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Evaluation of the Work and Health Service

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Executive Summary

The Work and Health Service – evaluation summary

The Work and Health Service (WHS) is delivered by the Sheffield Occupational Health Advisory Service (SOHAS) and commissioned by Sheffield City Council. Its core aim is to support job retention among individuals who are in work but facing work-related health issues. The service works on the principle of early intervention to address workplace issues before they escalate.

This evaluation examines how effectively the WHS supports service to users to remain in work by addressing health and employment issues. It finds that the WHS is valued by the majority of service users who took part in the evaluation, who mostly report positive changes in their health or employment situation. These changes are often attributed directly to WHS support.

However, issues with data collection processes in place before the evaluation mean it is not possible to say whether these findings are representative of the experiences of all service users. In other words, the evaluation tells us what the WHS does well, and why, but it is too early to conclude from available data how common these outcomes and impacts are. Key findings are detailed below.

Referrals

- The WHS has supported 20,943 service users since the beginning of 2004. Annual referrals rose to a peak of 1,420 in 2014 before falling to 575 in 2020, the year of the onset of the pandemic, and not risen above 725 (in 2022) since.
- The majority of service users were referred to the service via their GP (65 per cent). There were two other prominent routes for referrals: IAPT/Talking Therapies Workers (12 per cent) and self-referrals (nine per cent).
- Stakeholders interviewed were unanimous in their view that **the referral process was straightforward**, with little administrative burden.
- Service users were not always aware of the self-referral route which indicates a need to increase awareness of this route among potential service users.

Service user profile

Analysis of the 16,353 service users who accessed the service between 2004 and 2025 and are in work (i.e. employed, self-employed or off-sick from work) shows that:

- The WHS has **supported increasing proportions of individuals who are in work** (employed or self-employed**)** despite health issues (55 per cent in 2024 compared with 45 per cent of service users who are off sick). This suggests the service is increasingly providing early intervention support before employees take sick leave.
- **Mental health issues account for a significant and rising proportion of the issues** faced by service users:

- The most common health issue reported by service users by far was psychological issues (61 per cent of all service users). Looking at annual figures, this has risen from 39 per cent in 2004 to 75 per cent in 2024.

- The most common workplace 'exposure' issue at work by far was stress (66 per cent of all service users). Annually, this has risen from 42 per cent in 2004 to 80 per cent in 2024.
- Qualitative data highlights work-related causes of stress which include conflict with managers, employers or customers; and a failure of employers to agree to requests for flexible working or adjust performance expectations to accommodate employees' health conditions.
- Many service users working for larger employers still sought help from the WHS despite having access to work-based occupational health schemes. The primary reasons for accessing WHS support are **a lack of trust** in the objectivity of workplace-based provision or **a concern that employers do not act on the recommendations of workplace occupational health services**.

WHS Support

- WHS places no limit on the number of appointments or length of support but **most service users only seem to require a limited number of appointments over short periods of time:**
  - Over four fifths (82 per cent) of service users received support on either one or two occasions, with two thirds only receiving support once (67 per cent).
  - Just under three fifths (57 per cent) of service users receiving advice more than once access all support in a single calendar year.
- Survey respondents were **overwhelmingly positive about the support they had received**. The vast majority (84 per cent) rated the support they had received as 'good' (56 per cent 'very good' and 28 per cent 'fairly good'). Just three respondents (six per cent) rated the service as 'fairly poor'. Interviews and focus groups also indicated **high levels of satisfaction** with WHS support.
- Nearly all survey respondents and the majority of service users who took part in focus groups or interviews said they would recommend the service.
- Features of the WHS valued by service users included: empathetic and knowledgeable advisers who were seen as trusted intermediaries; consistent support from the same adviser; the perceived impartiality of the service; and the ability to access long-term support when workplace issues persisted or resurfaced.
- While service users were overwhelming positive about the WHS some did suggest improvements including: more face-to-face meetings; follow up meetings or letters; restoring Return to Work Plans and in person attendance of WHS advisers at meetings with employers; raising awareness of the WHS to 'spread the word'; and more emotional ('handholding') and employability support.
- Stakeholders interviewed were **almost unanimously positive** about the service and, alongside citing similar benefits to service users, also noted the value of: how advice empowered service users; WHS's accessibility where co-located; the skills and experience of advisers; early intervention to prevent issues escalating; and the distinctive offer which provided complementary expertise to referral organisations' skillsets and eased capacity pressures.
- However, stakeholders also identified a number of issues with the WHS including: a lack of comprehensive and robust data on outcomes and impact; the limited visibility of the service; potential duplication with other services; and a decline in funding which impacted on the WHS's ability to offer face-to-face meetings, provide staff training and target groups or areas that are currently underrepresented.

Outcomes and impact

Interviews, focus groups and survey data provide some indication of changes experienced by service users in terms of health and employment, and the extent to which WHS support was responsible for any change.

Health

- Qualitative data highlighted **positive health and wellbeing outcomes** among many service users as a result of WHS support including reduced stress and anxiety; physical health improvements; and greater confidence and self-esteem at work. A minority of interviewees were unable to identify any positive health impacts of the support provided by the WHS.
- Survey data also indicates positive outcomes around health:
  - just over one-third of respondents felt the support they had received had reduced the number of visits they made to their GP.
  - over two thirds (71 per cent) of respondents indicated that WHS support had made a positive difference to their mental health while nearly half (48 per cent) suggested support had made a positive difference to physical health.

Employment

- One of the most significant outcomes of WHS support for service users was **a sense of empowerment** derived from a better understanding of employment rights. This often led to greater confidence in challenging difficult situations at work.
- Survey data also suggests WHS support played **a key role in job retention**. Three quarters of respondents (25 out of 33 respondents) indicated that the support received had been either 'very' or 'quite' important to them remaining in or returning to work.
- Survey data also indicates WHS support made **a positive difference to experiences of work** and relationships with, or support from, employers or managers in terms of:
  - ability to talk about health conditions with employers/managers (58 per cent)
  - employer support in managing health conditions (46 per cent)
  - satisfaction with job (49 per cent)
  - ability to do the job (45 per cent)
- Only a minority of service users indicated WHS support had made little difference to their situation. This was usually attributed to the short-term nature of the support or its inability to change their situation.

Recommendations

For SOHAS

- Better promote the self-referral route to service users and services who signpost into the WHS.
- Review and improve the consistency of feedback on service users provided to referral partners.
- Explore the potential to restore elements of the WHS offer that were valued by service users i.e. Return to Work Plans (RTWPs) and the option of advisers attending meetings with employers.
- Improve data collection processes in line with evaluation team guidance.

- Explore the possibility of setting up more integrated data sharing processes with key referral partners (especially GPs).
- Increase the visibility of the service to referral partners and through marketing and communications.
- Provide information on inappropriate referrals to referral agencies to increase the quality of referrals.
- Explore options for targeted activities to engage groups or areas that are currently underrepresented e.g. individuals in precarious or temporary employment.

For Sheffield City Council (as commissioner of the WHS)

- Consider how to address issues with a lack of trust in workplace-based occupational health services that means employees working for large organisations with occupational health provision still seek out WHS support:
  - Undertake research or review the existing evidence base on reasons for a lack of trust in workplace provision and how this could be restored.
  - Work directly with key large public sector organisations (particular in health and education) to better understand and address this issue.
  - Review commissioning arrangements to ensure sufficient resource for targeting of smaller employers that do not have occupation health provision in place.
- Review the possibilities for supporting and funding the implementation of recommendations that go beyond existing contractual obligations (e.g. around marketing, training, employer advice workshops, and restoring Return to Work Plans and the option of accompanying service users to employer meetings).
- Work with SOHAS to develop options for better targeting and engagement of underrepresented groups and areas.
- Explore options with SOHAS for engaging more directly with employers to advise and train them on how to support employees with health conditions.
- Monitor improvements to SOHAS data collection processes and revise contractual expectations around data collection in line with the evaluation recommendations.

For referral agencies and wider partners in the work and health system

- Work collaboratively through appropriate governance structures within the local employment and health systems to **explore ways of addressing shortfalls or waiting times for services that impact on SOHAS's ability to deliver the WHS.**

Introduction

1

1.1 Overview of the Work and Health Service

This evaluation of the **Work and Health Service (WHS)** was commissioned by the Public Health team within Sheffield City Council who fund the WHS. The WHS is delivered by the Sheffield Occupational Health Advisory Service (SOHAS) who originated from the trade union movement, initially focusing on occupational injuries such as vibration white finger and asbestos-related illnesses. Over time, it has developed into a voluntary sector organisation delivering employment support with a strong emphasis on job retention.

The WHS mainly supports individuals who are in work but facing work-related health issues which means they are either still working but often struggling to stay in employment or off sick. The service works on the principle of early intervention to address workplace issues before they escalate to prevent health-related job loss or health conditions worsening. It offers advice on occupational adjustments and employment rights and, where consent is given, may advocate with employers on behalf of the employee. More detail on support offered is provided in Section 4.1.

The local economic context is significant. Sheffield has a high proportion of small businesses (0-49 employees) which, similar to England, make up nearly all the business base (98 per cent[1]). Many of these do not provide their own occupational health services. The WHS service is intended to address this gap by supporting individuals who are struggling to stay in work due to health-related challenges but do not have access to occupational health support through their workplace.

1.2 Job retention: the policy context

Job retention refers to support designed to help individuals stay in employment by addressing barriers to remaining in work such as health issues, workplace conflicts, or skills gaps. It is a component of employment and health services that has historically been under-funded. While successive governments have prioritised getting people into work, less focus has been placed on supporting people to remain in work when health-related issues develop.

This may change with the recently launched **Independent Review into the Role of Employers in Health and Disability** (DWP and DBT, 2025a) headed by Sir Charlie Mayhew. Due to report in Autumn 2025, its terms of reference include *'a particular focus on working together to understand what employers and Government can do to increase the recruitment,* ***retention*** *and return to work of disabled people and people with long-term health conditions* [our emphasis]'. It builds on a commitment in the **Get**

[1] Source: ONS.

Britain Working White Paper (HM Government, 2024:8) to *'consider what more can be done to enable employers to:*

- *Increase the recruitment and retention of disabled people and those with a health condition, including via the new jobs and careers service.*
- *Prevent people becoming unwell at work and promote good, healthy workplaces.*
- *Undertake early intervention for sickness absence and increase returns to work.'*

This evaluation has the potential, therefore, to generate valuable insights on job retention services to feed into this national conversation.

1.3 Our approach

The evaluation was tasked with exploring whether the Work and Health Service supports people to stay in work (job retention). Data was collected through four sources:

- **Customer Relationship Management (CRM) data** collected by SOHAS on WHS service users
- A new **survey of service users** implemented by the evaluation team
- In-depth qualitative data collected by the evaluation team through **interviews and focus groups** with service users and stakeholders
- A **rapid evidence review** of existing academic and policy literature.

Customer Relationship Management data

SOHAS collects data on all service users via a Customer Relationship Management (CRM) system in the following areas: referral routes, personal characteristics, health issues, employment status, employment sector and issues experienced at work (known as 'exposure issues'). Only minimal information is collected on support provided (the number of times advice was given by advisers and if advice was provided about benefits). Moreover, no information is collected on outcomes achieved by service users. To address these limitations a new survey of service users was designed and implemented by the evaluation team in consultation with SOHAS (see below).

A total of 20,943 unique service users were recorded via the CRM system between 1 January 2004 and 25 February 2025. Of these, 16,353 were in work i.e. employed, self-employed or off-sick from work. The analysis featured in this report focuses on these 16,353 service users only for the period between 2004 and 2025 (unless specific years are stated).

Service user survey

A new online service user survey was designed by the evaluation team to collect more detailed information on support provided by the service, any changes in employment and health experienced, and the extent to which WHS support contributed to change. The survey was administered by SOHAS between April-May 2025. In total 50 usable responses were received. Analysis of survey data is presented throughout this report to provide some indication of the range of support received and outcomes experienced. However, the number of survey responses to date is too low to assume that findings are representative of the experiences of all service users to date. It is anticipated that SOHAS will continue to administer the survey to new service users which means

findings will become more representative as the number of survey responses increases.

Qualitative research: interviews and focus groups

To gain more in-depth insights into perceptions and experiences the evaluation team conducted a series of interviews and focus groups with two key groups:

- **Service users:** A total of 20 service users were consulted through eight interviews and three focus groups with a total of 12 attendees (four in each focus group). Interviews and focus groups explored reasons for engaging with the service, the perceived value of support and outcomes experienced. In terms of employment status, 17 of the 20 service users were in work (of which three were on sick leave) and three were unemployed.
- **Stakeholders:** A total of 13 stakeholders were consulted through one focus group with WHS advisers (n=5) and eight interviews with stakeholders who managed, commissioned, or referred into, the service. This included stakeholders in primary care (GPs) and organisations delivering secondary care services. Interviews and focus groups examined the ease of referral processes; the perceived strengths of the WHS; its role within wider employment and health systems; the service's impact on health, employment, and wellbeing outcomes for service users; and aspects of the service that could be improved.

To maintain confidentiality, some details on service users' situations or experiences have been left out or anonymised while stakeholder roles are only presented in broad terms e.g. 'GP' or 'working in secondary care'.

Rapid evidence review

A rapid evidence review was undertaken to explore the effectiveness of job retention services in promoting positive employment and health outcomes. In total 11 sources were identified through searches of Google Scholar and the IDOX repository which provides access to documents from government websites and other 'grey' literature as well as academic papers.

1.4 Job retention services: the evidence base

Job retention services are a feature of national and local employment support. They are primarily aimed at individuals who face significant barriers to maintaining employment, such as people with disabilities, those recovering from illness or injury, and workers at risk of redundancy due to organisational changes or skill mismatches. They are designed to help individuals maintain employment by addressing barriers to remaining in work such as health issues, workplace conflicts or skills gaps. By focusing on early intervention and tailored support, job retention services aim to promote sustainable employment outcomes, preventing avoidable job losses.

The core interventions of job retention services typically include personalised advice and guidance, workplace adjustments, advocacy, career counselling, and access to specialist resources such as mental or physical health support. Implementation of job retention interventions often involves collaboration between specialist advisers, employees and, where appropriate, employers, to create tailored action plans that address clients' needs. Some job retention services may also offer training for employers on managing workplace diversity and providing reasonable adjustments, ensuring that both employers and employees are equipped to maintain a productive and positive working relationship.

A rapid evidence review of job retention services highlights **the positive impact these services can have in three main ways:**

- **Improving job retention** (Thomas et al., 2005; Woodall et al., 2017) or facilitating a **faster return to work** (Gloster et al., 2018), including for those with chronic diseases (Allaire et al., 2005; Varekamp et al., 2006).
- **Improving mental health** (Woodall et al., 2017; Farrell et al., 2006) and **physical health** (Varekamp et al., 2011). Improved health can, in itself, support job retention. In their evaluation of the Job Retention Rehabilitation Programme (JRRP), Farrell et al. (2006) found that health improvements were a critical factor in participants' ability to return to work.
- **Facilitating dialogue between employers and employees** to identify mutually acceptable solutions to work-related issues. According to Robdale (2004), job retention services can help to address communication barriers that often arise during sickness absences. For example, frontline advisers assisted employees in raising concerns such as workplace stress or bullying, enabling employers to investigate and address issues. This collaborative approach was reported to expedite return-to-work negotiations, with agreed upon outcomes including phased returns, permanent adjustments to working hours, or changes to job roles or environments. There is also some evidence that **employers appreciate support** in addressing sickness absence efficiently and effectively and facilitating constructive conversations with struggling employees (Gloster et al., 2019; Schafft, 2014; Woodall et al., 2017).

The literature reviewed identified a number of **factors that contributed to positive health and employment outcomes** including:

- **Client-centred support and holistic interventions** that include responsiveness to individual needs; taking a holistic perspective that addresses the full range of biopsychosocial challenges through a coordinated approach; and customised support packages, deploying bespoke solutions based on unique circumstances, such as combining psychological and physical therapies with workplace advocacy (Farrell et al., 2006; Thomas et al., 2005).
- **Case managers** who provide **emotional and practical support** including a valued sense of being listened to (Farrell et al. 2006; Thomas et al., 2005). They can also act as an **objective intermediary**, facilitating communication between employees and employers, and in some cases emphasising legal obligations to employers (Gloster et al., 2018; Thomas et al., 2005).
- **Early and proactive interventions** to address issues before they escalate, enabling timely solutions that minimise disruption (Farrell et al., 2006) and speed up returns to work (Gloster et al., 2018).
- **Empowerment and skill development** that enables clients to take an active role in their return to work journey. Thomas and Morgan (2021) identified self-determination and self-advocacy skills as critical for discussing adjustments and addressing work-related challenges. These findings highlight the importance of fostering clients' confidence and problem-solving abilities as a feature of job retention services.
- **Collaborative Return to Work Plans (RtWPs)** developed in collaboration with case managers that are tailored to an individual's occupation and sector have been associated with higher satisfaction and improved outcomes (Gloster et al. 2018).

While some employers welcome advice from job retention services on how to support employees (see above), other **employers hinder the effectiveness of job retention interventions**. Farrell et al. (2006) identified several barriers:

- **Resistance to engagement:** Employers could be reluctant to establish contact with staff or allow workplace access, limiting the ability of job retention professionals to mediate effectively.
- **Lack of interest in employee support:** Some employers were perceived as indifferent to helping employees return to work, particularly when the absence was related to complex or long-term health issues.
- **Limited understanding of health conditions:** Employers frequently lacked awareness of how specific illnesses affect employees, particularly when the conditions were undiagnosed or involved uncertain recovery timelines.
- **Inflexibility**: Employers were sometimes criticised for inflexibility around rehabilitation plans, such as phased returns or adjusted duties, which could facilitate smoother transitions back to work.
- **Knowledge gaps:** Many employers lacked understanding of sickness absence management and vocational rehabilitation, limiting their ability to effectively support employees.

1.5 Report structure

The remainder of the report is structured as follows:

- Section 2 details the main referral routes into the WHS, the volume and source of referrals, and the perceived ease of making referrals by partner agencies.
- Section 3 profiles service users in terms of their demographic characteristics, employment status and health issues. It also presents data on issues faced in the workplace and their willingness to use occupational health services where available.
- Section 4 outlines the WHS offer and presents survey data on support received. It also explores the perceived value of support from the perspective of service users and stakeholders.
- Section 5 looks at health and employment outcomes experienced by service users and the extent to which WHS support contributed to any change experienced.
- Section 6 concludes by reflecting on potential improvements to the WHS and data collection processes.

Referrals and partnership

2

2.1. Referral routes

Referrals into the WHS are made through three main sources:

- **Primary care organisations:** GPs or clinicians working in GP surgeries (e.g. occupational therapists or physiotherapists).
- **Secondary care organisations:** this includes specialist organisations supporting those, for example, with experience of severe mental health issues, brain injuries, strokes, Myalgic Encephalomyelitis (ME), Long COVID or diabetes.
- Workers in **voluntary sector organisations** such as social prescribers, link workers, mental health practitioners, many of whom operate in community settings.

In recent years SOHAS broadened the range of agencies they receive referrals from, partly in response to a drop in referrals from GP practices during the COVID-19 pandemic.

2.2. Volume and source of referrals

Table 1 shows the number of service user referrals between 1 January 2004[2] and 25 February 2025. A total of 20,943 service users were referred to the service in this period. Referrals rose to a peak of 1,420 in 2014 before falling to 575 in 2020, the year of the onset of the pandemic. Referrals then rose for two years to 725 in 2022 but remain below pre-pandemic levels.

[2] There were a further 393 referrals pre-2004. These cases have been excluded as the service was not fully up and running at this time.

Table 1: Service user referrals by year

Year	Total referrals	Year	Total referrals
2004	904	2015	1,210
2005	942	2016	1,188
2006	995	2017	1,156
2007	1,010	2018	1,029
2008	880	2019	956
2009	1,006	2020	575
2010	1,182	2021	587
2011	1,226	2022	725
2012	1,302	2023	699
2013	1,324	2024	614
2014	1,420	2025	13
Total			**20,943**

SOHAS does not currently meet the referral targets for service users set by Sheffield City Council (1,000 new clients and 250 returning clients per year). One stakeholder suggested that this may be due to the target being '*too ambitious*' relative to service capacity and funding as well as an increase in the proportion of returning service users which limits the number of new service users.

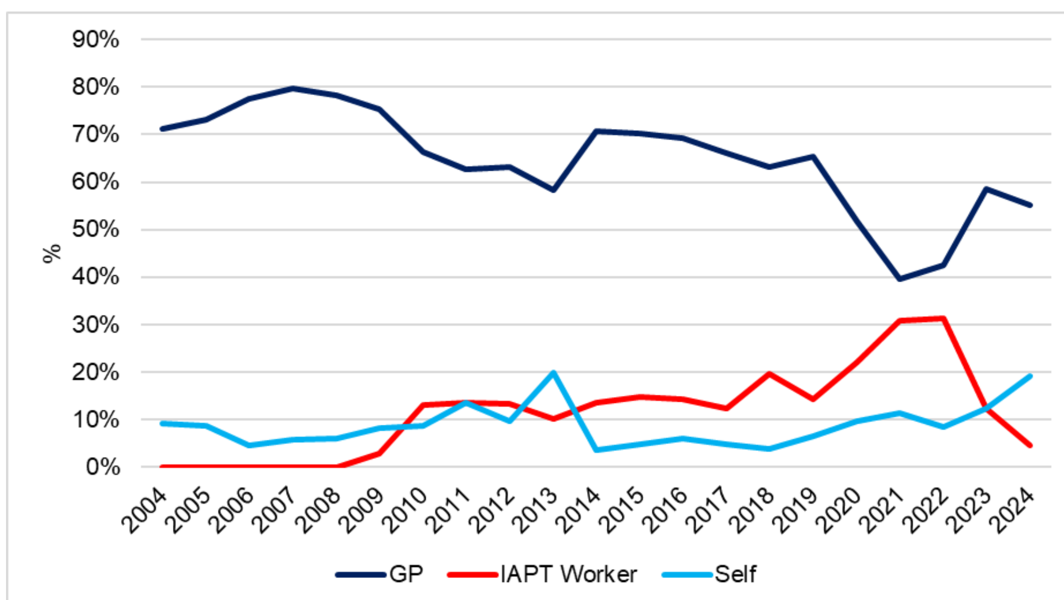
Table 2 below shows that the **majority of service users were referred to the service via their GP** (65 per cent). There were two other prominent routes for referrals: IAPT/Talking Therapies Workers (12 per cent) and service users making self-referrals (nine per cent).

Table 2: Service user referral routes

Route	Count	Per cent
GP	10,700	65
IAPT/Talking Therapies Worker	1,881	12
Self	1,392	9
Counsellor	303	2
Nurse	277	2
Mental Health worker	264	2
Advice Centre	174	1
Occupational therapist	155	1
Colleague	94	1
Physiotherapist	53	0
Sheffield Carers Centre	48	0
Cavendish Centre	44	0
Waiting room	44	0
Website	39	0
Solicitor	35	0
Midwife	23	0
Cancer nurse specialist	22	0
Stroke Pathway	21	0
Home crisis team	16	0
Other	768	5
Total	**16,353**	**100**

Figure 1 below indicates the volume of referrals from the three main referral routes over time. This shows the proportion of referrals from GPs generally falling until 2022 (with the most dramatic falls coinciding with the pandemic), after which the proportion then started to rise, before falling back again in 2024 to 55 per cent of all referrals. Conversely, the proportion of referrals made by IAPT/Talking Therapies Workers increased over time, until falling away in 2023 and 2024. This fall is linked to changes in policy when IAPT/Talking Therapies were allocated funding to employ their own embedded employment support workers. Self-referrals have been rising in recent years, from just four per cent in 2014 to 19 per cent of all referrals in 2024.

Figure 1: Main service user referral routes (2004-2024)



Base: 16,353

2.3. Ease of referral process

Stakeholder interviews showed services referring into the WHS were **unanimous in their view that the referral process was straightforward**, with little administrative burden. The precise process varied across organisations. One GP described, for example, asking patients to book a slot with an onsite WHS adviser at the practice reception following their GP appointment: '*It's very easy because I'm not having to fill out a great big form. I'm not writing a referral letter. I can simply get somebody booked in very, very easily'.*

Other types of organisations provided clients with the contact details (website or telephone number) for clients to self-refer. The online self-referral form was seen as accessible and easy for most clients to fill in, but one secondary care organisation noted providing support to less '*tech savvy'* patients to do this. Finally, one organisation contacted the WHS directly with patient information by email or telephone, with advisers subsequently contacting patients directly using the information provided.

However, it became clear in focus groups that **service users were not always aware of the self-referral route**: '*I didn't realise that you could self-refer yourself'.* This indicates a need to increase awareness of this route among potential service users.

Service user profile

3

3.1. Service user profile

Customer Relationship Management (CRM) data provides information on the key characteristics, employment status, health conditions and work-related issues experienced by service users. Unless stated, analysis in this section focuses on the unique 16,353 service users who accessed the service between 2004 and 2025 and are in work i.e. recorded as either employed, self-employed or off-sick from work on the CRM. Table 3 below shows the groups excluded from our analysis as they are not in work.

Key characteristics

- Sixty per cent of all service users have been female and 40 per cent have been male. The proportion of male and female service users was very similar in the first few years for which data was collected but has since changed with female service users comprising nearly two thirds (65 per cent) of all service users between 2021 and 2024. Correspondingly, the proportion of male service users has fallen since 2007.
- Table 3 shows the age distribution of service users overall. Over half of service users engaged (52 per cent) were aged between 35 to 54.

Table 3: Service user age

Age range	Count	Per cent
18 to 24	1,091	7
25 to 34	3,189	20
35 to 44	3,916	24
45 to 54	4,646	28
55 to 64	3,241	20
65 or over	230	1
Total	**16,313**	**100**

Data on ethnicity collected through the CRM to date is not sufficiently robust to present here. Recommendations on improving the quality of data collected are provided in Section 6.3.

Employment status

Table 4 provides a breakdown of the employment status of service users. Almost four-fifths (78 per cent) were employed, self-employed or off-sick from work. This represents 16,353 service users. The analysis featured in the rest of this report focuses on these service users only (i.e. those highlighted in **bold**) for the period between 2004 and 2025 unless otherwise stated.

Table 4: Service user employment status

Employment status	Count	Per cent
Employed	**7,525**	**36**
Off-Sick with Work Related Ill-Health	**6,024**	**29**
Off-Sick	**2,338**	**11**
Retired (Age/Early)	1,463	7
Unemployed Health	1,380	7
Unemployed	1,052	5
Self-employed	**301**	**1**
Student	188	1
Employed/Carer	**139**	**1**
Retired (Health)	106	1
Carer	94	0
Parenting	88	0
Furloughed	**17**	**0**
Employed/Parent	**9**	**0**
Other	219	1
Total	**20,943**	**100**

The latest data covering a full year shows that in 2024 the service engaged a slightly larger proportion of service users who were employed or self-employed[3] (55 per cent) compared with those off-sick (45 per cent in 2024),[4] with similar proportions in the two preceding years. This suggests the service is increasingly providing early intervention support before employees take sick leave.

Table 5 shows the sectors of employment in terms of service users' most recent jobs. The most common sector was '*Health'* (20 per cent) followed by '*Education'* and '*Retailing and Wholesaling'* (both 13 per cent), and then '*Other Services'* and '*Public Administration and Defence'* (both 11 per cent). This data suggests that while the service is intended to target employees working in small and medium-sized enterprises (SMEs) with less than 250 employees, many may be working for larger employers such as the NHS or large educational institutions that already offer occupational health services to employers[5].

This is reflected in interviews and focus groups. Most worked in large public and private sector organisations, often with access to company-based occupational health services. Some were employees of the city's largest employers including a large educational provider and the local authority. Very few worked in small companies lacking occupational health services. Most were white-collar workers in roles including social work, teaching, civil service, and administrative or managerial roles. Section 3.3. presents findings on why employees with access to workplace-based occupational health services still sought external support from the WHS.

[3] Includes: 'Employed', 'Self-employed', 'Employed/Carer', 'Furloughed' and 'Employed/Parent'.
[4] Includes: 'Off-Sick with Work Related Ill-Health' and 'Off-Sick'.
[5] SOHAS provided estimates based on trawling service user case records that two thirds of new service users over the last 15 months worked for large employers with more than 250 employees. However, the evaluation team were unable to verify this as the data is not captured systemically in the CRM system.

Table 5: Employment sector (service user's most recent job)

Sector	Count	Per cent
Health	3,172	20
Education	2,034	13
Retailing and Wholesaling	2,022	13
Other Services	1,800	11
Public Administration and Defence	1,796	11
Transport and Communications	1,079	7
Business Services	885	6
Manufacturing of Metals	825	5
Other Manufacturing	725	5
Construction	540	3
Hotels and Catering	445	3
Banking and Insurance	377	2
Defence and Security	140	1
Energy and Water	52	0
Agriculture, Fishing and Forestry	40	0
Utilities	40	0
Arts and Entertainment	29	0
Information and Communication	26	0
Mining and Quarrying	11	0
Total	**16,038**[6]	**100**

Health issues

Sixty per cent of service users were recorded as having at least one health issue. Given that the service is targeted at those whose health is affected by their work, it seems unlikely that none of the other 40 per cent of service users had no health issue(s), which may mean this information was unrecorded.[7] Indeed, the proportion of service users with no health issues reported varies over time, rising from just eight per cent in 2007 to 64 per cent in 2020, before falling back to 23 per cent in 2024. This suggests a lack of consistency in how data has been collected over time.

Mental health issues account for a significant and rising proportion of the health issues faced by service users. Table 6 shows the most common recorded health condition by far was *Psychological* issues, which were experienced by three-fifths of service users (61 per cent). The next most common were issues with *Muscles/Joints/Repetitive Strain Injuries* (16 per cent) and issues with *Back* (seven per cent).

[6] A further 33 service users were recorded as 'Not Employed' and they have been excluded from this analysis.
[7] A very small number or service users without health conditions may be accessing WHS support in relation to work-related challenges arising from caring responsibilities. However, those recorded as having caring or parenting responsibilities account for no more than one per cent of service users.

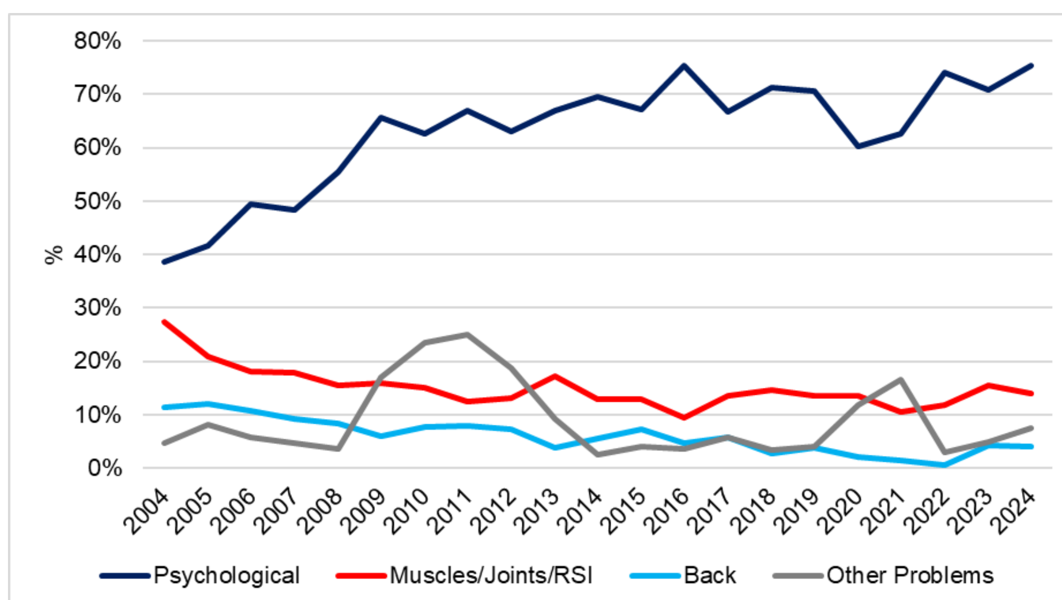
Table 6: Service user health issues recorded (of those who had at least one issue)

Health issue	Count	Per cent
Psychological	6,030	61
Muscles/Joints/RSI	1,525	16
Back	656	7
Nervous/System	302	3
Heart/Circulation	262	3
Injuries	250	3
Asthma	215	2
Chest	205	2
Reproductive	171	2
Skin	158	2
Digestive	128	1
Chronic Pain	100	1
Vibration Syndrome	92	1
Bladder/Kidneys	60	1
Eyes	56	1
Nose/Throat	52	1
Cognitive	33	0
Auto Immune	28	0
Other Problems	872	9
Base		**9,807**

The prevalence of *Psychological* issues was notably higher for younger age groups. The 25 to 34 age group had the highest proportion of service users reporting a psychological health issue (70 per cent), followed by the 18 to 24 group (66 per cent), the 35 to 44 age group (64 per cent) and the 45 to 51 age group (61 per cent). Figures were lower for those aged 55 to 64 (51 per cent) and those aged 65 and over (44 per cent).

Figure 2 shows the most common health issues recorded over time. **The proportion of service users recorded as having a *Psychological* health issue has risen significantly over the past two decades**, from 39 per cent in 2004 to 75 per cent in 2024. Conversely, the proportions recorded as having an issue with *Muscles/Joints/Repetitive Strain Injuries* or an issue with *Back* have broadly decreased. Figure 2 also shows the proportion of service users where health issues were recorded as *Other Problems.* There are two notable peaks, again perhaps indicating inconsistencies in how data has been recorded over time.

Figure 2: Most common health issues (2004-2024)



Base: 9,807

Stakeholders identified two broad trends in terms of the most common issues faced by service users:

- The predominance and ongoing increase in service users experiencing mental health difficulties (stress, anxiety and depression) or neurodiversity, particularly among young people.
- Growing complexity in cases caused both by a rise in co-morbidities,[8] particular among older people experiencing physical and mental health issues, as well as taking referrals from a broader range of agencies including those who support individuals with more complex medical conditions.

Stakeholder and service user interviews provide further insights into how psychological issues are related to experiences of work (see also Section 3.2). Mental health issues were often caused or aggravated by workplace factors including bullying, conflict with managers or employers, excessive workload and burnout, poor job design, inflexible working arrangements and poor management such as pressuring staff to undertake roles or tasks they are not capable of performing. As one GP explained:

> *I have plenty of patients who are clearly stressed and the stress has a major effect on their mental health, their sleep, their life, and* ***the issue is coming from work****… And there's no point in me simply giving them a pill or telling them to go and have some counselling when what they need to sort is the issue, which is work related stress.*

3.2. Workplace issues

The CRM records workplace issues reported by service users (known as 'exposure issues'). Table 7 shows **the most common issue by far was stress** which was experienced by two-thirds of service users. The next most common were issues with

[8] The CRM system provides data on comorbidities in terms of service users with two or more health conditions but inconsistencies in data over time means it is not considered sufficiently robust to present here. Recommendations for improving data collection are made in Section 6.2.

job design[9] (15 per cent) and lifting and noise (both six per cent). The prevalence of stress may be partly explained by the fact it can potentially be an outcome related to any of the other exposure issues which are more about the nature of the working environment.

Table 7: Workplace issues (of those who had at least one issue)

Exposure issue	Count	Per cent
Stress	5,886	66
Job Design	1,317	15
Lifting	511	6
Noise	506	6
Hours	383	4
Accidents	368	4
Dust	220	2
Chemicals	208	2
Conflict/Bullying	181	2
Fumes	171	2
VDUs	163	2
Vibration	157	2
Environment	95	1
Infections	94	1
Solvents/Oil	57	1
Asbestos	41	0
Radiation	8	0
Other	647	7
Base		**8,913**

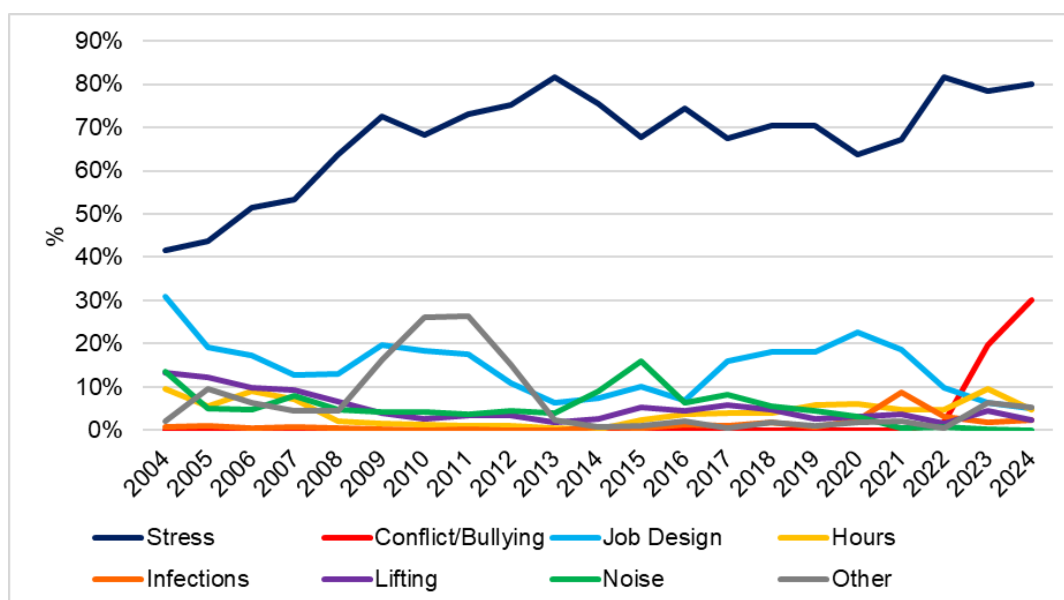
With regard to the largest issue of stress:

- A greater proportion of female service users were recorded as being exposed to stress compared to male service users (74 per cent compared to 56 per cent).
- The proportion of service users exposed to stress decreases with age. The youngest groups report the highest proportions (71 per cent of those aged 18-24 and 72 per cent of those aged 25 to 24); and the oldest the lowest (57 per cent of those aged 55 to 64 and 49 per cent of those aged 65 and over).

Figure 3 shows the four most common exposure issues recorded, along with issues which were recorded proportionately more frequently in recent years, over time. Most notably, it shows **the proportion of service users recorded as having an issue with stress at work rising over the past two decades**, from 42 per cent in 2004 to 80 per cent in 2024. This mirrors the trend in the increase in psychological issues over time shown in Figure 2 above. While this is unsurprising given that stress is a psychological issue, the prevalence of stress as a *workplace* place issue shows that mental health issues are intimately connected to experiences of work.

[9] Job design broadly refers to the process of establishing roles, tasks and working conditions, often with the goal of maximising both organisational performance and worker wellbeing. It can encompass the number and nature of tasks in any given role, the organisation of workstations, and the level of autonomy workers have among other things. For more details see https://oshwiki.osha.europa.eu/en/themes/definition-workjob-design

Figure 3: Workplace issues (2004-2024)



Base: 8,913

Service user interviews provide insights into how these workplace issues manifest. Many had engaged with WHS following disputes over **performance at work,** sometimes related to employer expectations they found difficult to fulfil due to health conditions: '*I was having difficulties with performance at work because of health issues'.* Another individual reported that they were embroiled in a dispute over their fitness for work with management resistant to making necessary work adjustments, arguing instead that: *'You are fit to do the job that you are employed to do'.* One employee became involved with the WHS during formal dismissal proceedings. Another individual had been given a verbal warning about their attendance at work following a period of absence due to sickness.

The WHS often become involved during **a breakdown of trust** between workers and their employers. Some had received formal warnings about their performance at work or periods of authorised or unauthorised absences. Others reported that they were harassed and bullied by management following a return to work. A few were embroiled in formal proceedings characterised by an adversarial approach and a total breakdown of trust. In one case an interviewee reported that their employer repeatedly gave misleading advice by informing her that she was not allowed to be accompanied by an advocate in meetings with occupational health. This individual also struggled to gain access to her occupational health report before it was sent to their employer (a large public sector organisation).

Service user accounts provide some insight into the experiences and situations which generate stress which, as the data above shows, is the most common workplace issue. **Personal conflict** with line managers was a common contributing factor to workplace stress. The perceived inability of management to respond appropriately to workplace incidents was mentioned by several interviewees. In one case management had allegedly failed to squash false allegations of inappropriate conduct. In another case health-related stress became a big issue when an incident at work was mishandled: '*I've got a problem with my direct line manager…an incident happened at work and they swept it under the carpet'.*

A **change of management personnel** often brought with it a change of approach which triggered conflict, stress and poor mental health: '*My new managers were horrible'.* Box 1 provides details of the case of a duty manager in a betting shop trapped between the 'rock' of an unsympathetic manager and the 'hard place' of challenging

and sometimes abusive customers. It also shows how the WHS can lead to a positive resolution of conflict with management and a reduction in work-related stress.

Box 1: Conflict with managers and customers

One interviewee had worked for several years as a duty manager in a betting shop in Sheffield. It was a highly stressful role given the abuse and threats routinely made by customers to staff, the pressures of accounting for all the money taken daily in the shop and the ever-present threat of disorder caused by youth congregating around the door of the premises. Refusal of service or barring people sometimes resulted in threats of violence or assaults. Responsible gambling initiatives had further heaped pressure on staff because they were now expected to approach individuals exhibiting signs of stress and encourage them to take a break: '*Well, first of all we don't speak their language* [many customers did not speak English as their first language]*, second some are quite aggressive people and if we went up to them and said, 'excuse me are you alright?'… we are putting ourselves in danger'.*

A new manager then brought a stricter approach to staff relations, disciplining staff for small errors in their work. This compounded problems of staff retention which further raised stress on the duty manager as they increasingly had to work with new staff unused to working in the industry. Eventually unable to cope, they requested more flexible working hours and to step down from the role of duty manager. This was flatly refused. They felt trapped between an unsympathetic manager and abusive and threatening customers. Becoming depressed and anxious they took time off work and spoke to their GP about their situation who referred them to the Work and Health Service.

They met the WHS adviser twice and explained their dilemma. This resulted in a letter to their employer. The letter '*helped me to articulate what I actually wanted because when you're explaining* [to management] *you're full of emotion'.* Talking to WHS advisers made them feel supported for the first time: '*I felt like there was no back up and after* [accessing WHS] *I just felt safe'.* A key outcome was that they were able to relinquish the stressful duty manager role and stick to working 24 hours per week. This improved their mental health: *'I'm starting to feel really good about myself because of it'.*

Stress can also result from **inflexible working arrangements** that impact on family life. One interviewee described accepting a job in the Civil Service only to be instructed to work in the office when they had believed it was a remote post. This forced a long-distance move that initially severed their social ties and meant a change of school for their young child. Moreover, it created financial pressures as they had to pay for two properties, one in the city where they now worked and another in their hometown. The resulting stress also worsened their mental health. It was at this point that their therapist referred them to the WHS who were able to lobby on their behalf with the result that the post was made remote for a six-month period.

3.3. Employer support

A key question for the research was why service users sought help from the WHS when they already had access to work-based occupational health schemes. Most of the service users interviewed worked for larger employers and had access to occupational health schemes but these were viewed as **primarily serving the interests of employers**: '*I got zero help from my employer because my employer caused it'.* Some interviewees suggested that occupational health providers tended to take the side of line managers during workplace disputes. One interviewee reported, for example, that the occupational health provider had colluded with her line manager to produce a *'roadmap to* [their] *sacking'*. Another interviewee who worked for a major

public sector employer observed the need for independent advice given their lack of trust in workplace-based provision: *'The occupational health providers are there to serve the employer and I think it's essential that there's a more objective service'.*

One implication of this lack of trust in work-based schemes is that is harder for SOHAS to meet targets stipulating that the majority of WHS service users work for SMEs. The evidence shows that the assumption that employees in larger organisations can access in-house provision isn't always borne out. As one stakeholder acknowledged, '*employees don't trust their large organisational occupational health teams which is an issue in itself for the system'.*

However, the decision to seek out WHS support was not always prompted by a lack of trust in work-based occupational health provision. A second issue reported by some interviewees was that **their employer was reluctant to make necessary adjustments** for physical or mental health conditions even after this had been recommended by internal occupational health services. Another related concern was the perceived tardiness of some employers to provide the necessary health-related support. One individual reported that they had '*been asking since last year* [over six months ago]'. WHS support was often sought out in such cases to lobby employers to put the required support in place to enable individuals to continue in employment.

Support

4

4.1. The Work and Health Service offer

The Work and Health Service mainly supports individuals who are in work but facing work-related health issues which means they are either struggling to stay in employment or off sick. The service works on the principle of early intervention to address workplace issues before they escalate to prevent health-related job loss or health conditions worsening.

The service offers advice on occupational adjustments and employment rights and, where consent is given, may advocate with employers on behalf of the employee. A distinctive feature of the service is that clients can return for further support if their health or employment issues persist or circumstances change. There are no limits on the number of appointments or the time period over which service users can access support. At the same time, the principle of early intervention is intended to minimise the need for repeat or intensive support.

A typical SOHAS appointment involves a 15-20 minute discussion to explore issues, followed by 15-20 minutes discussing potential options although appointments may last up to 90 minutes. Appointments are service user-led, allowing individuals to disclose their circumstances at their own pace and work towards identifying suitable solutions.

The service model works on the principle of rapid advice with all clients seen within two weeks of referral although the extent to which this target is met seems unspecified beyond qualitative insight from SOHAS staff who suggested this is achieved in the majority of cases.

The COVID-19 pandemic significantly reshaped the WHS model:

- GP referrals as a proportion of all referrals fell during the pandemic and, despite a post-pandemic bounce, remain below pre-pandemic levels. More referrals now come as self-referrals (via the SOHAS website or phone calls) or through referrals from non-GP agencies (see Table 2).
- Face-to-face appointments are available to service users although the number of these has fallen as WHS advisers operate from fewer GP practices following the pandemic, which is where most in person appointments were delivered. SOHAS are introducing a limited number of slots for face-to-face appointments in their office in central Sheffield but service users increasingly prefer remote appointments (telephone or videocall) since the pandemic.
- The WHS has not previously delivered remote support but now offer telephone consultations alongside face-to-face appointments, which many clients are comfortable with. Videocalls are also offered but rarely taken up However, WHS advisers acknowledged that phone appointments may be slightly less effective for some aspects of advice delivery.

- A triage system has been introduced to assess client needs at the point of referral. This 10-minute screening, conducted by administrators or sometimes the director, allows for a holistic assessment of the client's circumstances from the outset.

4.2. WHS support provided

CRM data shows that **the majority of service users only received advice on a small number of occasions over relatively short periods of time**. Over four fifths (82 per cent) received advice from the service on either one or two occasions, with two thirds only receiving support once (67 per cent), as shown in Table 8 below. Notably, a greater proportion of service users who were off sick received advice more than once compared with those who were employed/self-employed (39 per cent compared to 27 per cent). This suggests that more support is required once an individual takes medical leave which may provide tentative confirmation of the value of early intervention while individuals are still in work.

Engagement with the service also appears to be relatively time limited, even when advice is received on multiple occasions. Just under three fifths (57 per cent) of service users who received advice more than once accessed all support in a single calendar year.[10]

Overall, the data indicates that while there is no limit on the number of appointments or the length of support, most service users only seem to require a limited number of appointments over short periods of time.

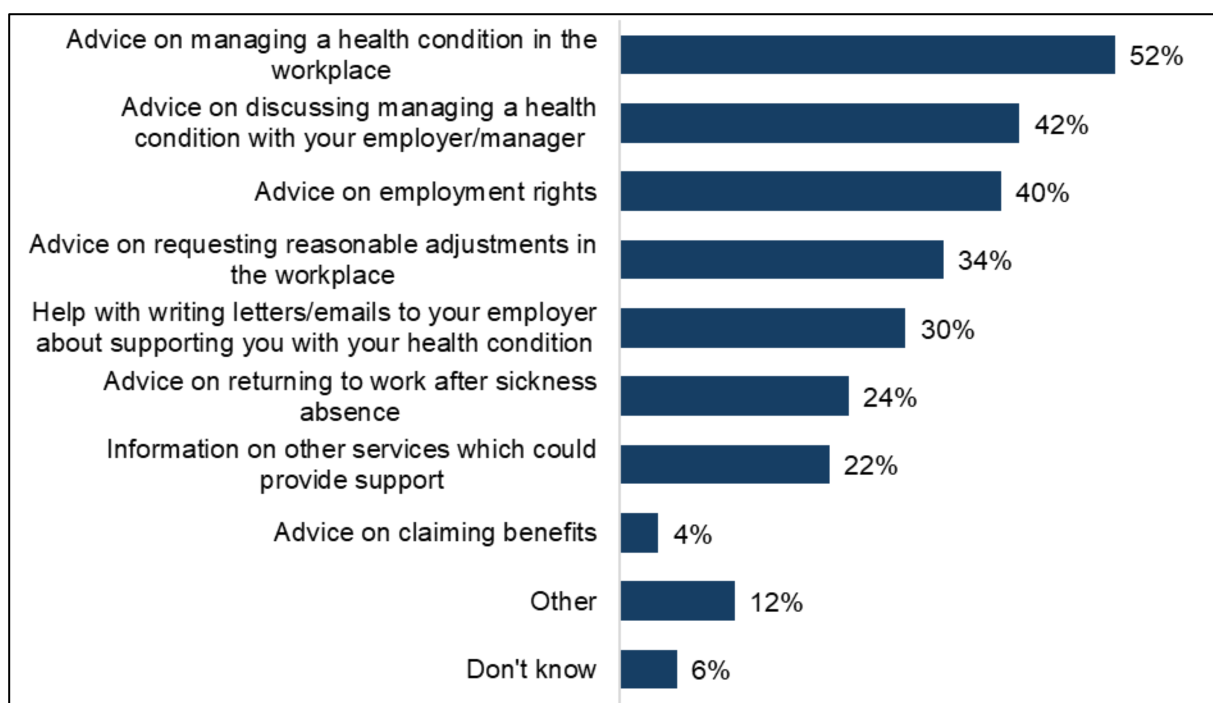
Table 8: Number of times service users received advice

Number	Count	Per cent
1	10,907	67
2	2,417	15
3	1,058	6
4	540	3
5+	1,431	9
Total	**16,353**	**100**

Survey respondents were asked what forms of support they had received from WHS advisers (Figure 4). Perhaps unsurprisingly, the two most common forms of support were related to managing a health condition. Over half of service users (52 per cent) received '*advice on managing a health condition in the workplace'* and over two fifths (42 per cent) received *'advice on managing a health condition with your employer/manager'*. Two-fifths had also received advice on employment rights. Only a very small proportion had received advice on claiming benefits. Again, it must be remembered that survey response numbers are low and this is not necessarily indicative of support received by all service users.

[10] The evaluation team only accessed data on year of appointments to maintain anonymity which means it is not possible to calculate the precise duration of support each service user received.

Figure 4: Forms of support received



Base: 50

4.3. Value of support

Service users

Service users were asked through interviews, focus groups and the survey to reflect on the value of support. This section presents data on positive experiences first before reflecting on issues with the service and elements that could be improved.

Positive experiences

Survey respondents were overwhelmingly positive about the support they had received. The **vast majority (84 per cent) rated the support they had received as 'good'** (56 per cent 'very good' and 28 per cent 'fairly good'). Just three respondents (six per cent) rated the service as 'fairly poor'.

Service users highlighted a number of elements of the service which contributed to positive perceptions and experiences (responses from interviews or focus groups unless otherwise stated):

- The **empathetic and knowledgeable approach** of WHS staff which made service users feel listened to:
  - One service user contrasted the sympathetic ear of WHS staff with the sense of not being listened to at work to by their line manager or occupational health team: '*I'd already been drawn and quartered and then for SOHAS to listen to me made the difference because there was nobody'*.
  - *Very professional and knowledgeable staff, advice and support provided are valuable.* (Survey response)
  - *I found the service to be very empathetic and helpful.* (Survey response)

- A sense that WHS advisers were **trusted intermediaries** who supported service users to face challenges they may otherwise have had to face on their own in an unequal struggle with their employer (see also Box 1):
  - *I wasn't alone, knowing that someone was there.*
- **Consistent support** from the same adviser that compared favourably with other services:
  - *When you go to your employer's occupational health you speak to one therapist and if they need to review it you go through another therapist who will understand your case very differently…and give a different analysis.*
- The **perceived impartiality** of the service was particularly valued: '*They're independent. They're not working on behalf of the company*'. Many service users reported that employer-based occupational health providers were biased and took the side of the employer (see Section 3.3).
- The **value of being able to access external occupational health support where none existed within the workplace** was highlighted as especially helpful for those working in small companies lacking occupational health services.
- **Long-term support** when workplace issues persisted. While the WHS often provided a short-term response to the needs of individuals in crisis, they also sometimes provided help and support over significant time periods where issues remerged or intensified (Boxes 2 and 3).

Box 2: Repeat WHS support to address issues related to recurring medical conditions

One service user with a physical health condition and a chronic neurological condition was employed in a senior management role for a major public employer. Following unrelated orthopaedic surgery in 2022, they experienced a '*crash'* in their chronic condition. They made a phased return to work but encountered pressure to return more quickly with thinly veiled threats of 'breach of contract' if unable to sustain working hours. A support organisation for their chronic condition signposted the individual to the WHS who '*reinforced the importance of a gradual return rather than rushing in and risking immediate relapse'.* This empowered the individual to assert their rights at work and led to their employer increasing the period of phased return from just eight weeks to seven months.

Despite a successful return to work, the service user then began to experience unwanted behaviour, including what could be interpreted as bullying, discrimination and harassment. Following a relapse in 2024, they took medical leave and sought WHS guidance around handling derogatory comments, engaging HR confidentially, creating a timeline of events and gathering associated evidence. A WHS adviser also suggested they should make an application for Personal Independence Payments (PIP). The service user was then able to negotiate a satisfactory settlement agreement with their employer with the aid of a solicitor. Leaving a highly stressful role has improved their mental health. They plan to return to work once they have seen improvement in their symptoms, rebuilt their energy levels and got stress under control.

Box 3: Providing long-term health-related support

One service user was an employee of a major food retailer where they have worked for 15 years. They have been supported by the WHS on several separate occasions for over a decade in relation to issues at work arising from a lack of support with mental and physical health conditions.

- **2014:** The service user was initially referred into the WHS by their GP following six weeks off work due to mental health conditions. During their time at work, they had also developed a contact allergy that made handling certain products problematic. The WHS provided information on their rights as a disabled worker which helped them to get the employer to provide Personal Protective Equipment (PPE) to enable them to handle certain products.
- **2016:** After seeking support for concerns about the employer paying *'lip service'* to occupational health reports and not making reasonable adjustments, the WHS wrote another letter reminding them of their legal obligations to disabled workers. This approach was ascribed to the attitudes of a manager who was notorious for '*flying by the seat of his pants'* regarding legal obligations. The arrival of a more professional and sympathetic line manager meant that the service user was able to reduce their hours at work and made no further call on the WHS for a number of years.
- **2022:** The individual reengaged with WHS to seek support when a new manager made life '*very difficult'* and put every obstacle in the way of realising necessary workplace adjustments e.g. the purchase of a chair to help the individual manage a degenerative joint condition. They had also experienced workplace bullying around the same time which led them to take four months off work. WHS supported them to challenge their employer with the possibility of an industrial tribunal which saw them make the necessary adjustments.
- **2024:** The service user was referred to SOHAS again following a period of absence due to ill health. The employer had allegedly not paid statutory sick pay.

Over a decade of support WHS helped the service user to remain in employment and secured several concessions including reducing working hours and the provision of PPE equipment as well as making them more aware of rights at work.

A few respondents highlighted the value of the service, even though the support they had received had not led to a positive outcome:

> *Whilst there wasn't anything that can be done to help me at this stage, I think the service is a useful one that can make a big difference to people. Dealing with work based occupational health can be daunting and having access to someone who can advise on this is helpful and invaluable. (Survey response)*

> *She was fantastic and very understanding. She helped me a lot but unfortunately the suggestions made fell on deaf ears with my employer.* (Survey response)

Further indication of satisfaction with the service is provided by the finding that **most interviewees reported that they would use the service again** should their situation necessitate it. Moreover, almost all respondents agreed they would recommend the service to others: '*Absolutely yes, because they are amazing warriors for us'.* Just two respondents said they would not. This appeared to be linked to a perception that follow up support from an adviser was delayed and based on incorrect information such as listing the wrong health condition: *'This gave me the strong and bad impression that I wasn't listened to at all. I wouldn't recommend such a service to anyone'.*

One interviewee had personally recommended the service to ten of her colleagues but also expressed some concerns that it could become oversubscribed. Very occasionally recommendations reflected a perceived dearth of appropriate provision elsewhere: *'I think I would use the service again, there isn't a lot [health-related support] in Sheffield'.* Around half of respondents also indicated that they had passed on advice or guidance they had received to their colleagues.

Of those who had not passed any information on, the most common reason for not doing so was that it was not relevant to colleagues. Overall, these findings suggest not just that most service users would recommend the service to others but also that some actively pass on information and advice to others. This means the benefits potentially extend beyond service users. As wider research shows, peer support can play a valuable role in sharing experiences and strategies for overcoming challenges in the workplace (Cameron et al., 2012).

Potential improvements

The vast majority of service users were overwhelming positive about the service although some did suggest improvements including:

- Some service users indicated that they were **have preferred face-to-face meetings** with advisers to develop trust rather than telephone calls: '*I think most people would agree that it's better to see the person than just hear them'.* While face-to-face meetings are provided in some instances, the WHS has limited capacity to offer this although is looking to expand this through office-based appointments (see 4.1).
- The **option of a follow up meeting or letter** which did not seem to have been provided consistently to all service users:
  - *The adviser was lovely and encouraging but I was expecting a report to back me up which never came and no answer when I tried contacting them. It made no difference to the position I was in as I left the job. But had I stayed to fight it would have been good evidence to have.* (Survey respondent)
- **Restoring valued elements of support** which no longer seemed available when service users re-engaged with the service:
  - *It would be helpful if they could do Return to Work Plans as they used to do. This helps the employer to follow medical advice and not argue or deny your rights to reasonable adjustments.* (Survey respondent)
  - *It was a shame advisers no longer are able to attend in person meetings at work as this made such a huge difference in a previous situation.* (Survey respondent)
- Measures to **raise awareness** of the service by better advertising, often rooted in very positive experiences and a desire to 'spread the word':
  - *No one knows what it means or has heard of it.*
  - *So it's not sort of advertised, there's no leaflets in the doctor's surgery.*

  Some interviewees also suggested greater visibility may have enabled them to access the service sooner before their situation became critical: '*I would have benefited from contacting them sooner'.* Separately, there was also a misconception among some that the only referral route was through GPs, suggesting a need for greater awareness of the self-referral option.
- **More emotional and employability support:** One service user identified a need for more *'hand holding'* and more support to find work after job loss such as help with job application forms and interview techniques.

Stakeholders

Strengths

Those commissioning or directly providing the service highlighted **a number of elements which they felt contributed to positive outcomes:**

- The **ability for service users to access the service over a period of time** which allowed for a change in circumstances e.g. taking up a new job which required WHS advice in relation to a new employer.
- Providing **a sounding board for service users to better understand the nature of employment and health-related issues**:

  > *They tend to land at our door because they just need people to be, like, 'you are going through tremendous stress' or 'you're going through burnout, do you recognise what burnout is'? Sometimes you go through symptoms and they're like yeah, tick, tick, 'I have this, I have this', and that's the only time they realise what they're going through is once they've spoken to us*.

- **Organisational independence** compared with occupational health services provided by employers that are perceived as doing '*whatever their line manager says they should do'.*
- Advisers' strong **knowledge of the local service landscape** and the embedded nature of the service within the local system.

One stakeholder also noted that the **unit cost per service user is low** compared to other employment support programmes, estimating it was at least ten times less, although precise figures were not available.

Wider stakeholders were largely positive about the service:

- I don't think there are any gaps. I think it's working extremely well. (GP)
- I think they're quite good, I know they're a good advocacy service. So yeah, I think they are quite important. (Secondary care service)

Specific features of the service identified as core strengths included:

- **Raising awareness of employment rights which served to empower service users (see also Section 5.2).** This was seen to play a significant role in helping patients return to and sustain employment.
- **The empathetic approach of advisers** in listening and supporting individuals to reflect on their own situations. One GP emphasised the importance of this '*cathartic*' approach as they didn't have the time to do this during patient appointments.
- The **ability to quickly and easily access the co-located service** within GP practices was valued by patients.
- The **skills and experience of WHS staff:** One referral agency noted the value of having an occupational health physician on the team: '*They've got that support and expertise in terms of job retention issues'.*
- **Early intervention** was seen as enabling work-related health issues to be addressed at an early stage before they escalate or deteriorate further.
- **Complementary expertise** to referral organisations' skillsets:

- *Often, it's around the legality where we reach the end of our knowledge and that's where we would then be signposting more to SOHAS…it doesn't lighten our load or improve efficiency for us, but it does add value to the offer that we provide to our patients.* (Secondary health care service)
- *We probably do more of the hands on stuff around that, but in terms of the legalities etc I think SOHAS have a bit more awareness of those kind of elements.* (Secondary health care service)
- *Very often when people are having particular issues with their workplace with bullying or stress at work... I find it difficult to sort of advise them exactly how to proceed with that. Because I don't have the skills. You know, we're not trained in specific occupational health and workplace issues.* (GP)

One GP also noted that feedback from the service through reports and actions plans helped, in turn, to **build their own capacity** to support patients with work-related health problems they might not otherwise be able to address.

- **Taking pressure off services**: One interviewee working in secondary care noted that '*having that external resource also takes the pressure off us a little bit when we're not doing the immediate occupational rehab'.*
- **A distinctive offer** relative to other health-related employment support. The service's ability to provide in-work support for those on medical leave or at risk of going off sick was seen to distinguish it from other major programmes that targeted those who were out of work.

Challenges

While largely positive about the service, stakeholders identified a number of **challenges,** some of which suggest ways in which the service could be improved (see also Section 6.1):

- A **lack of comprehensive and robust data on outcomes and impact**, indicating that this is an area for future development (see also Section 6.2).
- **Data sharing issues including a reliance on informal data sharing** where advisers had no access to referral organisations' IT systems, which limited the ability to coordinate support. Some WHS advisers operating from GP practices did have access to NHS laptops and systems but this varied by practice. Advisers that did have access to GP systems noted benefits including access to patient information as well as quick and direct communication with GPs. However, advisers that lacked access in some practices noted that this made feedback *'clunky…and time consuming'* and also created risks due to delays in GPs responding to safeguarding concerns raised.
- **Limited visibility of the service** due to a lack of integration with referral partner's IT systems (see above). One GP noted that, despite weekly surgeries held by advisers, the service sometimes slipped from their mind as it isn't a referral option on their practice system (SystmOne). Another noted that they tended to use other employment services because they were more familiar with these services, interacted with them more regularly, and had easy access to them (e.g., saved as favourites on their system).
- **Potential duplication** where other services have begun to provide vocational rehabilitation as part of their core offer (e.g. in the Long COVID service).
- The service occasionally faces **small-scale business continuity issues** (e.g., staff absence due to illness).

- **A decline in funding** for SOHAS combined with increasing competition in the post-pandemic employment and health service landscape to secure funding. This has a number of implications including:
  - A small budget for promoting the service which can **limit SOHAS's visibility relative to larger spending employment support programmes**.
  - A **lack of funding to target groups and areas** that are underrepresented in the service user base.
  - A **reduction in intensive face-to-face support** that is most suitable for supporting clients with cognitive difficulties or facing digital exclusion. One stakeholder noted:

    > *Historically it was a better service because they could go and work with the* [patient]... *I've had a patient who's a [public sector worker with a cognitive condition] and the SOHAS worker did an awful lot of face-to-face working directly, going to meetings, that sort of thing... but I haven't come across that for quite a while, it's been more a phone approach… there are some people who would struggle with that and the same with email, they're better face-to-face*. (Secondary health care service).

  - **A lack of resource for staff to take part in important training** around, for example, employment law and neurodiversity. This sometimes left WHS advisers feeling unprepared: '*I often feel it's take a deep breath and jump in to do the role without really having had the training first'.* This is compounded by a **lack of a consistent national qualification** for integrated work and health support workers. SOHAS have sought to mitigate this through **a strong internal culture of informal peer support** and learning that draws on the respective knowledge and expertise among the team:

    > *[We have] really experienced advisers, there's also some inexperienced advisers, so what we're doing with them, there's a constant learning programme, we don't call it that but that's what it actually is, because there's lots of supervision and peer group support work that underpins all work of the advisers* (SOHAS staff).

- The **challenge of supporting service users no longer able to access other more appropriate services** due to changes in eligibility criteria: This is particularly difficult for SOHAS in the context of declining funding (see above):
  - *Since Talking Therapies changed their referral pathway… we have to take that patient on because they have nowhere else to really go.*
- **A lack of provision in the wider health system** that negatively impacted WHS service users. Issues included long waiting times for mental health support or neurodiversity assessments, which can aggravate work-related health problems:
  - *It's the mental health services… People are waiting months and months to see counsellors and not managed well.* (SOHAS staff)
  - *In terms of neurodiverse patients, the length of time that it'll take to get an assessment never mind get treatment is years and years for children and adults with us and that is just meaningless…people become iller and iller and their employment situations often become much worse during that time.* (SOHAS staff)

Outcomes and impact

5

5.1. Introduction

Interviews, focus groups and survey data provide some indication of changes experienced by service users in terms of health and employment, and the extent to which WHS support was responsible for any change. This subsection looks firstly at health outcomes and the next subsection considers employment outcomes, with examples showing how the two are often interlinked. The lack of robust data collection on outcomes before the evaluation commenced means that the data is limited to a fairly small number of observations relative to the size of the service user population. Findings should therefore be considered indicative of the types of change experienced and the ways in which WHS support contributed to change rather than representative of the experience of all service users.

5.2. Health outcomes and impact

Some interviewees highlighted positive health and wellbeing outcomes as a result of WHS support.

- **Reduced stress and anxiety** experienced by those in dispute with their employer:
  - *I felt so supported and listened to and the help SOHAS has given me has contributed to me being settled a little bit with my anxiety.*
  - *I was internalising everything and was just taking on all the stress myself… it was affecting my relationships with my wife and with friends… the conversation with SOHAS was a reset and I've done a couple of mental exercises to help with that. People mentioned that they noticed the difference afterwards.*
- **Physical health benefits:**
  - One service user working for a major retailer was supported to secure personal protective equipment to manage allergies triggered by their working environment: '*It improved my health, certainly my physical health… it remedied that straight away. And, if you look to the mental health side, it took away the stress element'.*
  - Another service user working as civil servant was supported by SOHAS to secure a remote working arrangement with their employer which meant they no longer needed to live in a city away from their support network. This led to improvements in both mental wellbeing and an inherited physical health condition*: 'I'm able to get more sleep as that was a big challenge... my fatigue has kind of been managed and the pain is also being managed'.* It also helped to **improve their financial position** as they could relinquish one of their tenancies they had been forced to take up to be close to the office and **made it easier to fulfil parenting responsibilities:** '*I was on the verge of*

giving the job up...I was just living on the verge of poverty and I'm responsible for a [primary school age] child.' They concluded that: '*SOHAS has given me the opportunity to work, be a [parent] and earn money'.*

- **Greater confidence and self-esteem** at work:
  - *I would have still been believing that I couldn't do my job anymore and I was just a complete failure.*

On occasion, the health outcomes of support could be **transformational**. In one case support from the service was directly credited with preventing one individual from acting on suicidal ideation and helping them stay in work:

> *I would not be alive and still in employment if it was not for the support I received from SOHAS. My situation was very bad and it went through a tribunal process. The support I received, and still receive, from SOHAS has been instrumental in keeping me in employment. SOHAS has continued to provide me with supportive communications which feed into my on-going Stress Management Action Plan.* (Survey respondent)

Most of the service users who reported changes in health and wellbeing tended were employees facing challenges at work. However, one interviewee was an employer who used the service for support with the stress in managing their own company and emphasised the value of a **'preventive conversation'** to stop stress and anxiety escalating (Box 4).

Box 4: The value of preventative support to address work-related stress

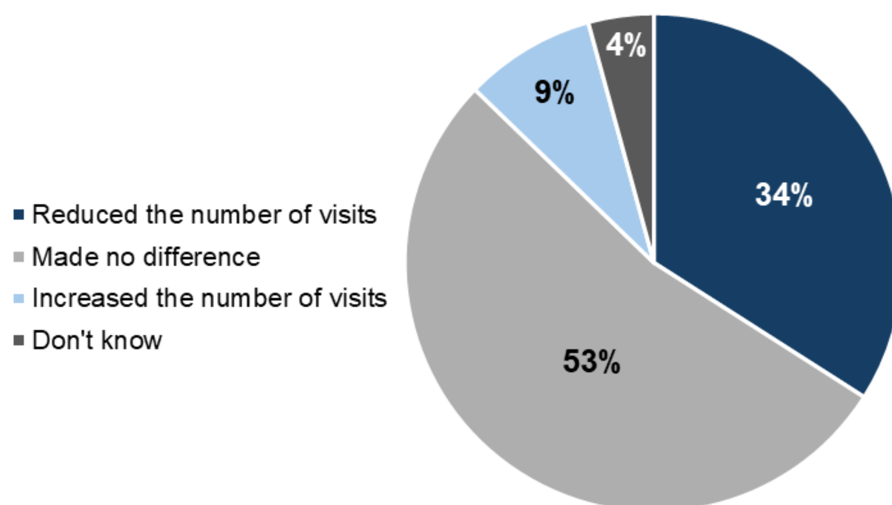
This service user was joint owner of a business who found the stresses of running a company were '*starting to affect my mental health…I'd got to the point where I was internalising everything and just taking on all the stress myself'*. This was negatively impacting their relationships with their spouse, business partner and friends.

The service user contacted the WHS with a view to stop their mental health issues escalating: '*It was more of a preventative conversation'.* They reported that the adviser '*had a good understanding of what I was going through and so it was useful to talk to someone'.* A series of conversations were described as a '*reset'* and entailed some mental health exercises to help them deal better with workplace stress. The service user reflected that the experience had taught them that it was reasonable to feel stress but there are ways you can cope with it and manage it more positively.

A **minority of interviewees were unable to identify any positive health impacts** of the support provided by the WHS: *'None because I still feel anxious and upset and aggrieved but what it has done is it's told me that I'm not over-exaggerating'.*

Survey data provides further insights into the impact of WHS support on health and wellbeing. A set of questions asked about what *difference* WHS support made to various aspects of health and the use of health services. Just over one-third of respondents felt the support they had received had reduced the number of visits they made to their GP (Figure 5). A small number of respondents (nine per cent, representing four respondents) indicated the support had resulted in an increase in the number of visits.

Figure 5: Difference support has made to the number of respondent visits to their GP



Base: 47

There was some evidence from interviews with wider stakeholders to corroborate the finding that WHS support can lead to improvements in health and a reduction in use of health services in some cases. One GP observed that: *'I certainly think once people are in the system, seeing the SOHAS adviser, they're much less likely to come back to myself so it probably reduces follow up with the GP because patients are getting the appropriate advice they need from the SOHAS adviser'* [GP]. Another GP explained how improving work-related challenges could have a positive impact on health: *'we believe [the WHS] does address, you know, significant issues that are driving their health problems... and their health improves as a consequence'.*

Survey data also shows that **over two thirds (71 per cent) of respondents indicated that WHS support had made a positive difference to their mental health** (a lot better, somewhat better, or a bit better) while **nearly half (48 per cent) suggested support had made a positive difference to physical health**. Just under one fifth (18 per cent) reported positive differences in their financial situation as a result of support.

Table 9: What difference has the support you received made to…

	…your overall mental wellbeing?		…your physical health?		…your financial position?	
	Count	Per cent	Count	Per cent	Count	Per cent
a lot better	10	23	10	25	4	10
somewhat better	11	25	4	10	1	3
a bit better	10	23	5	13	2	5
no difference	10	23	20	50	28	70
worse	3	7	0	0	4	10
don't know	0	0	1	3	1	3
Total	**44**	**100**	**40**	**100**	**40**	**100**

Note: 'not applicable' responses have been excluded.

5.3. Employment outcomes and impact

Qualitative data from interviews and focus groups provides insights into ways in which WHS support changed service users' perceptions or experiences of work and, crucially, enabled them to stay in an existing job or find a new one. The analysis below first considers the sense of empowerment some service users experienced before moving on to look at employment outcomes. Survey data on the difference WHS support made to employment outcomes concludes the section.

Empowerment

One of the most significant outcomes of WHS support identified by stakeholders was **a sense of empowerment** derived from greater awareness of rights and employer obligations. One WHS adviser described it as '*helping [service users] to gain some agency and control back over that situation by giving them options of how to go back to their employer'.* Wider stakeholders echoed this:

> *Just understanding what is appropriate for their employees to ask of them and… where they stand contractually…those are quite big things…often patients don't know what their legal rights are and contractual obligations...It gives them a bit more empowerment. (GP)*

> *The thing that stands out the most is around that knowledge and understanding of employment law and knowing what an employee should expect from their employer...where somebody's at a point that they're maybe on sort of performance review or staged meetings because of absence. So they're meeting with managers and HR...in those scenarios SOHAS can be really supportive to patients.* (Secondary health service)

This sense of empowerment also emerges clearly in service user accounts who frequently report that support improves their understanding of employment rights and empowers them to challenge problematic situations at work. This comes across both in terms of enhanced knowledge of, and increased confidence in asserting, rights at work:

- The provision of independent advice on employment rights helped to **clarify entitlements** around sickness absence and workplace adjustments:
  - *They just helped clarify the legal status because I didn't really know.*
  - *They pointed me in the right direction, in terms of what reasonable adjustments are and what workplaces are obliged to do.*
- **Instilling the confidence and knowledge** to challenge or negotiate changes with employers:
  - *I was being gaslighted by my employer to make out a lot of problems were created by me...*[WHS advice] *was very supportive to me as an individual and it gave me the encouragement to carry on and keep sort of fighting back.*
  - *It helped me weigh-up all the factors and options relating to my working life and feel supported in where I needed to be respectfully, diplomatically assertive. Whilst being aware of my rights, also seeing things from my employer's point of view, and therefore, and most importantly, how to pitch my case.* (Survey response)
  - *I go there with confidence, and I know my rights.*

Employment

WHS advisers suggested that job retention tends to be the most common positive employment outcome for service users: *'The majority of what we see is people who are trying to stay in their job roles, they just want to be supported well enough to be able to do that job to the best of their ability'*. However, they did sometimes support service users to seek alternative employment where returning to, or remaining in, their current job was not viable:

> *[There] is an option of saying, 'Perhaps it would be best for you if you looked for another job outside of this situation if nothing's going to change for you?'. Because that can often be very appropriate…particularly if the employment relationship's broken down.*

Advisers also observed that, in a minority of cases, a return to work was not always possible, particularly where there was a limiting physical health condition or a protracted period off work had impacted on mental health to a degree where an immediate return was not viable.

Data on employment status after accessing WHS support was not collected systematically before the evaluation. This means there is only survey data on employment status for a small number of participants (49 in total) as shown in Figure 6 below. Respondents were asked what their employment status was when they first received support from the service, and about their current employment status. The data shows that the majority of those who were employed full-time (30 hours per week or more) when they first engaged had remained in full-time employment.[11] Of those employed part-time (less than 30 hours per week) when they first engaged, over half (four out of seven respondents) had also remained in employment.[12] A further six[13] respondents who were employed but on sick leave when they first engaged had returned to work (four part-time and two full-time).

In total, **two thirds (33 respondents or 67 per cent) had remained in, or had returned to work** (out of all those that indicated employment status for when they first engaged with the WHS and when they completed the survey). Analysis of the characteristics of those who stay in or return to work shows that **service users who do not have a mental health condition were more likely to experience a positive employment outcome** (81 per cent, 17 out of 21 respondents) than those who did have one (57 per cent, 16 out of 28 respondents). It will be important to continue to analyse the characteristics of those experiencing positive employment outcomes as the number of survey respondents increases through future rounds of the survey, enabling more robust analysis. This could help, for example, to highlight any need to revise the nature or balance of support to meet the needs of any groups less likely stay in or find work.

The number of survey responses is currently too low to suggest that outcomes are indicative of the experiences of all WHS service users to date. However, data from surveys and interviews or focus groups does suggest that **WHS support made a difference where positive employment outcomes are reported**. Table 10 looks at the 33 respondents who had remained in or returned to work and how important they felt the support they had received from the WHS had been in helping them to do this.

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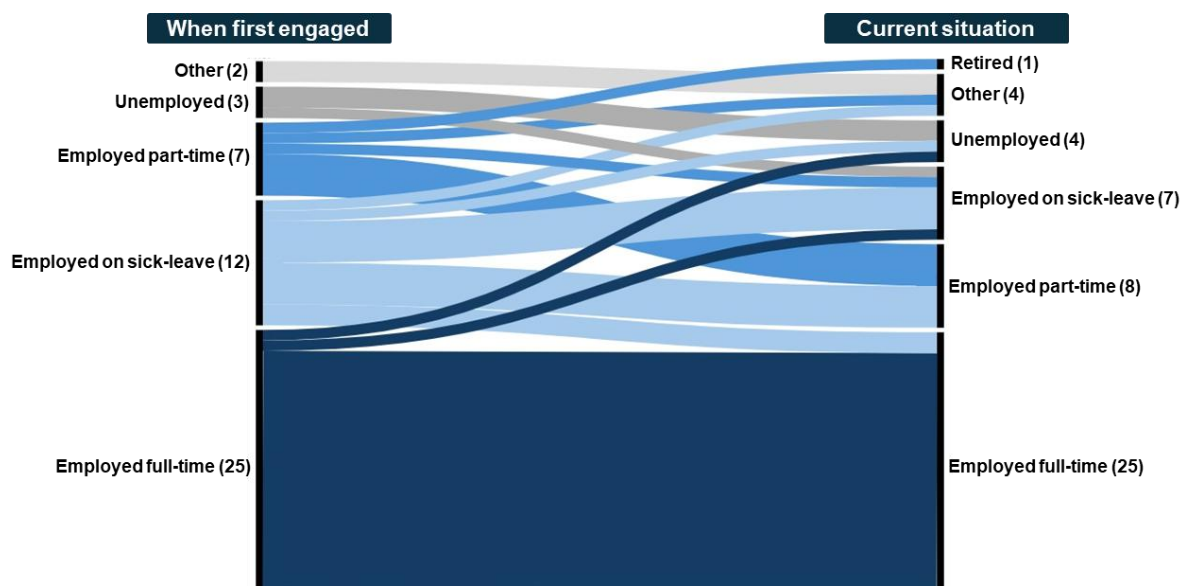
[11] This represents 23 people remaining in work: 16 were working in the same job with the same employer, one was working in a different job but with the same employer, and six were working in a different job with a different employer.

[12] All four were working in the same job with the same employer.

[13] Three were working in the same job with the same employer, two were working in a different job but with the same employer, and one was working in a different job with a different employer.

Around **three-quarters (25 out of 33 respondents) indicated that the support received had been either 'very' or 'quite' important to them in staying in a job, returning to work or gaining a new job.**

Figure 6: Respondent employment status (when first engaged and current)



Base: 49

Table 10: How important has the support you received been in helping you...

	…stay in your job?		…gain employment in a different job?		…helping you return to work?	
	Count	Per cent	Count	Per cent	Count	Per cent
Very important	9	45	3	30	-	-
Quite important	6	30	4	40	3	100
Not very important	2	10	-	-	-	-
Not important at all	1	5	3	30	-	-
Don't know	2	10	-	-	-	-
Total	**20**	**100**	**10**	**100**	**3**	**100**

Interview findings corroborate survey data by highlighting the role of WHS support in positive employment outcomes. Several interviewees indicated that SOHAS had been instrumental in helping them to **retain paid work**.

> *They helped me to keep my job. [Service user going through formal proceedings]*
>
> *I've stayed in work. I've continued working…It helped me get adjustments I've needed to stay in work.*
>
> *I would have transferred or left but I'm proud that I've rode the bad times now and I'm starting to feel really good about myself because of it.*

Survey data also indicates the extent to which WHS support made a positive difference to experiences of work and relationships with, or support from, employers or managers (Table 11). It shows that support made a positive difference (a lot/somewhat/a bit better) in terms of:

- Ability to talk about health conditions with employers/managers (58 per cent)
- Satisfaction with job (49 per cent)
- Employer support in managing health conditions (46 per cent)
- Ability to do the job (45 per cent).

The number of responses is low so, again, caution should be exercised in interpreting the figures. However, it provides a tentative indication that WHS support generates positive changes in experiences of work for many service users.

Table 11: What difference has the support you received made to…

	… your ability to talk about any health conditions with your employer/ manager?		…how satisfied you are with your job?		…how your employer supports you in managing any health condition?		…your ability to do your job?	
	Count	Per cent	Count	Per cent	Count	Per cent	Count	Per cent
a lot better	5	12	5	14	3	8	6	16
somewhat better	5	12	7	19	4	11	7	18
a bit better	14	34	6	16	10	27	4	11
no difference	9	22	12	32	11	30	18	47
worse	6	15	6	16	7	19	1	3
don't know	2	5	1	3	2	5	2	5
Total	**41**	**100**	**37**	**100**	**37**	**100**	**38**	**100**

‘not applicable’ responses have been excluded

Occasionally, individuals had been unable to retain employment but reported that **support had still helped them.** One service user praised the support they had received to try and secure workplace adjustments despite eventually leaving to find a new job when their employer failed to respond appropriately (Box 5). Another service user emphasised that WHS had enabled them to **make informed, strategic decisions that had safeguarded both their health and financial stability**. This former manager in the public sector indicated that WHS support was vital in helping them secure a financial settlement before leaving their job (Box 6).

In other cases, **WHS support actively played a role in helping individuals find a new job** that mitigated the work-related health issues they had faced in their previous workplace. One former public sector worker reporting taking on a new role in another company that is more supportive of their health needs following the disclosure of their disability and helpful advice from WHS on making reasonable adjustments. Suffering from a chronic long-term condition they now reported*: ‘I don’t have as many crashes; I’m sort of able to control my energy levels more’.*

All three examples highlight that job retention figures alone do not capture the full range of benefits the service provides. In other words, **leaving a job can be a positive outcome** with service users valuing the support received and, in some cases, finding alternative employment that is more conducive to health and wellbeing.

Box 5: The value of being listened to by WHS advisers

This service user had a neurodevelopmental disorder and also experienced chronic pain and a mental health condition that meant that they found it difficult to work in a noisy, stressful children's nursery. They reported feeling '*burned out'* all the time. Despite raising these concerns with their employer, they did not feel they were being taken seriously and consequently no action was taken. As a result their mental health began to deteriorate. At this point they were referred to the WHS by a support worker from another service. A WHS adviser drafted a letter making several recommendations such as regular breaks to reduce the pressure. This letter was followed up by a couple of emails. However, the employer argued that they could not make such workplace adjustments with the result that the service user left their job and quickly found another less stressful job.

The service user laid the blame squarely on their '*horrible employer'.* Despite having to find another job they rated the help received by the WHS highly (eight out of ten). They appreciated that the adviser has listened to their story and sought to bring about the workplace adjustments that would have made her working life a more positive experience. They concluded: '*SOHAS listened to me but I did not get the help I needed* [from my employer]'.

While the different data collected strongly suggest that WHS made a different difference in a range of employment outcomes, a few individuals felt that the impact was **minimal**. One concluded: '*I can't really say that it did make a difference'.* This was usually due to the short-term nature of their interaction with SOHAS: '*especially with it being so short… the difference was minimal.'* Another individual had had two separate contacts with SOHAS. The first was not especially helpful and was described as '*just being given information and then it's, like, "off you go, figure it out"'.* The second occasion was much more beneficial.

Reflections and learning

6

6.1. Improvements

The WHS is clearly valued by the majority of service users who took part in the evaluation, who mostly report positive changes in their health or employment situation. These changes are often attributed directly to WHS support.

At the same time, service users and stakeholders identified a number of aspects of the Work and Health Service that could be improved. These mostly draw on the data presented in the preceding sections although some new material is introduced here. Recommendations are provided for SOHAS (as the organisation delivering the WHS), Sheffield City Council (as the commissioning body) and for wider partners in the work and health system.

Recommendations for SOHAS

- Seek to understand the reasons why some service users are unaware of the option of self-referral into the WHS and to **better promote the self-referral option** directly to potential service users and to services who may signpost to the WHS. More broadly, issues around a lack of awareness of the WHS per se suggest a need to work with referral partners to **increase the visibility of the service** and to improve marketing and communications.
- **Review and improve the consistency of feedback** on service users provided to services referring into the WHS. While stakeholders highlighted the value of feedback where received, there was also inconsistency in whether feedback was provided for every referral made. Stakeholders expressed a preference for feedback on support provided and outcomes as a record for both their organisation and the individuals referred. This clearly has resource implications in terms of additional staff time. Improved feedback may also depend on improvements to data sharing (see next point).
- Review the possibility of setting up **more integrated data sharing processes** with key referral partners (especially GPs). Enhanced data sharing and integration of the WHS service into the IT systems of referral partners where appropriate (especially GP Practices) could have a number of benefits including:
  - Supporting better communication and coordination of support between SOHAS and referral partners.
  - Increasing the visibility of the WHS as a referral option on GP Practice systems and streamlining the process of referrals (e.g. by enabling GPs to identify and select appointments for patients).
  - Tracking whether patients have used and benefitted from WHS support.
  - Reducing the administrative burden of providing ad hoc feedback and current variability in whether feedback is provided.

- Explore the potential **to restore elements of the WHS offer that are valued by service users but are no longer provided**, particularly Return to Work Plans (RTWPs) and the option of advisers attending meetings with employers. Wider evidence suggests that structured and tailored advice in RTWPs can improve satisfaction, address multiple barriers and improve outcomes for service users (Gloster et al., 2018).
- **Provide information on inappropriate referrals to referral partners** to increase the quality of referrals. One primary care partner suggested it would be useful to get feedback from WHS advisers on whether they are making appropriate referrals to reduce the level of inappropriate referrals. A WHS adviser also suggested that the service name itself may contribute to confusion given the historic conflation of occupational health and occupational therapy, and that a rebranding or promotional campaign might therefore help clarify the service's remit and reduce inappropriate referrals.
- Explore options for **targeted activities to engage groups or areas that are currently underrepresented** in the WHS service user base such as individuals in precarious or temporary employment.
- **Review data collection systems** in line with evaluation team guidance (see full recommendations in section 6.2).

For Sheffield City Council (as the commissioning organisation)

- Consider how to address issues with a lack of trust in workplace-based occupational health services that generates demand for WHS support from employees working for large organisations with occupational health provision.
  - Undertake research or review the existing evidence base on reasons for a lack of trust in workplace provision and how this could be restored.
  - Work directly with key large public sector organisations (particular in health and education) to better understand and address this issue.
  - Review commissioning arrangements to ensure sufficient resource for targeting of smaller employers that do not have occupation health provision in place.
- Review the implications of a decline in funding for SOHAS over recent years and the **possibility of increasing funding** to support the implementation of recommendations that go beyond existing contractual obligations (e.g. around marketing, training of SOHAS staff, employer advice workshops, and restoring Return to Work Plans and the option of accompanying service users to employer meetings).
- Work with SOHAS to identify and support options for **better targeting and engagement of underrepresented** groups and areas.
- Explore options with SOHAS **to engage more directly with employers to advise and train them on how to support employees with health conditions**. WHS advisers highlighted the potential value of employer engagement activity which is currently constrained by lack of resource and capacity:
  - *Sometimes we speak to managers [and] they've never dealt with someone with mental health [issues] or they've never dealt with [another] health condition…I'd love to be able to go in and do training session to employers [to show] how you should support your employees, but because we're such a small service and funding it's just not a possible thing for us to.*

  Wider evaluation evidence indicates that job retention interventions can be more effective where supported by dedicated advisers who engage with employers to

provide advice and training on how to communicate with employees struggling with mental health conditions and substance misuse, and how to create workplaces conducive to general wellbeing (Schafft, 2014).

- **Monitor improvements to SOHAS data collection systems** and revise contractual expectations in line with the evaluation recommendations made in Section 6.2 (where feasible with existing resources).

For referral agencies and wider partners in the work and health system

- Work collaboratively through appropriate governance structures within the local employment and health systems to **explore ways of addressing shortfalls or waiting times for services that impact on SOHAS**'s ability to deliver effective job retention support. This could help to mitigate two key risks:
  - the WHS becoming a 'catch all service' for service users that can't access other support
  - the complexity of issues and support required increasing due to delays in access to other services leading to worsening health and employment issues.

6.2. Improving data collection systems

The evaluation has been limited by issues with data collection and quality through the CRM system and service user survey administered by SOHAS before the evaluation was commissioned. This has constrained the extent to which the evaluation team can report on key aspects of the WHS such as the profile of service users (e.g. ethnicity or employer size), outcomes experienced by service users, and impact. However, recognition of these issues meant the evaluation could pivot to improve existing data collection processes including the design of a new service user survey. We anticipate SOHAS will continue to administer the survey to future cohorts of service users to expand the volume of data on service users and outcomes experienced so that findings become more representative of the experiences of all service users.

The evaluation also recommends the following improvements to data collected through the CRM system:

- Adopting **standard ethnic group classifications** used by the Office for National Statistics (ONS).[14]
- Adopting standard questions and classifications used by the ONS related to **disability and health conditions**[15]. Including options to indicate when a service user *either* does not have any health problems or disabilities *or* if they prefer not to say, should also avoid any confusion regarding if data is missing or not.
- Incorporating key questions that are now in the revised survey into the CRM where there would be value in collecting this data for all service users such as:
  - The **nature of service users' employment** (hours worked per week and contract type).

[14] Ethnic group classifications, Census 2021 (ONS) available here: https://www.ons.gov.uk/census/census2021dictionary/variablesbytopic/ethnicgroupnationalidentitylanguageandreligionvariablescensus2021/ethnicgroup/classifications

[15] We suggest using the same questions related to disability and health conditions used in the revised service user questionnaire. A list of health conditions used by the ONS in the Labour Force Survey is available here (these are the same categories used in the revised service user questionnaire): https://www.ons.gov.uk/employmentandlabourmarket/peoplenotinwork/economicinactivity/articles/risingillhealthandeconomicinactivitybecauseoflongtermsicknessuk/2019to2023#data-sources-and-quality

- The **size of service users' employers**, in terms of number of employees. The categories used in the revised service user questionnaire could be used (i.e. 1-9, 10-49, 50-249 and 250+).
- **Support provided** by advisers. SOHAS may also want to consider collecting information on the way advice was provided i.e. in person, over the phone, via email etc.

- Taking a consistent approach to data collection regarding **workplace 'exposure' issues**. Including options to indicate when a service user either does not have any exposure issues or if they prefer not to say, should also avoid any confusion regarding if data is missing or not.
- Improving data collection on **outcomes** experienced by service users. The CRM system does not currently collect any information on outcomes achieved by service users (i.e. employment outcomes such as retaining or gaining work, health outcomes such as improvements in managing conditions at work or reduced GP usage, and other outcomes such as improvements in financial position). The ideal situation would be to collect this data systematically through the CRM from all service users e.g. through follow up contact by advisers after a set period of time following the first appointment. However, it is may to be too resource intensive for advisers to collect this data routinely.

A more feasible alternative is to continue to collect data on outcomes through regular waves of the service user survey. The **CRM could also be linked to survey responses**, potentially via the use of unique IDs to join the two data sources. This would have two benefits. First, it would enable analysis of the relationship between outcomes and all variables for which data is collected via the CRM system (e.g. age, ethnicity, support received etc). Second, it could reduce the length of the survey with potential benefits for completion rates as the survey would no longer need to collect data that is already collected through the CRM system (such as information on referral routes, service user characteristics, support received etc).

Of course, all of these recommendations have time and resource implications and it is important for SOHAS to work with Sheffield City Council (as the commissioning organisation) to identify what is feasible within the current contract, and what would require additional funding.

6.3. Looking ahead: lessons from the WHS

While job retention has often been a neglected element of the funding and delivery of employment support provision nationally and locally, the recently launched **Independent Review into the Role of Employers in Health and Disability**[16] places much stronger emphasis on prevention, retention and rapid rehabilitation to stem the rise in economic inactivity. Findings from the WHS evaluation may have direct relevance, therefore, given the Review's concern to identify ways to:

- Prevent ill-health from occurring in the workplace.
- Retain employees who are experiencing ill-health or disability-related barriers to work.
- Focus on rehabilitating employees to return to work more quickly.

[16] https://assets.publishing.service.gov.uk/media/679249349091065484572d35/keep-britain-working-terms-of-reference-pdf.pdf

The initial report from the review (DWP and DBT, 2025b) identifies the importance of a case management approach alongside collaboration between employers, employees and occupational health providers to support prevention and retention. Evidence from the evaluation certainly highlights the benefits of case management underpinned by personalised and empathetic support from experienced and knowledgeable advisers. It suggests that interventions by occupational health advisers can change employer practices and behaviours in ways that can increase the likelihood of employees remaining in post.

However, the key finding from the evaluation about the importance of impartial, external advice suggests a need for the review to consider different delivery models of occupational health. The review may benefit from a deeper understanding of how the relationship between employees and employers is sometimes adversarial. This can lead to a breakdown of trust in work-based occupational health services and create a need for external, impartial advice and advocacy. Such a service can empower employees by making them more aware of their rights and, by extension, increase confidence in seeking to negotiate workplace adjustments or changes with employers.

This is not to deny the potential benefits of work-based occupational health programmes which may operate well for some employees but to suggest the need for a mix of delivery models, including independent external support in cases when in-house provision does not deliver satisfactory outcomes for employers or employees.

At the same time, access to training for employers around employing and retaining employees with health conditions or disabilities may help to reduce workplace tensions and open up the space for the sort of collaboration between employers, employees and occupational health teams that the Review envisages. This kind of employer engagement activity is one of the recommendations of this evaluation. Organisations like SOHAS who are independent and understand both sides of the employer-employee relationship may be ideally placed to deliver precisely this form of guidance and support to employers.

A final point about the wider context is the challenge of operating in an evolving policy landscape where there is increasing risk of duplication as more work and health provision comes on stream through the Get Britain Working strategy. It will be important as provision is rolled out that the distinct and valuable niche organisations like SOHAS currently occupy is recognised and supported and not diluted by competing programmes. This will requires careful strategic coordination and governance of the employment and health landscape within Sheffield.

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