



**EVALUATION OF THE VOCATIONAL REHABILITATION SERVICE PILOT:
FINAL REPORT**

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SUMMARY

There is increasing evidence of positive links between good work and health. As a consequence, national and local policy in Scotland endorses work as an outcome for health services. Health services therefore have a role in helping people remain in work, return to work from sickness absence or enter the labour market if they have been out of work. **Vocational rehabilitation** (VR) defined as ‘*a process that enables people with functional, psychological, developmental, cognitive and emotional impairments to overcome barriers to accessing, maintaining or returning to employment or other useful occupation*’ can provide a clear focus and framework for work focused interventions in health settings.

The **Vocational Rehabilitation Service** (VR Service) was a pilot service which provided VR support for people with cancer, Multiple Sclerosis (MS) and inflammatory bowel disease (IBD). It was delivered between June 2011 to July 2014 by NHSGG&C and external partner agencies including Macmillan Cancer Support, Glasgow City Council, NHS Healthy Working Lives Greater Glasgow and Clyde and the Scottish Government.

The Service had a target of engaging 160 clients by the end of July, 2013. At the end of the pilot data collection period (June, 2011 to 19 May 2014):

- 303 people had used the VR service;
- 260 had been discharged;
- 43 clients were still receiving support.

This is almost double the numbers of clients which had been expected. The main referral sources were the NHS and self referrals. Self referrals were signposted from a range of sources including health professionals. The case managers were successful in raising awareness of the service and encouraging health professionals to refer and signpost.

The VR Service was evaluated positively by clients and referrers. This report presents the key findings from the evaluation of the Service.

Key Features of the Service Model

The service model offered:

- A **tiered case management process** with 3 Tiers
 - Tier 1 can be described as self help and was offered to all acute patients of working age with cancer, MS or IBD.
 - Tier 2 offered moderate support which could involve giving information about how to manage health conditions at work, providing a positive message about work and signposting/referrals to other services if additional support was needed.
 - Tier 3 offered specialist and intensive support using a bio-psycho-social model.
- **Specialist** support with a strong focus on clients’ work needs delivered by case managers who are vocational rehabilitation specialists;
- **Client led** support;
- **Open access** with referrals accepted from a wide range of sources;
- **Links to other services** to facilitate **referral** and **signposting**.

Case Management Interventions

The specialist support offered to clients involved:

- Detailed assessment of work skills and capacity, job requirements and demands, work environment and social support systems.
- Prioritising key issues and setting short term and long term goals.
- Problem solving.
- Supporting work preparedness and work readiness activities - building confidence.
- Strategies for managing particular health problems in the workplace.
- Negotiating a phased return to work, not just in hours but also tasks and responsibilities.
- Psychological interventions including coaching and other interventions underpinned by a range of CBT principled activities.
- Information and advice on disclosing diagnosis to managers and colleagues – legal rights and responsibilities.
- Referral or signposting to support services including careers advice and guidance.
- Liaison with employers including visiting work sites.
- Modifications to the work environment.
- Supporting withdrawal from work.

Client Views of the VR Service

Interviews with clients indicated several felt isolated and had no access to support around work before they joined the Service. Nearly half (45%) were off work sick and looking for support to get back to work. The next most important reason for engaging the service was help to remain at work. Just under a quarter of clients were looking for this kind of support. Smaller numbers of people were looking for support around changing job and giving up work.

The case management service was evaluated very positively by clients. The main aspect valued by clients was the specialist knowledge and support of the case managers. Clients also valued the Service's accessibility and flexibility focus on progression, and client led delivery.

Outcomes

The evaluation showed that the Service was associated with a range of outcomes including improvements in health. The EQOL5D was used to measure this. There were improvements across all domains with the biggest increases in the numbers with 'no problems' in the domains of self care, ability to take part in usual activities, pain and discomfort and depression and anxiety. It should be remembered that these clients have severe and enduring health conditions and any positive shift is important.

The Hospital Anxiety and Depression Scale (HADS) was used to measure two aspects of psychological health relevant to patients, anxiety and depression. There were declines in anxiety and depression between joining and discharge.

The Service was also associated with an increase in the numbers of people in work and reduction in the numbers off sick. These work outcomes were sustained as a follow up survey of 6 months after clients were discharged showed 92% of people who were in work when discharged were still in work. Some clients who were not at work when they were discharged had also returned to work so that the overall proportion of those in work at discharge has increased from 66% to 90%.

The Service worked effectively with clients with complex needs who face more barriers to returning to work including those living in the most deprived areas and in lower paid occupations.

Cost Benefit Analysis

The financial benefits which can be attributed to the pilot were substantial relative to the cost of delivering. In excess of £6 in benefits were realised for every £ spent within the 3 year pilot period. Benefits include evidence of significant savings in terms of Health Service usage and benefits to the national Exchequer through reduced welfare payments and increased tax and national insurance revenue.

The pilot also delivered a range of difficult to value benefits, including higher levels of satisfaction with health services and increases in self management.

In a roll out scenario, there is the potential to lower the unit cost of delivering the VR Service as the systems are already set up, referral arrangements are in place and capacity building work would be reduced.

Conclusions

Aspects of the service delivery which contributed to the outcomes are the following:

- Intensive **case management** which was a critical element of the VR Service and contributed to the achievement of outcomes for clients with complex needs.
- The **types of interventions** developed by the case managers which were effective and included increasing clients' confidence about returning to work; developing strategies to help clients to cope better at work and reduce stress; improving self management; and negotiating with employers to make workplaces more accommodating for clients.
- The **good relationships with referrers** (both external to the NHS and within acute services) assisted in the delivery of holistic support to clients as well as helping to reach clients who could benefit from the VR Service.
- **The way the service was delivered.** The best evidence of this is the clients' views which were very positive. The positive aspects of the service included the professional and knowledgeable approach of the case managers; the way the service was person centred and offered continuity of care and the proactive way the case managers sought help and support for clients. Nearly two thirds of clients (85%) felt the service had a positive impact on their work situation (with 66% agreeing strongly that it had).

Recommendations

1. The VR Service pilot has tested an approach which has provided vocational rehabilitation to three client groups which have had access to little work related support in NHS GG&C until now. The case management service model appears to have worked well, its key features should be retained and it should be used as the basis for any future provision. The referral pathways and the service model have worked well for three conditions already and could be used to assist people with other conditions.
2. Case management is critical to delivering success, particularly for people with more challenges and complex needs. It should remain a core part of the Service. The Service should focus on people with more complex needs as this is where it has potential to add most value.
3. The pilot has collected a range of evidence about outcomes, but the measurement of some of these aspects needs to be strengthened going

forward. Changes in work status are critical and can be measured fairly easily. The pilot is also associated with changes in health status and health service use and increased ability to self manage all of which is important to health services. The evidence base for these could be strengthened by more measurement of these aspects pre and post engagement in the service. The pilot has trialled some tools that are used in VR (including HADs, COPM and EQ-5D). A suite of measurement tools should be agreed upon and used routinely going forward.

4. This measurement should include case management outcomes. These outcomes include assessment of work skills and capacity, prioritising key issues, problem solving, supporting work preparedness, helping people develop strategies for managing health problems in the workplace, negotiating with workplaces, psychological interventions information and advice, referral and signposting, careers advice and guidance and supported withdrawal from work.
5. The Service has focused on people in work and this should continue to be the focus.
6. Good links have now been forged with referrers within acute services and the Service has a good reputation with them. These links should be maintained as there are many patients with health conditions who require work related support. Few of them are referred soon after diagnosis and links to acute services could be a good way of reaching these patients at an early stage in their illness.

1. INTRODUCTION

Vocational rehabilitation (VR), is defined as ‘a process that enables people with functional, psychological, developmental, cognitive and emotional impairments to overcome barriers to accessing, maintaining or returning to employment or other useful occupation’¹ The **Vocational Rehabilitation Service** (VR Service) was a pilot service which aimed to provide VR support for people in NHS Greater Glasgow and Clyde (NHSGG&C). It was delivered between June 2011 to July 2014 by NHSGG&C and a number of external partner agencies including Macmillan Cancer Support, Glasgow City Council, Healthy Working Lives Greater Glasgow and Clyde and the Scottish Government. The pilot assisted patients with cancer, Multiple Sclerosis (MS) and inflammatory bowel disease (IBD).

The VR Service pilot was staffed by three full-time case managers and one part-time administrator. It was managed by an Allied Health Professional (AHP) lead who had a small proportion of her time allocated to this role. Two steering groups advised on the delivery of the pilot and its evaluation.

This report is the final of 6 evaluation reports which have been produced every 6 months since the pilot began. The evaluation used a range of methods including:

- Consultation with stakeholders;
- Collection of information about clients’ characteristics and outcomes;
- Interviews with clients;
- Interviews with partner organisations and referrers;
- A staff survey and focus groups to identify the capacity building impacts; and
- A cost-benefit analysis.

This final report draws together findings from the earlier reports to present conclusions. It:

- Describes how the pilot was delivered;
- Presents the outcomes;
- Assesses what aspects of the service delivery contributed to the achievement of the outcomes; and
- Provides recommendations for the VR Service going forward.

The report is organised as follows:

- Chapter 2 provides an overview of the pilot;
- Chapter 3 presents the outcomes for clients;
- Chapter 4 assesses the costs and benefits of the Service;
- Chapter 5 presents the conclusions and recommendations.

¹ Scottish Executive (2007) *Coordinated, Integrated and Fit for Purpose: A Delivery Framework for Adult Rehabilitation in Scotland*

2. OVERVIEW OF DELIVERY OF THE VR SERVICE PILOT

Introduction

This chapter provides a brief explanation of recent policy and research developments which support the case for an increased focus on vocational rehabilitation. This provides the context in which the VR Service pilot was established. It also provides a brief description of the pilot's activities and considers how it has been delivered.

VR Policy and Research

There is increasing evidence of positive links between good work and health. As a consequence, national and local policy in Scotland endorses work as an outcome for health services.

- At a national level:
 - The *Health Works* (2009) 'Scottish Offer' calls on health services to make '*...commitment to include work outcomes as part of the patient recovery plan...ensuring that as many people as possible enjoy the benefits to long term health and wellbeing that remaining or returning to work can provide.*'²
- At a local level:
 - The NHS Greater Glasgow and Clyde's Policy Framework Statement 2013-16 - *Employability, Financial Inclusion and Responding to the Recession* - states there are plans to develop '*rehabilitation for people to help them to return to work to fulfil the requirements of the Scottish Offer*'.

Health services therefore have a role in helping people remain in work, return to work from sickness absence or enter the labour market if they have been out of work. VR can provide a clear focus and framework for work focused interventions in health settings.

Actions to deliver the Scottish Offer have led to the establishment of good models of VR in Scotland including pilot VR services in NHS Tayside, Lanarkshire and Lothian. In recognition of the role of NHS services delivering work support, the soon to be launched Health and Work Service will be provided by the NHS in Scotland and not private providers as in England.

However, research has continued to highlight gaps in work support for people with long term conditions. For example:

- Macmillan Cancer Support argues in their latest report³ that over three-quarters of working age people with cancer are not accessing any support services linked to work. Despite the evidence of the positive links between work and health, there has been little progress on delivering effective vocational rehabilitation for people with cancer.
- Sweetland (2010)⁴ argues people with MS need support focused on work retention. However, there is a lack of specialist VR support for people and health professionals with expertise in MS can feel poorly equipped to address work related issues.

² Scottish Government (2009) *Health Works: A Review of the Scottish Government's Healthy Working Lives Strategy*

³ Macmillan (2013) *Making the Shift: Providing Specialist Work Support for People with Cancer*

⁴ Sweetland, J., (2010). *Vocational Rehabilitation for People with MS*.

- Gay *et al* (2011)⁵ highlight how people often develop IBD early in life and this can have a profound effect on educational attainment and working life. Although people could work given appropriate support, people with IBD commonly report a lack of support. Crohn's and Colitis UK have urged the NHS to increase the focus on work outcomes for people with IBD.

Therefore, although there is policy support for vocational support, delivery remains patchy.

Rationale for the VR Service Pilot

When it was set up in June, 2011 the VR Service pilot aimed to increase work support in 2 ways:

- Supporting **capacity building** with health care staff so they would be able to provide more effective support to patients around work; and
- Providing a **case management service** to patients who need specialist VR support. It is important to emphasise the focus was on patients in work and not people who were unemployed.

The pilot's capacity building activities were designed to enhance acute health professionals' understanding of health and work and how to talk to patients about this with the expectation this would lead to greater numbers of more effective discussions about work. The rationale for this was based on evidence that effective return to work depends on workplaces that are accommodating **and** healthcare that has a focus on work⁶. Healthcare that has a focus on work would embed work support in patients' pathways. Embedding means:⁷

- Health professionals have the knowledge and skills to have a discussion about work; **and**
- Such discussions being seen by health services as an essential component of the wider service offer.

Even when the pilot was set up in 2011 there was recognition that there are considerable barriers to achieving work support as an integral part of the health service offer. These include lack of time, training and management support because local managers do not see VR as part of their remit. Many of these barriers still exist in 2014.⁸

Nevertheless the capacity building aimed to address these barriers and enable health professionals to deliver **Tier 1** and **Tier 2** of the VR service model specified in Figure 1 below.

- Tier 1 can be described as self help. Support at this Tier would be offered to all acute patients of working age with cancer, MS or IBD. This Tier would be appropriate for people able to manage themselves. It would require health professionals to provide information on work and health issues and signpost them for further information or support should that be needed.
- Tier 2 is moderate support. This could involve health professionals providing information to patients about how to manage their health condition at work, providing a positive message about work and signposting/referrals to other services if additional support is needed.

⁵ Gay, M., *et al* (2011). *Crohn's, Colitis and Employment – from Career Aspirations to Reality*.

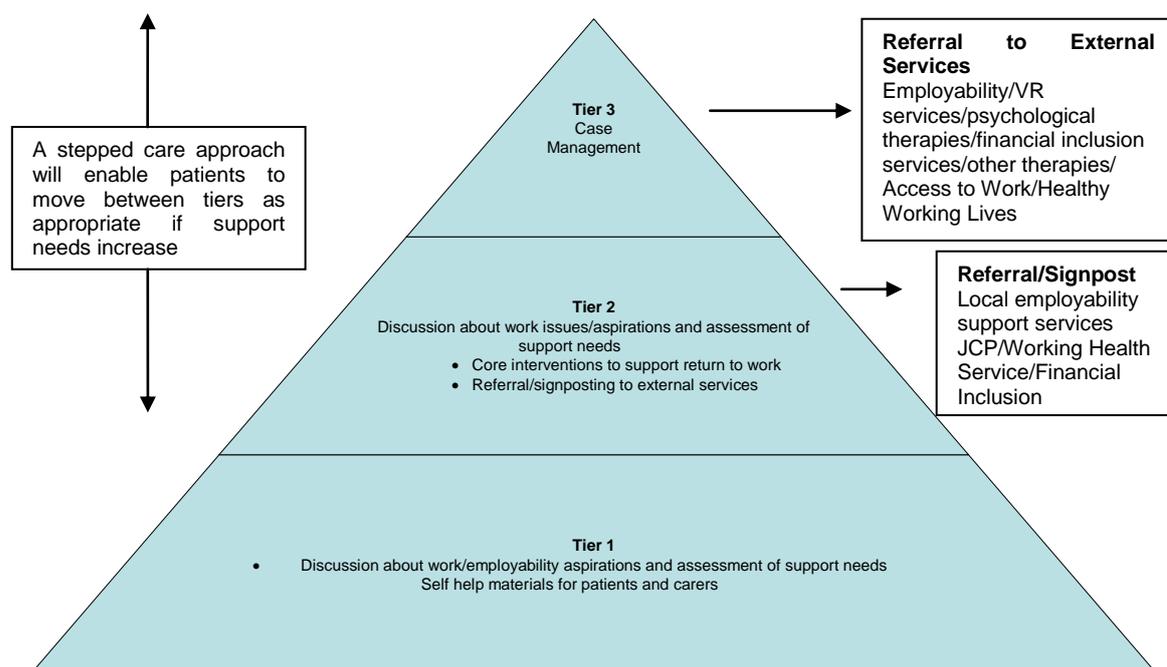
⁶ Waddell, G., Burton, A.K., and Kendall, V.R. (2008). *Vocational Rehabilitation, What Works for Whom and When?* Vocational Rehabilitation Task Group Report

⁷ Eva, G. (2012). *Thinking Positively About Work: Delivering in work support and vocational rehabilitation for people with cancer* Final Report

⁸ Feedback from interviewees with expertise in VR carried out in May, 2014.

Any issues that could not be addressed by health professionals would be referred to the pilot's **case management service**, or **Tier 3**. Case Management provides intensive and specialist case managed support using a bio-psycho-social model. It is a 'collaborative process which assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet an individual's healthcare, educational and employment needs, using communication and available resources to promote quality, effective outcomes'⁹. This approach aims to ensure greater consistency of support, which is also more holistic and integrated. This is increasingly being advocated as an essential element of VR services¹⁰.

Figure 1: Vocational Rehabilitation Service Model



Key Features of the Service Model

By having three Tiers the pilot offered a **stepped or tiered approach**. This approach, which is a key feature of the service model, starts with lighter touch interventions and progresses towards more structured interventions for those who need more support. This is cost effective and more likely to ensure better use of resources which can be limited in health services¹¹. As a range of factors can influence an individual's return to work independent of an intervention¹², not every individual will need the same level of support. Such an approach is advocated for a range of long term conditions.

⁹ Case Management Society UK quoted in Scottish Executive (2007). *Co-ordinated, Integrated and Fit for Purpose: A Delivery Framework for Adult Rehabilitation in Scotland*

¹⁰ Scottish Government (2009). *Health Works: A Review of the Scottish Government's Healthy Working Lives Strategy*

¹¹ Waddell, G, Burton, AK, and Kendall, N. (2008). *Vocational Rehabilitation, What works for whom and when?* Vocational Rehabilitation Task Force Group Report.

¹² NICE (2009). *Management of long-term sickness and incapacity for work* (PH19)

The other key features of the service model which particularly relate to the case management Tier were:

- Offering **specialist** support with a strong focus on clients' work needs delivered by case managers who are vocational rehabilitation specialists;
- **Client led** support with the particular interventions offered determined by the client's individual need;
- **Open access** with referrals accepted from a wide range of sources including self referral; and
- **Links to other services** to facilitate **referral** and **signposting** to services such as health, social care and employment services when clients need additional support for example around benefits or employability.

The model incorporated several features which are seen as components of successful VR for people with a range of long term conditions (e.g. Sweetland, 2010¹³ Crohn's and Colitis UK¹⁴, the National Cancer Survivorship Initiative¹⁵).

Revisions to the Pilot Aims

In the pilot's first year, it became clear there were major challenges to achieving the goal of health professionals delivering Tiers 1 and 2.

Prior to the VR service being set up, there had been a couple of small scale development projects undertaken to encourage Allied Health Professionals (AHP'S) to incorporate the 'Work Question' into daily practice. The areas targeted were Musculoskeletal (MSK) Physiotherapy, Cardiac Rehabilitation and Occupational Therapy. However, across the organisation 'Raising the Work Question' was not yet embedded into practice.

Initially, one of the key aims of this pilot was to build capacity around the 'Work Question' with health care staff; to allow them to provide more effective support to patients around their work issues. Very quickly, however, it was recognised that this 'bottom up' approach alone, would not succeed in embedding the assessment of work issues into the day to day clinical practice of front line staff. This recognition led to a delay in rolling out training to frontline staff in some areas of acute services and a review of the direction of the pilot.

In due course the case managers implemented a programme of awareness raising activity. Nearly 200 health professionals attended the awareness raising sessions over the first 18 months of the pilot. However, this was delivered as a 'Stand alone' training programme with a heavy reliance on front line staff being proactive in taking this aspect of assessment forward.

Clear differences across staff groups in terms of their willingness to engage in referring or signposting to the VR service began to emerge. Collection of feedback from health professionals who had been involved in the awareness raising sessions indicated that they perceived continued barriers to talking to patients about work. Although a high proportion felt work is good for health and people with long term conditions should be encouraged to stay in work or return to work if off sick, only a small number felt confident about supporting them to return to or stay in work and

¹³ Sweetland, J., (2010). *Vocational Rehabilitation for People with MS*.

¹⁴ Interview with Crohn's and Colitis UK May, 2014.

¹⁵ National Cancer Survivorship Initiative Work and Finance Workstream (2009). *Vocational Rehabilitation Strategy Paper: A Proposed Model of Vocational Rehabilitation in Cancer*

few felt they had good knowledge of information available to support patients. Other tasks tended to be given priority.

It was concluded that, for this pilot, it would be unrealistic to expect front line health professionals to do more than signpost to the VR service (i.e. deliver Tier 1). Therefore, it was decided at the end of the first year of the pilot that the case managers would take on delivery Tiers 2 and 3 any capacity raising activity would be focused on helping health professionals deliver Tier 1.

This meant the case managers no longer aimed to carry out any formal training, but focused on raising awareness of the case management service and supporting health professionals to signpost. The capacity building component of the case managers' work was reduced significantly and the focus was put on the delivery of the case management service. The key features of the model were not changed, only the responsibilities for the delivery of each Tier.

The case management service has been the focus of the pilot since the capacity building work was reduced. The remainder of this report focuses on this service.

Case Management Interventions

Before we look at the outcomes of the case management service it is useful to develop a clearer understanding of how it operated.

When a client was referred to or contacted the Service they were allocated a case manager who assessed what kind of support and level of support (i.e. Tier 2 or 3) might be needed. This case manager worked with the client throughout the time they were with the service dealing with all of the issues which might be factors affecting work. These issues vary across clients but can include:

- Their illness experience (symptoms and treatment);
- Self identity and the meaning of work;
- Family and financial contexts; and
- Work environment (including work relations with employers and colleagues and perceived performance).

The 3 case managers had health care backgrounds as well as specialist VR experience. The case managers used a bio-psycho-social approach to VR where this is defined as *'any process that enables people with functional, physical, psychological, developmental, cognitive or emotional impairments to overcome obstacles to accessing, maintaining or returning to employment or other useful occupation'*¹⁶.

They also used a person-centred and holistic approach. Wells *et al* (2010)¹⁷ capture the essence of this in relation to cancer: (in) *'... order for the individual to return to work after cancer, shifts and adjustments are required in each aspect of what is already a complex set of factors at the individual, organisational and societal level. This suggests that the most effective interventions...to improve return to work are likely to be multi-dimensional, addressing a number of component areas, while simultaneously tailored to an individual's life circumstances'* (p6). In such a context,

¹⁶ VRA Standards of Practice and Code of Ethics For Vocational Rehabilitation Practitioners (Chair Booth, D.J., VRA Doncaster 2013)

¹⁷ Wells, Dr M., Williams, Prof. B., Firnigl, Dr D., MacGillivray, Dr. S., Lang, H., Coyle, Dr. J., and Kroll, Dr T. (2010). *Returning to Work After Cancer: A qualitative meta synthesis of problems, experiences and strategies of working after cancer* Scottish Government Health Directorates Chief Scientist Office

'return to work' is not a one off event but a process in which the individual prepares for, or moves closer or engages in work.¹⁸ This provides a useful description of the case managers' approach but it did not just apply to their work with people with a cancer diagnosis. They also applied the approach to people with IBD and MS. It is important to note that although the pilot focused on these 3 long-term conditions the case managers' specialism is not in relation to a specific condition but ability to work with people with complex VR needs. Building on this Table 1 provides a description of the skills used by the case managers to support clients.

Table 1: Case Management Skills and Tasks

Key skills	Evidence
Detailed assessment of work skills and capacity, job requirements and demands /work environment and social support systems.	<i>Assessment was carried out for all clients although case managers did not assess functional capacity - If this is needed clients would generally be referred to Access to Work.</i>
Prioritising key issues and setting short term and long term goals.	<i>This was a key task with all clients. It is a very important part of rehabilitation and covers both the physical and psychological aspects.</i>
Problem solving.	<i>This could involve negotiations with unions, ACAS or other organisations for complex cases.</i>
Supporting work preparedness and work readiness activities - building confidence.	<i>This was an important task with most clients. This can be helped by encouraging people to take part in positive activities to build stamina and confidence which is transferrable into the work situation. Case managers offered ongoing support to build confidence.</i>
Strategies for managing particular health problems in the workplace.	<i>This was a common task – particularly around managing fatigue and energy conservation and there can be changes as patterns of work change. This could also include techniques to improve self management so that clients better manage their condition, treatment and overall health and well-being.</i>
Negotiating a phased return to work/ not just in hours/ also tasks/responsibilities.	<i>This was a key concern for clients. It involved supporting client to negotiate his or herself or being involved directly in the negotiations.</i>
Psychological interventions including coaching and other interventions underpinned by a range of CBT principled activities.	<i>This was also a key intervention with all clients and is a very important component in successful return to work.</i>
Info/advice on disclosing diagnosis to managers and colleagues – legal rights and responsibilities.	<i>This was also a common aspect of support and the case managers can also offer advice to employers about making reasonable adjustments under the Equality Act.</i>
Referral or signposting to support services including careers advice and guidance.	<i>Most clients were referred or signposted. A range of services are used, including positive activity, health and wellbeing, financial advice and employability. The case managers provided some support around looking for other opportunities and would also refer to SDS for this can help clients discuss the transferrable skills they may have.</i>
Liaison with employers including visiting work site.	<i>This was less common but was still needed and could involve liaison with colleagues and line managers.</i>
Modifications to the work environment.	<i>The case managers advocated around this – but did not carry out job analysis or modifications.</i>
Supported withdrawal from work.	<i>This was carried out when appropriate for specific clients.</i>

¹⁸ Chief Scientist Office (2011). *Returning to Work after Cancer: A qualitative meta-analysis of problems, experiences and strategies of working after cancer.*

The table illustrates how the case manager's role is multifaceted, involving:

- Assessing work skills and capacity, job requirements and demands and the client's social support systems;
- Prioritising key issues and setting goals;
- Helping to build confidence so that the client feels more prepared and ready for work;
- Helping clients to develop strategies for managing health conditions in the workplace;
- Negotiating a phased return to work;
- Liaison with employers and trade unions;
- Advocating around modifications to the work environment and information about reasonable adjustments;
- Psychological interventions to increase confidence and help clients to feel more positive about work issues; and
- Referring to other support services.

The role of the case manager requires expertise in a range of areas. It is a professional role and the case managers complied with a set of standards of practice and a code of ethics endorsed by the Vocational Rehabilitation Association. The case management approach was a critical element of a specialist VR Service. Further examples of how the case managers have worked are illustrated by the case studies in the Appendix.

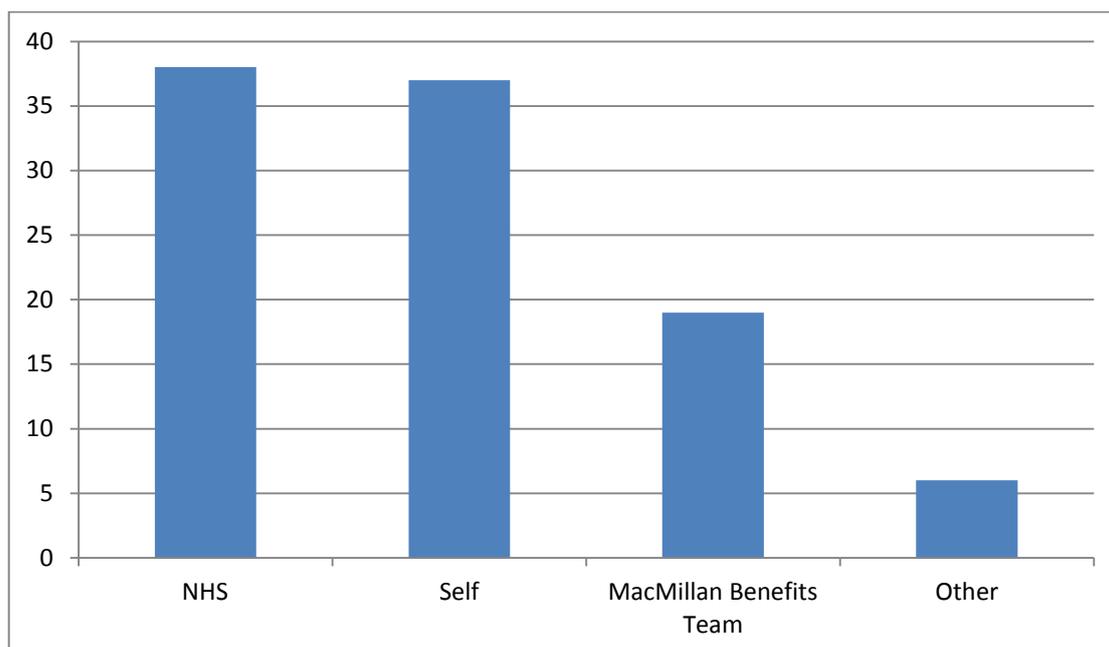
Case Management Service Outputs

This section presents what the case management service delivered during the pilot phase. Reflecting a shift away from awareness raising activity towards a greater focus on case management, the Service had a target of engaging 160 clients by the end of July, 2013. At the end of the pilot data collection period (June, 2011 to 19 May 2014):

- 303 people had used the VR service;
- 260 had been discharged;
- 43 clients were still receiving support (the majority of these have cancer, 9 people have IBD and 4 MS);

Therefore the case management service managed to assist almost double the numbers of clients which had been expected. In the later years of the pilot there were an increasing number of self referrals suggesting a strong demand for the Service. Figure 2 shows the source of referrals in more detail. The main referral sources are the NHS and self referrals. Self referrals could be signposted from a range of sources including health professionals. The fact that the main source of referrals was the NHS suggests despite the challenges encountered around capacity building at the start of the pilot the case managers were successful in raising awareness of the service and encouraging health professionals to refer and signpost.

Figure 2: VR Clients by Referral Source (%)



Source: VR Service Steering Group Report, March 2014. Sample size = 303

Client Characteristics

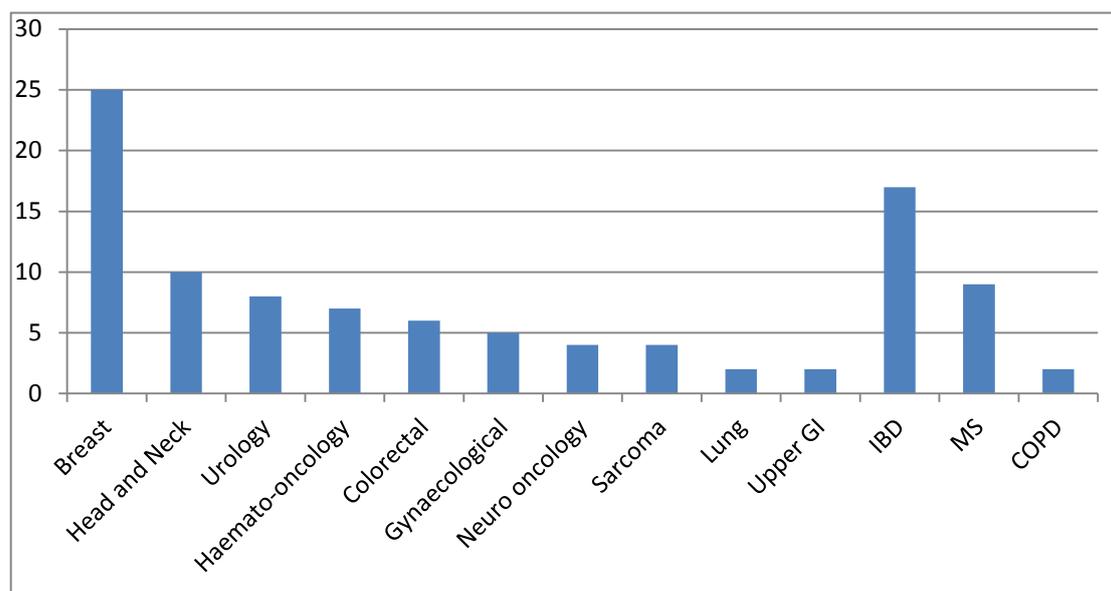
Data collected from clients showed they had the following characteristics.

- Most clients (60%) were female and 40% were male.
- The service worked across the working age group. The youngest client was 17 and the oldest 65. The mean age was 46.
- 98% of clients were white Scottish or white British.
- 80% were from within the NHSGG&C area. The other 20% were from Beatson coverage areas including NHS Ayrshire and Arran, Lanarkshire and Forth Valley.
- Nearly a third (29%) of clients lived in worst 15% of areas according to the Scottish Index of Multiple Deprivation.

The service had an initial focus on cancer and therefore the majority of clients had cancer:

- 73% had cancer;
- 17% IBD; and
- 10% MS.
- One person with chronic obstructive pulmonary disease (COPD) was also assisted at the beginning of the pilot.

Figure 3 shows the break-down of clients by long term condition in more detail. The figure shows people with a wide range of cancers have been assisted. The most common cancer diagnosis was breast cancer which accounted for a quarter of all clients.

Figure 3: Clients by Condition (%)

Note: Sample size = 303

Evaluation Data

Further assessment of the VR Service's outputs and outcomes is based on data collected for the evaluation by the case managers in the course of their work with clients. The aim was to collect data at these points on the clients' pathways:

- When they joined the service;
- When they were discharged; and
- In year 2 of the pilot at 6 months after discharge from the service.

As Tier 3 clients received a more intense intervention more data was collected for this Tier. Clients at Tier 2 received a lighter touch intervention and so the burden of data collection was also lighter for this Tier. The majority of discharged clients (194) received Tier 2 support. Fifty eight people with complex needs received case management support at Tier 3 and 8 people who did not engage were not allocated a Tier.

There are some gaps in the data as it was not possible to collect pre *and* post data for all clients due to changes in their circumstances. Nevertheless, there is enough pre and post data to make a useful assessment of the outputs in this chapter and outcomes in the next. Sample sizes are given to make the basis of the analysis clear.

Reasons for Engaging

Table 2 provides information about clients' main reason for engaging with the VR service.

- Nearly half (45%) were off work sick and looking for support to get back to work. This rose to 60% of Tier 3 clients, the majority of whom (68%) had been off work for more than 20 weeks. A review¹⁹ has highlighted that after 20 weeks absence the 'vast majority' of people do not return to work but enter the benefits system. This means almost half of the clients (and two thirds of Tier 3 clients) were vulnerable to entering the benefits system.

¹⁹ Dame Carol Black and David Frost (2011) *Health at Work: an Independent Review of Sickness Absence*

- The next most important reason for engaging was help to remain at work. Just under a quarter of clients were looking for this kind of support.
- Smaller numbers of people were looking for support around changing job and giving up work.
- The pilot also assisted people looking for employability support who were referred at an early stage of the pilot. As the focus of the pilot is people in work these clients were given lighter touch Tier 2 support.
- The case managers supported 4 clients looking for help for a family member.

Table 2: Main Reason for Engaging the VR Service by Tier

	Tier 2	Tier 3	All
	%	%	%
Help to get back to work as off sick	40	60	45
Help to remain at work	24	21	23
Employability support	21	0	16
Help to change job/occupation	9	14	10
Help to give up work	4	5	4
Help for a third party who is ill	2	0	2

Note: Sample size Tier 2 = 194; Tier 3 = 58

Table 3 shows client occupations. Clients worked in jobs at all levels of the occupational classification:

- Under a third were in managerial, or professional occupations;
- Around 17% were in intermediate skilled occupations; and
- About half of clients worked in lower skilled occupations.

Table 3: Client Occupations (Number and %)

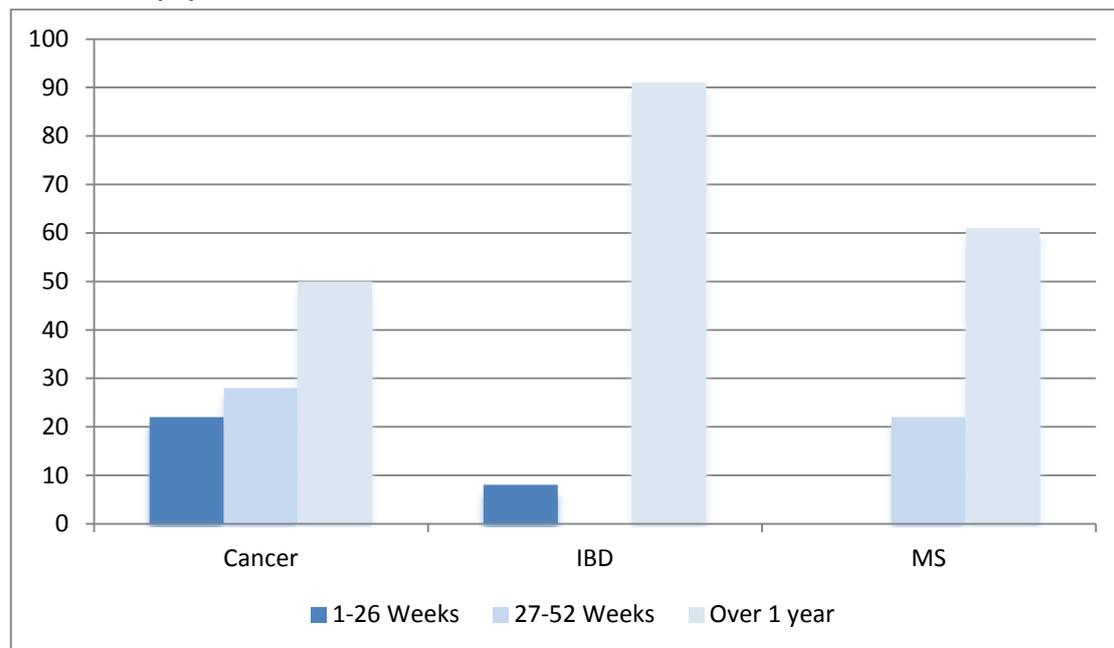
	Number	%
Managers, directors and senior officials	10	4
Professional occupations	38	16
Associate professional and technical	17	7
Administrative and secretarial	28	12
Skilled trades	12	5
Caring, leisure and other service	37	15
Sales and customer service	19	8
Process, plant and machine operatives	8	3
Elementary occupations	26	11
Unemployed	42	18
Other	2	1

Note: Sample =240. 'Other' includes student and retired

Figure 4 shows very few clients came to the service soon after diagnosis. This is particularly the case for people with IBD and MS. The majority of clients had been living with their condition for at least a year before they come to the service:

- Half of the clients with cancer had been diagnosed for over a year;
- 61% of people with MS had the condition for over a year;
- This rose to 91% of clients with IBD.

Figure 4: Time from Diagnosis to Referral to the VR Service by Long-term Condition (%)



Note: Sample = 259

This suggests that there is little work related support for people with these conditions and a need for greater attention to providing earlier intervention. Further support for this comes from interviews with the VR Service's clients which indicated several felt isolated and had no access to support around work before they joined the Service. Some examples of this are highlighted in the box below.

- One client felt the support he had had from medical staff and MS charities around work issues 'was nil – you are left to get on with it'. The case managers were 'like a breath of fresh air'.
- Another felt people with cancer are very vulnerable and need support and yet 'no-one is prepared to take their cases.'
- Another had not discussed work with any medical professionals as he felt that he should be able to handle the situation himself, but also none had raised work issues. The VR case manager was the first person he discussed work with; until then he was not even comfortable about discussing work issues with his partner. His confidence and self esteem was 'at zero level' and he felt that no one wanted to help him. He felt that he was 'no longer a person – just a number' and that people were seeing the illness as his fault.

Engagement in the VR Service

One of the key features of the service was open and quick access. There was never any waiting list for the VR service and the majority of clients were assessed within a service standard timeframe set to ensure people were seen as quickly as possible. The case managers aimed to respond to a referral within 5 days and carry out an assessment within 10 days. Assessment was client led with clients electing when they first wanted to meet a case manager. During the pilot:

- 42% of clients were assessed on the same day they contacted the service.
- Cumulatively, 73% were assessed within a week, 88% within 2 weeks and 95% within 4 weeks.
- The remaining 5% chose to delay assessment most commonly because they wanted to wait until treatment finished, but sometimes because their health deteriorated quickly and unexpectedly.

The vast majority of clients (94%) engaged fully in the service. Only 17 clients discharged from the service did not engage fully, for the following reasons.

- Eight did not engage at all. These clients could not be contacted for an assessment after being referred or did not appear for their initial appointment. This is a very low rate of 'no shows' for initial appointments.
- The other 9 withdrew early either because they did not want to take part or their circumstances changed – usually due to deterioration in health. This is also a very low withdrawal rate.

Interviews with referrers and clients suggest the factors which supported the pilot's high levels of engagement included:

- Appropriate referrals to the service;
- The service had high levels of credibility with both clients and referrers;
- The perceived quality of the service by clients – which is explored in more detail later in the report.

Client Progression

There was flexibility in the way clients were able to engage in the Service. The Service did not have a base where case managers could meet clients so they visited some clients in their homes or met them in other places.

- Around a fifth of clients preferred to meet the case manager face to face;
- Just under a third preferred phone contact; and
- The other half a combination of face to face and phone contact.

Telephone contact was therefore an important mode of delivery and received well by clients. This supports recent research on telephone contact which found patients generally felt it was a good way of delivering case management as long as there are opportunities for face to face interaction²⁰.

Within their client centred approach the case managers aimed to move clients on when they were ready. Clients had, on average, 9 contacts with their case manager. A contact is an arranged face to face or telephone appointment. As might be expected, Tier 3 clients had more contacts – the mean number of contacts for Tier 3 was 18 while for Tier 2 it was 5 (Table 4). Tier 3 clients also accounted for the larger proportion of all contacts.

Table 4: Client Contacts by Tier

	Mean number of contacts* per client	All contacts during the pilot	% of all contacts
Tier 2	5	899	45
Tier 3	18	1085	54
Third party	2	12	1

Note: * 'Contact' could involve a telephone conversation or face to face meeting or home visits.

²⁰ DWP (2013) *Telephonic support to facilitate return to work: what works, how and when?*

Sample size: Tier 2=190; Tier 3=58

Contacts were client led and took place over a number of weeks:

- 22% of clients stayed with the service for less than 4 weeks;
- 52% stayed for less than 12 weeks;
- 66% stayed for less than 16 weeks;
- A third was in contact with the service for over 16 weeks.

Throughput of clients increased over the lifetime of the pilot. The mean number of contacts fell from 10 in the first year to 8 in the second year and 6 in the third year. The Service therefore became more efficient. A number of factors contributed to this:

- Through experience, the case managers developed a clearer idea of the profile of clients and the kind of support they were likely to need;
- Case managers strengthened their understanding of 'what works';
- They established a network of contacts which they can draw on whilst still maintaining a client led service.

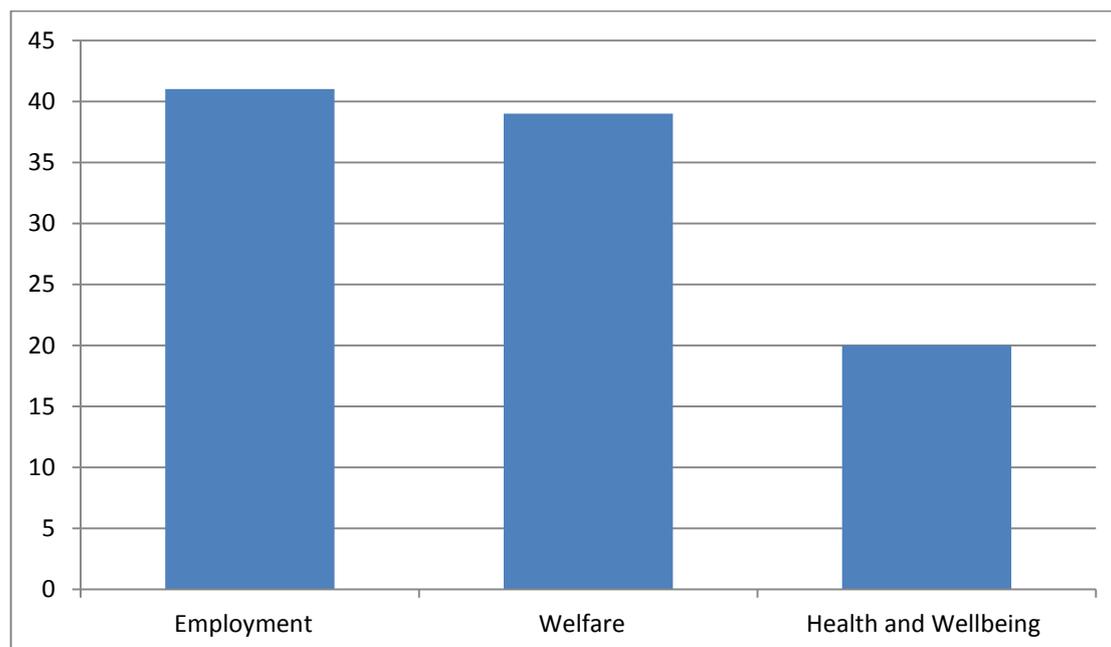
Partnership Working

Another key feature of the model was developing links with other services. The Service implemented this in two ways:

- The case managers worked with internal NHS partners and external partners to publicise the service and generate referrals and signposts;
- They also worked with partners to help clients to access additional support if this was needed.

Figure 5 shows the proportion of signposting and referrals and shows employment services (including Skills Development Scotland, disability employment advisers at Jobcentre Plus and Access to Work) were used most often. Welfare services were also used extensively followed by health and wellbeing services.

Figure 5: Referrals and Signposts (%)



Note: Figure is based on 75 referrals for 54 clients and 174 signposts for 124 clients

Client Views on Partnership Working

Clients benefited from referral and signposting in a range of ways:

- They increased awareness of other sources of support; and
- Were able to get help for other issues which were affecting their work situation.

Some examples of this are highlighted in the box below.

- A client was very concerned about what would happen when her sick pay finished after 6 months. The case manager advised her to make an appointment with a benefits adviser. Initially the client did not want to do this as she felt the adviser would not be able to help. However, the case manager was able to advise that the advisor can help people even if their circumstances change. The benefits adviser was able to make sure the client accessed Disability Living Allowance helping her financially.
- The case manager referred a client to Access to Work to help with travel to work. The client had not heard about Access to Work prior to contacting the VR service. She commented: *'nobody knows about these things'*.
- A client was put in touch with a range of services, including counselling and Look Good Feel Good which helped her improve her wellbeing.
- A client said she was offered no support around work throughout her cancer treatment and was unaware of the range of services that can offer support. The case manager was able to refer her to a range of services that helped her including a psychologist.
- A critically ill client had financial worries as he was sacked because he was unable to work and lost sick pay. The client was referred the client to the local Citizen's Advice Bureau (CAB) to look into the issue. At first the client was not happy with the adviser allocated to him and the case manager was able to advocate for another adviser to be allocated to his case. The CAB is continuing trying to resolve his pay issues but has identified an insurance policy which has provided an income so that the client's money worries have been resolved.

Benefits of Partnership Working Identified by Partners and Referrers

Nineteen referrers or partner agency representatives were interviewed for the evaluation to assess the benefits and added value of working with the VR Service.

Referrers were positive about the VR service:

- They commented the Service had a quick and easy referral process.
- Referrers felt they are not expert in some areas where patients need support such as employment law and the case managers were able to give more knowledgeable advice. This was particularly useful for complex cases who experienced more difficulties with employers.
- The case managers were also able to provide more in-depth and individual support than a Clinical Nurse Specialist (CNS) for example would be able to give a patient. Several of the referrers interviewed said they do not have the time to assist patients with work issues despite realising that there is a need for such support so it is good that they can refer to the VR Service.
- Referrers also said it is useful to have a service which understands chronic conditions and is able to see the implications of this for work support. Additionally the case management element of support was seen as very important as it ensured the people got client led and holistic support.

Referrers commented that the VR Service has encouraged them to be more proactive about discussing work issues with patients as they know that they have somewhere to refer where the patient will get good, relevant advice. Referrers felt more confident as they have somewhere to refer. *'Since the VR has come along I feel a lot more confident about responding as I feel I have somewhere to refer'* (IBD CNS).

Some referrers commented that a benefit is helping patients resolve issues related to work can help reduce stress related to work which can have a positive impact on the patient's attendance for treatment. One referrer described a specific example of this where the case manager had helped a client to negotiate time off for treatment. Another, working with young adults commented: *'when employment issues are a big stress this can have a massive impact on how patients cope with treatment. Therefore it is good to have somewhere to refer to have these issues dealt with.'*

A CNS working with IBD patients also commented that symptoms can be exacerbated by personal problems therefore it is important that these are addressed as part of care: *'before the VR Service there was not a lot we could do – now we can refer if the patient raises the issue of work'*. This adds to the *'toolkit'* referrers can use.

Referrers have also used resources provided by the case managers (such as leaflets and DVDs) with patients and have found them very useful.

External Partners

Case managers have also worked with a range of other external services to both refer clients to for support and as a source of referrals to the VR Service. All partner agencies interviewed said this had worked well and that good working relationships have been established. Working together in this way supplies benefits for both the VR Service and partners including:

- Access to specialist support for clients;
- On-going support if things change once the client is back at work;
- Complementing other services – for example the case managers are able to offer all round support to clients while partners can offer specific support on issues like benefits. Overall this leads to more effective support for clients.

Client Views of the VR Service

The above shows that the case management service met its targets and achieved a range of outputs. It is important to assess not just what was delivered but also the quality of the delivery. Client feedback is a critical source of this information. The evaluation used two ways to collect this.

- Twenty-four clients (mainly from Tier 3) were interviewed.
- A postal satisfaction survey given to clients on discharge.

The key findings from the client feedback are given below.

Client Interviews

The client interviews provided a very positive view of the VR Service. All clients placed high value on the Service and highlighted these aspects as important.

- Case managers responded quickly to clients and were proactive about keeping in touch on a regular basis throughout their involvement with the service.
- Case managers quickly developed a good understanding of the context for the referral and planned an appropriate, timely response – they delivered.
- They had strong knowledge and experience of health and work issues and were not fazed by any situations they encountered. They had specialist abilities and skills needed to tackle problems.
- Clients had a lot of confidence in the case managers' abilities to influence their situation and change things for the better.

- They were often the only people clients felt they could talk to about work. Clients felt they could be very honest with the case managers as they had no 'agenda' and worked with the client to get the best solution for the client.
- The case managers offered 'back-up' and someone to fight on clients' behalf.
- The case managers helped clients consider all options.
- The case managers were very understanding and good listeners.

Satisfaction Survey

The satisfaction survey of discharged clients had 74 returns.

- More than three quarters of respondents (80%) rated the service 'excellent' while a further 19% rated it 'good'.
- 78% rated the service as 'very helpful' with another 19% rating it 'helpful'.
- It is also clear clients felt involved in the service as 81% felt 'very involved'.
- Nearly two thirds of clients (85%) felt the service had a positive impact on their work situation (66% agreed strongly that it had).

The clients' comments on the satisfaction survey highlight the positive aspects of the service as:

- Professional and knowledgeable approach of the case managers;
- Person centred approach;
- Continuity – with clients having the same case manager throughout;
- The proactive way the case managers sought help and support for clients.

All would recommend the Service to other people and all would use it again. Only a small number of people commented about improvements to the service with the main thrust around the need to make information about it more widely available and to publicise it more.

Some comments from the client satisfaction survey are shown in the box below.

- *I felt I was listened to. I was given empathy and support at all times in a positive constructive way.*
- *Regular excellent support. Received information and leaflets about all services available to me and my family. Case manager was very knowledgeable of services.*
- *The support I received helped me work through some complex work issues.*
- *I have built a very good relationship with my case manager and opened up my true feelings and fears about my illness. She treated me with dignity and respect at all times. I was very much involved in the planning of my return to work and this was a positive experience.*
- *I was fully involved in the process and open/honest communication was a key part of how the service operated.*

Key Points

1. The VR Service Pilot was set up to deliver capacity building to help health professionals deliver work support more effectively and to test a case management service.
2. The experience has shown that there are several barriers to non-specialist staff delivering work support but that having a specialist service can make health professionals more proactive about referring and signposting to that service.
3. The case management service model's key features included a tiered approach, case management, open access, flexible delivery and links to other services.
4. Good partnerships with services which can provide additional welfare, employability and health and wellbeing services should they be needed by

clients were established to help clients with any additional issues related to work.

5. Referrers had a positive view of the VR Service and felt it adds value to their work with patients.
6. The case management service was evaluated very positively by clients. The main aspect of delivery valued by clients was the specialist knowledge and support of the case managers. Feedback also indicated the Service's accessibility and flexibility, focus on progression, and client led delivery were valued. The only improvement suggested by clients was the need to make information about the service more widely available and to publicise it more.

3. CASE MANAGEMENT OUTCOMES

Introduction

As a service focused on helping clients return to work or remain in work, work outcomes are a key measure of effectiveness for the VR Service. Getting clients back into work from sickness absence or preventing them losing their job can help clients avoid negative impacts on financial security, independence, social inclusion, general health and wellbeing and confidence and self esteem. Other negative labour market outcomes such as under-employment or job instability²¹ can also be reduced.

There are additional important outcomes for a VR service. The case studies in the appendix show examples of these and include:

- Increased awareness of health and work issues which help clients to make more informed decisions about work;
- Improvements in self – management;
- Improvements in self-confidence and positive feelings about work;
- Increased contact with employers and better support to work places that can, in turn, improve clients' work situations;
- Improvements in health; and
- Supported withdrawal from work if this is appropriate for some clients.

It is important to consider this range of outcomes when assessing the case management service.

It is also important when assessing any VR service to remember there are factors which are difficult for any service to impact on. For example, the extent to which return to work can be sustained may be affected by further sickness. A systematic literature review which looked at employment in cancer survivors²² found factors associated with greater likelihood of being employed or return to work were:

- *Work related factors*: including perceived employer accommodation, flexible working arrangements, counselling, training and rehabilitation services;
- *Demographic factors*: including younger age and cancer sites of younger individuals, higher levels of education and male gender; and
- *Cancer and treatment related factors*: less physical symptoms, lower length of sick leave and continuity of care.

While a VR Service can influence work related factors the others may be more difficult to influence. The overview of client characteristics presented above showed the VR service worked with more females and the biggest proportion were on long term sick leave and in lower skilled jobs. Consequently many faced significant challenges related to moving back into work. It is against this background that the Service's work outcomes need to be assessed.

Work Outcomes

Table 5 shows the changes in work status for all clients apart from carers who used the service for support for a third party, and shows the VR service:

- Was associated with an increase in the numbers of people in work - 66 were in work when they joined and this rose to 107 at discharge.

²¹ Amir, Z., Moran, T., Walsh, L., Iddenden, R and Luker, K. (2007) 'Return to Paid Work After Cancer: A British Experience' *Journal of Cancer Survivorship* 1;129-136

²² Mehnert, A., (2011) 'Employment and Work-Related Issues in Cancer Survivors' *Critical Reviews in Oncology/Haematology* 77 pp 109-130

- Was associated with a reduction in the numbers off sick - 139 clients were off sick when they joined and this fell to 62.
- Helped some people who have not been able to get back to work or sustain work attain some other positive outcomes, such as becoming self employed, entering education or volunteering.

Table 5: Work Status Pre VR and at Discharge (Number and %)

	Pre VR		Discharge	
	<i>Number</i>	<i>%</i>	<i>Number</i>	<i>%</i>
At work	66	26	107	42
Off sick	139	54	62	24
Unemployed	49	19	45	18
Not known	1	0.3	20	8
Retired	1	0.3	15	6
Full or part time education	1	0.3	3	1
Volunteering	0	0	3	1
Deceased	0	0	2	1

Note: Sample size = 257. 'At work' includes 3 self employed

Table 6 shows the outcomes in more detail according to the client's status when they joined the VR service. The table shows the different outcomes for clients depending on their starting point.

- 66 people were at work but at risk of losing their job or going off sick when they joined. 50 were still at work when they were discharged.
- 139 people were off sick when they joined and the VR Service assisted 53 to return to work.
- The Service also helped 4 people who were not at work when they joined to enter the labour market.

Table 6: Discharge Status by Pre VR Status

Pre VR		At Discharge	
At work	66	At work	50
		Off sick	8
		Unemployed	1
		Retired	2
		Not known	5
Off sick	139	Off sick	53
		At work	53
		Unemployed	8
		Retired	11
		In education	1
		Volunteering	2
		Deceased	2
		Not known	9
Unemployed/not at work	52	Retired	1
		At work	4
		Unemployed	36
		Off sick	1
		Volunteering	1
		In education	2
		Not known	6

Note: Sample size = 257. 'At work' includes 3 self employed

Table 7 shows the differences in outcomes by Tier. Tier 3 is associated with a much larger proportional shift into work than Tier 2, particularly for people who were off sick when they joined the VR service. This shows how positive outcomes can be achieved for people with complex needs and the important contribution case management can make to the outcomes.

Table 7: Client Work Status Pre VR to Discharge by Tier

	Tier 2		Tier 3	
	<i>Pre VR</i>	<i>Discharge</i>	<i>Pre VR</i>	<i>Discharge</i>
	%	%	%	%
At work	28	38	22	53
Off sick	46	27	78	14
Unemployed	25	20	0	13
Student	0.5	2	0	0
Self employed	0	0.5	0	3
Retired	0.5	3	0	14
Volunteering	0	0.5	0	3
Deceased	0	1	0	0
Not known	0	6	0	0

Note: Tier 2: Sample size=190; Tier 3 Sample size =58

Table 8 shows the changes in work status by whether clients live in the worst 15% of data zones determined by the SIMD. The VR Service is achieving comparable outcomes for all clients despite their level of deprivation. Although the number from the most deprived areas in work is smaller there has been a bigger proportional shift into work for this group. The shifts are similar for both groups for shifts from sickness absence into work. Again, the service is making an impact on a group likely to face more challenges. This is important as one study found low socio-economic position is a risk factor for a decline in employment for people following cancer²³.

Table 8: Client Work Status Pre VR to Discharge by Deprivation

	Worst 15%		Not in Worst 15%	
	<i>Pre VR</i>	<i>Discharge</i>	<i>Pre VR</i>	<i>Discharge</i>
	%	%	%	%
At work	16	28	29	52
Off sick	55	28	54	26
Unemployed	29	33	16	15
Other	0	11	1	7

Note: Sample size =259

²³ Torp, S., Neilsen, R.A; Fossa, S.D., Gudbergsson, S.B., and Dahl, A.A. (2012) 'Change In Employment of 5 –Year Cancer Survivors' *European Journal of Public Health* Volume 23 Issue 1 pp 116-122

Table 9 shows the outcomes by long term condition. The figure shows at discharge:

- People with IBD were most likely to be at work followed by people with MS and then cancer;
- People with cancer were more likely to be off sick followed by people with IBD and then people with MS.

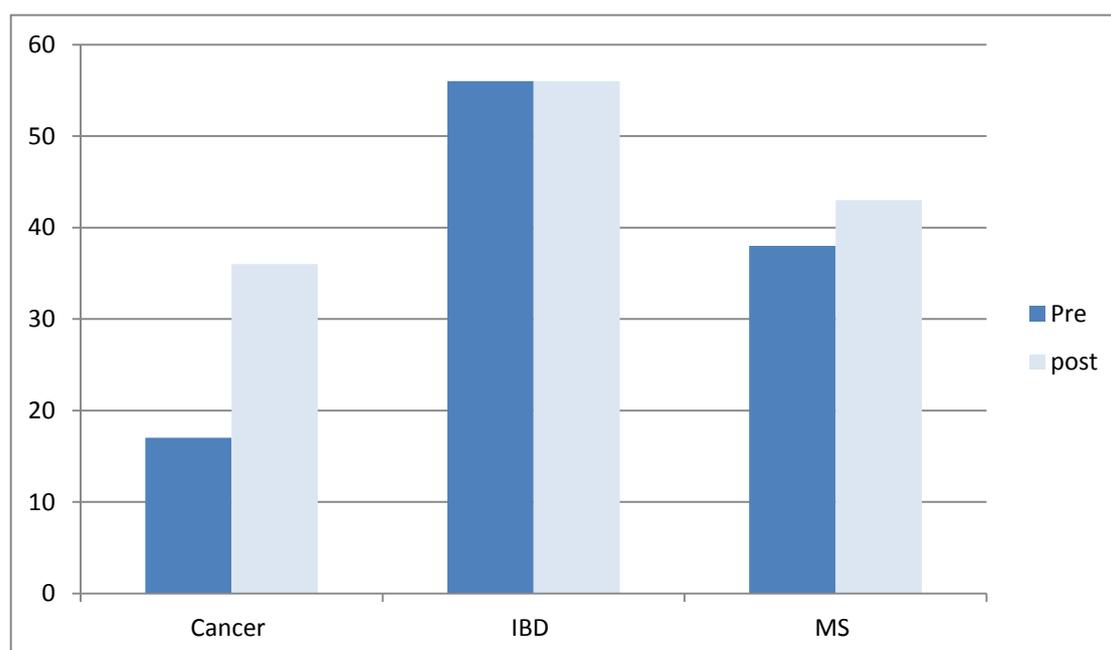
Table 9: Client Work Outcomes by Condition

	Cancer	IBD	MS	All clients
	%	%	%	%
At work	36	56	43	40
Off sick	28	13	10	24
Unemployed	16	22	14	17
Retired	6	2	14	6
Other	6	2	5	5
Not known	8	4	14	8
	100	100	100	100

Note: sample size =259

However, it is important to look at the shifts from joining to discharge *within* these long term condition groups. Figure 6 shows the changes for people who were at work when they joined the VR service. Low numbers of clients with cancer were at work when they joined. However, there were large proportional changes in the numbers moving into work for people with cancer compared to people with IBD and MS. More people with IBD were at work, so the Service helped keep these people at work.

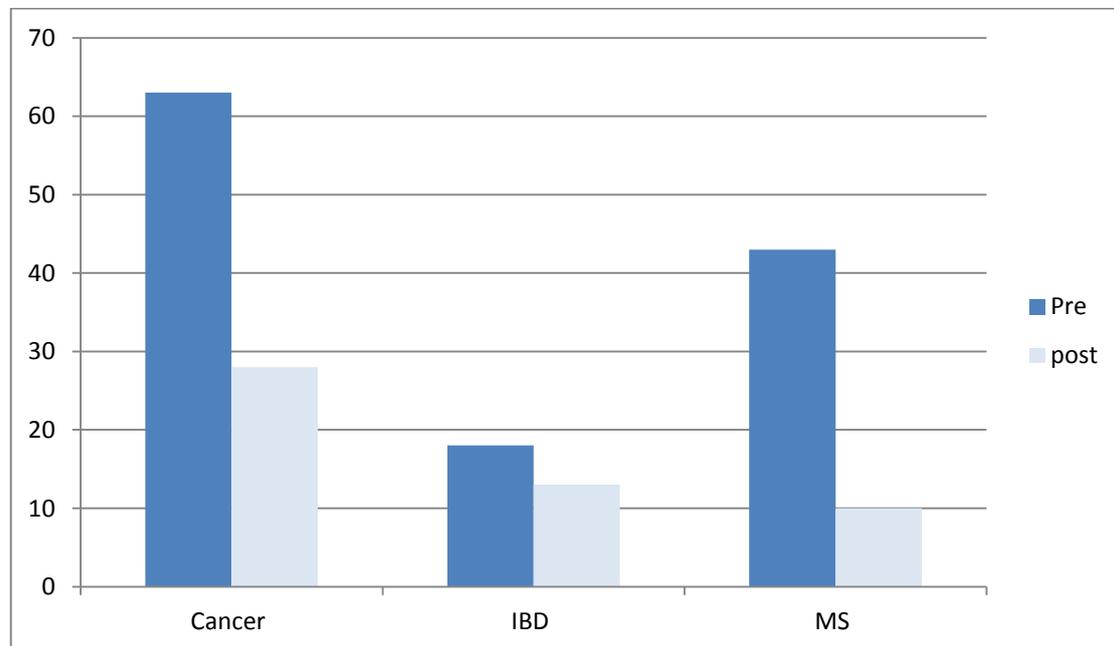
Figure 6: Clients at Work Pre VR to Discharge (%)



Note: sample size =259

Figure 7 shows the changes for people who were off sick. Here there are large declines in the proportion of people with cancer and MS who are sick compared to people with IBD because most of the IBD clients were in work when they joined.

Figure 7: Clients Off Sick Pre VR to Discharge (%)



Note: sample size =259

The figures show clients with different conditions had different support needs and the VR Service was able to meet these. The case managers were able to manage changeable aspects of the clients' different long term conditions.

Sustainability of Work Outcomes

A follow up postal survey of clients discharged from the service for 6 months has been carried out and there have been 30 returns to date. Although the numbers are small at this point the returns indicate Work outcomes are sustained:

- 20 people were in work when they were discharged and 92% of these were still in work at 6 months. Some clients who were not at work when they were discharged have also returned to work so that the overall proportion of those in work at discharge has increased from 66% to 90%.
- Two people entered full time education and volunteering when they were discharged and these have also sustained these outcomes.
- One person is off sick and 3 people have retired on medical grounds.

Case Management Interventions to Support Work Outcomes

The above shows the VR Service achieved work outcomes. This section presents information from the client interviews about **how** these outcomes are achieved. Waddell and Burton (2008) argue return from sickness absence depends on support from health services **and** workplaces that are accommodating. In this section we describe how the case managers intervened and influenced workplaces. Extracts from client interviews are used to illustrate the interventions.

Increasing Confidence about Return to Work

Nearly half of the clients were off work when they joined the Service and 68% of these had been off for more than 20 weeks. It can be daunting for clients who have been off work for some time to think about returning to work, so an important aspect of support is helping clients to become more prepared to return to work. Clients reported that intervention from the case managers increased their confidence about returning to work and this was a key to their return as it helped the return to work to be more successful and contributed to helping people sustain work.

The clients reported it was very useful to talk through the issues with the case managers. The case managers were perceived to have strong understanding of the issues and experience of responding to similar problems. This was very reassuring to clients as the examples in the box below show.

- This client's employer was very obstructive about her return to work. The case manager explained that the employer's response was not uncommon and this reassured the client. It was particularly useful to be able to talk to someone who understood such a context.
- Although this client had a good support network, she felt she had no one to talk to about work issues. The case manager helped the client work through her feelings about returning to work and to come up with a plan of action. This stopped the client quitting because she felt it was her only option.

There is some evidence of positive changes in clients' confidence about working. The Canadian Occupational Performance Measure (COPM) measures ability to perform occupational tasks. A higher score indicates greater levels of occupational capability and satisfaction. Pre and post VR measures have been taken for 6 Tier 3 clients and are shown in Table 10. The mean scores increased significantly (a change of 2 points or greater is seen as a significant improvement)²⁴ from joining to discharge.

Table 10: COPM Scores Pre VR to Discharge

	Pre	Post
Performance	4.9	7.0
Satisfaction	5.7	9.3

Note: Sample size = 6

Planning to Return to Work

Once the decision to return was made the case managers helped clients develop strategies to cope better at work to increase the likelihood that return to work would be sustained. Clients often anticipated problems before return and it was helpful to talk these through with a case manager. The examples below show this kind of intervention in practice.

²⁴ Canadian Occupational Performance Measure website:
<http://www.caot.ca/copm/questions.html> accessed January 2014

- A client referred herself soon after she had a cancer diagnosis. She had been on sickness absence for a month, but did not know how long she would need to be off. She regarded getting back to work as essential as she could not afford to not to work. Her consultant was supportive about returning to work after treatment, but did not give her any specific advice. The client felt she could benefit from speaking to someone who could help her to prepare for any problems which could emerge given the unpredictable nature of the illness and treatment. She felt such support would provide her with 'back up' should she have any problems. The client was able to discuss her feelings about being absent from work with the case manager. She had never been absent before for any significant length of time and felt during the 7 months she was off she was in 'limbo'. This was disorientating and had an impact on her ability to plan and look after herself. Over the next few weeks the support from the case manager helped to restore the client's ability to self manage. *'The discussions showed me that I did not have to play a sick role and that I would get back to work. At that time that was a very positive message'*. For this client this was the most valuable aspect of the service.
- A client was starting to feel 'guilty' about not being back at work, but at the same time was not feeling "100% ready" when she was referred to the VR Service. The client had always worked and was feeling guilty about being on benefits. She was worried about people's perceptions and that some might think she was 'skiving'. However there was no pressure from the client's workplace to get back to work. The client had had a very busy and stressful job and was worried about how the side effects she was experiencing as a result of treatment would impact on her capability at work. Her confidence was very low. The client found it very useful to talk through her feelings about work with the case manager. She was relieved that her feelings about work were part of the 'normal experience of cancer'. The case manager talked through her options the option the client wanted to pursue. The case manager also offered to liaise with the client's employer to discuss making adjustments so that the client was better able to manage the side effects which might impact on work. The case manager also helped the client to manage the anxiety the client had about work.

Preparing for Return

Once clients returned from work from sickness absence there were a number of factors that helped to make the return more likely to be successful and sustained. These included:

- Making sure the client's job was suitable;
- Ensuring the hours were manageable;
- Making sure the client was able to manage the effects of their condition at work.

Adjustment of these factors also helped clients who were worried about going off sick to remain in work. The case managers worked on these issues in a range of ways as the information from the interviews below shows.

Work adjustment helped make sure the job was suitable. This helped with return to work, sustained return and keeping people in who were at risk of going off sick at work. Interventions involved negotiating a different, perhaps less demanding role, or reduction in hours. This could be on a temporary or longer-term basis.

A client was referred to the VR Service just as she finished chemotherapy and due to start radiotherapy. She had been off work during chemotherapy and knew that she would not be able to return until after radiotherapy which would mean that she would have been off work for nearly a year. This was mainly because she had a physically demanding job and would not be able to perform this job during treatment. The client was not sure whether she would ever be able to return to this job but the chances of redeployment into a post at the same grade within her department seemed slim. Additionally, she had been absent through illness prior to her cancer diagnosis which had resulted in being disciplined. She was worried that her absence through cancer would escalate the disciplinary process and that she could lose her job. The client met with the case manager on a regular basis. The focus was on identifying redeployment options and planning a phased return to work. This involved talking through the client's feelings about returning to work and attending meetings with HR to discuss options. This was a great help to the client as although she was often able to answer questions fully this was not always the case and the case manager could step in when she felt '*her head was everywhere*' to help her put her case across in a clear way. The case manager also helped the client to understand her rights at work. The client was redeployed in a desk based job at the same pay grade she had been on prior to getting cancer. She has been back at work for 6 months and is hopeful that her redeployment will become permanent soon. The client feels this job is very suitable and she enjoys it. She feels if she had not been redeployed she might have returned to work but then would have likely had to go on sick leave and eventually would have retired due to ill health.

Phased return was helpful in ensuring hours were manageable and therefore supported sustained return. In many cases this worked smoothly, but in cases where there were issues the case manager ensured the issues were addressed.

An example is shown in the case study box below.

A client's employers were offering to support a phased return to work but they were not able to offer the client guidance about how to do this and were looking for the client to plan this herself. The client felt she did not have enough knowledge to plan this herself and so approached the VR service for support. The case manager worked with the client to develop a realistic phased return. These discussions helped the client realise she might need a longer phased return than she had anticipated and to consider the financial implications of the phased return and how she would manage on reduced wages during this time. The case manager helped the client develop a written phased return plan which was then given to the employers to help them to manage the return.

For most clients a range of strategies needed to be used. The example below shows this clearly.

When a client joined the VR Service she had been back at work for around 3 months after being off for 9 months recovering from surgery. She had initially returned on a phased basis and her workplace had been supportive during this time. However, when she returned to her full time hours which involved 12 hour shifts she felt she began to struggle and the side effects of her treatment and illness were presenting several challenges. Her workplace was no longer supportive. She felt they were not treating her fairly and taking no account of the effects of her illness. This had led to some confrontations with her line manager and was making her feel very depressed: *'I felt I was in hell on earth'*. The client was aware that cancer can have a profound effect on people *'I wasn't the same person as I was before cancer (and) I had worries about cancer coming back'*. However she felt her employer was unable to appreciate the effects of these changes and indeed was not willing to listen to the her views about work. The client wanted re-deployment but her employer was not willing to consider this. The negotiations were very drawn out as the client's HR department and line manager did not want to support redeployment. However, the case manager supported the client throughout the process. This included visits to the client's home as well as talking on the phone. The client really appreciated this as she felt she had no other support. Initially the client wanted to be redeployed at the same place she had always worked but the case manager helped her to look at other options including moving to another location. The client felt the case managers have *'a different insight and broader view of what I could or couldn't do'* and this helped her to consider other possibilities. Eventually the client moved to another job in a different location where the tasks and workload are more suitable for her condition. Throughout the process the case manager offered *'great support'*. The client feels that her current work situation, although not ideal is better than the one she was in when she first returned to work. She enjoys her job and is less tired so she has *'work/life balance'*.

Making Workplaces More Accommodating

An important aspect of case management was working with employers to make workplaces more accommodating for clients. The VR Service focused support to clients who were having difficulties with their employers. Client experiences indicated some employers were not supportive of employees' efforts to get back to work and could be unwilling to make reasonable adjustments or facilitate phased returns. The case study below is an example of how the case managers overcame this problem.

A client was looking to return to work after being absent for 11 months with shoulder pain. The client's job involved some heavy duties and she had requested these be changed to lighter ones until she recovered. However, her line manager said redeployment would only be possible for 12 weeks and if she was not able to go back to her normal duties after this time then she would be dismissed. The client wanted to get back to work because she felt it would be beneficial for her – she would be able to put cancer to *'the back of her mind'* and get back into a *'normal routine'*. However, she was not sure that she would be better within 12 weeks and was worried about losing her job. The case manager supported the client during a period of negotiation with her employer, accompanying the client to these meetings. This not only helped the client feel *'she had a person on her side'* but helped ensure she was able to get her point across to the employer: *'the people don't know what language to use but the case managers do'*. The negotiations were protracted as the employer sometimes agreed to something in a meeting and then changed his mind. The case manager was able to remind him what had been agreed at previous meetings. Initially, the employer offered lighter duties but on a different shift which would not have fitted in with the client's childcare arrangements. Through negotiation, however, the client was eventually offered lighter duties on her old shift. The client is now working the same hours as she did prior to getting cancer.

Further examples of how the case managers influenced employers are given below.

- A client was worried about approaching her employer about returning to work as she felt that she would be unable to cope with her job as it involved a lot of heavy work and she would need lighter duties. She felt her employer would be unwilling to consider such a change of duties and she was at risk of losing her job despite 14 years service. The client did not feel she could deal with this situation on her own and needed support. With the support of the case manager they client found out that although the employer was willing to continue to employ the client and alter her duties and hours, this would involve terminating the client's existing contract with immediate effect and providing her with a new one. This would break her service and reduce her employment rights. The case manager supported the client during negotiations with her employer. Initially, the client was very anxious about meeting the employer and it was helpful to have the case manager accompany her to the meetings. The case manager also involved ACAS in the client's case. Through ACAS she found out she was entitled to a 3-month notice period. ACAS felt the client should fight the decision to terminate the contract, but the client did not want to do this and was happy enough to get three months wages for the notice period. She accepted the new contract and is now working part time doing lighter duties.
- A client's workplace was unwilling to make any adjustments to make her return easier. She had been given a very difficult and stressful task which would have been difficult for anyone to cope with, never mind someone who was returning after having cancer. Her boss argued the only way to remove this task was to reduce he hours on a permanent basis. The client was unwilling to do this as this would mean a loss of one third of her pay. The client's union was involved in her case but it was taking a very long time to resolve the issue. This was taking a heavy toll on the client's wellbeing. Although she had initially felt strong, she was feeling increasingly vulnerable when she contacted the service. The case manager supported the client during the process of taking out a grievance with her employer alongside the union representative. The case manager was able to highlight how the length of time that this was taking to resolve was having a significant negative impact on the client's health. The case manager also provided advice on compiling evidence to support the client's case. The case manager also provided direct support to the client, helping her to feel more supported and that she had someone else looking after her interests. This helped her to feel less stressed. The client's grievance claim was upheld and she was able to return to the hours she worked before becoming ill carrying out a role that was more appropriate.

The case managers' negotiations worked in most cases, but there were some where despite all efforts they make no progress. In these cases there was often a better outcome for clients than may have been achieved without case management support. For example, one client explained: *'I left my job in the end not due to lack of help from the service but my company's attitude. I got a better way (outcome on leaving) due to (the case manager's) help'*.

It is important to remember that employers can be willing to support the client's return to work. The case managers facilitated the process in these situations and ensured work places remained supportive. An example of this type of work is given below.

A client's manager wanted to support the client's return to work, but was not sure how best to do this for someone with cancer. The case manager worked with the client and the manager, providing information about treatment and side effects and to devise work adjustments and a plan for phased return with the aim of eventually returning to full time hours. The initial return to work went well, with the client starting on very short hours and gradually building them up. The case manager also helped the client get support from Access to Work to help her with travel. However, once the client was back at work there was little progress around finding a new role for the client and she was finding it upsetting to be reminded about what tasks could no longer do. The case manager was able to help the client's manager understand this and the need for a change of role. It would have been difficult for the client to do this without support as she felt, following treatment, that meetings were difficult and she *'wasn't the same person'*. At that time the client felt the case manager was *'my voice'*. Eventually the client was moved to another part of the organisation. Although the client had less travelling, she was not given a role which allowed her to use her skills and experience effectively. Once again the case manager intervened, drawing together the client's HR department, manager and union to identify a new and more appropriate role for the client. Eventually the client moved into a new role which was appropriate. She now works full time with her hours compressed into a four day week. This allows her to cope better with the fatigue she still has post treatment. *'If it wasn't for this service I wouldn't be where I am now.'*

Even when employers are supportive it can be reassuring to have the support of the case manager. An example of this is shown in the case study below.

This client was recovering from surgery and struggling with both the side effects of treatment and anxiety and depression. She was worried about returning to work as she had a fairly strenuous job and she felt she would not be able to cope with this. She was unsure whether her employer would be willing to make adjustments or offer redeployment. The after effects of cancer were having a profound effect on her self confidence which was affecting her ability to travel and to interact with people on a day to day basis. She was particularly worried about approaching her employer to discuss returning to work although she knew that she would have to do this at some point as the employer had already contacted her to discuss a phased return to work. The client did not feel capable of negotiating a return to work: *'this can be very daunting'*. The case manager supported the client during meetings with the employer and occupational health to discuss redeployment and reduced hours. The case manager also supported the client to improve her wellbeing. This included referring the client to a psychologist and also supporting her to come to terms with the effects of cancer: *'I could speak to her about things I couldn't deal with'*. The case manager also referred her to organisations which could help with financial matters, including welfare rights and Jobcentre Plus. The client is eligible for Disability Living Allowance which helps with travel costs for work.

Enhancing Self Management

There is increasing focus on encouraging self-management for people with long term conditions and it is important to consider the VR Service's contribution to this. An evidence review²⁵ of self management found that self management can have a health benefit but that some approaches to developing it were more effective than others. Giving leaflets and advice was less effective than detailed case management by phone which motivated people to self care. The VR Service operated in this way.

²⁵ de Silva, D. (2011) 'Evidence: Helping People to Help Themselves' *The Canadian Nurse* 90 52

Although we described the work with employers in some detail above it is important to note that only a small proportion of the caseload involves work with employers. This also suggests the case managers are promoting the client's ability to self manage at an early stage.

Pre and post measurements of clients' ratings of their confidence about working, managing their condition at work and impact of their work on their condition show increases in confidence across these areas indicating the VR service is helping to build clients' ability to self manage and resilience. It is important to remember that through the interventions described above that the case managers are supporting the clients to take action and manage themselves – they are not doing things for the clients.

Another aspect of this is that there is little evidence of client dependence on the service. Only 4% of all of the clients discharged to date have been re-referrals. These clients come back to the service because of a significant change in circumstance.

Further evidence of the way the service is building capacity to self manage comes from 6 month follow up of discharged clients. The majority of people (75%) feel they do not need more support from the VR service.

Looking at the above examples together a process for the case management service emerges involving:

- Building clients' confidence that return to work is possible;
- Planning for return;
- Preparing for return and a number of strategies can be put in place to help with this such as phased return, work adjustments and making workplaces more accommodating;
- Enhancing self management and making return to work more likely to be sustained.

This is not a linear process for most clients and different clients may need more or less support around different aspects.

Supported Withdrawal from Work

The quality of vocational rehabilitation must not be judged solely on return to work. If people are unable to go back to work because they are too ill and are helped to attain other outcomes (such as a pension) this can also be considered good rehabilitation work²⁶. Case managers have supported withdrawal from work for a small proportion of clients. The case study below is an example of this intervention.

A client had finished treatment just under a year before he joined the VR Service. He had had a long period of recovery and felt he needed to retire on medical grounds. However, the occupational health and HR departments at his workplace were being very unsupportive and were not willing to assist with getting evidence to support early retirement so he could access his pension. The client was feeling very isolated and felt that he was having to deal with this on his own when he was not really fit to do so. The case manager acted as an advocate for the client and the other organisations which were not supporting him effectively. For example, the occupational health department had agreed to support the client's application for retirement initially, but they had made a very weak case as they had failed to include the views of the client's GP, cancer nurse specialist and consultant and instead only included evidence from an agency doctor. The case manager challenged the occupational health department to re-consider their position and eventually they produced another letter which was more supportive of the client's wishes. The case manager also supported the client to collect the evidence from his own health professionals to build a fairer case. The case manager also negotiated support from the client's union. Initially, the union was not willing to help as the client had let his union dues lapse while he was ill and could not afford to pay them. However, the case manager persuaded the union to see this was harsh and they decided to be support his case.

Health Benefits

It is essential that health services delivering return to work outcomes *see return to work as a health outcome*²⁷. If people are back at work they are more likely to be well and this means they are likely to be better able to self manage and use health care less frequently, reducing health service costs.

Clients had low levels of health and well being when they came to the VR Service. Clients also worried that going back to work would have a negative impact on their condition. Around a third of Tier 3 clients were not confident about managing their condition at work when they join the VR Service.

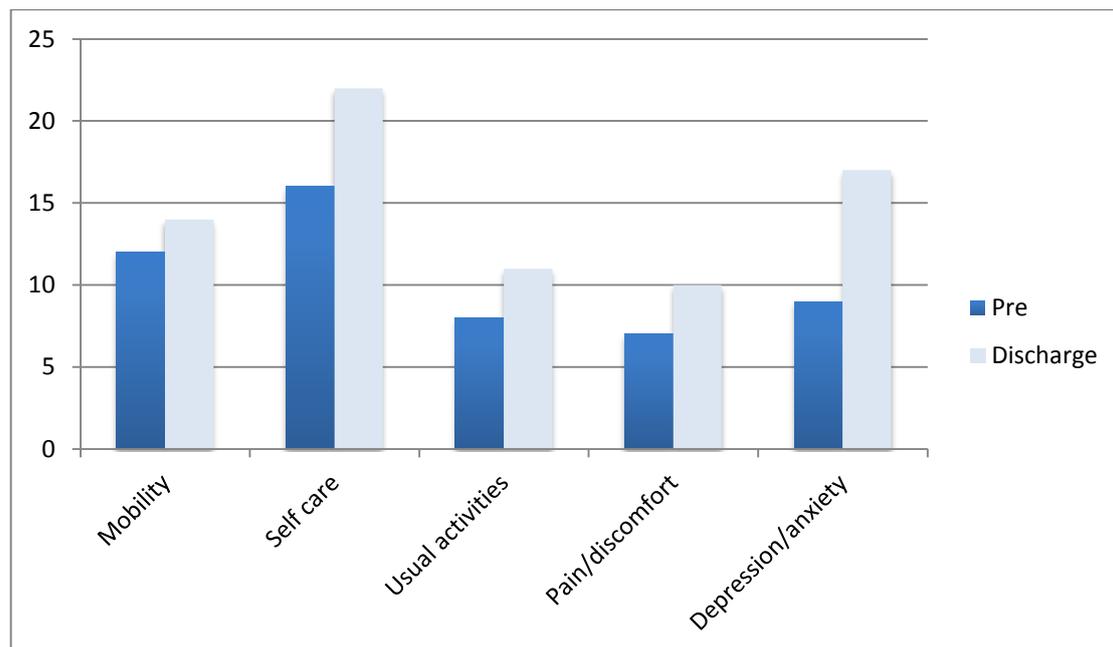
The use of health assessment tools with a sample of Tier 3 clients pre and post discharge was trialled as part of the evaluation to identify if this would be useful in evidencing health improvement in this patient group. The range of tools trialled were those being utilised in other areas of VR delivering support to patients experiencing mild to moderate health difficulty.

There is some evidence of changes in health from pre VR to discharge for Tier 3 clients using the EQOL5D to measure this. The mean overall EQOL5D score for clients based on ratings of their health at both these points is shown in Figure 8. There were improvements across all domains with the biggest increases in the numbers with 'no problems' in the domains of self care, ability to take part in usual activities, pain and discomfort and depression and anxiety. The mean score for clients on a scale of 0-100 (where 100 is the best possible state) increased from 62 pre VR to 75 at discharge. It should be remembered that these clients have severe and enduring health conditions and any positive shift is important.

²⁶ Delbruck, H., (2006) 'Vocational Integration in Cancer Rehabilitation' in Gobelet, C., and Franchignoni, F., *Vocational Rehabilitation*

²⁷ DWP (2013) *Telephonic support to facilitate return to work: what works, how and when?*

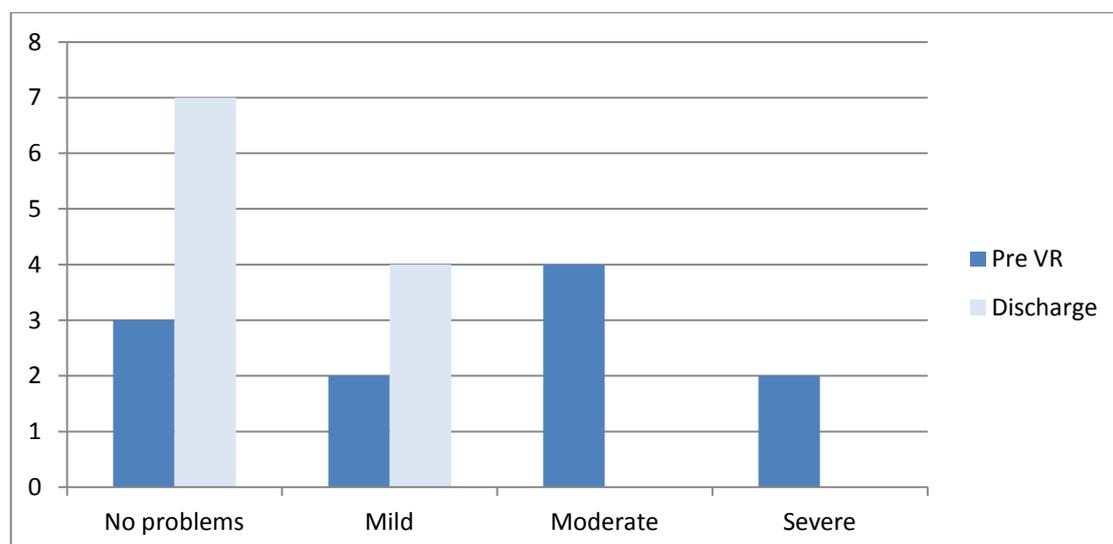
Figure 8: Numbers of Clients with 'No Problems' Pre VR and at Discharge (Measured by the EQOL5D)



Note: Sample size = 28

The Hospital Anxiety and Depression Scale (HADS) was used to measure two aspects of psychological health relevant to patients, anxiety and depression. In this scale three cut off levels indicating clinically relevant distress are used. These are mild (scores of 8-10), Moderate (scores of 11-14) and severe (above 15). Figure 9 shows the changes in the scores for 11 Tier 3 clients where pre and post measurements were possible. The Figure shows over half of these clients came to the VR service with moderate and severe anxiety. By discharge only 4 clients had mild anxiety.

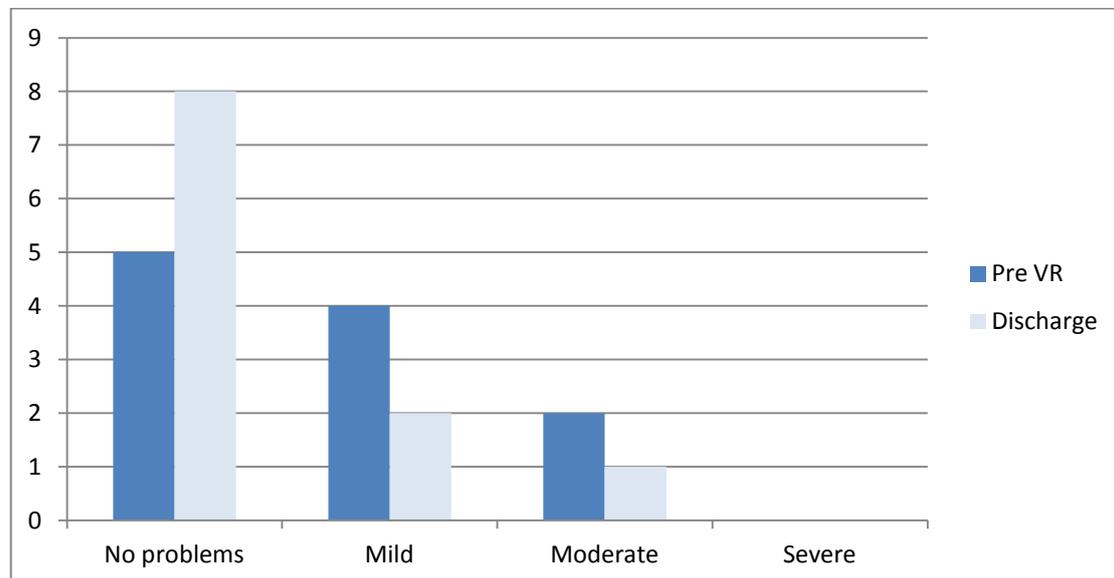
Figure 9: HADS Anxiety Scores Pre VR and at Discharge (Number)



Note: Sample size = 11

Similarly, depression has declined from joining to discharge. At referral 4 people had mild depression and 2 moderate. By discharge this had fallen to 2 people with mild depression and 1 moderate (Figure 10).

Figure 10: HADS Depression Scores Pre VR and at Discharge (Number)



Note: Sample size =11

Interviews with referrers identify the benefits of reducing depression and anxiety:

- Health professionals working with people with cancer commented that stress and worries about work can impact on how people with Cancer cope with treatment. If this can be dealt with effectively it can improve the patients' experience of treatment.
- A CNS working in IBD services commented that stress can sometimes exacerbate symptoms of IBD and so reducing stress associated with work could have a beneficial impact on the management of the patient's IBD symptoms.

The trial of these tools suggests they can be valuable in demonstrating self reported health improvement but there may also be other tools which may be more appropriate for the Service and further work could be carried out to identify these particularly focusing on tools that could be used across the Tiers.

Key Points

1. The case management service worked with a client group which faced considerable challenges to returning to or remaining in work.
2. The Service was associated with a range of outcomes including an increase in the numbers of people in work and reduction in the numbers off sick.
3. Tier 3 was associated with a much larger proportional shift into work than Tier 2, particularly for people who were off sick when they joined the VR service. This shows the positive contribution case management made to achieving outcomes.
4. The Service seemed to work effectively with clients who faced more barriers to return including those living in the most deprived areas and in lower paid occupations.

5. A follow up postal survey of clients who have been discharged from the service for 6 months indicates work outcomes are sustained.
6. The case management service contributed to a range of other important outcomes including increasing clients' confidence about returning to work and helping to make workplaces more supportive for clients.
7. The Service supported increases in self management which is an important outcome for people with long term-conditions.
8. The Service was also associated with improvements in health particularly in relation to depression and anxiety. This also contributes to self management and may reduce the need to use other services.

4. COST BENEFIT ANALYSIS

Introduction

This section aims to quantify the benefits of the service in financial terms and set these against the costs of delivering the service to assess whether the service can cover its costs. The costs are examined first, followed by an assessment of the benefits in terms of returns to HM Treasury from taxes, savings in benefits payments to the Department for Work and Pensions, reductions in health service costs to the NHS and savings for employers.

Estimation of Costs

The costs of delivering the VR Service pilot over the 3 years are staff costs and support costs, and these are close to £460,000. Most of this is staff costs²⁸ with around £6,000 devoted to administrative and training costs.

There are other costs associated with the delivery of the pilot including the costs of:

- Managing the project;
- Health professionals spending some of their time discussing work with patients to assess whether they could benefit from the service; and
- Referring or signposting clients to the pilot.

These costs have not been quantified for this analysis because it was not possible to identify which staff have been involved in this work or what proportion of their time was allocated to supporting the VR Service Pilot.

Assessment of Benefits

The benefits of the case management service are assessed in relation to three areas.

- Return to work – where the VR Service has helped clients return to work from sickness absence, reducing dependency on welfare benefits and reducing costs for employers.
- Sustaining work – where the VR Service has helped clients to remain in work when they are at risk of losing their job and becoming unemployed or going on sick leave, again reducing demand on welfare benefits.
- Health and wellbeing - where the VR Service has helped clients manage their condition better so that use of health services has declined.

Returning to and Sustaining Work

Table 6 in Chapter 3 showed the vocational outcomes for the VR Service for all clients who engaged with the service apart from 3 carers. The key points are that the VR Service has been associated with:

- 50 people who were at risk of losing their job or going off sick to remaining at work.
- 53 people returning to work from sickness absence.

This group of 103 beneficiaries of the pilot is the basis for assessing the value of the benefits associated with the VR Service as they could potentially have found themselves on welfare benefits. The financial benefits of the VR Service basically fall under two categories.

²⁸ Annual staff costs consist of: Three Band 7 Case Managers @ £43,159, approximately £130,000, one Band 3 Assistant @ £21,300, approximately £21,000.

- Savings in benefit payments realised by the Department of Work and Pensions.
- Savings in sickness benefit (statutory sick pay) and increases in tax returns to HM Treasury.

Attribution of Positive Outcomes to VR Service

Although 103 clients of the VR Service appear to have benefited by a positive change in status comparing their position before and after taking part in the pilot, it cannot be assumed that all of these are direct beneficiaries of the pilot as some may have moved from sickness absence to work and some may have sustained their work in any event.

Although we have no control group we can use the evidence of previous studies to generate an estimate of the proportion of clients with various long term conditions who might have been at danger of losing their job or failing to return to work from sickness absence. It should be noted that these studies focus only on individual medical conditions, and therefore there are difficulties extrapolating the results to the range of conditions catered for by the VR Service.

The evidence base is strongest for rates of return to work after cancer and it is useful to use this as three quarters of the VR Service clients had a cancer diagnosis. In relation to return to work:

- Mehenart (2011) found between 26-53% of people with cancer lost their job over a 72 month period after diagnosis (23% to 75% of these people were redeployed). Overall 63.5% (range 24% to 94%) of people returned to work²⁹.
- Another study reported approximately 60% (range 30% to 93%) of cancer patients return to work after 1 to 2 years.³⁰
- A study in the Netherlands found 60% of cancer patients returned to work after diagnosis.³¹

Studies have looked at the risk of job loss for people with different conditions:

- A meta-analysis of studies that looked at unemployment rates for people with cancer found that they were 1.4 times more likely to be unemployed than controls³². A more specific study found cancer increases the chance of being unemployed by 7-8 percentage points³³.
- The meta-analysis of the effects of cancer highlighted above found 34% of cancer survivors were likely to be unemployed;
- Sweet (2010) found only about 20% to 30% of people with MS are employed 5-15 years after diagnosis³⁴. Doogan and Playford (2014) report a similar proportion of people (25%) in work after 10 years.³⁵

²⁹ Mehenart, A. 'Employment and Work Related Issues in Cancer Survivors' *Critical Reviews in Oncology/Hematology* 2011 Volume 77 Issue 2

³⁰ de Boer, AGEM, Taskila, T., Tamminga, S. T., Friggs-Dresen, M.H.W., Feuerstein, M., Verbeek, J.H., 'Interventions to Enhance Return-to Work for Cancer Patients' *The Cochrane Library* 2011, Issue 2.

³¹ Roelen, C.A., Koopmans, P.C., Groothoff, J.W., Van Dr Klink, J.J, and Bultman, U. 'Return to Work After Cancer Diagnosed in 2002, 2005 and 2008' *Journal of Occupational Rehabilitation* Volume 21 Issue 3 pp335 -341

³² Angela G. E. M. de Boer; Taina Taskila; Anneli Ojajarvi; Frank J. H. van Dijk; Jos H. A. M. Verbeek. 'Cancer Survivors and Unemployment: A Meta-analysis and Meta-regression'. *JAMA*, 2009;301(7):753-762

³³ Moran J.R, Farley Short P., Hollenbeak, C.S. 'Long-term Effects of Surviving Cancer' *Journal of Health Economics* (2011) Volume 3 Issue 3 pp 505-514

³⁴ Sweet, J. (2010) *Vocational Rehabilitation for People with MS*

- Gay, *et al.* (2011)³⁶ found one third of people with Crohn's and Colitis and felt at risk of losing their job as a result of their condition. The survey also found IBD can make it hard for people to work. Half of the respondents said their IBD makes it hard for them to work at all.

It should also be recalled that the majority of the VR clients had been off sick on a long term basis (over 20 weeks). The Independent Review of Sickness Absence (2011)³⁷ highlights that after 20 weeks absence, the '*vast majority*' of people do not return to work but enter the benefits system. Dame Carol Black said '*if you have been out of work for 20 weeks then you have a very low chance of returning to your own job - that chance may be only 25%*'.³⁸

Taking the results of these various studies together we can assess the benefits associated with the two groups of clients assisted by the Service.

Clients Staying in Work

The evaluation of the VR Service pilot has shown that of the 66 clients in work prior to the pilot, 50 (76%) were still in work at the end of the pilot.

The wider research and evaluation evidence shows a very wide range of percentages of working individuals who lost their job following diagnosis and/or who failed to be redeployed having lost their job. Although the average figure for cancer patients remaining in employment over the long term was around 60%, the variation across studies was in the range 30% to 90%. Additionally, a number of the studies indicate clearly that some of those who remain in work over the long term have significant periods of intervening unemployment. Additionally, many of these studies seem to be based on the population or samples of the population of people with cancer or other serious conditions.

In relation to the VR Service pilot we assume that the percentage of those who would have stayed in work without the service would be much lower than the 60% average emerging from prior research and evaluation evidence for the following reasons:

- The fact that individuals have opted to participate in VR Service pilot almost certainly indicates a perception of a relatively high risk of their condition impacting adversely on their work situation. In effect, they are likely to be individuals impacted more seriously by their condition than the average individual with broadly the same condition.
- As the average stay on the pilot was only around 15 to 20 weeks it would appear that the VR Service pilot participants are not experiencing lengthy intermittent spells out of work or off sick, which must be deemed an additional benefit.

Given this, rather than assume that 60% would have remained in work in the absence of the pilot we have gone for the lower quartile figure of 45%. Applying the 45% figure to the 66 individuals employed prior to the pilot brings out a figure of 30 individuals likely still to be in employment post-pilot. As the actual figure still in employment is 50 the additional 20 is attributed to the VR service pilot.

³⁵ Doogan, C., and Playford, E.D, (2014) 'Supporting Work for People with Multiple Sclerosis' *Multiple Sclerosis Journal* Volume 20 No. 6

³⁶ Gay, M., *et al.* (2011). *Crohn's, Colitis and Employment - From Career Aspirations to Reality*. Hertfordshire: Crohn's and Colitis UK

³⁷ Dame Carol Black and David Frost (2011) *Health at Work: An Independent Review of Sickness Absence*

³⁸ BBC News Website April 10th April 2013 accessed on 27/01/14

Clients Moving from Sickness Absence to Work

The evidence on successful job re-entry following a job loss associated with a serious medical condition is again very mixed. One of the evaluations for people with cancer suggests that between 23% and 75% of those losing their job were subsequently re-employed. However, for individuals with MS the figure is only around 20% to 30%. The other very telling statistic here is the assessment by the Independent Review of Sickness Absence (2011) report and subsequent commentary that where individuals have been out of work for 20+ weeks the chances of returning to their own job are only around 25%.

In relation to the VR Service pilot we assume that the percentage of those who are off work due to sickness but who subsequently return to employment is much lower than the average of around 50% based on studies of those with cancer who subsequently become re-employed.

- An important argument here is that the majority of those off work due to sickness at the start of the pilot had been away from work for at least 20 weeks.
- Potentially, those being referred into the service or self-referring, were people who saw a danger that they would not return to work without a support service of some kind – in other words they are likely to have been clients with more significant health issues.
- A significant proportion (27%) of the clients had MS or IBD where the return to work percentages are much lower according to the research record.

Given this we have assumed that 30% would have returned to work in the absence of the pilot. Given this we would attribute 37 of the successful return to work cases to the VR Service pilot.

Estimation of Financial Benefits

Savings in Welfare Payments

A potential long run cost where medical conditions impact upon employment is that individuals may find themselves on welfare payments rather than earnings for a significant period in the economically active age range. The most likely benefit for these individuals is employment and support allowance (ESA). The Independent Review of Sickness Absence (2011)³⁹ estimated the cost of an average claimant receiving ESA at 2011 rates at £8,500.

Above we estimated that, on reasonable assumptions, 57 individuals were sustained in work or helped back into work as a direct result of their involvement with the VR Service pilot. This generates an **annual saving** to DWP, and ultimately HM Treasury, of around **£485,000**.

Benefits from Increased Tax and National Insurance Returns

The evaluation of the National Cancer Survivorship Initiative's Vocational Rehabilitation Project⁴⁰ used return to the Exchequer as a measure of the economic value of the pilots. The latest estimate of median gross annual earnings is £27,174⁴¹.

- The personal tax allowance is currently £9,440. Based on the 20% tax rate a person earning median wage will return £3,547 to the Exchequer annually.

³⁹ Dame Carol Black and David Frost (2011) *Health at Work: an Independent Review of Sickness Absence*

⁴⁰ Eva, G *et al* (2012) *Thinking Positively About Work: Delivering Work Support and Vocational Rehabilitation for People with Cancer* Final Report

⁴¹ *Annual Survey of Hours and Earnings*. December, 2013

- A person earning the median wage will also return to the Exchequer in terms of National Insurance contributions £2,306 annually.

On the assumption that, as a direct impact of the pilot, 57 individuals have been retained or have moved into work – and also assuming that they are on median earnings - the annual gain to the Exchequer:

- in terms of income tax is approximately £200,000 per year.
- in terms of individual National Insurance contributions is approximately £130,000 per year.

The **total annual benefit** to the Exchequer is therefore in the order of **£330,000**.

Sustainability of Impacts on Benefits and Tax Revenues

Preliminary data for a small number of clients who had been discharged for at least 6 months before the end of the evaluation shows that 92% of the clients in work when discharged were still in work after 6 months or more. It seems feasible to assume that the employment will be sustained for most clients, and consequently the financial benefits in terms of reduced welfare payments and increased tax revenues will also be sustained.

Another way to consider sustainability, is to assess the period over which these benefits will be generated proxied by the age of the clients assisted by the VR Service pilot. The average age of clients is 46 so they still have a substantial number of working years ahead of them.

Benefits from Reduced Health Service Use

Measures of health service use (Table 11), show for Tier 3 clients when they are discharged from the VR Service pilot:

- A decline in use of GP services.
- A decline in the use of outpatient services.
- No change in hospital stays.

The pilot was unable to measure pre and post-pilot Health Service usage for Tier 1 and Tier 2 clients. This means that the benefits in terms of reduced demands on the Health Service associated with the pilot are under-stated, although the anticipated benefits would be greater for the more intensive Tier 3 service.

Table 11: Health Service Use Pre and Post VR Pilot

	Pre VR	Post VR
Total GP visits in the last month	45	22
Total outpatients visits in last month	50	28
Total stays overnight in hospital in last month	5	5

Note: Table 11 is based on a survey of the 58 Tier 3 clients where 25 responses were received.

The Scottish Costs Book⁴² estimates that the average cost for attendance at a GP surgery is £66 and £139 for a consultant-led outpatient clinic. Given this, on the basis of the returns for the 25 clients, the reduction in monthly costs is in the order of:

- £1,500 for GP services.
- £3,000 for outpatient services.

⁴² ISD Scotland/ NHS National Services Scotland (2013) *Scottish Health Service Costs*

As the sample was based on approximately only half of Tier 3 clients the savings in terms of Health Service usage can be grossed up by a factor of 2, yielding a **monthly saving of around £9,000**.

Although a decline in outpatient visits over time might be expected as patients come to the end of treatment, the reduced number of GP visits is a good indication that the VR Service is helping develop self-management in clients thereby potentially saving health service time and costs over the longer term.

- An IBD nurse explained how the case managers have been able to help patients negotiate time off to attend hospital for treatment helping the patient to complete the treatment regime. In this way the VR Service is helping to reduce non-attendance at clinics.
- A cancer CNS commented that reducing a patient's anxiety also reduces the instances when patients need to see a CNS.
- One referrer described how the case managers were also identifying support needs for patients that had not always been picked up by medical staff including counselling and psychological therapies. This is improving the patients' treatment pathways.
- Case management as an approach can allow targeting of resources and more efficient use of services, thereby leading to cost savings in other health services.

On the assumption the reduced costs for the NHS are sustained over one year, for those involved in the VR Service pilot the value of the savings is in the region of £108,000 – and if this benefit is maintained over a longer period the financial value of the savings can become considerable. However, we were unable to find research studies which provided indications of the longevity of this type of benefit for the NHS in relation to changed behaviours brought about by interventions such as the VR Service pilot.

It is also important to remember there is a large amount of research which supports the health benefits of return to work. People who are in work are generally healthier and less likely to place a demand on health services. A cost benefit analysis framework has estimated that every person on ESA who enters work saves the health service £1,031⁴³. If the VR Service contributes to reducing people going on to ESA then it is contributing towards these savings.

Benefits for Employers

Sickness absence imposes significant costs on employers. A recent survey of employers found the average annual cost per sick employee to be £600 in the UK⁴⁴. The costs of sickness absence include:

- Occupational sick pay.
- Securing temporary employees to cover for the absent employee's duties which can also include additional overtime payments to existing staff.
- Where cover is not obtained the loss of revenue due to reduced output or service provision.

Additionally, recruitment costs will be imposed on the employer if the employee is unable to come back to work. The median cost of filling a vacancy was £2,000 in the UK for 2013⁴⁵.

⁴³ Department for Work and Pensions (2010) *Social Cost Benefit Analysis Framework Working Paper 86*

⁴⁴ CIPD (2012) *Absence Management 2012*

⁴⁵ CIPD (2013) *Resourcing and Talent Planning 2013*

An estimate of the savings to employers in terms of sickness absence costs due to the impact of the VR Services pilot on keeping individuals in work and helping others return to work is around £34,000. It is difficult to make an assessment in relation to recruitment costs as too many arbitrary assumptions would have to be made.

Other Benefits Difficult to Value

The VR Service pilot has delivered benefits that cannot be valued but which are nevertheless meaningful for clients, health services and employers. These include:

- Satisfaction with care – an important function of any health service;
- Increases in self management which is associated with reduced costs for health services as patients use services less;
- Freeing up NHS frontline staff time to deal with clinical issues by providing VR specialist support.
- Efficient and better access to other services through referral and signposting;
- Increased confidence – and therefore productivity – at work;
- Perceived better health and wellbeing.

All of these outcomes are evidenced in the case studies and extend to clients whether they have been able to return to work or not.

Potential for Cost Reduction

As might be expected for a pilot project the number of clients increased year on year:

- The pilot worked with 77 clients in the first year;
- 120 in the second year; and
- 106 with 3 months still to run in the third year.

There is clearly potential to increase the number of clients worked with each year as the service has now established a good referral base, has been increasing throughput of clients year on year and now has a focus on case management rather than capacity building. The potential for scaling up the outcomes without the need for more case managers seems very strong, and this means that if such a service were rolled out and once it had achieved its capacity volumes in terms of clients the unit cost of the service would be much lower than has been experienced in the pilot phase.

Overview of Costs and Benefits

The costs and the estimates of the benefits of the VR Service over 3 years based on our assumptions about the number of beneficial outcomes which can be attributed fully to the pilot are summarised in Table 12.

- The total cost of the VR Service pilot as noted at the outset of the chapter is around £460,000.
- The estimate for the benefits that can be attributed to the pilot, using prior research and evaluation evidence from a wide range of studies, is in excess of £2.8m with savings in welfare payments and increases in tax revenue the major components, but with sizeable cost savings in terms of health service usage.
- Looking at costs and benefits together, the conclusion is that for each £ spent on the VR Service pilot £6 of benefits have been realised.
- The benefit estimate could well be significantly understated as it is calculated only for the 3 year life of the pilot. To the extent that some of the benefits are sustained – and the evidence in the evaluation suggests that this is likely in terms of employment retention – the benefit to cost ratio will continue to

increase for a number of years, particularly in the light of the fact that the average age of the clients was only 46.

- It is perhaps the case that the Health Service usage benefits are more difficult to sustain over the medium to longer term but they are nonetheless substantial in the short term as evidenced in the evaluation.

Table 12: Costs and Benefits Summary

	Benefits and Costs (£)	Beneficiary
Savings in Welfare Payments	1,455,000	DWP
Tax and National Insurance Payments	990,000	HM Treasury
Reduced Health Service Usage	324,000	NHS
Reduction in Absence	102,000	Employers
Total Benefits	2,871,000	
VR Costs	460,000	

Key Points

1. On pragmatic but reasonably well supported assumptions the financial benefits which can be attributed to the pilot were substantial relative to the cost of delivering. In excess of £6 in benefits were realised for every £1 spent within the 3 year pilot period.
2. In addition to the benefits to the national Exchequer through reduced welfare payments and increased tax and national insurance revenue, there was evidence of significant savings in terms of Health Service usage.
3. If we assume that people sustain work then the benefits/cost ratio improves significantly with each passing year.
4. The pilot delivers a range of difficult to value benefits, including higher levels of satisfaction with health services and increases in self management.
5. In a roll out scenario, there is the potential to lower the unit cost of delivering the VR Service as the systems are already set up, referral arrangements are in place and capacity building work would be reduced.

5. CONCLUSIONS

Conclusions

The evaluation sought to describe how the pilot was delivered, present the outcomes and assess what aspects of the service delivery contributed to the achievement of these outcomes. Below we consider each of these areas.

In terms of the pilot's delivery:

- The pilot has demonstrated there are challenges to front line staff providing work support that goes beyond providing self help information and signposting. However, the availability of a case management service as a resource has encouraged some health professionals to be more proactive about supporting patients around work and therefore there has been an increase in work related support offered by acute services to the 3 patient groups assisted by the VR Service. Referrers were very positive about the VR Service and viewed it as a high quality service which they were happy to refer to.
- A service model was established and delivered well. The model built on research and best practice in VR by offering:
 - A **stepped or tiered approach**;
 - **Specialist** support which can address barriers to work and encourages client progression and **self management**;
 - **Case management**. Case managers are skilled in a range of areas and their role is multifaceted.
 - **Flexible** and **accessible** support;
 - **A partnership approach** between key services such as health, social care and employment services;
- This model worked for people irrespective of their long term condition.
- Clients were very positive about the VR Service identifying the skills and specialist knowledge of the case managers as a key aspect that they valued.

In terms of the case management service's outcomes:

- The case management service worked with many clients who faced significant challenges related to moving back into work and as such were vulnerable to losing their jobs and entering the benefits system. It is against this background that the Service's work outcomes need to be assessed.
- Clients with different long term conditions tended to have different reasons for joining the VR Service. For example, clients with IBD were more likely to be in work and looking for support to stay at work, while clients with cancer were more likely to be off sick and looking for support to get back to work. The Service met these variable needs.
- The Service was also effective at assisting clients in lower socio – economic groups.
- The Service was associated with a reduction in the numbers off sick, an increase in people in work and has also helped people attain other positive outcomes, such as becoming self employed, entering education or volunteering.
- It has also helped some people who have not been able to get back to their own jobs attain other positive outcomes, such as becoming self employed, entering education or volunteering.
- Intensive case management support was associated with a much larger proportional shift into work than lighter touch support at Tier 2. This shows how positive outcomes can be achieved for people with complex needs but also that case management support is needed to achieve these outcomes.

- Although the numbers are small, 6 month follow up of clients suggests work outcomes are sustained.
- The Service also helped deliver a range of other outcomes including increases in clients' confidence about return to work, increases in clients' abilities to self manage, support to workplaces to improve conditions for clients and improvements in health and wellbeing.
- A **cost benefit analysis** has identified that the direct costs of the service are more than covered by the benefits generated to the Department of Work and Pensions and employers within the 3 year period of the pilot. There are also substantial benefits to the NHS. If we assume people sustain work then the benefits/cost ratio improves significantly with the passage of time. There is also strong potential to increase the benefits by scaling up.

Aspects of the service delivery which contributed to the outcomes are the following:

- As we indicated above intensive **case management** was a critical element of the VR Service and contributed to the achievement of outcomes for clients with complex needs.
- The **interventions developed by the case managers** were effective and included negotiating with employers to make workplaces more accommodating for clients; increasing clients' confidence about returning to work; developing strategies to help clients to cope better at work and reduce stress; and improving self management.
- The **good relationships with referrers** both external to the NHS and within acute services assisted in the delivery of holistic support to clients as well as helping to reach clients who could benefit from the VR Service.
- **The way the service was delivered was important.** The best evidence of this was the clients' views which are very positive. The positive aspects of the service included the professional and knowledgeable approach of the case managers; the way the service was person centred and offered continuity of care and the proactive way the case managers sought help and support for clients. Nearly two thirds of clients (85%) felt the service had a positive impact on their work situation (with 66% agreeing strongly that it had).

Recommendations

1. The VR Service pilot has tested an approach which has provided vocational rehabilitation to three client groups which have had access to little work related support in NHS GG&C until now. The case management service model appears to have worked well, its key features should be retained and it should be used as the basis for any future provision. The referral pathways and the service model have worked well for three conditions already and could be used to assist people with other conditions.
2. Case management is critical to delivering success, particularly for people with more challenges and complex needs. It should remain a core part of the Service. The Service should focus on people with more complex needs as this is where it has potential to add most value.
3. The pilot has collected a range of evidence about outcomes, but the measurement of some of these aspects needs to be strengthened going forward. Changes in work status are critical and can be measured fairly easily. The pilot is also associated with changes in health status and health service use and increased ability to self manage all of which is important to health services. The evidence base for these could be strengthened by more measurement of these aspects pre and post engagement in the service. The pilot has trialled some tools that are used in VR (including HADs, COPM and

EQ-5D). A suite of measurement tools should be agreed upon and used routinely going forward.

4. This measurement should include case management outcomes. Table 2 above showed the key tasks carried out by the case managers during the pilot. This could form the basis for specifying the service outcomes for the VR Service alongside vocational outcomes. These outcomes include assessment of work skills and capacity, prioritising key issues, problem solving, supporting work preparedness, helping people develop strategies for managing health problems in the workplace, negotiating with workplaces, psychological interventions information and advice, referral and signposting, careers advice and guidance and supported withdrawal from work.
5. The Service has focused on people in work and this should continue to be the focus.
6. Good links have now been forged with referrers within acute services and the Service has a good reputation with them. These links should be maintained as there are many patients with health conditions who require work related support. Few of them are referred soon after diagnosis and links to acute services could be a good way of reaching these patients at an early stage in their illness.

APPENDIX: CASE STUDIES

Case 1

This client was referred to the VR service by the benefits adviser at the Beatson. The client was at the end of treatment which had been very intensive – involving 2 surgeries, radiotherapy and chemotherapy. At the time the client was feeling very stressed and worried about losing her job as she approached the end of a 12 months absence period. The client was worried that her organisation's absence management policy would lead to dismissal due to incapacity. Work issues were therefore '*top of the agenda*'.

During treatment the client had viewed returning to work as something to '*work towards*' as it represented part of recovery. However, the client knew that she faced living with the effects of treatment for up to five years and was not sure that she would be able to go back to her previous job. The client really did not feel ready to return to work but '*wanted to come up with a strategy to keep my post*'.

The physical and emotional effects of cancer and treatment were having a profound impact on the client's confidence about returning to work. These included '*cognitive fogginess*', fatigue, feeling drained by the treatment and not feeling emotionally ready to return to work.

Additionally she had some money worries – her partner was also sick and on half pay and although the client had some critical illness cover, the couple's income had halved.

VR Interventions

Although the client had a good support network, she felt she had no one to talk to about work issues. The case manager helped the client to work through her feelings about returning to work and to come up with a plan of action. This stopped the client quitting because she felt it was her only option.

The case manager investigated the client's absence policy and found out that there were a range of options at the end of 12 months. For example, the client had not been aware that she could use annual leave to extend the period of absence. The case manager got the client's union involved and helped get her a different occupational health manager who was more willing to take a fairer approach and put a phased return to work plan in place.

She also put the client in touch of a range of support professionals who could help to answer additional questions the client had, for example about financial issues.

Outcomes

Improved awareness of health and work: The client has started to realise that having cancer has had a profound effect on her life and she is no longer sure that full time work in her previous job is feasible. The client is considering retiring on the grounds of ill health. She is considering doing a different type of job which would allow use of skills in a different way. The case manager has also helped the client to consider these other options.

Better self management and improved referral pathways: The client is feeling more positive about the future and knows how to access other services such as Macmillan Financial Services which can offer further support.

Case 2

This client found out about the VR service through a Brain Tumour UK meeting which the case managers attended. He had been having treatment for tumours for 5 years. Prior to this he had been a director in a company, but over the course of the illness he had been continually demoted until he was eventually working as a cleaner. Although cancer was not impairing his abilities at work he felt his employer was trying to discourage him from returning to work by being unsupportive and cutting wages in the hope that he would decide to resign. His job was not secure and he had money worries as he was on half of his previous salary and was not eligible for any benefits. However, the client did not want to resign as he had 17 years service with the company and was entitled to a works pension and lump sum – but he felt he was being *'bullied out'*.

When he joined the VR Service he had not discussed work with any health professionals as he felt he should be able to handle the situation himself, but also none had raised work issues. The VR case manager was the first person he discussed work with; until then he was not even comfortable discussing work with his partner. His confidence and self esteem were at *'at zero level'* and he felt no one wanted to help him – he was *'no longer a person – just a number'* and that people were seeing the illness as his fault. Prior to cancer work had been a very important part of his identity - *'my whole life'*.

VR Interventions

The case manager supported the client to prepare for meetings with his employer and union. Although the case manager was not allowed to attend meetings with the employer she came along to the meetings with the union. The case manager was very encouraging and persistent and did not want to give up as she felt he had a case and would be able to get his pension and lump sum. This was a key aspect of the support as the case manager made him aware of his employment rights and that he did not need to be treated this way. This helped him when he felt like giving up. The case manager put him in touch with Macmillan Financial Services which helped to secure this. The case manager also helped develop a longer term solution to employment issues by discussing other options to returning to his original employer. She put him in touch with employability services to help look at other jobs.

A key element of the support was building the client's confidence so that he was able to think about these longer term solutions. The case manager did this by encouraging the client to be more active again and get back to some of the activities he had done prior to having the problems with work including more physical activity. This helped him to feel better. *'The case manager treated me as a person again rather than this horrible alien because I have a tumour'* – this had a positive impact on his mood and motivation. The case managers *'make people believe they can get back – up until then most people are telling them that they can't'*.

Outcomes

Improved return to work rates: The client eventually left his original employer and although he initially had a number of jobs, with the case manager's help and encouragement he applied for another managerial job which is better paid and has more responsibility than his previous post.

Better awareness of health and work issues: The client was made aware of his rights and eventually received his pension and lump sum.

Better self management: The case client's mood and attitude to his illness has changed dramatically since he has been using the VR service. The case manager encouraged him to 'get out and about' prior to this he was '*just huddled in the house*' and thinking he '*deserved to be sick*'. His self perception has changed and he is '*determined to make something of himself*'.

Improved referral pathways: The case manager referred or signposted the client to a range of other services. The client found some of these more helpful than others but has increased awareness of additional support.

Case 3

This client found out about the VR service from the service's leaflet. The client was recovering from surgery and was struggling with the side effects of treatment and anxiety and depression. She was worried about returning to work as she had a fairly strenuous job and felt she would not be able to cope with it. She was unsure whether her employer would be willing to make any adjustments to assist her to do her job or offer redeployment. The after effects of cancer were having a profound effect on her self confidence which was affecting her ability to travel and to interact with people on a day to day basis. She was particularly worried about approaching her employer to discuss returning to work although she knew that she would have to do this at some point as the employer had already contacted her to discuss a phased return to work. She did not feel ready for this. When she saw the leaflet she thought she would 'give it a try' to see if it could be of any help.

VR Interventions

The client did not feel capable of negotiating a return to work with her employer: '*this can be very daunting*'. The case manager supported the client during meetings with her employer and occupational health to discuss redeployment and reduced hours. The case manager also supported the client to improve her wellbeing, including referring her to a psychologist and supporting her to come to terms with the effects of cancer: '*I could speak to her about things I couldn't deal with*'. The case manager also referred her to organisations which could help with financial matters, including welfare rights and Jobcentre Plus. The client is eligible for Disability Living Allowance which helps with travel costs for work.

Outcomes

Better self management: The client feels she is managing the psychological effects of cancer better. The case manager looked at all aspects of return to work, and this holistic approach was necessary to help the client deal with the multifaceted impact of cancer.

Improved referral pathways: The client was referred to a number of different services which all made a contribution to her return to work.

Improved return to work rates: The client feels that she would not have been able to return to work successfully without the support of the VR Service as she probably would have been unable to secure a reduction in hours or redeployment to a suitable post without the intervention and support of the case manager.

Reduction in absence: Redeployment within the same workplace rather than elsewhere in the organisation was very important to the client as it meant that she was able to carry on working with colleagues she already knew and with whom she felt comfortable. This made her feel happier and more confident about returning to work.

Better awareness of health and work issues: The case manager helped the client to develop a better understanding of what needed to be put in place to enable her return to work and to achieve this through negotiations with the employer.

Increased hours worked: The client is working part time now as this suits her better as she still has some ongoing health problems. She feels that she is able to sustain her part time hours at the moment. In the longer term she may be able to return to full time work, but she is not sure.

Case 4

This client was referred to the VR service by a Macmillan nurse who was giving her specialist support around a year after cancer had been diagnosed. At the time the client was looking to return to work after being absent for 11 months with shoulder pain. The client's job involved some heavy duties and she had requested her duties be changed to lighter ones until she recovered. However, her line manager said redeployment would only be possible for 12 weeks and if she was not able to go back to her normal duties after this time then she would be dismissed. The client wanted to get back to work because she felt it would be beneficial for her – she would be able to put cancer to *'the back of her mind'* and get back into a *'normal routine'*. However, she was not sure that she would be better within 12 weeks and was worried about losing her job.

VR Interventions

The case manager supported the client during a period of negotiation with her employer about returning to work. She accompanied the client to these meetings. This not only helped the client to feel that *'she had a person on her side'* but helped ensure that she was able to get her point across to the employer – *'the people don't know what language to use but the case managers do'*. These negotiations were protracted as the employer sometimes agreed to something in a meeting and then changed his mind. The case manager was able to remind him what had been agreed at the meetings. Initially, the employer offered lighter duties but on a different shift which would not have fitted in with the client's childcare arrangements. Through negotiation, however, the client was eventually offered lighter duties on her old shift. The client is now working the same hours as she did prior to getting cancer.

Outcomes

Improved referral pathways: The case manager referred the client to Access to Work which helps her get to work. This has been very helpful. The client had not heard about Access to Work prior to contacting the VR service *'nobody knows about these things'*.

Improved return to work rates: The client does not feel she would have returned to work in the absence of the VR Service as she feels she would have been offered an unsuitable shift which would have meant that she would have had to pay for childcare and it would therefore not have been financially worthwhile.

Reduction in absence: The client was offered lighter duties which meant that she was able to get back to work. She was able to do these for longer than originally offered thanks to the intervention of the VR Service.

Better awareness of health and work issues: The client was not aware of her rights prior to accessing the VR Service. Although she was a member of the union in her workplace, she felt they were working more for the employer and were not supporting her. The case manager had an excellent understanding of the issues, clarified them for the client and helped her to feel supported. It is very useful to have this support as clients can feel *'very emotional'* which makes it difficult to take part effectively in negotiations.

Better self management: The client felt it was very useful to have *'someone there to bounce ideas off'*.

Case 5

This client was referred to the VR Service by Macmillan Benefits. At the time the client was still having treatment. The side effects were serious and distressing had left her feeling concerned about her ability to return to work once treatment was finished. Although the client was not considering returning to work until treatment was finished, the referrer felt it would be good to talk to a case manager about her concerns. Work was very important to this client and she had worked for over 25 years with the same organisation.

VR Interventions

The case manager supported the client through telephone contact all through her treatment cycles. Treatment did not go smoothly and there were some complications. The client was *'very up and down'* during this, but the case manager was a great source of support *'always at the end of the phone'*. During this time the case manager was able to put a range of support in place to assist with the client's wellbeing. These included help from occupational therapists to help the client manage day to day tasks including self care in her home, with a service that provides wigs in the event of hair loss and services that provide support to the family of people with cancer. This was a tremendous support to the client and her family *'she thought about everything else that the family can't think about'*.

Once the client completed her treatment she met with the case manager to discuss returning to work. Treatment had left her with significant problems which meant that she would not be able to do her job as it involved some physical tasks. However, the case manager felt it was important the client return to her old workplace so that a more appropriate role could be found for her. At this point the client *'couldn't see a way forward'*. She had lost confidence and was worried about all of the things that needed to be put in place to allow her to return to work.

The client's manager wanted to support the client's return to work, but was not sure how best to do this for someone with cancer. The case manager worked with the client and the manager, providing information about treatment and side effects and to devise work adjustments and a plan for phased return with the aim of eventually returning to full time hours.

The initial return to work went well, with the client starting on very short hours and gradually building them up. The case manager also helped the client get support from Access to Work to help her with travel. However, once the client was back at work there was little progress around finding a new role for the client and she was finding it upsetting to be reminded about what tasks could no longer do. The case manager was able to help the client's manager understand this and the need for a change of role. It would have been difficult for the client to do this without support as she felt, following treatment that meetings were difficult and she *'wasn't the same person'*. At that time the client felt the case manager was *'my voice'*.

This led to the client being moved to another part of the organisation. Although the client had less travelling, she was not given a role which allowed her to use her skills and experience effectively. Once again the case manager intervened, drawing together the client's HR department, manager and union to identify a new and more appropriate role for the client. Eventually the client moved into a new role which was appropriate. She now works full time with her hours compressed into a four day week. This allows her to cope better with the fatigue she still has post treatment. *'If it wasn't for this service I wouldn't be where I am now.'*

Outcomes

Better self management: During treatment the case manager put a range of support in place which helped the client manage the effects of cancer and treatment.

Improved referral pathways: The case manager referred the client to a range of support services appropriate at all of the stages gone through in the course of the client's return to work.

Improved return to work rates: All of the support the case manager put in place allowed her to return to work. If she had not changed role she would not have been able to return.

Better awareness of health and work issues: The manager increased her awareness of how cancer affects people in the workplace and how people with the same cancer diagnosis can have very different needs.

Increased contact with employers and increased support to workplaces: The case manager worked effectively with the client's manager, union representative and HR manager to allow them to put effective support in place for the client.

Increased hours worked: The client was eventually able to return to full time work, organised in a way that should help her sustain these hours in the longer term.

Case 6

This client heard about the VR Service through her consultant. During an appointment she had told the consultant about the problems she was having at work and the consultant asked the staff nurse who was there to refer her to the VR Service. At the time she had been off work for over a year and was waiting on a transplant. She was worried about work because although she wanted to get back she knew she would still have to have 18 months off work following the transplant before she would be ready to return, although it was difficult to predict exactly when she would be able to return. She was also worried that she would not be capable of doing the same job when she returned. She was worried about losing her job as she had been off for so long. Her workplace was beginning to put pressure on her to return to work and had approached her with a view to giving an ill-health retirement package. The consultant felt the decision should be made after the transplant and not before and said she would give her view on work then.

VR Interventions

The case manager got in touch with the client's union as she felt the client was in a unique situation and needed to have the union involved. The union representative was able to secure an agreement that if the client needs to be redeployed when she returns then this will happen. The case manager also helped the client to build up her self confidence and self esteem through putting her in touch with a range of other services which can help with this including a counsellor and 'Look Good Feel Good'. The client felt the case manager understood her situation and was '*a good listening ear*'. The case manager '*phoned on a weekly basis and when she said she'd do something she did. I wished I'd met her from day one.*'

The client is now on a year's career break and by January 2015 the consultant will be able to make a decision about whether she is fit to return to work.

Outcomes

Better self management: The client's worries about work and the effects of cancer had a profound effect on her self-esteem. The case manager's work with the client and referral to other appropriate services helped build these back up. '*I could open up and speak to the case manager and can't always do this with hospital services. Hospitals don't really have time for major problems and issues.*'

Improved referral pathways: The client was put in touch with a range of services which helped her improve her wellbeing.

Better awareness of health and work issues: The client was made aware of the option of a career break and this has helped her to avoid unemployment at this stage.