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Health & Work Support Pilot: Interim Evaluation Report - Implementation & Early Delivery Review

ECONOMY AND LABOUR MARKET

social research

Health & Work Support Pilot: Interim Evaluation Report

Implementation & Early Delivery Review

March 2020

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1. Executive Summary

The Health & Work Support pilot is a two year project funded by the UK Government's Employers, Health and Inclusive Employment Directorate[1] and the Scottish Government.

The pilot was launched as part of the Scottish Government's No One Left Behind Strategy[2] in June 2018 with the aim of making improvements to the way early intervention is provided to individuals who have health conditions or disabilities, in order to help them sustain or return to work. In addition to providing help to individuals the pilot also provides advice, training and support to employers on issues related to health and work.

The pilot was developed on the premise that although there is already early intervention support available, the existing support landscape is complex and confusing. As such the project was originally conceived of as a "single gateway" which would act as the primary entrance point for a range of pre-existing NHS-led health and work related services, with the expectation that this approach would increase the number of individuals and businesses accessing support.

The service is being piloted across Dundee City and Fife and will run between June 2018 and June 2020 with the aim of enrolling 6,000[3] individuals across this time period. The primary service offer to individuals consists of up to 20 weeks of case management[4], holistic biopsychosocial assessment[5] and fast track access to health and work focussed clinical interventions (including physiotherapy and counselling services).

The Scottish Government and the Work and Health Unit have committed to a robust evaluation of the pilot and this report forms the first part of such an undertaking. This review focuses on the set up and early delivery stage of the pilot. It considers the extent to which the pilot is beginning to make a difference to the clarity, coordination and efficiency of the landscape of support.

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[1] Please note that this directorate, which is joint funded by the Department for Work & Pensions and the Department for Health & Social Care, was previously known as the Work and Health Unit.

[2] https://www.gov.scot/publications/one-left-behind-next-steps-integration-alignment-employability-support-scotland/

[3] Following the development of this report, target numbers have been re-profiled – see Appendix 3 for more details on this and responses to other recommendations from this report.

[4] Case Management is a generic terms with many definitions however it tends to be defined by a focus on the planning and co-ordination of care for an individual as opposed to the delivery of clinical interventions (see Hutt et al, (2004) '*Case-Managing Long Term Conditions'* London: King's Fund). Within the Health & Work Support pilot, assessment, care planning and co-ordination, review and discharge functions form the central tasks of case management.

[5] Biopsychosocial refers to a holistic approach to service delivery which incorporates consideration of an individual's wider socio-environmental situation in addition to their biological and psychological health. (See Engel, G. L. (1977) "The Need for a New Medical Model: a Challenge for Biomedicine*" Science* Vol. 196 (4286): 129 - 36).

The report summarises findings from commissioned research delivered by Rocket Science UK Ltd as well as additional research undertaken by Scottish Government analysts (further information about the methodology is set out in Appendix 2).

Key findings covered in this report include that:

- To date the pilot appears to be increasing the numbers of individuals accessing support in comparison to pre-existing services however this is largely due to widening of eligibility criteria.

- The pilot has struggled to meet its targets.

- Individuals who have recently become unemployed tend to present with mental health concerns as a primary issue whereas those in employment tend to present with musculoskeletal issues as their primary condition.

- Initial findings question the assumption that existing occupational health support provided by large employers (public and private) are adequately meeting the needs of their staff. This will require further exploration throughout the rest of the pilot.

- Call handling services within the pilot could be further streamlined to improve client experience by cutting down on the number of contacts required before reaching the point of receiving care.

- The employer facing component of the pilot requires further development. Levels of engagement with employers has varied significantly between pilot sites and requires further exploration.

- There is scope for further improvement of the pilots marketing materials and overall approach.

- The pilot's primary mode of access for individual clients (i.e. self-referral) assumes a level of health literacy and capacity to engage. This may be problematic for more vulnerable members of the population.

- The pilot's capacity to collect outcome data on clients requires further development and prioritisation.

- Case Managers reported an increase in the referral of clients with a range of intersecting and complex needs who may not have been seen by other mainstream services. The level and type of service required may therefore be more demanding than initially expected.

- In keeping with findings from the wider research literature, the Case Manager role within the pilot requires further clarification.

2. Introduction

2.1 Purpose of the Report

This interim evaluation report provides an overview of the implementation and early delivery phase of the Health & Work Support (HWS) pilot, during the period June 2018 to March 2019.

This review offers an opportunity for reflection on lessons learned to date and for the identification of enhancements and changes that could be made to further improve performance and impact.

The report has been developed using a number of sources of information, including:

- Externally commissioned fieldwork, delivered by Rocket Science, which included:
  - Interviews with stakeholders.
  - A survey with local delivery staff.
  - Focus groups with local delivery staff.
- Focus groups and interviews with local participants delivered in-house by Scottish Government.
- In-house analysis of data collected from the HWS management information system.

2.2 Purpose of the Pilot

The Health & Work Support (HWS) service is a two year pilot running in Dundee City and Fife from June 2018 to June 2020. This pilot is funded by the Department for Work and Pension's (DWP) and the Department for Health and Social Care's (DHSC) Employers, Health and Inclusive Employment Directorate, as part of its Work and Health Innovation Fund, with additional funding from the Scottish Government.

The pilot is intended to contribute to a number of strategic commitments across the Scottish Government, details of which are outlined in a variety of key documents. Centrally, the Health & Work Support service forms part of the 2018 'No One Left Behind' Scottish Government Strategy for employability support[6]. The strategy aims to facilitate the development of more effective integration and alignment between employability and other support services, including health services, in order to help groups with multiple challenges (e.g. disability, illness, homelessness, substance misuse) stay, return, or transition into employment. The action points within the strategy describe how the pilot will act as a primary entrance point for NHS-led

[6] Scottish Government (2018), *No One Left Behind: Next Steps for the Integration and Alignment of Employability Support in Scotland* - https://www.gov.scot/publications/one-left-behind-next-steps-integration-alignment-employability-support-scotland/

support, introducing a streamlined alternative to the complex and confusing landscape of existing health and work support services.

In addition to the above the pilot features within the Disability Employment Action Plan[7], with specific reference to increasing accessibility of the service and exploring additional use of mental health training and interventions. Commitments are also described in the Mental Health Strategy[8], including working with employers around mental health support for employees and also exploring ways to connect mental health, disability and employment support.

More broadly through its focus on improving health, supporting people to stay in or get back into work and also supporting employers, the pilot intends to contribute towards the following outcomes within the National Performance Framework[9]:

- We are healthy and active.
- We have thriving and innovative businesses with quality jobs and fair work for everyone.
- We have a globally competitive, entrepreneurial, inclusive and sustainable economy.
- We tackle poverty by sharing opportunities, wealth and power more equally.

2.3 Pre-Existing Health Related Employment Support in Scotland

The landscape for health and employability support services nationally is considered to be confusing and difficult to navigate for those in need of health and work services. The pilot focuses on streamlining the following national services:

- **Working Health Services Scotland (WHSS)** – a Scottish Government funded service, delivered by the NHS, for self-employed individuals and employees of Small to Medium Enterprises (SMEs) who are at risk of unemployment due to ill health.

- **Fit for Work Scotland** – a DWP-funded service for employees of companies of any size and sector, who are on sick leave or at risk of sick leave for four weeks or more.

- **Healthy Working Lives (HWL)** – a Scottish Government funded service offering employer-focused advice and guidance on health and work (e.g. risk and safety, employment law, health policy).

[7] Scottish Government (2018), *A Fairer Scotland for Disabled People: Employment Action Plan* - https://www.gov.scot/publications/fairer-scotland-disabled-people-employment-action-plan/

[8] Scottish Government (2017), *Mental health Strategy 2017 – 2027*- *https://www.gov.scot/publications/mental-health-strategy-2017-2027/*

[9] See https://nationalperformance.gov.scot/ for more details.

These services have been reconfigured and brought together under the banner of the HWS pilot within Dundee City and Fife[10]. This constitutes the 'core services' that are offered to clients.

In addition to the above the HWS pilot has added a pathway for those who have become recently unemployed and who are experiencing ill health or a disability as a barrier to re-employment.

2.4 Who Does the Pilot Aim to Help?

The pilot is focussed on targeting; those at risk of losing employment due to a health condition and/or disability, individuals who are recently unemployed due to ill health and/or disability and employers who require support, in the form of advice or training, for health and work issues.

Pre-existing services (detailed above) largely focussed on individuals with musculoskeletal (MSK) problems whereas the pilot has widened its remit to include a focus on those with mental health concerns related to work. The overall eligibility criteria for the pilot is as follows:

- An adult aged 16 plus;
- In paid employment or self-employment experiencing a mental / physical health condition or disability that is affecting their employment;
- Or unemployed for up to 6 months, experiencing a mental / physical health condition or disability that is affecting their prospects of employment;
- Living or working in Fife or Dundee City;
- An employer in Fife or Dundee City who requires advice on mental / physical health, disability and work issues.

Dundee became one of the two pilot areas for a number of reasons including pre-existing high levels of demand for health and work services. Fife was felt to be an appropriate complementary pilot area with a more dispersed population and a tighter labour market (less unemployment).

It should also be noted that these two areas are different in terms of population size and make-up, geography (including rural and urban differences) and wider service provision.

[10] Note that HWL & WHSS continue to run as national services across the rest of Scotland.

2.5 How is the Pilot Set Up?[11]

There are two main referral routes into the service: self-referral (via website, or the national phone line), or referrals from GPs and other health professionals. Access to the pilot follows three steps, each delivered by a different delivery partner:

1. **National Pilot Phone Number (delivered via Healthy Working Lives[12])** – provides telephone access to the pilot for clients who self-refer. If clients are seeking clinical support and live or work in the pilot area, then they are considered eligible for triage and are transferred to the next stage.

2. **Pilot Triage and Enrolment Service (delivered by Salus)** – the main call handling service within the pilot, providing triage and enrolment. Clients access Salus either via the HWL advice-line or directly via a web-form provided on the Salus website. Salus establishes whether clients are eligible for the pilot by taking them through a triage system. Eligible clients are then enrolled into different 'workstreams' (explained below) before being transferred to case management staff in the local pilot areas. Those who are not eligible are signposted to other relevant services.

3. **Case Management (delivered by local NHS Boards) -** the case management service represents the core of the pilot and incorporates bio-psychological assessments, action planning, onward referral for clinical interventions and access to self-management materials. Case Managers normally contact clients by telephone to conduct the initial assessment before referring clients to clinical support where required (i.e. the intervention[13]). This part of the pilot is intended to last up to 20 weeks. Case Managers can also signpost to a variety of other services within the local area that offer support.

There are three workstreams within which individuals can be enrolled, dependent on their employment status and background. Services offered by the workstreams are largely similar, involving both case management as well as the potential for onward referral for clinical interventions, although the focus of support will vary dependent on an individual's needs.

[11] See figure 1 below for a diagrammatic representation of the pilots service delivery model.

[12] Please note that Healthy Working Lives (HWL) is an umbrella term referring to a programme of services delivered in partnership by the territorial Health Boards and NHS Scotland. Within this report the term HWL is used to generally refer to the work of two teams working under the HWL banner; one providing call handling duties for the pilot's phone number (delivered by the national HWL team) and the other providing support to employers within the pilot areas (delivered by the local HWL team members located in NHS Tayside and NHS Fife).

[13] Primarily physiotherapy and counselling which are provided by a combination of in-house and commissioned delivery.

Working Health Services Scotland - individuals employed by an SME (less than 250 staff), whether absent or present at work and struggling to stay in employment due to a health condition or disability;

Large Employer/Employee Service (LEES)[14] - individuals employed by larger organisations (more than 250 staff), whether absent or present at work and struggling to stay in employment due to a health condition or disability;

Employability and Health – individuals recently unemployed (less than 6 months) as a result of a health condition or disability;

A fourth workstream is available for employers:

Healthy Working Lives – for employers in the Fife and Dundee pilot area who require advice and support around health and work issues.

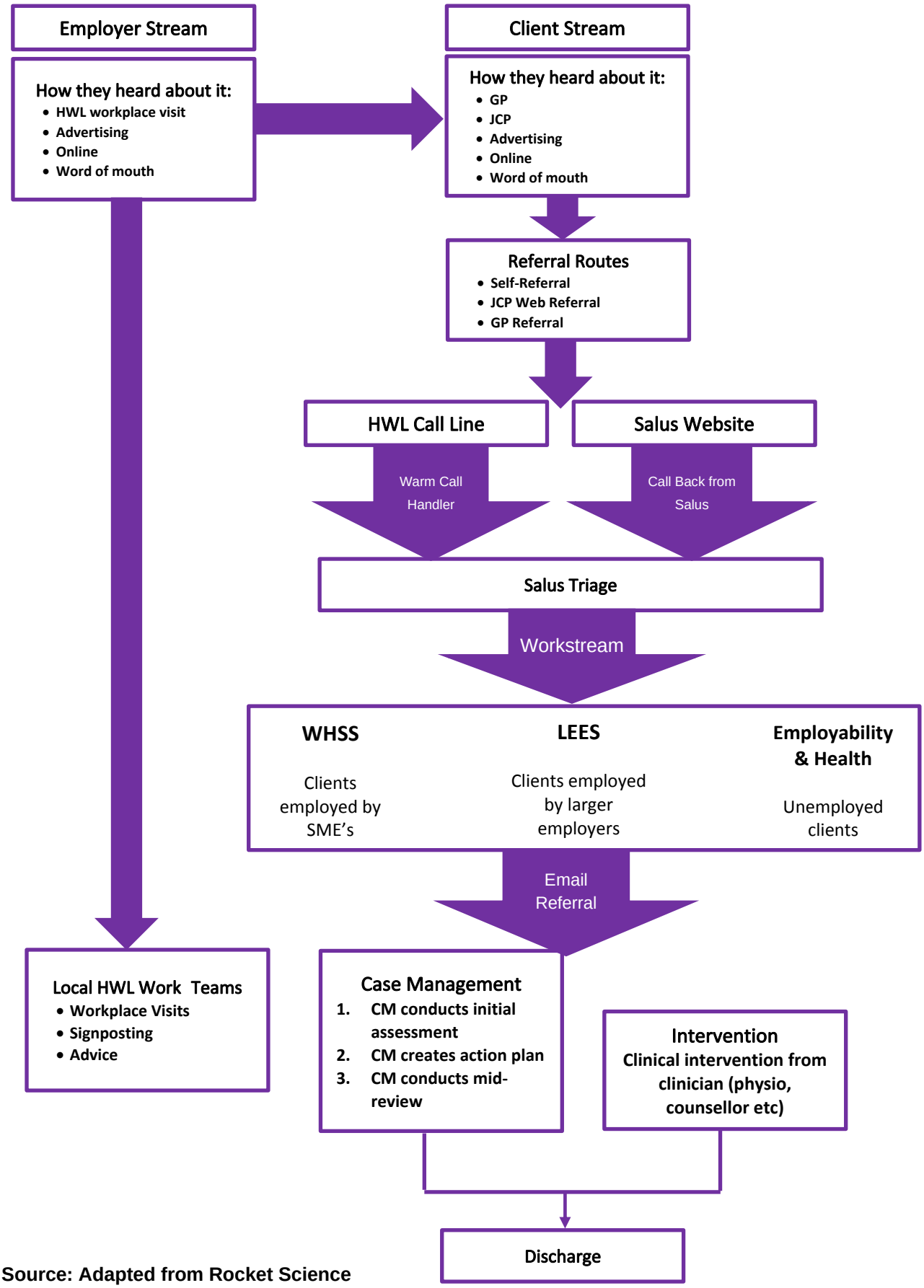
In addition to the above there is a 'light touch' element to the pilot (referred to as the Local Support workstream) which provides support and signposting for clients not meeting the eligibility criteria. It is important to note that individuals in receipt of this light touch service do not count towards the services target numbers.

The operational work of the pilot is also supported via the work of a dedicated Improvement Advisor within the Scottish Government's national pilot team. The Improvement Advisor works with both pilot staff and wider stakeholders using techniques based on the Scottish Government's Three Step Improvement Framework for Scotland's Public Services[15].

[14] It should be noted that although not originally included in the pilot, clients who are employed by large organisations with access to Occupational Health (OH) services are now considered eligible for the service under certain circumstances. This change was made as it was felt that there were situations in which employees of large organisations may have concerns around their OH provision, experience difficulty accessing it, or their in-house OH services may not be capable of meeting their needs (e.g. through limited availability of clinical services such as physiotherapy).

[15] https://www2.gov.scot/Resource/0042/00426552.pdf

Figure 1: Process Map of the Health & Work Support Pilot



Source: Adapted from Rocket Science

3. Findings

This section presents summary data followed by an analysis of key stakeholder interviews, focus groups and online survey results as well as brief case studies derived from interviews and focus groups with clients.

3.1. Management Information Data[16]

3.1.1 Throughput

Table 1: Total number of service users for Fife and Dundee by each stage of the pilot service (June 2018 to March 2019)

Stage of HWS	Number of service users		
	Fife	Dundee	Total
Enrolments (Salus)	332	597	929
Clinical Assessments (Case Managers)	289	484	773
Discharges conducted (Case Managers)	124	128	252

Source: Scottish Government Health & Work Pilot MI data, June 2018 - March 2019.

Analysis of management information (MI) data suggests that there is a degree of drop-out at each stage of the pilot, from enrolment through to discharge across both sites. The largest proportion of drop-out occurs between assessment and discharge suggesting it is likely that clients have received clinical input. It should be noted however that as clients are eligible for up to twenty weeks of support there will be a significant time lag between enrolment and discharge.

It is interesting to note that Fife and Dundee have very similar numbers of discharges despite a much larger number of clients being enrolled into the service in Dundee which suggests potential variations in process and practice between the two sites.

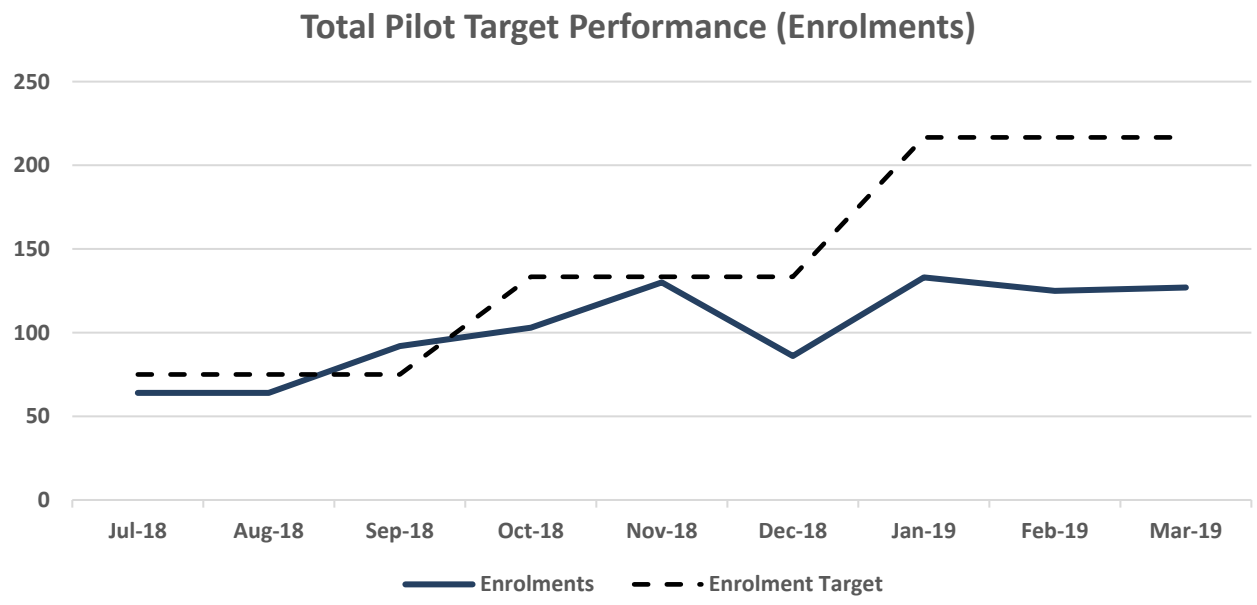
3.1.2 Target Enrolments

The target set for the pilot (with regards to individual clients) is 6,000 enrolments over the two years of the pilot with an even split across the two pilot sites. To begin with this target was also split evenly across the pilot period, however following feedback in September 2018 a decision was taken to re-profile the monthly targets

[16] Please note that data presented here may differ from those in Scottish Government statistics publications as the data was extracted from the management information system at different points in time.

so that they gradually ramp up over the life of the pilot (see black dotted line in chart below).

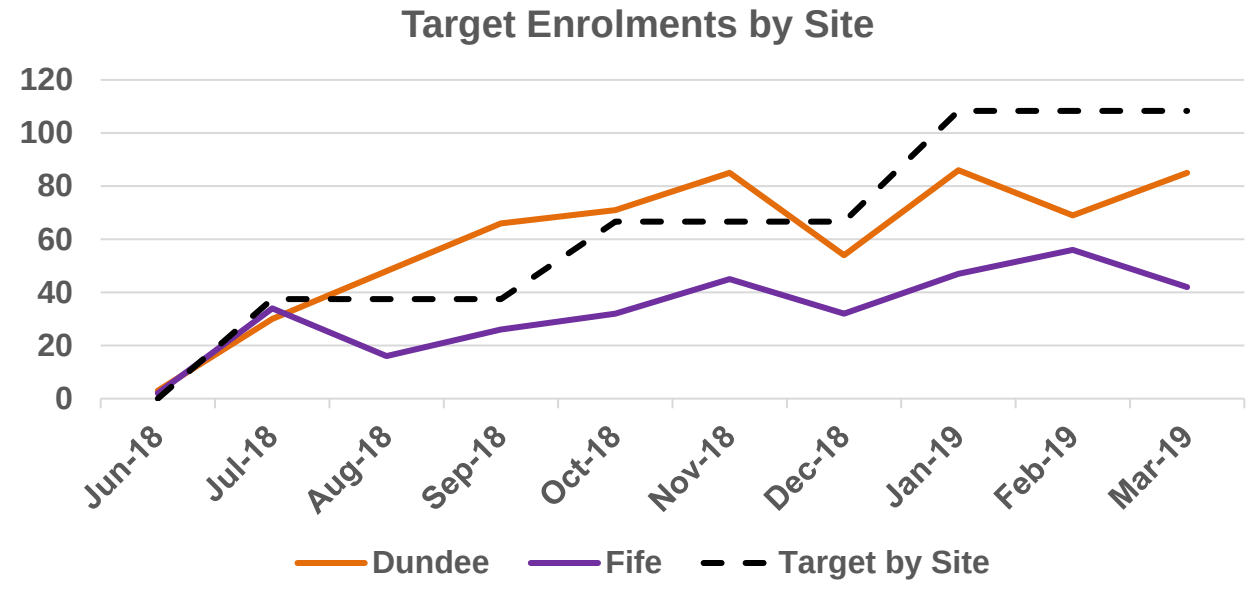
Figure 2: Pilot Target Performance (June 2018 to March 2019)



Source: Scottish Government Health & Work Support Pilot MI data, June 2018 - March 2019.

Figure 2 demonstrates that, as a whole, the pilot has reached its monthly target only once (September 2018). The maximum number of clients seen in a given month appears to reach a plateau at around 130 clients. Given that the target increases over the two year period the gap between actual performance and the target continues to increase.

Figure 3: Target Enrolments and Achieved Enrolments by Pilot Site (June 2018 to March 2019)



Source: Scottish Government Health & Work Support Pilot MI data, June 2018 - March 2019.

Figure 3 shows that Dundee exceeded the target on a number of occasions during the early period of the pilot whilst Fife has yet to successfully meet the target. It should be noted however that the Tayside area (which includes Dundee) has consistently tended to be high performing relative to other areas for similar pre-existing services such as Working Health Services Scotland. Additionally as noted elsewhere in this report, variations in labour market conditions, geography and marketing are likely to have impacted on differences in performance between the two pilot sites.

3.1.3 Enrolments

While there are a number of ways clients hear about the service the majority of individuals will refer themselves into the pilot instead of being referred by someone else (e.g. GP, DWP Jobcentre, employer). Figure 4 demonstrates that the most common way clients hear about the service and then self-refer is through their GP in both Dundee & Fife (58% and 54% respectively). Jobcentres are the second most common referral route in Dundee and the third most common in Fife, yet both account for approximately 13% of their total referrals. Other Health Professionals account for 14% of referrals in Fife, compared to 9% in Dundee.

Figure 4: Total number of enrolments by source for Dundee and Fife (June 2018 – March 2019).

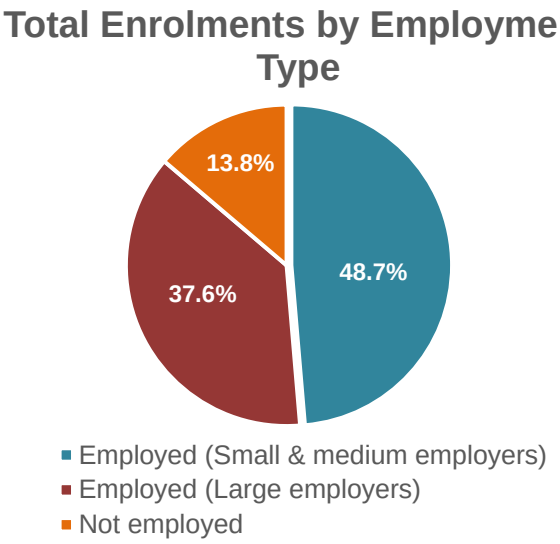
Source of Referral	Dundee	
GP	344	57.6%
Jobcentre Plus	80	13.4%
Employer	62	10.4%
Other Health Professional	52	8.7%
Prior Knowledge / Referral	22	3.7%
Other	20	3.4%
Word of mouth	16	2.7%
Unknown	1	0.2%

Source of Referral	Fife	
GP	179	53.9%
Other Health Professional	45	13.6%
Jobcentre Plus	42	12.7%
Employer	34	10.2%
Other	14	4.2%
Word of mouth	13	3.9%
Prior Knowledge / Referral	4	1.2%
Unknown	1	0.3%

Source: Scottish Government Health & Work Support Pilot MI data, June 2018 - March 2019.

Of the 929 individuals enrolled onto the service, 86% were employed and 14% unemployed (see figure 5 below). This figure was relatively similar across both Dundee and Fife. It should be noted that it had initially been anticipated that the short-term unemployed would make up approximately one third of the overall enrolments into the pilot and therefore this represents a significantly lower number than expected.

Figure 5: Enrolment number by business size.



Source: Scottish Government Health & Work Support Pilot MI data, June 2018 - March 2019.

Of the 801 individuals who were employed, 56% were from small and medium businesses (<250 employees or self-employed) and 44% from larger employers (>250 employees).

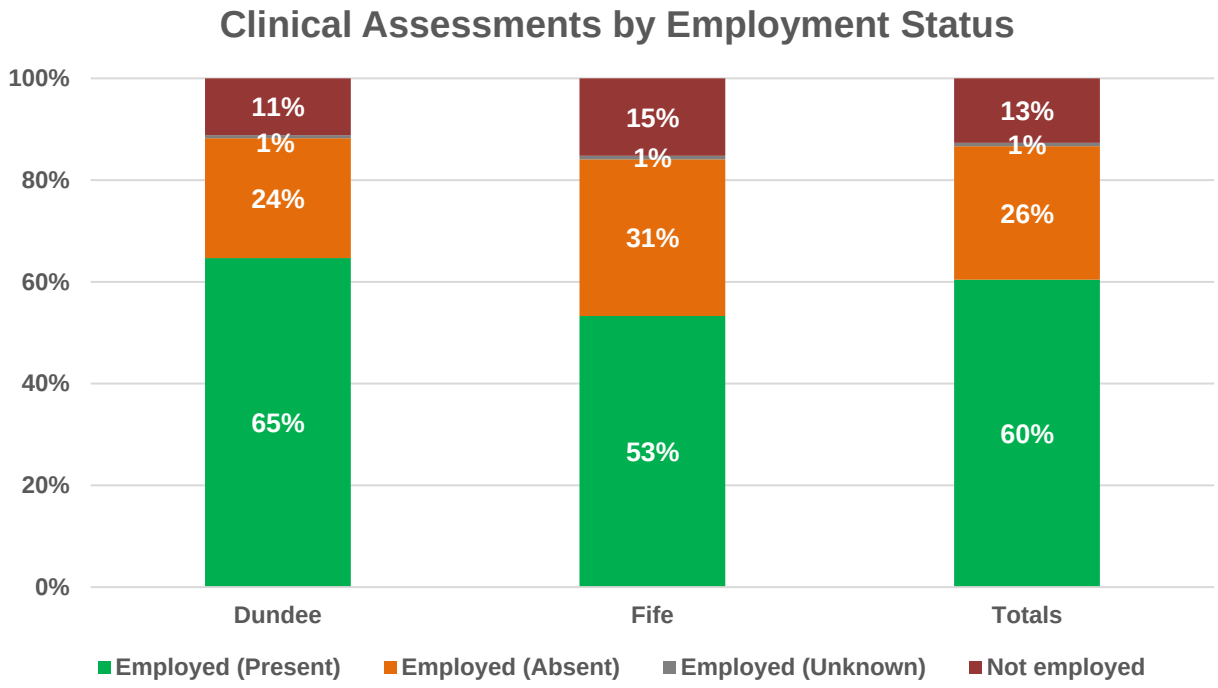
Comparison of the two pilot sites reveals that Dundee has many more enrolments from individuals working for larger employers. Within Dundee 49% of those in employment came from larger employers whilst Fife only had 34% from this same group. This may be partly explained by variations in the overall labour market between the two areas or/and by differences in the marketing approach adopted by each pilot site.

It should be noted that a significant proportion of the large employers which individual clients work for are made up of public sector organisations, including local councils and NHS services. Overall this raises questions about the degree to which existing occupational health services within larger employers, including public sector employers, are adequately meeting the needs of their employees. This is an issue that requires further exploration and will be followed up in subsequent phases of the evaluation.

3.1.4 Clinical assessments

Of the 773 eligible clients who were assessed by Case Managers, most were employed and present at work (60%). It should also be noted that in addition to the above, 39 clients who are part of the Local Support stream were also assessed during this time period with the majority of these assessments taking place in Fife (69%).

Figure 6: Total clinical assessments in Fife and Dundee by Employment Status



Source: Scottish Government Health & Work Support Pilot MI data, June 2018 - March 2019.

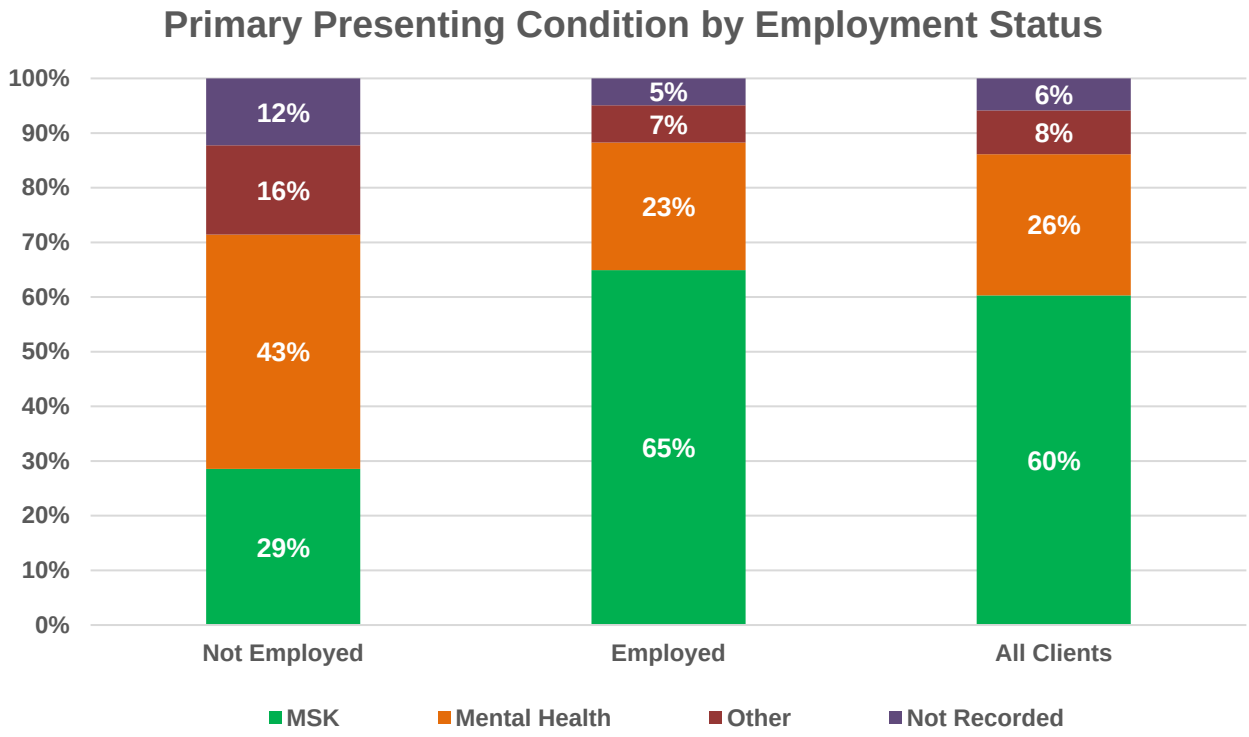
3.1.5 Primary Presenting Health Condition[17]

Historically the main client group of pre-existing services report musculoskeletal (MSK) conditions. The pilot has added a focus to target those experiencing mental health problems which are impacting on their employment.

Although the pilot is receiving a higher percentage of clients with mental health conditions (26%), the majority of continue to present with MSK as their primary condition (60%). It should be noted however that there are significant numbers of individuals who present with multiple conditions, including combinations of MSK and mental health related difficulties.

[17] This data was from completed clinical assessments and may omit service users for whom clinical assessments were carried out and not recorded.

Figure 7: Primary Presenting Health Condition by Employment Status[18]



Source: Scottish Government Health & Work Support Pilot MI data, June 2018 - March 2019.

There are clear differences between the conditions reported by clients and their employment status as shown in the chart above. Namely:

Not employed – more people with mental health conditions (43%) accessed the service than those with MSK conditions (29%).

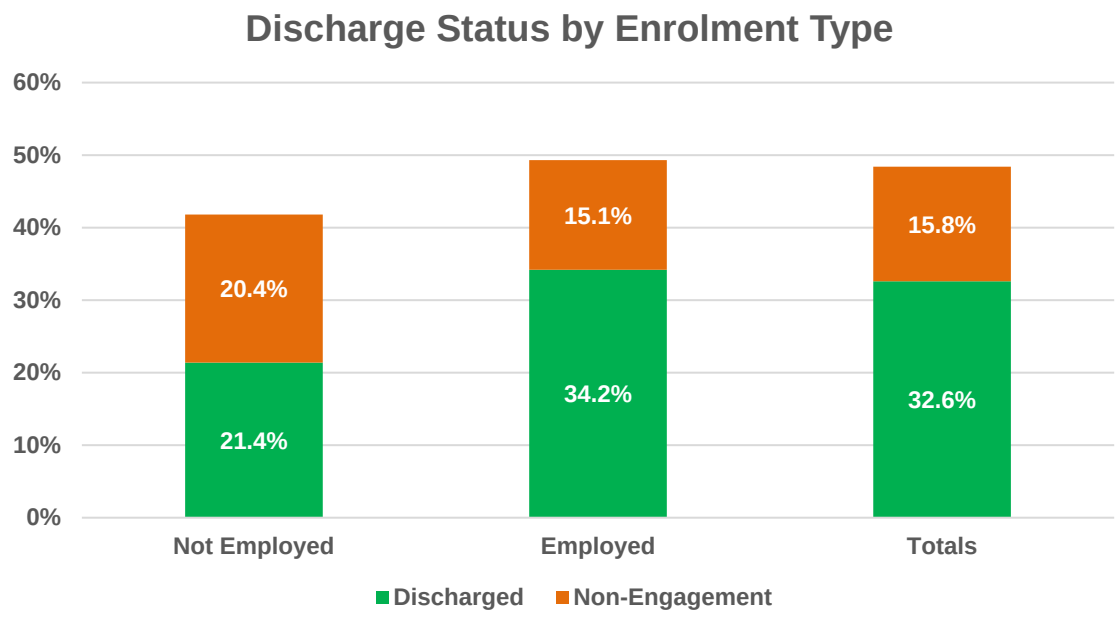
Employed – a higher percentage of people with MSK conditions (65%) than mental health conditions (23%) accessed the service.

3.1.6 Discharge and Outcomes

As previously noted lower numbers of clients than expected have successfully been discharged to date. This may be due to difficulties faced by Case Managers in engaging clients until the final discharge appointment. At present, data suggests that 33% of all clients who have been assessed to date have received a discharge whilst 16% have dropped out of the service before receiving a full service. Analysis by employment status suggests that those not in employment are more likely to drop out (20% of all assessed) than those in employment (15%) and are therefore less likely to see the service through to discharge.

[18] Please note that individuals on sick leave are counted as part of the employed group.

Figure 8: Discharge Status by Employment Type



Source: Scottish Government Health & Work Support Pilot MI data, June 2018 - March 2019.

Partly due to the issues noted above there is currently a very limited amount of data on outcomes available for clients. Full analysis of outcomes for clients will form a central part of the analysis which is due to be undertaken as part of the second phase of the evaluation process.

3.1.7 Employer Engagement

Whilst the service has a target to provide support to an additional 200 employers, work is still ongoing to reach agreement between service delivery partners on a definition for this target.

Data that is currently available suggests that across both pilot areas, 53 employers have engaged with the service to date (June 2018 to March 2019), although the majority of this engagement has been in Fife as opposed to Dundee. Reasons for this will be explored in more detail in subsequent stages of the evaluation.

In addition to formal engagements with employers (in order to provide a particular service) local Healthy Working Lives staff situated within the pilot have also been engaged in marketing activity, primarily directed at SME's. It is hoped that building relationships and raising awareness of the service will eventually lead to increased uptake of the service, both by employers and their employees.

3.2 Design and Development

3.2.1 Pilot Design

There was a six month lead-in between funding being confirmed and the service going live in June of 2018, with the bulk of service delivery, process and data collection design taking place during this period. This was seen by many of the strategic staff who were involved as being very pressurised and has had knock-on effects through to the implementation stage, including impacts on staffing, securing premises for the delivery teams, defining roles and on data collection processes.

Despite the challenges experienced, the general view from staff and stakeholders is that there was significant buy-in from all service delivery partners.

"It (design phase) has been good, a lot of buy in from different stakeholders – there's also been academics involved and generally people with a real wealth of experience…. without that kind of early relationship building the project would not have got off the ground."

Stakeholder interview

3.2.2 Staffing and Premises

There were a number of recruitment challenges that had an impact on the design and early implementation period of the pilot. Such recruitment issues were noted to have affected both local delivery teams as well as the Scottish Government's national pilot team.

"There was a lead in time, but, because of budgets and recruiting issues, it was difficult to recruit staff because money hadn't come down or the financial plan was not signed (off) by the appropriate people."

Stakeholder interview

With regards to the logistics surrounding set up of front-line delivery, Fife initially struggled to obtain suitable premises for their team. The team in Dundee were, on the other hand, able to secure use of facilities at a local hospital with relative ease. This was attributed by some stakeholders to the structures and processes in place within local NHS services and variations between local health boards. This should be noted for any potential future service provision which uses the pilots existing structure as there may be significant variation in both the availability of premises and buy-in from senior stakeholders within local health services.

3.2.3 Data Collection

Staff noted concerns with the data collection system and processes in place for the pilot[19]. In particular there were issues identified with the design of questionnaires used during contact points with the client (assessment, review, discharge). This has resulted in unnecessary duplication (and therefore increased burden of use) throughout the system as well as inconsistencies in the amount and type of data collected for individuals. This has potential negative consequences both for effective service delivery as well as for future evaluation of the service[20].

3.3 Early Implementation

3.3.1 Changes since the design stage and knowledge of the pilot

There have been a number of changes to the pilot since the launch in June 2018, including changes to eligibility criteria, processes and data collection[21]. Whilst the changes were generally perceived as positive and as adding value to the pilot, they have also caused some issues and frustrations. According to the staff and stakeholders who were consulted these frustrations have mainly been related to issues pertaining to communication of changes, rather than with the changes themselves.

One of the potential consequences of this is that amongst local delivery staff (Case Managers) there appeared to be a perception that the call handlers (HWL and Salus) lacked knowledge of the pilot with regards to its aims and eligibility criteria. Both Salus and HWL were however open in talking about the challenges that they encountered in adapting to changes required by the pilot. Representatives from both organisations felt that the changes contributed to a lack of clear understanding in the initial weeks after implementation.

“With two extra weeks we would have had time to look at what the different streams were doing and be more confident.”

Call handling focus group

It should also be noted that unlike the Case Managers call handling staff work across a number of different services with variant aims and eligibility criteria.

[19] The majority of data collected is recorded within the Syntax system (which is provided by Salus) with both Salus call handlers and local Case Managers inputting into this system.

[20] It should be noted that, due to the lack of availability of analytical staff during the design stages, the development of data collection systems was led by Case Management Staff.

[21] Example of changes include widening of eligibility criteria to include clients employed by large organisations (more than 250 employees).

3.3.3 Liaison Between Service Delivery Partners

Stakeholders noted that experience developed working together on pre-existing services (such as Fit for Work and Working Health Services Scotland) was beneficial with regards to the development and implementation of this service.

However throughout the consultations, there was some concern that the pilot may not have been a high priority for all delivery partners. Some stakeholders reported that there may be issues with organisational priorities and agendas being given precedence over the pilot. It was also reported that there were some challenges associated with running localised pilots within existing nationwide services.

Surveys conducted with front-line staff indicated that 65% of Case Managers 'agreed' or 'strongly agreed' that they coordinated well with HWL, with 73% indicating the same for Salus.

Although the online survey indicated that the majority of Case Managers felt that the service coordinated well with HWL and Salus, the findings from the focus groups and interviews did not fully support this. It was also noted that call handling staff were somewhat disconnected from the clients total journey through the service. As clients are passed from HWL to Salus and from Salus to case management, staff involved at the various stages of the pilot reported not being fully aware of what happens to clients throughout their involvement with the service. The overall feeling from delivery staff was that the pilot coordinates reasonably well from the clients' perspective, but behind the scenes there is less coherence.

3.3.4 Governance

Some stakeholders noted that there were still governance related issues that needed to be resolved. For example, all three delivery partners have their own governance and reporting standards outwith the pilot, which can result in decisions made outwith the pilot's governance structure that have consequences for the running of the service.

Concerns were also raised regarding the effectiveness of the pilot's governance groups with regards to their capacity or willingness to provide sufficient challenge and to hold the different delivery partners accountable for the progress of the pilot. This issue may also result from having multiple service delivery partners involved in the delivery of the project, which may result in a lack of coherence with regards to governance.

3.4 Service Delivery

3.4.1 Referrals and Client Support Needs

Key to the design of the pilot is that the clinical interventions provided to participants are not markedly different to what can be accessed via mainstream

CLIENT CASE STUDY 1

Client 'A' works at a SME and had been suffering from a flare up of a longstanding back problem. She heard about the pilot through her employer and decided to get in touch, hoping that she would receive quick access to physiotherapy.

The client self-referred and was assigned a Case Manager who she engaged with via phone appointments. The Case Manager in turn assigned her to a physiotherapist from whom she received clinical support.

The client reported that the input she received prevented her from needing to take time off work and equipped her with the knowledge she needed for ongoing self-management.

"I absolutely cannot fault it, it was a great service, it was so quick, anyone that I spoke with was helpful..."

Client A

routes or through pre-existing services. Rather what has changed is the access routes into these interventions.

Feedback from client focus groups and interviews suggests that the pilot's capacity to circumvent longer waiting times for mainstream NHS services is seen as one of its main selling points and key strengths.

"I would have gone privately if this service wasn't available, I was seen within 10 days which is brilliant.... before things become even more troublesome..."

Client interview

However one of the unintended consequences of providing faster access routes into clinical interventions has been the number of clients entering the service with significantly more complex care needs than was initially anticipated. As noted in the data section, the majority of clients self-refer but are made aware of the service from their GP. However Case Managers have noted that they receive referrals from GPs which are not necessarily appropriate for the service, for example, clients with terminal cancer or long term mental health conditions that will require years of ongoing support. While such individuals may benefit to some degree from the support provided, the pilots focus on work may not be appropriate, and as such they may be better served by mainstream NHS services.

"GPs want a permanent service they know they can go to…but it has to be more work focused, it has to be clearer that we are trying to keep these people in work. We have to justify the people that are trying to come through the service. GPs will use us for anything in order to not put clients into long waiting lists."

Case Management focus group

Across all service delivery partners it was felt that clients who were being referred or signposted by GPs were less likely to be aware of the specifics of the pilot's service delivery offer. These clients were often

under the impression they were simply calling up to book an appointment for either physiotherapy or counselling.

"They think they're calling to book in an appointment (with a physio) – if the GP says, 'Phone that number and you'll get physio' they think that's all they need to do."

Call handling focus group

"...when the GP gives them the number they don't explain, they phone up and think they will get an appointment immediately and are disappointed."

Case Management focus group

This appears to be corroborated to some extent by the feedback received from clients during interviews and focus groups. Several of those interviewed who were directed towards the pilot by their GP were simply told that the HWS pilot would provide them with fast track access to clinical interventions without necessarily explaining the service in detail.

"They never really told me much about it...I found out more once I actually contacted the...service"

Client interview

The additional level of complexity of patients has resulted in more time being needed for interventions, and additional training requirements for staff being identified (i.e. training for suicide prevention), all of which impacts on capacity.

Case Managers reported that in some cases, this was the first support that some clients had received, despite having serious health concerns (mainly to do with mental health issues). This highlights the value of the pilot in attracting people who may not realise how serious their condition is, or who have slipped through the gaps in the current service landscape.

"You hear relief in people's voices when they realise we can help."

Case Management focus group

CLIENT CASE STUDY 2

Client 'B' works at a SME in Dundee and had been struggling with mental health concerns when she contacted her GP. Her doctor recommended that she self-refer to the pilot in order to avoid having to wait for potentially over a year to be seen by mainstream NHS services.

She had managed to continue to attend work during this time and was looking for some preventative help before her condition got worse.

Although she found accessing the service relatively straightforward she had difficulties in obtaining appointments with the counsellor due to the fact that the service only operates during normal office hours. She stated that she had waited up to six weeks between counselling appointments which were carried out on the phone. During this time she had several crisis episodes and felt unclear about who to turn to for help.

CLIENT CASE STUDY 3

Client 'C' was unemployed at the time she engaged with the pilot. She heard about the service from a Work Coach at the local JCP.

She self-referred into the pilot, looking for a service that could help her communicate her health needs to a prospective employer. The Client's Case Manager put together a letter which detailed her health condition (fibromyalgia), how it would impact on her work and any adjustments she might need.

The client included these in applications and was successful in gaining employment.

Client 'C' felt that the support she received from the Case Manager, including the report on her health condition, helped her get back into work and that she would definitely recommend the service to others.

Case Managers felt that it was their clinical backgrounds (as occupational therapists, nurses, mental health nurses etc) that enabled them to address the wide range of client needs, even those that have proved more complex.

"I provide a general and holistic assessment, but because I'm an occupational therapist I feel as if I do interventions at that point as well. I'm able to support people who have a physical or mental health problem that requires urgent intervention, and this can lead to an action plan or a longer intervention occurring at the point of assessment."

Case Management focus group

In addition to the issues outlined above there have also been some challenges associated with referrals from Jobcentre Plus (JCP). Namely, the number of referrals from JCP for unemployed individuals has been significantly lower than originally anticipated. JCP staff have highlighted the issue of drop outs in reference to this (i.e. the difference between the number of clients who agree to self-refer into the pilot at the point of discussion with their Work Coach versus the number who actually do make contact). This may be due in part to the fact that the pilot's primary mode of access for individual clients (i.e. self-referral) assumes a level of health literacy, capacity and willingness to engage which may be problematic for more vulnerable members of the population.

As a result of such issues being identified, a formal web-based referral route from JCP through to Salus is being developed. This will allow JCP Work Coaches to refer the client directly, or the client can self-refer using a computer in the Jobcentre.

3.4.2 Client Experience and Quality of Engagement

Staff reported that irrespective of the various challenges the service has faced, they are working hard to ensure that these do not have an adverse impact on the client's experience.

One of the areas that has been identified for improved efficiency is the access route into the service. The multi-stage process to ultimately refer clients to a clinician

such as a physiotherapist or counsellor has been reported as being clunky with too much repetition. It remains the case that by the time clients have had their first physiotherapy or counselling session, they could have spoken to five different people in the service[22]. It is felt by many that there is a risk that clients might feel unsatisfied with this process. In response to such concerns both Salus and HWL suggest that the service could be provided with only one call handling service.

"*When a client is calling in, they're told, 'Call here then call here then call here'*

Case Management focus group

Case Managers raised concerns that the current system of having two call handling services increased the risk of client disengagement. This is supported by HWL and Salus who, as previously noted, both suggested that only one service delivery partner is actually required to deliver the initial call handling element of the pilot.

3.4.3 Staff Roles

It was clear from the fieldwork carried out that there is a need for clearer definitions, guidance and expectations about staff roles. Case Managers in particular reported a lack of clarity with regards to their role. This is due to the fact that the service is designed with the expectation that the Case Manager role is there to provide assessment, review, referral and discharge functions in addition to liaising with wider affiliated services and employers where appropriate. However, Case Manager's emphasised that their background and training as clinicians meant that they are also capable of providing a range of clinical interventions to clients as opposed to simply referring clients on to others for intervention (e.g. physio or counselling).

"I provide a general and holistic assessment, but because I'm an occupational therapist I feel as if I (can) do interventions at that point as well."

Case Management focus group

"There was...confusion around who was doing what. The roles were a bit unclear."

Call handling focus group

Concerns around ensuring clarity with regards to Case Managers' roles is more widespread than this service alone. A review of the literature around Case Management led services highlights the importance placed on ensuring clarity of

[22] For example a potential client journey could involve contact with; HWL call handler > Salus Call Handler > Duty Case Manager > Case Manager > Physiotherapist / Counsellor

roles and remits (see Goodman et al, 2010[23], Chapman et al, 2009[24], Ross et al, 2011[25]). A review of Case Management led services undertaken by the King's Fund in 2011 stated that:

"Case management programmes have often been characterised by confusion over roles, which can lead to tension.... These problems are mostly due to a lack of clarity regarding role boundaries and/or a lack of communication between the different care providers"

(Ross et al, 2011).

Given existing concerns with regards to capacity within local Case Management teams (further discussion of which is found below) this is an issue with requires further exploration. If Case Management staff are struggling with existing workloads, as has been suggested, then clarity around staff roles is vital to ensure that staff are not engaging in additional work that is not required nor expected of them. However it should also be noted that as qualified clinicians Case Managers may feel that their skill are being under-utilised if expected to simply provide a basic case management function.

3.5 Pilot performance

An initial look at comparative data between pre-existing services (Working Health Services Scotland and Fit for Work) and the pilot demonstrates improvements with regards to numbers of clients accessing help. However this increase appears to be largely supported by widening of eligibility criteria to include individuals not qualified for access to pre-existing services (e.g. the unemployed, those employed by large organisations and off work sick for less than four week). Actual growth in core target client groups, such as those employed by SMEs, has been limited to date (less than 5%).

Additionally it should be noted that growth in client numbers varies between the two pilot areas with Fife demonstrating stronger improvements in the numbers of SME clients accessing support over baseline figures as compared to Dundee. This is due to the fact that a significant proportion of Dundee's increase in activity has been supported by the inclusion of clients from large, often public sector employers whereas the service in Fife has continued to receive the majority of its clients from SMEs.

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[23] Goodman C, Drennan V, Davies S, Masey H, Gage H, Scott C, Manthorpe J, Brearley S, Iliffe S (2010). *Nurses as Case Managers in Primary Care: The contribution to chronic disease management.* Report for the National Institute for Health Research Service Delivery and Organisation programme.

[24] Chapman L, Smith A, Williams V, Oliver D (2009). 'Community matrons: primary care professionals' views and experiences'. *Journal of Advanced Nursing*, Vol. 65, no 8, pp 1617–25.

[25] Ross S, Curry N, Goodwin N (2011). *'Case Management: What it is and how it can be implemented'.* King's Fund.

3.5.1 Targets

Targets are one of the biggest challenges associated with this pilot. The focus on enrolment numbers (targets) is seen as a concern by many stakeholders who feel that there should be greater focus on other outcomes from the pilot. In addition, there is confusion as to how the target numbers were derived.

"It's about what each individual client needs and what quality we can provide…it would be sad to give that up because we can't get the targets. Do we want to be a very unique service or just meet numbers?"

Case Management focus group

"*The numbers are very unrealistic; they didn't get them right."*

Call handling focus group

The equal split of targets between Fife and Dundee (1,500 each per annum) is seen to be problematic in so far as that it is not reflective of the local populations (Fife has a 16 plus population of 307,437 and Dundee 124,734[26]) . Additionally the underlying geography of each of the pilot sites is likely to have an impact given that the Dundee pilot site serves a discrete city based population whereas in Fife the population is dispersed over a much larger and largely rural area.

From the fieldwork undertaken to date, it is clear that although the pressure of meeting target numbers appears to fall largely on Case Managers, they feel that they have very little opportunity to actually influence the number of people calling the service and are primarily there to provide assessment and support to individuals within the service.

HWL and Salus filter eligible clients through to local delivery teams yet are not aware of any targets they need to meet, or if local teams are meeting their targets. They also have limited opportunity to influence the total referral numbers.

It should be noted that during the focus groups, Case Managers stated that in their opinion they were already at full-capacity based on the current number of people accessing the service. Although strategic level interviewees felt that it was a well-funded pilot, especially in relation to its size, findings from the implementation period suggest a potential mismatch between targets and resources, with the potential need for more staff in all organisations as client numbers increase. Case Managers in Dundee noted that the time between physiotherapy and counselling sessions is already increasing, with some clients still in the service, past the expected 20 weeks. This suggests that the level of staffing resource is not well aligned to targets and expectations of numbers of clients coming through the service.

[26] Derived from National Records of Scotland 2018 Population Estimates

3.5.2 Marketing

Marketing activity has been viewed by those within the pilot as a key mechanism which can influence whether targets are met, but it is not without its own challenges.

Key considerations for marketing from consultations were that:

- Awareness of the programme was still low among the public and employers in both pilot areas.
- It was felt that the NHS branding should be more apparent as people reported to Case Managers that they thought it was a private service which they would have to pay for.
- Case Managers stated that marketing material should be adapted to more clearly indicate both eligibility criteria and what the service offers.
- Staff stated the use of the word “disability” might be off-putting to some individuals as people with mental health problems or common MSK issues may not view themselves as having a disability.
- Some stakeholders felt that the national 0800 number may be having an impact on the target numbers as people don’t feel comfortable calling/receiving calls from a non-local number.
- Referral numbers are expected to increase as a result of word of mouth from both employers and clients who have been through the service.
- As the pilot is set out, there are three clear and distinct target groups (employed, unemployed and employers). These three groups have different needs and this suggests that targeted marketing approaches are required.
- Marketing should not be a responsibility of existing staff and a specialist role should be created for this purpose.

3.6 Employer engagement

The pilot includes a pathway for employers to access support or advice for their employees who may need additional support. This can include information and advice, work-place visits by trained professionals, or a referral into the pilot for the employees that they are concerned about. However, engagement with employers – and learning about how to effectively engage employers in helping their staff make use of the service - is still at an early stage.

Stakeholders did not offer many views on the employer stream. This could be down to the low numbers coming through the service which could in turn be related to the marketing of the service. Marketing to employers is still at an early stage and there is scope to draw on HWL and Salus’s experience to develop effective local approaches to raising awareness with employers and encouraging them to help staff come forward for appropriate support.

More work is required to further develop this stream and to develop an effective marketing approach that engages employers in the local areas. This is particularly important for the pilot as engagement with employers provides opportunities to engage with individuals upstream.

4. Discussion

4.1 Summary of Findings

A pilot is an opportunity to test and learn, and based on the stakeholder consultations, the Health & Work Support pilot is achieving this goal. The pilot was launched over a short space of time and this has resulted in challenges throughout the service. While many of the frustrations of the first few months of implementation still remain, it is important to note that steps have been taken wherever possible to overcome challenges and improve the service.

There are ongoing concerns about the pilot not reaching its targets and while early analysis suggests improvements to the number of individuals accessing support as compared to pre-existing services this will need to be explored in more detail in subsequent phases of the evaluation. It is likely that access routes, service awareness and marketing play a part in the pilot's struggle to reach its targets, and this means that it is a priority to undertake a careful disaggregation of the different markets and client groups and develop appropriate engagement approaches.

It also seems possible that the existing targets for the pilot are not realistically achievable in light of available staff capacity. There is evidence that clients who are already coming through the system are seeing delays in getting access to a physiotherapist or a counsellor as a result of increases in referral numbers. If the service continues to grow towards its target numbers it is conceivable that clients will be in the service longer that 20 weeks because of the wait time between appointments. This will consequently have a knock on effect on the service's capacity to continue to engage in marketing work as well as to conduct assessments for new clients.

There is a question about how effective this service will be given that one of its central appeals to referrers and clients appears to be based on its ability to circumvent long waiting lists for mainstream health services. Although wait times in the pilot are considerably less than the general NHS is experiencing, the pilot needs to consider whether it is still worth developing this model on a national scale, or to invest this time, money, and lessons learned into mainstream NHS services.

There appears to be scope to explore the current match between demand (which is lower than expected) and the level of resources that were put into place. Already these resources appear to be stretched to the extent that staff feel that the levels of demand are threatening service quality. This is an area that requires further exploration, including an assessment of realistic workload levels and the scope to manage service delivery more efficiently, drawing on the different experience and structures in the two pilot areas.

4.2 Lessons Learned and Next Steps

A number of key findings were highlighted in the executive summary section of this report, some of which have been individually highlighted below as next steps (4.2.1 to 4.2.4). These have been selected because they are deemed to be priority areas for action.

The remaining key findings are largely contingent on additional analysis during future phases of the evaluation – these have therefore been combined into the final next step (4.2.5).

4.2.1 Although the pilot has implemented a 'single gateway' model, further consideration needs to be given to streamlining the "back-office" functions of the pilot.

Implication for the pilot: there should be a review of the contact handling process in order to streamline the service and mitigate the risk of client disengagement.

Implications for future service provision: at the national level the current structure of services may need to be reviewed in the context of wider health and work approaches.

4.2.2 There are issues around data gathering across the service.

Implication for the pilot: There should be a discussion with delivery staff about what constitutes positive outcomes for clients and how these outcomes can be recorded. Additionally, it will be important to ensure that the data recording system is revised to ensure that it is fit for purpose.

Implications for future service provision: any future provision of services will need to prioritise development of robust data recording systems. This should be accompanied by early training and support to ensure that the staff are appropriately trained.

4.2.3 The number of clients presenting with complex needs has been higher than expected thereby creating additional demands on pilot staff.

Implication for the pilot: Consideration should be given to the suitability of the current target given both the higher level of need which clients are presenting with as well as available staff capacity. This will require further information gathering and analysis to ensure that any changes made are evidence based.

Implications for future service provision: Any targets set for any potential future service should take into consideration the above noted difficulties. Moreover engagement with referrers, particularly GP's, is required to ensure that there is clarity with regards to the kind of clients the service is designed to support.

4.2.4 Need for clarification of Case Manager Role

Implication for the pilot: More engagement is needed with Case Managers and others to clarify what the expectations are of the Case Manager role.

Implications for future service provision: Case Management based services have an unclear evidence base at present and as such any potential future service provision should take this into consideration. Appropriate steps may include conducting a formal literature review as well as using data from the pilot to critically develop an evidence base, where possible.

4.2.5 Need for follow up of additional learning points during following phases of the evaluation

A number of learning points were identified during the implementation review process for which there is currently not sufficient evidence to make robust recommendations. As such these areas require further exploration during future phases of the evaluation, details of which can be found in the table below.

Initial Learning Point	Future Evaluation Work
Initial findings question the assumption that existing occupational health provision provided by large employers (public and private) are adequately meeting the needs of their staff.	This will be followed up via fieldwork with both clients who have access to in-house occupational health support as well as via engagement with occupational health providers.
The employer facing component of the pilot requires further development.	This will be followed up via fieldwork with employers and pilot staff involved with the employer facing component of the pilot.
There is scope for further improvement of the pilots marketing materials and overall approach.	A more detailed analysis of the impact of marketing will be made during the next stage of the evaluation. This analysis will then be used to inform recommendations.
The pilot's primary mode of access for individual clients (i.e. self-referral) assumes a level of health literacy, capacity and willingness to engage which may be problematic for more vulnerable members of the population such as those that are unemployed and/or are suffering from mental health issues.	This will be followed up via a combination of detailed analysis of the pilots management information data as well as fieldwork with clients, referrers and staff.

Appendix 1 – Process Timescales for the pilot

Table 2: Process timescales for the HWS Pilot [Source: Developed at inception meeting in conversation with national pilot team].

Dates	Process
Late 2014 / Early 2015	Strategy unit put proposal together
Summer 2017	Evaluability assessment was undertaken with Health Scotland which was key in securing the funding Predictive analytics added in to the bid
Oct / Nov 2017	Bid with Department for Work and Pensions for 82% of funding Bid approved
Late 2017 – June 2018	Design stage: Setting up the call handling systems, website to allow for referrals, deciding on a name, logos, starting up communications and marketing and raising awareness Promotion materials distributed in Libraries, GP practices, Community centres, Council offices.
June 2018	Went live, soft launch in both areas (26th June)
December 2018	First radio adverts launched TV adverts being planned Producing more focused promotion material aimed at employers
March 2019	Work towards automation of the process to allow for online referrals from Jobcentre Plus (JCP).

Appendix 2 – Details of Fieldwork

Interviews

Rocket Science undertook a total of 20 semi-structured interviews from the 18th of February to the 1st of April 2019.

Role	Organisation
National Project Lead	Scottish Government
Dundee Team Local Lead	NHS Tayside
Fife Team Local Lead	NHS Tayside
Salus General Manager	Salus (NHS Lanarkshire)
Head of Health & Work Services (Health Working Lives)	NHS Health Scotland (Healthy Working Lives)
Deputy Director for Employability	Scottish Government
Head of Policy for Employability	Scottish Government
Head of Strategy Unit	Scottish Government
Health Improvement Policy Lead	Scottish Government
Improvement Lead	Scottish Government
Strategy Unit Statistician	Scottish Government
Senior Jobcentre Lead (Dundee)	DWP (Local)
Senior Operations Lead (Jobcentres) - Fife	DWP (Local)
NHS Tayside – Healthy Working Lives Local Delivery Lead	NHS Tayside
Work & Health Unit Delivery Lead	DWP (UK Government)
Dundee City Employability Lead	Dundee City Council

Role	Organisation
Salus Call Handling Lead	Salus (NHS Lanarkshire)
AHP Lead	NHS Fife
Fife Voluntary Action Lead	Fife Voluntary Action (3rd Sector)
NHS Tayside – Health and Safety Advisor, Workplace team	NHS Tayside
Statistician	Scottish Government

Surveys

Rocket Science designed an online survey for frontline staff involved in the pilot. There is a separate survey for HWL, Salus, and case management staff. The survey ran from the 13th February to the 1st March. A summary of responses is provided below (as of the 21st February). The response levels are considered representative as more than 90% of relevant staff members took part in the surveys.

Survey	No. of responses
HWL	5
Salus	4
Case Management	20

Focus Groups

Focus Groups were set up with front line delivery staff through March 2019. Below is a summary of these Focus Groups. Findings from the Focus Groups were analysed thematically.

Focus Group	For whom	Date / Time
1	Dundee Case Management Staff	12th March; 14:00
2	HWL Staff (Glasgow)	13th March; 10:00
3	Dundee Case Management Staff	14th March; 14:00
4	Fife Case Management Staff (Glenrothes)	18th March; 11:30
5	Salus Staff (Hamilton)	19th March; 14:00

Client Focus Groups/Interviews

Ten clients were involved in providing feedback on their experience with the pilot either through telephone interviews, face to face interviews or in focus group settings. Clients were selected using stratified random sampling.

Interviews and focus groups were semi-structured and information gained was analysed thematically.

Details can be found below.

Work Status	Dundee	Fife	Totals
Employed (SME)	3	2	5
Employed (Large Organisation)	3	0	3
Unemployed	1	1	2
Totals	7	3	10

How to access background or source data

The data collected for this social research publication:

☐ are available in more detail through Scottish Neighbourhood Statistics

☐ are available via an alternative route

☒ may be made available on request, subject to consideration of legal and ethical factors. Please contact Arfan.Iqbal@gov.scot for further information.

☐ cannot be made available by Scottish Government for further analysis as Scottish Government is not the data controller.

Appendix 3 – Response to Recommendations

Since the production of the initial version of this report a number of steps have been taken in response to the recommendations made. Details relating to actions that have been undertaken are summarised below.

Streamlining of Back-Office Functions

There are currently no plans to make substantial changes to the delivery of call handling services during the lifecycle of the pilot. However as part of broader strategic reviews taking place across Scottish Government, consideration of the future provision of health and work related advice line services are currently taking place. Findings from the Health & Work Support pilot, including from the Interim Evaluation report, are feeding into this process.

Issues Regarding Data Gathering Across the Service

Since the production of this report the entire data collection process for the pilot has been reviewed and revised in order to both, streamline data collection as well as to ensure consistency of collection across the service.

In addition both pilot areas have prioritised improving discharge information as part of structured improvement projects which the service is undertaking under guidance from a Scottish Government Improvement Advisor.

Complexity of Client Presentation and Service Performance Targets

Subsequent to the initial production of this report a review was undertaken of the current target set for the pilot. The review findings as well as recommendation for a revised target was presented to the DWP's Work and Health Unit Delivery Board which accepted the recommendation. The target set for year two of pilot has therefore been revised down to a range between 2,250 and 2,500 (resulting in an overall pilot target of 3,596 to 3,864 across the life of the pilot). This recommendation was based on consideration of three key factors:

- Baseline performance
- Sample Sizes Required for further evaluation
- Staff capacity

In addition to the above, both pilot areas are continuing to test innovative ways to support clients with complex mental health conditions. Examples include exploring the potential of group sessions, using peer volunteers, Wellness Recovery Action Plan (WRAP) facilitators and capping caseloads for selected Case Managers. Counselling provision has also been increased to help meet demand.

Clarification of Case Manager Role

Discussions have been held within the Scottish Government's national pilot team and with local pilot leads regarding the Case Manager role however no formal decisions have been made regarding changes. It is unlikely that any substantial changes will be made during the lifecycle of the pilot however further clarification of the role as well as determination of its impact will form part of the next phase of the evaluation. Findings from this will be synthesised with the existing evidence base in order to determine how best to develop the role with regards to future service delivery.

Other areas of interest identified throughout the report will also be further explored during the remainder of the pilot, including via the next two stages of the evaluation process.

social research

The views expressed in this report are those of the researcher and do not necessarily represent those of the Scottish Government or Scottish Ministers.

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