Public Policy Institute for Wales
Sefydliad Polisi Cyhoeddus i Gymru

Improving Health & Employment Outcomes through Joint Working

January 2018

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[1] In October 2017 the PPIW became part of the Wales Centre for Public Policy. The Centre builds on the success of PPIW, and will continue the Institute's work of meeting Welsh Government Ministers' evidence needs, alongside a new mission to support public services to access, generate, evaluate and apply evidence about what works to key economic and social challenges. This assignment was commissioned for the final PPIW work programme.

Contents

Summary

- Evidence suggests that the most effective support for people with chronic health conditions trying to stay in work, or return to work, is provided through joined-up interventions that combine support for skill acquisition, vocational guidance and motivation, with clinical or rehabilitation provision.
- These joined-up interventions demand optimal collaboration across an array of institutional stakeholders – such as healthcare professionals, employment services, employers, and third sector providers. We suggest it is only by improving joint working between these groups, and these individuals, that further substantial and sustained progress can be made. In this report, we draw upon available evidence and expert opinion to highlight how to improve institutional collaboration around health and work.
- Intervening early is key. It is not always more costly, and must become a more prominent element of our healthcare offer as chronic conditions become more prevalent, as our population ages.
- Work should be regarded as a clinical outcome by healthcare practitioners. There is emerging evidence that social prescribing models that focus either directly or indirectly on work outcomes can be effective in promoting job retention, return to work or vocational rehabilitation.
- A plurality of referral pathways is vital to ensure people can access support when they need it. GPs are a key entry point, and need consistent access to occupational therapy and/or social prescribing to meet increasing demand. Job brokering services can play an important role, especially if seen as independent of DWP and job centres; the third sector might play an increased role here.
- Evidence suggests that paying attention to effective implementation, and not just the desired model, is critical. Key factors include:
    - Co-producing the theory of change (what the joint intervention is trying to do and how) with all partners, so they 'buy in' to the approach;
    - Staying faithful to evidenced models, to achieve full impact (e.g., the Individual Placement and Support implementation approach);
    - Co-location and data sharing, which form a platform for integrating interventions;
    - Strong execution, including project management, governance and data-sharing.

Context

Measures to support job retention and return to work among those working age people with health conditions have been a policy priority across the UK for several years. Despite historically high employment rates in Wales and in the UK as a whole, significant regional variations exist in unemployment rates among adults, young people and those with long-term illness and disability.

Both the UK Government and the Welsh Government have acknowledged the importance of progressing policies to the benefit of those individuals who remain detached from the labour market or who are at risk of falling out of work as a result of their health[2]. In Wales there are almost 160,000 Employment and Support Allowance (ESA) claimants (May 2017 data) and, despite this number being in decline over recent years, the Welsh Government is attaching priority to supporting efforts which help even more of this group back into work. The 2016 Work, Health and Disability Green Paper set out proposals to halve the disability employment gap and to improve both health and employment outcomes – including progression within work - for people with chronic health conditions. The demographic imperative to improve employment outcomes is also growing. As the UK's working age population gets older and has to work longer before retiring, the proportion of the economically active workforce with a chronic condition is set to grow, with over 40 per cent forecast to have at least one chronic and work-limiting health condition by 2030 (Vaughan-Jones & Barham, 2009).

In this context, many 'active labour market' policies aimed at supporting unemployed people back to work are having to consider how some of the health barriers to work can be overcome. Here, traditional 'human capital' interventions to support skill acquisition, job search skills, vocational guidance and motivation are being supplemented with interventions which involve clinical or rehabilitation support, which help functional restoration or improve mental wellbeing, as a route to fuller labour market participation. The evidence-base for a range of interventions which help people with the two most common work-limiting health conditions to remain active in the labour market (mental illness and musculoskeletal disorders (MSDs)) has grown considerably in recent years. However, several barriers to the adoption and implementation of these interventions remain, many of which are institutional and involve optimal collaboration between a number of stakeholders – especially employment advisors, healthcare professionals and employers. For example, despite recognition of the therapeutic benefits of

[2] For example, the forthcoming Working Wales employability programme is an example of an initiative which will focus on supporting improved employability among people who are both close and more distant from employment.

good quality work for these workers from the Chief Medical Officer for England, (Heron, Bevan and Varney, 2016) the goal of persuading many healthcare professionals that they should attach priority to 'work' as a clinical outcome of care has been difficult to progress. Similarly, among some employment advisors, the complex needs of people with comorbid health problems, or the need to support job search in a manner which is informed by the biopsychosocial approach can often be resisted on the grounds of expediency or in pursuit of targets. Even where health professionals and employment support services are well-coordinated and integrated it can be difficult to engage with some employers who find job redesign and vocational rehabilitation complex, disruptive and costly.

It is increasingly clear, therefore, that it is only by improving the way that institutional stakeholders work together that further substantial and sustained progress can be made to improve health and employment outcomes for those who need help back into work and those at risk of falling out of work. In Wales, the Healthy Working Wales initiative provides support to both employers and healthcare professionals (as well as to individuals), and the Fit for Work Service has been helping to support both workers and employers to manage job retention and return to work through case managed interventions led by Occupational Health (OH) professionals. In Wales the health and work policy domains straddle both devolved and non-devolved responsibilities. This means that the need for cross-agency and multi-stakeholder collaboration is even more important if those people with complex health and other challenges, who have been unemployed for a long period or whose skills need to be updated, are to get the multi-agency support they need. There will be a need for more intensive effort to embed joint working to improve both health and employment outcomes for those whose health makes their position in the labour market vulnerable or precarious.

In the early summer of 2017 the Public Policy Institute for Wales (PPIW) commissioned the Institute for Employment Studies (IES) to conduct an expert-led review to explore how employers, health services and employment services in Wales can work together more effectively to produce better health and work outcomes. This document presents the findings and conclusions of this review.

Primary review questions

The main questions which the review has addressed are:

1. What are the different ways in which health, employment services and employers can work more closely together to assist people who are in work but are at risk of leaving,

have recently left work, or have been out of work for a long period, due to MSD or mental ill-health?

2. What are the barriers preventing more effective joint working?
3. How can employers, the health service, the Welsh Government and the Department for Work and Pensions (DWP) overcome these barriers and ensure sustainable joint working practices?
4. Are there any structures or processes which need to change to ensure closer working of health and employment services for long term success?

Approach

IES has a long track record of evaluation and applied research in the field of health and work, examining literature on interventions, conducting large-scale impact and economic evaluations of major government programmes (e.g., the Work Programme, Access to Work, the Fit Note and the Fit for Work Service), assessing the effectiveness of a variety of active labour market policies targeting people of working age who have work-limiting health conditions, and working in multi-agency projects both in the UK and internationally. Drawing on this experience, IES has drawn together, in a concise and focused way, the evidence on cross-institutional and multi-agency working arrangements which have a track record of success and from which transferable and scalable lessons can be learned and adapted. We have used two main sources in conducting the review:

- Evidence from published and unpublished literature;
- Expert focus groups and interviews with researchers, policy analysts and other authorities with a track record of work in this field.

The body of this report will be structured as follows:

- Lessons from the literature;
- Lessons from experts; and
- Main conclusions and policy implications.

The review was not intended to collect primary data but rather to tap into the large body of expertise, data and insight which already exists in this area. As a result, this document is intended to provide a succinct and accessible overview of our findings. More detail from individual studies or from our consultation with experts can be made available if required.

Evidence from the Literature

Understandably, the primary focus of the literature in this area is on the effectiveness and impact of interventions to support people back to work. Only in relatively recent times has systematic attention been paid to the role of stakeholders and stakeholder collaboration in the effective and sustained delivery of these interventions.

We reviewed the existing literature in this field (both in the UK and internationally) and identified a number of themes which are relevant to the issue of stakeholder collaboration and effective 'on the ground' implementation. These are:

- Logic Models/Theories of Change
- Pooling Budgets
- Prevention & Early Intervention
- Fidelity Models & Implementation Science

A summary of each is set out below, and references to the main studies appear at the end of the paper.

Co-producing logic models and theories of change

Spelling out the logic behind an intervention and the outcomes it is expected to deliver is arguably the most important aspect in the process of designing the intervention and evaluating it. A Logic model is a generic term that describes various representations of return to work programmes linking their contexts, assumptions, inputs, intervention logics, implementation chains and outcomes and results (Champagne & Rivard, 2016). For example, let us take a logic model for an intervention aimed at helping unemployed people living with depression or anxiety back to work. A logic model, at its simplest, would need to set out how the clinical needs of these clients will be supported in order to ensure that interventions to support job search and engaging with the labour market will have the best chance of success. In one sense, a logic model is like a hypothesis – it is a way of setting out the logical chain of measures which need to be put in place to get the best outcome.

However, providing the logic to a model alone is unlikely to impact upon its delivery and take-up across organisations. Indeed, imposing a logic model upon organisations from above is unlikely to result in positive outcomes as organisations may resent having something imposed on them which they have not been involved in developing.

The important element of these models is to collaborate in the co–production of the logic models to ensure that all partners agree from the outset on the end goals, how the outcomes will be achieved and the role of the different partners in achieving those outcomes. If the right people are involved in the design of the models, then the evidence shows that they are more likely to succeed and result in effective collaborative working.

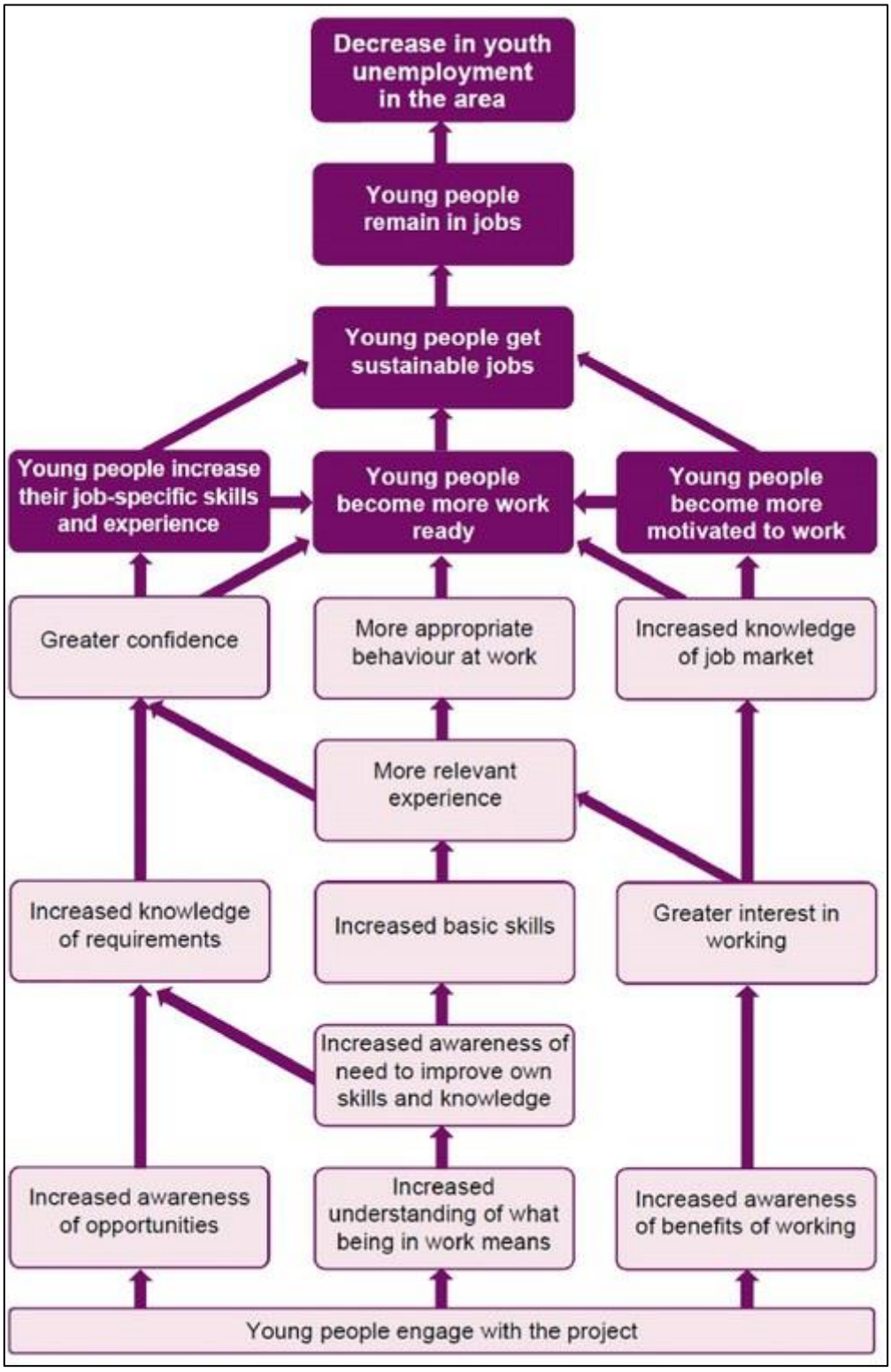
These models can be relatively simple or more complex:

Intervention logics are relatively simple models that graphically illustrate programme components – the intervention logic takes a narrow but descriptive look at the relationship between inputs and results and it summarises a complex theory into basic categories. In the case of a return to work (RTW) intervention, the intervention logic may also include the rationale or the needs that the intervention is trying to address following through to what would be the expected outcomes, e.g., sustained return to work, improved self-management of health while in work.

Logical frameworks (or log-frames) present the intervention logic in table format and add information on how the achievement of objectives can be demonstrated through indicators, how these can be obtained (sources of verification) and what assumptions and risks were identified.

Theory of Change (ToC) models link the context of a policy intervention, activities and results in order to explain how and why the desired change is expected to happen. ToC explains (rather than simply describes, as is the case for other models) the causal relationships between context-input-output-outcome-impact in order to understand the combination of factors that will ultimately lead to the expected impacts. As such, ToC takes a wider view of a desired change by considering a contextual situation, assumptions (or pre-conditions that need to be met to allow the change) and related risks, as well as intended and unintended effects. In many ways, the ToC approach is a way of developing a working hypothesis of the process by which an intervention is expected to deliver both intermediate and final outcomes. An example of a ToC model designed to support a youth unemployment intervention appears in Figure 1, overleaf.

Figure 1 A Theory of Change Model for a Youth Unemployment Intervention



Source: The National Council for Voluntary Organisations (NCVO), 2017

In this example, the lighter coloured boxes represent intermediate or 'enabling' outcomes which are expected to lead to the final or primary outcomes in the darker boxes. Ideally, the various stakeholders involved in delivering this intervention would come together both to map out the model and its elements and, in doing so, develop a shared view of the pathways to a successful intervention and (crucially) what part each stakeholder plays in its delivery. Thus, an important intermediate outcome in this model is 'greater confidence' which, according to this ToC, is expected to contribute to both improved job-readiness and an increase in job-specific knowledge and experience. The model also looks at the factors which might contribute to 'greater confidence' and, in this example, the ToC highlights both increased knowledge of job requirements and more relevant experience. It might be expected that the delivery team planning and executing this intervention would agree what actions are needed to deliver 'greater confidence', who is accountable for them and how it will be measured.

Whatever approach is taken, it is common to question and challenge different elements of the model and links between these elements that suggest potential causal mechanisms by asking questions such as 'What (human, financial) resources are required to carry out the activities? What kind of collaboration, management or information-sharing will be needed to increase the chances of a successful intervention? What else needs to happen for the activities (outputs, outcomes, impacts) to occur? What are the risks / what can possibly go differently than planned?' (Armistead and Pettigrew, 2008). It is vital that all of the relevant stakeholders are present when exploring these questions to create collaborative solutions where each partner can see their role in achieving the outcome. Through early collaboration each stakeholder can take ownership of the process as well as be held accountable for each aspect of their delivery. This can result in more effective partnership working and accountability frameworks in what can be complex delivery models.

The ToC approach can be used to both plan and diagnose the success factors associated with high impact implementation of job retention and RTW programmes. It can also be used as a communication and (process) evaluation tool to ensure that all the stakeholders are bound to a central and shared set of expectations about the outcomes they are seeking.

Pooling budgets

Some studies highlight finance as an issue defining the success, or otherwise, of RTW interventions. While the literature highlights both the level and continuity of funding as important determinants of sustainability, another common challenge is that of shared or 'pooled' budgeting which, at least in theory, can reduce the occurrence of siloed ownership and decision-making. This is especially the case if one agency is paying for an intervention,

but the financial and other benefits accrue to another agency. Beyond the work and health field, such models have been used extensively in other policy areas, for example, children's services (Willis, 2011) and, in Wales, the Gwent Frailty Project (Lewis, 2015). McDaid (2012) highlights several different approaches to pooled budgets, which include:

Budget alignment: Budgets may be aligned rather than actually joined together. For instance, a health commissioner can manage both a health budget and a separate local authority budget to meet an agreed set of aims.

Dedicated joint funds: Departments may contribute a set level of resources to a single joint fund to be spent on agreed projects or delivery of specific services. This may often be a time-limited activity. There is usually some flexibility in how funds within the budget can be spent. A variant of this in the UK is the Personal Budget, which pools funds from several sectors but leaves it to the discretion of service users as to how funds should be spent.

Joint-post funding: There may be an agreement to jointly fund a post where an individual is responsible for services and/or attaining objectives relevant to both departments. Theoretically this can help ensure cooperation and avoid duplication of effort.

Fully integrated budgets: Budgets across sectors might become fully integrated, with resources and the workforce fully coming together. One partner typically acts as the "host" to undertake the other's functions and to manage all staff. To date this has largely been restricted to partnerships between health and social care organisations, or for the provision of services for people with mental health needs.

Policy-orientated funding: Central or local government may set objectives that cut across ministerial and budget boundaries and the budget system. Money may be allocated to specific policy areas, rather than to specific departments, as has been seen in Sweden through the following example.

Pooled budgets have been used to help develop joint approaches to rehabilitation and return to work for individuals with chronic health problems. One successful example comes from addressing musculoskeletal health problems in Sweden, where the health, social insurance and social work sectors have worked together to address this issue (Hultberg, Lonnroth & Allebeck, 2007). Indeed, Swedish cross-sectoral initiatives have been the subject of several evaluations. This so-called SOCSAM scheme allowed social insurance and social services to voluntarily move up to 5 per cent of their budgets, along with a matched contribution from health services, to a pooled budget to jointly manage rehabilitation services to help individuals on long-term sick leave return to employment. Along with funding, joint financial management arrangements were set up, helping to foster the development of joint services and a more

holistic approach to activities. The scheme was evaluated in eight localities and compared with experiences elsewhere in the country where schemes were not introduced. The evaluation found that return to work rates and interdisciplinary collaboration between health and social care professionals improved compared to control areas (Hultberg, Lonnroth and Allebeck, 2003). This Swedish experience also suggests joint funding arrangements and collaboration at local or regional level can be effective, where institutional structures are closer to stakeholders and have a better understanding of local problems (Nathan and Axelsson, 2007; Stahl et al., 2010; Moran et al., 2011).

Prevention and early intervention

There are several advantages (Bevan, 2015) to improving access to early intervention for working age people with chronic illnesses such as MSDs who may be at risk of reduced work ability or even job loss:

- *Better treatment*. In general, the quicker an individual receives a diagnosis, the more rapidly they can get access to appropriate treatment which can stabilise or control their symptoms;
- *Reducing the risk of developing comorbid conditions*. For many people with chronic conditions issues like pain, fatigue, depression or anxiety can become a significant issue which can increase healthcare costs and reduce functional capacity;
- *Aiding a return to activities of daily living*. Early intervention can ensure people with chronic conditions, especially if they are playing an active part in the management of their condition, can become more self-reliant and rely less on health and social care services; and
- *Staying in or returning to work*. People whose health conditions are being well-managed are more likely to remain economically active, continue to pay taxes and be less reliant on welfare payments (Squires et al, 2011; Warren and Bambra, 2013).

There is growing evidence that, if 'work' is regarded as a clinical outcome and that if patients of working age are given early access to treatments and therapies which improve their functional capacity and work ability, benefits can be derived by employees, employers and by wider society (Abosolo et al, 2005; Rogerson et al, 2010).

Example – Early Intervention for Workers with MSDs in Spain

An early intervention clinic was established in Madrid to test the impact of a 5-day early intervention among workers with MSDs compared with conventional treatment. This two-year intervention (Abasolo et al., 2005) with over 13,000 MSD patients resulted in a 50 per cent reduction in permanent work disability (i.e. people leaving work completely) and a 39 per cent reduction in temporary work disability (i.e. people having sick days from work as a result of their condition). In addition, patient satisfaction with this intervention was high and, analysis of the cost-effectiveness of the intervention in relation to the reduction in temporary work disability showed that for $1 of expenditure, $15 was saved in productivity benefits.

Despite these arguments, it is too often the case that opportunities to align clinical interventions, workplace interventions and welfare system support are frequently missed or not given sufficient priority. There are several barriers to early intervention, especially among people of working age:

- *Primary Care*. Often, GPs do not regard work as a clinical outcome to which they should attach priority. This means that treatments or therapies which may help an individual stay in or return to work may not be prescribed early enough. Providing training on work outcomes for GPs and other clinical groups can help here (Cohen et al, 2016). Giving GPs access to online or telephone resources on occupational medicine, or even shared access to OH nursing support within GP surgeries can help GPs put more emphasis on the work outcomes which patients want to prioritise.
- *Secondary Care*. Again, work ability is most often a second-order priority in these clinical settings. There have been some experiments in introducing work outcomes and aspirations in 'shared decision-making' tools being used in secondary care – especially in rheumatology[3];
- *Health Technology Appraisal (HTA)*. In some countries, HTA looks at the economic and societal benefits of giving patients access to treatment which will help them remain in work (Bevan, 2012). In others, only the direct clinical benefits and cost are examined. This makes the funding or early clinical interventions less likely. The National Institute for Health & Care Excellence (NICE), has shown some recent flexibility here, allowing work outcomes to be considered in the assessment of the value for money of medical devices such as insulin pumps for people of working age living with diabetes.

[3] See http://www.fitforworkuk.com/projects/

- *Employer behaviour*. Among many employers, failure to refer employees early to an Occupational Health specialist can extend the time that they are away from work through sickness absence and can increase their risk of leaving work permanently. Fit Notes and, more recently, the Fit for Work Service have had some impact here, though more needs to be done to extend their 'reach' so that more employers are aware of their benefits.
- *Social Welfare*. Some welfare systems place more emphasis on interventions which reduce flows of claimants onto benefits than aligning with clinical and workplace interventions to prevent job loss. This can mean that some people leave the labour market before receiving a welfare-related intervention. Recent emphasis by the Welsh Government and by the DWP on promoting in-work support to encourage job retention is welcome here[4].
- *Concerns over Costs*. It is still common to find that early intervention is regarded as the most costly option. This is clearly an issue at a time when healthcare spending is subject to greater controls. However, where there is evidence that targeting resources at early interventions can save money in the medium to long-term, it is increasingly important to highlight practical examples which allow clinicians and others to see such interventions as investments rather than costs. There are now more examples of cost-effective early interventions (such as in first-episode psychosis – McCrone et al, 2010) which should help to demonstrate the cost utility of giving clients access to early support.

Effective early intervention is, ultimately, a form of prevention as it can ensure that symptoms are discovered, treated and have only minimal impact on an individual's work ability (Fisher et al, 2013). In order to achieve the clinical, societal and economic benefits of early intervention, however, it will be important that all stakeholders (clinicians, policy-makers, employers and patients) coordinate their efforts. As chronic ill-health becomes more prevalent, early intervention will need to become a more prominent feature of the sustainable healthcare landscape. There is also some emerging evidence that some social prescribing models which focus, either directly or indirectly, on work outcomes can be effective in promoting job retention, return to work or vocational rehabilitation. The 'Bridging the Gap' example, below, illustrates a direct model in Leicestershire.

Example - Employment-Focused Social Prescribing

[4] This includes initiatives such as the in-work component of Healthy Working Wales and DWP initiatives such as Access to Work & Fit for Work, which have a focus on job retention.

Bridging the Gap (BTG) provides support to unemployed people with health conditions by assessing their needs and providing them with access to services to help them to both move towards employment and to better manage their health condition. The service takes an evidence-based approach by integrating health and employment services, whilst utilising the assets of the individuals themselves. Patients can either self-refer to the service, or be referred by their GP or JobCentre Plus Work Coach. In this sense it provides GPs with a holistic referral option that goes much wider than a medical consultation, covering medical (including physio and mental health) and non-medical issues as appropriate. This can operate alongside existing treatments to improve health and well-being. BTG case managers provide individualised support, and also act as a signposting or gateway service, providing service users with, and referring them to, an extensive range of interventions and activities. Clients are linked with sources of information and support within the community and voluntary sector such as volunteering, training, and financial, legal and housing advice. The service is distant and distinct from the Work Programme or other government mandated intervention.

The Bridging the Gap pilot programme is a Department of Health 'Innovation, Excellence and Strategic Development' funded initiative. It is delivered by two partner organisations – The Fit For Work Team Ltd and Pathways Community Interest Company.

Source: Steadman et al, 2017

A potentially promising area of research which might allow more targeted preventative interventions among people at work is the concept of 'work instability'. This approach is based on the principle that premature withdrawal from work (leading to work loss) may, for workers with certain health conditions, be possible to predict early enough for preventative action to be put in place. Validated measures are now available for use by clinicians and occupational physicians in conditions such as rheumatoid arthritis and multiple sclerosis (Wicks et al, 2016). The results suggest that vulnerability to job loss attributable to poor health can be spotted early and that remedial interventions and adjustments to job demands should be introduced to support job retention.

The importance of fidelity to models & implementation science

Some supported employment intervention models are designed around a very clear set of principles which focus not just on the intervention received by the client but also on the role and even the location delivery processes adopted by the stakeholders providing the support. Individual Placement and Support (IPS) is perhaps the most well-known of these models. IPS

supports people with severe mental health difficulties into employment. It involves intensive, individual support, a rapid job search followed by placement in paid employment, and time-unlimited in-work support for both the employee and the employer. The literature on IPS has much to say about the fidelity of the approach and is increasingly informing the discipline of 'implementation science' which seeks to codify the learning about implementation success factors in supported employment and other public policy interventions (Hasson, 2010, Main et al, 2016; Noel et al, 2017).

Effective integration of IPS specialists with mental health services is a strong theme emerging from a number of studies and previous research found that the degree to which integration of IPS with mental health services occurs predicts success (e.g. Rinaldi et al., 2011; Howard et al., 2010; Burns & Catty 2008).

The IPS Fidelity Scale includes several items which refer to the integration of services (team assignment, team member contact, collaboration with DWP and their contractors). Many studies focus primarily on co-location of IPS employment specialists in health teams. Different formats were used, for example:

- Full-time co-location: all sites involved mental health teams that formed partnerships with an IPS provider to co-locate an employment specialist into each mental health team (van Veggel et al., 2015)
- Part-time co-location: the IPS employment specialists were co-located at the mental health service for four of five days per week which enabled daily informal contact with mental health case managers, clinicians and shared consumers (Waghorn et al., 2014)
- Modified co-location: the IPS employment specialists were located at the mental health outpatient clinic but offered support in the community (Areberg & Bejerholm 2013).

Ottomanelli et al. (2014) reported on a culture shift which paved the way for integration of services, where IPS specialists engaged the services of the healthcare team to actively direct their efforts toward addressing the medical and psychosocial barriers to work. This required embracing the principle of zero exclusion and continuous education on the value of work and on the principles of the IPS model (Bond et al, 2016).

The evidence suggests that collaborative effort to build stakeholder relationships pays off. One study found that IPS employment specialists spent about 40 per cent of each week out in the community building relationships with new and existing employers. IPS adult studies with strong fidelity indicate that employment specialists spend 60–70 per cent of their time in job development in the community (Swanson et al., 2008). According to Howard at al. (2010), compared with other dimensions, the IPS intervention in the UK scored less well on:

- organisation dimension (integration of rehabilitation with mental health treatment);
- services dimension (rapid search for a competitive job); and
- number of contacts between IPS staff and clients[5] (compared to a few other studies which reported on this), which suggested that IPS implementation may have been sub-optimal.

The authors also hypothesised that the nature of the relationship between the IPS worker and the client (which was an independent predictor of outcome in a major European IPS trial - EQOLISE (Burns & Catty, 2008)) could also explain the poorer outcomes found in their study (Howard at al. 2010). In another British study, the IPS sites showed substantial room for improvement on 10 of the 25 items examined:

- Item 5: Integration of supported employment with mental health treatment through frequent team member contact
- Item 6: Collaboration between employment specialists and key staff members in Government DWP programmes and their contractors
- Item 8: Role of employment supervisor
- Item 10: The Mental Health Trust demonstrates a focus on competitive employment
- Item 11: Executive team support for supported employment
- Item 17: Job development - Frequent employer contact
- Item 18: Job development - Quality of employer contact
- Item 21: Competitive jobs
- Item 23: Time-unlimited follow-along supports
- Item 25: Assertive engagement and outreach by integrated treatment team (van Veggel et al., 2015).

Ottomanelli et al. (2014) concluded that some subtle modifications of the core IPS principles may be needed in the field of physical disability. For example, with a visible physical disability, the IPS specialists did not have to decide whether to disclose to employers the disability itself. Instead the emphasis of the IPS specialists was on working with employers to understand how a person with a given set of physical impairments can competently and capably perform a job with appropriate support from the IPS specialist and health care team. Logistical issues such as transportation needed special consideration and lower caseload ratios than those in the mental health field were preferable given the level of medical complexity.

[5] Of the 109 patients in the intervention arm, 73 (6 per cent) engaged with staff (i.e. had at least one direct contact with an employment consultant); of these individuals, the mean number of contacts with or on behalf of clients was 14 (s.d. = 10).

In the next section, the evidence from the literature is supplemented by some reflections from experts in the field.

Expert Perspectives

IES has collected views from a number of experts and stakeholder through:

- A focus groups of evaluation researchers convened at the IES offices in Brighton;
- A meeting of policy stakeholders in Wales convened by the PPIW; and
- A series of interviews and discussions with individual experts ranging from clinicians, employers, policy analysts, supported employment experts and vocational rehabilitation specialists.

The organisations represented in this consultation include the Learning & Work Institute, RAND Europe, the Centre for Musculoskeletal Health and Work, Mind UK, The Work Foundation, Institute of Occupational Medicine, London School of Economics, the Engineering Employers Federation and the National Institute for Health and Disability Insurance, Belgium.

Overall, the challenges and issues raised in this expert consultation echo many of those emerging from the review of the literature. However, a set of ten themes could be distilled from their contributions and these are summarised, on a non-attributable basis, below.

Role of general practitioners & other healthcare professionals

While an increasing number of GPs understand that being in work is important for some of their patients, their primary role is as the 'patient's advocate' and this will mean – on occasion – doing what they can to remove (and protect) them from what they regard as 'toxic' work situations. Many also argue that they are not well-informed about the work status of their patients, their desire to stay in or return to work, the demands of their jobs or the efficacy of the adjustments or accommodations which employers might be able to offer to help vocational rehabilitation. Few GPs have access to reliable or accessible Occupational Health (OH) advice, but those with access to OH nurses appear to feel more confident that they can meet some of the vocational rehabilitation needs of their patients. GPs are also very time-limited and resent operating a kind of 'police force' for the welfare system. In addition, continuity of GP care may be interrupted (e.g., through the use of locums) which may make it less easy to focus treatment on work outcomes.

Therefore, local initiatives to support job retention or return to work may rely heavily on GPs recognising that work can have therapeutic benefits for patients and prioritising work as a clinical outcome. They can be suspicious of the motives of both employers and employment service workers and can be reluctant to provide information, support referrals to schemes, pilots or trials. Among other healthcare professionals such as physiotherapists and occupational therapists (OTs) there is a more explicit expectation that their interventions will support both employment and health outcomes. However, a common concern is that this expertise is only patchily commissioned and hard to access (e.g. self-referral to physiotherapy) or that GPs are reluctant to refer their patients to services which they regard as poorly resourced or associated with long waiting times (e.g. Improving Access to Psychological Therapies (IAPT) services[6]). As mentioned earlier, there are now some examples (such as the Bridging the Gap initiative in Leicestershire) which are examining the potential of using social prescribing methods to direct patients to services which will, directly or indirectly, support them back into work-related activity or even real jobs (Steadman et al, 2017).

Employment services

One of the characteristics of several Active Labour Market Programmes (ALMPs) in recent years has been the perceived influence of targets. The desire to demonstrate a reduction in claimants, a strong flow off benefits and improved (& sustained) employment rates has been dominant. In the eyes of some stakeholders (claimants/employees; employers, third sector specialists and healthcare professionals), this has made open, trust-based collaboration more difficult in some circumstances. Some experts were explicit in arguing that the DWP and Job Centre Plus (JCP) were 'toxic' brands which held back the ability of other parts of the system to provide job retention or back to work support. In practical terms, this can mean that some individuals can feel more coerced and judged than supported, that the needs of employers can be ignored or over-simplified, and that healthcare professionals feel under pressure to compromise their ethical commitment to patients. There were also concerns that the skills of some employment advisors lagged behind the ambition of the programmes they were being asked to deliver. Specific examples of skill deficiencies included those associated with providing support to clients with complex health needs, job retention interventions in workplaces and building constructive relationships with local and often small employers. Other barriers identified by the experts included the challenges of delivering 'job brokering' for those whose health may mean a change in career, and the limited use of the Access to Work scheme. This scheme was seen as very positive in principle but too skewed towards providing

[6] NHS England programme of interventions for treating people with depression and anxiety disorders.

transport rather than job redesign and the creative implementation of reasonable adjustments. The Remploy model of delivering Access to Work which focuses on mental health adjustments[7] (has been successful and more signposting to this and similar services for both clients and employers is likely to prove beneficial.

Employers

In general, employers appear more willing to engage in efforts to retain the services of existing staff with health challenges than to recruit new staff who have a poor health history. In theory, this should mean that programmes to support job retention might be expected to be more effective vehicles for employer engagement. While there is some evidence to support this, there is a wider concern that employment schemes frequently fail to demonstrate a pragmatic understanding of the pressures which employers (especially SMEs) face and the practical help they need if they are to make accommodations for existing or new staff. For an increasing number of employers, the moral case for helping sick or disabled workers is gaining traction, but it is not displacing the business case. If employers are to play a more active and collaborative part in the process of job retention and return to work, there may need to be more active stakeholder management by employment services, especially with the roll-out of Universal Credit (see below). Some experts argued that the government should be more creative with incentives (e.g., reduced National Insurance contributions or tax breaks on spending on vocational rehabilitation interventions). However, these interventions would need to be chosen carefully, be evidence-based and might range from line manager training, early access to physiotherapy & MSD interventions, to mental health first aid training. These would have to be carefully considered and indeed, some supply infrastructure may need to be developed to ensure smaller employers have access to suitable interventions. Any incentive would also need to consider the 'additionality' of the intervention. In short, it should not be the aim to incentivise employers for interventions that they are currently offering. Other experts argued that incentives would not work and that, after years of campaigns and exhortation from government, it is time to legislate more firmly to ensure employer compliance with their long-established duty of care towards employees with illness and disability.

Third sector

There are many small but very specialist employment support charities which, especially as part of local initiatives, could play a more active part in helping 'hard to reach' groups or those

[7] See https://www.remploy.co.uk/employers/mental-health-and-wellbeing

with specialist or complex needs (e.g., those with schizophrenia or fluctuating conditions). Many of these charities feel they were marginalised by the Work Programme or were invited to join consortia to bid for service provider contracts, only to eventually play a very minor role. In some cases, these third sector organisations are more trusted than government employment services or large 'prime' contractors and could play a more active part in the design & delivery of some specialist services. They can often have a good record of building effective relationships with employers, yet these strengths are often underutilised.

In-work conditionality

There is now a much bigger emphasis on 'progression' for those on in-work benefits (especially with Universal Credit). This can mean more hours or increased rates of pay. We found concern that this may mean that JCP workers will now need to work more closely with employers to examine whether this 'progression' condition is being met and that, in doing so, it may cause friction with employers. One question, in this context, being raised by some of the experts, was '*How will health barriers to progression be accounted for by employment advisors?*' More specifically, it was argued that the incentive to reduce dependence on benefits by increasing paid hours worked or even the rates of pay themselves, may conflict with the resourcing model of the employer or their perception of the (relative) value or worth to the organisation.

Co-location

In interventions such as Individual Placement & Support (IPS) the co-location of health & employment support workers is required by the highly protocolised approach to service delivery. It is correlated (through Fidelity audits) with good employment outcomes. Given this experience, it may be that other forms of cooperative and integrated service delivery might be built into future service specifications. Some of the experts also highlighted that co-location should not, where possible, mean that programmes operated out of Job Centres because of the conditionality connotation which it promoted. Pilots of supported employment schemes where JCPs were proposed for co-location with, for example, IAPT services had notably fewer referrals and higher than average drop-outs. It may be that, building on the success of the IPS model, the evidence that embedding employment specialists into care settings can be effective in delivering better integrated services might be sufficient to require that this becomes the default position when health and work services are being designed and commissioned.

Plurality of referral pathways

One of the aspirations of the Green Paper which was supported by many of the experts was the need to widen the range of referral pathways by which employees or unemployed job seekers access the support they need. It was acknowledged that research and piloting work is now being undertaken into the steps which might be needed to extend the use of social prescribing (Steadman et al, 2017); physiotherapy self-referral; referral from pain clinics[8]; SME referrals to NHS OH services and employer referral to external OH, the Fit for Work Service or to the NHS OH service. In part, these innovations were felt to be useful because the GP referral pathway had been placed under an undue weight of expectation and had not sufficiently delivered.

Execution of policy

A frequent comment made by some of the experts was that even good policy ideas often underperformed when implemented. For example, the Fit Note was widely felt to be a 'great idea' because it focused GPs, employers and patients on 'capacity' rather than 'incapacity' and forced all parties to think about workplace accommodations and RTW planning. However, the execution of the Fit Note was seen as poor because it was not electronic from the beginning, was not 'sold' well to GPs, contained too little advice for employers and received only minimal funding. Some experts were concerned that the RTW and vocational rehabilitation potential of Universal Credit may not be fully realised for similar reasons. An example of a more successful policy intervention is the Scandinavian part-time sick leave schemes, which allow employees to 'flex' their sick leave and recovery. These schemes consistently show better outcomes and return to work rates and the Welsh Government might therefore consider delivering and evaluating a small number of pilot schemes – perhaps in conjunction with the roll-out of Universal Credit which shares some of its characteristics.

Data sharing

One of the challenges which some experts identified based on their experiences of evaluating large 'back to work' programmes was that of data sharing between agencies. In some ways this echoes the issue of siloed budgets, raised in the literature section, above. The argument is that genuine multi-stakeholder collaboration is hard to achieve if data about a claimant's/patient's benefits, health status and employment position cannot be tracked,

[8] For example, a Warwick University project using referrals from pain clinics for people with chronic MSD problems. See https://warwick.ac.uk/newsandevents/news/uk_study_to/

monitored and shared between agencies. In practice, this means gaining consent, developing data sharing agreements and protocols and developing IT systems and management information agreements with agencies such as DWP, NHS Digital and HMRC. By May 2018, of course, any data sharing between agencies and collaborating stakeholders will need to be compliant with the new General Data Protection Regulation *(*GDPR*)*, meaning that gaining consent, responsibility for the protection of personal data and the conduct of data protection impact assessments will all affect the way such collaboration agreements and protocols will need to be drafted.

Programme management & governance

As suggested by some of the 'implementation science' literature, some of the experts identified a number of programme management issues as key differentiators when thinking about successful and unsuccessful interventions. More specifically, there was a view that in some circumstances, too much democracy was a barrier to establishing leadership roles and clear lines of accountability and that an occasional reluctance to embrace project management disciplines and chase progress tirelessly often became issues which held back effective implementation.

Conclusions

The literature and evaluation evidence on 'what works' in the field of health and work is growing rapidly, as is the realisation that:

- Context matters: no intervention is implemented in a vacuum and a clear view of the context for programme implementation is a very important determinant of success;
- Stakeholder collaboration is crucial: it may be obvious that all the stakeholders in programmes to support job retention and return to work – even if they share the same high-level goal – have slightly different perspectives and agendas which can derail even the best designed intervention. Politics, personalities, power, information asymmetries and reputational issues can all mean that implementation and sustainability are compromised. The evidence shows that effort expended to minimise the impact of these challenges can pay dividends;
- Good 'process' leads to good 'outcomes': designing, commissioning and implementing a successful intervention, according to the literature, is as much about the 'how' as it is about the 'what'. Service specifications should, therefore try to include logic models or theory of change consultation and mapping. This approach is increasingly being recognised as a valuable part of the planning stage of complex, multi-agency collaborations, partly because the process of putting together a ToC model can help clarify roles and ensure a shared understanding of responsibilities, resulting in co-produced tailored interventions and clarity about the ultimate outcomes being sought. In the Welsh context it is also possible that building logic models or ToC maps might help clarify responsibilities when collaborations cut across responsibilities which are devolved and those which are not. This seems especially relevant in the health and work domains because the discipline of jointly producing a ToC model should enable any ambiguities in role clarify between agencies to be 'surfaced' and resolved early on;
- There is a 'science' to implementation: there is now much more codified knowledge about how the chances of successful implementation can be increased. Around the world there are now communities of practice or 'learning communities' whose purpose is to capture the design and implementation lessons from complex supported employment interventions (Becker et al, 2014; Bond et al, 2016). These insights need to be built more systematically into programme design and, indeed, should always be evaluated as a 'process' strand alongside the 'impact' or even 'economic' components;

- Fidelity works: one of the reasons that the IPS model (originally used only with people living with severe mental illness) is being trialled among clients with mild to moderate mental illness, MSD, alcohol dependence and spinal injuries for example, is that the clear correlation with programme fidelity and health/employment outcomes lends itself to scalable and transferable interventions which can be audited, compared and evaluated. In addition, fidelity models which prescribe both the nature of the intervention and how it should be delivered act as powerful tools for convening stakeholders with different agendas and objectives.

This review has only been able to summarise the growing richness of our understanding of how health and employment interventions for people living with health conditions can be made to work more effectively. However, as policy makers develop a more lucid understanding of the need to focus on 'process' and 'implementation', it is hoped that all programme design and evaluation will include these disciplines routinely.

Appendix 1 – Individual Placement and Support (IPS) Key Principles

The **Individual Placement & Support (IPS)** approach is an evidence-based approach for people with a mental health condition who want to find paid employment. The IPS approach is based on 8 principles:

1) The focus is to help people find “competitive employment” i.e. regular jobs in the community, rather than sheltered or therapeutic work

2) The IPS service will support anyone who wants to find paid employment

3) Job search will be based entirely on your preferences for employment

4) The most effective way of finding work is to start searching immediately, rather than training or volunteering first

5) Employment specialists work closely with the community mental health teams and other health professionals involved in your care

6) Employment Specialists will approach local employers in your area to find vacancies and educate employers about mental health

7) Support is time-unlimited for as long as you want paid employment and continues once you are in work – however the aim is to support you to feel confident to manage independently so a “stepping down approach” will be discussed and agreed with you when appropriate

8) Benefits advice is provided to help clients navigate the system

For more information on IPS, how it works and the evidence-based underpinning it, the Centre for Mental Health website has several free resources:

https://www.centreformentalhealth.org.uk/what-is-ips

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