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Evaluation of In-Work Support Service

Final report

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Evaluation of In-Work Support Service: Final Report

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Views expressed in this report are those of the researcher and not necessarily those of the Welsh Government

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Glossary

Acronym/Key word	Definition
CBT	Cognitive Behavioural Therapy
CCT	Cross-Cutting Themes
CQFW	Credit and Qualifications Framework for Wales
ESF	European Social Fund
FSB	The Federation of Small Businesses
GP	General Practitioner
HR	Human Resources
HCP	Health Care Profession
IWS	In-Work Support
L&W	Learning and Work Institute
MI	Monitoring Information
MSK	Musculoskeletal
NHS	National Health Service
RCS	Rhyl City Strategy
SME	Small and medium sized enterprises
SBU	Swansea Bay University Health Board
WCCG	Welsh Clinical Communications Gateway
WG	Welsh Government
WEFO	Welsh European Funding Office
WLHCs	Work-Limiting Health Conditions

1. Introduction

1.1 In June 2022, the Welsh Government (WG) appointed Learning and Work Institute (L&W) to evaluate the latest phase of their In-Work Support Service (IWS). The evaluation started in July 2022 and was completed in October 2022. It follows an initial evaluation of IWS published in April 2019.[1] This covered activities between September 2015 and June 2018. The key findings and recommendations from this evaluation are set out in sections 1.10 and 1.11

1.2 The Healthy Working Wales: In-Work Support Service was a Welsh Government and European Social Fund (ESF) funded programme which began in September 2015 and ran until December 2022. IWS was originally intended to finish in August 2018 and was extended for a further four years to December 2022, following a re-evaluation in 2018.

1.3 IWS' objectives were to tackle poverty and social exclusion through sustainable employment in parts of North and South Wales by reducing sickness absenteeism and presenteeism rates in the workplace.

1.4 IWS took a preventative approach that was intended to curb job losses resulting from work-limiting health conditions (WLHCs) or disabilities by early intervention. The IWS operation supported absentees (participants who have reached or are expected to reach four weeks of sickness absence) and presentees (participants who are at risk of long-term sickness absence) with rapid free access to a range of practical, personalised support and therapies to address personal barriers such as mental health issues (including stress, anxiety and depression) and physical health symptoms related to muscle and joint pain which are impacting on their ability to work. IWS also provided enterprise support which consisted of free advice, guidance, training and support for small and medium-sized enterprises (SMEs) based in the delivery areas to develop and implement a workplace health programme (WHP) to promote workplace well-being.

1.5 The wider policy context has changed significantly since IWS started in 2015. COVID-19's impact on people's health and the labour market, and the subsequent cost of living crisis, mean that providing support for people with

[1] Welsh Government (2019) Evaluation of In Work Support Operation: final report

health conditions to return to and stay in work is an increasingly important part of the employability landscape.

1.6 The wider policy context for IWS is aligned to the seven shared national well-being goals enacted by the Well-being of Future Generations Act (2015).[2] The goals include A Prosperous Wales which aims to develop a skilled and well-educated population in an economy that generates wealth and provides employment opportunities, allowing people to take advantage of the wealth generated through securing decent work. The Act also includes five ways of working (thinking for the Long Term, Prevention, Integration, Collaboration and Involvement), and a set of indicators to measure how far the well-being goals have been enacted.

1.7 The theory of change developed during the initial stage of IWS[3] identifies a range of achievable long-term outcomes for IWS including improved health, better work, improved equality of opportunities, and reduced poverty and social exclusion. This suggests that IWS has the potential to contribute to several indicators from the Well-being of Future Generations Act relating to employment, in particular the percentage of people in employment, the percentage of people on permanent contracts and in receipt of the living wage, and in relation to improved health; in particular the mean mental health well-being score, and the number of people engaged in two or more healthy lifestyle behaviours.

1.8 IWS and the planned wider roll out has an important role in ensuring WG meet the priority in their new employability and skills plan of 'supporting people with a long-term health condition to work.'[4] Specifically the plan identifies the role of 'increased employability, vocational rehabilitation and multi-professional occupational health services for people in and out of work with mental ill-health and long-term health conditions.' The focus in IWS on prevention and early intervention clearly has a critical role in ensuring the success of this agenda.

1.9 IWS was delivered by two providers. Swansea Bay University Health Board (SBU) covered Swansea, Neath Port Talbot and Bridgend local authority areas,[5] and used predominantly remote methods of delivery. Rhyl City Strategy (RCS)

[2] Welsh Government (2015) *The Well-being of Future Generations (Wales) Act (2015)*
[3] Welsh Government (2018) Evaluation of In Work Support: Theory of Change
[4] Welsh Government (2022) Stronger Fairer Greener Wales: A plan for employability and skills.
[5] Bridgend is no longer part of SBU, having moved to Cwm Taf Morgannwg University Health Board

initially covered Conwy, Denbighshire and parts of Gwynedd around Bangor, before being expanded to cover the whole of Gwynedd and Anglesey, and was then expanded again to Carmarthenshire and Ceredigion from October 2021. RCS used a mix of face-to-face and remote methods of delivery.

1.10 The initial evaluation followed a similar methodology to the current research; utilising depth interviews and Monitoring Information (MI) analysis. The evaluation team noted findings were limited due to challenges in recruiting the full quota of participants but identified several key learnings. It was noted IWS engaged a much higher than expected number of presentees and made good progress in supporting these people to stay in work and improve their health. A significant shortfall in absentee referrals was identified primarily due to not receiving anticipated referrals through the Fit for Work programme. While there was evidence of individual participants achieving expected outcomes, there was much less evidence of successful outcomes for enterprises. This was primarily due to fewer and less intensive engagements than anticipated. Finally, the evaluation also highlighted the difference in approach between RCS, a third sector organisation, and SBU, an NHS organisation, and suggested SBU needed to adapt to running a service outside the NHS.

1.11 The evaluation also made a number of recommendations for ongoing delivery and future similar interventions.

- Recommendation 1: The original targets set for engaging and supporting employers were unrealistic and should be revised.
- Recommendation 2: Light touch employer interventions should either be recognised as outcomes under Welsh European Funding office (WEFO), or employer support would need to change significantly to meet existing targets.
- Recommendation 3: It was important for NHS based organisations delivering EU funded services to recognise this service as separate from NHS provision.
- Recommendation 4: IWS should focus on those geographical areas and client groups which face the greatest need.
- Recommendation 5: Identified good practice including principles of early intervention, the use of time limits for meeting clients and the quick turnaround for therapy support, which should be continued for future delivery

- Recommendation 6: Adequate resources should be dedicated to promoting the service to employer groups and GPs to ensure clients are recruited efficiently from the outset.
- Recommendation 7: Employer support should be offered in a more flexible coordinated manner to meet the needs of individual organisations.

1.12 This second evaluation carried out by L&W has been informed by the previous research and included the following research aims:

- To evaluate the performance and perceived impact of the IWS against delivery aims, including the benefit of its workplace health programmes
- To assess progress against cross cutting themes
- To assess how IWS has contributed to the goals of the Well-being of Future Generations Act
- To examine whether relevant recommendations made in the previous evaluation have been, or are being, met
- To explore how effectively IWS was able to respond to the additional challenges presented by the COVID-19 pandemic.

1.13 A further set of more specific objectives were identified to answer these research aims:

- To consider how much of the intervention was delivered, whether activities were delivered as intended and whether there were any unintended outcomes
- To assess how successful IWS has been in reaching its target groups (broken down by demographics) and to assess what worked well in reaching different target groups
- To assess participants' experience of receiving support from IWS, both for sickness absentees and presentees
- To assess how the support provided helped employers to develop and implement workplace health programmes and the extent to which employees were helped by those programmes
- To assess what contribution IWS made to the goal of tackling poverty through sustainable employment
- To assess to what extent IWS is perceived to have prevented job loss
- To assess to what extent IWS has encouraged and supported organisations paying the living wage
- To examine how IWS identified language preference e.g. English or Welsh for its participants and how it provided opportunities to meet the demand
- To assess the effect the COVID-19 pandemic has had on the service, including the management and implementation of the IWS

- To assess the effect of changes made to IWS as a result of the COVID-19 pandemic on sickness absentees, presentees and furloughed participants.

1.14 The report contains the following chapters:

- Chapter 1: Introduction to the report
- Chapter 2: An outline of the evaluation methodology including the profile of fieldwork participants and a consideration of the methodological limitations
- Chapter 3: An overview of service delivery setting out the key components for delivery, and outlining some of the challenges identified by delivery partners
- Chapter 4: An analysis of client data
- Chapter 5: Research findings in relation to awareness of the service, recruitment and referrals
- Chapter 6: Research findings in relation to delivery of support
- Chapter 7 Research findings in relation to client and employer outcomes
- Chapter 8: Conclusions and recommendations summarising the evaluation and setting out recommendations for future delivery.

2. Methodology

2.1 This chapter sets out the evaluation's mixed method approach and offers a view about the strengths and limitations of the approach adopted. The chapter also provides a profile of interview participants, and an overview of the process of client data analysis.

2.2 The qualitative research included the following activities:

- Preparing research instruments which included discussion guides for use with a range of participants including project staff, clients, employers, stakeholders and GP practices, and a short additional survey for GPs.
- Conducting semi-structured interviews with:
    - 62 clients
    - 13 staff members
    - eight employers
    - four Health Care Professionals (HCPs) and surveying three additional HCPs
    - three stakeholders.
- Interviews were conducted online or by telephone and offered in Welsh or English.
- Interviews were transcribed and analysed using a thematic framework approach.[6]

Methodological considerations of qualitative research

2.3 A sample of 350 participants from each delivery partner were contacted to invite them to participate in an interview. These were selected from databases supplied by RCS and SBU. The sample was restricted to clients who had engaged with the service in the last 18 months to improve participant recall. It was not possible to sample participants using characteristics such as absentee or presentee, age, gender, ethnicity, or presenting condition due to restrictions in the data sharing agreement. Information collected from participants during interviews suggested a limited number of absentees were interviewed but other characteristics were

[6] Goldsmith, L. J. (2021). Using Framework Analysis in Applied Qualitative Research. The Qualitative Report, 26(6), 2061-2076. (NSUWorks)

proportionately represented within the sample. From an intended quota of 70 participant interviews, 35 were conducted with SBU, and 27 with RCS (62 interviews in total).

2.4 From an intended quota of 16 staff interviews, eight members of staff were interviewed from RCS and six from SBU. Staff contact details were supplied by delivery partners. Interviews were held with staff across the organisations to include senior managers, therapists, case workers and administrative staff.

2.5 From an intended quota of 16 employer interviews, four employers were interviewed in each delivery area. Employer contact details were supplied by delivery partners, and 120 employers were contacted across the two delivery partners. The significant shortfall was attributed to several factors. Firstly, many contact emails were no longer recognised, as staff had moved onto new employment opportunities. Secondly, some employers responded they did not have time to take part in interviews due to challenging circumstances such as staff shortages and financial pressures. Finally, some contacted employers reported they had minimal contact with IWS and did not feel participation in an interview would be insightful.

2.6 From an intended quota of 16 GP interviews, three interviews were successfully secured with GPs, as well as one additional interview with an occupational therapist. A further three responded to a short survey about their experiences. All but one of these participants worked in RCS delivery areas. This significant shortfall was due to the unprecedented pressures experienced by GPs following the COVID-19 pandemic. GP contacts were supplied by delivery partners with additional recruitment support from wider stakeholders.

2.7 A significant shortfall was also experienced in the number of stakeholder interviews. Only three interviews were secured from a target of 12. These interviews were with policy experts, and representatives from third sector organisations. This was primarily due to very limited contact details being supplied by delivery partners.

2.8 The shortfall in recruitment across participant groups should be seen as a limiting factor in the research. However, participant and staff views were well represented, providing detailed insight into service delivery. These findings can

therefore be reported with confidence, while findings relating to employers, GPs and stakeholders should be treated with more caution.

Overview of client data analysis

2.9 The client data analysis was conducted using anonymised participant data supplied by the delivery partners. It included analysis of participant characteristics, details of the support received, and analysis of participant outcomes.

2.10 There is limited evidence on sustained participant outcomes, available from the MI analysis. Equally the data collected on participant health and well-being and return to work may be incomplete and not represent outcomes achieved. This is due to limited data supplied by the delivery partners. In order to report a successful sustained outcome, delivery partners had to collect written evidence from clients six months after they had left the service. Both partners, but particularly SBU, found it challenging to collect this evidence. This meant there was a low participant response rate. There were additional challenges in how outcomes were recorded, with “no response” recorded as “no positive outcome” for all of SBU’s delivery, and a proportion of RCS’ delivery. Further information about the challenges for delivery partners in collecting outcome data is discussed in chapter 3.

3. Overview of service delivery

This chapter summarises the IWS, including details of delivery partners, the elements of delivery and differences between the approaches taken in the two areas. It also highlights a range of issues raised during the interviews with delivery staff relating to performance and data management which have impacted to some extent on implementation.

Key features of the service

3.1 The IWS consisted of two elements:

- **Individual support:** Rapid, free access for individuals who are employed or self-employed and live or work in the delivery areas to a range of practical, personalised support and therapies to address mental health issues (including stress, anxiety and depression) and physical health symptoms related to muscle and joint pain which are impacting on their ability to work.
- **Enterprise support:** Free advice, guidance, training and support for small and medium-sized enterprises (SMEs) based in the delivery areas to develop and implement a workplace health programme (WHP) to promote workplace well-being. The different elements of the WHP as delivered by the two partners are set out in Table 3.1. It is important to note the wide variation in what constituted a WHP. The minimum requirement for a WHP was that it involved two interventions, which could mean that one member of staff attended two webinars. However, as set out in section 6.49 below, some WHPs involved sustained engagement over a number of months with enterprises being supported through bespoke advice, guidance and support, access to webinars and seminars, as well as support for individual staff members.

3.2 There was no single delivery model, and a different approach was taken in the two areas. The key features of these are summarised in Table 3.1, together with changes to the delivery methods made in response to the pandemic.

Table 3.1: Overview of service delivery

Lead partner	**SBU**	**RCS**
	SBU plans and delivers NHS services for the local area. IWS is branded as 'Well-being Through Work – In-Work Support.'	RCS is a social enterprise specialising in employment and well-being
Coverage	Swansea, Neath Port Talbot and Bridgend	Anglesey, Carmarthenshire, Ceredigion, Conwy, Denbighshire and Gwynedd
Individual support	Up to six sessions of personalised one to one support from an occupational therapist or physiotherapist (or both). Needs assessed, and support overseen, by a case coordinator. *Delivered by telephone* This included attending the six-week 'Managing Your Well-being' course *Delivered face-to-face pre-pandemic then moved online; now offered both online and face-to-face.* Physiotherapy-led workplace assessment with report and recommendations for line manager *Delivered online* Open access well-being modules developed during the pandemic on a range of well-being topics Signposting and referral to support with wider issues impacting on personal well-being and work Support was delivered by NHS therapists	Holistic assessment and tailored support plan, developed and overseen by a case coordinator. Support plan may include talking therapies, physical therapies, or coaching. It may also include liaison with the employer about changes at work to aid recovery, or support with other issues that are impacting the participant at work, e.g. problem debt, relationship issues. *Delivered face-to-face pre-pandemic then moved to telephone (mental health) and online (physiotherapy); mixed model now offered* Support was delivered through a framework model, with 30+ independent therapists matched to participants. Thematic workshops *Delivered online* The scheme provided a separate intervention for *people who fall into the 'underemployed' category, supporting them to secure a promotion, move from a temporary to a permanent contract, or increase their hours.* This may include a 'career coaching' programme, and/or support to understand the impact of the change on personal finances
Enterprise support	Thematic seminars / webinars *Delivered face-to-face pre-pandemic then moved online; now mixed model* Bespoke advice, guidance and support for individual SMEs	Thematic seminars / webinars delivered as open courses or direct to individual SME enterprises *Delivered face-to-face pre-pandemic then moved online; now mixed model* Bespoke advice, guidance and support for individual SMEs Well-being Champions training and network facilitation

3.3 Both areas had a strong focus on building local partnerships to facilitate referrals into the service, signposting of participants to wider support, and employer engagement. There was some variation in partner development which reflected the different profiles of the delivery partners. In the SBU area, delivery was aligned with NHS services and attempts were made to integrate IWS within wider NHS services. Meanwhile, RCS drew on its well-developed networks with third sector support organisations to develop and extend its offer of support to participants with a wide range of life issues that intersected with work, health and well-being.

Performance, data and reporting

Operational targets

3.4 Table 3.2 provides an overview of the operational targets for IWS across both delivery partners. These were set by WEFO, with one additional target around number of enterprises engaged set by WG.

Table 3.2: Operational targets as of December 2022

Output indicator	Performance target
Sickness absentee participants	7,276
Sickness absentee target - 50% returning to work after absence	3,638
Presentee participants	4,052
Presentee target - 50% have improved health and well-being (WG target only)	2,939
Enterprises engaged (WG target only)	2,800
Enterprises supported	1400
50% supported enterprises having adopted or improved equality and diversity strategies and monitoring systems	700
Implementing Workplace Health Programmes (WHPs)	700

Source: IWS operational targets to December 2022

3.5 In addition to these outputs, delivery partners were set targets for engaging with particular demographics groups. From the total cohort supported, the target was that two per cent of clients should be from an ethnic minority background, 55 per cent should be women, and five per cent should have caring responsibilities.

Delivery partner views on performance, data and targets

3.6 Delivery partner staff in both areas raised concerns during interview about a number of aspects of the performance, data and reporting requirements for the service. The following issues were highlighted as areas of concern in relation to the individual support element:

- **Collecting evidence to demonstrate participant eligibility** In order to be eligible for support, participants needed to be both in work and live or work in the delivery area. For most of the delivery period, WEFO required hard copies of documentary evidence to prove this. SBU, as a service which processes referrals by phone, has always found securing eligibility evidence very challenging. Staff stated, as the service follows NHS codes of ethical practice, they do not withhold support from participants for whom they have not been able to collect eligibility evidence, meaning that the service has been unable to claim for some of the support delivered.

3.7 Prior to the pandemic, RCS processed referrals in person and experienced fewer difficulties, but with the move to remote registration and assessment in response to COVID-19, it too began to struggle to secure admissible evidence, particularly from participants without the necessary digital skills and access:

> ‘When it was face-to-face, people used to bring the documents in, slap them on the photocopier, there you go, thank you very much. Trying to do it online, you've got people's different technical ability, you can't just take a picture and WhatsApp it to somebody, email is seen as an audit trail, and then if you've got attachments on the email you've got to keep the email as well as the attachment. So it just becomes more onerous in terms of signing off, yes you're eligible.’ (Staff interview, RCS)

3.8 RCS staff stated they had lost participants who had been unable to comply with these data requirements. Delivery partners wanted a much simpler system for collecting evidence of eligibility from participants, making best use of digital methods and with appropriate provision in place to ensure those without digital capability were not excluded.

- **Presentee and absentee targets** Delivery targets for supporting presentees and absentees were felt to be unhelpful, because they over-emphasised

work with absentees. RCS reported at one point they were required by WEFO to stop accepting new referrals from presentees to focus on supporting absentees, because this cohort was considered to be at greater risk of becoming unemployed, at the start of the project. This was because they had exceeded their target for presentees, even though they had a shortfall in referrals from absentees. Delivery partners stressed the distinctive value of the service as a form of early intervention to prevent long term sickness absence, and the appropriateness of focusing the bulk of its work on supporting presentees. As the landscape changed, WEFO acknowledged the growing issue of presenteeism and agreed for the project to support referrals from presentees and absentees based on demand.

- **Collecting outcomes data** Collecting outcomes data when a participant was discharged from support, and sustainability data on employment outcomes six and twelve months later, presented significant challenges. Delivery partners reported, once participants had finished receiving support, they did not typically engage with attempts to collect evidence about their work status. It was suggested, rather than requiring participants to attend a post-support meeting with their case coordinator, therapists could capture signed evidence on intermediate work outcomes in the final treatment session when the participant is discharged. The specific requirement for absentees to return to work within four weeks in order for them to count towards outcome targets was also felt to be unhelpful for failing to recognise that in some instances it may take longer. The challenges in collecting outcome data are evident in chapter 4, although it is notable that RCS were much more successful in collecting participant outcome data. This is due, at least in part, to RCS having established face-to-face contact with participants to facilitate collecting physical evidence. Interview participants from SBU also reflected that participants with mental health conditions may be unwilling to revisit their experience of support, as they wanted to put the experience behind them.

3.9 With regard to the enterprise support element, the following issues were raised:

- **Unrealistic targets** In the 2018 refresh, new targets were set for the delivery of enterprise support. Each delivery area was tasked with engaging 1,600 unique businesses, supporting 800, and implementing WHPs with 400.

Delivery partners stated – even without the disruption to employer engagement caused by the pandemic – these targets were unrealistic because they did not take account of the amount of time and resource that it takes to initiate and develop relationships with SMEs. One interviewee noted this issue contributed to a loss of morale among some team members and uncharacteristically high staff turnover.

- **Demonstrating eligibility** The amount of paperwork required from SMEs to demonstrate their eligibility to access even light touch support, such as participation in a webinar, was felt to be inappropriately onerous and delivery partners stated it resulted in some deciding not to engage with the service. It was felt the requirements weighed particularly heavily on small and micro-businesses and sole traders, who might also have the greatest need for the service:

  ‘The organisations that potentially need the help the most because they don't have those other support systems in place to access, there shouldn't be that, you know, prohibitive burden of proof placed upon them.’ (Staff interview, SBU)

- **Defining an SME** The definition of SME meant the service excluded some local organisations from engaging. This included, for example, a branch of a large organisation or one whose parent company was registered outside the delivery area:

  ‘A business can still be in some way linked to a multinational organisation, or a global organisation, but to all intents and purposes that factory in Neath Port Talbot is still operating, pretty much, like an SME. They might have these connections to a global provider but, actually, when it comes to well-being support, often there's still nothing for those staff.*’* (Staff interview, SBU)

- **Enabling re-engagement** SMEs were operating in a dynamic business context, and as such, their support needs and capacity to prioritise engagement with the service were constantly changing. Delivery partners stated the restriction against claiming for any support they provide to

employers with whom they have previously implemented a WHP was unfair, because it did not recognise the way in which new support needs emerge.

3.10 Some of these issues are picked up again in the sections below on delivery outcomes.

4. Client data analysis

4.1 This chapter offers an analysis of 8,972 IWS participants. A database of IWS RCS clients was received in August 2022 and contained 7,180 entries. A database of IWS SBU clients was received in August 2022 and contained 1,792 entries.

4.2 The time period for the analysis is from the start of delivery in 2015 to the end of July 2022.

Employment profiles

4.3 The majority of IWS clients (88 per cent) were employed when they came into contact with the service as shown in Table 4.1. A higher proportion of RCS' clients than SBU were self-employed when they came into contact with the service.

Table 4.1: Client employment status at start of IWS intervention

	RCS		SBU	
Employment status	Number	%	Number	%
Employed	6123	85	1749	98
Self-employed	1057	15	43	2
Total	7180	100	1792	100

Source: RCS and SBU databases (August 2022)

Geographical profiles

4.4 In terms of geography, Table 4.2 shows RCS IWS clients were widely distributed across the eligible local authorities. Conwy accounts for the largest number of clients (32 per cent) while Anglesey accounts for the fewest (14 per cent). Clients who lived outside the RCS delivery area in Flintshire, Wrexham, Wales Other and Outside of Wales were supported because they were employed/self-employed in the RCS delivery area and so eligible to receive support. Limited take up from Carmarthenshire and Ceredigion can be explained by delivery only beginning in October 2021.

Table 4.2: RCS clients by Local Authority

Local Authority	Number	%
Conwy	2308	32
Denbighshire	2091	29
Gwynedd	1656	23
Isle of Anglesey	1001	14
Flintshire	98	1
Wrexham	9	<1
Carmarthenshire	8	<1
Wales Other	1	<1
Outside of Wales	8	<1
Total	7180	100

Source: RCS Database (August 2022)

4.5 SBU's IWS clients were well distributed across the eligible local authority areas, as shown in Table 4.3. Swansea, with the largest population, accounts for the largest proportion (at 38 per cent). In total, 64 clients were supported who were employed within an eligible area but not resident.

Table 4.3: SBU clients by Local Authority

Local Authority	Number	%
Swansea	682	38
Bridgend	571	32
Neath Port Talbot	475	27
Carmarthenshire	34	2
Rhondda Cynon Taf	10	<1
Vale of Glamorgan	6	<1
Cardiff	5	<1
Newport	3	<1
Monmouthshire	2	<1
Outside of Wales	2	<1
Merthyr Tydfil	1	<1
Powys	1	<1
Total	1792	100

Source: SBU Database (August 2022)

Service delivery information

4.6 Analysis of the combined monitoring databases shows that 63 per cent of IWS are presentees and 37 per cent are absentees.[7] These proportions differed between contracted providers. Table 4.4 shows that 64 per cent of RCS IWS clients are presentees while 55 per cent of SBU IWS clients are presentees. A small number of RCS clients (66) were furloughed at the start of IWS intervention.

Table 4.4: Status at start of IWS intervention

	RCS		SBU	
Client status	Number	%	Number	%
Presentees	4625	64	984	55
Absentees	2489	35	808	45
Furloughed	66	<1	0	0
Total	7180	100[8]	1792	100

Source: RCS and SBU databases (August 2022)

4.7 In terms of service type accessed, three in five IWS RCS clients (61 per cent) accessed the physiotherapy service, as shown in Table 4.5. In contrast 78 per cent of SBU clients received mental health support as shown in Table 4.6. This difference reflects the services available, with RCS focused on delivering physiotherapy support, and SBU mental health support.

Table 4.5: Type of service accessed by RCS clients

Service	Number	%
Physiotherapy	4319	61
Counselling	2740	39
Physio & Counselling	29	<1
Drugs and Alcohol	12	<1
Counselling & Addictions	8	<1
HR Support	6	<1
Did not disclose	66	<1
Total	7114	100

Source: RCS Database (August 2022)

[7] A client presentee is defined as someone in work but at risk of a long-term absence from work due to sickness. A client absentee is defined as someone who has reached or is expected to reach four weeks of sickness absence from work.
[8] Total is less than 100 per cent due to rounding

Table 4.6: Type of service accessed by SBU clients

Service	Number	%
Received mental health support only	1399	78
Received physio only	250	14
Received mental health and physio	109	6
No support recorded	34	2
Total	792	100

Source: SBU Database (August 2022)

4.8 Data on the primary condition of SBU clients was made available in the database. As shown in Table 4.7, the primary condition for the majority (82 per cent) of SBU clients was mental health.

Table 4.7: Primary condition of SBU clients

Primary condition	Number	%
Mental Health	1474	82
MSK	318	18
Total	1792	100

Source: SBU Database (August 2022)

Demographic profiles

4.9 The age profile of IWS clients was similar for RCS and SBU as shown in Table 4.8. Over half of RCS clients (54 per cent) were aged between 43 and 62 (i.e. born in the 1970s and 1960s). Similarly, just over half of SBU clients (51 per cent) were aged between 43 and 62.

Table 4.8: RCS and SBU clients' year of birth

	RCS		SBU	
Decade	Number	%	Number	%
2000s (<22 years old)	45	<1	12	<1
1990s (23-32 years old)	961	13	272	15
1980s (33- 42 years old)	1432	20	433	24
1970s (43-52 years old)	1756	24	434	24
1960s (53-62 years old)	2131	30	477	27
1950s (63-72 years old)	766	11	161	9
1940s (>72 years old)	89	1	3	<1
Total	7180	100	1792	100

Source: RCS and SBU Databases (August 2022)

4.10 The age profile of RCS clients was similar for presentees and absentees, as shown in Table 4.9. For SBU clients who were presentees, just under a half (47 per cent) were born in the 1980's or after. Only 30 per cent of SBU clients who were absentees were born in the 1980's or after, as shown in Table 4.10.

Table 4.9: RCS clients' year of birth by absentee/presentee status

	Presentees		Absentees	
Decade	Number	%	Number	%
2000s (<22 years old)	26	<1%	16	<1
1990s (23-32 years old)	612	13%	332	13
1980s (33- 42 years old)	894	19%	519	21
1970s (43-52 years old)	1134	25%	612	25
1960s (53-62 years old)	1389	30%	725	29
1950s (63-72 years old)	501	11%	265	11
1940s (>72 years old)	69	1%	20	<1
Total	4625	100%	2489	100

Source: RCS database (August 2022)

Table 4.10: SBU clients' year of birth by absentee/presentee status

	Presentees		Absentees	
Decade	Number	%	Number	%
2000s (<22 years old)	9	<1%	3	<1
1990s (23-32 years old)	197	20%	75	9
1980s (33- 42 years old)	262	27%	171	21
1970s (43-52 years old)	224	23%	210	26
1960s (53-62 years old)	212	22%	265	33
1950s (63-72 years old)	78	8%	83	10
1940s (>72 years old)	2	<1%	1	<1
Total	984	100%	808	100

Source: SBU database (August 2022)

4.11 Overall, 59 per cent of IWS clients are female (5,310 of 8,972) and 41 per cent are male, as shown in Table 4.11. The proportion of female SBU clients was slightly higher than the proportion of female RCS clients. The proportions are in keeping with the operation's funded target of 55 per cent of clients being women.

Table 4.11: Client gender

	RCS		SBU	
Gender	Number	%	Number	%
Female	4198	58	1112	62
Male	2982	42	680	38
Total	7180	100	1792	100

Source: RCS and SBU databases (August 2022)

4.12 Overall, 59 per cent of RCS clients who are presentees are female and 41 per cent are male, as shown in Table 4.12. Similarly, 58 per cent of RCS clients who are absentees are female and 42 per cent are male. For SBU clients who are presentees, 63 per cent are female and 37 per cent are male, as shown in Table 4.13, while 61 per cent of SBU clients who are absentees are female and 31 per cent are male.

Table 4.12: RCS client gender by client status

	Presentees		Absentees	
Gender	Number	%	Number	%
Female	2711	59	1450	58
Male	1914	41	1039	42
Total	4625	100	2489	100

Source: RCS database (August 2022)

Table 4.13 SBU client gender by client status

	Presentees		Absentees	
Gender	Number	%	Number	%
Female	620	63	492	61
Male	364	37	316	39
Total	984	100	808	100

Source: SBU database (August 2022)

4.13 Overall, 4 per cent of IWS clients self-declared they had a disability and the proportion varied between 2 per cent in RCS to 11 per cent in SBU, as shown in Table 4.14.

Table 4.14: Client disability

	RCS		SBU	
Disability status	Number	%	Number	%
Disabled	171	2	193	11
Not disabled	7003	98	1599	89
Did not disclose	6	<1	0	<1
Total	7180	100	1792	100

Source: RCS and SBU databases (August 2022)

4.14 The percentage of RCS clients who self-declared they had a disability was slightly lower for presentees (2 per cent) compared to absentees (3 per cent), as shown in Table 4.15. The percentage of SBU clients who self-declared they had a disability was the same for both presentees and absentees (both 11 per cent), as shown in Table 4.16.[9]

Table 4.15: RCS client disability by client status

	Presentees		Absentees	
Disability status	Number	%	Number	%
Disabled	96	2	74	3
Not disabled	4525	98	2413	97
Did not disclose	4	<1	2	<1
Total	4625	100	2489	100

Source: RCS database (August 2022)

Table 4.16: SBU client disability by client status

	Presentees		Absentees	
Disability status	Number	%	Number	%
Disabled	108	11	85	11
Not disabled	876	89	723	89
Did not disclose	0	<1	0	<1
Total	984	100	808	100

Source: SBU database (August 2022)

4.15 In terms of ethnicity, as shown in Table 4.17, 1.4 per cent of IWS clients were from a minority ethnic group. The proportion from an ethnic minority background

[9] The difference in percentage of clients with disabilities may be explained by the fact disabled people are more likely to experience poorer mental health, and are therefore more likely to seek support for their mental health Outcomes for disabled people in the UK (Office for National Statistics)

was higher for RCS clients. The overall proportion is short of IWS' target of 2 per cent of participants coming from a minority ethnic group.

Table 4.17: Client ethnicity

	RCS		SBU	
Ethnicity	Number		Number	%
Minority ethnic group	110	2	14	<1
White	7063	98	1772	99
Did not disclose	7	<1	6	<1
Total	7180	100	1792	100

Source: RCS and SBU databases (August 2022)

4.16 In terms of migrant status, as shown in Table 4.18, 2 per cent of IWS clients were migrants with the majority of these being from the EU. There was a higher proportion of migrants amongst RCS clients.

Table 4.18: Client migrant status

	RCS		SBU	
Migrant status	Number	%	Number	%
No	7006	98	1772	99
Yes - EU	104	1	8	<1
Yes - non-EU	65	<1	7	<1
Did not disclose	5	<1	5	<1
Total	7180	100	1792	100

Source: RCS and SBU databases (August 2022)

4.17 The majority of IWS clients (85 per cent) preferred to access services in English, as shown in Table 4.19. This was much higher for SBU clients, where only 13 clients wanted to access the service in Welsh.

4.18 While the majority of RCS clients preferred access to services in English, a high proportion of RCS clients had Welsh language skills. Amongst RCS IWS clients, 2,804 (39 per cent) could understand Welsh, 2,441 (34 per cent) could speak Welsh, 2,303 (32 per cent) could read Welsh, and 2,180 (30 per cent) could write Welsh. In contrast, 191 SBU clients (1 per cent) reported they could understand Welsh, and less than 1 per cent could read, speak or write Welsh.

Table 4.19: Clients' preferred language

	RCS	SBU

Preferred language	Number	%	Number	%
English	5890	82	1779	99
Welsh	1290	18	13	<1
Total	7180	100	1792	100

Source: RCS and SBU databases (August 2022)

4.19 Thirty one per cent of RCS clients and 36 per cent of SBU clients had dependants, as shown in Table 4.20. Based upon this analysis, the service has exceeded its target of supporting five per cent of participants with care or childcare responsibilities by some margin, at 32 per cent. As shown in Table 4.21 the same number of RCS presentees and absentees had dependants, and as shown in Table 4.22 a similar number of SBU presentees and absentees (37 per cent and 36 per cent) had dependants. The majority of clients with dependants were the primary carers of children, rather than disabled adults or older people.

Table 4.20: Clients with dependants

	RCS		SBU	
Dependant(s)	Number	%	Number	%
None	4945	69	1138	64
Primary carer of a child/children under 18	1890	26	570	32
Primary carer of person/people 65 and over	173	2	51	3
Primary carer of disabled adult 18 and over	172	2	33	2
Total	7180	100	1792	100

Source: RCS and SBU databases (August 2022)

Table 4.21: RCS clients with dependants by client status

	Presentees		Absentees	
Dependant(s)	Number	%	Number	%
None	3184	69	1716	69
Primary carer of a child/children under 18	1257	27	618	25
Primary carer of person/people 65 and over	87	2	80	3
Primary carer of disabled adult 18 and over	97	2	75	3
Total	4625	100	2489	100

Source: RCS database (August 2022)

Table 4.22: SBU clients with dependants by client status

	Presentees		Absentees	
Dependant(s)	Number	%	Number	%
None	622	63	516	64
Primary carer of a child/children under 18	322	33	248	31
Primary carer of person/people 65 and over	25	3	26	3
Primary carer of disabled adult 18 and over	15	2	18	2
Total	984	100	808	100

Source: SBU database (August 2022)

4.20 Eighteen per cent of RCS clients lived in a single adult household while just under a quarter of SBU clients (24 per cent) lived in a single adult household (Table 4.23). Seventeen per cent of RCS clients who were presentees lived in a single adult household, while 20 per cent of RCS clients who were absentees lived in a single adult household, as shown in Table 4.24. Similarly, for SBU clients, a larger percentage of absentees lived in a single adult household when compared to presentees (26 per cent and 22 per cent respectively), as shown in Table 4.25.

Table 4.23: Clients living in single adult households

	RCS		SBU	
Living in a single adult household	Number	%	Number	%
Yes	1323	18	428	24
No	5857	82	1364	76
Total	7180	100	1792	100

Source: RCS and SBU databases (August 2022)

Table 4.24: RCS clients living in single adult households by client status

	Presentees		Absentees	
Living in a single adult household	Number	%	Number	%
Yes	803	17	505	20
No	3822	83	1984	80
Total	4625	100	2489	100

Source: RCS database (August 2022)

Table 4.25: SBU clients living in single adult households by client status

	Presentees		Absentees	
Living in a single adult household	Number	%	Number	%
Yes	215	22	213	26
No	769	78	595	74
Total	984	100	808	100

Source: SBU database (August 2022)

4.21 In terms of highest qualification attained, the vast majority of IWS RCS clients have attained at least a level 2 in the Credits and Qualifications Framework for Wales (CQFW) (91 per cent) with 36 per cent having achieved a level 5 or higher, as shown in Table 4.26. Similarly, 91 per cent of SBU clients have

attained at least a level 2 CQFW while 45 per cent have achieved a level 5 or higher.[10]

Table 4.26: Clients' highest qualification

	RCS		SBU	
Qualification level	Number	%	Number	%
None	324	5	135	8
Below CQFW Level 1	66	<1	0	<1
CQFW Level 1	262	4	12	<1
CQFW Level 2	1452	20	325	18
CQFW Level 3	1817	25	353	20
CQFW Level 4	692	10	157	9
CQFW Level 5	656	9	240	13
CQFW Level 6	1235	17	379	21
CQFW Level 7	558	8	173	10
CQFW Level 8	118	2	18	1
Total	7180	100	1792	100

Source: RCS and SBU databases (August 2022)

Duration of support

4.22 The average duration between a client starting to see a therapist and their final appointment was similar for RCS and SBU, with clients being supported for around 100 days.

4.23 Based on 6,108 RCS clients who had been discharged from IWS as of August 2022, on average each client had been supported over a period of 92 days. The duration of support varied between each client – 44 were seen and discharged on the day whilst 1,533 had been supported over a period of 100 days or more

4.24 Based on the 1,710 SBU clients who had been discharged from IWS as of August 2022, on average each client had been supported over a period of 100 days. The duration of support varied between each client – 2 were seen and discharged on the same day whilst 668 had been supported over a period of 100 days or more

[10] A level 2 qualification is equivalent to GCSEs at grade 4 and above. A grade 5 qualification is equivalent to a Foundation degree

4.25 As set out in section 6.19 below, there was considerable variation in the duration of support, with clients typically receiving weekly or fortnightly support at the start of their treatment, moving to monthly sessions once an action plan was established.

4.26 In terms of the number of IWS sessions accessed by clients, data for 1,758 SBU clients found on average they had accessed 3.1 sessions each. The number of IWS sessions accessed were not made available in the RCS dataset.

4.27 Just under one-third of SBU clients (554 of 1,792) were recorded as being early leavers i.e., clients who had voluntarily withdrawn from the service before accessing all therapy sessions to which they were entitled. Comparatively, 13 per cent of RCS clients (769 of 6,154) were recorded as being early leavers.

Client outcomes

4.28 There is limited data to evidence sustained client outcomes given the challenges delivery partners experienced in collecting and recording client outcomes. This was primarily because WEFO required sustained outcomes to be followed up six months after support had been completed. This meant delivery partners found it difficult to collect responses from participants because they were no longer engaged with the service. An additional challenge was SBU believed ‘no response’ received from participants should be recorded as ‘no outcome achieved’. Prior to January 2019, RCS also recorded ‘no response’ as ‘no outcome achieved’, changing their reporting post January 2019.

4.29 Analysis of data supplied by RCS shows 79 per cent of presentees and 70 per cent of absentees reported improved health and well-being as shown in Table 4.27. While, as shown in Table 4.28, 52 per cent of presentees and 38 per cent of presentees reported being in employment six months after their support ended. Presentees were therefore more likely to report both positive health and positive employment outcomes. However, it is important to note sustained employment outcomes should be treated with caution; 16 per cent of presentees and 29 per cent of absentees are recorded as no response. As outlined above, a proportion of “no employment outcomes” recorded prior to January 2019 can also reasonably be expected to be “no response.” However, as Table 4.29 shows 44 per cent of absentees were recorded as returning to work following their

programme of support, which is close to meeting the target of 50 per cent of absentees returning to employment.

Table 4.27: RCS Clients' improved health and well-being [11]

	Presentees		Absentees	
Improved health and well-being	Number	%	Number	%
Yes	3197	79	1436	70
No	727	18	484	23
No response	140	3	146	7
Total	4064	100	2066	100

Source: RCS database (August 2022)

Table 4.28: RCS Clients' sustained employment outcomes

	Presentees		Absentees	
In employment six months post support	Number	%	Number	%
Yes	2127	52	785	38
No	1307	32	677	33
No response [12]	630	16	604	29
Total	4064	100	2066	100

Source: RCS database (August 2022)

Table 4.29: RCS Clients' return to work after a period of absence [13]

	Absentees	
Returned to work after period of absence	Number	%
Yes	921	45
No response	1145	55
Total	2066	100

Source: RCS database (August 2022)

4.30 Analysis of data supplied by SBU shows 26 per cent of presentees were recorded as reporting improved health and well-being as shown in Table 4.30. Table 4.31 shows that 4 per cent of presentees and 5 per cent of absentees were recorded as being in employment six months after their support ended. However, the evidence from the qualitative research of both positive outcomes reported

[11] Table includes outcomes for clients who are recorded as completing their programme of support .
[12] Only included as a response post January 2019. Prior to this 'no response' was recorded as 'no'.
[13] Table includes outcomes for clients who are recorded as completing their programme of support.

and of the challenges SBU faced in collecting participant outcome data means that this data should be treated with caution as it is likely to significantly underrepresent achieved outcomes. It is highly likely the significant difference from outcome data collected by RCS can be largely explained by these challenges. As shown in Table 4.32 a much higher 22 per cent of absentees were recorded as returning to work following support received.

Table 4.30: SBU Clients' improved health and well-being

	Presentees	
Improved health and well-being	Number	%
Yes	252	26
No	732	74
Total	984	100

Source: SBU database (August 2022)

Table 4.31: SBU Clients' sustained employment outcomes

	Presentees		Absentees	
In employment six months post support	Number	%	Number	%
Yes	39	4	37	5
No	828	96	719	95
Total	867	100	756	100

Source: SBU database (August 2022)

Table 4.32: SBU Clients' return to work after a period of absence

	Absentees	
Returning to work	Number	%
Yes	176	22
No	632	78
Total	808	100

Source: SBU database (August 2022)

5. Awareness, engagement, and referrals

5.1 This chapter sets out findings on the ways in which participants, employers and GPs were initially engaged and gained access to the service. Drawing on evidence from across the interviews, it sheds light on the effectiveness of different approaches to raising awareness and engaging different groups.

Participant outreach, referral and access

Hearing about the service

5.2 Participants heard about the service in a range of ways. Most commonly, it was through their GP practice, while other routes included the workplace, primary and secondary healthcare professionals, third sector referral partners, marketing campaigns on the radio and social media, internet searches, and word of mouth from family, friends and colleagues.

5.3 Both SBU and RCS have established links to GP practices in their delivery areas, through the Health Board and as a legacy of the Fit for Work programme, respectively. RCS estimated at least four in five of its referrals come via this route, although one interviewee noted some GP practices were better than others at promoting the service. Participants described being given service information and contact details by their GP or occasionally another staff member such as a practice nurse. Communication methods included handing out a card or leaflet, showing the participant a poster in the surgery, and providing verbal information over the phone.

5.4 While participant interviews suggest GPs provided relatively little detail about the service when signposting patients, this was not generally viewed as a problem. Being directed to the service by their GP gave participants confidence it would provide a credible response to their health condition. Delivery partners stressed this was the most appropriate referral route because it provides a measure of "filtering", helping to ensure individuals accessing the service meet its eligibility criteria.

5.5 Aside from GP practices, evidence suggests the other way in which participants most frequently find out about the service is through their workplace. Typically, participants who mentioned this were employed by large public sector bodies or third sector organisations whose work included a well-being dimension. They

reported receiving the information either through a general staff email or newsletter, or in a more personal way from a colleague with an interest in the participant's workplace well-being, such as their line manager or organisational HR manager. In the latter cases, the information was sometimes imparted in the context of a structured process for supporting the participant to return to work following a period of sickness absence. Several interviewees also reported they had been receiving physiotherapy through their employer's workplace scheme and were signposted to the service by the practitioner to enable them to continue accessing treatment once the allotted number of sessions had been completed.

5.6 Staff in the SBU delivery area indicated there had been a marked increase in recent years in the number of participants who found out about the service through their workplace, following the strategic decision to strengthen the enterprise engagement aspect of the work. Interviewees suggested there was scope to further drive up referrals through closer integration of the individual and enterprise elements of the service, so that enterprise engagement functioned as a more consistent means of reaching individuals who need support within SMEs.

5.7 A key recent development in the SBU delivery area was co-location of physiotherapy outreach services in employer premises. Employers were offered the opportunity to host a physiotherapist and promote the service to their staff. Individuals could book an appointment in advance, and the visiting physiotherapist processes referrals and carries out initial assessments on site.

5.8 In both delivery areas, it appears the profile and reputation of the service grew over time among referral partners as a rapid route by which individuals can receive the support they need. A third sector referral partner in the RCS delivery area described it as the "go-to service" for work and well-being, emphasising its specialist knowledge and holistic approach.

5.9 Nevertheless, a number of participants stated the service could be better publicised and promoted. For example, they reflected they had only found out about it by chance, or that they would have been able to benefit from accessing an earlier intervention if they had known about the service sooner. A few participants reported they had received information about the service through multiple channels and this sense of familiarity provided additional encouragement to self-refer. For example, one participant described how she was signposted to

the service by her GP and realised she had received a leaflet about it from her employer (a secondary school) several months earlier, which she was able to track down for further information.

5.10 Critical for engaging participants with the service was the sense it was relevant to their individual needs and circumstances. A small number of interviewees indicated they would have liked to have had a better understanding from the outset of exactly what the service offered and how it might help them. However, most believed they had sufficient information to inform their initial decision to contact the service. A number of participants followed up signposting with an internet search to obtain more information.

5.11 In terms of key messages, three themes were reported to be particularly effective in engaging participants with the service.

- Its distinctive focus on supporting people who are in work;
- The opportunity which it offers to bypass NHS waiting lists and gain rapid access to therapies;
- The fact it is free at the point of access for participants.

5.12 Several of those who had accessed mental health support also stated the service appealed to them because they wanted to avoid taking medication and instead were looking for practical support to manage their condition. Often, they mentioned wanting to talk to someone outside of their immediate circle of family and friends who was trained to listen and would respond in a supportive and non-judgemental way.

Referral process and accessing the service

5.13 Most participants access the service through self-referral after being signposted to it via one of the routes outlined above. In the SBU delivery area, for example, around 80 per cent of referrals were self-referrals. Participants typically contacted the service in the first instance by telephone or email, although RCS introduced an online self-referral form which enabled participants to make their referral outside office hours. This was seen as a valuable development, and delivery staff stressed the whole process of bringing participants into the service could be streamlined by digital integration of online referral form and registration paperwork. Mechanisms were also in place to enable direct referral of individuals

to the service by both GPs (see section 5.39 below) and employers, although evidence indicates these were not routinely used.

5.14 Participants were generally very positive about their experiences of the referral process. It is worth noting here that, for many who took part in interviews, some months if not years had elapsed since referral, and they often found it difficult to recall exactly how the process had worked. Equally, they were not generally aware of the different stages of the "participant journey" such as referral, registration, and initial assessment. Nonetheless, this evidence highlights a number of key aspects of the service that worked well for participants and contributed to a satisfactory experience.

5.15 **Speed of access.** Almost without exception, participants who were interviewed commented favourably on the speed with which they moved from referral to treatment. This could be as little as a day or two and was rarely more than a fortnight:

> 'I was really, really impressed with the response, and how quickly it was all sorted. It was nice to have somebody saying, 'Yes, we can help you.' (Client interview, RCS)

5.16 Some participants contrasted this rapid referral with the waiting lists for treatment on the NHS or through mental health charities. Referral partners also praised the fast access offered by the service:

> 'The speed that they pick up. I don't know how they do it. Sometimes we'll end up with a six month waiting list but they're always very quick at what they do, and I think that stands out from other services. There's a number, you give them a ring, and there we go. They'll have an assessment and then they're already on board which is great. That really does stand out.' (Stakeholder interview, RCS)

5.17 **Effective initial assessment.** Participants valued the thoroughness of initial assessment – although they did not always use that term – and felt it resulted in their support needs being accurately identified and their being matched to appropriate support:

> 'I felt that they knew the kind of support that I needed and that they felt confident that they would be able to offer it.' (Client interview, SBU)

5.18 Initial assessment typically consisted of structured, in-depth questioning and listening by a case coordinator to understand exactly what support will most benefit the individual and match them to appropriate provision. The case coordinator was an occupational therapist or physiotherapist, depending on the nature of the condition mentioned on referral, and may or may not be the same practitioner who subsequently provided support to the individual. Decisions about support were generally reached through discussion between the participant and the case coordinator, with the aim to empower the participant. Not only were the participant's therapeutic support needs taken into consideration, but also their preferences in relation to factors such as geographical location, language, and delivery method (face-to-face, online or by telephone). For example, one participant described how the initial assessment process identified she would benefit from support from a therapist who specialised in working with trauma cases. In another case, a participant opted to receive support from a physiotherapist based near her home rather than her workplace as it was more convenient. Only one interviewee suggested the initial assessment had been less than effective, stating that it missed her need for specialist bereavement counselling, which she later went on to access via another service.

5.19 **Holistic approach**. Initial assessment provided an opportunity for case coordinators to identify any wider issues which were impacting on the participant's workplace well-being, such as debt, housing, domestic abuse or bullying in the workplace, and to signpost or refer to additional support as appropriate. Ongoing staff training and development was provided to case coordinators in both delivery areas to build their skills and knowledge around wider support. This holistic approach was seen by delivery partners as one of the service's key strengths and a feature which set it apart from the support which individuals would receive through mainstream NHS therapies. It was regarded as an area where there is considerable scope to develop the service so it could more effectively address the breadth of participants' needs.

Referrals of complex cases

5.20 Evidence indicates the open nature of the service meant that in both delivery areas some individuals were accessing it who had more complex needs, particularly in relation to mental health. Self-referrals sometimes came from

people with severe and enduring mental health conditions who were signposted to the service by their GP. In some instances, GPs were suggesting the service as part of a package of interventions which also included, for example, medication and other psychotherapies. Participants and delivery partners recognised the support they offered could complement other treatment options. However, evidence also suggested the service may be engaging participants who were unable to get the specialist support they need from services such as community mental health teams, as these were now so over-stretched. In such cases, delivery partners believed they had a role to play in filling in the gaps:

> ‘We can't be the whole solution for everybody, of course not, but having support when you really need it, even if it's not completely the right support, even if we need to signpost further down the line. Being able to have the opportunity to talk to somebody and have that support for self-management strategies, and coping mechanisms, and all that sort of thing, just having somebody to listen when you're really at your lowest ebb can make such a difference.’ (Staff interview, SBU)

5.21 At the same time, delivery partners indicated not all their therapists had the skills and experience to work with more complex cases, so it was imperative initial assessment matched participants to appropriate support.

Impact of COVID-19

5.22 Delivery partners indicated that at the very start of the pandemic, the participant referral rate dropped "to virtually nothing". This was attributed to two main factors. First, people were preoccupied with dealing with the multiple daily challenges arising from the pandemic, such as illness and bereavement, working from home, being furloughed, home schooling, and living in lockdown. Secondly, key referral routes were disrupted as individuals were no longer able to routinely access their GP, were distanced from their workplace, and the co-location of outreach staff in referral partner organisations ceased.

5.23 As the pandemic progressed, the service experienced a resurgence in self-referrals, including from individuals whose support needs were a direct result of the COVID-19 context. For example:

- Participants developed muscle and joint pain due to prolonged periods of sitting, particularly where they were working from home with an inappropriate workstation set-up, such as using a laptop on the sofa.
- Mental health difficulties including anxiety, depression, and obsessive compulsive disorder increased as participants struggled with issues including health anxiety, social isolation, stress, and bereavement.
- Participants began to refer with mental and physical support needs linked to Long COVID.

5.24 Nonetheless, evidence from SBU suggests that only by the second half of 2022 had the number of individual referrals begun to approach pre-pandemic levels.

Employer outreach and engagement

Hearing about the service and who is being engaged

5.25 Employers heard about the service in a range of ways including direct marketing emails, the internet, via their networks, information posters, events such as business breakfasts delivered by SBU, and word of mouth. Employer interviewees stressed the importance of using multiple and diverse communication channels to maximise the chance of information being picked up by the key individual in an organisation who can take it forward, and of repeat messaging to increase the likelihood of employers hearing about the service at the point when they were ready to engage.

5.26 Staff from both delivery organisations reported it had been very challenging to reach SMEs and engage them in developing WHPs, particularly those that were not already “warm” to supporting staff well-being. RCS stated it had most success in engaging small third sector organisations (“organisations like ourselves”) which were committed to workplace well-being in principle but lacked the internal capacity to implement effective practices.

5.27 To strengthen their reach and engagement with employers, the delivery partners developed more tailored and targeted approaches and there were signs this was effective in connecting with a more diverse range of businesses. They were building partnerships with organisations including the Federation of Small Businesses (FSB) and Business Wales, and with membership bodies for enterprises in key sectors. For example, RCS worked with sector bodies to

develop targeted outreach and support for SMEs in hospitality, hair and beauty, and agriculture:

> ‘Recently we've done a piece of work with [a charity supporting workers in the agricultural sector] reaching out to some of the agricultural sector, to farmers, vets, agricultural merchants.… Using partnership approaches with those really trusted organisations who've got really good penetration into those communities, that's been really key for us.’ (Staff interview, RCS)

5.28 Such an approach enabled greater reach and efficiencies than could be achieved by attempting to engage from scratch with individual organisations which may only have a few employees.

Eligibility and accessing the service

5.29 Employers who were interviewed were generally positive about their experience of accessing the service, with one describing it as “seamless.” However, evidence from delivery partner staff suggests there were some underlying issues which significantly hampered their employer engagement and support. As was noted in section 3.9 above, the amount of paperwork required from employers to demonstrate their eligibility to access support was felt to be disproportionate, while some organisations were excluded as they did not meet the definition of SME.

Impact of COVID-19

5.30 The evidence suggests a mixed and evolving picture in terms of the impact of the pandemic on employer engagement. Delivery partners reported that, until recently, many SMEs had been focused on keeping their core business afloat in the face of challenges such as furlough, staff sickness, falling demand for their products and services, and rising costs. In this way, they were not in a position to prioritise accessing the service, and demand for support was particularly scarce during the period of greatest COVID-19 restrictions. However, the return to more normal working practices threw into sharp relief for many employers the toll that the pandemic had taken on staff well-being, now exacerbated by the cost of living crisis. Alongside this, businesses were struggling to recruit and retain staff, and recognised the importance of looking after their existing workforce. In this context, there were signs of renewed interest from SMEs in accessing support:

> ‘What we're starting to see now is that people are starting to feel quite burned out. There's massive employment issues because they can't recruit. A lot of them have had issues with supply and demand. So, they've had all sorts of challenges on top of the pandemic. So, now we're starting to see organisations that we may have initially engaged with two years ago, where they've attended the odd event, they've come along to one of the business breakfasts, now, we're seeing them coming through and asking for that additional support.’ (Staff interview, SBU)

5.31 This sense is confirmed by evidence from an employer interviewee, who reflected they were only able to engage with the service once their business had recovered from the worst of COVID-19, as well as being prompted by the fact that well-being was on the agenda of their professional body:

> ‘I think we hurt people. I didn't know how to support them. I thought I needed extra resources, somebody to give me new ideas about what I could do. Then the world started to shift post COVID-19. My professional body started sending things about well-being and it felt like it was okay to actually, in our organisation, in our profession, have limits and say we're not okay. I think that probably gave me the confidence.’ (Employer interview, SBU)

5.32 While engaging SMEs became more difficult at the height of the pandemic, the service was permitted by WG to widen its remit and work with organisations of any size which had support needs linked to workplace well-being. This opened up the opportunity of engaging large public sector employers such as local authorities, universities, colleges, schools, care homes, and emergency services which continued to operate during the pandemic, often delivering frontline services. A delivery partner interviewee reported there was high demand for support from such organisations, which also had the internal structures such as dedicated HR departments to engage with the service and promote it to their workforce. This was also an important factor in driving up self-referrals from individuals seeking support.

Engaging and involving GPs

Hearing about the service

5.33 GPs heard about the service in various ways: through other GPs; a personal contact from the service; an umbrella organisation; or through leaflets sent to their surgery. However, there was a general feeling the service was not sufficiently well-known among GPs and wider promotion was needed.

5.34 GPs also indicated it would be useful to have more feedback about the service, in terms of numbers supported back to work, which would help them promote the service better:

> ‘Even if it's just stats, the number of people referred to [IWS] you know, 75 per cent were back at work within 6 weeks or something. I don't know, whatever it is, and that might be handy just to say to people when you're referring them to the service.’ (GP interview, RCS)

5.35 Most of the GPs interviewed felt they had a reasonable understanding of who would benefit from the physiotherapy services. However, there was less clarity about the mental health support offer, with one GP in particular expressing concern that they lacked sufficient expertise in mental health to make appropriate referrals:

> ‘We often feel we're not quite sure who would benefit from which therapy. You know we're not experts in which therapies would help, whether it would be one to one, whether group sessions would be better... So we sometimes do feel we don't know enough about what would benefit patients and how to identify which would benefit more.’ (GP interview, RCS)

5.36 Evidence from participants and delivery partners appeared to confirm the sense that GPs would benefit from having better information about the mental health support available. Participants reported being told they could access counselling, or six sessions of counselling, through the service. Delivery partners stated this was unhelpful, because it meant participants had a preconceived view of what they needed based on their GP’s comments before the service had assessed them. The health profession hierarchy could then hamper the ability of the practitioners delivering the service to engage participants with support options other than intensive one-to-one therapy, even though these may in fact be more suitable:

‘When someone's got counselling in their mind, and if they're feeling vulnerable and unwell, then that's what they want. So who are we to say, 'You don't need that, you need to go on one of the anxiety courses'?’ (Staff interview, SBU).

5.37 All the GPs interviewed valued the service and saw it as meeting significant needs among their patients, with speed of referral the most important aspect of this:

‘It’s been a really helpful service, when you've got people coming into you and you know that the waits are so long in hospital and you know that if you send anybody with minor mental health stuff, it's just not going to get seen, because they're only seeing the suicidal people. It's really handy to have something else there.’ (GP interview, RCS)

5.38 They also identified COVID-19, and the subsequent challenges experienced by the NHS, were likely to lead to increased demand for the service:

‘I mean we've seen a huge spike in mental health and then contributory physical health. And it's, yes, I guess a time when you hear more pressures from the physios or the mental health services in the hospitals, then you, kind of, want another outlet.’ (GP interview, RCS)

Views of referral process

5.39 Self-referral was the preferred method for all GPs, with little evidence of GPs making direct referrals. SBU sought to increase direct referrals from GPs with limited success. Since April 2021, Well-being Through Work was included in the Welsh Clinical Communications Gateway (WCCG) for the SBU area, which sends electronic referrals direct from GP practices to other services within the health board. However, the anticipated boost that this would give to referrals was not realised. SBU attributed this to ongoing systemic difficulties which hamper efforts to raise awareness of the service and its presence on the WCCG among GPs:

‘We still haven't managed to get that much traction because we don't get to engage directly with GPs. We end up dealing with practice managers, and practice managers are overworked. So, a lot of the time…we don't know what information they pass on to GPs. So, we send out GP bulletins and things like

that, but I still think there's huge swathes of GPs, within the project area, that still aren't aware that we're on WCCG or don't really know about the service, even though we've tried very hard.' (Staff interview, SBU)

5.40 It was suggested the service should become the default direct referral pathway on the WCCG for people in work who see their GP with a relevant condition, and concerns were expressed that eligible individuals were being placed on NHS waiting lists instead of being referred directly to the service. Yet evidence from GPs themselves indicates they see self-referral as preferable, both because it saves time from their heavy workload, and because the service is for people who are in work and can therefore generally be regarded as competent to refer themselves.

5.41 GPs discussed the advantage of having a card they could hand out to patients or sending a text message to tell patients about the service. Prior to the pandemic, SBU was piloting a model to facilitate self-referral which co-located an occupational therapist within GP practices, so that eligible individuals could immediately self-refer after being signposted to the service by their GP. Evidence from the pilot showed the approach was effective in expediting access to the service.

5.42 There was some suggestion from GPs that, ideally, they could be cut out of the referral process altogether, if individuals were effectively engaged through promotional activities:

'What aids our work here is if patients don't actually present to us and if they take us out of the equation. So, if patients are able to just get this ball rolling themselves without our input, that does release us to take care of the people with chronic diseases rather than the odd pain that then does settle quickly without our inputs. For patients to know about it without involving us.' (GP interview, RCS)

5.43 Beyond this, GPs interviewed generally felt they had a clear idea of when they would refer to the service and to NHS services:

'I guess if we're worried about somebody and we refer them into the NHS services, you know if they don't turn up or whatever and then they commit suicide, well, there's the whole thing that you've entered the right pathway and

you referred them, and you tried to do it. If you said, 'Oh, I'll refer them to RCS', and they didn't refer on, is there a trail of responsibility, so probably why I keep it within, if it's more severe mental health, the normal NHS pathways.' (GP interview, RCS)

5.44 However, GPs also felt the service could be trusted to refer any high need patients, for example those in need of surgery, back to NHS pathways.

6. Delivery of support

6.1 This chapter sets out findings on the delivery of support for individuals and employers, respectively. Drawing on evidence from across the interviews, it seeks to illuminate the experiences of those accessing support and the ways in which it is tailored to the specific needs and circumstances of the individual or organisation.

Support for individuals

Overall views and satisfaction

6.2 Participants were overwhelmingly positive about the support they received through the service. High levels of satisfaction were evident in the responses of those who were interviewed, and delivery partners confirmed their own mechanisms for collecting participant feedback showed a similar picture.

6.3 The service was orientated towards the delivery of person-centred support which is tailored to the distinctive needs of individual participants. Evidence is discussed below which sheds light on participants' experiences of the service in relation to the following key aspects of delivery, with a particular focus on how effectively they feel it met their needs:

- Delivery methods.
- Volume, duration and intensity of support.
- Support for self-management of health.
- Therapeutic relationship.
- Performance against cross-cutting themes (diversity and inclusion, and language preferences).

6.4 Where data is available, the analysis highlights differences between physical and mental health support, and the differing approaches taken in the SBU and RCS delivery areas. In addition, where relevant, there is discussion of how service delivery was impacted by the pandemic, and how this affected the experiences of participants.

Delivery methods

6.5 On the whole, interview evidence suggests participants were satisfied with the method by which they received support, although the evidence below indicates that, in some cases, this was with an understanding of the limitations on the kinds of support available.

6.6 Three main delivery methods were used for individual support: telephone; face-to-face; and online via platforms such as MS Teams and Zoom. The development of online support was initially driven by the need to maintain services during the pandemic but continued to be offered in both areas as an option to support participants with both mental and physical health needs.

6.7 Participants and delivery partners highlighted the following general benefits to remote delivery, whether by phone or online:

- It is less time consuming and easier for participants to fit appointments in and around work, for example in their lunch hour.
- It makes support more accessible and less time-consuming for individuals living in remote and rural areas with poor transport links.
- It facilitates access for participants without access to private transport or whose health condition means they cannot drive.
- It reduces the number of missed appointments and the impact of this on service delivery.

6.8 This legacy of a more diverse menu of delivery options was seen as a helpful development towards meeting individual needs, and it is apparent both services sought to give participants some choice over how they receive the service.

6.9 It was a key point of difference between the two delivery areas that SBU historically delivered both mental health support and physiotherapy predominantly by phone, while RCS did so face-to-face . Consequently, the need to switch to remote delivery in response to the pandemic had far greater implications for RCS, which moved quickly to offer telephone and online appointments. Staff interviewees reported many participants initially asked to pause their support and a minority did not return. However, as the lockdown and protective measures continued, many opted to resume accessing support as they

decided remote delivery was preferable to nothing at all. Indeed, this attitude was widely reflected in comments from interviewees in both delivery areas who had accessed any kind of support during the pandemic. Even where they indicated that the delivery method used would not have been their first choice, they were pleased the support had been available at all, recognising the service was operating under extraordinary conditions.

6.10 Evidence from participants who had accessed physiotherapy points to a strong preference by some for face-to-face support. One interviewee in the SBU delivery area had turned down the offer of an internal referral from mental health support to physiotherapy when they found it would be delivered via Zoom, stating that previous experience suggested this would be "hopeless." In particular, some participants highlighted the importance of therapists feeling the affected tissue to make an accurate diagnosis and delivering some hands-on treatment. Several participants in the RCS delivery area who accessed face-to-face physiotherapy reported massage and manipulation formed a key element of the support package. Some in the SBU delivery area, where face-to-face physiotherapy was not available, stated they would have liked to have had this option, for the first session at least.

6.11 Nevertheless, participants who received physiotherapy online were generally pleased with the approach and felt it met their needs. They described being able to show the physiotherapist where they were experiencing pain and demonstrate issues such as restricted range of movement which allowed their condition to be effectively diagnosed. The therapist was then able to demonstrate suitable exercises and to watch the participants repeat them. One interviewee said:

> 'It was nice to see a face and have some sort of visual contact with someone…. It was much more engaging [than telephone support] and I did appreciate that more especially when she went into the discussion about what exercises would be good for me, because she could actually demonstrate them, and I could [do] them and she could confirm that I was doing it correctly.' (Client interview, SBU)

6.12 Although face-to-face physiotherapy appointments resumed in RCS as soon as protective measures were lifted, some therapists continued to offer it online, and this was preferred by some participants.

6.13 Due to the small number of interviewees who had received physiotherapy support by telephone, there is insufficient data to come to a view on the effectiveness of telephone rather than online delivery of physiotherapy.

6.14 Very few of the participants interviewed had accessed mental health support face-to-face, although those that did said they had welcomed this. While some others stated they would have preferred face-to-face support, they accepted that this was not available and were satisfied with the alternatives. In only one instance did an interviewee suggest remote delivery had hampered the effectiveness of support, stating they would have preferred to meet the therapist face-to-face in a quiet and neutral space with no distractions, rather than conducting the sessions from home.

6.15 In most cases, participants who accessed telephone or online mental health support indicated they actually preferred this approach as it was less practically and emotionally demanding, and they felt more comfortable and less self-conscious than they would have in a face-to-face meeting. There were suggestions that remote delivery may be particularly helpful for some people who were struggling with their mental health. One participant said:

> ‘I like speaking face-to-face, but to be honest, after dealing with the kids in school, it’s so horrible that I think I feel safer speaking to somebody on the phone or on FaceTime.’ (Client interview, SBU)

6.16 Most of the evidence gathered through participant interviews relates to support delivered one to one, whether mental health support or physiotherapy. However, a small proportion of interviewees had accessed the group support delivered by SBU via its Manage Your Well-being course. They were generally very positive about the experience, highlighting a range of features of the group setting which they found beneficial, including: sharing experiences and coping strategies; hearing from people of different ages and backgrounds; finding it a less intimidating environment than a one-to-one setting; and making them feel less alone and isolated:

> ‘It was nice to be in a group. There were some really nice ladies and gentlemen in the group. We were all sharing different information, and I think it gave us all a lot more confidence to actually open out about things. I know I got really low at one stage, and, you know, just the pain was too bad that I

thought that I just can't be bothered to wake up tomorrow, and I think that the course certainly [showed that] there's things can be done.' (Client interview, SBU)

6.17 With the easing of protective measures, the course was offered either online or in person. The introduction of online delivery enabled SBU to offer the course as a continuation option to some participants who reached the end of their one-to-one sessions but who were felt to need more support.

6.18 As with other delivery methods, participants' views of effectiveness of online group sessions largely reflects personal preferences and circumstances. For example, one participant stated they "loved" the Zoom classes while several others stated they would rather have met face-to-face.

Volume, intensity and duration of support

6.19 The service is designed to deliver up to six sessions of support to eligible individuals. Some research participants accessed six one-to-one sessions as a block to address a single specific issue, while others were supported with fewer sessions and occasionally just with one. There were also a few instances of individuals accessing the service several times for support with different needs.

6.20 Evidence from the interviews suggests participants accessing support through RCS were likely to receive a block of six sessions, and this applies both to those receiving mental health support and physiotherapy. In the SBU delivery area there was much more variation in the volume of support individuals received, with most having fewer than six sessions among both mental health support and physiotherapy participants. The evidence that SBU were more likely to deliver fewer sessions is supported by client data analysis. As set out in section 4.27, close to one in three (31 per cent) clients in the SBU delivery area were early leavers compared to only one in eight (13 per cent) in the area served by RCS.

6.21 The intensity and duration of delivery varied considerably. Therapists were clearly aware they were delivering a limited service and aimed to maximise the benefit for participants. Generally, for participants receiving the full entitlement of mental health support, initial sessions took place with greater frequency (weekly, fortnightly, or monthly), and then the remainder were scheduled further apart in order to taper the support and reduce the participant's dependence on it.

Sessions for some participants were spaced out for up to six months. One participant described how the scheduling of sessions was tailored to reflect their needs:

> ‘[The therapist] was very keen on making sure that I felt comfortable with the length of time that we were going to leave between each session. And there was always the thing of, 'Well look, if something happens between now and then, it's not a case of we can only speak in two weeks' time, if something comes up, get in touch.' Either herself or somebody else could help me out at that time. So I never felt that I was being cast adrift, I always knew they were there to back me up if needed.’ (Client interview, SBU)

6.22 Several interviewees who had received physiotherapy stated spacing of sessions was based on the length of time the therapist deemed necessary for the participant to practise the exercises they were given and / or allow healing to take place.

6.23 Participants generally stated they were satisfied with the duration and intensity of support. A few interviewees reported they had actively taken the decision to end the support once they judged they had made sufficient progress and knew how to manage their condition effectively without further intervention from the therapist. Making this kind of decision helped participants to feel in control of the process.

6.24 However, it also is evident for some participants with mental health support needs, the withdrawal of support after six sessions could be a profoundly negative experience:

> ‘My life literally turned on its head. I was absolutely gutted that it came to an end so quickly. It would have been nicer for it to have gone a bit longer or maybe not as frequently… Just to check in. It ended quite abruptly. I wasn't quite ready to let her go.’ (Client interview, SBU).

6.25 In such circumstances, participants reported being offered the opportunity to access on-going support privately from the therapist – an option which was generally deemed unaffordable – or directed back to the NHS, which they knew had long waiting lists. Several interviewees reported they were able to access further therapy through their workplace scheme, with varying degrees of effectiveness. As noted above, SBU also appeared to have offered access to the

online course as a way for some individuals to continue receiving support from the service. However, there did not appear to be any consistent and reliable solution in place to ensure participants in either delivery area who needed further support after six sessions were able to access it in a timely way.

6.26 Delivery partners suggested this rationing of support to six sessions in all cases was one of the key weaknesses of the current delivery model. As well as pointing to the kinds of situations just described, they also questioned the fact that the six sessions included all the mental health, physical health, and wider support that an individual may access over an indefinite period of time. They argued this limits the potential effectiveness of the service by failing to recognise individuals may develop new support needs as their circumstances change:

> ‘So they've had physio at the start, and then four years later they've had something terrible happen in their lives that could do with some counselling support, but we're having to say, 'Sorry, you had physio four years ago.’ ‘(Staff interview, RCS)

6.27 At the same time, however, it was suggested in some staff interviews that the focus in the current delivery model on providing support through therapy sessions meant the potential to meet the needs of some individuals through fewer intensive interventions was overlooked. In particular, it was argued many people could be helped with advice and guidance delivered by a therapist in the case coordinator role, rather than needing to be referred for formal therapy sessions:

> ‘We’ve been challenged at times when someone hasn’t wanted therapy, they just wanted the support of the case coordinator, which to me is ideal. I’d have thought that maybe 50 per cent of people should not need therapy, they would want just the support of the case coordinator.’ (Staff interview, SBU)

Support for self-management of health

6.28 A key feature of the service’s approach to supporting individuals was its emphasis on developing participants’ skills and knowledge to manage their own condition as a way of improving their health. In effect, the treatment model aimed to equip individuals to become their own therapist and gain lasting benefit from the support intervention.

6.29 Interview evidence from participants on both support pathways describes how therapists supported them to understand and apply a range of tools and techniques designed to promote effective self-management. The following examples were cited by participants who had received physiotherapy:

- Physical exercises to be carried out regularly to strengthen and repair muscles and increase an individual's functional range of movement.
- Advice on implementing practical adjustments to working practices, such as taking regular breaks, spending less time sitting, reducing heavy lifting and using personal protective equipment such as knee pads.
- Guidance on discussing with an employer how to facilitate healthier workplace practices, for example by providing a standing desk.
- Advice on lifestyle behaviours including diet and exercise.

6.30 Meanwhile, participants receiving mental health support described being supported to learn how to apply a range of cognitive tools and techniques to:

- Cope with difficult situations and manage stress.
- Challenge unhelpful thought processes.
- Promote better decision-making.

6.31 To facilitate participants' independent application of the suggested tools and techniques, it was evidently routine for the therapists delivering the service to follow up a support session by sending relevant resources out by email, or by post if participants prefer. Examples of resources cited by participants in interviews included exercise sheets, cognitive behavioural therapy worksheets, and links to online materials.

6.32 Delivery partners in both areas suggested there was considerable scope to further develop the self-management aspect of the service, with a particular focus on strengthening its offer around targeted preventative support and early intervention. For example, SBU physiotherapists were looking at ways of expanding their workplace outreach to develop awareness around healthy working practices, diet and exercise. Meanwhile, RCS delivered webinars on sleep which have been well-received. It was suggested by some delivery partner staff that the current model emphasised providing support through intensive

therapies, which people tend to access when their problems have already escalated to a certain level of seriousness. This meant there were missed opportunities to address prevention and early intervention.

The therapeutic relationship

6.33 The support models used in the service were based on the development of a strong, positive therapeutic relationship between the participant and the therapist. The two parties needed to work collaboratively to help motivate the participant to engage with the self-management tasks proposed by the therapist. Central to a positive therapeutic relationship was the need for participants to trust the therapist and believe they understood and cared about their individual situation.

6.34 Overwhelmingly, those participants interviewed spoke with warmth and conviction about the therapists who supported them. Adjectives such as “kind,” “caring,” “lovely”, and “like a friend” were often used. Participants described feeling listened to, so the therapist could understand how best to support them. Those who received mental health support in particular talked at some length about the qualities of the practitioner and the therapeutic relationship that had developed over the course of the support sessions. Several stated they had looked forward to their next session and talking to the therapist:

> ‘She had just the right mix of being someone you can talk to, and you feel comfortable with. I know she's not my friend, don't get me wrong, but I did feel she really cared about how I felt and how I wanted to proceed. She knew all I wanted was to go back to normality and be myself.’ (Client interview, SBU)

6.35 The evidence suggests a strong rapport developed when the therapist was perceived by the participant as being not only friendly, attentive and caring, but also professional, knowledgeable and respectful. The fact support was delivered by the same therapist throughout was noted by several participants as an important factor in helping to build trust and rapport.

6.36 In a small number of cases, interviewees reported the therapeutic relationship had not developed well. One participant stated they felt they were listening to the therapist more than the therapist listening to them, and another highlighted they did not feel they developed a connection with their therapist:

‘I felt like I was talking to somebody who wasn't sure how to deal with my situation...I spent more time listening to her situation, and I guess she was trying to show that she understood, but I just spent most of my time listening and agreeing and, 'Yes, I understand that.'' (Client interview, SBU)

6.37 Where participants did not develop trust and rapport with the therapist, it is evident this resulted in an overall sense of dissatisfaction with the service.

Performance against cross-cutting themes

6.38 Service delivery aimed to promote the following cross-cutting themes:

- Equal Opportunities & Gender Mainstreaming (including the Welsh language)
- Sustainable Development
- Tackling Poverty and Social Exclusion

6.39 This section considers how far the principles of equal opportunities and gender mainstreaming were applied to service delivery, while a wider consideration of how far IWS was successful in promoting these themes in terms of outcomes achieved is included in chapter 8. Sustainable development, and tackling poverty and social exclusion are considered in relation to outcomes in chapter 8, but the research did not find evidence of these themes in relation to service delivery.

6.40 There is limited data relating to equality, diversity and inclusion available from the qualitative research. Additional evidence from case studies supplied by the delivery partners were therefore included for consideration.

6.41 No participants who took part in interviews described having any specific arrangements made for them to address barriers associated with protected characteristics. The evidence from the interviews suggests this is because they did not request or require specific adjustments, and no participants described requesting accommodations that were not met. However, as evidence presented above shows, some who were experiencing ill-health and disability valued the opportunity to access the service remotely. This was supported by evidence from a case study where remote appointments made it easier for a wheelchair user to attend.

6.42 Evidence from the case studies also demonstrates delivery partners offered services tailored to meet the needs of particular groups. This included webinars

for older participants on topics such as positive ageing, and keeping fit and well for older workers, or for women on topics such as the menopause.

6.43 Evidence from the interviews indicates that delivery partners had taken steps to make the service more accessible and address issues that may exclude some groups. For example, RCS staff acknowledged they knew the social-demographic profile of those using the service did not reflect that of the local population, and they wanted to address this. This included developing improved processes to make the self-referral process accessible for individuals with sensory impairments, including the provision of a British Sign Language (BSL) interpretation service to support participants.

6.44 With regard to meeting participants' language preferences, interviewees reported being asked which language they would like to receive support in at referral and at registration. Although not all could recall this happening, they stated they were sure they would have been asked.

6.45 Delivery partners confirmed all forms, paperwork, and communications were available in both Welsh and English. RCS staff stressed the organisation has a commitment to promoting Welsh and has increased the use of Welsh on all its social media channels. When it was observed that people who were clearly Welsh speakers were not asking for the service to be delivered in Welsh, the way in which RCS asked about language preference was changed. Individuals were asked to express their preference for the language in which they complete paperwork and the language in which they receive support separately, to allow for the fact that not all Welsh speakers may be confident in business Welsh.

6.46 However, partners in both delivery areas stated they have a shortage of Welsh-speaking staff, despite their efforts to recruit to address this. While they were able to meet the needs of participants who would like to access the service in Welsh, doing so often meant that the participant would have to wait longer. Given a choice between receiving support quickly and receiving it in Welsh, most opted for the former. As a result, most delivery took place in English. Yet there were indications that where Welsh language preferences were met, this can add to a participants' overall sense of satisfaction with the service. A participant who accessed physiotherapy in Welsh said:

‘She was really good, and she was a fluent Welsh speaker, which was great, because I’m a fluent Welsh speaker, so it was quite good to speak fluently in Welsh with her.’ (Client interview, RCS)

6.47 This indication that meeting clients’ Welsh language preferences can increase their satisfaction with the service was supported by evidence from a case study supplied by SBU, where the participant found it easier to express themselves and build rapport with their therapist because the support was delivered in Welsh.

Support for employers

Type and intensity of support received

6.48 The support delivered to employers varied considerably in its nature and intensity. Examples of support that were cited by employers and delivery partners during interview included:

- Training for well-being champions, who acted as a source of information and advice in the workplace and promoted well-being to colleagues.
- Webinars covering topics such as stress management, mindfulness, sleep hygiene, and financial well-being.
- Support with developing and implementing well-being strategies, action plans, and wider HR policies
- Facilitating online staff well-being surveys and producing a report of findings and recommendations.
- Embedding a focus on well-being in induction and staff performance and development review processes.
- Promotion of the individual support element of the service, including by direct marketing and outreach at employers’ premises, to encourage self-referrals from staff members.

6.49 The minimum employer engagement requirement for support to be recognised as a WHP was two interventions. As one delivery partner noted, this could mean that one member of staff has accessed two webinars. At the other end of the scale, some organisations accessed an extensive range of support:

‘Some employers want everything…We'll send them our menu of support and they'll say, 'Oh, yes, these all look great, how many can we have?' And then you've got other businesses where it might just be the business owner that turns up for two webinars.’ (Staff interview, SBU)

6.50 Delivery partners stressed in many cases the interventions SMEs wanted were fairly light touch as they did not have the resource to devote to anything more:

‘Because they’re so small, they don’t want a complicated overhaul of their well-being policy or their approach to well-being; they just want us to come in and do some training.’ (Staff interview, RCS)

6.51 In some cases, the delivery partners worked with employers to create a bespoke package of support. For example, one third sector employer already had some workplace well-being activity in place and the nature of its work meant staff received training on mental health and were aware of some approaches they could use in their work with clients, but it was clear staff were struggling with stress, overwork, and poor work-life balance. Therefore, the employer asked RCS to develop a session of higher-level well-being training which was appropriate for staff with some prior knowledge and experience.

Employer satisfaction with the service

6.52 The employer interview sample was small so findings should be interpreted with some caution. The available evidence points to high levels of employer satisfaction with the service. Employers valued the knowledge and expertise they were able to access and the responsiveness of the delivery partners to their specific needs. For example, one employer described how their WHP involved being supported to access and use a suite of resources to help with the development and implementation of well-being policies and practices:

‘When you're a small business and you're starting from nowhere...It was just a one-stop shop all in the same place. I can't rave about it enough. I thought they were very skilful people. I thought they were very kind in how they delivered the service. I thought they were phenomenally professional. I thought the resource information and the resource bank that they linked you into at the end was exceptional.’ (Employer interview, SBU)

Impact of COVID-19

6.53 Both delivery partners reported the pandemic created a surge in demand from employers for well-being support. The delivery partners' effectiveness in shifting from face-to-face to online delivery meant they were able to respond to this and extend the reach and range of support they provided:

> 'We got more and more and more and more people wanting our service at the same time, because they didn't have to take time out particularly. They could do it via online media and remotely. We got very, very, very popular.' (Staff interview, RCS)

> 'I think we had webinars up and running by the May [2020]. We were really, really responsive. It was our finest hour, to be honest.' (Staff interview, SBU)

6.54 A staff interviewee from SBU stated they had long wanted to offer webinars for employers, as they recognised this delivery method had the potential to address the issue that many SMEs struggle to release staff time for training. The pandemic provided the urgent motivation to develop online support.

6.55 With the lifting of pandemic protective measures, areas adopted a hybrid approach to business support. Delivery partners reported the flexibility was highly beneficial and gave them more scope to tailor support to the needs of different organisations. While in-person support continued to be important for engaging employers, the webinars allowed much greater penetration with organisations and individuals that were otherwise difficult to reach.

7. Outcomes

7.1 This chapter presents findings on outcomes experienced by individuals and employers as a result of the support they accessed through the service. It considers how the delivery partners performed against funded targets where this information is available but draws primarily on evidence of self-reported outcomes from interviews with participants and employers, together with additional observations from delivery partner staff and stakeholders.

Participant outcomes

Performance against funded targets

7.2 Table 7.1 sets out the performance of the service against the funder target numbers of clients supported. This table shows that neither delivery partner was able to recruit and support the expected number of sickness absentee participants, with SBU only recording 41 per cent of the expected target and RCS 47 per cent. The reasons for this are set out in the initial evaluation, and primarily relate to not receiving anticipated referrals through the Fit for Work programme. SBU were successful in recruiting 89 per cent of their presentee target, while RCS delivered support to 175 per cent of their presentee target. This meant RCS were close to achieving their overall recruitment target, while SBU recruited 58 per cent of programme participants in total. As noted in section 5.30, delivery partners identified COVID-19 had a significant impact on referrals, with SBU estimating referrals did not return to pre COVID-19 rates until 2022.

Table 7.1: Performance against funded targets of clients supported

Output indicator	Programme target	Achieved (July 2022)	% of programme target achieved
SBU - presentee participants	1102	984	89
SBU – sickness absentee participants	1,980	808	41
SBU total participants	3082	1792	58
RCS- presentee participants	2,648	4625	175
RCS- sickness absentee participants	5296	2489	47
RCS-furloughed participants	n/a	66	n/a
RCS total participants	7944	7180	90

Source: RCS and SBU database (August 2022) and IWS operational targets (December 2022)

7.3 Two further operational targets related to participant outcomes. The target for absentees was that 50 per cent would return to work after sickness leave, and for presentees that 50 per cent would experience improved health and well-being.

7.4 From the data supplied by RCS 79 per cent of presentees reported improved health and well-being, meaning RCS exceeded this target by a considerable margin. In contrast 44 per cent of absentees were recorded as returning to work, which falls slightly short of the 50 per cent target.

7.5 From the data supplied by SBU 26 per cent of presentees reported improved health and well-being, while 22 per cent of absentees were recorded as returning to work after a period of absence. However, a cautious approach needs to be applied to these reported outcomes due to the issues with collecting and recording responses.

7.6 It is important to note that for quantitative health and employment outcomes, it is not possible to infer whether the intervention was responsible for any changes experienced.

Outcomes for individuals

7.7 It was suggested by some delivery partner staff that the outcomes monitoring approaches and reporting requirements put in place by the service's funders were quite limited relative to the range of well-being benefits that participants reported through their own feedback mechanisms:

> 'I am forever seeing feedback that it has transformed people's lives. Not only do we bail people out in their dark days, but the therapists and the case coordinators are just brilliant at providing tools that enable people to manage their health effectively in the longer term. People talk about that: 'You've given me some real insights into what I need to keep me healthy.'' (Staff interview, SBU)

7.8 The qualitative interviews provided an opportunity to explore participants' experiences in-depth, with the aim of developing a more expansive and nuanced understanding of the ways in which the support made a difference to their well-being. The discussion below looks at outcomes reported in the two domains of health and work. It adopts a conceptual approach which proposes it is helpful to distinguish between intermediate and major outcomes. Intermediate outcomes are those which relate to the direct impact of the support on the participant's current health condition or work situation. Major outcomes, meanwhile, are those which have the potential to make a difference for the individual in the longer term. The analysis deals separately with outcomes reported by participants accessing physiotherapy and mental health support, as this structure allows for consideration of evidence on the methods by which individuals believed outcomes were achieved.

7.9 It is worth noting that, in the context of IWS, health-related outcomes can be regarded as intermediate outcomes on the way to achieving the service's ultimate goal of enabling participants to remain in work.

Outcomes from physiotherapy support

7.10 Participants who accessed physiotherapy overwhelmingly reported the support exceeded their expectations and their goals in accessing the service were achieved. GPs who took part in interviews generally felt the physiotherapy component of the service had been effective:

‘I think the physio probably does meet their needs in terms of the majority of patients I've not heard back from after I've referred to them, for their physical problems. I've said, 'If it's not any better, come back', but they've not. So I'm presuming that that means that they have worked from a physio point of view.’ (GP interview, RCS)

Health-related outcomes from physiotherapy

7.11 Participants reported the following intermediate outcomes from physiotherapy.

- Physical benefits, including: reduced pain, becoming pain free, and having improved strength, function or mobility in the affected area.
- Taking part in everyday activities again such as: driving; making a meal; carrying out tasks associated with caring for a disabled son, including lifting him in and out of his wheelchair; and going on long walks.
- Reduced dependence on medication as a result of being in less pain, with interviewees stating they were taking fewer painkillers or had stopped taking them completely.

7.12 In addition, participants reported a major outcome in the form of being empowered to manage their own health more effectively. Participants described how, during the treatment process, the physiotherapist supported them to develop the knowledge and skills to take control of managing their condition for themselves, so that after discharge from the service they were able to take the necessary steps to deal effectively with a recurrence of the pain or injury.

Participant vignette

Rhian* works full-time for her local council. She developed neck pain and numbness down one arm due to a compressed nerve. Her job was desk based, and the amount of time spent sitting in one position had increased as a result of working from home during the pandemic. Her condition was being investigated through the NHS when she heard about the service through her employer's HR department.

Rhian accessed six sessions of physiotherapy via MS Teams. The physiotherapist gave her exercises to do to alleviate the injury and prevent its recurrence and coached her on the importance of taking frequent breaks from sitting at her desk. Being supported to do the exercises gave Rhian the confidence that she could do them without making the injury worse. Her condition improved considerably: she was in less pain and had much greater range of movement in her neck. She now has a much better understanding of how to manage her health. She continues to take frequent breaks throughout the day, and practises the exercises as needed.

*All names in the vignettes in this section are pseudonyms, with some details being changed to ensure anonymity

Work-related outcomes from physiotherapy

7.13 Most participants reported their expectations were fulfilled with regard to the impact of the support in relation to work.

7.14 They identified an intermediate outcome in the fact that they were able to stay in or return to work. Some participants stated they were able to return to work more quickly than would otherwise have been the case. Many of those interviewed had physically demanding jobs, and reported they were again able to carry out aspects of their role that had been painful, difficult or impossible prior to receiving physiotherapy. These included: a firefighter whose job involved carrying heavy equipment; a motor vehicle technician whose role required bending and application of strength; and an estate gardener who used heavy tools for pruning large trees. An Early Years practitioner said:

> 'If I hadn't been offered these sessions, I think I would have been afraid to start lifting again because I wasn't sure if I could lift with my back after the surgery. But after going to the physio then I started to relax a bit and feel like, 'Okay, I can start lifting.'' (Client interview, RCS)

7.15 As a major outcome, participants reported being empowered through knowledge, understanding and skills to better manage their health in the workplace. This included managing the specific condition for which they had sought support from the service, but also enacting changes in the workplace with the aim of preventing muscular-skeletal problems from arising in future. Some participants reported that, thanks to the support, they had a better understanding of what they need to promote good physical health at work and are thus able to articulate their needs effectively to their employer. As a result, some had been able to implement different ways of working, such as using personal protective equipment and obtaining a standing desk so they could vary their working position throughout the day.

Evidence of positive outcomes not being achieved

7.16 There is little evidence from the interviews that participants on the physiotherapy pathway felt health and work outcomes had not been achieved. One participant who had received support with lower back pain stated that it had helped to reduce pain and to increase mobility but that the situation has since deteriorated. However, they acknowledged this was because they had stopped doing the prescribed exercises.

Mechanisms contributing to positive outcomes from physiotherapy

7.17 Participants were asked what features of the support had worked well and contributed to its effectiveness. It should be noted they generally explained work-related outcomes as a direct result of the health-related outcomes and did not routinely differentiate between health or workplace outcomes when highlighting aspects of the service which they found to be helpful and effective.

7.18 They identified a range of mechanisms by which they believed the positive outcomes they experienced had been achieved.

7.19 **Exercises to perform independently,** both between support sessions and following discharge from the service. Participants described being given a range of stretches and strengthening exercises and stated this was one of the key ways in which the support empowered them to manage their condition in the future. They valued the fact that the physiotherapist generally took steps to ensure they had a record of the recommended exercises, for example by following up the

session with an email summarising the exercises and including links to resources such as YouTube video demonstrations.

7.20 **Personalised support from a qualified physiotherapist**, which meant the therapist was able to focus on the individual, tailor the support to meet their needs, and guide them through the process:

> ‘I felt that I was given the luxury of time, somebody to listen, somebody to understand my issues and give me bespoke exercises.’ (Client interview, RCS)

7.21 Several participants described how the physiotherapist explained in some depth the nature of their problem and how the support would help to alleviate symptoms, praising the depth of their professional knowledge and skills.

7.22 **The speed at which support was accessed following referral**. It was widely noted that acting quickly to address physical problems, particularly in the case of injury, was important for efficiently achieving a positive outcome, and this was referenced by participants as one of the most valuable aspects of the service. A participant who damaged their ankle and was consequently unable to carry out their physically demanding job said:

> ‘I'd looked at the GP service, I'd looked at the NHS, and I think there was a 16 week wait for physio, to try and get in, somewhere in [name of district]. Which, for this type of injury, if I'd have waited 16 weeks, it would have caused more damage. I needed to access the physio quickly. So, by accessing the physio quickly, it's probably saved the NHS an awful lot of money.’ (Client interview, RCS).

7.23 **Hands-on treatment**, in the form of physical manipulation and massage of the affected area. This type of intervention was available only in the RCS delivery area and was suspended during the period when COVID-19 measures prohibited close contact services. A minority of participants received face-to-face physiotherapy, but those that did were unanimous in citing hands-on treatment as critical to their recovery.

Participant vignette

Bethan* is in her late 50's and has worked as a gardener for over 30 years. She developed a shoulder injury as a result of sustained use of heavy equipment and found it increasingly difficult to use her right arm. Although she continued to work with the injury, she was unable to carry out key parts of her role and it also began to impact on activities in everyday life.

Bethan found out about the service through the nurse at her GP practice and self-referred. She was quickly assessed and given a choice of a physiotherapist, so selected the one closest to her home. She received six sessions of physiotherapy, which included hands-on massage and manipulation together with exercises which Bethan was to continue at home between session and after discharge. By the end of the sessions, Bethan was able to resume all the duties of her job without pain and continues to perform the exercises if she experiences the onset of any discomfort.

Health-related outcomes from mental health support

7.24 In most cases, participants who received mental health support were very positive about the experience, but often found it difficult to describe very specific health-related changes with the same clarity and certainty as those who accessed physiotherapy. GPs suggested mental health conditions could be more complex and persistent, so there was a greater likelihood issues would not be fully resolved through the kind of interventions offered by the service.

7.25 Nevertheless, participants reported the following intermediate outcomes.

- Improved mental well-being, widely articulated as a general sense of feeling better, happier, calmer, and more confident and positive in themselves. For example, they described being able to think more clearly and no longer struggling to manage day to day activities. Several said they had been having suicidal thoughts at the time when they accessed the service, which had been effectively addressed:

  'If you look at me where I was twelve months ago and where I am now, you'd say it's two completely different people. I am so much happier. I'm

not on any medication. I'm not feeling how I was feeling at all. It is literally two different people. It's like two ends of the spectrum. You've got dark and depressing, and suicidal, and then you've got someone now who loves life and enjoys every moment.' (Client interview, SBU)

- Reduced dependence on medication for some participants, the desire to avoid taking medication such as antidepressants was an important reason for contacting the service, and they were pleased to be able to point to the achievement of this specific outcome.

7.26 They also reported the following major outcomes:

- Being empowered to manage their own mental well-being more effectively. Participants explained the therapy had equipped them with tools and techniques to recognise and respond effectively to both stressful external situations and their own personal behaviours and thought processes, to alleviate the detrimental impact on their mental health. For example, they described how they had developed a new mindset as a result of the support, as they were better able to recognise and challenge unhelpful and negative ways of thinking.

- Greater awareness and understanding of mental health and well-being support. Several participants stated that engaging with the service had raised their awareness of what support is available, including support to address wider issues which impact on wider well-being such as personal finance. One participant explained how the therapy had helped them to feel more empowered to seek help with some major challenges that they experienced and as a result they were seeking an autism assessment.

Participant vignette

Katherine* is self-employed and works part time as a legal typist for barristers' chambers. The work can be stressful and high-pressured, and Katherine finds it difficult to turn work down. She found her workload had become overwhelming and the boundaries between home and work life were increasingly blurred. Katherine contacted her GP for support as her mental health began to suffer and was provided with a link to self-refer to the service. The GP explained referral times were quicker than for NHS counselling services and the support would aim to help her stay at work. Katherine was also prescribed anti-depressants.

Overall, Katherine had a very positive experience. The therapist provided exercises and coping mechanisms to carry out between each session, as well as once the sessions had ended. She felt the therapy and medication complemented each other and contributed to both short-term and long-term improvements in her mental health. She was able to continue working and learned to cope better with the demands of her job, as well as feeling happier within herself and coping better with life more generally.

Work-related outcomes from mental health support

7.27 The majority of participants reported positive outcomes in relation to work. The following intermediate outcomes were reported and show greater range than for any of the other categories of analysis used in this discussion.

- Being happier at work.
- Improved workplace communications and relationships with colleagues.
- Being able to do their job better due to improved focus and concentration, having more energy, and having a more positive outlook on their job.
- Feeling empowered to better manage and cope with stressful situations at work.

7.28 These intermediate outcomes contributed to the following major outcomes.

- Returning to or staying in their current job. Participants who continued in their existing job described a range of individual situations at the time when they began receiving support, ranging from those who were still at work to those

who were on long term sick. Many of those who had taken time off stressed how the support hastened their return to work:

> 'If it hadn't been for the support, I'd probably have ended up being off for longer. Because I think I knew I could get back to work, knowing that the support was there.' (Client interview, RCS)

- Changing jobs. For a significant minority, accessing the support encouraged and enabled them to re-evaluate their work situation and make the positive decision to look for a new job. These individuals generally identified some aspect of their existing work as a major reason for their poor mental health. The support gave them the space to evaluate their situation and the confidence to make changes.
- Achieving better work life balance through being empowered to set boundaries.

Participant vignette

Lewis* works in IT. During the pandemic he moved to working mainly from home but had to go into the office several times a week to check on the systems. He developed obsessive compulsive disorder (OCD) due to fear of catching COVID-19 through touching contaminated equipment. Lewis' condition worsened when pandemic measures began to ease, and his employer began to propose a phased return to office-based working. Other than to see family, he stopped leaving the house.

Lewis self-referred to the service after hearing about it on a radio advert. He accessed Cognitive Behavioural Therapy (CBT) by telephone for about three months, weekly at first and then less frequently. Sessions were timed to fit in with Lewis' work commitments. From the first appointment, Lewis was confident the support would help as he began to learn techniques to help manage his anxiety. The therapist was attentive and non-judgemental and helped him understand the nature of his condition and how CBT could help.

By the time he was discharged from the service, Lewis was able to work in the office three days a week. He felt he had learnt a range of techniques which he could continue to apply in order to sustain and strengthen his recovery.

Evidence of positive work-related outcomes not being achieved

7.29 There were more examples of interviewees who had accessed mental health support stating their desired outcomes had been only partly achieved or, more

rarely, had not been achieved at all, than among those receiving physiotherapy. This had been anticipated by stakeholders during the set-up stage of IWS, as the expectation was that mental health conditions may be more complex to treat than MSK.

7.30 The following factors seem to have contributed to participants' sense they gained only limited benefit from the service.

- **Insufficient duration and / or intensity of support.** Some participants stated they began to see some improvement in their mental health, but the support ended too soon for them to gain any lasting benefit. Some reported a deterioration when support was withdrawn. One participant described how they were subsequently prescribed anti-depressants and sleeping tablets as there was nothing to fill the gap when they were unable to access any more support through the service. Another stated better signposting should have been offered on discharge, as they were unaware of how to access alternative support.
- **A different support model was needed.** Several participants stated while they had gained some benefit, the issues and challenges that underpinned their poor mental health required a different support model from that to which they were referred. For example, one participant who received therapy stated they needed specialist bereavement counselling, while another who was referred to a group session said they thought one-to-one CBT would have been a more effective approach.
- **Delivery of support did not meet individuals' needs and preferences.** For example, participants reported: they failed to build rapport with the therapist because the support was delivered via video call; they found a lack of structure and goal setting in the sessions unhelpful; and they received insufficient support to learn mechanisms for coping with stress.

7.31 Whereas it was very rare for participants who had received physiotherapy to report they had not yet returned to work, several of those who accessed mental health support stated this was the case. For example, some had opted to retire, where this was possible. Another was in the process of looking for a new type of work, having concluded that continuing in their previous sector was not

compatible with good well-being, and in another case the interviewee was still on sick leave and hoping to be redeployed within the organisation on medical grounds.

Mechanisms contributing to positive outcomes from mental health support

7.32 As with participants who accessed physiotherapy, those who received mental health support generally reported positive change in their working lives as a product of health-related outcomes.

7.33 They attributed positive outcomes to the following features of the support:

- **The speed with which they moved from referral to therapy**. An interviewee from one of the delivery partners suggested this is perhaps the main reason why the service is proving effective in supporting people who have more complex mental health needs but were struggling to access mainstream services:

  ‘We actually still see really good outcomes for those participants. And I think that's got to come down to the fact that they're having that initial assessment, usually within five working days, sometimes sooner. Obviously, we always make it clear, the limitations of our service, and we're not a crisis service. But the feedback from participants is that it's made a massive difference. (Staff interview, SBU)

- **Relationship with the therapist.** Participants often stressed the value of having been listened to with attentiveness, kindness, and respect by someone with whom they had a strong rapport and whose professional skills and insights they trusted. This was key to giving participants a sense they were being treated as individuals and the support delivered was based on an understanding of their needs.

  ‘Just to have somebody who's non-biased to talk to and to just put things into perspective for you and rational how you are thinking because they've got an understanding. They're not judging you. I was pushing myself a bit too quickly and [the therapist] would be like, write how you're feeling and do it on a scale factor. She was like, you think you are there but you're not. To be honest, I think it was an invaluable service.’ (Client interview, SBU)

- **Self-management tools and techniques** helped participants to gain control of their thought processes, challenge negative and unhelpful thinking patterns and behaviours, and feel less stressed and anxious. For example, one participant described how beneficial the breathing exercises they had learned were, while another said they were continuing to work with the tools and techniques from the sessions to strengthen their recovery from OCD. These were viewed as resources which could be drawn upon in an ongoing way, as and when they were needed.

Other factors contributing to positive outcomes

7.34 While most participants taking part in an interview categorically stated they believed the service had been instrumental in supporting them to realise positive outcomes in relation to health and work, they were also able to identify a range of other factors which had also helped, including:

- Support of friends, family, and work colleagues.
- Medication.
- Support in the workplace, for example from a line manager, trade union or HR staff.
- Support from their GP practice or other health professional.

7.35 Wider contributing factors were much more likely to be identified by interviewees who had accessed mental health support, underlining the greater complexity of issues they often experienced. Participants who received physiotherapy generally did not report other factors, although one did point to their own diligence in carrying out the exercises prescribed by the physiotherapist.

Outcomes for employers from workplace health programmes

7.36 It is difficult to draw firm conclusions about how far WHPs have contributed to improvements in workplace well-being. The evidence from interviews with employers indicate they experienced positive outcomes for their workplaces. However, the limited number of interviews conducted mean this evidence should be treated with caution.

7.37 Furthermore, as delivery partners noted, many of those who engaged with WHPs, for example by attending webinars, did so out of personal interest, not

with the aim of bringing about change within their organisation. It was in response to this latter concern that SBU developed a differentiated suite of well-being sessions, some of which were designed for all staff while others were targeted at line managers and supervisors:

> ‘I think Welsh Government and WEFO were very focused on looking at improved workplace outcomes. They're very much focusing on, 'How can we demonstrate that this intervention has led to improvements in workplace well-being?' And sometimes we can do that but not the majority of the time, because a lot of the time, people sign up for sessions, and attend sessions, or the webinars, or in person sessions, but, actually, they're doing it for a variety of reasons and, often, it's because they're struggling as an individual. So they're not going to necessarily be sharing this learning on a much wider scale within their organisation.’ (Staff interview, SBU)

7.38 Nonetheless, employers who took part in interviews were able to point to benefits for their organisation. Overall, their evidence suggests a range of outcomes were achieved, including:

- Improved knowledge and awareness among the workforce of well-being issues.
- A higher profile for well-being within the organisation. One interviewee described the impact of having a trained well-being champion in in the organisation:

  > ‘The fact that you are able to say there is a well-being worker available to you, it gives that message to staff that we do care about your well-being, and we acknowledge that it's difficult to take care of and get that work-life balance. That in itself has planted the seed with everyone. I send out regular emails to everyone with little well-being ideas.’ (Employer interview, RCS).

- Strengthened existing well-being activities.
- Culture change, with a greater focus on the impact of work on well-being and more support for individual well-being, including support for working practices which promote better work-life balance:

‘[Our workforce is] much more open and I think we also ask about each other's welfare a little bit more often. I've also had some feedback from people that say they've tried different things to manage their own stress and what they've done and what worked for them and those sorts of things. These are conversations I've never had with my colleagues before.’ (Employer interview, SBU)

- Better understanding on the part of individuals about how to look after their own well-being at work.

7.39 Employers who reported positive outcomes identified the high quality, tailored support they had received from delivery partners as an important factor in enabling them to implement an effective WHP.

8. Conclusions and recommendations

8.1 This chapter presents conclusions and recommendations from the research, drawing on the aims and objectives of the evaluation set out in the introduction, and identifying areas for consideration to inform the wider roll out of IWS across Wales.

Conclusions

8.2 Qualitative evidence on the performance and impact of the service suggests it delivered substantial benefits for individual recipients of support, on both the physiotherapy and mental health pathways. By offering early intervention and promoting self-management of health, it enabled participants to return to work, minimised the amount of time taken off sick, and prevented individuals from going on sick leave.

8.3 The benefits of improved health and well-being are supported by quantitative evidence. However, the quantitative evidence of IWS supporting participants to return to, or stay in, work is weaker, and this data should be treated with some caution for the reasons set out above.

8.4 Core features of delivery contributing to the effectiveness of the support to individuals included: rapid referral and commencement of support, with targets in place; effective initial assessment and matching of participants to therapists; tailored and personalised support; and a focus on equipping individuals with tools and techniques to manage their own health.

8.5 Challenges remain in reaching those who may benefit from the service. This is evident in the shortfall for both delivery partners in reaching their operational targets for enterprise support and for SBU in falling significantly short of their operational targets for client engagement. While promotion of the service has improved, coverage and quality of information remains patchy. Delivery partners report gaps in the social-demographic groups they reach, and it is clear some individuals only find out about the service by chance, which means the timeliness with which they receive support is sub-optimal.

8.6 The volume, duration and intensity of support generally reflects individual needs. However, a minority of individuals, particularly those receiving mental health support, require more sessions than the service is funded to deliver. There is

currently no agreed and consistent way of responding to this, so that what happens in individual cases is extremely variable. Individuals who were not able to access appropriate further support report the poorest outcomes in terms of both health and work.

8.7 The revised targets for supporting SMEs were still too challenging and expectations about the kinds of outcomes that can be achieved and evidenced are unrealistic given the light-touch nature of the majority of interventions. Working with employer intermediary organisations is proving to be effective in increasing traction with SMEs but building the relationships that lead to individual employers accessing support takes time. The service has been hampered in helping some interested organisations because they do not meet the strict definition of an SME.

8.8 There is evidence of effective practice with employers which raises awareness and understanding of workplace well-being and promotes a more open and supportive organisational culture in relation to mental and physical well-being. Emerging practice on working with employers to engage individuals through the delivery of outreach and initial assessment in the workplace points to the potential for closer integration of the individual support and enterprise elements of the service as a way of engaging those in greatest need. The greater flexibility which was afforded to the service to work with large employers during the pandemic was beneficial in reaching individuals.

8.9 In both delivery areas, the service responded quickly and effectively to the challenges presented by the COVID-19 pandemic. Changes to the delivery methods for supporting individuals and employers enabled the service to continue to provide support throughout the period of protective measures. A legacy of this is that online delivery is now well-established. This allows greater choice and flexibility in how support is accessed and improves accessibility for some groups.

8.10 Challenges around evidencing eligibility and outcomes remain and were generally attributed to specific funder requirements relating to the format in which evidence has to be submitted.

Findings from previous evaluation.

8.11 The previous evaluation made a number of recommendations to be considered for future delivery. Some of these related to action on the part of delivery partners, and some to actions by WEFO or WG. The following paragraphs briefly consider how effectively delivery partners responded to the recommendations, as well as how far COVID-19 affected their ability to respond to these recommendations.

8.12 There was a specific recommendation for SBU that they needed to adapt to delivering a service outside of their typical NHS provision. Qualitative evidence from this evaluation suggests SBU delivered a flexible and responsive service that met participant needs. However, they experienced significant challenges with data collection that they were not able to resolve. They also significantly under recruited participants, with COVID-19 having a clear impact on referrals.

8.13 There was a general recommendation around the need for more flexible enterprise support. There was good evidence of this for both delivery partners, for example, SBU started offering outreach physiotherapy assessments within workplaces, and RCS introduced workplace well-being champions. COVID-19 acted as a driver for some of these increased flexibilities, allowing providers to start delivering webinars and online support to increase their offer to employers. The employers interviewed identified that flexible tailored support was one of the key successes of IWS from their perspective.

8.14 The challenges of promoting IWS to enterprises and GPs were noted in the previous evaluation and were evident again in this research. Both providers recognised this, investing significant effort in promoting the service. There was mixed success here with COVID-19 having a significant impact on GPs' and employers' capacity and willingness to engage with any initiative. It is noteworthy that both partners invested time and resource in trying to drive up GP referrals with limited success, while GPs themselves expressed a strong preference for self-referral. Working with GPs to increase self-referrals may therefore be a more effective strategy for wider roll out.

8.15 The evaluation also suggested IWS should be targeted at those groups and areas that need it most. Both providers noted more could be done to engage with priority groups. However, the fact that demand did not exceed supply may have

had an impact here, as partners focused on driving up referrals rather than targeting particular groups.

Wider policy outcomes

8.16 The evidence presented in this evaluation of individuals with health conditions being supported to return to, or stay in work, suggests the service has the potential to make a significant contribution to the delivery of the 'Healthy Work, Healthy Wales' priority area of action within the new Employment and Skills Plan.

8.17 While it seems unlikely IWS at its current level could contribute to change beyond that experienced by individuals or particular workplaces, a nationwide roll out could contribute to wider policy outcomes. However, consideration may need to be given as to whether particular client groups would need to be targeted in order to ensure impact. Renewed effort should also go into maximising the possibility of being able to demonstrate impact through data collection.

8.18 IWS' wider roll out has the potential to contribute to several indicators of The Well-being of Future Generations (Wales) Act (2015). Evidence from the qualitative research suggests IWS can help people stay in, or return to work, thus contributing to the percentage of people in employment. There is also qualitative evidence from both partners and quantitative evidence from RCS that IWS can have a positive impact on individuals' well-being and how they manage their health, thus contributing to mean mental health scores and number of people engaging in healthy behaviours.

8.19 IWS may also have the potential to contribute to indicators around better work such as the percentage of people being paid the living wage. However, this is not evidenced within the current research, primarily due to the small number of employers interviewed, and the longer time scale needed for these impacts to be observed. IWS also provides a good practice example of a joined- up approach to health and employment within public services.

8.20 There is some evidence, as set out below, IWS has contributed to progress against ESF's CCTs of Equal Opportunities and Gender mainstreaming, Sustainable Development and Tackling Poverty and Social Exclusion.

8.21 Analysis of MI data provides evidence on targets for delivery against specific groups, (notably gender, ethnicity, and those with caring responsibilities) as set

out in Chapter 4. Partners exceeded their target in relation to five per cent of clients having caring responsibilities, met their target in relation to 55 per cent of clients being women, and came close to their target of two per cent of clients coming from ethnic minority backgrounds. This demonstrates IWS was performing in line with expectations around equal opportunities for service delivery.

8.22 This is supported by the case study evidence supplied by the delivery partners, which demonstrates how delivery partners met positive action measures for different groups such as older people, people with disabilities, and women.

8.23 Qualitative evidence from this evaluation suggests the positive outcomes experienced by individuals and employers who have engaged with IWS have the potential to contribute to wider impacts around tackling poverty and social exclusion. This is primarily in relation to addressing health related barriers to employment.

8.24 Qualitative evidence from this evaluation suggests IWS has the potential to contribute to the cross cutting theme of sustainable development, in particular recognising and promoting health and well-being as one of the cornerstones of a healthy, vibrant economy. This is primarily indicated by the observed employer outcomes, where organisations identified IWS support had changed their organisational practice and policy in relation to health and well-being. However, this was not observed at sufficient scale to be confident progress towards this outcome has been secured.

8.25 The limitations of the supplied MI outcome data meant it was not possible to confirm this qualitative evidence with quantitative evidence by, for example, considering outcomes across client subgroups. It was also outside the scope of this evaluation to identify these wider impacts at a societal level. Furthermore, the negative impact of COVID-19 and the subsequent cost of living crisis on progress towards these outcomes creates additional challenges in understanding the positive impact of IWS.

Recommendations for future delivery

8.26 The recommendations set out below are informed by the evaluation findings, to build on and learn from what has already been achieved.

Recommendation 1

8.27 There is good evidence of learning by both delivery partners. This includes specific activities such as the development of workplace well-being champions, the delivery of physiotherapy outreach activities in workplaces, but also the adaptations made in response to COVID-19, and the flexible and responsive service offered to employers and individuals. WG should ensure the delivery infrastructure for a Wales-wide service includes clear communication mechanisms to ensure that such learning is captured and shared between delivery partners.

Recommendation 2

8.28 Raising awareness of the service has been the key challenge. National roll out provides an opportunity for WG and delivery partners to implement a more consistent strategic approach to raising the profile of the service across Wales. This should focus on the following key messages:

- IWS' distinctive focus on supporting people who are in work.
- The opportunity it offers to by-pass NHS waiting lists and gain rapid access to therapies.
- The fact it is free at the point of access for participants.

8.29 The roll out of IWS nationwide provides the opportunity for WG to lead a national promotion campaign to ensure IWS reaches the people who need it most. This should include the following elements:

- The development and use of a distinct and recognisable "brand." This would address the consistent issue raised by interview participants about the lack of visibility and recognition for IWS.
- The use of diverse communication and outreach methods, together with repeat messaging, with the aim of maximising reach and timeliness of contact.
- Consistent engagement of wider stakeholders and partners to reach both individuals and employers, such as FSB, Business Wales, Working Wales, Trade Unions, industry sector representative bodies, and third sector organisations.

- Closer integration of the individual and enterprise elements of the service, so enterprise engagement functions as a more consistent means of reaching individuals who need support within SMEs.
- Information, support and resources for GPs and other healthcare professionals, to ensure they act as a consistent route for self-referrals.
- The promotion of workplace well-being champions as a national initiative within the service, with training, support and resources to encourage its adoption in organisations of all types and sizes. Similar initiatives have been adopted at a regional level in England, and a similar scheme is run within Wales by Time to Changes Wales, with a focus specifically on mental health. This initiative could build on the models developed by RCS and SBU as part of their employer support programmes, with training and online forums facilitated at a local level by IWS delivery partners. This could then be supported by light touch national infrastructure in terms of branding and training materials. The scale of the initiative would depend on the scale of planned enterprise engagement with IWS. However, the development of a workplace well-being champion could be a core component of IWS employer support. Experience from RCS suggests once champions are in place, the model is relatively self-sustaining.

Recommendation 3:

8.30 WG should consider the implications of a successful national promotion campaign leading to increased demand for the service. This may mean further consideration needs to be given to prioritising particular client groups, and therefore more targeted outreach. The challenges in promoting the service have meant that demand has not yet outstripped supply and so full consideration has not been given as to who would benefit most from the service. Enhanced management information systems, as set out in recommendation 7, are essential to understanding what groups would benefit most from the service.

Recommendation 4:

8.31 WG and delivery partners should further strengthen and develop the flexible delivery model to meet the needs of individual participants, to include the number of sessions, support offer, mode of delivery, choice of therapist and language preferences.

8.32 Particular consideration should be given to:

- How holistic support offered within IWS to address wider participant needs such as domestic abuse or debt management could be further extended.
- What shorter preventative activities such as workshops could be further developed to support earlier intervention.

Recommendation 5:

8.33 WG and delivery partners should agree and implement a consistent approach for meeting the needs of the small minority of participants who require more than six sessions to complete their support.

Recommendation 6:

8.34 WG and delivery partners should ensure the flexible model of support to employers continues with particular emphasis on the development and dissemination of examples of effective practice. Support for SMEs should continue to be a priority, as evidence shows they are less likely to have resources such as Occupational Health services or HR to support employees' health and well-being. This should include:

- Support with developing and implementing well-being strategies, action plans and wider HR policies,
- Support with embedding a focus on well-being in induction and staff performance and development review processes.
- Promotion of the individual support element of the service to employees

Recommendation 7:

8.35 Wider roll out provides an opportunity for delivery partners and WG to learn from the historic challenges around both evidencing eligibility and recording participant outcomes. Chapter 3 includes more detail about these challenges and how they could be addressed. The aim should be to develop and implement a simplified approach to both referrals and post intervention follow up. This should make best use of digital methods and include alternative provision for those without access to suitable technology or digital capabilities, and those with access needs such as sensory impairments. Consideration should also be given to how information about participants routinely collected by delivery partners, and therapists'

assessments can be used to evaluate how far outcomes have been achieved. This should include collecting evidence of intermediate as well as major outcomes.

Recommendation 8:

8.36 The challenges experienced in this and the previous evaluation suggest WG should give further consideration as to how the wider roll out is evaluated. This could include:

- Involving an evaluation team to carry out a formative evaluation. This would ensure, for example, that data collected meets the needs of the evaluation and delivery partners.
- Finding alternative ways to engage GPs and employers in the evaluation. This may include alternative research methods such as surveys which are less time intensive for participants.

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