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Evaluation of In-Work Support (IWS)

Theory of Change

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Evaluation of In-Work Support

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Abbreviations

ABMU	Abertawe Bro Morgannwg University Health Board
CCT	Cross-cutting themes
DHSS	Department of Health and Social Security
DWP	Department for Work and Pensions
ESF	European Social Fund
FfW	Fit for Work
FFWS	Fit for Work Service
IES	Institute for Employment Studies
IWS	In-Work Support
MI	Management information
MSK	Musculoskeletal
OB3	Old Bell 3 Limited
OH	Occupational health
RCS	Rhyl City Strategy
RTWP	Return-to-Work Plan
SME	Small and medium sized enterprises
THWW	Together for a Healthy Working Wales
ToC	Theory of Change
WEFO	Welsh European Funding Office
WLHCs	Work-Limiting Health Conditions

1. Introduction

- 1.1 In-Work Support (IWS) is a European Social Fund (ESF)-funded programme which began in 2015 (Department for Health and Social Services, Welsh Government, September 2015). Its 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). It provides employees who are on, or 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 GPs to help healthcare providers to address patients' work-related health problems. A further strand involves workshops for SMEs managers and employees to help improve workplace health and wellbeing. Abertawe Bro Morgannwg University Health Board (ABMU) delivers IWS across three South Wales local authority areas¹, while Rhyl City Strategy (RCS) is responsible for delivery in four North Wales local authority areas².
- 1.2 IWS is intended to address ESF's Cross Cutting Themes (CCTs) of Equal Opportunities, Tackling Poverty and Social Exclusion and Sustainability (Department for Health and Social Services, Welsh Government, September 2015). IWS' business plan integrated the CCTs in the operation's design and delivery; this is explored in detail in Chapter 4.
- 1.3 The original concept was for IWS to receive most of its referrals directly from Fit for Work (FfW) (Department for Health and Social Services, Welsh Government, September 2015). This would have entailed FfW GPs using a 'Return to Work Plan' to refer patients to IWS for further therapeutic interventions (ibid.). However, in light of the low number of referrals from FfW, FfW is no longer the main source of IWS' referrals and now all GPs, not just FfW GPs, can refer patients to IWS. The evolution of the referral approach is discussed in detail in Chapter 5.
- 1.4 In 2017, the Welsh Government appointed Old Bell 3 Research (OB3) and the Institute for Employment Studies (IES) to evaluate IWS. The evaluation is taking 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 (Bryer, May 2017, unpublished). Stage 2 involves the development of a Theory of Change (ToC) for IWS, set out in this report. The

¹ Swansea, Neath Port Talbot and Bridgend

² Anglesey, Gwynedd, Conwy and Denbighshire

ToC is designed to test whether IWS' interventions are working in the way that was originally intended. It incorporates a logic model that depicts participants' experiences of IWS (see Figure 5.1, p.23). The ToC and logic model will guide the next phases of the evaluation.

- 1.5 This report synthesises the findings from a documentary review, a series of stakeholder interviews and a stakeholders' workshop. Chapter 2 describes the methodology. Chapter 3 explores the needs that IWS is intended to address, the policy and operating environment, and IWS' aims. Chapter 4 sets out IWS' deliverables and the participant journey. Chapter 5 describes the ToC and presents the logic model for the project, looks at emerging practice in IWS' delivery and identifying issues that could be explored in the next phase of the evaluation. Chapter 6 summarises the validity and relevance of the ToC and implications for the evaluation.

2. Methodology

About Theory of Change

- 2.1 Theory of Change (ToC) is a methodological tool that can help reduce complexity during evaluations (Weiss C, 1995). A ToC can be developed at the outset of an evaluation to find out what stakeholders believe a programme is for, and how they think the programme will achieve its outcomes. The resultant ToC and any accompanying logic models illustrating how the outcomes are produced for different groups can form a helpful benchmark to guide the rest of the evaluation, enabling reflection on whether delivery is working as intended.
- 2.2 This ToC for IWS identifies the issues that policymaker stakeholders expected IWS to address and the 'outputs' and 'outcomes' that stakeholders hoped would result from IWS' activities. It describes IWS' participants (presentees and absentees), the programme's activities (the 'levers for change') and staff resources (the 'inputs'). It explores how stakeholders expected IWS to bring about change through the anticipated causal links between the participants, levers and resources, the outputs and outcomes (both intermediate and longer term). The ToC also examines the 'assumptions' and 'key principles' that underpin IWS, citing earlier research and programmes that informed IWS' design.

Documentary review

- 2.3 Stage 2 of the evaluation began with a limited documentary review including: IWS' business plan (Department for Health and Social Services, Welsh Government, September 2015) and other operational documentation; key Welsh Government and UK government policy documents relating to work and health; and research, evaluations and policymakers' experiences of work and health interventions. The documents that IES reviewed are listed in the Bibliography. The aim of the documentary review was to ensure familiarity with policy intentions and the evidence that policymakers drew on when designing IWS.

Stakeholder interviews

- 2.4 Alongside the documentary review, IES conducted interviews with 10 IWS stakeholders: senior policymakers from Welsh Government and the Department for Work and Pensions (DWP), and senior representatives of delivery organisations RCS and ABMU. The aim of the interviews was to identify whether stakeholders had consistent or divergent views about IWS' intended activities and outcomes, and to examine the assumptions and principles of IWS' design. Based on the

stakeholder interviews and the documentary review, IES formulated a draft participant journey infographic depicting IWS participants' experiences (see Annex A).

- 2.5 The interviews are subject to the usual limitations of qualitative research and it is therefore not possible to quantify how many stakeholders subscribed to particular views. It is also not possible to guarantee that each interview covered exactly the same issues, given the semi-structured nature of discussions.

Stakeholder workshop

- 2.6 At a workshop, IES presented the draft participant journey infographic to nine IWS stakeholders, the majority of whom had previously taken part in a stakeholder interview. IES facilitators guided the workshop participants to explore IWS' underlying assumptions and principles, to challenge the components of the participant journey, to identify gaps between the theory and delivery, and to contrast differences in RCS and ABMU's approach. Stakeholders helped to define the participant journey, clarifying how the programme was intended to operate for both employers and GPs, in order to reach consensus on the overarching ToC for IWS.

Analysis

- 2.7 IES carried out a thematic analysis of the findings from the desk-based research, stakeholder interviews, and stakeholder workshop to develop and refine the logic model and ToC. This is presented in Figure 5.1, Chapter 5.

Findings

- 2.8 Given the small numbers of stakeholders who participated in this stage of the evaluation, the findings are indicative.

3. Policy rationale for IWS

- 3.1 This chapter sets out the issues that IWS is intended to address and the policy rationale for the introduction of IWS.
- 3.2 Sickness absence and presenteeism are detrimental to good health and economic success. The annual cost to the Welsh economy of work-related ill health is estimated at £500 million (Health in Wales, 2017). Welsh and UK government policymakers developed IWS to address these issues. IWS' aims are to reduce under-employment and job loss caused by work-limiting health conditions (WLHCs). It does so by working directly with people with WLHCs, and also with private and third sector small and medium-sized enterprises (SMEs) and with healthcare professionals.

Sickness absence

- 3.3 The rate of employee sickness absence is higher in Wales than in the UK: 2.6 per cent compared with 1.9 per cent UK average (Office for National Statistics, 2017). In 2016/2017, 47 per cent of Welsh adults aged 16 and over reported that they had a physical or mental health condition or illness that was expected to last for 12 months or more; 33 per cent had a condition/illness that limited their ability to carry out day-to-day tasks (Welsh Government, June 2017). Musculoskeletal (MSK) conditions/illnesses (17 per cent), heart and circulatory illnesses (13 per cent) and 'mental disorders' (8 per cent) were the most commonly occurring (ibid.).
- 3.4 Sickness absence is more prevalent amongst particular employee groups. In the UK, groups that experienced the highest rates of sickness absence in 2016 included women³, older workers⁴, workers with long-term health conditions⁵, and smokers⁶ (Office for National Statistics, 2017).
- 3.5 Amongst public sector workers, sickness absence rates are higher than in the private sector⁷ (ibid.). In Wales, more of the working population is employed in the public sector than is the case in the UK (Welsh Government, July 2016)⁸. However, employees from the private and third sector generally lack access to occupational health (OH) services (Department for Health and Social Services, Welsh Government, September 2015).

³ 2.5 per cent sickness absence rate for women versus 1.6 per cent for men.

⁴ 2.9 per cent sickness absence rate for ages 65 and over versus 1.5 per cent for ages 16 to 24 and 25 to 34.

⁵ 4.4 per cent sickness absence rate for workers with long-term health conditions versus 1.2 per cent for those without.

⁶ 2.5 per cent sickness absence rate for smokers versus 1.6 per cent for those who have never smoked.

⁷ 2.9 per cent for public sector workers compared with 1.7 per cent for private sector workers.

⁸ In the year ending 31 March 2017, 27.3 per cent of all people in employment in Wales were employed in the public sector versus 21.8 per cent in the UK.

3.6 Sickness absence rates are lower amongst SMEs⁹ than in larger companies (Office for National Statistics, 2017). However, employees from SMEs lack access to OH services (Department for Health and Social Services, Welsh Government, September 2015). In addition, Black and Frost (2011) identified that churn between employment and the benefits system is more prevalent amongst those working in SMEs than in larger organisations. This is of particular concern in Wales, given the predominance of micro and SME employers. As a proportion of total enterprises, micro (94.9 per cent), small (3.6 per cent) and medium-sized (0.8 per cent) enterprises predominate (Welsh Government, November 2016). Micro, small and medium-sized enterprises account for 40 per cent of turnover and 62 per cent of employment in Wales (ibid.).

Presenteeism

3.7 Presenteeism is a less well understood concept than sickness absence. IWS policymakers defined ‘presentees’ as ‘*people at risk of long-term sickness absence*’ (Department for Health and Social Services, Welsh Government, September 2015). A recent literature review found that presenteeism generates healthcare costs, decreases organisations’ productivity and risks future health problems for the individual (Garrow, 2016). In 2017, the Centre for Mental Health estimated that the aggregate UK cost of presenteeism (defined as ‘*reduced on-the-job productivity*’) associated with mental health problems was £21.2 billion in 2016/17; this is an increase of 40 per cent on the corresponding figure for 2006 (£15.1 billion) (Centre for Mental Health, 2017; Sainsbury Centre for Mental Health, 2007). Addressing presenteeism implies a preventative approach to forestall the onset of absenteeism.

Role of employers

3.8 Research evidence shows that it is important to involve employers in influencing the health and wellbeing of their employees (Black, 2008; Waddell and Burton, 2004). Occupational health is concentrated amongst large employers, leaving SMEs relatively unsupported (Waddell and Burton, 2004).

Role of health services

3.9 GPs and healthcare professionals also have a role to play in addressing health and wellbeing in the context of work. Black and Frost (2008) concluded that GPs and healthcare professionals can lack understanding of the links between work and

⁹ In the UK in 2016, organisations with fewer than 25 employees had a sickness absence rate of 1.6 per cent versus 2.5 per cent in organisations with 500 and over employees.

health and feel ill equipped to offer advice to patients on remaining in or returning to work.

Policy and operating environment

- 3.10 IWS builds on the legacy of government policy and earlier programmes designed to tackle sickness absence.
- 3.11 Over the past decade, Welsh and UK governments have focused on addressing sickness absence. They have been guided by key principles in the research of Dame Carol Black, Waddell and Burton, among others (Waddell and Burton, 2004; Waddell and Burton 2006; Waddell, Burton and Kendall, 2008; Black, 2008; Black and Frost, 2011). These include the following concepts:
- work is generally good for health
 - early intervention is effective in returning sickness absentees to work
 - work-focused healthcare can help people to access and remain in work
 - employers can support employees to return to and remain in work.
- 3.12 From 2010 to 2013, the UK government's/DWP's Fit for Work Service (FFWS) pilots put these concepts into practice. Building on the recommendations of the Black and Frost review of the sickness absence system (Black and Frost, 2011), the pilots offered support for people early in their sickness absence. FFWS targeted certain groups: employees of SMEs and people with mental health and MSK conditions (Department for Work and Pensions, June 2015). Rhyl City Strategy (RCS) delivered the FFWS pilot in North Wales, funded by the ESF from 2013 (Department for Health and Social Services, Welsh Government, September 2015: Annex 16).
- 3.13 In parallel, between 2011 and 2014, ABMU Health Board (ABMU) in West Wales and the Valleys operated the ESF-funded Wellbeing through Work. This project provided in-work support via a multi-disciplinary team of therapists (Department for Health and Social Services, Welsh Government, September 2015: Annex 15).
- 3.14 The FFWS pilots informed the development of a rolled-out national Fit for Work service (FfW), which is in operation across England, Wales and Scotland. FfW again targets sickness absentees. It operates on the same principles, and uses some of the same elements, as the FFWS pilots. These include:

- recommendation for referral to additional clinical or non-clinical services
- biopsychosocial assessments to address participants' complex needs
- a return-to-work plan
- support from a case manager.

- 3.15 A range of Welsh and UK government policies contributed to IWS' objectives. These were listed in full in the IWS business plan (Department for Health and Social Services, Welsh Government, September 2015: Annex 8). The policies that were of most immediate relevance to IWS are discussed below.
- 3.16 In 2005 the Department for Work and Pensions (DWP), the Department of Health (DoH) and the Health and Safety Executive (HSE) announced a joint strategy to improve the health and wellbeing of working age people. This strategy identified work as important to improving people's health and reducing health inequalities, and encouraged health professionals and others to help employees to return to work quickly after a sickness absence (Department for Work and Pensions, Department of Health, Health and Safety Executive, 2005).
- 3.17 In *Our Healthy Future*, Welsh Government continued the theme of work being beneficial to people's health (Welsh Government, 2010). It identified priority health and wellbeing activities for 2010 through to 2020 that related very closely to IWS' objectives. These included: using prevention and early intervention to address avoidable ill-health; stopping people falling out of work from ill health; reducing health inequities by improving people's social and economic prospects; helping people to have a healthy and fulfilled working life; creating safe and healthy workplaces; partnership working towards the shared goal of health and wellbeing; strengthening the evidence on improving health and monitoring progress; and reducing the impact of common health problems.
- 3.18 Government policy has continued to evolve since the introduction of IWS, and this is discussed in Chapter 5, section 5.51.
- 3.19 IWS was informed by the government policies and activities discussed above. IWS formed part of the Department for Health and Social Services (DHSS)'s ESF bid, Together for a Healthy Working Wales (THWW) (Department for Health and Social Services, Welsh Government, September 2015). The original policymakers intended IWS to deliver a joined-up approach to addressing the ESF priority of 'tackling poverty and social exclusion through sustainable employment' (ibid.). Like

FfW and the FFWS pilots, the aim of IWS was to improve the health, wellbeing and employment opportunities of working age people. However, it broadened the approach by incorporating support for presentees as well as for absentees. GPs involved with the FFWS pilots had identified a lack of work-focused therapeutic interventions for sickness absentees. IWS was originally developed to address this gap by 'wrapping around' FfW provision (ibid.). The 'wraparound' element has since been dropped in light of the small number of onward referrals from FfW (ibid.).

4. About in-work support

4.1 This chapter briefly describes the intended participants, outputs and outcomes for IWS.

Participants, outputs and outcomes for absentees and presentees

4.2 Policymakers designed IWS to support 4,232 employees (including the self-employed) with a work-limiting health condition or disability, including both 'absentees' and 'presentees' (Department for Health and Social Services, Welsh Government, September 2015). The original business plan defined 'absentees' as employees who have reached or are expected to reach four weeks of sickness absence and 'presentees' as people who are 'at risk of long-term sickness absence' (ibid.). The participants, outputs and outcomes for IWS are set out in Figures 4.1 and 4.2 below, mapped against the relevant ESF cross-cutting theme (CCT) objectives (ibid.)¹⁰

¹⁰ The CCT objectives of 'identifying and supporting opportunities to promote and facilitate the use of the Welsh language' (Equal Opportunities CCT) and 'promote environmental awareness and good practice in the implementation of the activity' (Sustainable Development CCT) have been included in Figures 4.1 and 4.2 for the sake of completeness. However, it is important to note that, as recorded in section 5.49, these objectives were not 'front of mind' for the stakeholders who were interviewed.

Figure 4.1 Participants, outputs and outcomes for absentees and presentees

Participants	Outputs		Outcomes	CCT objectives
<p>1,640 absentees - employees with a WLHC or disability, to include:</p> <ul style="list-style-type: none"> • employees with mental health conditions • employees with MSK conditions • older people • women • the self-employed • employees with alcohol/ substance misuse issues 	<p>820 (50 per cent) 'absentees' return to work.</p> <p>65 per cent (533) remain in work at six months after return, while 60 per cent (492) remain in work at twelve months after return.</p>	<ul style="list-style-type: none"> • 55 per cent (902) women • 30 per cent (492) older people (over 54 years) • 2 per cent (33) migrants /BME/minorities (including marginalised communities such as the Roma) participants • 5 per cent (130) people with care/childcare responsibilities • 76 per cent (1,246) from the private or third sector. 	<ul style="list-style-type: none"> • Employees have fewer days off sick and return 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 • Employees have improved health, wellbeing and financial circumstances • Reduced demand on NHS and reduced benefit claims • Higher tax receipts. 	<ul style="list-style-type: none"> • Addressing barriers to sustainable employment which disproportionately affect equality groups (Equal Opportunities CCT and Tackling Poverty and Social Exclusion CCT) • Supporting older workers and those with health issues to remain in work (Equal Opportunities CCT and Sustainable Development CCT) • Recognising health and wellbeing as a cornerstone of the economy (Equal Opportunities CCT and Sustainable Development CCT) • Promoting social justice and equality of opportunity (Equal Opportunities CCT and Sustainable Development CCT)

Participants	Outputs		Outcomes	CCT objectives
				CCT) <ul style="list-style-type: none"> • Preventing unemployment, economic inactivity; reducing workless households and risk of poverty (Tackling Poverty and Social Exclusion CCT). • Promoting environment awareness and good practice¹¹ (Sustainable Development CCT) • Supporting the use of the Welsh language (Equal Opportunities CCT).
2,592 presentees – employees who are in work, but have a WLHC and are at risk of going on sickness absence, to include target groups, as for absentees.	1,296 (50 per cent) have an improved labour market situation e.g. increased hours, permanent contract, more flexible contract 70 per cent (907) remain in work at six	<ul style="list-style-type: none"> • 55 per cent (1,426) women • 30 per cent (778) older people (over 54 years) • 2 per cent (52) migrants /BME/minorities 	<ul style="list-style-type: none"> • As above. 	<ul style="list-style-type: none"> • As above.

¹¹ The IWS business plan stated that promotion of environmental awareness and good practice within IWS' activities would be measured by the following indicator "100% of workplace health programmes' activities will promote active and sustainable travel, be accessible to all and, wherever possible, [will be] close to good public transport routes" (Department for Health and Social Services, Welsh Government, September 2015: p.79).

Participants	Outputs		Outcomes	CCT objectives
	<p>months, while 65 per cent (842) remain in work at twelve months. They do not fall out of work.</p>	<p>(including marginalised communities such as the Roma) participants</p> <ul style="list-style-type: none"> • 5 per cent (130) people with care / childcare responsibilities • 76 per cent (1,970) from the private or third sector. 		
<p>Total 4,232</p>	<p>Total 2,116 (50 per cent)</p>			

- 4.3 Policymakers anticipated that 76 per cent of both absentee and presentee participants will come from the private and third sector because they assumed, in line with the existing evidence base, that public sector workers were more likely to have access to occupational health provision (Department for Health and Social Services, Welsh Government, September 2015).

Participants, outputs and outcomes for SME employers and employees

- 4.4 Policy makers planned for IWS to engage with and support SME employers and employees through workshops and programmes to help managers and employees to manage their own and their employees' health and wellbeing more effectively, and to raise awareness of WLHCs or disabilities in the workplace (Department for Health and Social Services, Welsh Government, September 2015). The participants, outputs and outcomes for SME employers and employees are delineated below, alongside the relevant CCT objectives.

Figure 4.2 Participants, outputs and outcomes for SME employers and employees

Participants	Outputs	Outcomes	CCT objectives
<ul style="list-style-type: none"> • 1,050 SMEs • 1,950 employees of SMEs will be supported. 	<ul style="list-style-type: none"> • 50 per cent (525) of SMEs will implement effective sickness absence and health policies and practices. 	<ul style="list-style-type: none"> • Improved workforce health • Lower employer costs from reduced sick pay • Improved productivity from reduced under-employment and days lost • Improved occupational health provision • Reduced staff turnover • Improved attitudes to and awareness of WLHCs • Reduced social stigma in relation to mental health conditions. 	<p>In addition to the CCTs for absentees and presentees:</p> <ul style="list-style-type: none"> • Supporting employers to employ disadvantaged individuals (Equal Opportunities CCT) • Supporting inclusive workplaces that promote equal opportunities, employee engagement and work life balance (Equal Opportunities CCT) • Supporting employers to adopt equality and diversity strategies and monitoring (Equal Opportunities CCT) • Supporting employers around workforce development and progression (Tackling Poverty and Social Exclusion CCT).

Participants and outcomes for GPs/health professionals

4.5 In addition, policymakers designed IWS to offer GPs and other health professionals 'learning packages' to improve knowledge, skills and confidence in helping patients back to work (Department for Health and Social Services, Welsh Government, September 2015). The business plan did not quantify the numbers of GPs and health professional participants and outcomes (ibid.). However, policymakers intended IWS' workshops to increase GPs' and healthcare professionals' understanding and awareness of health/work issues, including improved use of the Fit Note¹² (ibid.).

¹² When delivering the 'Fitness for Work' consultation, GPs will use Fit Notes appropriately to support patients in staying in or returning to work.

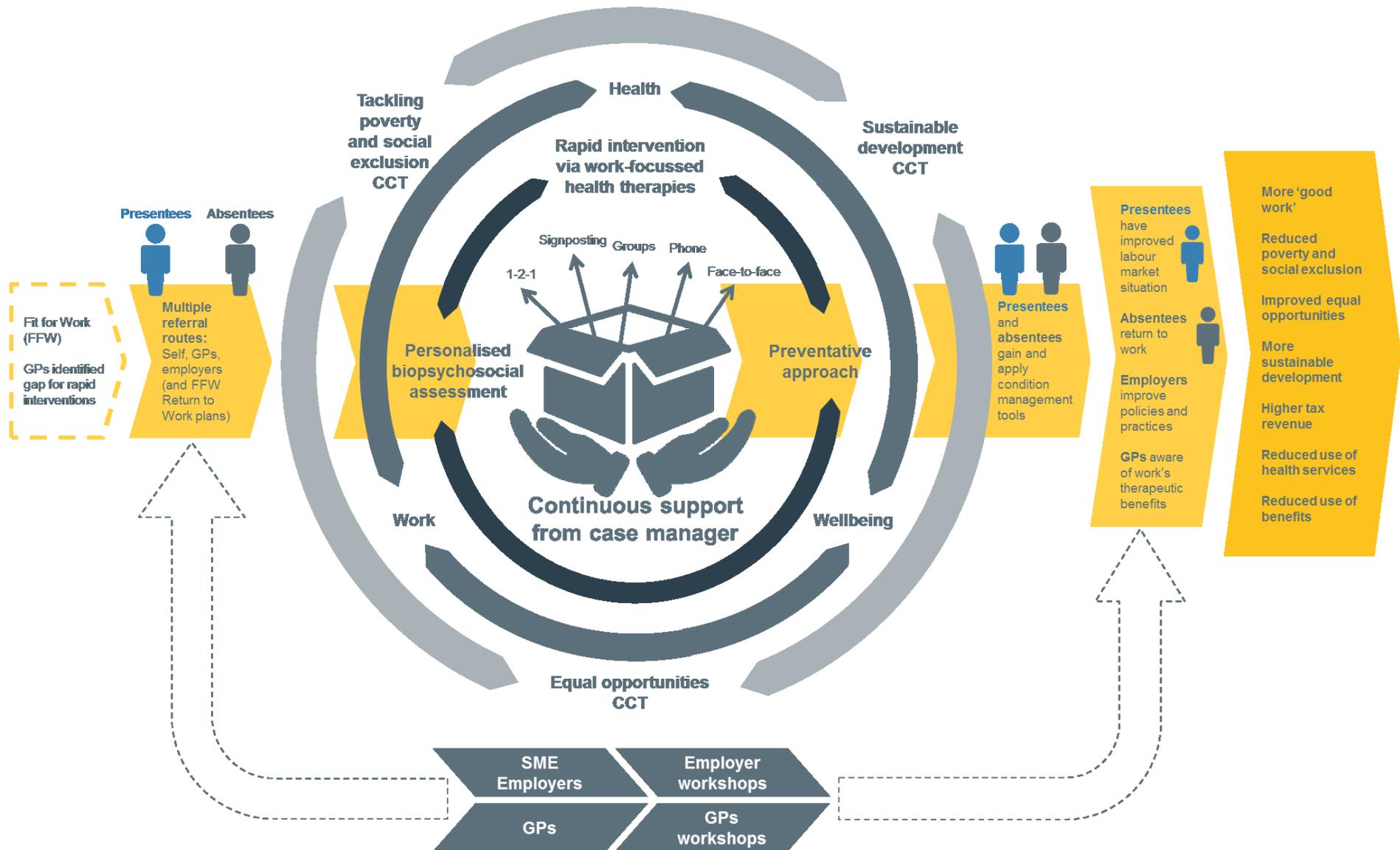
5. Theory of Change

- 5.1 This chapter presents an overarching Theory of Change (ToC) for IWS, illustrated by a logic model (Figure 5.1). The chapter describes the key principles that underpinned IWS' design, IWS' target participants, the 'levers for change' (activities) and underlying assumptions. It also examines the relevance and veracity of the ToC. Areas that the next phase of the evaluation could explore are highlighted in Chapter 6.
- 5.2 The researchers devised the ToC based on workshops and interviews with policymaker stakeholders who had designed IWS and with delivery stakeholders who were implementing IWS. The stakeholders clearly identified IWS' main principles, participants and activities (the 'levers for change'). However, they did not identify all the assumptions IWS' original policymakers had foreseen when IWS was devised. These were described in Annex 25 to the IWS business plan (Department for Health and Social Services, Welsh Government, September 2015) as 'additional dependencies and risks'. For example, during the workshop and interviews, stakeholders did not mention the need for WEFO to provide advice and support to the IWS project team.
- 5.3 As described in Chapter 3, IWS' original policymakers based IWS design on principles derived from recent research about work and health, including the work of Waddell and Burton, and Dame Carol Black. They also took inspiration from programme evidence, particularly Fit for Work and RCS' and ABMU's earlier programmes. During the workshop and interviews, policymaker stakeholders confirmed that these principles had been 'front of mind' when they had designed IWS. The guiding principles of IWS are set out below:
- Work is generally good for health and wellbeing (Black, 2008; Waddell and Burton, 2006).
 - A preventative approach to illness and the promotion of health and wellbeing is desirable and effective (Waddell and Burton, 2006).
 - Early intervention is important to ensure a rapid return to work (ibid.).
 - It is important to intervene at the right time (Waddell and Burton, 2004).
 - Within the first few weeks of sickness absence, formal vocational rehabilitation programmes are unnecessary for most people, because they are likely to recover naturally (ibid.).

- Intervention should address the participants' psychosocial barriers to returning to work or continuance in work, as well as the medical barriers (Waddell and Burton, 2004).
- It is important to involve employers in influencing the health and wellbeing of their employees (Black, 2008).

5.4 Stakeholders agreed that the multiple strands of IWS' work could be synthesised in a single ToC, illustrated in the logic model below. This depicts the participants – the 'absentees' and 'presentees' – who enter IWS through multiple referral routes. The intervention then delivers a series of activities – the 'levers for change'. Participants receive early intervention via work-focused health therapies, with support from a case manager. Provision is flexible and personalised: the logic model's central 'grey toolbox' represents a mix of different interventions in different modes, available to participants according to their personal needs. These are selected jointly with the case manager, based on the participants' individual needs, as identified by a biopsychosocial assessment. The concentric circles indicate the principles that underpin the intervention. The rationale and assumptions underlying each aspect of the model, and its predicted outcomes, are discussed in turn below.

Figure 5.1: In-Work Support logic model



Participants

5.5 IWS' original policymakers intended IWS to target specific groups of 'absentee' and 'presentee' employees:

- employees with mental health conditions
- employees with MSK conditions
- older people
- women
- the self-employed
- employees with alcohol/substance misuse issues

(Department for Health and Social Services, Welsh Government, September 2015).

5.6 The rationale is that these participant groups are most affected by work-limiting health conditions (WLHCs). Research in relation to the Employment and Support Allowance suggests that targeting the most affected groups is likely to improve employment outcomes for those who need it most (Sissons et al, 2011).

5.7 In addition, IWS was focused primarily at employees of SMEs in the private and third sector, who are generally considered to have less access to occupational health services.

5.8 In the workshop and interviews, stakeholders discussed whether different target groups and different WLHCs could influence programme outcomes. For example, several stakeholders suggested that some mental health issues were unlikely to be resolved within the lifespan of the IWS programme. The self-employed and individuals with alcohol and/or substance misuse issues were also mentioned as groups that could be challenging to work with. One stakeholder suggested that reaching these target groups would be '*ambitious*', as he felt this implied it would be necessary to educate healthcare providers to recognise people who would benefit from the IWS support within these groupings.

5.9 In addition to people on sickness absence, IWS targets 'presentee' employees. IWS' original policymakers had defined presenteeism as '*people at risk of long-term sickness absence*' who, as a result of participating in IWS, should achieve an '*improved labour market situation*' (Department for Health and Social Services, Welsh Government, September 2015). In research literature, presenteeism has alternatively been defined as '*when workers go to work when ill and are unable to*

perform effectively due to their ill health' (Gervais, 2015), or, more simply, as *'showing up for work when one is ill'* (Garrow, 2016). Stakeholders recognised that a focus on presentees was an important preventative approach to WLHCs. However, most stakeholders acknowledged that the concept of presenteeism was relatively new, and it was unfamiliar to some stakeholders. At interview, stakeholders did not consistently define presenteeism. One stakeholder pointed out that there is not always a clear cut distinction between absenteeism and presenteeism. This is consistent with research evidence that the same individual might decide to take sickness absence, but the next time they feel unwell they might decide to go into work (Garrow, 2016). At the workshop, stakeholders agreed that they were unclear what an *'improved labour market situation'* for presentees would comprise (Department for Health and Social Services, Welsh Government, September 2015). The IWS business plan suggested that outcomes for presentees could include a permanent contract or increased hours (ibid.). However, some stakeholders questioned whether increased hours would imply an improved labour market situation. A few stakeholders suggested that a work-related promotion could be a feasible outcome for presentees, but others doubted that this would be realistic.

- 5.10 The evaluation is working with the original policy definitions of presentees as *'people at risk of long-term sickness absence'* and of *'improved labour market situation'* comprising an employee increasing their hours and / or moving to a permanent contract (Department for Health and Social Services, Welsh Government, September 2015). During the next stage of the evaluation, there will be the opportunity to further explore what is meant by presenteeism and *'improved labour market situation'*, as discussed in section 6.15.
- 5.11 Stakeholders advised that IWS is designed with the assumption that participants already want to work. IWS policymakers did not intend to change people's attitudes by persuading them of the beneficial effects of work on health:

'There isn't an element of the project which is around raising awareness ... Whilst people may become a bit more aware by engaging with a therapist or whatever, we're not trying to change that person's attitude or encouraging them to think about, "Actually, work might encourage your recovery". They'd have had to have made that decision for themselves to come to us.'

Stakeholder

- 5.12 Accordingly, participation in IWS is voluntary (although one delivery stakeholder reported that when participants had been referred to IWS by an employer, they sometimes assumed participation was mandatory). Stakeholders expected work-motivated participants to refer themselves proactively to IWS and to engage with its support. Even when referrals are initiated by the employer or GP, stakeholders confirmed that it is still the participant who phones to access IWS support, and accordingly, employees must consent to the referral. Stakeholders also assumed that participants will be willing and able to engage with subsequent therapy:

'It's working with people who want to remain in work, so these aren't people who are very far away from the jobs market ... so, in that sense, the project is working with willing participants.'

Stakeholder

- 5.13 IES asked stakeholders if participants accessed IWS because they wanted to engage with occupationally-focused therapies or because they wanted rapid access to, for example, physiotherapy. Stakeholders thought that participants' main aim in accessing IWS support would be to access treatment more quickly than they might through other means. They perceived that participants were likely to be less interested in whether IWS support was occupationally focused. In the words of one stakeholder: *'when we promote it, in terms of encouraging people to refer, they would probably want to know they're getting treatment quicker ... They're going to be less bothered about whether it's work focused or not'*.

Levers for change

- 5.14 IWS involves several activities, or 'levers for change'. Stakeholders expected these levers to accelerate the participants' return to work or improved labour market situation. The main levers that stakeholders identified were: work-focused health interventions, early or rapid intervention, flexible personalised support, multiple referral routes (including marketing), workshops with GPs and SMEs, as well as varied delivery mechanisms. These are each discussed below.

Work-focused health interventions

- 5.15 Stakeholders considered that the fact that IWS' health interventions include a work focus (even if participants were not motivated by this; see paragraph 5.13) was an important lever of change for IWS:

'It is about that interface between health and work, isn't it? So it is, "This is affecting me, this is affecting work". People ... don't just want the therapy, they also want support around that ... That might be the employer liaison; that might be discussing what the work situation is that's causing stress, for example.'

'It's actually the work-based context that sets us apart and makes us different, say, from mental health or pure counselling.'

Stakeholders

Stakeholders assumed that, by incorporating advice about work within the health intervention, IWS will result in a faster return to work or 'improved labour market situation'.

Early or rapid intervention

- 5.16 Early or rapid intervention is another lever for change that stakeholders recognised as important. Stakeholders who had been involved with FfW identified IWS as theoretically filling a gap in FfW by providing, for example, rapid access to physiotherapy. Policymakers intended these interventions to facilitate a quicker return to work, whereas FfW could only recommend such therapies.
- 5.17 Early or rapid intervention implies that participants move quickly from the point of referral/self-referral to IWS to receiving interventions. Policymakers planned for participants to wait just a few days to receive therapy after their first contact with IWS.
- 5.18 Stakeholders confirmed that IWS is based on the rapid intervention principles for sickness absentees described in the Dame Carole Black review (Black, 2008) and developed in earlier FfWS pilots, as well as earlier ABMU and RCS projects (see Chapter 3). Stakeholders agreed that about four weeks was the optimum point to intervene with absentees to avoid 'deadweight': *'At four weeks, most people will go back anyway. At the four-week point, those who are not going back are the ones who need our support'* (Stakeholder). Neither the stakeholders nor the IWS project documentation identified what the ideal timing of interventions would be for presentees.

5.19 Stakeholders reported that, in practice, self-referred presentees and absentees could refer themselves to IWS at any time. Delivery stakeholders also noted that GPs were not always aware that four weeks was the ideal time to refer absentees. There was consensus amongst the stakeholders at the workshop that there was a need to be *'a bit flexible'*. They assumed that a four-to-eight-week window was realistic for absentees. While they did not specify the ideal timing of intervention for presentees, stakeholders predicted that, in general, prompt but flexible intervention timing would usually be effective in achieving IWS' outcomes.

Flexible personalised support

5.20 Flexible personalised support was another guiding principle of IWS. Some stakeholders highlighted support from the case manager as an important lever of change. IWS was based on the assumption that participants' needs are multi-faceted and not necessarily entirely health related. This is in line with evidence from Waddell and Burton, which indicated that it is important to address psychosocial barriers, as well as medical barriers, to returning to work/continuance in work (Waddell and Burton, 2004).

5.21 Delivery stakeholders recognised that participants' needs are indeed diverse and not always health related. While it was common for participants to 'present' with a health-related issue, it was then important for the case manager to *'dig below the diagnosis'* (stakeholder) through discussion with the participant, to identify any additional social or psychological needs. The case manager would then signpost them to the appropriate support. For example, delivery stakeholders noted that case managers often identified a need for participants to receive assertiveness training or information about legal rights, to help them to tackle difficult conversations at work.

'So [a participant is] struggling with depression, but actually when you look under that, it may be that there's a relationship issue in work that is causing the low mood. And the person hasn't got these certain skills or needs some support given about how to intervene or to have that difficult conversation in the workplace. So, when you almost get to the causal root, you can then provide the right support and intervention rather than, "It's depression".'

Stakeholder

- 5.22 Policymakers designed IWS to address these multi-faceted needs through flexible, personalised support. This begins with the biopsychosocial assessment, administered by a case manager, that measures participants' needs in relation to all aspects of their lives, not just their WLHC. Some stakeholders identified the biopsychosocial assessment – '*looking at the individual and what are the broad obstacles to them returning to work*' (Stakeholder) – as an essential lever for change in IWS.
- 5.23 Continuous end-to-end support from the case manager also implied a personalised relationship with the participant. One stakeholder felt this was a particularly important lever for change, noting that a personal relationship with the case manager would tend to make IWS delivery more consistent, and would promote understanding of the individual's situation.
- 5.24 A further element of personalisation is the physical and/or psychological therapies. IWS provision theoretically allows participants the option to access more than one therapy, potentially increasing the scope for personalisation. Delivery stakeholders confirmed that accessing more than one therapy was sometimes possible. However, they also noted that, as demand grows, funding could restrict ABMU's and RCS' ability to give participants access to multiple therapies.
- 5.25 Flexible personalisation is also apparent in the option to vary the frequency of IWS therapy session timings. Some participants opt for six sessions over six weeks; others choose to spread sessions over a longer period. ABMU participants, who are assessed by phone, are given a further choice of whether they want to continue by phone or change the mode of contact. There also appears to be some flexibility in when the case manager follows up after the therapeutic intervention.

Multiple referral routes

- 5.26 Unlike FfW, IWS' services are not integrated within NHS systems. It might be concluded that IWS is even more reliant on good communications between programme partners: employers, GPs, participants and IWS staff.
- 5.27 There are four referral routes into IWS: Fit for Work (FfW), self-referral, GPs and employers (Department for Health and Social Services, Welsh Government, September 2015). Using multiple referral routes could generate a more diverse participant population. For example, one stakeholder noted that GP referrals were likely to lead to participants being focused on their health issues, whereas

participants referred by other routes might be more interested in non-health issues, such as workplace relationships.

'I think, by the very nature of referrals coming from GPs, it's going to be the health issue that is forefront in people's minds, because they've come straight from their GP. I think, if people are getting referred by employers, they might not be necessarily coming with the health issue in the forefront of their minds, or it won't necessarily just be a straight therapeutic approach that they're after, and it would be looking more at the associated issues.'

Stakeholder

- 5.28 When IWS was first designed, policymakers intended GPs to refer participants to IWS from Fit for Work (FfW) and with a Return-to-Work Plan (RTWP) (Department for Health and Social Services, Welsh Government, September 2015: p.13). This would also indicate eligibility for receipt of the IWS (ibid.: p.26). In practice, during the first year of IWS, FfW generated few referrals to IWS. Consequently, stakeholders no longer expected FfW to be the main referral route for IWS, and the ToC reflects this. However, there remains an expectation that some FfW referrals will be made, although the extent of this referral route has not been quantified. Where it is used, stakeholders advised that the case manager would utilise the RTWP to determine to which therapies to refer the participant.
- 5.29 Stakeholders hoped that GP referrals, employer referrals and self-referrals would compensate for the low number of referrals from FfW.
- 5.30 Logistical considerations might influence which referral routes IWS staff focus marketing on. Delivery stakeholders reported that, in the earlier phases of the programme, they had focused on GP referrals as GPs were felt to be *'a fertile recruitment ground'*.
- 5.31 To generate referrals, prospective participants, GPs and employers need to hear about IWS' services through word of mouth, outreach and marketing, which takes the form of leaflets and posters. As would have been expected in light of the focus upon receiving FfW referrals, IWS' business plan (Department for Health and Social Services, Welsh Government, September 2015) did not place much emphasis on marketing, but stakeholders pointed out that successful marketing has emerged as a critical lever for change for IWS.

- 5.32 The IWS business plan states that IWS' marketing messages should engage GPs' and employers' commitment (Department for Health and Social Services, Welsh Government, September 2015: p.50). During the qualitative research, stakeholders queried whether, in practice, GPs might be reluctant to refer because, as a pilot, IWS is not integrated within NHS systems and will end in the foreseeable future. In addition, the marketing message to GPs has been complicated by the fact that FfW referrals are no longer the main referral route to IWS. One stakeholder pointed out that the marketing messages have been adjusted: *'the difficult marketing challenge was to market Fit for Work alongside In-Work Support, and the relationship between the two, in the early days of this project. So, that was the big challenge and now the challenge is going back on those messages'* (Stakeholder).
- 5.33 However, the stakeholders collectively agreed that it was not important whether GPs 'believed' in the therapeutic effect of work, provided GPs continued to refer people to IWS. Policymaker stakeholders said they had realised, when they designed IWS, that it would not be possible to determine why GPs make referrals to IWS.
- 5.34 For IWS to succeed, positive relationships between delivery partners will be important. For example, stakeholder feedback suggested that RCS is benefiting from its existing close relationships with GPs, which might have influenced good awareness of IWS amongst local GP practices.
- 5.35 IWS' original policymakers had intended IWS referrals to come from SME employers. In practice, it appears from stakeholders' feedback that few employers had referred employees to IWS. It was unclear why this was the case.

Workshops for GPs and SMEs

- 5.36 IWS provides workshops: for GPs to help healthcare providers to address patients' work-related health problems; and for SMEs to help improve workplace health and wellbeing. IWS' policymakers appeared to have assumed that both GPs and SME employers would be engaged by the IWS workshops: both willing and able to attend the workshops and to implement their recommendations. Discussions with stakeholders revealed that, in practice, this assumption might be unrealistic.
- 5.37 The mode of delivery for the employers' workshops has varied. Initially, ABMU had offered short taster sessions to stimulate demand, but changed to larger and longer group sessions as more employers signed up. RCS found that engaged employers were seeking ongoing rather than one-off support. One delivery stakeholder

reported that *'we're still in that journey of trying to strike the balance in terms of what employers want and what we can resource'*.

- 5.38 Stakeholders said they expected the employer workshops to focus on increasing employers' understanding of how they can better support their absentee or presentee staff. They predicted that the workshops would thus act as a preventative measure to people being made unwell by work. However, the delivery stakeholders indicated that employers want more tailored provision that takes individual organisations' needs into account. This suggests that the planned *'light touch'* and *'generic'* workshops might fall short of employers' expectations.
- 5.39 The IWS business plan had not stipulated that the IWS workshops with GPs and SMEs would generate referrals from GPs/healthcare professionals and employers (Department for Health and Social Services, Welsh Government, September 2015). In that sense, IWS was not designed as an 'integrated' programme, unlike FfW. Similarly, during the research discussions, stakeholders did not suggest that attendance at IWS workshops would encourage employers and GPs/healthcare professionals to make referrals to IWS.

Varied delivery mechanisms

- 5.40 Stakeholders agreed that the IWS ToC applied equally well to both RCS and ABMU. While there are differences in how ABMU and RCS operate IWS (set out in 5.41 below), IWS gives the delivery organisations the freedom and flexibility to work towards the same outcomes but in a slightly different way (hence the 'grey toolbox' metaphor within the ToC). The IWS business plan stated that IWS would give policymakers the opportunity to compare an NHS delivery model (ABMU's) with a third sector delivery model (RCS) (Department for Health and Social Services, Welsh Government, September 2015: p.116). Stakeholder policymakers confirmed that their original intention was to have a 'mixed model', utilising different delivery modes (for example, phone and face-to-face support) to 'compare and contrast'. Some of the emerging differences are described below.
- 5.41 ABMU and RCS allocate staff resources to IWS differently: RCS subcontracts external therapists, whereas ABMU uses therapists from its in-house vocational rehabilitation team. In addition, RCS case managers are not health professionals, whereas ABMU case managers are. ABMU and RCS also deliver IWS differently: the ABMU case manager carries out the participant assessment by phone, while RCS case managers do so face-to-face. Furthermore, ABMU's therapists deliver

therapy sessions predominantly by phone, while RCS-contracted therapists usually provide face-to-face sessions. A further difference is that, under RCS' framework agreement with its therapists, therapists are limited to delivering six sessions, while ABMU therapists can deliver up to eight. These differences were known when the business plan for IWS was drawn up. There is an assumption that differently staffed organisations will be able to deliver the same outcomes.

- 5.42 The IWS business plan stated that IWS would include group-based therapies as well as one-to-one provision (Department for Health and Social Services, Welsh Government, September 2015). This involves an assumption that both modes of delivery will be equally effective in delivering the intended outcomes. The stakeholder workshop discussion revealed that RCS is increasing provision of group therapy sessions to help facilitate access to more than one type of therapy.

Programme outcomes and external factors

- 5.43 IWS' original policymakers had intended IWS to return participants to the labour market or deepen their labour market engagement. The achievement of those longer-term outcomes is dependent on intermediate outcomes. It is not yet clear what those might be. However, stakeholders were in agreement that, for absentees and presentees, they could include both health-based and non-health-based outcomes. An example of the former could be a participant with back pain who experiences reduced pain as a result of IWS' interventions, enabling them to drive. An example of the latter could be a participant acquiring self-management 'tools' from the work-focused therapies that enable them to deal with situations more effectively in the workplace. Attitudinal change was another potential intermediate outcome that stakeholders suggested.
- 5.44 IWS targets (as shown in Figure 4.1 above) imply that half the absentee and presentee participants are not expected to achieve hard outcomes of a return to work or an improved labour market situation during the lifetime of the IWS programme. However, these participants could still benefit from IWS interventions addressing their WLHC and other issues that make it difficult for them to remain in and thrive in work. For example, a participant who receives a work-focused psychological therapy might experience improvements in their resilience, confidence and self-efficacy that could help them to return to work in the future.

- 5.45 IWS was designed to focus predominantly on helping people with mild-to-moderate WLHCs, rather than severe WLHCs (Department for Health and Social Services, Welsh Government, September 2015). Policy stakeholders advised that this was because they assumed that people with severe WLHCs would not be able to continue in work without more intensive interventions. The business plan stipulated that RCS and ABMU would signpost people with more serious conditions to other sources of support (ibid.). However, RCS and ABMU stakeholders reported that, in practice, they were seeing some participants with more severe conditions. It is unclear what progress IWS is likely to make in addressing such conditions. In addition, one stakeholder suggested that the nature of some mental health conditions is such that it might take longer to achieve progress than the 12-month duration of IWS, compared to MSK conditions that might be more amenable to rapid intervention. This evidence suggests that, in practice, the profile of IWS participants might not be completely in line with original policy intentions.
- 5.46 Some stakeholders perceived that the Welsh European Funding Office (WEFO) requirements to prove participants' eligibility for IWS services have become more stringent since the start of IWS. Without the necessary paperwork from participants, RCS and ABMU cannot evidence the outputs. Stakeholders reported that ABMU's phone-based delivery makes it particularly difficult for ABMU to obtain paperwork to demonstrate eligibility. Moreover, the limited referrals via FfW (since referral from the service indicates eligibility) heightened this difficulty for ABMU. This change to the original design has, according to several stakeholders, greatly reduced the number of outputs that ABMU has been able to claim. Over the life of the programme, this could reduce the number of outputs and outcomes that IWS is able to evidence to WEFO's satisfaction, which in turn might affect the outcomes that ABMU and RCS can report.
- 5.47 Stakeholders advised that some groups of participants were continuing to meet informally, after IWS had officially ended, for self-support. The IWS business plan anticipated that IWS could help to develop peer support networks (Department for Health and Social Services, Welsh Government, September 2015: p.48). This peer-to-peer support could be described as ongoing engagement to manage the effects of WLHCs and to improve labour market position, and could constitute an intermediate outcome of the IWS operation. However, there are no funding incentives for RCS and ABMU to monitor and evaluate this type of activity.

- 5.48 The IWS business plan predicted that IWS' planned outcomes of reduced sickness absence and presenteeism would have a profound longer-term impact on the economy and society (Department for Health and Social Services, Welsh Government, September 2015). The stakeholders interviewed were also hopeful that IWS would support people's health and wellbeing and promote good practice in occupational health management. They hoped that, in time, this could reduce economic inactivity and its resultant costs for employers, health services and tax payers. Several stakeholders also expected IWS to promote 'good work' as one of the fundamental determinants of good health.
- 5.49 IWS' business plan integrated the European Social Fund's Cross Cutting Themes (CCTs) for Equal Opportunities, Tackling Poverty and Social Exclusion and Sustainability in the operation's design and delivery. During the interviews and workshop, stakeholders generally agreed that IWS outcomes were likely to improve prosperity and help disadvantaged groups, thereby implicitly contributing to the CCTs' provisions in relation to poverty, social exclusion and equal opportunities. However, stakeholders expected such outcomes to post-date the duration of the IWS programme. Their immediate focus was on the shorter term outcomes of reducing sickness absence and presenteeism. When asked about other outcomes of IWS, stakeholders did not suggest that IWS should result in improved environmental awareness and good practice (which appear within the Sustainable Development CCT) or in the promotion of Welsh language (which appears within the Equal Opportunities CCT). This might suggest that some of the CCT objectives are more 'front of mind' than others for stakeholders.
- 5.50 Some stakeholders hoped that IWS could lead to positive outcomes for public services. The Well-being of Future Generations (Wales) Act (2015) requires Welsh public bodies to take a more joined-up approach when policymaking (Welsh Government, 2015). A few stakeholders viewed IWS as a potential good practice exemplar of such successful integration of health and employment services. Another suggested that IWS would benefit healthcare professionals, at least in the short term, by giving them a constructive service to which to refer patients, instead of simply offering repeat prescriptions or Fit Notes. Stakeholders also expected IWS to produce evidence about the strengths of different delivery methods that could benefit future policymaking.

5.51 IWS is being implemented against an evolving policy background and the evaluation will need to consider IWS' progress in the context of key developments. *Taking Wales Forward 2016-2020*, Welsh Government's five-year plan to promote healthy lifestyles and choices through interventions on preventing ill health and encouraging more activity, includes supporting people into sustainable employment and tackling mental ill health in the workplace (Welsh Government, 2016). *Prosperity For All – the national strategy* identifies areas that Welsh Government has prioritised for 'early intervention', including mental health (Welsh Government, 2017). Under the strategy's health and wellbeing objectives, the government announced its intentions to roll out a national In-Work Scheme: '*an In-Work Scheme with rapid access to early, work-focused interventions for a range of conditions, helping people to stay in work or return to work more quickly from long-term sickness absence*'.

Validity of Theory of Change

5.52 At this point, and as demonstrated by the evidence gathered in this stage of the evaluation, the theories underpinning IWS appear to be based on sound principles grounded in the latest policy and research evidence on best practice.

6. Conclusion

- 6.1 This chapter highlights key issues suggested by the ToC that the research team could review in the next stages of the evaluation.
- 6.2 In considering these, it is important to note that the evaluation will be constrained to some degree by the extent of management information (MI) data that is available and the timing of when that is provided. It will be necessary for the evaluation to work within sensible parameters for what is achievable, given that the evaluation is due to end in August 2018. As noted below, longer-term outcomes for IWS might not be detectable within that timescale.
- 6.3 Additional factors that might affect the evidence that the evaluation can generate are indicated by the project risks and dependencies, identified in Annex 25 to the IWS business plan (Department for Health and Social Services, Welsh Government, September 2015). These include some of the assumptions detailed in Chapter 5. They also include additional dependencies and risks, such as the need for WEFO to provide advice and support to the IWS project team. The evaluation team will be aware of the ongoing risks to the project that could affect the parameters of the evaluation.
- 6.4 Finally, the evaluation is not of an unlimited scale and the primary research design has been agreed as part of the commissioning process. It will thus be necessary to agree with Welsh policymakers the most critical issues emerging from the ToC research to address in the later stages of the study.

Participants

- 6.5 As MI data emerges from RCS and ABMU, the evaluation team should be able to assess participant characteristics, interventions and outcomes. This should allow the evaluators to determine if IWS has been successful in reaching its target groups of participants in the intended way. This could include analysis of the types of WLHC that participants present with. The evaluation could also consider whether the types of WLHC affects programme outcomes. For example, are some WLHCs and target groups, as stakeholders have suggested, more challenging to engage and move forward? On that basis, the evaluation team could assess whether the IWS model is suitable for all the WLHCs and target groups identified in the original business model.

- 6.6 The evaluation will gather qualitative data about the participants' experiences. This could include what participants say they have gained from IWS, what they valued about the different forms of support within IWS, and what they believe to have been the most important and least important levers for change in their experience.

Work-focused health interventions

- 6.7 Similarly, the evaluation could investigate what work-focused health interventions look like in practice. For example, to what extent and how do IWS staff and participants prioritise the work focus of therapy sessions? What is the perceived value of the work content to participants? Are work-focused health interventions an effective 'lever for change' in moving the participants on to positive outputs and outcomes?

Early or rapid intervention

- 6.8 Stakeholders predicted that interventions within four to eight weeks of an individual going on sickness absence would be realistic and should be successful in achieving progress and avoiding 'deadweight'. The evaluation could explore what the timings of referral and start/completion of intervention have been in practice, and what bearing these timings have on outputs and outcomes. Examining the timings of referrals would establish whether the planned rapid referral of a few days is consistently achieved. Depending on the scale of referrals from FfW, the evaluation could also consider whether IWS complements FfW, as was originally planned, by providing rapid access to therapies.
- 6.9 For presentees, the evaluation could review the time that elapses between presentee participants contracting a WLHC, their referral to IWS and any subsequent therapeutic intervention. The evaluation team could also consider whether individual participants experience both absenteeism and presenteeism before they are referred to IWS. As mentioned above, it could be interesting to examine what effect these situations and timings are having on IWS' outputs and outcomes.

Flexible personalised support

- 6.10 The research literature identifies flexible personalised support as the gold standard for responding to individuals' multiple and complex needs. The evaluation could investigate what activities have been delivered in practice and their success as a 'lever for change'. This could include: reviewing the efficacy of the IWS biopsychosocial assessment in capturing participants' needs; examining the

relationship between case managers and participants; and assessing the extent to which session timings and delivery modes are adjusted to suit participants' needs.

Multiple referral routes

- 6.11 OB3 intend to gather data on the numbers of participants entering IWS via each referral route to enable an understanding of the demand via each route. In the next stage of the evaluation, the qualitative research could look below the surface of this data, to explore the influence of relationships between IWS and the organisations and individuals making referrals to IWS, the success of current marketing and gains made under previous programmes, and the reliance on participant motivation already alluded to above.

Workshops with GPs and SMEs

- 6.12 Depending on the MI data, the evaluation team could assess the number and types of workshops that have taken place with GPs and employers. In addition, interviews with employer organisations could reveal the extent to which group sessions have met employers' expectations and needs. The evaluation team could also investigate whether there is cross-fertilisation of employer referrals resulting from employer attendance at workshops, as an unintended consequence of this activity.

Varied delivery mechanisms

- 6.13 As stated above, policymakers intended IWS to utilise a '*mixed model*' to '*compare and contrast*' the effects of different staffing and organisational structures, and delivery modes on outputs and outcomes. Through MI and interviews, the evaluation could investigate these differences. However, it is important to note that the resultant evidence about what works in delivering in work support will be indicative only. Given the overlap between RCS and ABMU's modes of delivery, neither can be said to be a true comparison group for the other, which will therefore preclude counterfactual analysis.

Programme outcomes and external factors

- 6.14 Depending on the data that can be made available¹³, it might be possible for the evaluation team to consider outputs and outcomes by WLHC (possibly contrasting mild, moderate and severe conditions) and by target group.

¹³ It should be noted that it will be difficult to measure the impact of IWS because of the lack of counterfactual data.

- 6.15 Given the focus on presentees, useful data might be generated on what an ‘improved labour market situation’ looks like for this group. For example, whether this includes a permanent contract or longer hours, and whether this varies from individual to individual. Potentially, this would add to the evidence base of what is meant by presenteeism and what outputs and outcomes can be realistically expected for presentees.
- 6.16 The evaluation might be able to further define intermediate outputs and outcomes, whether health based or non-health based. Intermediate outputs could include, on the evidence of stakeholder interviews, the acquisition of condition management tools in group settings. Soft outcomes could be explored with participants at interview, such as attitudinal change.
- 6.17 Stakeholders were keen that the evaluation should capture the outcomes for both eligible and ineligible participants¹⁴: *‘it’s a key point maybe for the evaluation that we need to recognise the activity, because those people are still benefiting. So, we can count them, I would say, in the evaluation’* (Stakeholder).
- 6.18 As noted above, the final list of issues to be explored by the evaluation must be agreed with Welsh Government in the context of the data that can be made available and/or captured within the bounds of the agreed evaluation model. However, this chapter has identified multiple opportunities for the IWS evaluation to generate new insights which could help the development of future policy initiatives targeting individuals with work-limiting health conditions.

¹⁴ As an NHS organisation, ABMU is unable to limit its support only to those who meet the WEFO eligibility criteria. It thus serves a wider population than those it is funded to support.

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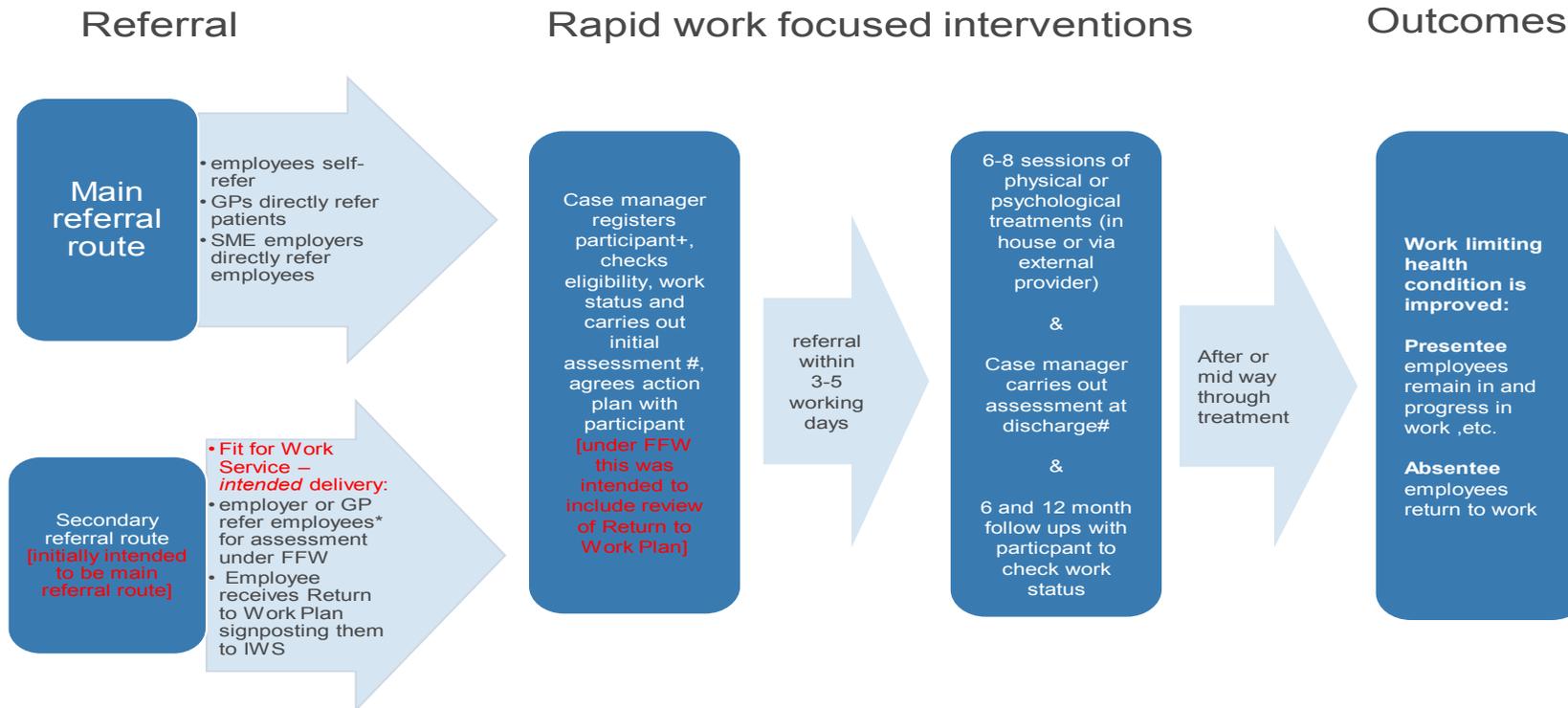
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Annex A In-Work Service participant journey



*employees on, or at risk of, a 4-week sickness absence

+case manager must contact employee within 1 working day of being contacted by ESF project team

self assessment tool, measuring wellbeing in eight domains, using 10 point scale