WORK FOUNDATION

Addressing the health obstacles to employability

A mid-term evaluation of the Bridging the Gap programme

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This study was conducted on behalf of The Fit for Work Team as part of the Bridging the Gap initiative's Department of Health 'Innovation, Excellence and Strategic Development' (IESD) funding. NB In 2017, The Fit for Work Team is rebranding to become Healthy Working Futures.

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Executive Summary

The Bridging the Gap programme (BTG) is a Department of Health 'Innovation, Excellence and Strategic Development' (IESD) funded initiative. The programme builds on the available evidence base and seeks to support the integration of health and employment services (whilst utilising the assets of the individuals themselves) in order to support people with health conditions. It aims to provide people with the right type of services to help them move towards employment and to better manage their health condition.

The Bridging the Gap programme is delivered by two partner organisations – the Fit for Work Team Ltd and Pathways Community Interest Company. The pilots run in the East Midlands - Leicester, Leicestershire (with a smaller number of clients in Derby, Derbyshire, Nottingham and Nottinghamshire) under the name "The Fit for Work Team"[1], and in Greater Manchester and Cheshire under the name "Pathways" (henceforth, the East Midlands and Manchester/Cheshire pilots will be referred to as "TFFWT" and "Pathways" respectively). TFFWT is a multidisciplinary, not for profit, social enterprise that provides expertise and services across the work and health agenda.

This evaluation covers an 18 month period from November 2014 to May 2016. In Year 1 the BTG service operated in the two geographical areas that TFFWT and Pathways were already working in, Leicester/shire and Greater Manchester. In Year 2 the programme was expanded to the wider North West and East Midlands regions.

The Work Foundation has evaluated BTG based on data provided by both TFFWT and Pathways centres. The evaluation undertakes statistical analysis of client data provided, a cost benefit analysis (CBA) using the New Economy Model, and qualitative interviews with clients from both centres. The report describes the context of the evaluation; the incidence of LTCs and the prevalence of unemployment in the regions covered by the service, and the client's journey through the BTG service. The second part of the report then describes the methodology, before the third part discusses the findings of the evaluation.

Key findings:

- There are **very good health improvements for people with LTCs**. We have found that over 80% of clients in Pathways (according to EQ5D and star assessments) and over 57% in TFFWT show health improvements.
- The most widespread health conditions were found to be mental health and musculoskeletal disorders (MSKs). 64.3% in Pathways and 41.9% in TFFWT have one or more mental health conditions, and 14.6% of people in Pathways and 20.1% in TFFWT reported at least one form of MSK.
- There is a high level of comorbidity between mental health and other health conditions. Due to differences in the classification of health conditions between the two centres, we are limited in comparison by the data.
    - For Pathways - In people living with various health conditions, those with the highest rates of comorbidities with mental health were cancer, gastrointestinal, gynaecological

[1] This organisation is not related to the national Fit for Work programme

    - For TFFWT - vision, gastrointestinal, gynaecological and ENT illness had high rates of comorbidity with mental health illness.
- There are **good improvements in terms of work readiness** and other employment-related outcomes. 38.2% and 65% of clients completing the service at Pathways and TFFWT were assessed to be work ready within the period of this evaluation. According to BTG internal analysis results have continued to improve for Pathways since this evaluation was completed.
- Results regarding the effectiveness of specific interventions in terms of work readiness were mixed. Key interventions were physiotherapy, confidence-building and job search.
- We could not say which health conditions represented a higher barrier to work readiness.
- The data shows that GPs are the main referrer in Pathways (68%) whereas JCP is the main referrer in TFFWT (57%). As for the likelihood of disengaging with the programme, people who had been referred by a GP in Pathways were more likely to continue in the service compared to people who had been referred by JCP. 34.1% of the former disengaged, were ineligible or declined service compared to 44.9% of the latter. On the contrary, in TFFWT withdrawal rates were slightly higher for GP referrals compared to JCP, although there was not a significant difference between the two.
- The overall financial benefits of the programme:
    - Total possible annual fiscal savings resulting from movement into employment: £646,357.
    - Total possible annual fiscal savings resulting from health benefits: £1,929,148
    - For BTG as a whole over 18 months during 2014-2016, it is estimated to have generated on average £3.68 per £1 spent.
    - In terms of social value, BTG is estimated to have generated £8.99 per £1 spent.

The BTG service provides the crucial link for integrating health and employment support offered by the government to the most vulnerable in society. It goes beyond what GPs and JCP can offer individually and is an excellent model of social prescribing: it gives GPs the opportunity to prescribe a service that meets their patients' needs which are not entirely or always clinical. BTG offers GPs an alternative route of referral to support people with health conditions and LTCs whose wellbeing is worsened by their unemployed status.

The CBA calculated in this evaluation supports the strong evidence in the literature that personalised support is extremely helpful in supporting return to work[2]. Case management defines the success of BTG, as described by the interviewees in terms of the confidence raising, empowerment and self-management support provided by the case managers. It provides assistance in manoeuvring through the health and employment systems that many people find daunting and overwhelming. The interviews allowed us to directly hear the voices of those who have benefited from the service and to understand the human impact it has had – an impact that would be impossible to capture in numbers.

[2] A systematic review of 42 papers assessing various welfare-to-work schemes in the UK from 2002-2008 found that the use and quality (i.e. competent and well-informed) of personal advisors and individual case managers made a significant difference to the likelihood of securing an employment outcome. This review also emphasised the value of having a range of services in one place (i.e. a one-stop-shop approach). For more details see: Dudley, C., McEnhill L. & Steadman, K. (2016). Is welfare to work, working well? Improving employment rates for people with disabilities and long-term conditions. London: Work Foundation. Available at: http://www.theworkfoundation.com/wp-content/uploads/2016/11/405_Work-Programmes.pdf

Through the evaluation we make the following **programme recommendations**:

1. Consider using the Patient Activation Measure.
2. Continue to closely monitor withdrawal rates and to address the reasons behind them.
3. Continue to develop and improve engagement with referrer bodies.
4. Better reflect the gender and ethnic make-up of the unemployed and economically inactive populations in the regions.
5. Develop more detailed information on health status in TFFWT.
6. Provide more interventions that are directly aimed at helping people return to work and finding a job.

We also make the following **evaluation recommendations**:

1. Continue refining and developing data collection systems and outcome data.
2. Consider constructing a programme-level Theory of Change.
3. Embed impact measurement and reporting into the organisation.
4. Use impact data for internal decision-making.

BTG is an important evidence-based model that is providing valuable insights into what support is most appropriate and effective for achieving employment outcomes for people with LTCs and other barriers to work.

Contents

List of Figures

Glossary

BTG	The Bridging the Gap programme
CBA	Cost-benefit analysis
CCGs	Clinical Commissioning Groups
GM	Greater Manchester
JCP	JobCentre Plus
LTCs	Long-term conditions
MSK	Musculoskeletal conditions
Pathways CIC	Pathways Community Interest Company
TFFWT	The Fit for Work Team

1. The Bridging the Gap programme

The Bridging the Gap programme (BTG), as will be described in more detail, seeks to bridge the gap for those with long-term health condition and work by offering a range of support services to its clients.

In terms of social prescribing as a means of improving work outcomes, Steadman et al (2017) show there are two potential pathways. The first provides a direct pathway, where an individual is referred to a focussed work support service, and the second is indirect, where an individual is referred to non-work social prescribing activities which have a positive impact on them (e.g. through improvements to health and wellbeing, social inclusion, confidence) which might put them in a better position to think about work and related goals in the medium to longer term[3]. BTG is one of the pioneering examples of the first pathway.

1.1. Aims and objectives

The overall aim of this study has been to evaluate the feasibility and effectiveness of BTG as a model for improving work readiness and health and wellbeing outcomes for unemployed people with health conditions. This study will also make recommendations for service development and programme improvement, and will identify the learning from this process.

We sought to answer the following questions:

1. Does BTG respond to the needs of the service users in addressing health barriers to work / employment?
    a. Are there any health improvements for people with health conditions?
    b. Which health conditions are most prevalent? Is there comorbidity?
2. Has the programme been successful in improving the health and employment-related outcomes of service users?
    a. Are there any improvements in terms of work readiness and other employment-related outcomes?
    b. What interventions are most effective in delivering work readiness?
    c. Do certain health conditions represent a higher barrier to work readiness and employment outcomes?
    d. Which referral routes are most highly correlated with retention in the service?
3. What are the overall financial benefits of the programme? How would these be used to support a business case to potential commissioners?

This study is important in filling a gap around outcome development and measurement of 'social prescribing' programmes and 'what works' in terms of the different models currently in practice. Our colleagues, Steadman et al (2017) show that *"currently we are unable to rigorously assess the extent to which social prescribing is achieving work outcomes, nor which model is most effective (and cost-effective) in doing so. Though we are able to draw out some of the key features as regards work, without specific data collection on work outcomes we cannot identify what services are finding particular success in this regard, and why."*[4] The collection of data on work and related outcomes that BTG has done has not only

[3] Steadman, K., Thomas, R. & Donnaloja, V. (2017). *Social prescribing, a pathway to work?* London: Work Foundation.
[4] ibid

allowed us to evaluate, compare and improve services, but will also improve recognition of the importance of work as a key determinant of health and wellbeing.

1.2. Background – a model programme for social prescribing and person-centred, integrated services

BTG is a Department of Health 'Innovation, Excellence and Strategic Development' (IESD) funded initiative. The IESD funding is for the period October 2014 to September 2017. The programme builds on the available evidence base and seeks to support the integration of health and employment services (whilst utilising the assets of the individuals themselves) in order to support people with health conditions. It aims to provide people with the right type of services to help them move towards employment and to better manage their health condition.

BTG is a model of person-centred 'social prescribing' – a service that links people with appropriate sources of support across sectors, including within the community. It provides GPs with a holistic referral option that goes wider than the medical consultation, covering medical (including physiological and mental health) and non-medical issues as appropriate. Social prescribing can operate alongside existing treatments to improve health and well-being.

Through its case managers, BTG offers a comprehensive service, but also acts as a signposting or gateway service offering social prescribing in the form of an extensive range of interventions and activities, linking clients with sources of information and support within the community and voluntary sector (such as financial, legal and housing advice, and volunteering and training opportunities). The Department of Health has previously proposed the introduction of social prescribing for those with long-term conditions, aiming to promote integrated health and social care, in partnership with the voluntary and community sector. NHS England is promoting access to non-clinical interventions from voluntary services and community groups as a way of making general practice more sustainable.

The BTG client base consists of people who are unemployed and have a health related condition preventing them from working. This includes long-term conditions and disabilities. Clients do not have to be on employment-related benefits to be eligible, and are not accepted while they are on the Work Programme. Previous research by the Work Foundation has indicated a preference for health and employment co-location sitting outside of the mainstream welfare-to-work programmes[5], i.e. distant and distinct from conditionally or mandatory activities. This is to avoid the controversy of perceptions of coercion. Services operating outside of mainstream JCP provision may therefore provide a better chance of integrating services.[6]

The Bridging the Gap programme is delivered by two partner organisations – The Fit for Work Team Ltd[7] and Pathways Community Interest Company. The pilots operate in the East Midlands – Leicester, Leicestershire (with a smaller number of clients in Derby, Derbyshire, Nottingham and Nottinghamshire) – under the name "The Fit for Work Team"; and in Greater

[5] Steadman, K. & Thomas, R. (2015). *An Evaluation of the 'IPS in IAPT' Psychological Wellbeing and Work Feasibility Pilot*. London: Work Foundation.
[6] Dudley, C., McEnhill L. & Steadman, K. (2016). *Is welfare to work, working well? Improving employment rates for people with disabilities and long-term conditions*. London: Work Foundation.
[7] TFFWT is a multidisciplinary, not for profit, social enterprise that provides expertise and services across the work and health agenda. The organisation is not related to the national Fit for Work programme.

Manchester and Cheshire under the name “Pathways”. Henceforth, the East Midlands and Manchester / Cheshire pilots will be referred to as “TFFWT” and “Pathways” respectively.

This evaluation covers an 18 month period from November 2014 to May 2016. In Year 1 the BTG service operated in the two geographical areas that TFFWT and Pathways were already working in, Leicester/shire and Manchester. In Year 2 the programme was expanded to the wider North West and East Midlands regions. For the third year, it is anticipated that BTG will have developed and be ready to roll-out a training package, to enable other people to provide the service in other areas. There is a need to develop a business case to take to other Clinical Commissioning Groups (CCGs) and Local Authorities (LAs) to encourage them to take on BTG services; this evaluation will inform the development of this.

The Work Foundation has evaluated BTG based on data provided by both TFFWT and Pathways centres. The evaluation undertakes statistical analysis of client data provided, a cost benefit analysis (CBA) using the New Economy Model, and qualitative interviews with clients from both centres. This introduction is dedicated to giving context to the evaluation, including: the incidence of long-term health conditions; the prevalence of unemployment in the regions covered by the service; and, the client’s journey through the BTG service. The second section then describes the methodology, before the third section discusses the findings of the evaluation.

1.3. Long-term conditions and unemployment

People with long-term health conditions (LTCs) experience disproportionately lower employment rates relative to their peers without such conditions. At the end of 2014, the UK Labour Force Survey (LFS) data indicated that 59.6% of people with long-term conditions were employed compared to 73.5% of the working-age population as a whole.[8] [9]

Unemployed people were more than twice as likely as employed people to report having a limiting LTC (17% versus 9%). Among working-age people, those who are economically inactive have the highest prevalence of LTCs (42%) and limiting LTCs (31%) even when accounting for age and income. The following infographic (Figure 1) produced by the Work Foundation and Public Health England provides further data on unemployment and economic inactivity.

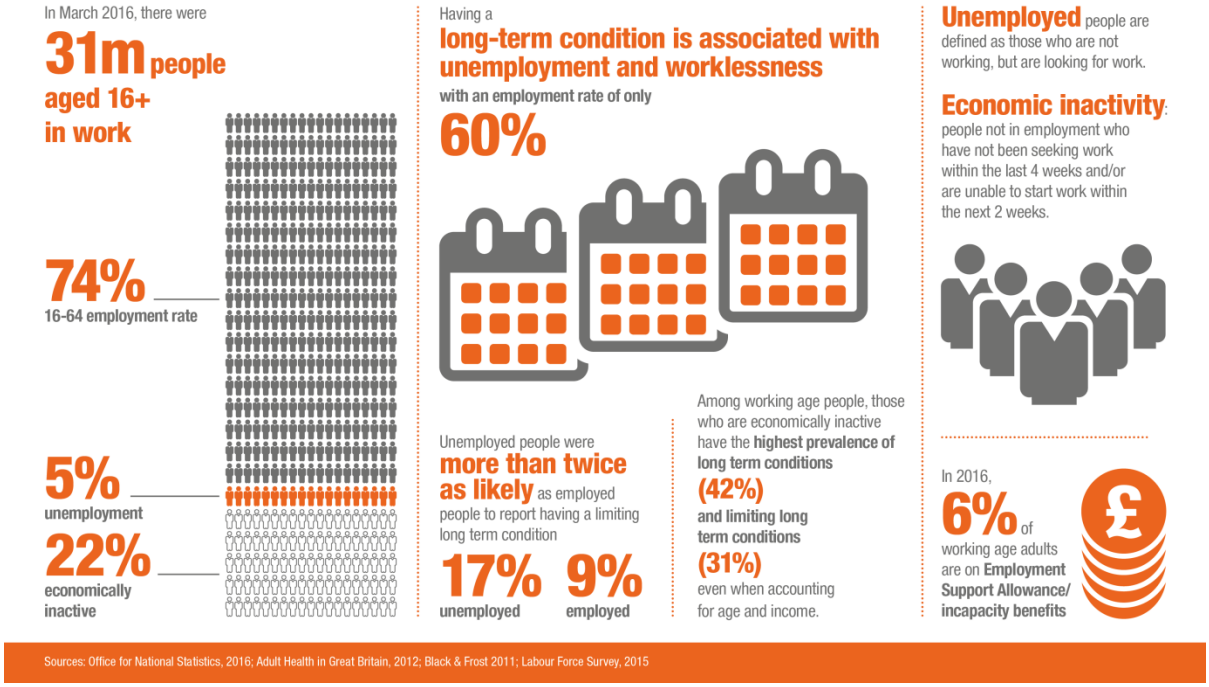
The high rate of long-term morbidity of these conditions is complicated by the fact that often two or more LTCs coexist with each other. The most common comorbidity combination (defined as the co-occurrence of two or more LTCs) is the coexistence of mental and physical conditions; it has been estimated that around 30% of people with long-term physical health conditions also have a mental health condition, and that 46% of people with mental health problems also report suffering from physical long-term conditions.[10]

[8] Dudley, C., McEnhill L. & Steadman, K. (2016). *Is welfare to work, working well? Improving employment rates for people with disabilities and long-term conditions*. London: Work Foundation.

[9] DWP/Department for Work and Pensions (2015). *Labour force survey analysis of disabled people by region and main health problem*. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/406369/labour-force-survey-disabled-people.pdf

[10] Naylor, C., Parsonage, M., McDaid, D., Knapp, M., Fossey, M. & Galea, A. (2012). *Long term conditions and mental health. The cost of co-morbidities*. London: The King's Fund- Centre for Mental Health.

Figure 1: Unemployment and economic inactivity



Source: The Work Foundation and Public Health England (2016). A full set of Health and Work infographics is available from: http://www.theworkfoundation.com/2016/09/13/talking-numbers-on-health-and-work/

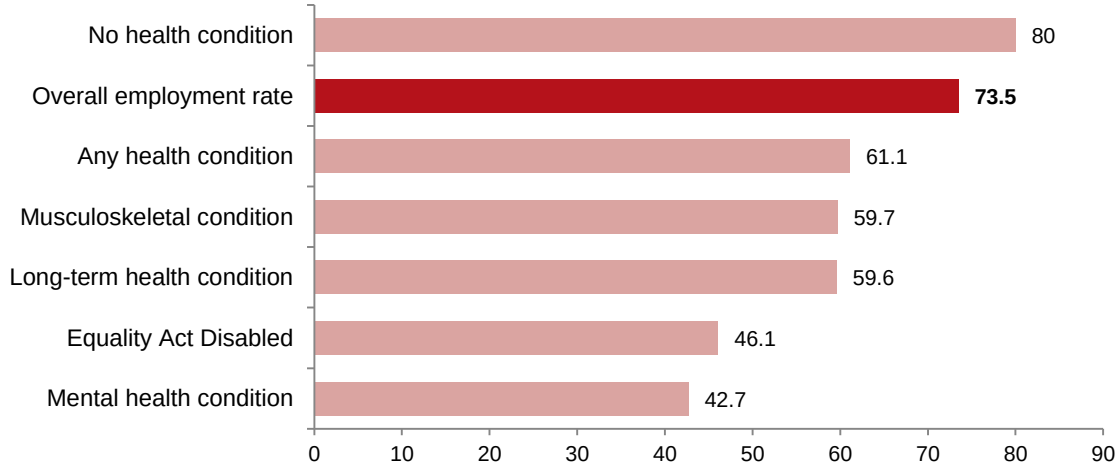
The burden of LTCs for the individual and society is not limited to the challenges directly related to ill health and the resulting healthcare costs, but is exacerbated by the correlation of these conditions with high rates of unemployment (see Figure 2). For example, poor mental health is a leading cause of worklessness and sickness absence in the United Kingdom – the employment rate has been found to be 42.7%[11]. Further, it has been estimated that 300,000 people fall out of work onto ESA a year as a result of developing an LTC[12]. Whilst MSK is the most common health condition of ESA claimants coming from work, mental health conditions are a close second. This contrasts with ESA claimants overall, where the most common condition is mental ill health. ESA claimants coming from work are more likely to have recently developed the condition than those not coming from work. Nearly a third of individuals coming from work reported that they were awaiting treatment of their health condition 12–15 months after their initial ESA claim.[13]

Many people with long-term health conditions want to work and with the right support can contribute significantly to the economy[14] [15]. For example, only 8% of people with schizophrenia are in employment, despite research suggesting that over 70% of them want to work[16]. Given that over a third of the working-age population (34 per cent) report having at

[11] Gifford, G. (2015). *Labour Force Survey analysis of disabled people by region and main health problem*. London: Department for Work and Pensions.
[12] Black, C. & Frost, D. (2011). *Health at work – an independent review of sickness absence*. London: TSO.
[13] Sissons, P., Barnes, H. & Stevens H. (2011). *Routes onto Employment and Support Allowance*. DWP Research Report No. 774.
[14] Grove, B. (1999). Mental health and employment: shaping a new agenda. *Journal of Mental Health*, 8(2), 131-140.
[15] Secker, J., Grove, B. & Seebohm, P. (2001). *Challenging barriers to employment, training and education for mental health service users. The service users' perspective*. London: Institute for Applied Health & Social Policy, King's College London.
[16] Minassian, D.C., Owens, D.R. & Reidy, A. (2011). Prevalence of diabetic macular oedema and related health and social care resource use in England. *British Journal of Ophthalmology*, 96(3), 345-349.

least one long-term health condition, developing interventions and providing support to improve the employment prospects of people with such conditions, is a vital task.[17]

Figure 2: Employment rates and health conditions (%)



Sources: Department for Work and Pensions (2015) Labour Force Survey analysis of disabled people by region and main health problem in Steadman et al (2017)[18]

Studies have demonstrated that some work-like activities, such as volunteering, have been found to have a positive impact on people with LTCs[19] [20] [21] [22]. Sugihara et al reported that for those with mental health problems, volunteering compensates the negative effects of unemployment, giving them a sense of purpose, reducing isolation and helping them to build or expand social networks[23]. For people who are vulnerable because of their health and are often isolated, volunteering can be a useful to move them towards work readiness. Many of the other interventions that BTG offers have also been shown by the literature to have proven benefits to the unemployed.

Most recently the case for action in bridging the health and employment gap and the significant inequality that this causes has been set out in the *Work, health and disability green paper* by The Joint Work and Health Unit at Department of Health and the Department for Work and Pensions.[24]

[17] Steadman, K., Sheldon, H. & Donnaloja, V. (2016). *Complexities and challenges: working with multiple health conditions*. London: Work Foundation
[18] Steadman, K., Thomas, R. & Donnaloja, V. (2017). *Social prescribing, a pathway to work?* London: Work Foundation.
[19] Wahrendorf, M., Ribet, C., Zins, M. & Siegrist, J. (2008). Social productivity and depressive symptoms in early old age – results from the GAZEL study. *Aging and Mental Health*, 12(3), 310-316.
[20] McMunn, A., Nazroo, J., Wahrendorf, M., Breeze, E. & Zaninotto, P. (2009). Participation in socially-productive activities, reciprocity and wellbeing in later life: baseline results in England. *Ageing and Society*, 29(5), 765-782.
[21] Choi, N.G. & Kim, J. (2011). The effect of time volunteering and charitable donations in later life on psychological wellbeing. *Ageing and Society*, 31(4), 590–610.
[22] Nazroo, J.Y. & Matthews, K. (2012). *'The Impact of Volunteering on Wellbeing in Later Life'*, Invited Seminar, Women's Royal Voluntary Service, London, May 2012.
[23] Sugihara, Y., Sugisawa, H., Shibata, H. & Harada, K. (2008). Productive roles, gender, and depressive symptoms: evidence from a national longitudinal study of late-middle-aged Japanese. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, 63(4), 227-234.
[24] The Joint Work and Health Unit (2016). *Work, health and disability green paper: improving lives*. London: DH, DWP. Available at: https://www.gov.uk/government/consultations/work-health-and-disability-improving-lives/work-health-and-disability-green-paper-improving-lives

1.3.1. Health and unemployment in Leicester and Manchester

Both Leicester and Manchester have rates of long-term morbidity and associated unemployment that are higher than the country's average:

- 7.5% (n=16,930) of residents aged 16-64 in Leicester are on Employment Support Allowance (ESA) and Incapacity Benefits compared to the average of 6.2%.
- 8.6% (n=31,630) of residents aged 16-64 in Manchester (excluding Greater Manchester) are on ESA and Incapacity Benefits.[25]

The quality of people's health in Leicester is worse on average than in the rest of England. Within Leicester itself, life expectancy in the most deprived areas has been estimated to be 7 years shorter for men than the average in the least deprived areas and 6 years shorter for women.[26]

The prevalence of acute mental health conditions in Leicester is also particularly severe, with suicide rates being higher than average[27]. The risk factors of poor mental health are high, with most ward areas experiencing deprivation. The rate of emergency care used for mental illness is also high, but recovery is poor[28]. Evidence gathered by Wheatley (2015) suggests *"a complex picture of depression and anxiety in Leicester, with lower than expected rates of diagnosed depression, especially given the high rates of risk factors for poor mental health, such as high levels of deprivation, unemployment and low levels of educational attainment."* He suggests that *"the factors which may explain this low recovery rate may be suboptimal patient assessment prior to referral [...], and lack of knowledge of the range of mental health services across the statutory and voluntary sectors."*[29]

The health of the long-term unemployed is particularly worrying, as it is significantly worse than the average in England.[30]

The health of people in Manchester is generally worse than the England average[31]. It has the second highest rate of long-term sickness for a city at 19.1%, compared with the England average of 16.9%[32]. Like Leicester, the health of the long-term unemployed is also worse than the national average.[33]

Leicester, Manchester, and the North West more generally, find themselves to be particularly vulnerable to a high prevalence of long-term illness and associated unemployment. This prevents them from gaining the benefits of 'good work' and leaves them at risk of experiencing the disadvantages of persistent unemployment.

In response to these issues, BTG was developed, to support people with LTCs to become more work ready and to support them with self-management of their health conditions.

[25] Nomis, 2015.
[26] Public Health England (2016). *Health profiles: Leicester*. Available at: http://fingertips.phe.org.uk/profile/health-profiles
[27] ibid
[28] Wheatley, M. (2015). *Mental Health in Leicester: a joints specific needs assessment*. Leicester: Public Health England.
[29] ibid
[30] Public Health England (2016). *Health profiles: Leicester*.
[31] Public Health England (2016). *Health profiles: Manchester.* Available at: http://fingertipsreports.phe.org.uk/health-profiles/2016/e08000003.pdf
[32] Community Mental Health Profiles 2013, Public Health England
[33] Public Health England (2016). *Health profiles: Manchester*.

1.4. The Bridging the Gap Programme – The client's journey

People are eligible for the programme if they are unemployed and have a health condition. Referrals can be made by third parties including GP clinics, secondary health services, JobCentre Plus, charities and others, or people can self-refer directly to the service.

Bridging the Gap provides a holistic service that uses social prescribing. The client entering the service is assessed for their employment and health needs using a biopsychosocial, comprehensive assessment that is person centred, and a plan of action is developed jointly by the individual and their case manager. The biopsychosocial model enables the service to provide individually tailored, practical and motivational support and advice to clients in order to move them closer to employment and improve health outcomes. The client's journey begins with an initial appointment with a case manager. This can happen face-to-face or over the phone, and lasts up to an hour. The meeting aims to identify the client's personal barriers to returning to work and assess their health situation. Once the barriers to work and wellbeing are identified, the case manager and client agree an individual action plan.

For some people the aim might be to learn how to manage their health condition, improve health behaviours and reduce the need for GP visits. The overall objective of becoming work ready is therefore broken down into more tailored goals as required. For instance, for someone with a long-term condition, being able to self-manage ill-health is an important asset in the work environment, for someone experiencing chronic pain the action plan could involve attendance on a pain management course.

Beyond health related issues, the client is given the chance to discuss any obstacle he or she might feel relevant to their unemployment status. Such non-health related issues range from housing and financial difficulties, to relationship challenges and lack of skills.

If, along the way, the client does not feel that work readiness is an achievable and appropriate goal, they can opt out of the service and withdraw at any time.

Clients are usually discharged from BTG after an average of 12 weeks, but this may vary according to the client's needs, i.e. once the client and the case manager agree that work readiness has been achieved. The case manager follows up with each client after discharge, at 1, 3 and 6 months. Work-related outcomes, such as participation in voluntary work, work placement, training and employment, are measured both at discharge and at follow up. In addition, work readiness is measured, if work-related outcomes are yet to be achieved.

2. Evaluation of the BTG pilots

This section covers the objectives and methodology of the evaluation of the BTG pilot programmes, and then discusses the findings of the data analysis, cost benefit analysis and interviews.

2.1. Methodology

The evaluation covers the 18 month period from November 2014 to May 2016, and seeks to answer the first two research questions (see 1.1 above) with a combination of quantitative and qualitative analysis, with the third question being addressed by conducting a cost-benefit analysis using the New Economy Model. This methodology forms part of official government guidance on cost benefit analysis and is recommended by the National Audit Office.

2.1.1. Key elements of the quantitative analysis

The Work Foundation undertook quantitative analysis of administrative data on service users in both centres, information included: client profiles, obstacles, outcomes and health assessment scores. Data was anonymised and provided to the evaluators separately for Pathways and TFFWT on encrypted spreadsheets. No control sites were used.

The quantitative analysis carried out involved basic descriptive statistics, correlations and cross-tabulation and logit regressions. The independent variable included in the model is 'work readiness' for both centres which is the designated outcome of the programme.

2.1.1.1. Data collection and data quality

Questionnaire data collected by the TFFWT case managers and collated into a central database was sent on a monthly basis to the research team at The Work Foundation for intermediate review and analysis. Analysis of the data on a monthly basis was not possible however, as significant work needed to be done to synchronise, streamline and update the data across both centres to bring it into a form fit for analysis in the six months prior to the evaluation. TFFWT was extremely responsive to ongoing data requests and data gathering and open to feedback. This has meant that part of this formative evaluation was not only to carry out an intermediate evaluation but to assist in improving the data collection system itself, making future evaluations more straightforward.

2.1.1.2. Description of data sets supplied

The Work Foundation has been given access to the following data and documents:

Report name	Description
Client Referral data (Pathways and TFFWT)	Referral data for clients in Pathways and TFFWT. This includes information that ranges from dates of entry and exit into and out of service, obstacles faced, interventions received and outcomes achieved.
Application Form for Innovation, Excellence and Strategic Development (IESD) Fund 2014-15	The proposal includes the aims and objectives of the service and a plan for its delivery.

Report name	Description
End of year grant monitoring pack for strategic development projects that started during 2014-15	Information on how the funding has been spent and the milestones achieved
Client Care Pathway	Infographic explaining the client's journey
Summary statistics on year 1	Statistics on demographics, engagement rates and achieved health outcomes.
Audit C	Scoring system for the Audit C scale

2.1.1.3. Outcomes indicators used

Service performance was measured on **health and work outcomes**, using the following indicators:

- Changes in **health status** as measured on the EQ5D and the Well-being Star assessment scales (see 3.2.8).
- **Work readiness** – defined in terms of improved confidence, self-esteem and acquisition of the necessary skills to apply for jobs and complete interviews.

This evaluation reports on descriptive statistics and, where possible, breaks down the data based on client characteristics including gender, ethnicity, age, health status/barrier. The measures provide important insights into early employment-related outcomes. However, limited improvement in employment outcomes, as measured by employment per se, over the first 18 months is to be expected as the effects of the programme take longer to be realised and measured, especially with more recent clients.

As explained above, BTG's main goal is to make people 'work ready' as a performance / outcome measure. The BTG team believe that there is a *"need to go beyond the emphasis on employment outcomes as the only measure. Where clients are often very far from work, performance measurement needs to account for the stepped, long-term approach that they will require – recognising and rewarding progress for both advisers and clients."*

2.1.2. Qualitative analysis

In order to better interpret and understand clients' journeys, The Work Foundation conducted four semi-structured interviews with BTG clients. Clients were suggested by Pathways and TFFWT.

Interviews were recorded and thorough notes taken. These were subjected to qualitative thematic analysis. Recordings were deleted after transcription. Transcripts and notes were stored securely.

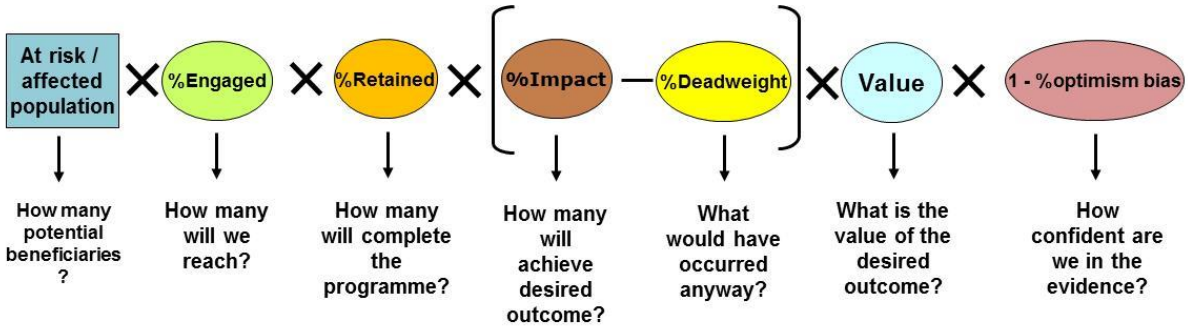
2.2. Cost Benefit Analysis – New Economy Model

Economic analysis was conducted using the New Economy Cost Benefit Analysis (CBA) tool based on the Manchester Model. The New Economy CBA tool has been adopted by central government and published as supplementary guidance to HM Treasury's Green Book[34]. This is designed to measure the economic costs (fiscal costs) and the public social value of public

[34] HM Treasury (2014). *The Green Book Appraisal and Evaluation in Central Government*. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/220541/green_book_complete.pdf

services. It was deemed a good tool to use in this formative evaluation given the type of data collected and the desire to expand and roll-out the programme more widely based on demonstrable and quantifiable impact.

Figure 3: Running the CBA model



Source: New Economy[35]

The New Economy Model was used to do an ex-post cost benefit analysis of the BTG service. The model's analysis timeframe is over the first 18 months of the service. Cost measures including capital costs, revenue costs and in-kind costs were provided by TFFWT for both centres.

The main inputs required by the tool were:

- Client data (collected by case managers) on outcomes.
- The counterfactual/deadweight – what benefits would have accrued even if the programme didn't exist.
- Costs – the costs of running the programme.

Quantified benefits of BTG ('work readiness' support for people with health conditions) are split into two parts according to changes in fiscal benefits (which have a direct impact on government expenditure), and public value benefits (which have wider societal effects). This model estimates the value of these two different types of benefits (or outcomes) associated with delivering the service.

Fiscal benefits (savings to the taxpayer which are associated with project outcomes):

- Reduction in unemployment benefits payments as individuals gain employment.
- Increased output resulting from increased employment.
- Improved health outcomes and resulting reduced healthcare costs.
- Reduced visits to the GP.
- Access to training.

Public value benefits (benefits to the individual that are not fiscally quantifiable and that, in turn, have positive spill-over effects on society):

- Improved health.
- Wellbeing improvements associated with health gains:
  - Increased confidence / self-esteem.

[35] See: http://www.neweconomymanchester.com/media/1452/140402-gm-cba-overview.ppt

- Reduced isolation.
- Positive functioning (autonomy, control, aspirations).
- Improved Emotional well-being.

2.2.1. Assumptions for the CBA analysis

Outcome indicators:

- We use "improved well-being of individuals" as a proxy for "Work ready" that is broken down into "increased confidence/self-esteem", "reduced isolation" and "positive functioning" and "emotional well-being". These are all categories measured at final discharge.
- As a measure of improved health outcomes we used the EQ5D indicator.
- Manchester Pathways recorded alcohol dependency prevalence among its clients so we have included the impact this has had for the target population of working-age population in Manchester.

Identifying the target population: The target population was the **172,760**[36] ESA claimants in Greater Manchester, Leicester and Leicestershire plus the number of people who were long-term ill and economically inactive in same areas (**140,500** individuals[37]).

Identifying the affected group: Over the course of 18 months, the BTG service enrolled 1,485 people who were fully engaged in the programme.

Assessing the impact on the affected population: All clients who are discharged as 'work ready' as a result of the service are assumed to benefit fully from increased employment prospects and getting closer to the labour market.

Allowing for deadweight: Deadweight proportions (i.e. what would have happened anyway) can be calculated from the local level DWP flow rates for benefit claimants plus other research on 'into work' movements. The difference in the job outcome rate for BTG and the deadweight rate is the additional added value resulting from the delivery of BTG. We assume that the counter-factual is 'doing nothing' and the status quo, i.e. the proportion of people who would stay on ESA, given existing access to other services. We look at overall trends by region, where the data is available, or at a national level.

- The deadweight rate for "fiscal benefit of moving people off benefits and into work" is given by the difference between ESA claimants in November 2014 and Feb 2016 in Greater Manchester, and Leicester and Leicestershire[38] which amounted to 4% (a decrease) in Greater Manchester and -4% (an increase) in Leicester. This implies that the situation in Greater Manchester improved as people moved into work, whereas in Leicester and Leicestershire the situation worsened as the number of ESA claimants increased during the first phase of the pilot. For the CBA model this means that the deadweight is positive for Greater Manchester (reflecting the proportion of people in the target population we would expect to achieve outcome

[36] Nomis (2016). *Labour market profile. ONS. February 2016 statistics combined for both areas*. Available at: https://www.nomisweb.co.uk/reports/lmp/lep/1925185547/subreports/dwp_time_series/report.aspx; https://www.nomisweb.co.uk/reports/lmp/lep/1925185552/subreports/dwp_time_series/report.aspx

[37] Nomis (2016). *Labour market profile. ONS Apr 15-Mar 16 combined for both areas*. Available at: https://www.nomisweb.co.uk/reports/lmp/lep/1925185547/subreports/dwp_time_series/report.aspx; https://www.nomisweb.co.uk/reports/lmp/lep/1925185552/subreports/einact_time_series/report.aspx

[38] Nomis (2016). *Labour market profile. ONS*. Available at: https://www.nomisweb.co.uk/reports/lmp/lep/1925185547/subreports/dwp_time_series/report.aspx

regardless of intervention) and negative for Leicester (reflecting how many people would have gotten worse without an intervention).

- The deadweight rate for "improved health outcomes" is given by the difference between economically inactive, long-term ill people in October 2013-September 2014 and April 2015-March 2016 in Greater Manchester and Leicester and Leicestershire[39] which amount to -2% and -9% respectively. This implies a general health decline in the target population in both regions. We include this deadweight to show the proportion of those in the service who we would expect to have a decline in health without the service.
- The deadweight rate for "alcohol consumption problems" is assumed to be 0%. This assumption is made in the absence of any directly comparable statistics; however, we take into account the decline in overall alcohol consumption, flat rate of alcohol related hospital admissions, balanced against a small increase of 1-3% in those presenting themselves for treatment[40]. For the CBA model this means that left alone, the proportion of those in the service with alcohol consumption problems would have remained the same.
- Absent comparable data for other measures, we assumed the deadweight for all other wellbeing measures to be the same as the deadweight of moving people off ESA benefits and into work.

Cost of the service: Data on cost expenditure for both centres was provided centrally by TFFWT. The total cost for both centres was **£743,277**. Specific cost lines for the BTG project as a whole were shared with us by the provider.

BTG provides some services directly, it also funds some external services; both are included in the total costs. *NB a proportion of social prescription is signposting to existing services, funded externally, for which there is no direct cost at point of delivery to the client or the service, therefore the costs of these service cannot be calculated or used in the CBA.*

Over the 18 months of this evaluation, the programme has increasingly relied on internal provision of services such as case management (the core service) and auxiliary services such as physiotherapy, counselling, occupational therapy, and psychological wellbeing. As noted above, effective referral is vital to the success of social prescribing; therefore it is important that referral costs are identified. However, since referrals are made to community partners we have no clear estimate of this – ideally this would be by a detailed analysis of the costs of supporting agencies for the cohort. Further key referrals to professional / technical training and volunteering normally occurs at discharge when the client is deemed 'work ready' and therefore costs are borne after the service ends.

Mental health: The importance of mental health for individual wellbeing is captured in the model and monetarily quantified accordingly. The model divides wellbeing in the following domains and uses individual willingness to pay (value) to monetarily quantify them the public (not fiscal) value as follows:

- Increased confidence/self-esteem: £3,500
- Reduced isolation: £8,500

[39] Nomis (2016). *Labour market profile. ONS*. Available at: https://www.nomisweb.co.uk/reports/lmp/lep/1925185552/subreports/einact_time_series/report.aspx

[40] Public Health England (2013). *Statistics for alcohol treatment activity in England 2012-13 National Drug Treatment Monitoring System.* Available at: http://www.nta.nhs.uk/uploads/alcohol1213statsrelease.pdf

- Positive functioning (autonomy, control, aspirations): £3,500
- Emotional well-being: £3,500

Other potential benefits not quantified in the model: There are additional benefits accrued as a result of volunteering opportunities offered by BTG. These include skills development, leading to better employment prospects as well as improving emotional well-being. These will not be realised until the person completes the volunteering programmes in question. Thus, the benefit realisation of the service will not be fully captured at this stage.

Furthermore, lower unemployment rates could be associated with other benefits that are not captured in this model, such as lower crime rates. Greater social benefits resulting from improved wellbeing could also have a positive effect on family and community wellbeing and keeping family and relationships together – in addition to the specific advice given on relationships, housing, financial and legal issues. Although there is no evidence that can be quantified at this stage the New Economy model could be customised in the future to monetise these benefits.

3. Outcomes from the evaluation

3.1. Data collection limitations

Data was provided separately by each service provider and analysed independently by the Work Foundation. The data set is rich in information and detail. The finalised data files used for the analysis were produced as a result of an iterative review and feedback process between The Fit for Work Team's data analyst and Work Foundation researchers to recode variables and to address the problem of incomplete data. Feedback was provided to improve the quality and consistency of the data on a rolling basis. The data set for TFFWT Leicester showed lower data quality **so the impact measures we present are likely to be underestimated**. A detailed outline of the limitations of the data collection is given in Appendix 1. The main issues with the data were inconsistencies in the templates used for collection, in terms of the format and the level of detail presented (rather than that collected). The data collection process and templates were synchronised between the two centres using a process of feedback and iterative improvements in order to reach the point suitable for comparative analysis. The other problem encountered was the need to find a sustainable balance between the desire for consistent and frequent data collection from clients and the burden this placed on case managers. Initial assessments provided a rich and thorough data set, but data on discharge and follow up was less rigorous lending to a problem of missing data that could have possibly lead to an underestimation of outcomes and impacts. Finally, classification of interventions differed between centres, so for example, where a case manager offered careers advice, or job brokerage, this was not filtered out and classified separately in Pathways (unlike in TFFWT). The data therefore was not fully capturing the breadth of interventions and service provision within Pathways.

3.2. Key findings from analysis

3.2.1. **Case management** – an essential component of the service and its unique selling point

Clients described the case manager as a 'professional friend', a personal coach who can offer personalised advice and customised action plans.

It is becoming less likely that individuals with long-term health conditions using JobCentre Plus will come into contact with specialists, who will have an understanding of the barriers to work presented by their health, as well as by other linked barriers. BTG provides a way of meeting additional need in areas where long-term conditions are particularly prevalent, including enabling access to Occupational Health and vocational rehabilitation advice as well as signposting to health and community partners. This is crucial to ensuring that individuals with health conditions receive appropriate support.

3.2.2. **Engagement** – the main referral routes between the two centres vary, both have a high initial withdrawal rate

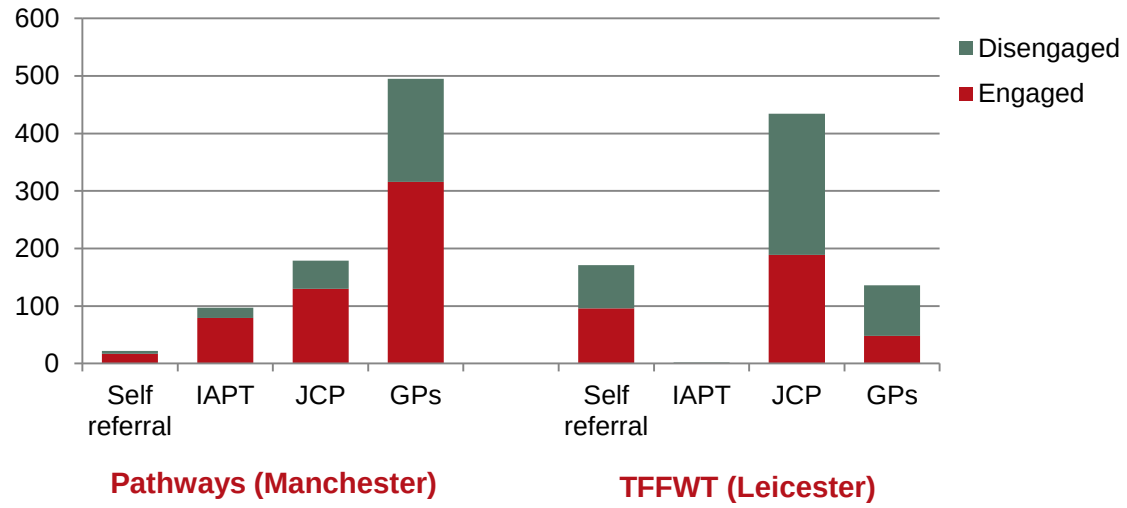
The analysis was conducted on 727 clients in Pathways and 759 in TFFWT. In Pathways, 28.3% people were not contactable by the service (and as such had a "pending" status)[41]; these were excluded from the analysis. In TFFWT, 54% of referred clients were withdrawn

[41] The 19 cases that were defined as 'pending' have received referrals however:
(a) it has not been able to establish contact and therefore a processes prior to disengaging the client is underway;
(b) the assessment has yet to be scheduled due to the referral being received late on within the calendar month; or
(c) the assessment has been scheduled but not within the calendar month.

from the service as they were deemed inappropriate referrals. Reasons given for withdrawal included the returning of nil forms and ineligibility (e.g. because individuals had severe or fluctuating health conditions, they were on the Work Programme, or they were already in employment)[42]. Those with severe or fluctuating conditions, such as major surgery or chemotherapy, may be deemed as not being in a position to get 'work ready' until they entered into a stage of remission and recovery. In addition, the level of support and the effectiveness of the service at that stage may mean that work is not a viable option if severity of health issues requires the need to focus on recovery. This was handled on a case by case basis. In Pathways 39.9% of clients were still in the programme at the time of the analysis. 31.1% had been discharged from the programme and 29% had disengaged with the service. The data provided did not allow for distinction of service status in TFFWT (e.g. currently engaged, discharged or disengaged). Based on the discharge dates it could be seen that 329 clients had already been discharged from the service.

The first stage of data analysis was conducted by looking at referral routes, in order to answer whether different referral routes are associated with differences in retention rates in the service. The data shows that GPs are the main referrer in Pathways (68%), whereas JCP is the main referrer in TFFWT (57%). Conversely, JCP referrals in Pathways are only 15% and GP referrals in TFFWT are only 18.7%.

Figure 4: Referral routes and programme engagement



As for the likelihood of disengaging with the programme, people who had been referred by a GP in Pathways were more likely to continue in the service compared to people who had been referred by JCP. 34.1% of the former disengaged, were ineligible or declined service compared to 44.9% of the latter. On the contrary, in TFFWT withdrawal rates were higher when related to GPs compared to JCP, although there was no significant difference between the two. 64.7% of the clients referred by a GP withdrew either because they were not contactable, because they were employed, because they had returned nil forms, or declined service, compared to 56.5% of those who had been referred by JCP. Overall, withdrawal rates appear to be higher in TFFWT.

[42] Due to the quality of the data, our analysis of the "withdrawal" status in Leicester is limited when no explanation was given.

Pathways also had a consistent number of referrals coming from IAPT, 18.5% of which disengaged, declined service or were ineligible. Only two people were referred by IAPT to TFFWT, one of whom withdrew as they returned nil forms. Only 3% self-referred in Pathways, five of whom either disengaged or declined service and two of whom are on a pending status. 22.5% people self-referred in TFFWT, of whom 43.8% withdrew.

The withdrawal rate for the period immediately after referral is high, amounting to almost 30% of clients in Pathways and over 50% of clients in TFFWT. Reasons for this may include the referrer not appropriately understanding the nature of the service or inadequately explaining what the service involves to the client.

Referrals were taken from GPs, JCPs and individuals. The main referrers for Pathways were GPs, whereas in TFFWT the main referrer was the JCP, and the use of secondary referral routes differs as well. This may imply that the two centres have concentrated building relationships with different categories of referrers. This hypothesis is confirmed by the significantly lower rate of withdrawal for clients referred by the main referrer in Pathways – GPs. Pathways had an explicit strategy to identify and target GPs directly for referrals, and not JCPs. Referrals by GPs in Pathways therefore are underpinned by an understanding of 'work as a social determinant of health'. The higher rate of self-referral in TFFWT might signal that the service is better known in that area. The high average withdrawal rate in TFFWT, on the other hand, should be noted and investigated further.

Working relationships and external partnerships with BTG and other community initiatives and health partners would likely be improved by the external partners having a clearer understanding of the welfare to work environment.

3.2.3. **Referrals to external services** – good utilisation of available community services

As well as providing many services in-house, both centres refer to external services in the community as required. These include training, physiotherapy, financial advice, Access to Work, careers advice, occupational health nurses and GPs, occupational therapists, pain management programmes and legal advice.

Each provider differs in the types of in-house services it supplies, and those to which it refers. Their service designs are based upon an understanding of what is available within each locality and what is necessary for the support of clients. The differences between the two services therefore should, in theory, not affect the client in terms of receiving the interventions they need.

Achieving the right balance between the provision of health services in the centres and in the community (including through the NHS) requires an assessment of what is already available in the community and can be integrated into the service and what needs to be provided directly to the client. The centres' management need to ensure that staff have sufficient knowledge of health support available in the community on an ongoing basis. Linking people into community assets enables them to access local services when other issues in their lives occur after exit from the service.

3.2.4. **Demographics of clients** – under-representation of the economically inactive white population in both centres and of women in TFFWT

In TFFWT, 58.9% of the cohort were men and 36.5% were women[43]. In Pathways, the gender makeup was more balanced, with 53.6% male and 46.3% female clients. In terms of ethnic makeup 62% of clients in TFFWT and 69.5% of clients in Pathways were white. In both cohorts, more than half of clients were single (64.7% in Pathways and 54.1% in TFFWT).

Figure 5: Economic inactivity by ethic group and gender

	Greater Manchester	Leicester and Leicestershire
Ethnic group		
White	88.4%	74.7%
Mixed / multiple ethnic group	1.8%	1.7%
Asian / Asian British	7.4%	20.4%
Black African / Caribbean / Black British	1.8%	2.1%
Other ethnic group	0.7%	1.1%
Sex		
Males	53.0%	49.5%
Females	47.0%	50.5%

Source: ONS [from Nomis - 9 January 2017]

A basic comparison with the target population of the economically inactive in both regions would indicate that the white population is under-represented in both centres, whilst women are under-represented in TFFWT (36.5% versus 50.5% of the population).

3.2.5. **Length of stay in service** – clients spend less time in Pathways than TFFWT

The average length of stay in service was 9.8 weeks in Pathways and 12.4 weeks in TFFWT[44]. Pathways offers a maximum of 13 weeks of intervention, whereas TFFWT offers a 12 week service, except for in special circumstances.

Guidelines regarding the number of interventions clients receive differ between centres. This is not surprising given that Pathway's clients have, on average, more severe health issues. TFFWT's criteria are based on number of weeks, and for Pathways, on number of interventions. Furthermore, the data shows a few inconsistencies; in TFFWT, clients stay in service longer than the centre's target, and they also stay longer compared to Pathways. TFFWT will not automatically discharge patients when the 12 week target is approaching, it can decide to retain clients if the case manager and client want to continue seeking benefit from the service.

3.2.6. **Health conditions** – mental health and MSK are the most widespread health conditions

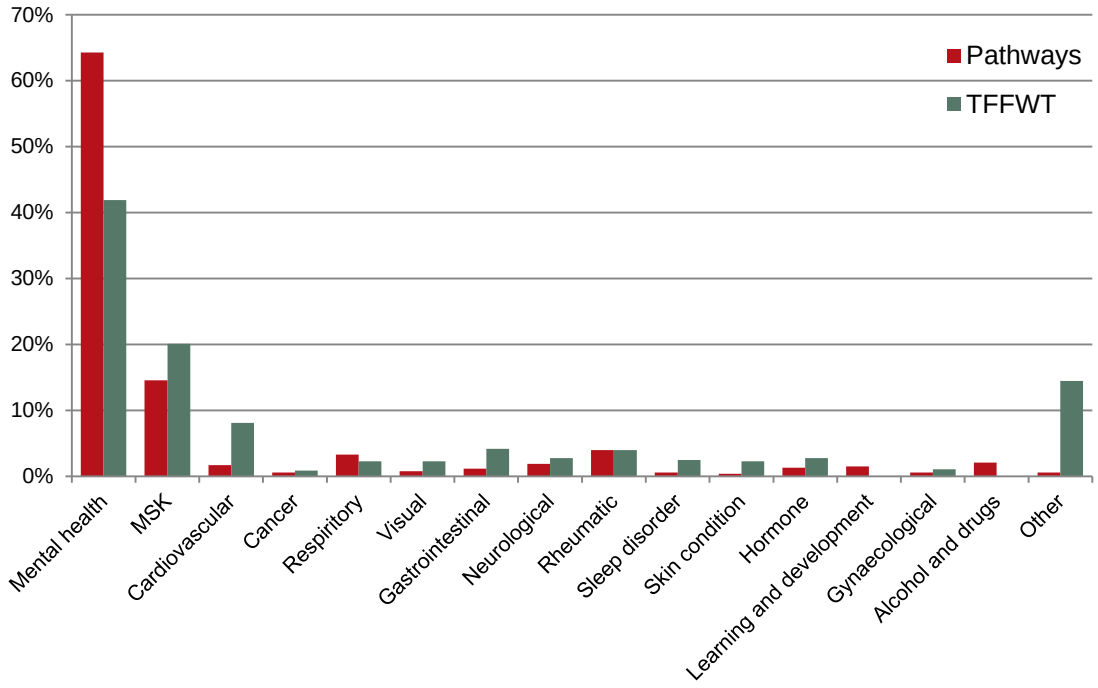
The most widespread health conditions were found to be mental health and Musculoskeletal Disorders (MSKs). 64.3% (n=335) of clients in Pathways and 41.9% (n=148) in TFFWT have one or more mental health conditions, and 14.6% (n=76) of people in Pathways and 20.1% (n=71) in TFFWT reported at least one form of MSK.

[43] Some client gender data was incomplete.
[44] Some length of stay data was inconsistent and that it appears as if clients stayed in TFFWT beyond the 12 week length of the service.

Other conditions that were reported in Pathways were: 0.6% cancer, 1.7% cardiovascular diseases, 3.3% respiratory conditions; 0.8% visual problems; 1.2% gastrointestinal conditions; 1.9% neurological conditions; 4% at least one rheumatic condition; 0.6% sleep disorders; 0.4% skin conditions; 0.4% at least one renal condition; 1.3% hormone conditions; 1.5% learning and development disabilities; 0.6% gynaecological conditions; 2.1% alcohol and/or drugs problems; and, 0.6% have “another” condition.

Conditions reported in TFFWT: 0.9% cancer; 8.1 % cardiovascular diseases; 1.4% fibromyalgia; 2.8% neurological problems; 2.3% respiratory problems; 2.3% eye/vision problems; 1.4% ENT problems; 4.2% gastrointestinal problem; 4% rheumatic conditions; 2.5% sleep disorders; 2.3% skin diseases; 2.8% hormone problems; 1.1% gynaecological problems; and, 14.5% have other types of health issues.

Figure 6: Client health conditions



Consistent with the literature, mental health issues and MSK are the most widespread health issues in both centres. The prevalence of other health conditions is low, although almost 15% of clients in TFFWT reported non-specified health conditions.

3.2.7. **Comorbidity** – high rate of comorbid mental health issues

Having more than one long-term health condition – also known as having ‘comorbidities’ – is associated with worse health and worse employment outcomes[45]. Our analysis has shown that for the BTG client group, mental health, the condition that concerns the highest number of clients, was comorbid with a number of other health conditions in both centres.

Due to differences in the classification of health conditions between the two centres, we are limited in comparison by the data. In people living with various health conditions, those with the highest rates of comorbidities with mental health appeared to be:

[45] Steadman, K., Sheldon, H. & Donnaloja, V. (2016). *Complexities and challenges: working with multiple health conditions*. London: Work Foundation.

- Pathways - cancer, gastrointestinal, gynaecological.
- TFFWT - vision, gastrointestinal, gynaecological and ENT illness.

3.2.8. Health Improvements – health status measures confirms the vast majority show health improvements as a result of BTG, and the higher complexity of cases in Pathways

The main measure of health status used was the EQ5D measure[46]. Health status was measured at the start of the service and at discharge. Substantial movements and variations between the centres were measured. In Pathways, 81% of clients showed improvement (in terms of EQ5D measures); in TFFWT, 57% of clients improved.

In Pathways a statistically significant association between mental health (1% significance level Anova), MSK (5% significance level), gastrointestinal (5% significance level) and service status was found, compared to other health conditions. Clients with the aforementioned conditions appear to be more likely to either still be in service.[47]

A second measure was used to quantify health status improvement, the Well-being Star[48]. Data collected showed that in Pathways 85.6% of clients discharged improved using this measure and 78% improved in TFFWT. It should be noted however, that in both centres Star data was not collected consistently for every client.

Despite the higher complexity of cases in Pathways, over 80% of clients in Pathways and over 57% in TFFWT showed health improvements.

3.2.9. Benefit movement – low rate of movement off work-related benefits

Available data showed that 1.4% moved off benefits in Pathways and 7.6% did so in TFFWT. However due to differing terminology used between the two centres for classification of discharged/disengaged there could be issues with this data; e.g. clients who had disengaged at the initial stages of BTG were labelled as discharged by Pathways.

The low movement off benefits reflects the low rate of employment at discharge. The lower percentage for Pathways likely indicates the higher complexity of cases and thus the greater distance of their clients from the labour market. The aim of the BTG service is to make people ready to go back to work, but direct job brokerage to actively apply for jobs is not provided. Pathways has now introduced job brokerage, so going forward it would be good to track if there are changes in the data.

3.2.10. Work readiness – the rate of work readiness is higher in TFFWT

38.2% and 65% of clients who completed the service in Pathways and TFFWT were assessed to be work ready. This is a key measure of impact of the success of the programme. The definition of work ready is seen within this programme as the client feeling more confident, and willing to re-enter the labour market and thus increasing their employment prospects. The differing rates between the centres are understood within this evaluation to be due to the different client profiles and complex health conditions presented amongst the clients at 1st appointment. In section 3.2.6 it was shown that clients in Pathways

[46] EuroQol five dimensions questionnaire "EQ-5D" is a standardised instrument for use as a measure of health outcome. Applicable to a wide range of health conditions and treatments, the EQ-5D health questionnaire provides a descriptive profile and a single index value for health status

[47] Because of data limitations we could not distinguish between different service statuses in Leicester and therefore were not able to carry the same statistical analysis.

[48] See: http://www.outcomesstar.org.uk/well-being-star/

had a much higher rate of mental health problems (65% in Pathways compared to just over 40% in TFFWT).

3.2.11. **Work readiness and interventions** – a mixed bag, but key interventions such as physiotherapy, and job support are important

A statistical breakdown of those who were 'work ready' by the interventions they received was carried out.

Physiotherapy and voluntary work, as well as exercise, seem to be the most effective with over 20% of clients who received these interventions becoming work ready.

A logit regression analysis model was undertaken, using work readiness as the dependent variable and all interventions with at least 5 clients included as independent variables. Results should be taken with extreme caution as the fit of the model is weak due to the small sample size and large number of dependent variables. However results of the regression showed:

- **TFFWT:** Case management and referral to voluntary work seem to have greatest effect on being work ready. All clients in the service automatically get assigned a case manager, so this finding emphasises the importance of this element of the programme for achieving the work ready outcome.
- **Pathways:** The effectiveness rates for individual interventions in Pathways are higher than TFFWT, though it is difficult to compare due to differing classification of interventions between the centres. In the regression analysis physiotherapy, job search support, and Access to Work (a government programme) appear to have positive and significant effects on work readiness.

3.2.12. **Work readiness, interventions and health conditions** – high usage of emotional support interventions reflects comorbid mental health issues for people with MSK

For clients with mental health conditions the main interventions in Pathways were case management, psychological therapies, and confidence building. In TFFWT these were job search, confidence building, occupational health, skills advice, and psychotherapy.

TFFWT's top interventions for people with MSK are more jobs focused; all clients receive case management and 95.8% received one or more of the following: careers advice; job search support; occupational health; confidence building; and, skills advice. In Pathways 19.7% (n=15) people with MSK received psychological therapy support which seems to reflect the high rate of comorbid mental health.

Our analysis showed that there is no statistically significant association between health conditions and work readiness in either service provider. The implication being the ability to become work ready is not related to the client's specific health condition. However the high rate of uptake of psychotherapy in Pathways and case management and confidence-building in TFFWT for people with MSK reflect the high rate of comorbid mental health issues in both centres.

3.3. Findings from client interviews

Four interviews with clients were conducted, 3 females and 1 male. Clients had a range of physical and mental health conditions (with some having multiple health conditions), while several had additional barriers to work, such as family bereavements.

3.3.1. General views

Overall, clients were very positive about BTG – one individual went so far as to describe the service as *"life-changing"*. Positive reference was made to the range of activities and support available through BTG. Many clients highlighted the helpfulness of staff, and several singled out their case managers for praise. Case managers were seen as supportive, attentive and approachable, with clients feeling able to have actual conversations with them to discuss their needs. This was felt to contrast with their prior experiences with JobCentre advisers.

Clients cited how important it was for them that they had somebody to listen to them as they made 'life decisions' or when dealing with major stress events like a family bereavement. They also said how important it was for them to receive support and advice on improving confidence and effort in getting work ready.

3.3.2. Journey towards work

All the clients interviewed felt that the programme had helped them move closer to work. For some, the effect had been dramatic, but others still felt quite far away from employment.

BTG's stepped approach to returning to work was viewed positively, with most clients feeling that this had given them the time and space to progress towards the labour market. One client described having had a psychotic episode and becoming unable to work, but after joining the service and benefitting from the advice and support on offer, joined a training course on mental health that enhanced knowledge of their own condition and was able to become qualified for a role in her chosen profession and to gain the confidence to apply for jobs.

3.3.3. Services, activities and interventions

The most important service provided is the constant access to a case manager/advisor by phone. Though case managers did have face to face sessions with interviewees during their time in the service, the clients cited that they valued the ongoing conversations, encouragement and advice on what to do as the most beneficial aspects of the programme. This support also addressed feelings of social isolation – for example one client was moving to a different area where they had no friends. Clients spoke about their positive interactions with case managers and how this helped build their confidence.

Overall the feedback received from clients was overwhelmingly positive. Above all, it reflects the person centred support the service is able to give its clients, which the data is not able to capture. What has come across as particularly valuable is the relationship clients have with their case manager and the opportunity to be listened to and supported by them.

3.4. Findings from the New Economy Model

The outcomes, associated fiscal benefits, and the government agencies that benefit from the accruement of these outcomes are listed in Figure 7, below.

Figure 7: Outcomes and benefits incorporated within the New Economy Manchester cost-benefit model

Outcomes	Benefits	Who does benefit accrue to?	Pathways		TFFWT	
			Fiscal benefit	Public value benefit	Fiscal benefit	Public value benefit
Increased employment (reduced benefits payments and health impact)	1) Fiscal benefit of moving people off benefits and into work	DWP / HMT DH	£225,067.82	£335,534.79	£421,288.68	£628,064.04
	2) Improved health outcomes	Individuals	£1,350,198.38	£2,142,923.75	£578,950.16	£918,862.05
Mental health	Reduced health cost of interventions		£36,536.01	£36,536.01	£30,895.81	£30,895.81
Reduced visit to GPs	Benefit of reduced visit to GPs		£6,396.93	£6,396.93		
Entry to training	Benefits of training		£15,946.26	£15,946.26	£9,068.57	£9,068.57
Reduced alcohol dependency	Reduced health & criminal justice costs	NHS, Police, CJS	£59,997.98	£106,596.42		
Improved well-being of individuals	Increased confidence / self-esteem	Individual		£158,676.70		£297,208.67
	Reduced isolation	Individual		£385,357.71		£127,871.87
	Positive functioning (autonomy, control, aspirations)	Individual		£158,676.70		£384,963.88
	Emotional well-being	Individual		£537,059.62		£398,209.95
Total			**£1,694,143.38**	**£3,883,704.88**	**£1,040,203.22**	**£2,795,144.84**

3.4.1. Main findings

3.4.1.1. Benefits in the New Economy Model

BTG provides benefits in two forms: the economic benefits of people either being ready to return to work or enter into work, and the wellbeing benefits that flow from these people being in work or becoming ready to work eventually.

The Fit for Work Team:

- 35 clients moved into employment at discharge and 16 were still in work at follow-up.
- 31 moved into training at discharge, 8 were still in training at follow-up.
- 35 moved into voluntary work at discharge, 21 were still volunteering at follow-up.

Pathways:

- 41 clients moved into employment at discharge and 29 were still in work at follow-up.
- 21 moved into training at discharge, 7 were still in training at follow-up.
- 15 moved into voluntary work at discharge, 4 were still volunteering at follow-up.

Total possible annual fiscal savings resulting from movement into employment: £646,357[49]

Total possible annual fiscal savings resulting from health benefits: £1,929,148

3.4.1.2. Where have savings been made?

Majority of fiscal/economic savings is to NHS/DWP:

- 6% of the benefits of moving people into employment go to the NHS. 94% to DWP.
- 13% of the benefits of improved health outcomes go to the NHS. 87% to DWP.
- 8% of the benefits of improved mental health go to the local authority. 92% to the NHS.
- For Pathways, 100% of benefits of reducing dependency on alcohol go to the NHS.

3.4.1.3. Cost Benefit Ratio

We have calculated the fiscal impact of BTG comparing the costs of the programme against the estimated fiscal flow backs to the public purse in terms of additional tax revenues and reduced benefit expenditure.

For BTG as a whole over 18 months during 2014-2016, it is estimated to have generated on average £3.68 per £1 spent. In terms of social value, BTG is estimated to have generated £8.99 per £1 spent.

It should be stressed that these narrow fiscal impact calculations are not the right basis on which to determine whether a public programme represents good value for money. The basis for that decision is our wider cost benefit analysis figures which take account of all potential benefits to society against the programme's costs. There are after all many public services rightly provided by the state where the costs of doing so outweigh any fiscal flow backs. These are provided because it is judged that their benefits to society outweigh the costs of providing them.

BTG service providers already have some insight into these factors (e.g. through understanding where their services have added to other provision), but have not considered these comprehensively. Understanding how BTG delivers outcomes in the wider context of change, for example in relation to going beyond services that exist already in the NHS and DWP, will enable them to identify its unique impact, increasing the strength of its reporting.

Figure 8: Cost Benefit Ratio (CBR)

	Fiscal	Public value
Benefits - Total for both centres	£2,734,346.60	£6,678,849.72
Costs - Total for both centres	£743,277	£743,277
Benefits-Costs	£1,991,069.60	£5,935,572.72
Benefits for every £1 cost	£3.68	£8.99

3.4.1.4. Reducing the demand for mental health and GP services

Citizens Advice has published research showing that 20% of GP consultation time is spent attending to non-medical related issues, such as relationship breakdown, debt problems and issues at work. Moreover, the majority of GPs said that this meant less time to see other

[49] 15% reduction has been made for possible optimism bias

patients, increased the stress of their job and led to extra costs for their practice and the NHS.[50]

The New Economy Model shows the positive impact that the BTG service has on reduced GP visits and reduced health cost of interventions totalling £73,828.74 in benefits to the economy.

[50] Caper, K. & Plunkett, J. (2015). *A very general Practice: How much time do GPs spend on issues other than health?* Available at: https://www.citizensadvice.org.uk/Global/CitizensAdvice/Public%20services%20publications/CitizensAdvice_AVeryGeneralPractice_May2015.pdf

4. Recommendations

In this section we reflect on the key issues for future development of the programme – identifying the main challenges from our findings and recommendations for future implementation.

4.1. Strengths of the programme

Work has been identified as a key component of social inclusion and a key factor in addressing health inequalities. BTG is designed to help people take control by supporting them to tackle the biopsychosocial health obstacles that exclude them from work. This is a tremendous challenge requiring integrated services that target the people who are the furthest from the labour market.

Manchester in particular has higher rates of economic inactivity due to long-term sickness than the national average (26.2% vs 22.4% in Great Britain[51]). Existing government programmes to support people return to work do not report satisfying results; the Work Programme – a flagship programme that aims to move people off welfare and into work – delivers job outcomes for 5% of ESA (Employment and Support Allowance) claimants compared to the 16% target.[52]

In summary, this formative evaluation found the key strengths of BTG to be the following:

- **BTG provides the crucial link for integrating the services of health and employment support** offered by the government to the most vulnerable in society. It goes beyond what GPs and JCPs can offer individually and is an excellent model of social prescribing. It gives GPs the opportunity to prescribe a service that meets their patients' needs which are not entirely or always clinical. BTG offers GPs an alternative route of 'prescription' to support people with health conditions and LTCs whose wellbeing is worsened by their unemployed status.
- The CBA, calculated in this evaluation, supports the strong evidence in the literature; personalised support can be extremely helpful in supporting return to work[53]. **Case management defines the success of BTG**, as described by the interviewees in terms of the confidence raising, empowerment and self-management support provided by the case managers. It provides assistance in manoeuvring through health and employment systems that many clients find difficult. The interviews allowed us to directly hear the voices of those who have benefited from the service and to understand the human impact it has had – an impact that would be impossible to capture in numbers.

[51] Nomis (2016). *Labour Market Profile - Greater Manchester (Met County)*. Available at: https://www.nomisweb.co.uk/reports/lmp/la/1967128590/report.aspx?town=greater%20manchester#tabempunemp

[52] Dar, A. (2016). *Work programme: background and statistics. Briefing paper*. London: House of Commons Library.

[53] A systematic review of 42 papers assessing various welfare-to-work schemes in the UK from 2002-2008 found that the use and quality (i.e. competent and well-informed) of personal advisors and individual case managers made a significant difference to the likelihood of securing an employment outcome. This review also emphasised the value of having a range of services in one place (i.e. a one-stop-shop approach). For more details see: Dudley, C., McEnhill L. & Steadman, K. (2016). *Is welfare to work, working well? Improving employment rates for people with disabilities and long-term conditions*. London: Work Foundation. Available at: http://www.theworkfoundation.com/wp-content/uploads/2016/11/405_Work-Programmes.pdf

4.2. Programme Recommendations

Having conducted a thorough review of the data and in consultation with the BTG service providers in an ongoing process of continued review, feedback and consultation over the course of a year; we make the following recommendations to improve BTG:

1. **Consider using the Patient Activation Measure** (PAM) as a way of developing person-centred care in the particular context of telephone tailored case management. PAM is a tool to both support people getting more involved in their health and care, and/or as a way of measuring patient involvement in their healthcare. This will bring the programme in line with NHS England, which has agreed a five year licence to use the PAM tool with up to 1.8 million people through key NHS change programmes as part of its Self-Care Programme and to scale up support for those with LTCs. The BTG providers should carefully consider the findings from the evaluation for NHS England which focuses on practical lessons and points to consider for those who wish to use PAM and learn from the experiences of those who have been using it in different projects in their local areas.[54]
2. **Continue to closely monitor withdrawal rates and to address the reasons behind them**: further investigation is required to understand what the high rate of initial withdrawal is caused by, especially in TFFWT. We suggest exploring with referrers if there is clarity in what the service aims at delivering and on its eligibility criteria.
3. **Continue to develop and improve engagement with referrer bodies**: the two centres present with very different referral rate patterns from JCPs and GPs based on different strategies and context that suit each region. TFFWT receiving more referrals from JCPs and Pathways from GPs. Even though there does not need to be equal/similar patterns of referrals of different referrers, we suggest exploring the relationship between withdrawal rates and referral routes to see if different relationships the two centres have developed with the their referrer bodies can be improved. In particular addressing the tension between messages from advisers and health partners, and messages from JCPs around the misconception that it is a requirement to enrol on the BTG service for financial benefits. The considerably higher rate of self-referral in TFFWT is a positive signal that this centre is well-known and trusted in the area.
4. **Better reflect the gender and ethnic make-up of the unemployed and economically inactive populations in the regions**: together with referrers, the service should try and increase the uptake of under-represented groups.
5. **Develop more detailed information on health status in TFFWT**: more information should be collected on the 15% of clients in TFFWT who reported non-categorised health conditions. As a start, TFFWT could follow the template of Pathways for health condition categories.
6. **Provide more interventions that are directly aimed at helping people return to work and finding a job**: all the interventions that appear to have a positive impact on the level of work readiness of clients are closely related to support that actively address the confidence and ability of clients, as well as the opportunities to enter directly into the world of work. This might suggest that the service should provide

[54] Armstrong, N., Tarrant, C., Martin, G., Manktelow, B., Brewster, L. & Chew, S. (2016). *Independent evaluation of the feasibility of using the Patient Activation Measure in the NHS in England*. Available at: https://www.england.nhs.uk/wp-content/uploads/2016/04/pa-interim-report-summary.pdf

more interventions that actively help people find jobs and retain work, e.g. job brokerage. Although, in theory, this is supposed to be the role of JCPs, in reality BTG could offer an additional period of working with an employment support worker within their service. The BTG teams have pro-actively set up this service for a sample of clients during the period April to September 2017.

4.3. Evaluation recommendations

Further to the programme level recommendations the following actions can be taken to improve the quality of any future evaluation:

1. **Continue refining and developing data collection systems and outcome data**. The centres have been collecting project data for many of their activities (e.g. expenditure, number of clients engaged, client feedback, interventions and outcomes etc.), moving towards systematic data collection, undertaken on a consistent basis, and streamlined across centres needs continuous improvement and review. By improving the classification of interventions and collecting more detailed and consistent outcome data, the discharge data (end data) for TFFWT should be more consistent with Pathways'. With improved data BTG will be able to increase the confidence it has that it is achieving its desired impact.
2. **Consider constructing a programme-level Theory of Change**[55]. The BTG providers should consider carrying out a Theory of Change exercise (i.e. mapping how its activities lead to long-term outcomes, via interim outcomes) that considers the overall impact across all centres (not just the two under consideration here as strategies may differ according to local needs). This would enable BTG's staff to understand how their service relates to the broader objectives of the programme, as well as providing a platform to develop a common and consistent measurement system across the two organisations. It would also help in identifying key outcomes and areas where different activities are achieving the same type of outcomes. The BTG teams can construct their Theory of Change as a group, in order to capture the input of different members of staff, stakeholders, and even beneficiaries.
3. **Embed impact measurement and reporting into the organisation**. Some senior BTG staff have the skills to collect and interpret outcomes and impact data. TFFWT and Pathways should continue to monitor the impact of the service internally on an ongoing basis using the basic headlines in this evaluation and the CBA framework. Different levels of the organisation may require different types of training regarding impact assessments, to reflect their different roles. For example, as case managers collect the applicable data from clients, BTG project managers need to understand how this data is aggregated and can be used to inform decisions (for example, budgetary/resource allocation decisions, strategies and targets focussing on outcomes); and Directors should ensure BTG's impact is maximised and safeguarded by reviewing the aggregated impact data presented to them to identify the greatest areas of impact. Although this occurs already to some degree, it would be good to have a clear internal monitoring and reporting around an agreed process.
4. **Continue to improve data management system and impact data for internal decision-making**. As alluded to in point 3 above, the impact data collated by BTG is not only useful for external stakeholders who wish to understand the difference BTG

[55] See: Nesta (2014). *Guidance for Developing a Theory of Change for Your Programme*. Available at: https://www.nesta.org.uk/sites/default/files/theory_of_change_guidance_for_applicants_.pdf

makes, but should also be used to inform BTG's strategy and internal decisions. To deliver most effectively on its social mission, BTG needs to understand how it delivers its social mission, and be able to utilise its available data to understand where to allocate its finite resources in pursuit of that mission. The New Economy framework developed here can be used as the starting point for this process of developing an 'impact-led' strategy. For example, if the method of outcomes measurement and financial valuation are kept the same for a particular activity, BTG would be able to compare its impact from one year to another, and use this to evaluate performance separately from the organisation's pure financial performance.

5. Conclusion

The evaluation aimed to answer some key questions. The following section addresses these questions:

1. *Does BTG respond to the needs of the service users in addressing health barriers to work / employment?*
    a. *Are there any health improvements for people with health conditions?*

Yes, we have found that over 80% of clients in Pathways and over 57% in TFFWT showed health improvements (according to EQ5D and Star assessments).

    b. *Which health conditions are most prevalent? Is there comorbidity?*

The most widespread health conditions were found to be mental health and Musculoskeletal disorders (MSKs). 64.3% in Pathways and 41.9% in TFFWT have one or more mental health conditions, and 14.6% of people in Pathways and 20.1% in TFFWT reported at least one form of MSK.

There is a high level of comorbidity between mental health and other health conditions. Due to differences in the classification of health conditions between the two centres, we are limited in comparison by the data.

For Pathways – cancer, gastrointestinal and gynaecological conditions had the highest rates of comorbidities with mental health.

For TFFWT – vision, gastrointestinal, gynaecological and ENT illness had high rates of comorbidity with mental health.

2. *Has the programme been successful in improving the health and employment-related outcomes of service users?*
    a. *Are there any improvements in terms of work readiness and other employment-related outcomes?*

Yes. 38.2% and 65% of clients who completed the service in Pathways and TFFWT were assessed to be work ready (as of mid-2016).

    b. *What interventions are most effective in delivering work readiness?*

Results were mixed, the key interventions of physiotherapy, confidence-building and job search support were all important.

    c. *Do certain health conditions represent a higher barrier to work readiness and employment outcomes?*

There was no correlation between health conditions and work readiness.

    d. *Which referral routes are most highly correlated with retention in the service?*

The data shows that GPs are the main referrer in Pathways (68%) whereas JCP is the main referrer in TFFWT (57%).

As for the likelihood of disengaging with the programme, people who had been referred by a GP in Pathways were more likely to continue in the service compared to people who had been referred by JCP. 34.1% of the former disengaged, were ineligible or declined service compared to 44.9% of the latter. TFFWT withdrawal rates were slightly higher for GP referrals compared to JCP, although there was no significant difference between the two.

3. *What are the overall financial benefits of the programme? How would these be used to support a business case to potential commissioners?*

Total possible annual fiscal savings resulting from movement into employment: £646,357

Total possible annual fiscal savings resulting from health benefits: £1,929,148

For BTG as a whole over 18 months during 2014-2016, it is estimated to have generated on average £3.68 per £1 spent. In terms of social value, BTG is estimated to have generated £8.99 per £1 spent.

Appendix: Data limitations

This table illustrates the main issues identified within data collection and how the teams in both centres overcame them:

Issue	Solution
The initial format/template of the spreadsheet used to present the data was inconsistent between the two service centres, thus not allowing for comparison	After several reiterations, the layout of spreadsheets, tabs and alignment were unified into one template
The level of detail on health conditions was much higher in one service compared to the other (e.g. back pain vs. MSK)	Variable names across centre databases were unified into similar broader categories
A lot of data was not coded, not allowing for statistical analysis	Data was coded into binary “yes/no” outcome variables
There was a large amount of duplicate variables with different outcomes	Most duplicates were eliminated

Below is a list of further limitations to the quality of the data that were only partially overcome. These factors need to be considered when interpreting results from the data analysis:

- Data is missing, indicating that it was not recorded systematically and regularly for every client.
- Data for The Fit for Work Team revealed who had withdrawn at the early stages of recruitment (before a first appointment), but does not distinguish between those who are still currently engaged and those who had disengaged after some time.
- The health condition of 14.5% of the cohort in TFFWT was reported as “other”. This number is quite high, suggesting that maybe more health categories could be added to the current ones.
- Differences existed in reported conditions between the two services: no ENT in Pathways, no learning disability, drug and alcohol abuse in TFFWT (which may explain the point above).
- Inconsistencies existed within the coding of work readiness, with the number of work ready people having originally been underestimated. Often, despite people being recorded as having found a job at discharge or follow up, they had not been recorded as work ready. This is an inconsistency, since having found a job implies work readiness. The variable had to be recoded to reflect this.
- Lack of clarity in the coding of data: for example under ‘obstacles’ there are redundant categories.

WORK FOUNDATION

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