



NHS Lothian Working Health Services Year 1 – End Summary 2010

Project Management Report and Final Statement to the Project Board and to Roderick Duncan at Scottish Government

NHS Lothian's Pilot Vocational Rehabilitation Service objectives in Year 1 was to provide through the medium of Working Health Services Lothian, a rapid access, and case managed multi – disciplinary team approach to vocational rehabilitation. Working Health Services maintains strong partnership working links with Lothian employability partners.

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Working Health Services
Developing Vocational Rehabilitation across Lothian

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Fit for Work Pilot	
Project Title	NHS Lothian WHS Project – Year End Document NHS Lothian Working Health Services is a partnership with Healthy Working Lives and Scottish Government Year end : July 2009 – June 2010
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Review of Performance of NHS Lothian Working Health Services 2009/2010

Working Health Services has had a successful year in 2009 / 2010 with the implementation of partnership working with Scottish Government, Healthy Working Lives and NHS Lothian. This report outlines the background narrative to the year and makes some key observations on global performance. It should be read in conjunction with the formal statistical analysis as formally undertaken by Margaret Hanson at '**Works Out**', when it becomes available

The Working Health Services Project Plan and the quarterly Highlight Reports of 2009 / 2010 should also be referred to as they outline progress against key objectives in the first 3 quarters of the year.

The key achievements to date have been:

- The development of a communication and marketing strategy that has engaged with SME employees, SME employers, health professionals and the employability sector. This has led to 300 referrals to the service to date
- Set up of a signposting service for vocational rehabilitation within routine NHS work, across the City of Edinburgh area, East, West and Mid Lothian areas. This is an ongoing process.
- Establishing and delivering on employment outcomes that assist:
 - the individual client remain in work or return to work
 - referring health personnel and GPs
 - the needs of employers
- Providing Employability Training for relevant groups and the establishment of ongoing workforce development in employment awareness and work related rehabilitation.

Key Observations

The key observations that merit further discussion for the project at year end (July / August 2010) are listed below. These are seen as contributing to the continuing success of the NHS Lothian Working Health Service and the future Fit for Work provision. They revolve around 3 main areas:

1. Referral relationships and Company Size
2. Marketing and Communications
3. Waiting List *harvesting* from musculoskeletal physiotherapy waiting lists

Observation 1.

Referral Relationships and Company Size

The relationship of company size to referrals is a highly important one in our view. It is a subject that needs more discussion strategically and one that will not disappear as the demand for vocational rehabilitation increases and as the Fit for Work Services evolve.

The current audited figures in Lothian show that Lothian Working Health Services pilot (**hence forth known as WHS**) received and accepted a significant proportion of referrals from people who worked in both Small to Medium Enterprises (SMEs) and non SME categories. The common denominator being that someone in the referral pathway thought that these employed individuals were struggling in work and needed at a minimum, some degree of case management support - regardless of the company size.

The most salient feature of referrals in the last year has been the number of non SME referrals (this is defined as working in a company of >249 employees). Many referrals of non SME cases that were referred to **WHS** had some of the following features:

1. The Occupational Health provider in the case had in many instances not been informed of a person's absence from work. This was for a variety of reasons some of which are discussed below. In large part it might be caused by what we already know : many employers are not routinely monitoring sickness absence (*Chartered Institute of Personnel and Development*)
2. Many times the Human Resources input and / or Occupational Health provision to the employee was limited, or even absent, despite the employer having both these services as part of their make up.
3. It is also the case that occupational health services although commonly presumed to exist in companies over 249 in size are sometimes not present at all.

We have identified a number of reasons as to why the above might be happening:-

- a. Although many employees anticipate access to OH provision as part of their employment contract if seriously sick or ill, some are not routinely being given access to their own OH provider by their employer.
Our experience, in part based on our discussions with OH colleagues, indicates that access to OH provision can be a '**gate kept**' process. This appears to relate to the need by employers to manage the internal the problem their own way and / or the financial costs to the employer division that comes with referral to Occupational Health. Thus, access to OH can be limited by an employer's imperative to minimise employee contact on cost / profit grounds. This is especially noticeable in low pay jobs as are commonly found in the large service sector.
- b. OH signposting of an employee from an employer / line manager to the OH provider can also be denied for dispute reasons or because of the way in which increased sickness absence is seen to impact on operations. The reasons are complex.

The function of **WHS Lothian** in these many instances has been to use case management principles to liaise with HR and OH providers to effect positive change in the behaviour of the employer / and / or connect the employee to their service provider. Our analysis of the figures supports this as an effective strategy in returning people to work.

Does everyone in a non SME company (>249 employees in size) have an Occupational Health Provider?

The experience by WHS Lothian of the restricted access of some employees to OH provision in non SME companies has challenged the assumption on which basis it was assumed **WHS Lothian** would operate. Namely, that our services would be aimed at small to medium enterprises (SME's) because larger companies would have in-house access to OH which their employees could access.

Our experience now tells us that we cannot pre suppose that working in a large company (more than 249 employees) automatically provides access to fit for purpose occupational health services, or that these services will be easily accessible, responsive and proactive. The possible reasons for this have been set out above. We have found for example that many supermarket chain employees although in working in big companies get no access to meaningful OH services.

It is also our experience that many out sourced Occupational Health providers in large companies, and within the large public sector in Lothian, appear to have limited access points; telephone-only based services, and in some case, minimal face contact time. They may or may not have additional services such as physiotherapy and counselling given on a time limited basis. They rarely have access to Occupational Therapy. Unless unionised, workers may lack adequate access to independent legal / employment advice. To this end our strong relationship with '**Support at Work**', (Advocacy and Employment Service) in the last 18 months has been one of the key employability developments of the project.

As the broad literature on vocational rehabilitation informs us then, the quality and responsiveness of Occupational Health varies widely (Waddell, G. & Burton, A., Kendall, N, 2008; Black, Dame Carol., 2008. Hubbard, G, 2009).

Our own experience in the year 2009 / 2010 strongly supports this view.

At what point then (and by what route) should people be referred to a service like Working Health Services?

There is a strong argument to be made for a WHS Lothian approach that enrolls all referrals to the service, and thereafter supplies formal case management to all such referred workers until such times as either :-

- a) Core vocational rehabilitation interventions occur - as in the case of SME referrals. The integrated multi disciplinary team can provide this if specialist intervention is needed.
- b) It is established that there is an OH provider in existence and that there is no barrier to accessing the OH service. Sometimes it is about advocating for the employee (with their permission) to ensure a positive response from the OH provider.

It is now our view therefore that all primary referrals to WHS Lothian should be accepted until either of the above categories is established. This is important to both referring health professionals and self referring patients. The following key points inform this view.

Key Points on referral and company size

- Referral to WHS for vocational rehabilitation or case management input often occurs because a GP or an employee is being proactive about the vocational problem
- Given that the primary goal of WHS Lothian is to help individuals to stay in employment - this necessitates all positive referrals being accepted for basic case management regardless of the company size.
- It is a truism that company size means little to an individual in vocational need of help or a GP who cannot fathom apparently arbitrary criteria.
- This approach tends to cement the relationship with referrers (especially GPs) and starts the flow of referrals. It also allows for the refinement of the referrals process and the referring criteria over time - thereby getting 'buy in' from GPs.
- It ensures equal access to VR interventions for all and avoids the accusation of a two tier NHS system solely based on the sometimes immeasurable company size criteria. It also enables WHS staff to develop stronger mainstream relationships and mainstream the 'work question' with existing service cultures who might be encouraged to audit existing work / vocational standards.

Observation 2

Marketing and communication

Marketing the WHS Lothian service from the outset has been a challenging process. It has however been aided by a clear communication plan that seeks to encourage self referral and referral from GPs in particular. The reality of marketing and growing the WHS 'brand' has therefore involved the need to 'loss lead' in order to grow the service. This is intrinsically linked to referral relationships.

To obviate the problem of a low referral of SME candidates in the WHS project initially, the project board agreed at the outset to accept referrals from GPs and others regardless of company size for purposes of case management only (i.e. if a non SME case was accepted then only case management services were provided – core therapies were not provided. These were then sought from the OH provider where present).

The following justification is offered in support of our service approach:

- a) **Open Door Policy** to referral. This approach was adopted by WHS Lothian from JCP+ and other employability partners. The premise here is that someone seeking help in the employability pipeline should not have the phone put down on them, simply for not meeting a single criteria (being employed in SME<249 employees in size). Nor should referrals (the problem) simply be handed back to the GP on grounds that the person does not meet the single criteria. Strict adherence to the rule without discretion although technically correct, is a poor form of marketing and is less likely to get 'buy in' for future referral. Instinctively it goes against every mainstream theory on employability and in practice, appears to have little justification.
- b) **General Practitioner Events:** both narrative and anecdotal feedback from numerous protected learning time events with GPs has been very helpful in shaping the WHS Lothian response to GP needs. GPs make it clear at every opportunity that when afforded the opportunity they will refer to the service, regardless of whether there is an Occupational Health provider in existence. Over 20% + of our referrals met this category and justify this decision to see the Non SME referrals. (see referrer relationships above)

GPs are also notoriously overloaded by approaches from service pilots like WHS. Routinely they can be reluctant to engage with a new service and fail to refer for reasons of time. They also inform us that they cannot / will not spend the time differentiating company sizes when referring an individual. It is not a criterion that appears to work for them and their patients.

- c) Generally, WHS Lothian's experience of marketing and communication in 2009 / 2010 is that an **open door policy** on referral leads to increased overall referral from GPs. This has been vindicated in the second year of the project as FFWS took over and as numbers increased.

Key Points on communication and marketing

- In future consideration needs to be given to the **Open Door Policy** that processes all referrals to the right level of case management (in the case of non SMEs) and more detailed service intervention locally (in the case of SMEs). Crucially, such an approach does not hand the problem back to the GP (referrer) and continue the cycle of employability need. This same scenario applies equally well to patients who self refer.
- This then involves a marketing plan to GPs that might initially ‘loss lead’ in order to grow the service so that GPs especially can be encouraged to ‘buy in’ as stakeholders.
- It is very important that vocational rehabilitation as a concept not be confused with other service approaches. Although clearly compatible with aspects of ***condition management programmes, absentee management systems and Occupational Health provision*** it needs to be stressed that people are volunteering themselves for the vocational rehabilitation service. They are not conditionally bound in any way to attend.

Greater thought also needs to be given to the clarity and adoption of well established vocational rehabilitation specific concepts so that service users and referrers do not misinterpret the function of vocational rehabilitation in mainstream services for that of formal Occupational Health.

- **The WHS service is not de facto an Occupational Health Provider**, with ‘implied powers’ over referred clients as employees, as is the case in the standard OH service provision. Similarly self referring patients are not the product of a condition management process or in receipt of statutory benefits that mandates their attendance to the service. Nor can they be ‘absentee managed’. They are first and foremost the client (and NHS patients) with all that this entails.
- Patients will also tend to self refer to WHS Lothian even if they have an Occupational Health provider. This can be for several reasons. How is this to be approached long term?
 1. Patients / employees will sometimes choose not to inform their employer of a health condition as they do not trust the employer's intentions and instead seek help from a neutral service like the NHS.
 2. Patients will sometime regard employers, line managers and the OH provider (rightly or wrongly) as part of their problem. Again this leads to self referral and is best managed through case management back to the employer. Again the conduit of case management is used.
 3. It must also be remembered that if the work place is regarded as extremely difficult by the employee then it is unlikely without case management help that they can trust, that they are going to initiate discussion with the employers’ OH provider. Our work this year has routinely involved work site visits and mediation meetings between employee and employer either within our service centre or in the work site. These are proven to work.

The key point to be learned from the marketing and communication strategy to date is that a WHS Lothian approach that facilitates positive benefits to the willing employee; is constructive to the employer and provides the GP with the rehabilitation support he requires is likely to be the most effective way to proceed. So long as any communication and marketing plan displays too strict an adherence to the core criteria as was set at the outset of the project (<249 employees), then that criteria will bring with it self imposed constraints that are likely to militate against the employability culture we seek to create. The consequence is limited referrals.

Observation 3

Waiting List 'Harvesting' of Musculoskeletal Cases

The literature on vocational rehabilitation informs us that many medical conditions have need of vocational rehabilitation (Bhattacharyya, M., et al 2007; Schonstein et al 2003; Benedict W et al 2004; Hubbard et al 2009). There are many cases that encompass a single diagnosis. There are many that have multiple diagnoses. Significantly there is a large group of self referrers who may be deemed to have no formal diagnosis at all if you consider that **stress** is one of the biggest reasons for referral in the present day and is not even an International Classification Disease (ICD) category and only becomes so, when an anxiety state is diagnosed.

The experience of WHS Lothian is that many conditions merit vocational input and that many types of conditions were referred to the WHS Lothian service in the first year. How we label them is an important consideration. Similarly if we call the NHS service response to that vocational rehabilitation need 'Occupational Health' are we really using the right term? Occupational Health as a term is commonly understood to have strong formal ties to the employer and is usually a purchased service made by the employer. .

It is also not surprising that as a pilot service it was not within our gift, in the first year, to dictate the nature of the conditions that were referred, even if the service operates strict criteria. Similarly as a new service, referrers are often unsure about what is to be referred. Ideally, the WHS pilot would reflect referral rates that the research literature tells us is out there. This is a counsel for perfection on which we continue to work.

What is known in Lothian and more generally from the FFWS statistical returns to date is that mental health referrals (and their impact on functional capacity for work) are apparently deficient relative to MSK conditions referrals. Why might this be? Likewise significant medical groups of patients with conditions such the cardiovascular, respiratory and neurological conditions appear reduced in comparison.

Musculoskeletal Referrals (MSK)

The subject of musculoskeletal referral in particular is most noteworthy and requires more strategic discussion in our view. In Lothian as elsewhere it is clear that those patients with musculoskeletal conditions form an important part of the vocational rehab pathway - but only part of it.

When Lothian Working Health Services negotiated access to physiotherapy musculoskeletal waiting lists in March / April 2010 our referral numbers jumped up and our target recruitment figures changed dramatically. Patients on these lists who were deemed to work in an SME (core criteria), got ready access to physiotherapy through Working Health Services. In other words we harvested them as recruits. This follows the example of what was operating in Tayside and Borders although both these projects have now established a pipeline connection to these lists and any patient in an SME is advised to self refer to Working Health Services.

Arguably, providing rapid physiotherapy services to such patients prevents them from going off work or maintains them in work because of this intervention. It can also possibly return people to work. Using waiting lists in this way can also form part of the marketing strategy that seeks to loss lead in order to grow the WHS service.

However, from our experience we have concerns that harvesting these waiting lists and rebadging them as vocational when in many instances they only have a routine physiotherapy need and often non work related, carries risks for service development.

Our clinical experience in 2009 / 2010 is not dissimilar to the findings from the interim Dundee report of 2009 that found such individuals often only required a physiotherapy intervention and utilised no other vocational related services. Two recent internal musculoskeletal audits of 650 patients by Lothian WHS staff of the Lothian MSK lists (available upon request) does suggest that many patients harvested on the sole criteria of working in a SME had nominal vocational rehabilitation need. These statistics can therefore be interpreted to indicate that such patients were maintained at work. Those same statistics equally can be interpreted to suggest they did not need substantive vocational help and that to all intents and purposes they were at minimal risk of absence in the first place.

In many instances they simply needed a faster intervention from standard physiotherapy pathways and this is what was substituted by WHS Lothian. Their 'work needs' often appeared tangential and in many case the patients explicitly reported no problem at work when interviewed. They were still given service by WHS during the audit on the grounds of SME status. Of the 650 patients screened by WHS Lothian, only a handful were returned to work as most were at work and had minimal VR need.

What does this mean?

In our view this potentially shows that we can use waiting list to harvest patients for the project to reach the operational recruitment number targets.

It is the easiest way of garnering referrals but limits the known broader strategy of the projects and the needs of mental health and other complex conditions which we know are harder to rehabilitate but are more costly if they are allowed to become chronic. Dame Carol Black draws attention to this in her report (Working for a Healthier Tomorrow) quoting CBI figures whereby it is estimated that 175 million work days were lost in 2006. The CBI estimates that 43% of the 175 million lost days are due to sickness absence of greater than 20 days. Critically this figure reflects just 6% of the total workforce and the implications of their absence. One might argue therefore that overly focussing on MSK conditions among people in work and coping, will not serve the broader agenda well. To

this end Lothian is re-evaluating its approach to harvesting patients off of these lists by raising the entry criteria. This also allows the WHS Lothian service to continue to garner appropriate referrals but also to devote resources to other high risk VR areas that are more reflective of the need which is known.

Key Points on musculoskeletal waiting list 'harvesting'

- Explicit or implicit waiting list harvesting inflates referral numbers to the pilots but it does not appear to be a feasible and a long term substitute to identifying and harvesting broader VR need that exists. In particular the harder to reach groups within mental health and other clinical areas who form part of the group costing society the most.
- Interestingly, NHS Lothian MSK audits reveal there were more people working in the non SME category on these waiting lists than those working in SMEs. On average in Lothian both SME and non SME patients have to wait up to 16 weeks to see physiotherapy. Therefore it is quite possible to remove someone from these lists because they are in an SME, whilst leaving the non SME candidate waiting the full 16 weeks.

This latter group, it should be mentioned are presumed to have OH support. This suggests that waiting lists need to be discussed in relation to the broader picture of vocational need and not simply harvested without more searching questions as to the practice. Again this is not to suggest that the links to MSK waiting lists is wrong, just that the entry criteria to WHS now needs analysed and possibly refined.

- As a result of this awareness, it is posited here that the orientation of the WHS Lothian service resources might not be best directed at short term cases (presenteeism) epitomised by the MSK waiting list but better directed at the 6% of employees absent from work who cost employers 43% of employer's costs. These do include MSK referrals but also many other diagnoses.
- It is worth emphasising that one of the big outcomes and recorded benefits of the Lothian WHS programmes to date is the ability of its integrated NHS multidisciplinary team to return chronic cases to work - i.e. people off from work in that crucial 6 weeks to 6 month period of absence that we know leads to increased dependency and eventual flow onto social security benefits.
- As the WHS service refines itself then, MSK 'harvesting' of physiotherapy waiting lists need monitoring. Perhaps multiple criteria for enrolment to WHS need to be considered. Just being in an SME cannot be enough in itself, although clearly MSK referrals generally remain an ever present referral source of a well managed VR case management and signposting service.

Final Project Statement

It is the view of **Working Health Services Lothian** that the statistical data gathered and the associated descriptive elements that have arisen in the year July 2009 – June 2010 have provided interesting information and lessons that continue to be discussed and analysed. The analysis made within this report is wholly compatible and we believe compliments the forthcoming statistical analysis that *Works Out* will produce in the near future

Clearly, like any new project the assumptions that we made at the outset of the project shaped our initial approach. Our initial case management approach was predicated on the assumptions of the core criteria of company size. Our initial service approach therefore worked towards meeting the perceived needs of employees in small to medium enterprises (business < 249 employees in size). As a form of action research however, we discovered that with increased exposure to the many issues operating within the employability pathways, a more sophisticated understanding and service approach was needed. The numerous and complex factors that pertain in the employability field continue to be learned.

It is now our view that some of the operating assumptions around vocational rehabilitation and the service approaches we adopted need further testing and re modelling. There are many complex issues that require unpicking in the employability field in order that the common ground is established between the employee, the employer and the general practitioner - as the guardian of the Fit Note. Central to this employability triad is the core criteria for the WHS Lothian service.

Our experience over the last year leads us to this question: should there be a redraft of the core criteria to ensure that each user in the above employability triad gets their needs addressed in some equal measure?

This leads to another important question that arises when the time comes for the FFWS Lothian pilot to cease being a pilot and become a more mainstream service. Namely, how can a NHS vocational rehabilitation service provision be freely open for self referral from someone working in an SME, but yet their equivalent in a non SME be denied access to NHS help simply by dint of working in a company of greater than 249 employees? Such employees (or patients) may have vocational needs that are equally valid to SME employees - but they are potentially being denied access to an NHS service solely on the company size criteria and on the value judgements associated with these criteria. The charge can reasonably be made that this leads to a two tier NHS system and one that is unsustainable and too unsophisticated an approach going forward.

It appears to point to a need for a generalised case management model that at least initially disregards company size at point of referral to Working Health Services.

In future, the Working Health Services Lothian model (or its replacement) should as much as possible avoid an inclusion criteria that makes vocational case management and rehabilitation inoperable for a large section of the intended users. Presuming, that by inclusion, we mean people trying to stay in work or get back to work.

The core solution in our view is linked to integrated and regional specialist multi-disciplinary teams as already set up in conjunction with Healthy Working Lives that have been shown to stop the flow of employees into long term sickness. These teams would follow vocational rehabilitation principles that have been shown to work.

Such a team in Lothian although small in size could be the hub for regional VR and support regional specialism and assist mainstream grassroots NHS and employability colleagues to deal with more routine vocational rehabilitation needs. The 'work question' in our experience has to be asked locally and repeatedly.

If the Fit Note is part of a 5 -10 year cultural shift that we as health professionals are engaged with, then the teams currently working in Lothian, Tayside and the Borders appear to epitomise the best operational model. Preliminary outcomes from these teams justify this opinion and appear statistically robust. They are about to be published.

The comments made in this document form part of the broader analysis. Working Health Services Lothian's experience and the service approach we adopted in the year 2009 / 2010 is clearly open to debate. We welcome a more interrogative analysis by our colleagues so that the community of practice around vocational rehabilitation can be developed further.

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