of supporting some 120 new participants per month over the remaining three month period.
[8] Further consideration is given to the profile of participants in Chapter 4 of the report, based upon an analysis of the operation's datasets

situation upon leaving the operation, against a target of 30 per cent doing so. The operation has been less successful in achieving its target of participants returning to work after a period of absence, having only achieved a fifth of its overall target to date.

3.14 The operation has also struggled in relation to its two funded targets for supporting employers to either adopt or improve their equality and diversity strategies and monitoring systems as well as to implement workplace health programmes, having only achieved six per cent and 25 per cent of the operation's targets to date. This significant under-performance can be primarily accounted for by the fact that the operation's provision to employers does not meet WEFO's requirements for recording outputs against these targets i.e. the provision of awareness raising and training workshops to employers will not necessarily result in a change or improvement to an employer's equality and diversity strategy or their workplace health programme. The operation has in fact worked with a greater number of employers and their employees but these activities have not been reported e.g. in the case of RCS a total of 104 employers and 215 employees have been involved in employer-related training.

Expenditure

3.15 As at the end of May 2018, the operation had spent 75 per cent of its overall three-year budget (£3.3m of £4.4m) and had drawn down £2.3m of its £3.0m ESF funding allocation.

3.16 In light of this underspend, it is understood that at the time of drafting WEFO was reviewing a revised IWS business plan in order to extend the operation until December 2022.

4. Participant level monitoring data

4.1 This chapter offers an analysis of 2,766 IWS participants. A database of IWS RCS clients was received on 26 October 2017 and contained 2,024 entries. A database of IWS ABMU clients referred to the service up to the end of November 2017 was received in December 2017 and contained 742 entries.

Employment profile

4.2 The majority of IWS clients (87 per cent) were employed when they came into contact with the IWS service as shown in Table 4.1. A higher proportion of RCS' clients were self-employed when they came into contact with the service.

Table 4.1: Client employment status at start of IWS intervention

	RCS		ABMU	
	Number	%	Number	%
Employed	1691	84%	713	96%
Self-employed	333	16%	28	4%
Volunteering	0	0%	1	<1%
Total	2024	100%	742	100%

Source: RCS Database (October 2017) and ABMU Database (December 2017)

4.3 The majority of IWS clients were employed in the private sector when they came into contact with the IWS service, although the proportion varied between RCS and ABMU clients, as shown in Table 4.2. Just over a third of ABMU clients were working in the public sector compared with only 13 per cent of RCS clients. Overall, 81 per cent of IWS clients were from the private or third sector which is higher than the 76 per cent who were anticipated to come from these sectors.

Table 4.2: Client's employer at start of IWS intervention

	RCS		ABMU	
	Number	%	Number	%
Private	1759	87%	404	54%
Public	265	13%	273	37%
Third	n/a	n/a	65	9%
Total	2024	100%	742	100%

Source: RCS Database (October 2017) and ABMU Database (December 2017)

Geographical profile

4.4 In terms of geography, Table 4.3 shows that RCS IWS clients are widely distributed across the eligible four north west local authorities. Conwy accounts for the largest number of clients and Anglesey accounts for the fewest. A small number of clients have been supported outside of the eligible local authority areas.

Table 4.3: RCS Client's Local Authority

	Number	%
Conwy	767	38%
Denbighshire	548	27%
Gwynedd	404	20%
Isle of Anglesey	278	14%
Flintshire	25	<1%
Outside of Wales	2	<1%
Total	2024	100%

Source: RCS Database (October 2017)

4.5 ABMU's IWS clients are equally well distributed across three of the four eligible local authority areas, as shown in Table 4.4. Bridgend accounts for the largest proportion (at 34 per cent). Carmarthenshire accounts for a very small proportion of all clients (at 2 per cent). In all, some 15 clients (less than one per cent) have been supported from outside the eligible geographical area.

Table 4.4: ABMU Client's Local Authority

	Number	%
Bridgend	249	34%
Swansea	234	32%
Neath Port Talbot	226	30%
Carmarthenshire	18	2%
Powys	5	<1%
Rhondda Cynon Taf	4	<1%
Cardiff	3	<1%
Vale of Glamorgan	1	<1%
Newport	1	<1%
Caerphilly	1	<1%
Total	742	100%

Source: ABMU Database (December 2017)

Demographic profile

4.6 The age profile of IWS clients is similar for RCS and ABMU clients. Over half of RCS IWS clients were born in the 1970s and 1960s (i.e. access the service in their 40s or 50s), as shown in Table 4.5. Data for ABMU clients is presented as age, rather than the date of birth, as shown in Table 4.6, and so cannot be directly compared with RCS clients. However, half of ABMU clients are aged in their 40s or 50s when accessing the service. The operation had a target of 30 per cent of participants being aged 54 and above - the analysis suggests that this has been achieved.

Table 4.5: RCS clients' year of birth

	Number	%
1990s	210	10%
1980s	377	19%
1970s	486	24%
1960s	622	31%
1950s	279	14%
1940s or earlier	48	<1%
No data	2	<1%
Total	2024	100%

Source: RCS Database (October 2017)

Table 4.6: Age of ABMU clients when referred to service

	Number	%
>20	3	<1%
20s	110	15%
30s	149	20%
40s	219	30%
50s	213	29%
60s	48	6%
Total	742	100%

ABMU Database (December 2017)

4.7 Overall, 57 per cent of IWS clients are female (1,584 of 2,766) and 43 per cent are male, as shown in Table 4.7. The proportions are similar for ABMU and RCS clients and are in keeping with the operation's funded target of 55 per cent of clients being women.

Table 4.7: Client gender

	RCS		ABMU	
	Number	%	Number	%
Female	1148	57%	436	59%
Male	876	43%	306	41%
Total	2024	100%	742	100%

Source: RCS Database (October 2017) and ABMU Database (December 2017)

4.8 Overall, four per cent of IWS clients are disabled and the proportion varies from a low of two per cent in the case of RCS to 10 per cent in the case of ABMU clients, as shown in Table 4.8.

Table 4.8: Client disability

	RCS		ABMU	
	Number	%	Number	%
Disabled	48	2%	72	10%
Not disabled	1795	89%	370	90%
Did not disclose	181	9%	0	0%
Total	2024	100%	742	100%

Source: RCS Database (October 2017) and ABMU Database (December 2017)

4.9 In terms of ethnicity, 1.7 per cent of IWS clients are of a Black and Minority Ethnic (BME) background and a slightly higher proportion of ABMU clients are recorded as such, as shown in Table 4.9. The overall proportion is just short of the operation's target of two per cent of participants coming from a BME background.

Table 4.9: Client ethnicity

	RCS		ABMU	
	Number	%	Number	%
Black and Minority Ethnic (BME)	29	1%	17	2%
White	1995	99%	725	98%
Total	2024	100%	742	100%

Source: RCS Database (October 2017) and ABMU Database (December 2017)

4.10 The majority of IWS clients (86 per cent) preferred to access the service in English, as shown in Table 4.10, and this was much higher at 99 per cent in the case of ABMU clients. Only three ABMU clients wanted to access the service in Welsh.

4.11 A higher proportion of RCS IWS clients had Welsh language skills despite not wanting to access the service in Welsh. For instance, 809 clients (40 per cent) understood Welsh, 671 (33 per cent) spoke Welsh, 626 (31 per cent) could read

Welsh and 574 (28 per cent) could write in Welsh. No comparative data was available for ABMU clients.

Table 4.10: Client's preferred language

	RCS		ABMU	
	Number	%	Number	%
English	1653	82%	738	99%
Welsh	371	18%	3	<1%
Total	2024	100%	742	100%

Source: RCS Database (October 2017) and ABMU Database (December 2017)

4.12 Data on clients' household composition and the proportion of clients with dependents were made available for RCS clients only. Tables 4.11 and 4.12 show that just under a fifth of RCS clients were living in a single adult household and that the majority (at 68 per cent) did not have any dependents. Based upon this analysis of RCS clients only, the operation has exceeded its target of supporting five per cent of participants with care or childcare responsibilities by some margin, at 32 per cent.

Table 4.11: RCS Clients living in single adult household

	Number	%
Yes	367	18%
No	1650	82%
Did not disclose	7	<1%
Total	2024	100%

Source: RCS Database (October 2017)

Table 4.12: RCS Clients with dependants

	Number	%
None	1368	68%
Child/children under 18	552	27%
Old Person/People (65 & over)	39	2%
Disabled Adult (18 & over)	30	1%
Child/children under 18 and Disabled Adult (18 & over)	15	<1%
Child/Children under 18 and Old Person/People (65 and over)	7	<1%
Disabled Adult (18 & over) & Old Person/People (65 & over)	8	<1%
Did not disclose	5	<1%
Total	2024	100%

Source: RCS Database (October 2017)

4.13 Finally, data on participants' highest qualification was made available for RCS clients. The data, set out at Table 4.13, shows that clients have a wide range of qualifications although very few have none or qualifications at Level 1 or below on the Credits and Qualifications Framework for Wales (CQFW) whilst a third have a qualification at Level 5 or above.

Table 4.13: RCS Clients' highest qualification

	Number	%
None	138	7%
Below CQFW Level 1	17	<1%
CQFW Level 1	71	4%
CQFW Level 2	404	20%
CQFW Level 3	503	25%
CQFW Level 4	213	11%
CQFW Level 5	168	8%
CQFW Level 6	298	15%
CQFW Level 7	162	8%
CQFW Level 8	47	2%
Did not disclose	3	<1
Total	2024	100%

Source: RCS Database (October 2017)

Nature of service accessed

4.14 An analysis of the monitoring datasets shows that 75 per cent of IWS clients are presentees and 25 per cent are absentees. This compares with the operation's target of 61 per cent being presentee and 39 per cent being absentee clients. There are considerable differences in the proportions by contracted provider. Table 4.14 shows that 83 per cent of RCS IWS clients are considered to be 'presentees' at the point when they first come into contact with the service and only 17 per cent are considered 'absentees'. By comparison just over half of ABMU clients are considered presentees.

Table 4.14: Status at start of IWS intervention

	RCS		ABMU	
	Number	%	Number	%
Presentees	1674	83%	396	53%
Absentees	350	17%	346[9]	47%
Total	2024	100%	742	100%

Source: RCS Database (October 2017) and ABMU Database (December 2017)

[9] Defined as clients on 'sick leave'

4.15 The type of service most commonly accessed by RCS clients is physiotherapy, reported as having been accessed by two-thirds of RCS' clients, as shown in Table 4.15.

Table 4.15: Type of service accessed by RCS clients

	Number	%
Physiotherapy	1389	69%
Counselling	601	30%
Physiotherapy and Counselling	21	1%
Drugs and Alcohol	10	<1%
Counselling and Addictions	3	<1%
Total	2024	100%

Source: RCS Database (October 2017)

4.16 Data covering the primary condition for ABMU clients was made available (but not the type of service accessed). Table 4.16 shows that 70 per cent of ABMU clients accessed emotional health support.

Table 4.16: Primary condition of ABMU clients

	Number	%
Emotional Health	522	70%
MSK/Muscular Skeletal	156	21%
Mental health	51	7%
Other	3	<1%
Total	742	100%

ABMU Database (December 2017)

Hearing about the service

4.17 Table 4.17 shows that the most common method of coming to hear about IWS was via GPs, identified by 75 per cent of all RCS clients and 31 per cent of ABMU clients. Other methods were less important overall, although healthcare professionals and occupational health professionals played an important referral role in the case of ABMU clients. The Fit for Work (FFW) service accounted for less than 1 per cent of all referrals to the IWS in the case of RCS clients.

Table 4.17: Method of hearing about IWS

	RCS		ABMU	
	Number	%	Number	%
GPs	1521	75%	229	31%
Therapist	167	8%		
Employer or colleague (incl. Human Resources (HR))	132	7%	123	17%
Other healthcare professional			225	30%
Occupational Health			60	8%
Family, friend or word of mouth	123	6%	39	5%
Other	37	2%		
RCS or ABMU staff	15	<1%		
Fit for Work	15	<1%		
Marketing	13	<1%	59	8%
Website	1	<1%	1	<1%
Accessed service before			6	<1%
Total	2024	100%	742	100%

Source: RCS Database (October 2017) and ABMU Database (December 2017)

4.18 In terms of referral sources, the most common method of being referred to IWS was self-referral, identified by 97 per cent of all RCS clients and 92 per cent of ABMU clients, as shown in Table 4.18:

Table 4.18: Referral sources to IWS

	RCS		ABMU	
	Number	%	Number	%
Self-referral	1957	97%	674	92%
Family/Friend	32	<1%	0	0%
Employer	18	<1%	2	<1%
GP	10	<1%	5	<1%
Other	7	<1%	3	<1%
Other healthcare professional	n/a	n/a	41	6%
FFW	n/a	n/a	6	<1%
Total	2024	100%	731	100%

Source: RCS Database (October 2017) and ABMU Database (December 2017)

Referral and speed of accessing service

4.19 The first client referral was taken by ABMU in September 2015 whilst the first client referral to RCS took place in November 2015. In the case of RCS during 2016 1,099 clients were referred to the service and 911 were referred to it over the course of the first 10 months of 2017. In the case of ABMU 85 clients were

supported during the September – December 2015 period, with 256 referred to the service during 2016 and 401 during the first 11 months of 2017.

Table 4.19: Clients referred to the IWS Service

	RCS		ABMU	
	Number	%	Number	%
2015	12	<1%	85	11%
2016	1,099	54%	256	35%
2017	911[10]	45%	401[11]	54%
Total	2,024	100%	742	100%

Source: RCS Database (October 2017) and ABMU Database (December 2017)

4.20 As shown in Table 4.20 the majority (85 per cent) of ABMU IWS clients were inactive (i.e. discharged) at the end of November 2017 whilst 15 per cent were still 'live' cases.

Table 4.20: Status of ABMU IWS clients on database at end of November 2017

	Number	%
Active	110	15%
Inactive	632	85%
Total	742	100%

ABMU Database (December 2017)

4.21 An analysis of RCS database shows that on average, clients were seen by a therapist or counsellor within 10 days of having been referred to the service. During early 2017 the waiting time to see a therapist/counsellor increased e.g. during the first three months of 2017 the average waiting time for clients was 17 days. No such comparable data was available for ABMU clients.

Duration of service

4.22 In terms of the duration of service, the average duration between starting to see a therapist and a client's last appointment with RCS was as follows:

- based on data for 1,584 RCS clients who had been discharged from IWS as at October 2017, on average each client had been supported over a period of 56 days (i.e. on average, just under two months per client)

[10] January - October
[11] January – November

- the duration varied from one RCS client to the next - 51 were seen and discharged on the same day whilst 117 were supported over a duration of 100 days or more (i.e. more than three months).

4.23 For ABMU IWS clients, the average duration between being referred to the programme and being discharged was as follows:

- based on data for 608 ABMU clients who had been discharged from IWS as at the end of December 2017, on average each client had been supported over a period of 79 days (i.e. on average, just over 2.5 months per client)
- the duration of service for ABMU clients varied – 161 clients were supported over a duration of 100 days or more (i.e. more than 3 months).

4.24 In terms of the number of therapy sessions accessed by clients, data for 1,551 RCS clients showed that on average clients had accessed 5.4 sessions each. The number of therapy sessions varied from one to 16 per client. Less than 10 per cent of RCS clients (157 of 1,584) were recorded as being early leavers i.e. clients who had voluntarily withdrawn from the service before accessing all therapy sessions to which they were entitled.

4.25 ABMU provided data on the number of telephone assessments undertaken with clients, the number of telephone and face to face sessions accessed and the number of group sessions attended. Overall, based on data for 632 clients:

- 581 clients had one telephone assessment and 41 had two telephone assessments each
- 361 ABMU clients received telephone based services, ranging from one to eight sessions each but averaging two sessions per client
- 105 ABMU clients received face to face based services, ranging from one to 12 sessions each but averaging just under two sessions per client
- 99 of the 632 ABMU clients participated in group based sessions, attending between one and nine sessions each, averaging four sessions per client[12].

[12] These clients would also have been entitled to access individual telephone or face to face services.

Outcomes

4.26 Of the 350 absentee clients supported, RCS' database reported that 123 were known to have returned to work at the point of being discharged: however, it is important to note that not all absentee clients on the database had been discharged from the service at the time of analysis, therefore the final rate of returning to work is not known. Of those clients on the database, 1,417 were known to have reported that their health or labour market status had improved at the point of being discharged.

4.27 For ABMU IWS clients, information on the work status of 543 discharged clients was made available. Of these, 425 were in work and 118 were not at the time of analysis.

4.28 Of the 1,042 RCS clients who had been discharged from IWS up until 31 March 2017 (i.e. allowing for a six month window to enable RCS to conduct a follow up survey):

- 560 (54 per cent) were known to be in employment six months after leaving the project and 17 (2 per cent) were not. Of those in employment the vast majority (96 per cent or 535 clients) were presentees. No information was available for the remaining 465 (45 per cent) clients
- 511 (49 per cent) were known to have an improved health or labour market position 6 months after leaving the service. 61 (6 per cent) were not. No information was available for the remaining 470 (45 per cent) clients.

4.29 Data gathered as part of the initial and end assessment for 815 RCS clients was analysed. The assessment, based upon the Health Star approach, covered eight key areas of life and clients were asked to score each element between 1 and 10. The eight areas assessed were managing mental health and wellbeing, accommodation, physical health, social, cultural and spiritual, finance and money, relationships, work and occupation, and confidence. The analysis for 815 RCS clients showed that:

- overall, 629 RCS clients reported a reduction in the scores provided between the initial and end assessment (i.e. they reported an improvement to these aspects of their lives). 17 clients reported no change and the remaining 168 clients reported an increasing score (i.e. that these aspects of their lives had worsened)

- considering the three main elements which IWS could be expected to impact the greatest it was found that:
    - in terms of work and occupation, data for 821 RCS clients showed that on average clients reported a reduction of 2.9 across this aspect of their life. In all, 627 clients reported an improvement, 96 showed no change and the remaining 98 reported worsening of their condition
    - in terms of physical health data for 824 RCS clients, the data showed that on average clients reported a reduction of 2.3 across this aspect of their life. In all, 582 clients reported an improvement, 97 showed no change and the remaining 145 reported worsening of their condition
    - in terms of managing mental health and wellbeing data for 823 RCS clients, the data showed that on average clients reported a reduction of 2.0 across this aspect of their life. In all 536 clients reported an improvement, 147 reported no change and the remaining 140 reported worsening of their condition.

4.30 Data was made available by ABMU on the health outcomes of supported clients using the EQ5D Outcome Measurement tool[13]. Each ABMU client was asked to complete the EQ-5D health questionnaire pre and post intervention. Clients were required to indicate which statements best described their health in relation to five dimensions (e.g. mobility, self-care) on the day in question. Clients could select one of five options for each health dimension and a score of between 1 and 5 was then allocated to each response, with one being the best health score and 5 being the worst score.

4.31 An analysis of outcomes data made available for a total of 671 clients who provided a pre and post score for all five dimensions of the EQ-5D elements is shown at Table 4.21. The data has been analysed in line with guidance issued by the Office of Health Economics[14]. It shows that the greatest area of positive change between pre and post intervention, identified by over half of ABMU clients, was an improvement to levels of anxiety or depression followed by an improvement to being able to undertake usual activities, cited by under half of ABMU clients. The smallest positive change was observed across the dimensions of self-care and mobility. Indeed 80 per cent or higher of ABMU clients reported no change against these

[13] The EQ-5D is a patient-reported outcome measure that captures five dimensions of health-related quality of life: mobility, self-care, usual activities, pain/discomfort and anxiety/depression
[14] See 5 Things You Should Do with EQ-5D Data

dimensions. A small minority (12 per cent or 79 clients) reported no change across any one of the five EQ-5D dimensions.

Table 4.21: Change in ABMU EQ-5D health outcomes

	% reporting deterioration	% reporting no change	% reporting improvement
Anxiety/depression	6%	41%	53%
Usual activities	7%	47%	46%
Pain/discomfort	10%	59%	31%
Mobility	6%	80%	14%
Self-care	4%	87%	9%

Source: ABMU, Base = 671 clients (November 2018)

4.32 In addition to these dimensions, all ABMU clients were also asked to rate how good or bad their health was on the day in question using a scale of 0 to 100, with 100 being the best health possible. An analysis of data for 649 clients who provided a score both before and after intervention showed that the average score increased from 63.2 to 78.4, demonstrating a positive improvement.

Satisfaction with the service

4.33 Table 4.22 presents the average scores provided by RCS clients about the service accessed. The findings paint a positive experience with a number of average scores calculated at 4.9. A slightly lower average score was provided by clients in terms of their satisfaction with the result of intervention, at 4.6.

Table 4.22: RCS clients levels of satisfaction with service

	Average score given (from 1 to 5)
Overall impression of IWS (n=838)	4.9
Friendliness, knowledge and willingness to help (n=838)	4.9
Timescales of accessing the service? (n=836)	4.9
How case co-ordinator supported client during their time in the IWS (n=836)	4.9
Overall experience received from therapist/provision (n=839)	4.8
Advice/treatment given (n=839)	4.8
Process of accessing Fit for Work first and receiving a Return to Work Plan (n=103)	4.7
Satisfaction with result of intervention (n=836)	4.6

Source: RCS Database (October 2017)

4.34 As shown in Table 4.23, very high proportions of RCS clients were satisfied with the service accessed. No comparable data was available for ABMU clients.

Table 4.23: RCS clients levels of satisfaction with service

	Proportion agreeing
Whether they would recommend service to others (n=839)	99% (827)
Whether they felt comfortable in the premises treatment was provided (n=839)	99% (832)
Whether IWS helped them to return to work quicker than if they had not accessed service (n=486)	95% (463)

Source: RCS Database (October 2017)

5. Rationale and need

5.1 This chapter considers the views of management staff and front-line delivery staff (including therapists) based at both RCS and ABMU as well as local stakeholder organisations about the underlying rationale and need for the IWS service.

Purpose of IWS

5.2 The fieldwork revealed that management and front-line delivery staff as well as local stakeholder organisations have a consistent view that the purpose of the IWS operation is to keep employees in work or get them back into work after a period of ill-health. The focus of the intervention was also believed to be about helping clients to better manage their health conditions on an ongoing basis. Indeed, several therapists emphasised the importance of this element of the operation adding that IWS had a role to play in 'educating clients about their lifestyles and to cope with their health condition'. The service was consistently viewed as being focused on supporting clients with one of two health related issues in the main, namely emotional health and musculoskeletal conditions.

5.3 Many of these contributors also emphasised the purpose of IWS as a service which provides the earliest possible intervention to clients, on the basis that early intervention will lead to quicker health improvement outcomes and thus quicker return to work periods. A few front-line delivery staff were eager to stress however that the focus of the service was on getting individuals to return to work when ready and appropriate to do so, as opposed to the emphasis being on 'as soon as possible':

'the quickest return to work is not always the best approach. Neither should we encourage an individual not to go off work, if that is what they need.'

5.4 It was also emphasised during the course of the fieldwork that the health related issues experienced by IWS clients ought to be mild to moderate in nature. However, in reality several staff and therapists argued that IWS had in fact supported clients with a much broader range of health issues, with some of them being severe in nature. This, it was suggested, had been due to the fact that the majority of referrals to the operation came via GPs and these clients will have already identified health difficulties and taken the decision to seek medical support. Staff and therapists

frequently argued that GPs will take the view that clients with moderate to severe health symptoms stand to benefit from IWS intervention, despite the intervention being limited and time bound, because of the long waiting times to access mainstream support.

5.5 Another important purpose of the operation was thought to be around supporting employer organisations, and SMEs in particular. It was frequently suggested that IWS had been designed so as to support SMEs who did not have any formal occupational health and human resources provision and in this respect it was noted that the operation could add significant value to these employers who lacked the necessary expertise or resources. It was also reported that IWS had an important function to support individuals as self-employed business owners, particularly in the case of RCS (where a higher proportion of service users are indeed self-employed people as set out at Chapter 4). Some contributors observed that it was a shame that the operation had not been designed to support employees based within larger businesses or public sector organisations, although in reality it was acknowledged that these type of clients did form a minority of participants.

Equalities driven

5.6 Contributors expressed a mixed view as to whether IWS is considered to be an equalities driven intervention. On the one hand several management and front-line delivery staff observed that the service is open to all and that eligibility is not means-tested in any way. Indeed, it was acknowledged by a few project staff that some clients who were accessing IWS could probably afford to pay for similar private sector services in the absence of the service.

5.7 Contributors also emphasised that the service can be accessed by all individuals who are in work regardless of their demographic profile or whether they fall into any particular 'disadvantaged' group. However, others were keen to note that tackling health inequalities and supporting the Welsh Government's in-work poverty agenda represented a 'fundamental building block' for the operation. Contributors based at RCS also reported upon their efforts to actively target IWS to those employees based within low paid and 'blue collar' sectors such as construction, care, tourism and retail. It was argued that supporting individuals who were living in poverty and

deprivation was a fundamental objective for RCS and that this ethos had been applied to the delivery of IWS.

5.8 In the same manner it was suggested that the higher than average levels of dependency upon welfare benefits across the region served by ABMU meant that clients supported via IWS would naturally come from more disadvantaged backgrounds and that in this sense the operation was viewed as being one which had equality embedded into it by default.

Need

5.9 The fieldwork suggested that there is a substantial need for IWS and the evidence presented for this by contributors was two-fold. First, contributors argued that there is a real lack of alternative services which clients could turn to in the absence of the operation. It was observed that the waiting times for NHS funded therapy services was lengthy and it was not unusual to hear from front-line delivery staff that individuals could expect to wait up to 12 months for similar support via the NHS. In addition, contributors drew upon the lack of appropriate employer funded occupational health support for employees as evidence of need given that local employers were largely dominated by micro businesses and SMEs.

5.10 Across north Wales, GP practices who contributed to the evaluation suggested that there were some alternative non NHS services in place for those with mental health issues, such as Parabl[15] and Mind[16] although one of these was considered to offer a 'quite limited [service] and [there] can be a wait'. However, none of them could identify any other alternative physiotherapy services for patients, other than what was being provided via the NHS.

5.11 Second, it was also frequently argued that the high level of demand which had materialised for IWS, particularly across north-west Wales, was further evidence that there was a need for the operation. In this respect several contributors argued that it had been appropriate for the operation to have geared up to support clients with the two biggest health conditions which affected their ability to work, namely Musculoskeletal (MSK) conditions and mental health related issues.

[15] Parabl website
[16] Mind website

5.12 One recurring theme to have been raised over the course of the fieldwork related to the underlying rationale for limiting IWS to eight local authority areas only. Whilst it is understandable that the IWS has been made available in those areas served by the two providers, several contributors suggested that it would be logical to offer it at a pan-Wales basis in the future as the need for the service was equally as great in other parts of Wales.

5.13 There was also a strong and clear message from across GPs, local stakeholder groups and clients that IWS should continue as an ongoing intervention as they did not perceive that the need for intervention would slow down in the immediate future. Many interviewees expressed their concerns about the possible withdrawal of the service. For instance one north-west GP practice was of the opinion that:

'to lose this system will lead to more unemployment and other secondary physical and mental health issues and financial problems which affects not just the patient but their surrounding close/extended families.'

6. Implementation models

6.1 This chapter sets out to assess and compare the implementation models adopted by the operation across the two areas served by RCS and ABMU. The chapter presents the local governance arrangements, local management and delivery arrangements and monitoring processes in place.

6.2 The IWS operation is led by the Welsh Government who employ a small core team to oversee the work of the two contracted delivery providers. Contributors broadly welcomed the role of the Welsh Government as lead sponsor for the initiative, not least as this had removed financial cash-flow challenges experienced by one provider during previous ESF funded provision. However, a few contributors, whilst welcoming of the approach, recognised that it bought with it the disadvantage of not being able to deal directly with WEFO in relation to queries.

The RCS model

6.3 The delivery of the IWS operation across north-west Wales is currently overseen by the RCS Board. An IWS project steering group was initially established, evolving from the steering group which had been in place for the predecessor Fit for Work pilot. However, the steering group was disbanded once the service became fully established in light of members' views that its ongoing contribution would add little value to the service.

6.4 The IWS operation across north-west Wales is managed by a small team based within RCS, a not for profit organisation which aims to help people fulfil their potential through work. The service is overseen by the Operational Director and managed by the Operational Manager. The core team also includes a Business Development Manager who is responsible for employer and local stakeholder liaison and a team of five administrators. Seven non-medical case co-ordinators are employed to oversee and deal with clients accessing the services working from premises in Conwy, Gwynedd and Denbighshire.

Use of contracted providers

6.5 Client services are provided via a team of contracted therapists who are used on an 'as and when basis'. Interviewed therapists typically support between six and 20 RCS clients at any given time. These contractors were sourced at the outset of the

project via a competitive tendering process and in all up to 24 contractors were appointed to the delivery framework.

6.6 The feedback on the procurement of contracted therapists and counsellors was very positive: staff raised awareness of these opportunities amongst potential local suppliers across the region and actively worked with partners such as Business Wales to promote tendering opportunities. One therapist reported:

'I was approached by Business Wales. I'd never tendered before but had done similar projects for the NHS'.

6.7 As a result of the procurement process, it was thought that a good geographical and linguistical coverage of contractors was obtained other than across south Gwynedd where it proved impossible to appoint a local provider. Some of the contracted providers had worked for RCS on previous initiatives whilst a few contractors who contributed to the evaluation observed that this had been their first tendering exercise and that the IWS operation had enabled them to strengthen their own business sustainability and in some cases, expand their practices.

6.8 It was also suggested that the model of using contracted providers was cost-effective in that contractors were only being used when and where they were needed. It was also argued that it allowed the service to include an element of 'client choice' when deciding upon a therapist.

6.9 Feedback from RCS staff and contracted providers suggests that the implementation model and its management by the core team at RCS is appropriate and highly efficient. The relationships between the RCS core team and its contracted therapists were considered to be 'very good' and 'effective'. Therapists frequently commented upon the 'well run' management of the operation and the 'good levels of communication' in place between them and the core team. They also believed the operation to be 'very efficient ... with any issues sorted and resolved very quickly'. One therapist added:

'the fact that RCS sits outside the medical sector means it can be a more caring establishment. Its an ethical organisation and is run professionally. It's also very small and can respond quickly to any issues'.

6.10 Contracted therapists were also positive in their views about the opportunities to collaborate and share experiences with each other, adding that the 'team approach' had been a strength of the programme and had been helpful in addressing the isolated manner of working often associated with therapy and counselling.

The client journey

6.11 The client journey has been articulated clearly by RCS, as set out in Annex A, and feedback from core staff and contracted providers suggest that internal processes have been well considered and in place from the outset of the service. Indeed, it was suggested that having clear processes and client documentation from the start had been a real strength of the operation across north-west Wales.

6.12 Clients who contact the service will typically deal with a member of the administrative team in the first instance, who will undertake a basic eligibility check to ensure that callers are either employed or self-employed and live or work within one of the eligible local authority areas. An appointment will be made for the client to meet with a case co-ordinator who will, during that face to face meeting, complete an eligibility check based on the paperwork provided by the client, as well as complete a registration form and initial assessment. The case co-ordinator will provide the client with information about the team of therapists and counsellors available and the client is able to make an informed choice about which provider they wish to access. An onward referral to the provider is made by the case co-ordinator who is then expected to contact the client within a 48 hour period to arrange an initial assessment and, as appropriate, ongoing therapy sessions. The contracted therapist is expected to meet with the client within a five day period.

6.13 Clients are able to access up to six face to face sessions with their chosen therapist and these are arranged directly between the client and therapist. Contracted providers are expected to share a copy of the initial assessment with RCS as well as the necessary discharge paperwork. During the course of treatment, case co-ordinators maintain regular contact with clients to monitor the service accessed.

6.14 RCS undertake three, six and 12 month follow up reviews with every client: a short web based survey is issued to each client and if no response is forthcoming, a telephone call is made to collect feedback.

6.15 Representatives from the ABMU-led service have looked to the RCS model as good practice and information has been shared with ABMU with a view to assisting the organisation with their delivery of IWS.

The ABMU model

6.16 The IWS operation is better recognised as the Wellbeing through Work service in the case of ABMU. This brand has enabled ABMU to continue with the branding it had in place for two similar schemes delivered previously. The services provided via the Wellbeing through Work service is made available to both ABMU employees and those employed by other employers. However only those clients based with other employers are considered IWS clients.

6.17 The IWS operation is managed by a small core team within ABMU consisting of a Head of Service, Project Manager, a Partnerships Manager and an Employer Engagement officer. Therapy services are delivered via a team of employed physiotherapists and occupational therapists, who are also responsible for undertaking initial client assessments. The Head of Service reports to the ABMU Workforce and Organisational Development Committee which meets bi-annually.

6.18 ABMU management and delivery staff observed that being part of the NHS was of critical importance to the service, in that this offered 'an inherent trust and is a good selling point' for clients. The other strengths of this approach were considered to be the location of a whole team within one department, thereby allowing for the effective sharing of knowledge and information. It was noted that the single location of the team allows for a weekly team meeting to take place. In addition, it was argued that the service is able to draw upon the wider expertise and specialists from other departments across ABMU if needed. Indeed, it was noted by ABMU representatives that being able to access and link with other NHS provision, such as physiotherapy services, allowed therapists to liaise with medical consultants directly about the ongoing needs of IWS clients.

6.19 The main issues identified by ABMU representatives of the model deployed were twofold – as an NHS organisation it was suggested that they are unable to turn clients away from the service even if they don't satisfy the operation's eligibility requirements and secondly, it was thought that they face greater difficulties and are less flexible as a large public sector organisation to respond to funding

requirements set by the Welsh Government and WEFO. For instance, it was reported that it had been a challenge to secure the necessary internal approval to allow the service to collect eligibility evidence, such as national insurance data, from clients as it was feared that this change went against the principle of a free at the point of access NHS service.

The client journey

6.20 Clients will make contact with the operation directly and will usually do so via telephone or email. More recently, the service has started to take clients on board via a weekly drop-in session at a mental health clinic in Bridgend.

6.21 Initial assessments with clients are usually undertaken by phone and clients who satisfy the operation's eligibility requirements are then allocated to the most appropriate therapist.

Clients' initial assessment

6.22 A key difference between the initial assessment approach adopted by RCS and ABMU is whether clients are required to undertake this on a face to face basis or by telephone. In either case, each provider offered a strong argument on the advantages of their approach.

6.23 In the case of RCS, clients meet with case co-ordinators for their initial assessment on a face to face basis as the project team find it easier to collect the necessary paperwork from clients to demonstrate their eligibility in this way. Some case co-ordinators also argued that they find it easier questioning clients about sensitive issues on a face to face basis:

'they open up much more [on a face to face basis], it seems to be more personal. You can read their body language and establish eye contact which is really important'.

6.24 Case co-ordinators will meet with clients at various locations across the four local authority counties, including one of three RCS offices (Rhyl, Ruthin and Bangor) and various other public locations such as libraries. Over time, and as client numbers have increased, case co-ordinators have undertaken a greater proportion of monitoring conversations with clients via telephone due to greater demands upon their time.

6.25 In the case of ABMU, clients access the initial assessment by telephone. ABMU staff and therapists argued that telephone based initial assessments allow clients to access the service quicker than having to wait for a face to face meeting, and these are usually arranged within a week of a client contacting the service. The same contributors also argued that a phone based assessment was usually more convenient for clients in that they did not have to travel to meet with the assessor. This was thought to be particularly important for clients suffering from MSK issues as driving or travelling could be challenging. In the same manner it was suggested that clients who were struggling to manage their emotional health and wellbeing might prefer to undertake a telephone assessment from the safety and comfort of their own home. More recently, the service has started to adopt more creative ways of undertaking initial assessments, including via Facetime and Skype.

6.26 The main issue involved with undertaking telephone based assessments was thought to be difficulty accessing client eligibility evidence in order to satisfy the operation's paperwork requirements.

Collaboration with local organisations

6.27 The extent to which IWS has collaborated with other local stakeholders, other than GPs, varies. Delivery staff suggested that the service does consider whether clients require any further or ongoing support after their contact with the operation comes to an end. In the case of RCS, it was reported that the absence of any in-house client group therapies meant that any client wishing to access further support would have to be directed to another organisation.

6.28 In the case of RCS, the service has collaborated with Business Wales, the Federation of Small Businesses (FSB), the Department for Work and Pensions (DWP), colleges and local authorities to recruit prospective clients and employers. This has frequently involved joint attendance at various events and using organisations' network of contacts to promote IWS services.

6.29 It also collaborates with a range of on-going referral support providers such as Cruse Bereavement Care[17] (to offer further support on bereavement issues), Cais[18] (for support with alcohol and drugs and who are also one of the IWS contracted

[17] Cruse Bereavement Care website
[18] Cais website

providers), Parabl[19] (talking and counselling services) and refers clients to online support sites e.g. a mindfulness online programme.

6.30 RCS finds that this is better value for money than running its own group based session. For example, a mindfulness course was delivered on two occasions but the costs incurred in making the necessary arrangements and its facilitation proved to be more expensive than delivering similar support on a one to one basis.

6.31 Collaboration between ABMU and local stakeholder organisations has been slower to get established. The extent of any collaboration with the business community, such as membership organisations, is more limited. At the time of undertaking the fieldwork efforts to establish links with another mental healthcare provider, Assisting Recovery in the Community (ARC)[20], was observed as starting to bear fruit in terms of client referrals received.

6.32 The service has also collaborated closely with Community Mental Health Support Services such as those covering the counties of Swansea and Neath Port Talbot as well as DWP, via its Mental Health provision. These linkages have proved invaluable as Primary Mental Health Services frequently refer patients to IWS having received the initial referral from GPs. Indeed, one such contributor commented that whilst younger GPs in their area were more inclined to refer patients directly to IWS, the older and more traditional GPs tend to automatically refer patients to the Mental Health Services regardless of the patients' needs.

Monitoring approaches

6.33 RCS based contributors expressed a view that meeting the monitoring and reporting requirements set by WEFO as a condition of EU funding was onerous but nonetheless accepted as necessary. RCS has previous experience of delivering ESF funded initiatives and representatives took the view that they were well prepared to meet the requirements for this operation. Some contributors suggested that significant administrative resources had to be allocated to meet ESF reporting requirements and that this often prevented them from providing a greater return on investment.

[19] Parabl website
[20] Assisting Recovery in the Community (ARC), a Bridgend CBC scheme to support individuals with mental health issues with practice advice and guidance.

6.34 Case co-ordinators at RCS recognised that whilst the amount of paperwork required of clients to complete was substantial, it was, in their view, important that this was managed effectively by staff and providers so that individuals were made aware of these requirements at the outset and that their expectations were managed. Two RCS contracted providers observed that some clients found the end of service evaluation forms challenging to complete, particularly addressing questions about how the service had impacted and been of benefit to their working circumstances.

6.35 Nonetheless the feedback from interviewed RCS clients about the paperwork involved with the operation suggests that the requirements asked of individuals is acceptable. A number of interviewed clients commented positively that the paperwork had been completed on their behalf by case co-ordinators during their initial assessment and accepted that they had been required to provide proof of eligibility.

6.36 In contrast, meeting the monitoring and reporting requirements of the operation has presented significantly more challenges for an NHS organisation as the ABMU could not refuse to treat any individual who wished to access IWS support, simply due to its remit as an NHS funded organisation providing care 'free at the point of contact'. Furthermore, the organisation has found it difficult justifying to clients why should need to provide the necessary paperwork to prove their eligibility for support, simply because clients expect to be able to access an NHS-run service without producing any verification documentation.

6.37 ABMU has also found it difficult to gather the necessary client eligibility documentation due to initial assessments being undertaken by phone. As a result, the IWS operation has only been able to report upon and claim a small proportion of the clients who've accessed the service against its WEFO funded targets.

6.38 ABMU representatives welcomed the recent relaxation of the rules by the Welsh Government and WEFO to allow them to use an employment contract if issued within the last year rather than recent payslips and recent utility bills as evidence of client eligibility.

7. Engagement and recruitment

7.1 This chapter discusses the efforts deployed by RCS and ABMU to engage clients, GPs and employers. It considers the findings of fieldwork with provider representatives, GPs, employers and clients.

Engaging clients

Fit for Work Service

7.2 It is worth noting that during the early stages of implementation, IWS' ability to recruit clients was significantly undermined by the lack of expected absentee client referrals from the Fit for Work service. It was expected that the Fit for Work service would form the main referral route for this group of clients but in the absence of these referrals, the operation had to modify its recruitment methods and approaches.

7.3 The lack of referrals via the Fit for Work service was regarded as 'very frustrating' for all concerned and was thought to have significantly hampered the operations' ability to meet its funded targets for supported absentees.

'This didn't happen. It raised a lot of issues for us in the first year – the goalposts kept shifting and it was fraught with frustrations'.

7.4 Indeed, in the case of ABMU, the lack of referrals from the Fit for Work service was thought to have been detrimental to the organisation's capability to meet its funded targets, largely as the implementation model had been designed to satisfy this approach. As a result, it was not expected that the service would be required to allocate much resources to the marketing of IWS.

7.5 Both RCS and ABMU have focused on trying to make up for lost ground in terms of absentee targets, and in the case of RCS greater priority has been awarded to recruiting and supporting absentee clients. RCS representatives reported that absentee clients who make contact with the service are prioritised over presentees, in that they access an immediate appointment with a case co-ordinator (usually the following working day). However, RCS representatives acknowledged that there was a clear rationale for doing so regardless of the need to meet funded targets: first the financial circumstances of absentees were often more challenging,

particularly if they were already in receipt of incapacity benefits, and second, they could potentially be facing more severe health issues than presentees.

7.6 RCS representatives also observed that a broader definition of an 'absentee' client has been adopted for the service compared to the business plan definition, in part to address the low achievements as a result of the Fit for Work service not referring these clients to the operation. The original business plan defined 'absentees' as employees who have reached or are expected to reach four weeks of sickness absence. It was observed that only a very small proportion of RCS absentee clients have already been off work for four weeks. It was suggested that clients who have been off work for even a few days are classified as absentees, despite it being unclear at that point whether they are likely to be off work for a period of four weeks or more. Indeed, it was suggested by some project staff and therapists that it was likely that many of these clients would be in a position to return to work sooner.

Methods of recruitment

7.7 An analysis of the findings for 35 RCS interviewed clients suggests that the vast majority had come to hear about IWS from their GP or medical practice. A small number had come to hear of the service via their employer or from colleagues within their organisation who had previously accessed IWS. Indeed, their feedback suggests that word of mouth as a source of getting to hear about IWS is increasing in importance in this area, as it was not uncommon to hear interviewed clients comment that they had since 'recommended the service to other people'.

7.8 Likewise, an analysis of the findings for 17 ABMU interviewed clients suggests that the majority had come to hear of IWS via their GP whilst others mentioned a range of additional methods including drop-in clinics, their employer and local organisations.

7.9 It was fairly common to hear that interviewed clients (both RCS and ABMU) had suffered with their health condition for some time prior to accessing the service but that a recent worsening of their condition had resulted in them contacting their GP for advice and support. For instance, around half of the interviewed ABMU clients reported that they had suffered with their health condition for 'a few months' prior to making contact with the operation and their main motivation for seeking help was to better identify the cause of physical pains and learn how to better manage their condition.

7.10 A large minority of interviewed clients (both RCS and ABMU) mentioned that their health condition was directly related to their work circumstances and could attribute work as either the main factor or one of several factors which had led to either their physical health issues or emotional state. Furthermore, the majority of interviewed clients (both RCS and ABMU) took the view that their health condition was impacting upon their ability to work effectively. Many presentees suffering from MSK for instance reported that they were in pain and discomfort whilst at work and that as a result they were finding it difficult to concentrate, to fulfil their usual duties, to stand or sit for long periods of time and in some cases lacked patience with customers or colleagues. Feedback from one RCS client illustrates this:

> 'I had tennis elbow and had been to the GP, they'd referred me for an appointment with a physio, but there was a four-five month waiting list. When I was in work, one of my bosses saw that I was struggling and in pain and said that I couldn't go on like this. He recommended IWS as he'd used it himself a few years ago. I'd stayed in work as I want to work, it's not me to take time off, but colleagues had noticed I was in agony and typing and writing was difficult. I'd been in pain for about a month and it was getting worse. The IT and writing aggravated it, it affected my concentration and my mood. I didn't want to take pain killers, I didn't want it to get the better of me. I didn't know how I would cope if it didn't get better soon.'

7.11 Provider representatives and contractors alike reinforced the fact that most clients had come to hear about IWS from their GP or medical practice. They suggested that whilst clients are aware that the service can be accessed on a voluntary basis they are highly influenced by the advice of their GPs to do so i.e. they are very likely to act on their GPs advice and self-refer to the service. It was suggested that several factors were at force here including the high degree of trust attached to GP advice, the fact that clients were ready to seek support having made contact with the medical profession to access it and a perception amongst some RCS clients that IWS functioned as an extension to the NHS, to which they were entitled access.

7.12 With time, provider representatives argued that a growing proportion of clients are being referred to the service via routes other than GPs. This was thought to be due in part to the service becoming better established, resulting in more word of mouth referrals, but also, in the case of RCS in particular, due to the increased focus on

targeting employer groups and associations. These routes have included Jobcentre Plus (JCP) work coaches and mainstream programmes such as Access to Work who have also been targeted by the operation.

7.13 It was reported by both RCS and ABMU that the efforts required to target employers in order to generate client referrals is significantly greater than for GPs, not least because of the lower number of potential clients per employer but also in part (in RCS's case) due to these targeted employees being less likely to turn up for appointments. RCS representatives suggested that these prospective clients are the most concerned about whether they have to pay for the service and less likely (compared to those referred by GPs) to be ready to access the service.

7.14 Some RCS therapists reported referring a very small number of clients whom they consider could be eligible for support to IWS directly. One such therapist explained that 'I will refer some clients who approach me. If I feel that they need more than one or two sessions and I think they may struggle to pay for them, then I will tell them about IWS'. Others did not think this to be appropriate fearing it would be unethical to refer their own fee paying clients to the operation as well as being inappropriate to create demand for the service.

7.15 RCS has trialled several different promotional methods to target prospective clients, including media campaigns (e.g. local newspapers) as well as social media, and found some to be more effective than others. Overall, RCS has found general public facing campaigns to be less effective than other more targeted approaches.

7.16 RCS representatives noted that efforts had been made to target clients from low income backgrounds and low paying employment sectors. This work had proved successful in some sectors (such as care, retail and construction) but not in others: 'I don't think we really get to hairdressers, to your mechanics … are we really reaching a cross-section of people?' In contrast, RCS representatives observed that other groups, such as young people aged 25 and under in need of counselling therapy, were very well represented across their client cohort. A few RCS contributors commented that south Gwynedd had been a difficult area to recruit clients from and attributed this to lower population levels and a lack of demand for services.

Motivation for accessing the service

7.17 Provider representatives and practicing therapists argued that clients are motivated in the main to access IWS in order to improve their health and 'get better'.

7.18 In terms of the importance of being able to return to work or undertake their normal duties at work, provider representatives and therapists argued that this is also an important motivator for clients. Indeed, it was argued by RCS representatives that all prospective clients are questioned about their motivation to stay or return to work and clients are informed that they will be unable to access the service if they are not motivated by such factors. Several provider representatives reported that returning or staying in work was a crucial motivator for self-employed clients, and that they were forming a larger proportion than expected of the client base in the case of RCS.

7.19 Another important motivator for accessing the service, identified by both interviewed clients and provider representatives, was that clients were informed that they could access the service quickly. The extent to which this rapid access to the service materialised is discussed at Chapter 8.

Engaging GPs

RCS

7.20 In the case of RCS, significant efforts have been deployed to target the 106 GP surgeries that operate across the four local authority areas in north-west Wales and this was applauded by GPs who contributed to the evaluation. Feedback from RCS representatives suggests that this element of the work has been time consuming and challenging, not least due to difficulties on the part of GPs to find time to meet with staff but also because of the regular use of locum doctors at many practices who are more difficult to identify and target. It was reported that at the time of fieldwork all but three of these GP surgeries were now referring clients to IWS and one factor which was thought to account for the non-referrals was the higher than average proportion of elderly patients registered at these three surgeries.

7.21 Many lessons were identified by RCS representatives about the most effective ways of engaging with GPs. It was suggested that formal presentations to groups of GPs at their practices has been ineffective and also logistically difficult to arrange.

Instead, informal approaches such as being based in a surgery kitchen or communal area and adopting an opportunistic approach to meet with GPs and responding to their specific questions, was considered to work much better. Furthermore, it was considered important to keep abreast of any new GPs appointed and to target these individually once in post. RCS also makes available promotional literature to display at GP surgeries and for GPs to give directly to patients.

7.22 In terms of feedback from GPs, responses from eight GP practices in the north-west suggests that the first contact for most surgeries had been through a presentation delivered by a member of the RCS team at the practice itself. Some of the practices had been involved with the predecessor project, Fit for Work, and essentially considered IWS a continuation of this. One of these practices had been concerned that the service would change and possibly deteriorate as a result of it becoming a Welsh Government led provision, given that their experiences of Fit for Work had been excellent.

7.23 One GP practice had a particularly close relationship with RCS' IWS operation:

> The GP practice had previously hosted RCS at their medical centre and collaborated closely with IWS's predecessor, Fit for Work. They now use IWS extensively. In this case the practice also utilises the broader strengths of RCS by, for example, sending new GPs as well as medical students to meet with RCS staff to gain an understanding of how IWS operates. The practice also takes advantage of networking opportunities offered via RCS in order to establish contact with other voluntary services and organisations.

7.24 The feedback from GPs working with RCS (as well as one client and one employer) suggested that there was some confusion on their part as to which clients could access the service with one taking the view that only employees whose employers did not offer any occupational health support could now access IWS.

7.25 GPs main reason for referring patients to the RCS operation was rapid access to therapy particularly in light of the long waiting times which patients would otherwise experience for NHS funded provision:

‘[the] NHS here is still in special measures and it’s a bit ridiculous, waiting times are long’

‘a quick effective service can keep people in work rather than waiting 13-14 weeks and possibly be absent from work on Statutory Sick Pay’.

7.26 A few GPs who had been involved with RCS liked the fact that they could give information to patients about the service via a discreet information card, but that it was the patients’ responsibility to resolve their own health issues:

'I like this scheme as I just give out the card with the telephone number and the patient phones themselves. They take responsibility for it. I like that the patient then takes responsibility for accessing the service themselves'.

ABMU

7.27 In the case of ABMU, the organisation has found it a challenge to promote the service to the 90 GP practices within their area, not least as the organisation was initially unclear how it should promote the service in response to the lack of client referrals expected via the Fit for Work service, but also due to the fact that GPs are perceived to have not been in a position to prioritise the service. As one ABMU representative commented ‘GPs have so many things thrown at them. This is just not their priority’. The organisation has attempted to meet with Practice Managers to brief them on IWS but despite distributing promotional materials to consultation rooms, the response from these efforts was still considered to be low at the time of fieldwork.

7.28 As a result, ABMU decided to approach GP surgeries as employing organisations in their own right and offer awareness raising sessions and training to their staff. This has proved more successful and at the time of undertaking the fieldwork, ABMU representatives commented that they were starting to see some GPs becoming more reliant upon IWS and were ‘starting to refer in’.

7.29 This was echoed by the four GPs who contributed to the evaluation who did not consider that their practices had yet to engage meaningfully with the service in terms of referring patients. One of these practices had heard of the programme but had not had any involvement with it whilst another reported having received promotional posters and leaflets from the service to display at their practice.

7.30 The other two practices reported that ABMU had informed them about IWS but as yet they had not referred any client to the service. These practices made some general observations about the service in that they had an impression that it was not adequately resourced and so were concerned about increasing the demand to some extent by referring clients to it. They also observed that no promotional documentation had been made available to them as yet to allow them to share information with patients.

7.31 One GP practice had been involved with the programme as an employer and had referred three members of staff who were showing signs of work-related stress to the programme. Their feedback on this service is considered at Chapter 9 as an employer organisation.

Engaging Employers

7.32 Engagement with employers has served two purposes for the IWS operation. First, the operation set out with an objective of raising awareness and understanding amongst the employer community about managing ill-health within their workforce and set out to achieve this via the delivery of group based workshops and training events. Second, the IWS operation has targeted employers as a conduit for reaching and engaging with employees who could benefit as clients of the service.

7.33 In the case of RCS, the organisation has also targeted umbrella and business group associations as means of reaching employers and feedback from RCS representatives suggests that this approach has been appropriate and effective. For instance, one local business group representative commented that:

‘they approached us to hold a workshop in the county and so we promoted the event to the network and gave information about it to our businesses. It would have been impossible for them to have targeted individual businesses directly so making use of groups like ourselves seemed very practical’

7.34 Feedback from both RCS and ABMU suggests that it has been challenging to target and engage employers in order to secure employee referrals, not least as both providers would have been required to engage with a larger number of employers (in comparison with GP surgeries) in order to secure similar referral numbers. Indeed one contributor observed that ‘a lot of work has to be put in for minimal referrals’. It was also suggested by one RCS representative that these employees

were less likely to turn up for their appointment than those referred to the service by their GP. In the case of ABMU it was suggested that employers had been 'sceptical' of the service as it was being provided free of charge.

RCS

7.35 In the case of RCS, employers have been targeted via a number of methods including attendance at various events and fairs arranged by other organisations for the business community. RCS has also benefited and built upon existing networks it had in place across the counties of Conwy and Denbighshire, but had to set out to develop new networks across Gwynedd and Anglesey in light of the fact that it has not previously operated in these counties. Project staff suggested that there were both advantages and disadvantages to working in new and traditional counties – although RCS had established contacts with the business community in Conwy and Denbighshire, the promotion activities had to address and overcome mis-conceptions about IWS due to RCS's previous involvement with the delivery of the Fit for Work initiative.

7.36 RCS has also specifically targeted employers from particular sectors, associated with low pay, such as the care sector. The service (at the time of undertaking the fieldwork) also intended to target other sectors such as the tourism sector.

7.37 An analysis of RCS's database of employers supported (as at January 2018) suggests that a real mix of sectors and type of employers had been involved with the operation at that point, including third sector organisations (some of whom were membership based organisations so could disseminate information to a wider audience) and private sector employers from across sectors such as care, construction and retail. These were also well distributed across the four local authority target areas of the operation.

7.38 In all, 11 employers who had been involved with RCS's IWS operation were interviewed as part of this evaluation. All 11 employers had come to hear of IWS via a direct approach by RCS, including being invited to a workshop via an intermediary or membership organisation. All but two employers reported that they had attended an employer workshop delivered by RCS on the themes of either stress management or managing sickness in the workplace.

7.39 Their motivations for getting involved differed. In some cases, employers simply wanted to hear more about the service whereas others could see the benefit of

learning about how to better deal with absentee issues within the workplace and become better at managing stress in the workplace. One such employer for instance noted that:

'we didn't have anyone off sick at the time. It was more about knowing that it was going to happen. We anticipated the need for advice and guidance when it came to occupational health'.

7.40 In other cases, the employing organisation was aware that they did not 'manage sickness well' and wanted to explore new ways of preventing it and to get staff to return to work quicker. In one particular business, the employer reported that the use of zero hours contracts was in part contributing towards their high absence rate and they wanted to explore methods of dealing with this.

7.41 In at least two cases the interviewed representative observed that they were fairly new to their HR role within the organisation and had considered the RCS workshops as an opportunity to further their knowledge around occupational health matters. Others attended for personal reasons in that they wanted to gain their own stress management tools. It was commonly reported by those interviewed that these employer organisations lacked any occupational health provision internally.

7.42 The low number of client referrals secured via the promotion and provision available to employers was considered by contracted therapists to have been a missed opportunity to reach a broader range of clients other than those referred via the traditional route of GPs. This was considered to be particularly true for prospective clients who may be suffering from mental health issues, yet did not associate with this term due to the stigma attached to this. One therapist commented:

'clients have come to IWS very much via the traditional route and whilst it's been a worthwhile gap to fill, I'm not sure whether this is what the project set out to achieve. The clients I've seen have been typical NHS patients'.

7.43 Of the 11 employers interviewed, three of them were aware that their employees had accessed IWS as a result of the information which had been disseminated internally. A few others were unable to comment adding that the confidentiality of the service meant that they simply would not have been informed of any employees who had accessed therapy services directly.

7.44 RCS issues regular information to employers once they become involved with IWS, including regular email updates and a quarterly newsletter which includes client case study materials. This was regarded as being an effective method of keeping employers informed about IWS provision and reminding them that the service existed.

ABMU

7.45 In the case of ABMU, efforts to target employers, other than GP practices as employers in their own right, has been limited to date. An analysis of their employer database shared for evaluation purposes shows that of the 12 employers listed, three were GP surgeries and the remaining nine were third sector organisations such as housing associations and voluntary groups. The operation has also collaborated with DWP's small employer advisers to ensure that information packs are supplied to those employers who engage with JCP and it was reported that this had resulted in some referrals.

7.46 The four employers who contributed to this evaluation had come to hear of ABMU's IWS either via attendance at events or via other professional meetings at which the service had been discussed. Their motivations for getting involved primarily related to their desire to attend an employer event which ABMU was arranging for employers on managing sickness and stress in the workplace.

8. Client services and experiences

8.1 This chapter considers the services provided to clients by RCS and ABMU. It discusses clients' experiences of accessing the service including the timeliness and quality of the service, the nature of support provided and clients' perceived impact on health and employment outcomes.

8.2 It draws primarily upon the findings of interviews with 53 clients (35 RCS and 18 ABMU) but also considers the views of provider representatives, GPs and local stakeholder organisations.

Initial assessment

RCS

8.3 Fieldwork with 35 RCS clients confirmed that initial assessments with a case co-ordinator are undertaken on a face to face basis. Interviewed RCS clients consistently reported that they had been able to see the case co-ordinator very quickly after initially making contact with the service. One such interviewee observed:

'they contacted me within a day and I saw the physio very soon afterwards'.

8.4 Interviewed RCS clients also reported that the length of time that they had to wait before being contacted by a therapist for treatment was exceptionally short and significant praise was offered for this quick turnaround. Indeed, RCS clients often reported being very surprised at how quickly they had been able to access the service, particularly in light of expected delays to access similar NHS funded provision. The following experience was not uncommon to hear over the course of the fieldwork:

> One RCS absentee client had been off work for a couple of weeks when, during his second appointment, his GP provided him with information about IWS. After making contact by telephone he met with a case co-ordinator within 'a day or so' and they provided him with a list of three different counsellors based in his area from whom he could choose, explaining the differences in approach between counsellors. The client selected a Cognitive Behavioural Therapy (CBT) counsellor who contacted him 'pretty much immediately' thereafter.

8.5 Contracted providers echoed the quick turnaround for clients with one therapist noting:

'I saw someone this morning at 8.30am after having had the referral yesterday at 2pm. I happened to have a cancellation and could fit them in.'

8.6 The quick turnaround was particularly appealing to GPs, whose patients would otherwise have had to face significant waiting times to access similar NHS funded provision. Indeed several interviewed GPs commented upon this point, adding that the quick intervention was in effect 'filling in the cracks' of the NHS system and that whilst waiting, it was not unusual for patients to return to their GP on several occasions.

8.7 Indeed, many interviewed RCS clients commented positively upon the fact that they were given a choice as to the therapist they would like to see, in contrast perhaps to their NHS experience.

8.8 In terms of the value of the initial assessment, RCS contracted providers suggested that the initial assessment completed by non-medically trained case co-ordinators was useful background information but had a fairly limited clinical assessment value for them. For instance, the case co-ordinators assessments did not shed light on whether clients suffered mild, moderate or severe health conditions. As one therapist reported:

'I do my own assessment, I don't rely on the case co-ordinators' one. The bio-psychosocial assessment gives me some idea about the client but as a professional therapist I need to do my own diagnosis.'

ABMU

8.9 The fieldwork with 18 ABMU clients revealed that initial assessments were conducted by phone. The majority of clients had been satisfied with this approach, adding that it had been convenient for them to fit the assessment around their working day and reduced the need to travel for an appointment:

'both the assessment and the counselling were over the telephone and that suited me at the time'.

8.10 However, a small number of clients suggested that the approach had felt impersonal and they would have preferred to have met the assessor in person in a 'comfortable and relaxed' environment.

8.11 The feedback from ABMU clients suggested a mixed picture in terms of the speed at which they were able to participate in an initial assessment, which varied from two weeks to six or eight weeks. Clients who had been able to participate in the initial assessment within a two week period were mostly satisfied with this turnaround whereas those who had been required to wait much longer were more critical. One such client was critical of the waiting time to access the service although, given that they were suffering from a moderate to severe health condition, this example does raise questions as to whether the IWS was the most appropriate service for the client at the time:

'six to eight weeks wait for the assessment at a time when I was in an acute state of disrepair appeared to be quite a long time. I accept that mental health professionals are thin on the ground, but it was difficult'.

8.12 However not all clients were prepared to wait even a couple of weeks for treatment:

> 'I had the initial assessment over the telephone a week after ringing the service. The man was fabulous. He was very good, rang when he said he would, followed things up. I was offered 6 physio sessions and a work place assessment. I got the impression I'd get access to the physiotherapist quite quickly … but I made an appointment with a chiropractor the next day. I was worried about getting back to work and looking after the children.'

8.13 ABMU clients also reported mixed experiences about their journey to access IWS therapy following the initial assessment and it was noteworthy that eight of the 18 clients interviewed did not receive support (indeed some of these did not receive an initial assessment either). The main reason why clients had been unable to access the service was due to it being offered too late in the day followed by difficulties on their part to access it. Examples of these experiences are illustrated below:

> The delay in being able to access the service meant that one client had left her post due to the fact that she was struggling to cope. When eventually contacted by the service she concluded that it would no longer be relevant for her. Another client, who had come to hear about the service from her employer, decided to access private physiotherapy support after a month of not hearing back from IWS after making initial contact and sharing eligibility paperwork. Similarly a third client participated in an initial assessment but heard nothing further from the service about the follow up support. A fourth client had difficulties sharing his eligibility paperwork with the service despite attempting to do so via email and in person.

8.14 These experiences point to a lack of communication on the part of the service about how long clients can expect to wait for an initial assessment and support thereafter. This often created uncertainties for interviewed clients and added to their concerns. It was perhaps not surprising that a number of clients reflected upon their lack of confidence with the service and those who had faced difficulties in accessing it were reluctant to re-engage with it when ABMU contacted them to request that they complete follow up evaluation forms.

Nature of support

RCS

8.15 RCS clients are currently able to access up to six therapy sessions on a face to face basis. During its initial delivery period the operation allowed clients to access more than six sessions provided a strong case was made by their therapist. However, a decision was made to limit the number of sessions in light of the increase in demand for services and the need to deliver a service within a defined budget.

8.16 The vast majority of interviewed RCS clients reported that they had been able to access the maximum allowance of six therapy sessions via IWS. In the few cases where this had not materialised clients explained that they had been unable to attend a particular appointment due to various personal circumstances. Only one interviewed client decided that he did not wish to pursue with the service after the initial couple of counselling sessions and had taken the view that it was not appropriate for them:

‘it just wasn’t working for me. I just couldn’t talk. There was no rapport. I got quieter and quieter. Maybe it was the wrong time for me.’

8.17 The majority of interviewed RCS clients regarded six sessions as being adequate for them to resolve their health conditions:

‘To be honest six sessions was probably enough. The treatment was working and I was getting a lot better and the exercises in-between were helping as well. I didn’t want to take time or sessions from someone else. The exercises did help to relieve the pain, the symptoms got better and I’ve kept the exercises up as a way of preventing it coming back’.

8.18 RCS representatives and contracted providers alike also thought that this upper limit of six sessions was appropriate for the vast majority of clients with mild to moderate health issues and in those cases where it was considered generous, contracted providers were encouraged to bring the service to a close earlier.

‘The six session model works well. It’s about right. You can do a huge amount in six sessions with a client. It’s important to manage their expectations. Most clients are delighted that they can get six sessions with me to be honest. As a therapist you learn to stretch the last couple of sessions over a few weeks to allow clients to reflect on how they’re coping.’

8.19 The fieldwork with RCS clients revealed that the vast majority received regular sessions with their therapist (often weekly initially) which lasted up to an hour. Some type of therapies (e.g. osteopathy therapy) were accessed for a shorter duration of time per visit. There was then a tendency for the final sessions to be arranged over a longer period of time.

8.20 The experience of one contracted provider illustrated this:

> One contracted provider works on a self-employed basis and will typically support between 15 and 20 IWS clients at any one time. Around half of their clients will be supported on a weekly basis whilst others are supported on a less frequent basis. It is not uncommon for counselling sessions to be accessed on a regular weekly basis initially with final sessions spread out thereafter. Clients tend to want to 'save their final session' with the counsellor for fear of being without the support in place. It was argued that the focus of the counselling session provided is on the individual client, perhaps in contrast to the focus of any occupational health sessions which they may have accessed via their employer which was perceived as being focused on getting the client back to work as soon as possible, rather than when the client is ready to do so.

8.21 Project staff, therapists and interviewed clients alike reported positively upon the fact that they could be entitled to up to one hour sessions with therapists, and that this amount of time was adequate and appropriate.

8.22 A small number of RCS clients argued that they could have benefited from further sessions but appreciated that the provision of six sessions had been fairly generous by comparison to other provisions such as via the NHS. RCS contracted providers argued strongly that it would be helpful to have some element of discretion to offer a small number of further sessions to a small number of supported clients as had been the case previously, when RCS had some degree of flexibility to offer more therapy sessions when required.

8.23 Two RCS clients argued that they would have wished to access IWS services to address both MSK and emotional health issues. One of these explained:

'My mental health had deteriorated towards the end of the [MSK] sessions. I was replaying the accident in my head a lot and there were moments when memories would be triggered. If I could have accessed counselling when the physio sessions were coming to an end that would have been great and supported me over that psychological hurdle, but I was told you could only access one service. I eventually paid for private counselling myself'.

8.24 Likewise, some GPs argued that it was a disadvantage that a patient could only ever access the service once, as illustrated below, although some GPs were under the impression that clients could indeed access the service a second time:

'I had someone who needed a service a second time after 18 months, but was told she could not access the service again'.

8.25 RCS has responded to the fact that it cannot provide any further sessions by providing some group based sessions for clients. These have focused on particular themes such as managing pressure at work and dealing with sleeping issues. Some contracted providers also reported that they had referred clients on to other group based services available outside of IWS, including mindfulness groups and exercise classes. In other cases, contracted providers were aware that clients who required further support continued to wait for NHS funded provision whilst a small number took the decision to continue with paid-for therapy services delivered by the same provider.

ABMU

8.26 It would appear that interviewed ABMU clients accessed fewer individual therapy sessions compared to those via RCS – the maximum number of sessions accessed by those interviewed was four sessions. Three of the interviewed clients suggested that they had only been able to access 'one or two' sessions with a physiotherapist and that the focus of these sessions had been on familiarising themselves with appropriate exercises to do themselves in order to control their health condition. In one of these cases the client had decided not to continue with the sessions as they felt that they had received what she needed. A fourth client reported that they had expected to access six sessions and therefore had been surprised when the counsellor had informed them during the fourth session that they did not think any further ones were needed[21].

8.27 At least two interviewed ABMU clients were supported via group based therapy sessions and they had very contrasting experiences to draw upon. One client had attended five group therapy sessions in all and found the experience to be extremely positive as it helped her regain her confidence and self-esteem and was able to return to work having taken a total of six weeks off. The other had not found

[21] Accepting of course that the IWS operation should not provide further sessions to clients who have been clinically assessed as not requiring any.

it helpful mostly due to the fact that the sessions had been an opportunity for 'people to vent about their situation, they weren't interested in a solution, they weren't interested in being positive'.

8.28 Two interviewed ABMU clients also reported that they had been visited at work by ABMU therapists who undertook an assessment of their working environment. In both cases these clients remarked that the assessment had been helpful in identifying inappropriate working positions and to gain advice on appropriate equipment which their employer should secure for them.

Health conditions

8.29 Interviewed clients reported that they were suffering from a wider range of health related issues but these could all be categorised into MSK conditions (with the most commonly reported issues relating to neck, shoulders, arms, lower back and sciatica nerve pain as well as repetitive strain symptoms) and emotional health conditions (particularly those associated with anxiety, depression, bereavement, divorce, separation, work related stress and low self-worth).

8.30 Representatives at RCS and ABMU suggested that those with emotional or mental health issues were more likely to have suffered with their condition for a longer period than those with MSK conditions although feedback from clients suffering MSK conditions would suggest that a fair number had struggled with some form of pain for a while but that a worsening of the condition recently had made them access support.

8.31 ABMU representatives observed that they were starting to see clients suffering from emotional health issues access support sooner than historically, possibly due to the increased media focus on mental health issues over the last couple of years.

8.32 In the case of those with MSK conditions, a strong argument was offered by therapists that early intervention correlates with success. One therapist commented:

'physiotherapy has been effective in about 70 to 80 per cent of cases. It's not so effective if the condition is a long standing one. They're likely to need more invasive intervention, possibly an operation'.

8.33 In many cases therapists reported that underlying health conditions were often seen to impact upon a client's ability to sleep as well as their ability to work or perform effectively at work. One therapist argued:

‘when you’re in pain your priority is your health, not work necessarily. But you do help clients who are really concerned about work, especially those who are self-employed. Work is probably one of many factors that they worry about … other things in their lives are probably just as important’.

Satisfaction with the service

RCS

8.34 Interviewed RCS clients were exceptionally satisfied with the quality of intervention received, frequently commenting upon the knowledge, expertise and ease of dealing with the therapist who had supported them.

‘When I met the case co-ordinator I was very tearful, very nervous about going. In fact I had to cancel my first appointment, I was hysterical. I found the sessions difficult at first but [name of counsellor] was very easy to talk to. She was so non-judgemental. It worked for me, it helped me cope with it, move on with life. It helped me understand what was happening and how I could deal with it. I was over thinking things but she taught me some techniques … how to breathe ... so I can pull myself back from that now ... take control of things’.

8.35 It was not uncommon to hear comments such as:

‘[they were] very impressive. I got 150 per cent of what I wanted, I’m made up with it and can’t thank them enough’.

8.36 Indeed, several RCS clients offered their praise for the initiative at a broader level:

‘I’ve been raving about it. I feel it should be an essential service that’s funded. Whoever came up with the idea deserves a pat on the back. I think it’s an inspired, incredible service.’

8.37 Interviewed RCS clients also welcomed the fact that they were able to access the service locally to them and that it was made available free of charge. Furthermore, many also mentioned the flexibility demonstrated by therapists and counsellors alike to meet with them at convenient times in order to work around their work commitments and any caring responsibilities which they had. For instance:

‘She saw me either on a Friday when I was free all day or after 3pm on a Monday when I finished work. It all worked around work and me looking after my grandchild.’

8.38 RCS representatives and contracted providers equally thought that clients were satisfied with the service provided, as this was evidenced in their verbal feedback and follow up surveys. Two key aspects which they thought were important to clients were the ‘free’ and ‘immediate’ nature of the service. GPs who had been involved with RCS also held the service in high regard and observed that they had received many positive comments from patients. For instance:

'it's as near perfect a service as you can get and the people at RCS are nice people too'

‘the therapists are excellent and effective. Many patients comment very positively about their experience of the scheme.’

ABMU

8.39 Some care should be taken when considering the views of interviewed ABMU clients about the quality of the service accessed as it draws on a very small sample, not least as nearly half had not been able to receive any support and the views of others were often influenced by their long wait to access the service in the first instance and the limited number of sessions accessed.

8.40 Those who reported a positive experience of the service highlighted the knowledge and expertise of the therapist allocated to them. Several clients also appreciated being able to meet with the same therapist over the course of their intervention.

8.41 The main issue raised by other clients related to the distance that they had been required to travel to meet with their allocated therapist and this was considered to have been inconvenient for them.

Health outcomes achieved

8.42 A wide range of positive perceived health outcomes were identified by interviewed clients, both presentees and absentees alike, as a result of accessing IWS intervention. Indeed it was often difficult to differentiate these improvements between presentees and absentees. Interviewed therapists suggested that this was largely due to the fact that the severity of a client’s health was not necessarily determined by whether they were an absentee or a presentee but rather by other factors such as their attitudes to working whilst ill or in pain and the necessity of having to continue to work or not. Furthermore, it was also observed that the

widening of the definition now used by RCS in particular for an absentee meant that there was very little difference between the health condition of an absentee and presentee.

8.43 The health improvements identified by interviewed clients included:

- a reduction in physical pain and discomfort, particularly amongst clients suffering with MSK conditions
- increased physical mobility as a result of gaining access to physiotherapy services
- a reduction in anxiety and an improvement in client mood
- being able to cope and better manage their health condition as a result of the techniques and exercises provided by therapists
- an acceptance of their health condition: some clients reported that gaining 'permission' from the therapist to take time of work had helped to ensure they recovered from their health condition
- psychological improvements such as clients reporting feeling 'in better control of their health' and taking the necessary steps to address their health conditions e.g. 'I'm on the road to recovery'
- changes in confidence and attitudes: a number of clients reported being 'a completely different person' and one therapist observed that clients 'start recognising why things are happening and that they can make a choice about these things'
- improved wellbeing: several clients reported that addressing their physical pain had lifted their emotional mood – 'just being able to get up and move about helped ... I was feeling very sorry for myself not being able to do anything in the house'
- improved sleep: a few clients reported receiving advice from their therapists on how to sleep comfortably and controlling their pain whilst in bed
- a better understanding of their medical condition: a few therapists reported that clients were better informed about their health condition as a result of their clinical assessment. One RCS client reported for instance that 'she [the physiotherapist] spotted the severity of the problem. Her diagnosis was

better than that of the GP. She spotted the underlying problem for my joint condition'

8.44 Whilst the majority of interviewed RCS clients who had accessed MSK therapy reported a reduction in physical pain, it was evident that in some cases their underlying health issue still existed. In these cases, clients suggested that an important outcome of the service had been to equip them to better manage their health condition using techniques and exercises suggested by the therapist. One such client acknowledged that it would take up to two years for their injury to heal but that IWS had 'gone as far as they could … I hadn't expected a miracle'.

8.45 Other contributors also noted that client health improvements were captured and reported by both RCS and ABMU via either the Health Star approach (in the case of RCS) and the EQ5D Outcome Measurement tool (in the case of ABMU) which would capture some of these health-related outcomes reported by interviewed clients. This data has been considered earlier within Chapter 4.

8.46 There was some, albeit limited evidence that taking up IWS support was helping to reduce the medication being used by clients as a number of clients reported using fewer or lower strength medication during their course of IWS service:

> One RCS client thought that in the absence of IWS she might have resorted to taking the usual amount of medication to control her pain. Over the course of accessing physiotherapy she did not have to seek GP or any other medical advice. In the absence of the service, the client thought that she would have taken stronger painkillers for a longer period of time.

8.47 The GPs that responded to the evaluation, who had collaborated with RCS perceived that the treatment provided for their patients was having a positive impact upon patients' health although none provided specific evidence to substantiate these views as part of the evaluation. Amongst the views offered were:

'There are improvements in physical health, mental health, well-being, productivity, family life, a prevention of secondary conditions (through taking pain killers for example) and tools to manage the condition in the future. We see evidence through continued presence in work and fewer GP appointments'

‘Those that I've spoken to are complimentary of the service and feel they've had a good, quick outcome. My sense is it's kept many in work, probably reduced the numbers of those returning for further appointments and potentially reduced further prescriptions'.

Employment outcomes achieved

8.48 The fieldwork revealed that there was a clear focus on work and employment issues across much of the provision made available by both RCS and ABMU. In most MSK cases, the service was focused on addressing physical issues so as to allow the client to continue in work or return to work. In some cases, this also involved a therapist undertaking a work based assessment for the client to assess the suitability of their work-station. In a minority of cases, interviewed clients did not think that there had been much focus on work issues, and these tended to be clients who had accessed emotional and mental health counselling support which tended to focus on personal issues.

RCS

8.49 Many RCS clients suggested that the therapy had equipped them with appropriate techniques and exercises to better manage their conditions in work. As one client explained:

‘I was a hundred times better each time. There’s still something there, once you have a weakness it never completely goes away, but I don’t have the same pain any more. I’m no longer in pain, I’m not on painkillers. I am now more sensible in work. I do less lifting and carrying as a preventative measure’.

8.50 Indeed contracted providers thought that educating clients to cope and manage their health condition for the long term was a critically important outcome for IWS, which was possibly not being adequately captured within the reported data. One therapist argued ‘a lot of what I do is to show clients what exercises they should be doing to manage their condition…I don’t know how many continue with these…there’s always an issue with pain…out of sight, out of mind’.

8.51 Feedback from another RCS client illustrates this point:

> One RCS absentee client who had accessed counselling sessions reported that the main benefit of the support had been to learn about different techniques and ways of approaching and managing low moods and possible depressive episodes. The client continues to apply these techniques. In his case the counsellor had also discussed the possibility of the client embarking upon some form of exercise in order to address his low moods and weight issues. The client acted upon the advice and argued that this change had been really important to his ongoing health.

8.52 Turning to consider the perceived impact for presentees and their employment situation the evaluation can only draw upon the views of interviewed clients. It is not possible to assess the extent to which these perceptions are accurate in light of the fact that the evaluation cannot draw upon any comparison group evidence. A few RCS presentees believed that in the absence of IWS they would eventually have had to take time off work, particularly those who reported being in pain and physical discomfort, as the wait for alternative NHS provision was long. One such client argued:

'It stopped me going off sick, I probably would have been off sick for two or three weeks otherwise.'

8.53 Other employment related outcomes achieved by presentees were thought to be more individualised and less measurable in their nature. The following outcomes were reported by interviewed clients:

- that they were now able to perform work tasks which they needed to do as part of their job and do so without pain
- that they had returned to 'normal' or 'full' duties rather than reduced or limited duties at work.
- being able to work pain free
- able to better focus and concentrate at work hence a reduction in mistakes and complaints about them
- take less time off work due to ill health
- increased productivity as a result of being able to stay at their office desk/work station for longer

- increased productivity as a result of being able to undertake work tasks quicker and more efficiently.

8.54 For RCS absentee clients, interviewed clients had mixed views about the extent to which IWS had helped them return to work. Some interviewees attributed their return to work entirely to the service received, others attributed their return in part to the service whilst others believed that IWS had a marginal role. Feedback from interviewed clients would suggest that the intervention was certainly perceived as enabling some absentees to return to work quicker than they would have otherwise done so whilst in other cases it is perceived as enabling clients to return to work 'stronger than I otherwise would have done'. Several RCS clients also questioned whether, in the absence of support, they would have been able to 'last back in work' in the absence of not addressing some of their underlying physical issues. However, in the absence of a comparison group, it is not possible to conclude on the extent to which any of this is the case.

8.55 The following example illustrates how the service was perceived to have helped a client to return to work:

> One RCS client who had been informed of IWS from her GP had been off sick for a month at the time of coming into contact with the service, largely due to depression but also due to work related stress. The client accessed six Cognitive Behaviour Therapy (CTB) counselling sessions and found that the sessions helped her to cope better with the depression. The counsellor discussed the possibility of returning to work during these sessions and advised the client not to return too early – the client had welcomed this advice as it had given her the confidence and reassurances to stay off work until she was ready to return. The counsellor suggested that she return to work on a phased basis, which she did over a period of two months before then returning to work on a full time basis. This client argued that the service had helped her return to a job which she was considering leaving permanently. Furthermore the counselling had helped her think differently about work and its responsibilities thereby increasing the client's chances of staying in the post long term.

8.56 A few therapists added that a clients' ability to return to work quickly was in part influenced by the degree of support and adjustment offered by their employer.

8.57 Interviewed therapists also observed that both absentees and presentees frequently reported concerns to them about the threat of losing their income (and surviving on

statutory sick pay) and their jobs. Indeed some therapists reported that 'losing work is often their biggest fear' and clients are relieved when they are finally able to return or continue in their job.

8.58 A small number of RCS clients who were still absent from work at the time of interview recognised that the IWS service alone could not help them return to work and in some of these cases it was observed that the service had bought about short rather than long term benefits. For instance, one RCS client was waiting for a hip replacement operation and whilst IWS had helped improve his physical mobility he argued that he would not be able to return to work until the operation proved successful. In another case, a client recognised that the value of osteopath therapy would be short lived, as he was required to access similar intervention several times previously in the past.

8.59 RCS contracted providers agreed that the outcomes achieved by clients suffering from moderate to severe health related issues, such as post-traumatic stress disorders, were more limited. One such therapist argued that 'the best you can expect to achieve with some of these is that they are referred on to further, more intensive follow on support.' Several contributors thought it would be difficult not to support these clients but recognised that IWS was effectively functioning as a 'holding' service for some of these clients until they could access further NHS provision.

8.60 A few other RCS clients identified other outcomes which they had secured following intervention. In one case a client observed that he would not have taken the decision to enrol at a university this coming autumn had it not been for the support, as the counselling had provided her with an opportunity to reflect upon her career and make future plans. Other clients who had accessed MSK support observed that they were now able to carry out sporting activities, which they had previously been unable to do.

ABMU

8.61 The fieldwork with ABMU clients found that the service had resulted in positive employment outcomes for only a few of those interviewed, largely due to the high number who did not take up the service and the fact that a few clients were only able to access one or two sessions, which they did not consider to be adequate. Where clients were able to identify positive outcomes, it was mostly suggested that

the support had been of value in ensuring that their health condition did not deteriorate so they would not be required to take time off work. One self-employed client reported that the service had helped him address physical back pain problems which meant that he could increase his working hours and income back to the levels that they were previously.

8.62 Interestingly feedback from a very small number of ABMU clients suggests that the service is perceived to have played a role in helping them to leave their job which accounted for much of their mental health issues. The experience of one client illustrates how IWS is perceived to have been of assistance in helping them make a managed move into another job:

> One client reported that the IWS therapist agreed that their work situation was impacting on their mental health and reinforced the client's perception that they were not over-reacting to what was happening in work. The client commented 'having this confirmation from an independent person was very important to me. She explained it was part of her role to keep me in work, but possibly not this particular job. I was already looking for other work by that point. I stayed in work two months longer than I thought I would due to the counselling support. I was at risk of leaving irrationally with no job to go to. With the intervention, I was able to think things through rationally and planned a way out that meant I wasn't unemployed and at risk of other consequences.'

9. Employer services and experiences

9.1 This chapter sets out the nature and usefulness of services provided by RCS and ABMU to employers and considers the benefits and outcomes of the work. It primarily draws upon the feedback of interviewed employers and representatives from RCS and ABMU.

9.2 Both RCS and ABMU project staff were aware that they had very high project targets to achieve in terms of supporting employers and, at the time of fieldwork, were mindful that they were under-performing against these. For instance, in January 2018 RCS had supported 86 employers against a target of 321. Feedback from project staff suggests that under-performance is largely the result of providers prioritising the establishment of services to participants over employers. Indeed, workshop and training provision for employers has only been in place at RCS since early 2017. Another factor to consider in relation to this under-performance was thought to be that RCS and ABMU were still awaiting clarification as to whether the nature of their work with employers satisfied WEFO's definition of 'helping employers to improve or implement equal opportunities policies'.

RCS

9.3 RCS has set out to support employers via the delivery of group based sessions. These have involved facilitating half day workshops on raising awareness and equipping employers with information on wellbeing in the workplace, such as managing stress within the workplace, managing sickness absence and flexible working practices. Employers have been recruited to these events via a mixed method approach, including awareness raising of upcoming events at targeted fairs and via membership organisations (e.g. FSB, the Construction Industry Training Board (CITB)) distributing information on their behalf.

9.4 According to RCS staff, the demand for these workshops has been positive but feedback from attendees suggest that many would benefit from a more in-depth follow up service e.g. a follow up workshop with employees. RCS is currently restricted from meeting these requests for follow up support directly due to the operation's need to prioritise resources to meet its overall employer target numbers.

9.5 Local stakeholders observed that employer focused workshops delivered by RCS have been well attended and that the feedback from employers in attendance has been positive. One local stakeholder commented:

‘employers tell us that they need information about wellbeing at work and the fact that these sessions are delivered in bitesize chunks make it appealing to them. I think our network found them useful … to pick up some hints and tips.’

9.6 In terms of the benefits that come about for employers, RCS staff suggested that the main objective is to ‘make them better employers’. It is hoped that the workshops in particular raise awareness amongst employers of the need to adopt appropriate health and wellbeing policies and procedures and ensure their implementation.

9.7 However, it was widely accepted amongst RCS representatives that the difference which could be achieved as a result of a short one-off workshop session for employers would be limited. Consequently, a few contributors questioned whether the drive to achieve targets was being made at the expense of intervention which could make a greater difference to fewer employers.

9.8 The feedback from interviewed employers who had collaborated with RCS reinforced this view. The majority of those who had attended workshops thought that the benefits to their organisation were fairly limited due to the relatively brief nature of intervention. Several employer representatives observed that the workshops had been well delivered and had reinforced their own good practices, provided them with practical tips and hints and enabled them to develop a better grasp of the subject area.

9.9 In terms of ways to improve the employer workshops it was suggested by one contributor that it would have been helpful to distinguish between sessions targeted at employers and employees, as their session had straddled into helping employees who were in attendance to deal with their own personal stress as opposed to concentrate on equipping them as managers to deal with employees facing such situations.

ABMU

9.10 In the case of ABMU, the type of intervention provided to employers was equally considered to be light touch and as a result could only expect to bring about some minor changes. Indeed, ABMU representatives argued that the service could have benefited from having an employment adviser on board to complement the work of the clinical team and function as a conduit between the client and employing organisation.

Employer feedback

9.11 Of the four employers (as well as one GP practice) interviewed over the course of the evaluation who had collaborated with ABMU, most of them reported that their main involvement with the operation was attendance at workshops around stress busting and sedentary working. The feedback on these sessions was broadly positive with all contributors commenting that they had enjoyed the sessions, that they had been well structured and concise and that they had been delivered professionally. In all cases, the sessions had been delivered solely for employees of each organisation and because of this, any examples used during sessions had been tailored individually.

9.12 In terms of the difference made, some employers regarded the workshops as having made a positive contribution to their organisation, as illustrated below:

> One third sector employer had worked with ABMU with the objective of improving their staff wellbeing policies and practices so as to secure a Gold Small Workplace Health Award as part of the Welsh Government's Healthy Working Wales scheme. As a small employer, they lacked any occupational health expertise and capacity internally. The employer arranged for ABMU to deliver two workshops on stress busting and sedentary working to a small group of its employees and reported that the feedback from staff was very positive. They had particularly appreciated having one session delivered by a trained physiotherapist. The sessions were regarded as being very useful and valuable to staff which had, amongst other things, contributed to a 'cultural shift' within the organisation. Since having been involved the organisation had implemented a number of changes including establishing an annual wellbeing survey for staff and installing cycle racks at their premises. Whilst impossible to distinguish the impact of the intervention in light of other developments which had also taken place it was suggested that IWS had contributed towards these: 'outcomes would have developed without the support but we wouldn't have been able to achieve everything'.

9.13 Others believed that the difference made was more limited and attributed this to the fairly light touch nature of the intervention, the fairly limited number of employees who had attended the sessions and having a workforce which did not at the time face any major health and wellbeing issues. One such employer commented:

'I don't think we've had enough involvement to say it's changed anything'.

9.14 All four employers welcomed the availability of this service for their employees, particularly given that they were small businesses and did not tend to offer any occupational health provision for staff. Only one of the employers who contributed to the evaluation who had worked with ABMU knew whether any of their employees had then gone on to access therapy support. The other three were unsighted about this given that it is a confidential service and observed that they had:

'no idea if employees have accessed the Wellbeing through Work programme as it's confidential'.

9.15 The one employer who had worked with ABMU and referred its employees to the service suggested that they had informed some 30 employees of the service but again had no certainty that they then accessed the IWS support. It was estimated that the majority of these employees were presentees but were struggling with their attendance.

9.16 However, some four of the 11 employers interviewed in relation to the work of RCS had done so. In some cases employers had only referred one or two employees whereas the referral rate was greater in other organisations. In one case, the employer would have welcomed access to promotional materials in order to distribute directly to staff so as to encourage referrals. One employer recalled having referred some three employees to IWS and suggested that they had all returned pretty swiftly to work: 'they were not off work for long' although did not know whether all three had accessed the service.

In one case the organisation estimated that they had referred up to 15 employees to the RCS IWS operation over the last few years and they had accessed physiotherapy services to deal with bad back and neck problems in the main. The employer was positive in their view about the benefits which this had brought about for the employees and themselves as an employer, adding that they perceived that absent employees had been able to return to work quicker than would otherwise have been the case. Their absence rate had reduced to 3 per cent, in part due to the support offered by IWS but also due to a change to the business' sickness policy in recent years which had become less generous than historically. In this case, the operation had also helped them develop a new stress management policy.

9.18 At least two RCS employers who had attended employer workshops were unaware that they could refer employees to IWS for support, suggesting that there had been a lack of follow on communication from RCS about this type of service. One of these also suggested that they would have welcomed further involvement with the operation:

‘ultimately for us, it’s been disappointing that there was no follow-up or an email of a list of workshops available to us or a phone call that made us aware of what else was on offer. We were hoping it was the beginning of something.’

9.19 Indeed another employer, who had informed a large number of employees about the ABMU service, suggested that it would be very helpful to know how many employees had in fact accessed the IWS service. Whilst they appreciated that ABMU could not disclose any personal information to them they would

‘just like to know how many contacted them from our organisation, just so that we get an idea if our own promotion of the service is working or not’.

10. Equality, diversity, sustainability and language

10.1 This chapter considers the extent to which the IWS operation has made progress against its cross cutting themes. It draws upon the views of contracted provider representatives, employers and clients in the main and builds upon the analysis of participant demography discussed at chapter 5 of the report.

Client services

10.2 All interviewed clients took the view that they had been able to access the services offered by the IWS operation regardless of their age, gender, disability, race, religious belief or sexual orientation. Likewise interviewed clients with any care or childcare responsibilities took the view that the provision had been able to accommodate their needs. Indeed, where interviewed clients felt that they had experienced any access issues these were largely attributed to the need to travel some distance to meet with an ABMU therapist.

10.3 In terms of good practice, the following positive client experiences were observed:

- physiotherapists had been prepared for clients to bring their children with them when attending physiotherapy sessions
- appointments were often made to accommodate any childcare or other caring commitments that clients had (e.g. appointments during school hours)
- clients had been offered a choice to meet with a male or female therapist in the case of RCS
- clients had been offered a choice of being seen by a Welsh speaking therapist in the case of RCS.

Welsh language

10.4 Feedback from RCS and ABMU representatives and a review of IWS promotional materials shows that they have been prepared bilingually. Some Welsh speaking clients could recall having seen these bilingual materials.

10.5 RCS employ some Welsh speaking staff to the roles of case co-ordinators and therapists. These tend to cover the counties of Gwynedd and Anglesey. The team has been unable to appoint a Welsh language administrator at its base in Rhyl so prospective clients are unable to access the service in Welsh from the outset,

although are allocated to a Welsh language case co-ordinator and (if available) a Welsh language therapist on request.

10.6 ABMU does not have any Welsh language capacity within its core team to deliver its services through the medium of Welsh and the demand for Welsh language services to date was thought to be low. ABMU representatives noted that services in languages other than English could be provided if required, drawing upon the inputs of other therapists from within the organisation.

10.7 A handful of RCS interviewed clients were Welsh speakers but no ABMU interviewed clients were. Most of the RCS Welsh speaking clients interviewed had been supported by a Welsh speaking case co-ordinator and a few of these had also been able to access support from a Welsh speaking therapist. One such client observed that she had been offered a Welsh speaking therapist and took this opportunity up. In other cases, the client had no preference about the language of provision and placed greater importance on the expertise and approach of the therapist. It would appear that overall being able to access a Welsh speaker was more important for counselling services than physiotherapy services.

10.8 Project staff and therapists alike observed that some RCS clients will specify their preferences for the language of their preferred therapist. They are able to satisfy the needs of Welsh language clients (provided the therapist is fairly local to them or if the client is prepared to travel)

Gender

10.9 In the same manner, RCS will enquire whether clients prefer to see a female or male therapist. In most cases the organisation is able to fulfil the client's request but it has struggled on occasion to meet the needs of male clients who have specifically requested support from a male counsellor, due to the limited number of male counsellors appointed to RCS's framework of providers. In these cases clients have been given the choice of seeing a female counsellor or waiting until a male counsellor becomes available.

Tackling Poverty and Social Exclusion

10.10 It is worth noting that several RCS representatives argued that a fundamental objective of the IWS operation was to support people to stay in work or return to work, thereby improving their financial circumstances. Feedback from many clients suggest that the intervention is achieving this objective, particularly in terms of being

perceived to enable clients to return to work sooner than they would have otherwise done so. Furthermore, it was observed that any client, regardless of their financial circumstances, was able to access the service as it was free and that this had been important in broadening the type of clients using therapy services. One RCS contracted provider for instance noted that the profile of IWS clients supported by their practice was in stark contrast to the profile of clients typically supported by them:

'IWS has opened up our practice to a broader range of patients. We've seen a real shift in the profile of people we work with. IWS clients are mostly from low pay, manual employment sectors who would never have considered using [type of therapy] before.'

Employer services

10.11 The feedback from employers as to whether they had been able to access IWS services in a way which accommodated their needs and requirements was more limited, not least as none of the employers interviewed had asked for the service to be provided in Welsh. Despite this, none of the interviewed employers raised any difficulties in accessing the service.

11. Conclusions and recommendations

11.1 This chapter presents our conclusions for the evaluation and offers a number of recommendations relating to the current operation and future intervention. In doing so we return to consider the key objectives of the evaluation, namely:

- to assess and compare the implementation of the operation in two areas, for absentee and presentee participants
- to assess and compare the implementation of the operation in two areas, for professionals, employers, GPs and other local stakeholder organisations
- to assess and compare the project management of the operation in two areas, and
- to assess perceived impact and usefulness of the services provided.

11.2 Before setting out our conclusions and recommendations, it is worth summarising some of the limitations associated with this evaluation and its findings.

Limitations of findings

11.3 First, the evaluation is only able to draw upon perceived impact findings as offered by interviewed clients, providers, GPs and employers. Interviewed clients have no way of knowing what would have happened in the absence of receiving IWS services and can only speculate at these scenarios. It is therefore very difficult to come to any firm conclusion about the overall impact of the IWS operation.

11.4 Second, the evaluation cannot offer any firm conclusion on the extent to which any outcomes reported by interviewed clients can be attributed to the IWS operation. The lack of any data for a comparator group e.g. data for a control group of absentees or presentees exhibiting similar characteristics to those of supported clients but who do not access any similar support makes it impossible to test the views of interviewed clients around the perceived difference made.

11.5 Third, care needs to be taken when interpreting the findings in relation to interviewed clients as the sample of clients interviewed represents a very small proportion of the overall client base for both RCS and ABMU. The issue is more pronounced in the case of ABMU as a result of the delay in accessing participant data, given that only 18 qualitative interviews were achieved and nearly half of

these took the view that they had not actually received support. The difficulties encountered in securing responses from clients may also have bearing upon the over-representation of interviewees who have particularly strong views (both positive and negative) and as such it is difficult to draw out any wider conclusions from the evidence gathered from interviewed clients.

11.6 Fourth, it is possible that feedback from GPs and local stakeholders who contributed to the evaluation may be biased as it is likely that those who have been most engaged with IWS and attach the greatest value to it have been the most inclined to contribute. It proved challenging to secure the input of GPs in particular, as well as local stakeholders in the case of ABMU, and as such care should be taken when drawing out any wider conclusions from these findings.

11.7 Fifth, in assessing and comparing the implementation of the operation across two different areas it is impossible to conclude whether one approach is better than the other given that other external factors such as different delivery organisations, different staff and models of delivery have such a significant bearing upon their implementation. Rather this evaluation can only identify and draw out the strengths and limitations of each approach adopted.

Programme implementation

11.8 The analysis of participant monitoring data suggests that there are similarities as well as differences in the profile of clients supported by ABMU and RCS. Both have client profiles which are similar in terms of gender and age. Also, geographically clients have been well distributed across their local authority target areas. RCS, however has been more successful in securing the engagement of self-employed clients as well as those working within the private sector whilst ABMU has succeeded in engaging a higher proportion of disabled clients and clients from BME backgrounds.

11.9 The analysis of participant monitoring data shows that overall three-quarters of clients supported by IWS are presentees and a quarter are absentees. The higher than anticipated proportion of presentees is largely accounted for by the difficulties in engaging with absentees, given that the operation was designed to accommodate absentee referrals from the Fit for Work scheme. In the event these referrals did not materialise and providers have had to allocate a greater proportion of their resource

to actively recruit this cohort. The difference between the proportion of RCS and ABMU clients who are absentees or presentees is notable, with RCS having supported a greater proportion of presentees.

11.10 The nature of services demanded by RCS and ABMU clients has also differed – whilst the large majority of ABMU clients have required emotional or mental health support the large majority of RCS clients have required physiotherapy support.

11.11 In terms of client engagement and referral routes, both RCS and ABMU have attempted to engage GPs and other healthcare professionals to raise awareness of IWS to prospective clients who have then self-referred for support. RCS has had greater success in securing the commitment of a greater number of GPs within their area to do so and many lessons can be observed from their experiences, not least the effort required on an ongoing basis to remind GPs about the availability of IWS.

11.12 In terms of the operation's outputs reported to WEFO, we conclude that IWS has made reasonable progress against its output indicator of supporting employed participants with work-limited health condition or disability particularly given the initial difficulties experienced in engaging with absentees, having engaged 3,410 participants as at the end of May 2018. The majority of these participants have, however, been presentees and this accounts for the exceptionally strong performance reported against the result indicator 'number of employed participants reporting an improved labour market situation upon leaving the operation' and the low number of participants reporting that they had returned to work after a period of absence.

Comparison between approaches

11.13 The models adopted by both RCS and ABMU have differed substantially. One model has been led by a third sector organisation, using a core team of non-medical staff and a network of contracted providers to deliver client therapy. The other model has been delivered by a health board utilising employed occupational therapists and physiotherapists to deliver all aspects of the service. The third sector organisation has been able to respond flexibly to the needs of the operation and its funders whilst the health board has been able to offer a service which has been embedded within NHS processes.

11.14 The two models have, in different ways and to different extent, been able to put into place the key levers of change identified within the Theory of Change report as being critical to the successful delivery of the IWS operation. These have included:

- an exceptionally rapid access to intervention, in the case of RCS
- flexible personalised support
- multiple referral routes into the operation with GPs playing a key role in the case of RCS and other health professionals playing an important role in the case of ABMU.

11.15 Client feedback about their experiences of the RCS service is exceptionally positive in terms of how quickly they have been able to access it, the ease at which they have been able to be supported, the quality of the therapists allocated to them and the appropriateness overall of the number of sessions available. The limited number of interviews achieved with clients who accessed ABMU services does not allow the evaluation to come to any firm conclusion about the quality of provision provided although it is concerning that nearly half of the ABMU clients approached reported not having been supported by IWS. In addition, given that the main reason cited for not being able to access the service related to delays on the part of the service, we would question whether it would be sensible to refrain from over-marketing in the future for fear of raising expectations which cannot then be fulfilled.

11.16 Whilst the provision available at ABMU is mostly phone based, the rationale offered by ABMU representatives for doing so (i.e. because it means clients can access the service quicker) is somewhat undermined by the fact that RCS clients, who are seen on a face to face basis, are supported at a much quicker pace.

Perceived Impact and usefulness of support

11.17 The participant data shows that at least a third of absentee clients (RCS) had returned to work at the point of being discharged. The participant data also shows that some 70 per cent of RCS clients reported that their health or labour market status had improved at the point of being discharged. Furthermore, the data shows that just over half of those discharged from the service were known to be in employment six months after leaving and a similar proportion were known to have an improved health or labour marketing position at that time. The participant data made available for the health outcomes achieved by ABMU clients shows that the

71 per cent of clients reported an improvement in their health condition and that the greatest change was observed in their levels of anxiety and depression as well as their ability to undertake usual activities. We conclude that these outcomes appear positive but in the absence of any counter-factual or comparable data it is difficult to offer a firm conclusion. The feedback from RCS clients suggests that early intervention is perceived as critical in addressing health issues.

11.18 Turning to consider the extent to which IWS is contributing to the outcomes identified within the Theory of Change model the findings of the fieldwork suggests that the operation is perceived to have helped improve the health and wellbeing of both absentees and presentees. The fieldwork also found evidence that the intervention is perceived to have positively impacted upon the number of days which an employee takes off as sick leave, provided the services can be accessed in a timely manner. The perception of several absentees suggests that IWS may make a positive difference to their ability to return to work quicker than would otherwise have been possible. In terms of the improved labour market situation of presentees the fieldwork found that this tended to vary from client to client, although some common outcomes were identified such as improved productivity, ability to perform tasks which they previously could not undertake and returning to full rather than reduced duties at work.

11.19 The fieldwork with clients suggested that some do perceive to gain improved financial circumstances as a result of accessing the provision, particularly those who are self-employed and some presentees who felt that they would otherwise have left their job as it had become untenable for them to stay on. In the same manner the fieldwork found that IWS is perceived to have a positive impact upon reducing unemployment amongst those with a WLHC: some clients who've accessed counselling support thought that the support has, in turn, helped them to secure another job for instance.

11.20 The fieldwork also encountered several examples of clients who perceived that they have reduced their need for NHS provision and this finding was supported by the views and perceptions of GPs.

11.21 It is more difficult to come to a view about the extent to which IWS contributes towards a reduction in long-term absences, not least because those classified as being absent from work include clients who have only been off for a few days and were unsure whether they would be off work on a long-term basis when making

contact with IWS. It is also worth considering that the operation has supported clients with moderate to severe health conditions and, whilst the intervention has delivered some short-term health improvements for this group, this cohort is more likely to be off work on a long-term basis.

11.22 We conclude that the IWS operation has, to date, only been able to make a fairly limited contribution to some of the employer outcomes identified within the Theory of Change model. This is primarily due to the fact that employer intervention has been very light-touch in nature and it would be unrealistic to expect a short half day employer workshop to generate outcomes such as improved workforce health, improved occupational health provision and reduced staff turnover. It would appear however that employer workshops have served to improve awareness and understanding of WLHCs within the workplace, which is one key outcome identified within the Theory of Change model.

11.23 Having said this however, the evidence from client interviews would suggest that some of these employer related outcomes are being achieved indirectly via client services. For instance, several presentees reported that their productivity had improved as a result of IWS given that they were able to undertake their normal duties without pain and discomfort.

Wider discussion

11.24 The evaluation has reinforced a point raised within the Theory of Change report that there is often not a clear-cut distinction between the characteristics of absentees and presentees. Indeed, the evaluation also found that the services offered to both groups and their experience of the intervention is the same – the only notable difference being that greater priority is given to supporting absentees due to the operation's need to address its shortfall against WEFO funded targets. The evaluation found that a broader definition of an 'absentee' client has been adopted than was originally planned for and there is a strong tendency for participants to be classified as 'absentees' even if they have only been off work for a very short period of time (i.e. a few days). As such, participants who are nearing a four-week absence period at the point of registration only form a small proportion of clients reported as 'absentees'. This development is, in our view, somewhat at odds to the underlying rationale for the operation in that the intervention was intended to focus on clients at greatest risk of long term sickness. The operation has been able to accommodate

this wider cohort of absentees due to the fact that the intervention is also able to support presentees. As such we conclude that the separation between absentees and presentees has not been particularly helpful to the operation's delivery and that it would have been easier to have considered clients as being placed along a continuum rather than falling into one of these well-defined classifications. Indeed, we would also add that from a reporting perspective to WEFO, the operation did not need to distinguish between its absentee and presentee outputs as a condition of its EU funding.

11.25 Contributors to the evaluation argued that there was a substantial need for the operation although this need was mostly found to be fuelled by gaps within the existing service (i.e. a shortfall within the provision available via the NHS service and a lack of employer led occupational health provision). From a client perspective, the evaluation found that there is a high level of demand for services but that this demand has primarily come from presentees or absentees who have only been off work for a short period of time. It is possible that some of these presentees and 'early- stage' absentees would return to work anyway after the four-week period of absence, but with lack of evidence to prove either way it is impossible to come to a firm conclusion about the operation's effectiveness and difference made. Despite this, the evaluation has raised some important considerations as to whether the operation has in fact fuelled demand for services amongst some audiences who would have achieved similar outcomes in the absence of intervention.

11.26 We conclude that there was not a clear rationale for focusing the operation on eight specific local authority areas and the selection of these areas was mostly influenced by the geographical coverage of the two delivery organisations and delivery logistical considerations. In our view, other than for financial resources and EU boundaries, we do not see why the services of the operation need to be restricted to specific local authority areas and that prospective clients who live or work outside of the selected areas be turned away for support. However, we recognise that funding restrictions would not make it viable to deliver the initiative on a large scale e.g. on a pan-Wales basis and we therefore recommend that any future similar intervention be better informed by levels of need (e.g. levels of sickness absence) and targeted towards those clients where the greatest added value can be achieved (i.e. clients who are least likely to achieve similar outcomes in the absence of intervention).

11.27 Another area to be raised by this evaluation relates to the number of therapy sessions which clients are able to access. The evaluation found that setting in place a maximum number of sessions to which clients are entitled was largely appropriate but there could possibly be a greater emphasis (particularly in the case of RCS) to reviewing whether clients require all these six sessions. Whilst we did not encounter any evidence to prove either way, the operation could become more efficient in communicating to clients that they will only receive their maximum number of sessions should their therapist consider this necessary in the future.

Recommendations

11.28 We offer the following recommendations which cover the current operation's implementation, future approach and lessons learnt to enable a stronger evaluation design:

11.29 In terms of the current operation's implementation:

Recommendation 1: The original targets set for engaging and supporting employers (i.e. to engage with 1,050 SMEs and for 525 of these to adopt or improve their equality and diversity strategies as well as for 130 workplace health programmes to be delivered) were highly optimistic, if not unrealistic given the resources allocated by the operation to this area of work. We recommend that the Welsh Government seeks to reduce these WEFO funded targets for the remaining duration of the operation so as to better reflect current achievements

Recommendation 2: At present the operation is focused on supporting employers via a light-touch intervention (such as a half day workshop) and this intervention can only be expected to raise awareness and provide information to employers rather than result in employers adopting changes to their sickness absence and health policies and practices. We recommend that the Welsh Government liaises with WEFO to address this matter as a priority to ensure that either (a) the operation's provision to employers can be counted as an eligible outcome against this target or (b) that the operation reviews and makes fundamental changes to its provision for employers so that it is considered as eligible activity from WEFO's perspective

Recommendation 3: We think it appropriate to highlight the lessons learnt for an NHS based organisation in terms of ensuring greater clarity at the outset that the IWS operation be delivered as a distinct, EU funded service rather than a service

which has been ‘mainstreamed’ into existing provision. It would have been beneficial for ABMU to have been able to scope out the implications for delivering a EU funded initiative at the outset and put in place the necessary arrangements to ensure that it could adequately meet EU funding requirements. This would include:

- ensuring that the initiative was communicated appropriately to prospective clients so that it was clear who was eligible and ineligible for the service (and how ineligible clients would be dealt with)
- adopting processes to collect the necessary evidence and registration information from prospective clients from the outset
- adopting quicker processes to meeting client needs e.g. setting in place maximum waiting times for clients to meet with a representative from the operation and thereafter to receive services
- allocating greater resources from the outset to promote the service to prospective employers (particularly using employer networks and member organisations) and GPs. As has been demonstrated by RCS, adopting a focus on lower paying employment sectors would have ensured that the service was targeting those clients least likely to have been able to pay for similar provision

11.30 In terms of making recommendations for future Welsh Government policy and future intervention:

Recommendation 4: There is a strong rationale for focusing any future intervention on those geographical areas and client groups which face the greatest need. In particular, there is a strong case for ensuring that intervention is better aligned to the operation’s underlying rationale i.e. to support those who are at the four-week absence point

Recommendation 5: We would recommend that elements of good practice in terms of operation delivery as identified via this evaluation be adopted within any future provision including the principles of early intervention, the use of setting time limits for meeting clients and the quick turnaround for therapy support

Recommendation 6: We would recommend that adequate resources be allocated from the beginning to promote the intervention widely via employer groups and GPs, to ensure that clients are recruited efficiently from the outset

Recommendation 7: We would recommend that any future intervention continues to support the needs of employers but does so in a more flexible, co-ordinated manner. There is scope to ensure that a more consistent offer is made available to employers across the operation, regardless of which provider delivers it, and that this offer includes the provision of an employer toolkit which could include healthy working policy templates that employers could modify and adopt as appropriate. Future approaches should allow for the needs of individual employers to be met, via individual advisory or training sessions for instance, in addition to the provision of group based awareness raising sessions.

11.31 We offer the following recommendation for undertaking a stronger evaluation of similar interventions in the future:

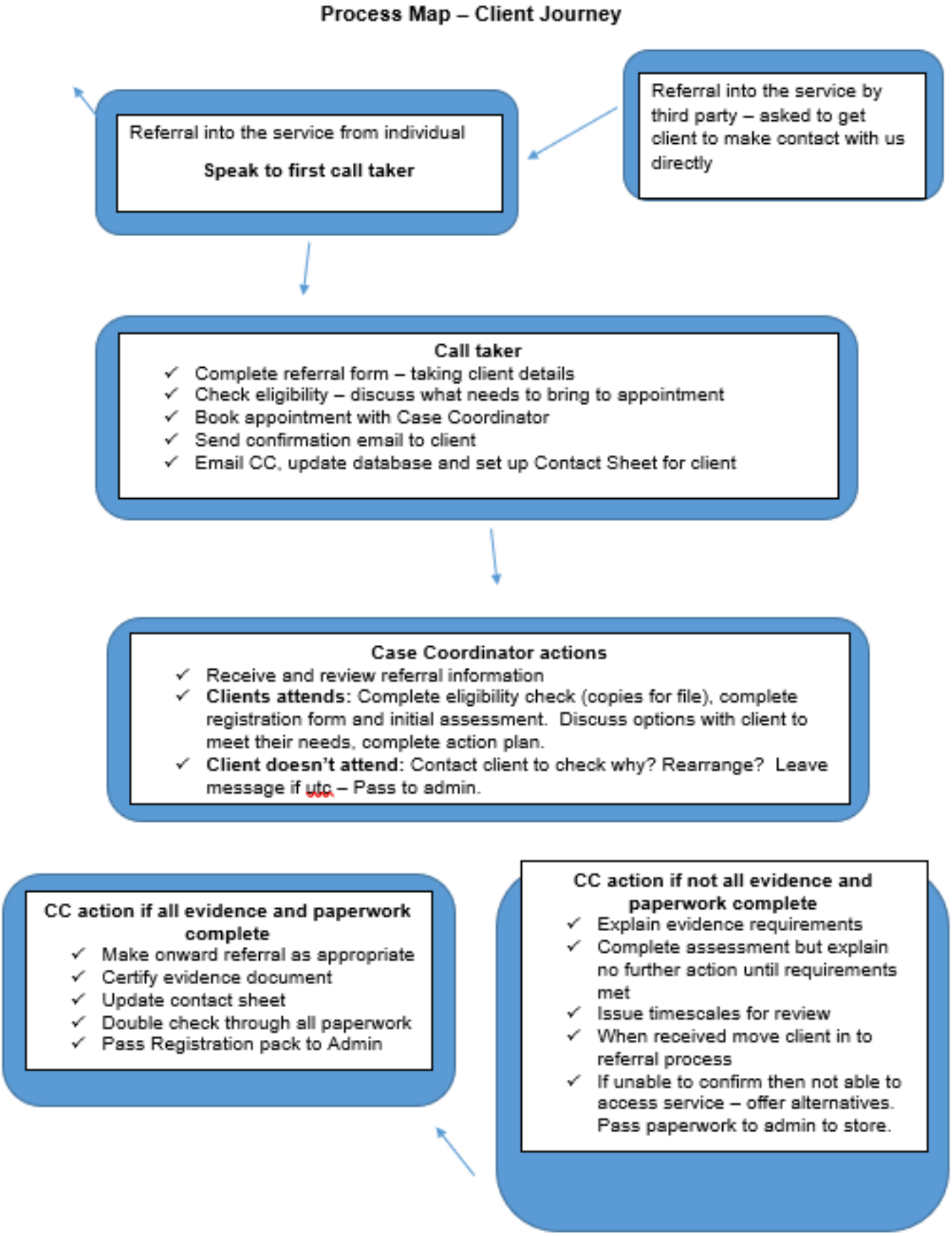
Recommendation 8: We recommend that:

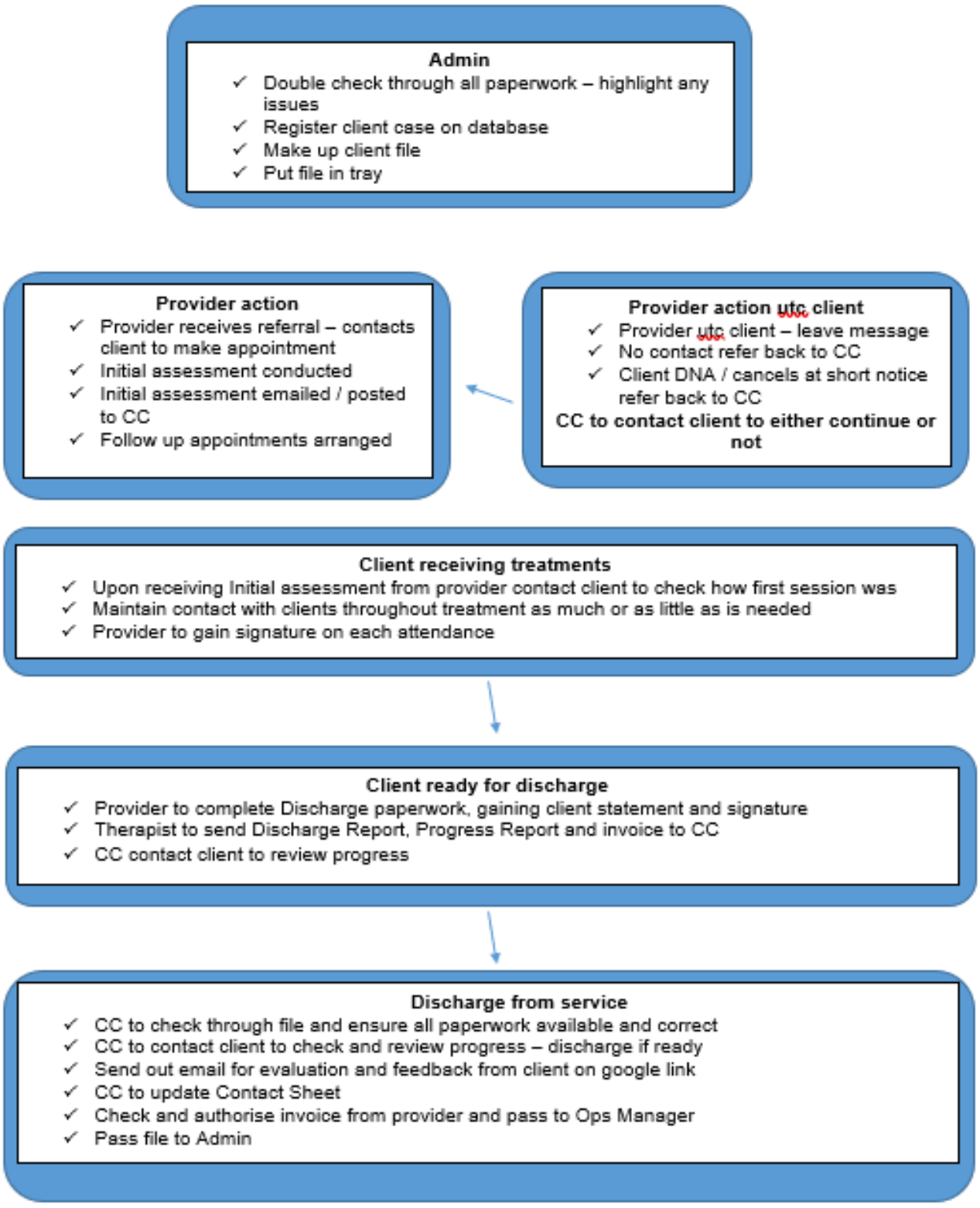
- A greater number of interviews with ABMU clients who had been supported would have provided a stronger evidence base for this evaluation. This could have been achieved had ABMU been able to share their database of clients at an earlier stage in the evaluation and/or if a larger sample of contacts had been requested initially to allow for any clients who had not been supported to be excluded from the research
- It would be feasible to give consideration to survey data available via the ESF Participant survey commissioned by WEFO for ESF funded operations. Consideration of quantitative survey data for those participants who will have contributed to this research would supplement the qualitative findings gathered via participant interviews conducted as part of the evaluation
- Consideration be given to re-interview a small number of participants and employers who contributed to the evaluation to understand the long-term benefits and impact of their participation within the IWS operation. From the perspective of participants, this would allow evaluators to assess the extent to which they have been able to return or stay in work, whether they have been able to better manage their health conditions in the long term and whether any work-related changes have been sustained
- It may be worth scoping the possibility of developing a participant control group to test whether the perceived changes experienced by participants could be attributed to intervention. This is by no means an easy task –

identifying and accessing such a control group who have not accessed similar support elsewhere would be challenging in light of the way IWS is delivered

- It is difficult to identify ways for securing the input of a greater number of GPs given the significant efforts deployed to contact and interview this cohort during the evaluation. However, it could be possible for the operation itself to help gather this type of feedback on the evaluator's behalf (e.g. during surgery visits) provided the research recognises the limitations of capturing feedback in this manner.

Annex A: RCS' client journey




Admin
✓ Double check through all paperwork – highlight any issues
✓ Register client case on database
✓ Make up client file
✓ Put file in tray
Provider action
✓ Provider receives referral – contacts client to make appointment
✓ Initial assessment conducted
✓ Initial assessment emailed / posted to CC
✓ Follow up appointments arranged
Provider action utc client
✓ Provider utc client – leave message
✓ No contact refer back to CC
✓ Client DNA / cancels at short notice refer back to CC
CC to contact client to either continue or not
Client receiving treatments
✓ Upon receiving Initial assessment from provider contact client to check how first session was
✓ Maintain contact with clients throughout treatment as much or as little as is needed
✓ Provider to gain signature on each attendance
Client ready for discharge
✓ Provider to complete Discharge paperwork, gaining client statement and signature
✓ Therapist to send Discharge Report, Progress Report and invoice to CC
✓ CC contact client to review progress
Discharge from service
✓ CC to check through file and ensure all paperwork available and correct
✓ CC to contact client to check and review progress – discharge if ready
✓ Send out email for evaluation and feedback from client on google link
✓ CC to update Contact Sheet
✓ Check and authorise invoice from provider and pass to Ops Manager
✓ Pass file to Admin

Admin discharge file

- ✓ Input all data required from file into databases
- ✓ Receive information back print and input
- ✓ Update contact sheet
- ✓ Check through file and complete client control sheet
- ✓ Input dates for follow up calls to be made
- ✓ Discharge client on system

6 month / 12 month follow up calls

- ✓ Admin to send client follow up review link
- ✓ If not heard back then telephone call to try and complete follow up questionnaire
- ✓ If 2 unsuccessful attempts then close interest
- ✓ Update system and client contact sheet with follow up information

Client file archived

Once 12 month follow up has been completed, the file should be archived and the database should be updated.