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Preventing health-related job loss

An evidence-based response to identifying what is needed to provide effective early-intervention caseworker support in the UK

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Executive summary

In recent years, the UK has experienced a sustained rise in the number of employed and unemployed working-age people reporting conditions that limit their ability to work. This trend has been accompanied by a corresponding increase in economic inactivity due to long-term ill health, with significant consequences for individuals, employers and public services. Policy reviews such as the *Commission for Healthier Working Lives* and the *Keep Britain Working Review* have highlighted the need for earlier, more coordinated support to help people remain in work or return to work (RTW) when health issues arise. Early-intervention caseworker-led support – where a dedicated professional provides personalised, work-focused assistance – has shown promise in both UK and international settings. However, provision in the UK remains fragmented, unevenly distributed and constrained by workforce and system limitations.

This report examines what is required to deliver effective, scalable and sustainable early-intervention caseworker-led support in the UK. It focuses on defining effective practice, mapping current provision and analysing workforce roles, supply, capacity and constraints, as a foundation for assessing delivery models and policy components.

Approach

The study was conducted by RAND Europe for the Health Foundation. It draws on a structured evidence review of UK and international literature, analysis of workforce and labour-market data, and engagement with stakeholders across the health, employment, occupational health (OH), insurance and voluntary sectors.

Key findings

Defining effective early-intervention caseworker-led support:

- Early-intervention caseworker-led support is best understood as a category of services with the overarching aim of supporting people to stay in work or RTW, rather than a single delivery model or profession.

UK and international evidence demonstrates the impact of caseworker support:

- A number of caseworker-led support models have been shown to improve clients' employment and/or health outcomes.

- While the findings of economic evaluations are often equivocal due to incomplete or uncertain underlying data on effectiveness, in many cases, the economic benefits of caseworker-led support models appear to outweigh their costs.
- Model effectiveness appears to be enhanced by early engagement (within days or weeks, not months, of absence), a focus on RTW, positive relationships between caseworkers and their clients, and provision of tiered or targeted support.

Current provision in the UK is fragmented and uneven:

- There is no single, nationally coherent source of caseworker-led support in the UK. Public provision has largely been delivered through time-limited national or regional programmes and pilots, resulting in geographic variation and discontinuity.
- The most recent programme, WorkWell, provides national funding and principles but allows local systems significant discretion in terms of delivery, meaning provision will vary across England.
- A small number of not-for-profit organisations, e.g. Sheffield Occupational Health Advisory Service and RCS Wales, have achieved relative stability, but coverage remains limited.
- Private provision exists through employer-funded OH and employee assistance programmes and group income protection, but access is uneven and concentrated among larger employers; many workers, particularly in SMEs or in insecure employment, cannot currently access caseworker support.

The caseworker workforce is large in aggregate but constrained in practice:

- Analysis of occupational data suggests a substantial potential labour pool with skills relevant to caseworker support, but only a small proportion currently work in dedicated early-intervention work-and-health-focused roles. Moreover, much of the wider skill base is tied up in other functions, such as nursing and social care, that cannot simply be repurposed.
- Effective caseworker support requires a blend of health, vocational, and coordination capabilities, yet many practitioners currently bring expertise in either health or employability rather than both.
- Existing work-and-health-focused roles (including occupational health (OH) case managers, vocational rehabilitation specialists and employment specialists) provide an important starting point for a more joined-up workforce. However, current roles, standards and training pathways remain fragmented and unevenly developed.
- Scaling caseworker-led support appears feasible in principle, but would require deliberate workforce development, including clearer role definitions, cross-disciplinary training, supervision, manageable caseloads and stronger system coordination.

Recruitment pressures and capability gaps limit scalability:

- Vacancy and recruitment data show sustained recruitment pressure across many relevant occupational groups, particularly in nursing, rehabilitation and social care, indicating structural workforce constraints rather than short-term shortages.
- Competing recruitment demands across national employability programmes and wider labour-market pressures are constraining workforce supply, particularly for non-clinical caseworkers with employment-support skills.

The current landscape is challenging for caseworker service providers to operate in:

- Funding for service provision is often short-term, leading to issues with programme continuity, recruitment and retention.
- Engagement with employers and general practitioners (GPs) is critical for the successful provision of caseworker support but is often difficult to achieve, especially within short timeframes.
- Referral routes into caseworker support are fragmented and do not promote early intervention.

Sustainable scale-up of UK caseworker support is possible but will require greater system coherence:

- Scale-up of caseworker support is desirable, given evidence that it can improve both employment and health outcomes.
- It also appears feasible, though workforce capacity may be a limiting factor, especially for models that require caseworkers with a healthcare background.
- Successful scale-up will require both an effective delivery model (or models) for caseworker support and a national system that supports delivery of that model. This system should create improved pathways into support, promote professionalisation of the caseworker role, establish sustainable funding and incentive mechanisms, and provide more coherent messaging about the benefits of caseworker support.

Implications and next steps

The findings also point to practical implications and next steps for the main actors involved in delivering or enabling early-intervention caseworker support.

For the government, the report points to the need to strengthen the publicly led work-and-health system so that it can provide a clearer national framework for early-intervention caseworker support while allowing flexibility in local delivery. Areas for action include clarifying core expectations for WorkWell and related provision, improving referral routes, supporting workforce professionalisation, exploring options for employer incentives and pooled support mechanisms for small and medium-sized enterprises (SMEs), and building on fit note reform already underway. The report also highlights the importance of moving towards more stable funding arrangements, stronger monitoring and evaluation, and clearer coordination across health, employment and insurance policy, where possible.

For employers, the report highlights the importance of acting early, engaging constructively with caseworker-led support, and ensuring that internal processes support retention and sustainable RTW. Relevant next steps may include strengthening sickness management and RTW policies, equipping line managers to have early and supportive conversations about health and work, capturing basic management information on absence and adjustments, and reviewing whether capability or dismissal procedures allow sufficient scope for adjustments and independent input. Over time, employers may also need to consider whether their current arrangements for OH, insurance, job design and line-management practice are sufficient to support workers with fluctuating or long-term health conditions.

For insurers, the report points to an important role in extending access to early vocational rehabilitation and case management for covered populations, while complementing rather than substituting for publicly funded provision. Potential areas for development include strengthening pre-absence and early-notification pathways, embedding insurer-funded support more fully within employer systems and clarifying how insurer-funded and publicly-funded support should link. The report also highlights the potential value (but also complexity) of exploring pooled mechanisms to extend access to group-income-protection-like (GIP-like) support for SMEs, alongside wider efforts to improve data sharing and evaluation across the system.

Detailed recommendations and suggested actions for the short-, medium- and long-term horizons are set out in Section 6.

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Abbreviations

ABI	Association of British Insurers
ASHE	Annual Survey of Hours and Earnings
AWCS	Additional Work Coach Support
BCR	Benefit-Cost Ratio
CBT	Cognitive Behavioural Therapy
CPD	Continuing Professional Development
CV	Curriculum Vitae
DHSC	Department of Health and Social Care
DMP	Disability Management Program
DWP	Department for Work and Pensions
EAP	Employee Assistance Programme
EASY	Early Access to Support for You
FTE	Full-Time Equivalent
GIP	Group Income Protection
GP	General Practitioner
HCHS	Hospital and Community Health Services
HR	Human Resources
ICB	Integrated Care Board
IPS	Individual Placement and Support
MH	Mental Health
MSK	Musculoskeletal
MSc	Master of Science
NHS	National Health Service
NWD	National Workforce Data Set

OH	Occupational Health
ONS	Office for National Statistics
OT	Occupational Therapist / Occupational Therapy
RAG	Research Advisory Group
RCT	Randomised Controlled Trial
RQ	Research Question
RTW	Return to Work
QED	Quasi-Experimental Design
SEQOHS	Safe, Effective, Quality Occupational Health Service accreditation
SMEs	Small and Medium-sized Enterprises
SOC	Standard Occupation Code
SOHAS	Sheffield Occupational Health Advisory Service
SWAP	Study of Work and Pain
UK	United Kingdom
VRA	Vocational Rehabilitation Association
WHIU	Workplace Health Intelligence Unit
WHSS	Working Health Services Scotland
WISE	Work Injury Screen Early

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1. Introduction

1.1. Background, policy context and rationale for the study

The United Kingdom (UK) has experienced a marked rise in the number of employed and unemployed working-age people reporting health conditions that limit their ability to work, alongside a sustained increase in economic inactivity due to long-term health conditions (ONS 2023; 2026a). This trend has created an imperative to support workers to stay in, or connected to, the workforce wherever possible. According to analysis undertaken by the *Commission for Healthier Working Lives* for the Health Foundation, 8.2 million working-age adults in the UK report a health condition that limits the type or amount of work they can do – more than one in five people aged 16–64. Each year, an estimated 300,000 people leave employment and exit the workforce entirely due to health-related issues, most commonly musculoskeletal (MSK) and mental-health (MH) conditions (Commission for Healthier Working Lives 2025). This figure represents not only a loss of individual livelihoods, but also a persistent structural challenge for the labour market.

This trend has wide-ranging implications for individuals, employers and the wider economy, contributing to labour market shortages, reduced productivity and increased pressure on public services. The *Keep Britain Working Review* estimates that poor workplace health currently costs employers around £85bn per year, reflecting both direct and indirect impacts (DWP & DBT 2026a). This includes approximately £47bn in lost output when workers are unable to work, £21bn in lost productivity from presenteeism, £10bn in statutory and occupational sick pay and a further £7bn associated with recruitment, conflict resolution and litigation. These costs highlight the scale of the economic burden borne by employers and the extent to which ill health undermines workforce participation and productivity.

Society also bears a high cost from economic inactivity due to ill health. Annually, the state pays an estimated £212bn, equivalent to nearly 70% of the income tax paid in the UK, to cover economic inactivity due to ill health (Department for Work and Pensions and Department for Business and Trade 2025). Moreover, public spending on incapacity benefits is expected to increase in real terms (2024/2025) from £20.9bn a year in 2019/2020 to £32.1bn by 2029/2030, indicating the increasing cost of economic inactivity due to ill health over time (Commission for Healthier Working Lives 2025).[1]

[1] These projections pre-date subsequent welfare reforms, including changes introduced through the Universal Credit Act 2025. Therefore, they may no longer reflect the most up-to-date forecast path for incapacity-related benefit spending, particularly given the lower health-related entitlement for many new Universal Credit claimants with less severe health conditions from April 2026.

For individuals, prolonged absence from work is frequently linked to a deterioration in physical and MH, loss of social identity and routine, reduced confidence and financial strain (DWP & DBT 2026a). Evidence suggests that the longer people remain out of work due to health conditions, the more difficult sustainable return becomes, compounding both personal and societal costs (DWP & DBT 2026a).

In response, there is growing policy momentum for early, coordinated interventions that support individuals to remain in or return to work (RTW) when facing health-related challenges. Both the *Commission for Healthier Working Lives* and the *Keep Britain Working Review* have highlighted the urgent need to strengthen the UK's approach to work and health, particularly through the development of sustainable, person-centred support models that can prevent avoidable job loss and support individuals before they disengage from the labour market (Commission for Healthier Working Lives 2025; DWP & DBT 2026a).

Caseworker-led support interventions – in which a dedicated professional provides tailored, one-to-one support to individuals navigating health and employment challenges – have shown promise in both UK and international contexts. These interventions seek to bridge gaps between healthcare, employment support and the workplace and to provide continuity and coordination of services. However, as this report will argue, existing caseworker-led support in the UK does not currently form a coherent national system. Instead, provision remains fragmented, with limited national coordination and variable access. Furthermore, there are gaps in workforce capacity, funding and training, and in integration with wider systems. Understanding what effective early-intervention caseworker-led support should involve and what is required to deliver it at scale therefore represents a critical policy and delivery challenge.

1.2. Project aims and objectives

This study was commissioned by the Health Foundation to address these challenges by developing a timely, evidence-based understanding of what is needed to deliver effective, scalable and sustainable early-intervention caseworker-led support for workers with health conditions in the UK. It aims to inform policy and commissioning decisions by identifying effective models, assessing workforce and system requirements, and developing practical recommendations for national implementation. The research responds directly to the priorities identified by the *Commission for Healthier Working Lives* and the *Keep Britain Working Review*, both of which call for early, coordinated and person-centred interventions.

Specifically, the project's objectives are to:

1. **Define effective early-intervention caseworker-led models** for improving workforce health and preventing health-related job loss, drawing on UK and international evidence.
2. **Assess the evidence base** by reviewing and evaluating caseworker-led models to identify best practices, common challenges, and lessons learned.
3. **Map current provision** of early-intervention caseworker-led support in the UK, including the range of delivery models, referral pathways and service integration.
4. **Analyse the workforce landscape**, including the supply, qualifications and training of those delivering caseworker-led support, and identify capacity gaps and development needs.

5. **Examine system integration and delivery realities**, exploring how caseworker-led models interact with public health, occupational health (OH), employment and social support systems.
6. **Identify funding and delivery models** that could support sustainable scale-up and long-term embedding of effective approaches.
7. **Develop actionable recommendations** for policymakers, commissioners and service providers on how to strengthen early intervention and prevent health-related job loss across the UK.

By delivering against these objectives, the study aims to produce a practical and policy-relevant evidence base to inform the Health Foundation, policymakers and wider stakeholders in considering the design of scalable, effective early-intervention caseworker-led support models and the conditions needed to support their implementation.

1.3. Structure of the report

This report is structured to provide a clear and comprehensive account of the research process, findings and implications for policy and practice as follows:

- **Section 1** introduces the study, outlining the background, policy context, rationale and objectives.
- **Section 2** describes the methodological approach, including the research questions, data sources and the strengths and limitations of the study design.
- **Section 3** maps the current system of early-intervention caseworker-led support in the UK, exploring current provision and workforce characteristics.
- **Section 4** presents the findings from the evidence review, covering the impact and cost-effectiveness of UK and international models as well as key components of effective practice.
- **Section 5** explores delivery realities and system constraints, drawing on insights from stakeholder interviews and workshops to assess practical challenges, enablers and implications for model design.
- **Section 6** provides a roadmap for strengthening early-intervention caseworker-led support in the UK, outlining recommendations for national implementation and scale-up.

2. Methodology

2.1. Research questions and key definitions

This study was commissioned to generate a robust, policy-relevant evidence base on how to design and deliver effective early-intervention caseworker-led support in the UK to prevent health-related job loss. The research draws on evidence from the UK and selected international comparators to explore effective practice and how this might be implemented at scale in the UK. It combines evidence synthesis with stakeholder engagement to inform practical, scalable recommendations for national implementation.

Table 1 below outlines the key topics explored in the study, the research questions (RQs) that guided the analysis and the corresponding report sections that address them.

Table 1. Key themes and RQs

Theme	RQ	Report section(s)
Defining effective models	RQ1: What defines effective early-intervention caseworker-led models for improving workforce health and preventing health-related job loss?	3.1, 4.3
Evidence from past and current models	RQ2: What evidence from reviews and evaluations of previous and current early-intervention caseworker-led models could inform best-practice models, and what are the challenges involved?	4, 5.2
Current UK provision	RQ3: What does current provision of early-intervention caseworker-led support look like in the UK?	3.2, 5.1
Workforce capacity	RQ4: Who delivers early-intervention caseworker-led support and what capacity exists in the workforce?	3.3
System integration	RQ5: How should early-intervention caseworker-led models be integrated into public and OH, employment and social support systems to improve work and health outcomes?	5.2
Payer and provider landscape	RQ6: What does the evidence suggest about how to establish the correct payer and provider landscapes, involving the public, private and not-for-profit sectors?	6.3
Funding and delivery models	RQ7: What funding and delivery models could support sustainable scale-up?	6.2, 6.3

Theme	RQ	Report section(s)
Implementation and recommendations	RQ8: What practical actions and next steps are needed to embed approaches nationally?	6.4, 6.5

Source: RAND Europe

We conducted a brief scoping phase to establish initial definitions of the key terms used in the research questions, including a rapid desk review and consultation with the Research Advisory Group (RAG) – see Section 2.2.5. These definitions were used to draft the search terms and inclusion/exclusion criteria for the evidence review (see Section 2.2.1 and Annex A).

For the evidence review, we defined a **caseworker** as an individual who provides tailored, personalised support to help workers with health conditions remain in work. This support will often include return-to-work planning and service coordination, and will generally involve more than one meeting between the caseworker and their client (Soler-Font et al. 2021; Vogel et al. 2017).

As several sources note, there is no academic consensus on the definition of **early intervention** in the context of support for workers with health conditions (Demou et al. 2016; Vargas-Prada et al. 2016): the target population for interventions labelled as 'early' varies from workers on their first day of sickness absence (Brown et al. 2015) to workers who have been absent for up to six months (Wynne-Jones et al. 2018). In this report, we consider intervention to be 'early' when provided to people currently in work (whether actively working or on sickness absence) and no later than two months from the start of a period of sickness absence. Therefore, the report does not consider caseworker support intended to help people find employment, nor does it consider caseworker support targeted only at workers on long-term sick leave.[2]

As noted above, this report focuses on caseworker support models with the potential to be effective and scalable in the **UK**. Therefore, we consider not only models previously implemented in the UK, but also models used in other countries that could be transferable to the UK context. Hence, our evidence review includes models from several high-income countries recommended to us by the RAG as having potentially relevant caseworker support models.

2.2. Methodological approach

The study combined a targeted evidence review, a workforce mapping exercise, key informant interviews and a participatory appraisal workshop. The methodology was designed to balance depth and breadth whilst generating findings that are both grounded in evidence and responsive to real-world delivery

[2] However, we do make occasional reference to Individual Placement and Support (IPS). IPS is not an early-intervention model as we define it, since the model focuses on supporting clients into work (although in-work support is also offered to clients and employers to help people stay in work). However, IPS is a well-evidenced caseworker model that is delivered at scale in the UK in a variety of treatment contexts, and is therefore interesting from the perspective of scalability.

contexts. The RAND Europe Research Ethics Committee granted ethical approval for the study on 16 October 2025 (project number 024958.000).

2.2.1. Evidence review

We conducted a targeted evidence review (Grant & Booth 2009) of academic and grey literature on early-intervention caseworker-led support for workforce health and preventing health-related job loss. The focus was on drawing out practical insights relevant to the UK context, including evidence on effectiveness, cost-benefit, workforce characteristics and system integration.

Search strategy

We formulated a structured search approach which involved identifying sources, constructing search strings, and setting inclusion and exclusion criteria. We used the finalised search terms (see **Table A1** in **Annex A**) to conduct systematic searches across the Scopus, PubMed, Google Scholar and Consensus databases. We employed Boolean operators to combine keywords related to support models and programmes, roles and delivery functions, employment retention and job loss prevention, health-related conditions, inputs, outcomes and impacts and study design. Search results were automatically sorted by relevance, and the top 30 results from each database were retained for screening.

In addition to this systematic search, we asked members of our RAG (see Section 2.2.5) to recommend literature relevant to our research questions.

Screening process

In total, we identified 206 sources. A member of the research team screened the titles and abstracts of these sources using predefined inclusion and exclusion criteria (see **Table A2** in **Annex A**). 64 sources met the inclusion criteria and were retained for full-text review. These sources were then screened once more for relevance to our research questions. This process yielded 26 high-relevance sources, which covered approximately 50 distinct caseworker-led models.

Data extraction and snowballing

We extracted data from included sources using a structured template (**Table A3** in **Annex A**) covering:

- Bibliographic details and geographic/sectoral focus
- Study design and methodological information
- Model or intervention description
- Caseworker and workforce details
- Outcomes and impact, including cost-benefit evidence where available
- Feasibility and scalability/transferability to the UK context.

In addition, we screened the bibliographies of included studies, where relevant, to identify additional sources and broaden the literature reviewed. We subjected any further related studies identified through this snowballing technique to identical screening and data extraction procedures.

Analysis and synthesis

Finally, we summarised and thematically categorised the extracted data according to the review's key topics and research questions, identifying recurrent themes and highlighting knowledge gaps.

2.2.2. Key informant interviews

We conducted interviews to gain insights from stakeholders involved in commissioning or providing caseworker support. We conducted 14 interviews involving a total of 23 key informants, with a maximum of three participants per interview. Group interviews were conducted when several informants from the same organisation wished to participate. Participants included national policy leads, commissioners, representatives of public, private and third-sector organisations involved in delivering (or supporting the delivery of) caseworker support, as well as representatives from professional membership bodies.

Sampling strategy

We adopted a purposive sampling strategy to identify and intentionally select individuals based on the breadth and depth of their knowledge and experience in relevant areas (Creswell & Clark 2026). We supplemented this with elements of convenience sampling to accommodate availability and maximise participation.

Interviewees were selected to provide a varied sample across the following sampling factors:

- Organisation size (small- and medium-sized enterprises [SMEs] and large companies)
- Sector (public, private and third sector)
- Field of activity (health, employment and insurance sectors)[3]
- Geography (UK and international cases).

Interview process

We conducted interviews via a secure online platform (Microsoft Teams), using a semi-structured topic guide (**Annex A**) to explore themes specific to each participant's expertise thoroughly and consistently. Core topics included:

- How the caseworker model works in practice, including the essential services offered, what counts as 'early intervention' and how eligibility for support is determined.
- Delivery structures and processes, including funding, partnerships, and barriers and enablers.

[3] These fields of activity reflect the scope of the study, which focuses on early-intervention caseworker-led support to help people stay in or RTW after a health-related issue. Health services, employment services, and insurer-funded provision are the three principal organisational contexts in which this type of support is delivered in the UK and comparable international systems. We did not include adjacent fields in which caseworker-style support is sometimes provided (for example, welfare rights and benefits advice, trade union representation, social work, or HR and people-management functions within employers) in the sampling frame. While this is a limitation of the study, we captured perspectives from some of these fields indirectly through the appraisal workshop and interviews with multidisciplinary services.

- Workforce needs, capacity and competencies.
- Integration with wider systems, policy context and scalability.
- Outcomes and available evidence, including costs and benefits.
- Policy and future recommendations.

We transcribed, thematically analysed and synthesised the interview findings to inform the appraisal workshop and final report.

2.2.3. Workforce mapping

To investigate the size and nature of the current and potential caseworker workforce, we conducted a mapping exercise, drawing on several sources: the evidence review, key informant interviews, a targeted analysis of UK job advertisements and role descriptions and secondary analysis of publicly available labour-market and workforce datasets.

Roles, qualifications and training pathways

To characterise the roles that caseworkers play in existing models and the qualifications and training pathways associated with them, we synthesised information from the evidence review and interviews with a targeted analysis of 19 UK job advertisements published in 2026 and 18 detailed role descriptions across public, private and third-sector organisations. The latter included NHS Trusts, the Department for Work and Pensions, national employability providers, occupational health companies and voluntary-sector rehabilitation services. Documents were identified through searches of major UK job platforms and provider websites, using search terms covering the role categories identified through the evidence review and interviews. They were included where they referred to UK-based roles delivering the caseworker functions.

Workforce supply and capacity

To estimate the size of the potential caseworker workforce, we drew on three publicly available datasets:

- The Annual Study of Hours and Earnings (ASHE)
- NHS England statistics on the Hospital and Community Health Services workforce
- Office for National Statistics (ONS) data on job advertisements for relevant roles.

For each of these datasets, we identified occupational categories whose members are most likely to include practitioners delivering early-intervention caseworker-led support, or to contribute to such support as part of a wider role. The evidence review and interviews informed our category selection. We then extracted headline figures for headcount, earnings and (for the ONS data) the volume of advertised vacancies. We used our interview findings to interpret these figures and to identify constraints not visible in the secondary data, such as caseload pressures and competing demands within practitioners' broader job roles.

The workforce-mapping exercise was designed to provide an indicative picture rather than a precise estimate. No UK dataset captures the workforce delivering early-intervention caseworker-led support as defined in this study, because the function spans multiple occupational categories and is typically

delivered as part of a wider role rather than as a discrete profession. The categories used in this exercise therefore include large numbers of practitioners whose primary function lies elsewhere (e.g. in clinical care, MH treatment or social care assessment), and the resulting figures should be interpreted as upper-bound indicators of the potential labour pool rather than estimates of actual caseworker capacity.

2.2.4. Appraisal workshop

Following completion of interviews, we held an online workshop with 19 participants from across the employment support, health, insurance and policy sectors, as well as two representatives from the Health Foundation and four facilitators from RAND Europe. The aim of the session was for participants to assess a series of proposed delivery and policy components using a structured framework based on four criteria:

- Feasibility: alignment with current institutional, operational and policy contexts
- Acceptability: likely support or resistance from key stakeholders
- Scalability: potential for regional or national rollout
- Sustainability: long-term viability in terms of funding, workforce and system alignment.

The appraisal components were determined based on findings from the evidence review and interviews. They included scaling up integrated work and health support, building a skilled caseworker workforce, implementing a tiered support model, strengthening employer responsibilities, creating incentive mechanisms for employers to invest in health and retention and leveraging insurance mechanisms (**Annex C**). We encouraged participants to consider both individual options and the potential for combining elements into hybrid or phased approaches.

2.2.5. Research Advisory Group (RAG)

The study was supported by a RAG comprising experts from work and health policy, employment support, occupational health, insurance and service delivery.

The RAG met at key stages of the study to provide guidance and quality assurance on:

- The scope and framing of the research questions
- Key aspects of the methodology (including the evidence review and interview approach)
- Sharing relevant sources from their networks and professional experience
- Review emerging findings and interpretations
- Contribute to discussions on feasibility, scalability and policy relevance of emerging options.

This expert input helped ensure that the study remained methodologically robust and relevant to policy and practice. However, final responsibility for the analysis and conclusions rests with the RAND Europe study team.

2.3. Strengths and limitations

The study's methodology had several key strengths. It combined a structured evidence review, stakeholder engagement, and a participatory workshop, enabling triangulation of findings. The research was guided by a clearly defined set of research questions, ensuring coherence and alignment across the different methods and activities. The evidence review applied a transparent and replicable search strategy, with predefined inclusion and exclusion criteria and a structured data extraction process. Diverse stakeholders across the public-, private- and third-sectors contributed insights, bringing policy, commissioning, delivery and evaluation perspectives across a range of geographies and organisational types. The appraisal workshop and RAG engagement helped to refine and validate emerging findings and ground the recommendations in real-world conditions and policy priorities.

We also note several important limitations. Since the study did not include a full systematic review (Grant & Booth 2009), some relevant studies may have been missed (particularly non-publicly available and non-English sources). Robust cost-benefit data were limited, necessitating cautious interpretation of findings on the costs and benefits of different caseworker models. In addition, while we drew interview and workshop participants from a range of sectors and geographies, our sample may not have fully represented all perspectives, particularly those of current or potential service users or frontline practitioners. Finally, the project's fixed timeframe (six months for data collection, analysis and synthesis) limited the scope for additional data collection or follow-up.

3. Mapping the current system

This chapter sets out our findings on the current system of early-intervention caseworker-led support in the UK. It begins with a working definition of the support model (Section 3.1), describes how this support is currently provided (Section 3.2) and maps the workforce that delivers it (Section 3.3).

This chapter's contents draw on the evidence review conducted as part of this study, key informant interviews with stakeholders, and secondary analysis of publicly available labour-market and workforce datasets, including the Annual Survey of Hours and Earnings (ASHE), NHS England Hospital and Community Health Services workforce data, and ONS data on online job advertisements. As noted in Chapter 2, the evidence review was not systematic and is unlikely to encompass all relevant models. However, we have made efforts to include recent UK models and international comparators. As the landscape of caseworker provision in the UK is complex and subject to frequent change, the picture presented here is indicative rather than exhaustive.

3.1. Defining effective early-intervention caseworker-led support

For this study, we define early-intervention caseworker-led support as a structured, personalised form of assistance delivered by a dedicated professional (commonly termed a caseworker, key worker, coordinator or vocational rehabilitation caseworker), who supports individuals to navigate health and employment challenges that affect their ability to remain in work or RTW. Support is considered 'early' when offered to people currently in work – whether actively working or on sickness absence – and no later than two months from the start of a period of sickness absence. Support may include preventing job loss, reducing productivity loss or supporting sustainable RTW following sickness absence.

This approach builds on established principles of case management, defined as a collaborative process that assesses, plans, implements, coordinates and monitors the services required to meet an individual's health, social care or employment needs using communication and available resources to promote quality and cost-effective outcomes (CMSUK 2009). The literature and stakeholder evidence reviewed for this study used the terms caseworker, key worker and coordinator interchangeably to describe the professionals delivering this function. However, job titles and organisational settings varied widely.

While delivery models differ in form and intensity, early-intervention caseworker-led support was consistently characterised by the following core features:

- **Individualised, person-centred planning:** caseworkers work collaboratively with individuals to develop a tailored plan based on the person's goals, needs, barriers and assets (Batty et al. 2022;

Waddell et al. 2008). This process includes recognising variation in health conditions, work environments and personal circumstances and avoiding a 'one-size-fits-all' approach.

- **Early, proactive engagement:** support is initiated while the individual is still in work or in the early stages of sickness absence rather than after prolonged absence or job loss. The evidence reviewed for this study consistently identifies the first weeks of absence as the period in which intervention is most likely to prevent the transition to long-term absence and labour-market exit (Black et al. 2017; Vargas-Prada et al. 2016; Waddell et al. 2008). This temporal feature distinguishes early-intervention caseworker-led support from generic case management, which may be offered at any point in a sickness or unemployment trajectory.
- **Ongoing one-to-one relationship:** a single key contact provides continuity over time, helping to build trust, sustain engagement and adapt support as circumstances change (Batty et al. 2022; Kantar Public et al. 2024; Waddell et al. 2008). This relational continuity distinguishes caseworker-led approaches from transactional or purely advisory services.
- **Coordination and navigation:** caseworkers act as a central link, connecting individuals to healthcare, occupational health, social care, employers, welfare services and training provision as needed (CMSUK 2009; Hanson et al. 2006; Vogel et al. 2017; Waddell et al. 2008). This coordinating function is particularly important in the UK context, where responsibilities for work and health are distributed across multiple organisations and sectors.
- **Clear, goal-directed focus on work outcomes:** while improving health and well-being is important, caseworker-led support is distinguished by its explicit emphasis on outcomes such as improving capability for work, preventing job loss, facilitating sustainable RTW and improving earnings and income (Hanson et al. 2006; IES 2023b; Waddell et al. 2008). This typically includes proactive employer engagement, advice on reasonable adjustments, phased RTW planning and alignment between health recovery and work demands (DWP & DHSC 2026b; Kantar Public et al. 2024; Waddell et al. 2008).

Effective caseworker models must bridge the boundary between clinical care and vocational support, ensuring these systems work in tandem. This does not require caseworkers themselves to be clinically qualified, and they came from a range of professional backgrounds across the models reviewed. However, it does require the capability to understand health information, work alongside clinicians and translate clinical advice into workplace adjustments and RTW planning. Effectiveness also depends on embedding a focus on work within healthcare from an early stage, through vocational rehabilitation and tailored support, while fostering workplace cultures that are proactive and accommodating, offering flexible working and supportive management to sustain recovery and employment. Real and lasting impact depends on addressing health and work as interdependent, mutually reinforcing dimensions of the same system.

The caseworker function can be delivered from inside or outside the employing organisation. In the models reviewed for this study, caseworkers were variously employed by health services, employment services, insurers, in-house occupational health teams or third-sector organisations. What was common across settings was a degree of independence from day-to-day line-management of the individual being

supported. Human resources (HR) and line-management roles are complementary to, but not synonymous with, the caseworker function as defined here.

Considering the above, it is important to note that early-intervention caseworker-led support does not refer to generic signposting, one-off advice or purely administrative case management, nor does it imply that all individuals with health conditions require intensive or long-term intervention. Rather, it describes a function and set of principles for the provision of support, not a single profession or delivery model.

This definition has two important implications for the remainder of this chapter:

1. It frames early-intervention, caseworker-led support as a family of approaches that can be delivered through different organisational forms, rather than as a single prescribed model. As Section 3.2 demonstrates, current UK provision reflects this diversity.
2. It implies that questions of workforce supply, training, cost-effectiveness and scalability must be addressed in terms of capability, role configuration and system integration and not simply workforce numbers. These issues are explored in Section 3.3.

It also highlights that effectiveness depends not only on the content of the support itself, but also on how support is accessed, coordinated and connected to wider services. These issues are considered throughout the report.

3.2. Overview of current provision of early-intervention caseworker-led support in the UK

In the UK, early-intervention caseworker support for workers with health conditions is currently provided by a wide range of both for-profit and not-for-profit organisations. This support is funded both privately (by employers or individuals) and publicly (by local or national government). As this section will demonstrate, the landscape of caseworker provision in the UK is both complex and subject to frequent change, making it difficult to map and navigate.

3.2.1. Public provision of caseworker support is fragmented and inconsistent.

There is currently no single source of publicly-funded caseworker support in the UK. However, in recent decades, government funding for caseworker support has repeatedly been made available through a variety of schemes and trials. These have included both national and regional programmes, most of which have been relatively short-lived. For instance, Fit for Work was a scheme that provided advice, an occupational health assessment and case management for workers in Britain who had been on sick leave for more than four weeks; the scheme was piloted in 2010–2013, rolled out in late 2014, but discontinued in most areas in 2018 due to low referral rates (Gloster et al. 2018). By their nature, pilot schemes have also provided support for only a short period and often only in certain regions. For example, the Health-Led Trials tested the use of a time-limited version of Individual Placement and Support (IPS) in the late 2010s in the Sheffield City Region and the West Midlands, finding positive results for in-work participants and more mixed results for out-of-work participants (IES 2023b).

Caseworker support under these national and regional schemes has been provided by a wide range of suppliers, including private-sector companies, social enterprises, charities and NHS trusts. In some cases, these organisations were specialist occupational health providers: for example, Fit for Work was delivered in England and Wales by Health Management Limited, an occupational health company (Gloster et al. 2018). However, this was often not the case: for instance, the delivery partners for the Health-Led Trials were the South Yorkshire Housing Association, Remploy (a provider of employment support services), Prospects (a charity) and Dudley & Walsall Mental Health Partnership NHS Trust (IES 2023b). Referral routes also differed between schemes: all accepted referrals from general practitioners (GPs), with many also welcoming referrals from employers or other support services, as well as self-referrals (IES 2023b; Gloster et al. 2018).

The most recent government-funded programme to offer caseworker support is WorkWell, which was piloted in 15 areas of England from 2024 (DWP & DHSC 2026b). In January 2026, the Department for Work and Pensions (DWP) announced that WorkWell would be rolled out across England, with funding made available to Integrated Care Boards (ICBs) to form local partnerships to deliver the service (DWP & DHSC 2026b). Although the government has provided a set of principles for the kind of support WorkWell services should offer (personalised care according to the biopsychosocial model, with case management by a Work and Health Coach supported by a multi-disciplinary team), WorkWell is not a single, unified, guideline-based model (DWP & DHSC 2026b). Instead, it provides local partnerships with funding and support to design and deliver their own caseworker services (DWP & DHSC 2026b). WorkWell provision will therefore vary across the country. This approach has some potential disadvantages (such as inconsistent provision across different areas), but also offers the opportunity to tailor support to the needs of local populations.

3.2.2. Some not-for-profit services offering caseworker support have achieved relative stability.

Against the backdrop of this shifting landscape, a small number of not-for-profit organisations have offered caseworker-led support for RTW and worker well-being for many years. These organisations may operate at a local, regional or national level. For instance, the Sheffield Occupational Health Advisory Service (SOHAS) has been providing personalised job retention support to workers in Sheffield since 1980, while RCS Wales was established in 2007 to combat economic inactivity in a single Welsh town and now operates across Wales. These organisations are generally largely publicly funded, often combining pots of medium-term funding from various local and/or national sources (RCS 2026; SOHAS 2022). As well as providing caseworker support, some also work with external providers to offer their clients medical treatment, such as physiotherapy, more rapidly than is usually available through the NHS, e.g. RCS (2026).

3.2.3. Caseworker support can also be accessed privately through various routes.

A number of for-profit companies also provide caseworker support for workers with work-limiting health conditions, often as part of vocational rehabilitation or occupational health support offers. Workers will generally access this support through their employer (e.g. through an Employee Assistance Programme), although self-referrals may also be possible. Another common route for employees to access caseworker

support is through an employer-sponsored insurance policy, such as a group income protection scheme. Group income protection schemes cover part of an employee's salary if they are unable to work due to chronic illness; they also provide support and rehabilitation services (ABI 2026). While not all group income protection schemes provide caseworker support as we define it in this report, many provide some form of administrative case management as part of a specialist vocational rehabilitation package.

However, many workers do not have access to these schemes. Smaller employers in particular rarely offer their employees occupational health support: a 2021 DWP report found that only 49% of medium-sized and 18% of small employers offered some form of occupational health support, compared to 92% of large employers (Tu et al. 2021). Similarly, only a relatively small number of employees access support through group risk insurance: a report by GRiD, the UK industry body for the group risk protection sector, found that around 8,500 people were helped to RTW by group risk insurers' interventions in 2024 (Onumonu 2025).[4] It should also be noted that, where RTW support is available through employee benefits or insurance schemes, it may or may not include the services of a caseworker. In short, the scale of private provision of caseworker services is difficult to determine. What is clear is that many groups of workers cannot currently access it.

3.3. Caseworker workforce mapping: roles, supply, qualifications and training

3.3.1. Overview of workforce roles and functions

Early-intervention caseworker-led support in the UK is delivered by a mix of professional roles spanning the health, rehabilitation and employment domains. No single national qualification, protected professional title or mandatory training pathway exists for those delivering early-intervention caseworker-led support in the UK. Staff therefore typically enter the workforce through a combination of related professions, employment-support backgrounds and sector-specific experience. Some possess clinical qualifications (e.g. nursing, physiotherapy, occupational therapy [OT], counselling) and subsequently acquire vocational-rehabilitation and employment-support skills in practice. Others enter from employment services, social care, human resources, third-sector advisory roles, or corporate well-being and insurance-based case-management settings, gaining health-related knowledge through short courses, on-the-job learning, or employer-led training programmes.

This wide range of professional backgrounds reflects the absence of a single, formalised career pathway. Unlike professions with dedicated qualification routes, early-intervention caseworkers may be occupational health nurses or physiotherapists, vocational rehabilitation specialists, employment advisers in Jobcentre Plus, disability or mental-health support workers, HR or employee-assistance consultants, or staff of insurance companies providing return-to-work services. Job titles vary widely, although common

[4] For context, UK government statistics for 2024/2025 suggested that around 8% of the UK's approximately 33 million workers, or more than 2.5 million people, had been off work for a continuous period of at least four weeks in the previous year (DWP & DBT 2026b; ONS 2024).

examples include employment adviser, work coach, occupational health case manager, vocational rehabilitation specialist and key worker.

Despite this diversity, these roles share a common focus on personalised, one-to-one assistance to help individuals remain in or RTW when facing health-related challenges. They operate across health, employment and social-care systems, often bridging organisational boundaries to coordinate support. These roles can be grouped into two broad categories (non-clinical employment support roles and clinical or clinically-informed roles), although in practice their functions often overlap and they work in tandem across systems.

Non-clinical employment support roles (employment advisers, specialists and work coaches)

This category includes roles that do not require a clinical qualification, such as employment advisers and specialists, Jobcentre work coaches and similar positions often based in employment services or community programmes.

Employment advisers support individuals to find, retain, or return to suitable work, often working with people who face barriers such as health conditions, disabilities, or long-term unemployment. They assess individuals' skills, interests and goals; provide tailored advice on job-search strategies, CV writing and interview preparation; and connect clients with employers, training providers and support services. Within the scope of early intervention, employment advisers focus on helping workers with health conditions to remain in their current job or RTW following sickness absence. This typically involves assessing the impact of the health condition on work, advising on reasonable adjustments and phased RTW plans, and liaising with employers, healthcare providers and other support services to coordinate appropriate support (Kantar Public et al. 2024; Waddell et al. 2008).

Work coaches are frontline professionals employed by the Department for Work and Pensions (DWP), primarily based in Jobcentre Plus offices (Kantar Public, ICF, BPSR 2024). Their role is to support individuals – such as those receiving Universal Credit or other employment-related benefits – in entering and sustaining employment (Kantar Public et al. 2024). They provide personalised coaching to help clients identify strengths, overcome barriers (including health-related challenges), and develop employment action plans (Kantar Public et al. 2024).

Work coaches assist with CV development, interview preparation, and job applications. Where appropriate, they also signpost clients to specialist services and support, including Disability Employment Advisers for more complex cases and Access to Work, a DWP grant scheme that helps disabled people and people with health conditions to start or stay in work (Kantar Public et al. 2024). In early-intervention contexts, they may deliver Additional Work Coach Support (AWCS), offering extended appointment times to better understand and address clients' health and employment needs (Kantar Public et al. 2024).

Emerging models, such as WorkWell, have introduced **Work and Health Coaches**, whose skill base mirrors that of social-prescribing link workers (DWP & DHSC 2026b). These coaches undertake an initial assessment, described by the programme as 'triage', co-producing RTW or 'Thrive' plans and connecting participants to local health and employment infrastructure (DWP & DHSC 2026b).

Non-clinical employment support roles collaborate closely with clinicians to ensure employment support is integrated with psychological or physical-health interventions. For instance, employment specialists working in mental-health services typically use the Individual Placement and Support (IPS) model, which follows a 'place-then-train' approach – helping clients move rapidly into competitive employment while addressing health needs concurrently (Frederick & VanderWeele 2019; Whitworth et al. 2024). A core element of IPS is proactive employer engagement: specialists make frequent face-to-face contact with employers to build relationships and tap into the 'hidden job market' (Nightingale et al. 2025). This allows clients to access job opportunities that are not publicly advertised and that are often uncovered – or even created – through these relationships, for example by 'job carving' roles to fit an individual's skills and health needs (IES 2023b).

Clinical and clinically-informed roles (occupational health and vocational rehabilitation case managers)

The second broad category comprises roles that involve clinical expertise or operate within healthcare or insurance settings. Professionals in these roles usually have health or allied health qualifications and focus on the intersection of health and work, helping to manage medical or functional issues that threaten a person's employment. They often work as part of, or in close coordination with, healthcare services or insurers, and bring clinical insight to RTW support.

Occupational health case managers are typically qualified health professionals – for example, specialist nurses, physiotherapists, or occupational therapists – who specialise in assessing and managing the relationship between health and work (Gloster et al. 2018; Shaw et al. 2024). Their primary role is to support workers experiencing health-related challenges (physical and mental) that affect their ability to work and to advise employers on how best to support these individuals (Vogel et al. 2017).

Core activities include structured assessments of fitness for work, advice on reasonable adjustments, development of phased RTW plans and liaison with line managers and HR to ensure safe, fair and legally compliant outcomes (Gloster et al. 2018; Vogel et al. 2017). Occupational health case managers do not typically diagnose or treat conditions but provide expert, impartial advice on how health impacts work capacity and what support is needed to regain or maintain the functional ability required for work (Vilsteren et al. 2015). They commonly apply a biopsychosocial model to understand how health, personal and workplace factors interact (Brown et al. 2015; DWP 2013; Bergman et al. 2022).

Many services – such as the former national Fit for Work programme – used occupational health case managers to provide telephonic assessments and produce formal RTW plans (Gloster et al. 2018). These professionals operate across sectors, including the NHS, private occupational health providers and large employers and are often involved in managing complex or sensitive cases such as long-term sickness absence or MH concerns (Soler-Font et al. 2021). Strict confidentiality and data-protection standards govern their work and, where support is available, it has the potential to play a key role in reducing sickness absence, supporting retention and promoting a healthy, productive workforce (Burton et al. 2013; Gloster et al. 2018; Hanson et al. 2006).

Vocational rehabilitation specialists (sometimes called RTW coordinators) perform a closely related function to occupational health case managers, with a strong emphasis on helping individuals with health conditions or disabilities to remain in, return to or access work (Waddell et al. 2008). Many vocational

rehabilitation specialists have clinical or allied health backgrounds and are often part of multidisciplinary teams that include clinicians, occupational therapists, physiotherapists and employment advisers (Vogel et al. 2017; Waddell et al. 2008). Vocational rehabilitation specialists typically assess the impact of health on work and vice versa, identify barriers to employment and develop tailored interventions such as fatigue management, workplace adjustments, confidence-building and RTW planning (Waddell et al. 2008). Their support may include simulated work tasks, coaching, liaison with employers and preparation of professional reports to inform workplace accommodations (Wynne-Jones et al. 2018).

While there is no single professional route into vocational rehabilitation, many practitioners come from clinical or allied-health backgrounds and develop vocational rehabilitation expertise through in-service training, mentoring and continuing professional development (Hanson et al. 2006; Waddell et al. 2008; Wynne-Jones et al. 2018). Their work is often grounded in a biopsychosocial and vocational approach and aims to promote sustainable employment outcomes aligned with individuals' health needs, skills and personal goals (Bergman et al. 2022; Burton et al. 2013).

In the UK, local models such as Greater Manchester's Working Well employ vocational rehabilitation workers who provide bespoke plans combining clinical and non-clinical support, including confidence-building and debt advice (Batty et al. 2022). Vocational rehabilitation specialists may also conduct workplace visits to assess the physical and organisational environment, distinguishing their role from purely office-based advisers.

It is important to note that, while present in the literature, the distinction between occupational health case managers and vocational rehabilitation specialists is not clear-cut. In practice, these roles share many core functions and skills, and the differences often come down to job titles, professional training and the context in which they work.

Other relevant roles within the wider workforce

In addition to these core categories, several other roles contribute to early-intervention caseworker-led support in the UK:

- **Line managers and members of HR teams** can act as caseworkers, particularly for simple cases where health problems are expected to be short-term and unlikely to result in prolonged absence (Hanson et al. 2006). In these situations, managers may coordinate adjustments, monitor progress and facilitate RTW planning directly with the employee. Case management in this context is not considered a distinct profession but rather an area of practice within one's existing role, requiring strong listening, communication and interpersonal skills. While managers can fulfil these roles effectively, the literature highlights several important limitations and considerations, including the limited suitability of non-health-professionals for complex or long-term cases, the potential risk of conflicts of interest and the need for appropriate training and support (Hanson et al. 2006).
- **Peer and group support** are discussed in the literature both as a component of rehabilitation programmes and as an informal source of assistance within workplaces (Hanson et al. 2006). Group-based, work-focused interventions, such as occupational therapy programmes incorporating shared sessions among workers with similar experiences, can form part of effective

RTW models and provide mentoring and motivational support (Gaillard et al. 2020). While the direct evidence on the effectiveness of peer or group support on RTW and employment outcomes remains limited, the literature suggests that it can act as an enabling or complementary mechanism within models to build trust, self-efficacy and engagement (Gloster et al. 2018; Hanson et al. 2006).

Qualifications, training pathways and professional standards

Taken together, the workforce reflects a broad but fragmented competency landscape, with varying degrees of formalisation and professional oversight, and the potential for inconsistent service quality. Building on the diverse role profiles described in this section, **Table 2** summarises the typical qualification requirements, training pathways and professional standards associated with each major role category identified in this review.

Table 2. Summary of typical qualifications, training pathways and professional standards by role type[5]

Role	Typical qualifications	Training pathways	Professional standards and frameworks
Employment advisers and specialists	No single required qualification; usually degree-level or equivalent experience in health, social care, psychology, or employability. Entry-level roles often require good English and numeracy skills, as well as experience in advisory or customer-facing settings.	Training in employer liaison, safeguarding, MH awareness, coaching, motivational interviewing; optional Level 4 career-information and advice qualifications; ongoing continuing professional development (CPD) through mentoring, e-learning and specialist modules; IPS training where relevant.	Internal provider quality frameworks; expectations for ethical practice, confidentiality and outcome-focused case management; IPS roles follow fidelity standards when embedded in clinical teams.

[5] This table draws on a targeted analysis of UK job advertisements and role descriptions, conducted separately from the main evidence review to support the workforce mapping in this section. The analysis covered 19 job advertisements published in 2026 and 18 detailed role descriptions across public, private and third sector organisations. Sources include NHS Trusts, the Department for Work and Pensions, national employability providers, occupational health companies and voluntary sector rehabilitation services. Documents were identified through searches of main online job platforms used (e.g. NHS Jobs, GOV.UK, Indeed and Reed) and direct visits to provider websites (e.g. the Vocational Rehabilitation Association), using search terms covering the role categories identified in Section 3.3.1. Documents were included where they referred to UK-based roles delivering the caseworker functions defined in Section 3.1. The synthesis reflects typical qualifications, training pathways and professional standards current in UK practice at the time of reporting. The role distinctions presented reflect how positions are described in the job advertisements and role descriptions reviewed, while recognising ongoing debates in the sector about the boundaries and overlap between these roles.

Role	Typical qualifications	Training pathways	Professional standards and frameworks
Work coaches	No formal qualifications required; typically GCSE-level education and strong communication, empathy and problem-solving skills. Many job descriptions value prior experience in customer service, employability, or welfare-to-work programmes.	Comprehensive in-house DWP training covering the benefits system, safeguarding, digital support, working with health conditions, signposting and retraining support, plus additional training for early-intervention roles (e.g. AWCS).	Governed by internal DWP service guidance, performance frameworks and quality standards rather than external regulation. Focus on consistent customer experience and adherence to organisational policy.
Occupational health case managers	Registered health professionals (e.g. nurses, occupational therapists [OTs], physiotherapists, general practitioners). Often require specialist occupational health credentials, e.g. diplomas/degrees/MSc in Occupational Health Nursing or Specialist Community Public Health Nursing (SCPHN-OH).	Formal postgraduate occupational health study; structured in-house training or CPD on case management, reports, workplace legislation, functional assessments and clinical skills (e.g. audiometry, spirometry); CPD in ergonomics or mental-health case management.	Regulated by Nursing & Midwifery Council Code of Conduct or Health and Care Professions Council Standards of Proficiency; Safe, Effective, Quality Occupational Health Service (SEQOHS) accreditation; clinical governance and information-governance standards; some services use recognised occupational health quality frameworks; strong expectation of evidence-based, confidential, biopsychosocial practice.
Vocational rehabilitation specialists	No single qualification route; practitioners are often allied health professionals with backgrounds in psychology, nursing, or rehabilitation. Some hold a Certified Disability Management Professional or a postgraduate vocational rehabilitation qualification.	Professional entry via health disciplines with additional vocational rehabilitation-specific training in functional capacity evaluation, ergonomics, case management and biopsychosocial approaches. CPD through Vocational Rehabilitation Association (VRA), Greater Manchester Neurorehabilitation & Integrated Stroke Delivery Network Vocational Rehabilitation Toolkit and employer-led training academies.	Guided by sector-led frameworks such as the VRA Standards of Practice and Code of Conduct; British Society of Rehabilitation Medicine Vocational Rehabilitation Guidelines; NHS vocational rehabilitation practitioners may align with clinical-quality standards in rehabilitation services; emphasis on ethical, person-centred, evidence-based practice.

Source: RAND Europe.

3.3.2. Workforce supply and capacity

Estimating the size and distribution of the workforce for early-intervention caseworker support is challenging because of its fragmented nature. No single dataset captures the total number of caseworkers in the UK, given their spread across different programmes and sectors. However, some indicators give a

sense of scale. Job titles and functions also vary considerably, and many practitioners deliver caseworker-type support only as part of a broader role. This section draws on secondary analysis of publicly available labour-market and workforce datasets, including the Annual Survey of Hours and Earnings (ASHE), NHS England Hospital and Community Health Services workforce data, and ONS data on online job advertisements by Standard Occupational Classification, to provide an indicative picture of workforce supply, capacity and constraint.

Potential labour pool

One broad indicator of scale is the size of occupational groups that plausibly include caseworker-type activities. Table 3 presents indicative job counts and pay levels for selected occupations using ASHE (ONS 2025). These groups have been selected based on our evidence review and reflect occupations most likely to include roles that either directly deliver early-intervention or caseworker-led support, or contribute to such support as part of a wider job role (e.g. through coordination, vocational rehabilitation, employer liaison or psychosocial support). The figures therefore reflect the potential labour pool, rather than the number of individuals currently working as caseworkers. For reference, the estimated median weekly earnings in Great Britain in April 2025 were £766.60, and the average was £720 (ONS 2025). The current statutory National Living Wage (for ages 21+) is £12.71 per hour, which equates to £476.63 per week for a 37.5-hour week or £508.40 for a 40-hour week (DBT 2026).

The table highlights several important features of the workforce landscape. First, the UK has a large pool of up to 2.2 million workers with potentially relevant professions (ONS 2025). Interview evidence consistently indicates, however, that only a small proportion of these roles currently deliver early-intervention, work-focused casework and fewer still do so with the necessary blend of health, vocational and coordination skills. This evidence indicates that, while the underlying skills needed for effective caseworker support already exist across many roles, they are dispersed across different professions, settings and programmes and do not currently form a coherent, work-and-health-focused system. As a result, a core challenge is aligning, developing and organising existing roles so that they can operate consistently and at scale.

Second, many specialist rehabilitation and clinical professions with core skills for early-intervention caseworker support – for example, physiotherapists, occupational therapists, psychologists and psychotherapists – are relatively small workforces compared to fields like nursing, social care or HR roles. These roles also tend to have relatively high median pay, from around £730 to over £900 per week (ONS 2025).

Third, employment and work-support roles (i.e. careers advisers, vocational guidance specialists and youth workers) and, particularly, social care and coordination roles (e.g. welfare professionals, youth/community workers and counsellors) have lower median pay and substantially larger headcounts (ONS 2025). These roles would likely require appropriate upskilling in health-related job retention, workplace adjustment and RTW planning to provide effective early-intervention caseworker support.

Fourth, nursing and community health roles constitute a large, clinically skilled workforce that is already under considerable pressure from broader system demands. While community nurses, mental-health nurses and nurse practitioners are well positioned to identify early work-related risks, stakeholders

interviewed consistently cautioned against assuming that additional caseworker functions can be absorbed without structural change or protected time.

Finally, while human resources roles appear prominently in Table 3, interviews and literature evidence indicate that HR professionals are more likely to act as partners and gatekeepers than caseworkers themselves, particularly in complex health-related cases.

Table 3. Indicative job counts relevant to casework support, median and mean weekly salary (2025)[6]

Standard Occupation Code (SOC)	Job description	Number of jobs (thousands)	Median weekly salary – Gross (£)	Mean weekly salary – Gross (£)
Employment and work support				
3572	Careers advisers and vocational guidance specialists	28	572.6	568.9
2464	Youth work professionals	N/A	N/A	598.5
Health professionals				
2221	Physiotherapists	77	757.8	760.6
2222	Occupational therapists	49	733.0	730.2
2224	Psychotherapists and cognitive behaviour therapists	12	728.8	809.7
2225	Clinical psychologists	17	908.4	965.0
2226	Other psychologists	21	622.9	741.4
2229	Therapy professionals not elsewhere classified (n.e.c.)	26	625.4	690.8
2232	Community nurses	95	684.8	675.3
2233	Specialist nurses	87	792.9	788.0
2234	Nurse practitioners	131	797.6	798.5
2235	Mental health nurses	28	731.3	742.9
2237	Other nursing professionals	801	724.7	714.1
Social care and coordination				
2461	Social workers	122	818.5	804.8
2469	Welfare professionals n.e.c.	17	709.2	731.5
3221	Youth and community workers	118	545.1	522.2
3224	Counsellors	23	544.3	537.8
3229	Welfare and housing associate professionals n.e.c.	176	522.9	512.1
Human Resources				
1136	Human resource managers and directors	191	1,056.8	1,200.8
3571	Human resources and industrial relations officers	160	642.3	717.9
4136	Human resources administrative occupations	23	498.3	497.6

Source: RAND Europe with data from ASHE (ONS 2025).

[6] ASHE covers employee jobs in the UK and excludes the self-employed and employees not paid during the reference period. Job counts are indicative and intended to provide an order-of-magnitude sense of the size of occupational groups, not precise estimates.

NHS workforce capacity relevant to work-and-health casework

The NHS workforce also contains a wide range of clinical and psychologically-focused practitioners who contribute directly or indirectly to work and health casework (NHS England 2026). Table 4 identifies NHS Hospital and Community Health Services (HCHS) roles whose functions most closely align with early intervention, RTW support and biopsychosocial vocational rehabilitation (NHS England 2026). These fall into two broad categories:

- Roles providing employment, well-being, or coordination support (e.g. well-being practitioners, employment support workers, care coordinators and peer support roles).
- Clinical and rehabilitation professions delivering occupational health or vocational rehabilitation functions (e.g. occupational therapists, physiotherapists and applied psychologists).

Drawing on NHS England HCHS staff workforce data for January 2026, these roles account for approximately 83,000 full-time equivalent (FTE)[7] staff (NHS England 2026). If the definition is broadened to include nurses, social workers and social care staff whose roles can contribute to maintaining or restoring work participation, this figure could rise substantially to around 435,000 FTE staff (NHS England 2026).

Both figures should be interpreted as upper bounds rather than as estimates of actual caseworker capacity. The vast majority of the staff captured are recruited and deployed primarily to deliver other functions (such as clinical care, MH treatment and social care assessment), and only a minority are likely to be engaged in early-intervention work-and-health casework as defined in this report. The figures therefore indicate the within-the-NHS workforce, not the volume of caseworker-led support currently being delivered. The same caveat applies to the labour-pool estimates in Table 3.

Table 4. NHS job roles relevant to casework support (January 2026)[8]

National Workforce Data Set (NWD) staff group	Job role	FTE
Additional Clinical Services	Assistant Psychologist	3,433
Additional Clinical Services	Assistant Psychotherapist	143
Additional Clinical Services	Care Coordinator	195
Additional Clinical Services	Children's Well-being Practitioner	320

[7] FTE is defined as a 'standardised measure of the workload of an employed person and allows for the total workforce workload to be expressed in an equivalent number of full-time staff. 1.0 FTE equates to full-time work of 37.5 hours per week, an FTE of 0.5 would equate to 18.75 hours per week' (NHS England 2026).

[8] These NHS figures overlap with the broader workforce estimates from Table 3. Rather than presenting an additional labour pool, they indicate the portion of that potential capacity currently employed within the NHS.

National Workforce Data Set (NWD) staff group	Job role	FTE
Additional Clinical Services	Clinical Associate in Psychology	331
Additional Clinical Services	Counsellor	667
Additional Clinical Services	Education Mental Health Practitioner	1,453
Additional Clinical Services	Employment Support Worker or Advisor	398
Additional Clinical Services	Family Therapist	32
Additional Clinical Services	Gateway Worker	166
Additional Clinical Services	Health and Well-being Coach	140
Additional Clinical Services	Mental Health and Well-being Practitioner	567
Additional Clinical Services	Peer Support Worker	798
Additional Clinical Services	Psychological Well-being Practitioner	2,636
Additional Clinical Services	Senior Peer Support Worker	128
Additional Clinical Services	Social Prescribing Link Worker	56
Additional Clinical Services	Support, Time, Recovery Worker	1,818
Additional Clinical Services	Trainee Children's Well-being Practitioner	73
Additional Clinical Services	Trainee Clinical Associate in Psychology	59
Additional Clinical Services	Trainee Education Mental Health Practitioner	487
Additional Clinical Services	Trainee Mental Health and Well-being Practitioner	42
Additional Clinical Services	Trainee Psychological Well-being Practitioner	746
Additional Clinical Services	Trainee Youth Intensive Psychological Practitioner	-
Additional Clinical Services	Youth Intensive Psychological Practitioner	18
Additional Professional Scientific and Technical	Applied Psychologist – Clinical	9,388
Additional Professional Scientific and Technical	Applied Psychologist – Counselling	356
Additional Professional Scientific and Technical	Applied Psychologist – Educational	28
Additional Professional Scientific and Technical	Applied Psychologist – Forensic	164
Additional Professional Scientific and Technical	Applied Psychologist – Health	66
Additional Professional Scientific and Technical	Applied Psychologist – Neuropsychologist	47
Additional Professional Scientific and Technical	Applied Psychologist – Occupational	14
Additional Professional Scientific and Technical	Child and Adolescent Psychotherapist	287

National Workforce Data Set (NWD) staff group	Job role	FTE
Additional Professional Scientific and Technical	Clinical Psychologist	-
Additional Professional Scientific and Technical	Cognitive Behavioural Therapist	1,130
Additional Professional Scientific and Technical	Counsellor	529
Additional Professional Scientific and Technical	Family Therapist	303
Additional Professional Scientific and Technical	High Intensity Therapist	3,528
Additional Professional Scientific and Technical	Psychotherapist	2,427
Additional Professional Scientific and Technical	Social Worker - Psychological Therapist	100
Additional Professional Scientific and Technical	Trainee Child and Adolescent Psychotherapist	122
Additional Professional Scientific and Technical	Trainee Clinical Psychologist	1,399
Additional Professional Scientific and Technical	Trainee Cognitive Behavioural Therapist	263
Additional Professional Scientific and Technical	Trainee Counselling Psychologist	23
Additional Professional Scientific and Technical	Trainee Family Therapist	13
Additional Professional Scientific and Technical	Trainee Health Psychologist	9
Additional Professional Scientific and Technical	Trainee High Intensity Therapist	714
Additional Professional Scientific and Technical	Trainee Other Applied Psychologist	63
Administrative and Clerical	Adviser	3,760
Allied Health Professionals	Occupational Therapist	15,310
Allied Health Professionals	Occupational Therapist Advanced Practitioner	151
Allied Health Professionals	Occupational Therapist Consultant	43
Allied Health Professionals	Occupational Therapist Manager	1,299
Allied Health Professionals	Occupational Therapy Specialist Practitioner	1,398
Allied Health Professionals	Physiotherapist	19,856
Allied Health Professionals	Physiotherapist Advanced Practitioner	846
Allied Health Professionals	Physiotherapist Consultant	150
Allied Health Professionals	Physiotherapist Manager	1,459
Allied Health Professionals	Physiotherapist Specialist Practitioner	3,188
Total		83,139

Source: RAND Europe, based on NWD data (NHS England 2026).

Signals of workforce demand and recruitment pressure

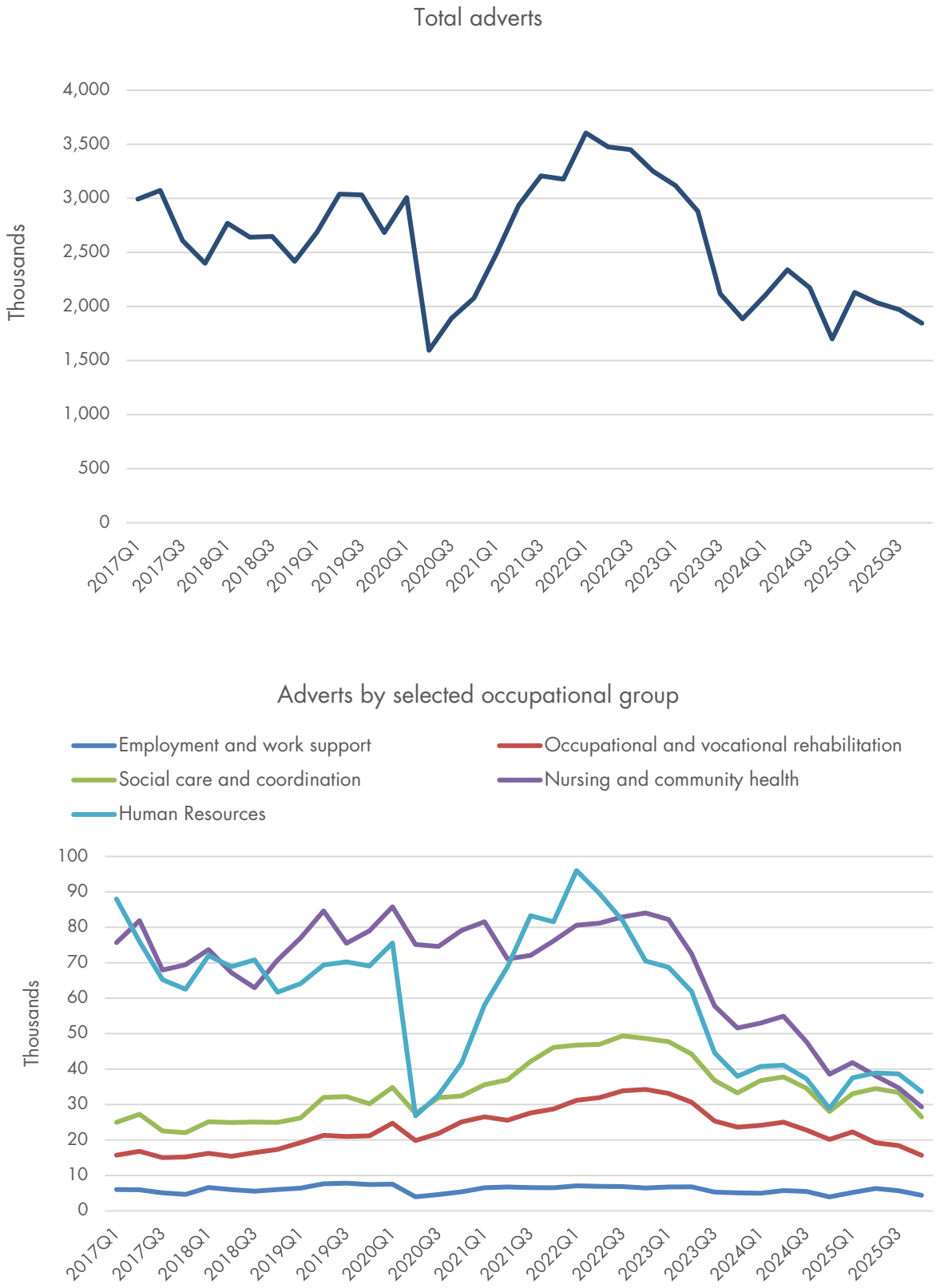
The static workforce estimates presented above provide only a partial picture. Vacancy and recruitment data offer insight into labour-market demand and the competitive pressures affecting roles relevant to early-intervention caseworker support. Figure 1 presents quarterly counts of new online job advertisements in the UK between 2017 and 2025 for occupational groups aligned with the categories used in Tables 1 and 3, drawing on data from the Labour demand volumes by Standard Occupation Code (SOC), 2020 – UK dataset (ONS 2026b).

Across the period analysed, demand for roles relevant to this study has been variable (ranging from 109,606 to 261,639 job advertisements per trimester) and unevenly distributed (ONS 2026b). Nursing and community health occupations generate the largest volume of job advertisements, frequently exceeding 70,000 postings per quarter before 2023, then declining more sharply in 2024–2025 (ONS 2026b). This high level of recruitment activity points to sustained pressure across clinically relevant parts of the health workforce rather than to demand for vocational caseworkers per se. While some nursing and community health roles involve skills relevant to early identification of work-related risk, these workforces are primarily recruited to deliver core health services. They are unlikely to offer substantial spare capacity for additional caseworker functions without structural change. Human resources roles also show sustained high demand, with marked volatility around the COVID-19 period and during the subsequent labour-market recovery (ONS 2026b).

Vacancy volumes for occupational health and vocational rehabilitation roles rose steadily through the late 2010s before increasing more sharply from 2020 onwards, peaking during 2022–2023 before easing somewhat in 2024–2025 (ONS 2026b). This trajectory differs slightly from wider labour-market trends during the COVID-19 period, which show a steep decline in the total number of vacancies between the second quarter of 2020 and the first quarter of 2021 (ONS 2026b). Occupational health and vocational rehabilitation roles also increased as a share of all advertised vacances, rising from around 0.5–0.7% of total job advertisements before 2020 to a peak of around 1.2% during the pandemic, before falling back to around 0.8–0.9% in 2025 (ONS 2026b). This finding suggests that demand for occupational health and vocational rehabilitation roles increased not only in absolute terms, but also relative to the wider labour market. Although vacancy volumes have since fallen, demand in 2025 remained somewhat above pre-pandemic levels in both absolute and relative terms (ONS 2026b). Similar trends are shown for social care and coordination roles. However, demand has remained relatively high in the post-COVID-19 period, potentially reflecting chronic recruitment challenges and high staff turnover in these sectors (ONS 2026b).

Employment and work-support roles generate lower absolute volumes of job advertisements and show greater stability over time (ONS 2026b). In contrast to health and care occupations, demand for employment adviser roles is potentially more cyclically driven by policy and programme funding than by long-term structural scarcity.

Figure 1. Quarterly new online job adverts in the UK, 2017–2025



Source: RAND Europe, based on ONS data (ONS 2026b).

Taken together, these findings reveal a nuanced picture of capacity. The UK appears to have a substantial pool of workers with skills relevant to caseworker support, suggesting that building capacity at scale should be possible in principle. The analysis of job adverts shows a sustained and potentially growing demand for occupational health and vocational rehabilitation roles. However, most of the existing capacity sits in roles whose primary purpose lies elsewhere and cannot simply be redirected into early-intervention work-and-health casework. In addition, the dual expertise required for this function, combining understanding of health conditions with knowledge of workplace adjustments, employer engagement and RTW planning, is unevenly distributed across the relevant workforce. Occupational therapists and OH professionals are notable exceptions: their training is explicitly designed to bridge health and work, and many already perform caseworker-type functions. For most other practitioners, however, expertise tends to sit predominantly on either the health or the employability side of this divide, with cross-disciplinary capability acquired through experience rather than formal training.

The picture presented by the SOC-based analysis above also understates the experience base that has built up in the UK over the past decade through the expansion of work-and-health programmes, particularly when support is extended to people currently out of work. The Health-Led Trials, the Work and Health Programme, the IPS expansion within MH services, Connect to Work and related programmes have collectively trained and deployed a substantial cohort of employment specialists, key workers and similar practitioners with direct experience of delivering caseworker-type support to people with health conditions. Because this experience base spans multiple SOC codes, the headline figures presented above do not fully capture it. The implication is that the practical workforce-supply position for early-intervention caseworker support may be more favourable than the SOC-based analysis suggests. However, the same practitioners are also subject to displacement risk where programmes are time-limited, or contract structures are short (see Chapter 5). The challenge, therefore, is not simply one of numbers, but of building a more coherent work-and-health workforce through clearer role definitions, cross-disciplinary training, supervision and career pathways, and strong commissioning and funding structures.

This challenge also needs to be understood relative to the potential scale of need. The Health Foundation estimates for the period 2014–2023 suggest that around 300,000 workers became economically inactive due to a work-limiting health condition each year (Gazzillo et al. 2024). DWP data indicate that around 1.2 million working-age people experienced sickness absence lasting four weeks or more in 2023/2024 (DWP 2025b). While not all of these individuals would require caseworker-led support, these figures indicate that the potential demand for early work-and-health support is growing and that any workforce designed to deliver such support at scale would need to be planned accordingly. Consulted stakeholders also emphasised that service quality depends on manageable caseloads and staffing levels. For example, fidelity benchmarks in IPS models indicate that optimal delivery is achieved with average caseloads below 15 clients per specialist, while caseloads above 41 substantially reduce the quality of employer engagement, follow-up and personalised support (IES 2023b). Overall, the evidence suggests that workforce constraints are not simply a matter of numbers, but of how roles are configured, supported and combined within the wider system.

4. Evidence review: understanding the impact of caseworker-led models

Box 1. Key findings from the evidence review

Key findings:

- There is evidence to suggest that many caseworker support models improve clients' employment and/or health outcomes.
- The economic benefits of early-intervention caseworker-led support models often appear to outweigh their costs.
- While more work is needed to clarify the impact of different model components, effective and viable models will likely involve early intervention that focuses on RTW, enables positive relationships to be formed between caseworkers and their clients, and provides tiered or targeted support.

This chapter presents our findings on the effectiveness of caseworker approaches in improving employment and health outcomes. It explores quantitative impact and cost-benefit evidence for existing models from the UK and elsewhere, before moving into a discussion of the evidence base for the effectiveness of specific model components.

This chapter's contents stem from the evidence review conducted as part of this study. Since this was not a systematic review, as noted in Chapter 2, this chapter is unlikely to encompass all relevant models. However, we have endeavoured to include all recent UK models with impact and/or cost-benefit evidence, alongside several international comparator models.

4.1. Impact of UK and international models

Table 5 summarises the 14 experimental or quasi-experimental studies of early-intervention caseworker models included in our evidence review. It sets out the content of each model, its target population, the country of implementation, the study design and its control or comparison condition, and the employment and/or health outcomes measured. In line with this report's definition of 'early intervention', it includes only studies that recruited participants who were absent from work for two months or less. It also excludes studies that recruited only participants returning to work after acute illness or surgery, as we felt this population to be substantially different from the general population of UK workers with work-limiting (most often chronic) health conditions.

The remainder of this section highlights key findings on impact from Table 5.

Table 5. Summary of studies of early-intervention caseworker models

Article (study name)	Model name and description	Target population	Study design and control/comparison condition	Country of study	Employment outcomes	Health and well-being outcomes	Cost-benefit analysis? (If yes, see Table 6 for details)
IES (2023b): Health-Led Trials	IPS-Lite, a time-limited variant of IPS	Workers struggling at work or on sick leave due to mild/moderate mental/physical health conditions.	Randomised controlled trial (RCT); control group received care as usual.	UK (England: Sheffield City Region)	3.2 pp. more likely than control to be in work for >=13 weeks in the first 12 months of the trial ($p<0.1$); +2.3 weeks in employment over 22 months ($p<0.1$); no statistically significant effect on earnings.	Small positive impact on health and well-being for treatment group vs control (health: +0.1 standard deviations, $p<0.1$; well-being: +0.18 standard deviations, $p<0.01$).	Yes
Wynne-Jones et al. (2018): Study of Work and Pain (SWAP)	Early, brief Vocational Advice Intervention involving case management and stepped care, using the Psychosocial Flags Framework to identify and overcome barriers to RTW or staying in work (Sowden et al. 2019).	Workers struggling at work or on sick leave (for <6 months) due to MSK pain and consulting with a GP or nurse practitioner.	Cluster RCT; control group received best current primary care.	UK (England: West Midlands)	9.3 days off work at 4 months (SD 21.7) vs 14.4 days in control (SD 27.7); adjusted incidence rate ratio 0.51 ($p = 0.048$). No statistically significant difference in mean days off work at 12 months.	Very few statistically significant differences in measured health outcomes.	Yes

Article (study name)	Model name and description	Target population	Study design and control/comparison condition	Country of study	Employment outcomes	Health and well-being outcomes	Cost-benefit analysis? (If yes, see Table 6 for details)
Brown et al. (2015)	EASY (Early Access to Support for You), a telephone-based sickness absence service in which employees are contacted on the first and third days of absence and (if necessary) referred to an occupational health service and assigned a caseworker on the 10th day of absence (Demou et al. 2016).	NHS Lanarkshire employees on sick leave.	Quasi-experimental design (QED); comparison group (Scottish NHS boards) were affected by non-specific tightening of NHS sickness absence policies.	UK (Scotland: NHS Lanarkshire)	21% reduction in sickness absence rates over study period (95% CI: 14% to 29%, p<0.001) vs 9% reduction in comparison group (95% CI: 4% to 15%, p<0.001).	Not analysed.	Yes
Bergman et al. (2022)	Working Health Services Scotland, a case-managed service offering rapid access to MSK treatment and holistic support from a case coordinator.	Self-employed workers or employees of SMEs with an MSK disorder.	QED: comparison group received support from the MSK National Advice and Triage service (not case-managed, longer waiting lists).	UK (Scotland)	Not analysed.	Small positive adjusted difference (+0.04, p<0.001) in quality of life (EQ-5D) change score in treatment group vs comparison group.	No

Article (study name)	Model name and description	Target population	Study design and control/comparison condition	Country of study	Employment outcomes	Health and well-being outcomes	Cost-benefit analysis? (If yes, see Table 6 for details)
McCluskey et al. (2006)	Guideline-based intervention delivered by occupational health nurses (early contact with absentees, addressing psychosocial obstacles, offering temporary modified work, communicating among players).	Employees of a large pharmaceutical company on sick leave for MSK disorders.	Non-randomised controlled trial; control group received usual care, generally involving contact with an occupational health nurse only upon RTW.	UK	Where protocol was followed: RTW was achieved 4.3 days faster than in the control group (95% CI 1.1-7.4). No statistically significant difference in duration of future absence. One site did not deliver the intervention as intended; intention-to-treat estimates not reported.	Not analysed.	No
Bültmann et al. (2009)	Coordinated and tailored work rehabilitation, involving a multidisciplinary work disability screening and the creation of a work rehabilitation plan, with parties coordinated by a social worker.	Employees on sick leave for at least four weeks.	RCT; control group received conventional Danish case management, i.e. an assessment interview every 8 weeks.	Denmark	Mean 657 hours (SD 565 hours) of sickness absence over 12 months from baseline vs 997 hours (SD 669 hours) for control (p=0.006).	No statistically significant differences in pain intensity or functional disability (except for pain intensity at three months after baseline, which improved more for the treatment group).	Yes
Skarpaas et al. (2019)	A nationally funded Norwegian rapid-RTW programme, including provision of a coordinator.	Workers on sick leave.	QED; comparison group participated in a rapid-RTW programme but did not receive a coordinator.	Norway	No statistically significant difference in time to RTW in adjusted analyses.	Not analysed.	No

Article (study name)	Model name and description	Target population	Study design and control/comparison condition	Country of study	Employment outcomes	Health and well-being outcomes	Cost-benefit analysis? (If yes, see Table 6 for details)
Oostrom et al. (2010)	A participatory workplace intervention for employees with distress, with an RTW coordinator guiding the employee and their supervisor. The treatment group received this intervention alongside usual care from their occupational physician.	Employees with distress and on sick leave for 2-8 weeks.	The control group received usual care from their occupational physician.	Netherlands	No overall effect on lasting RTW. However, the intervention was highly effective for employees intending to RTW despite symptoms: RTW after 55 days vs 120 days in control subgroup (hazard ratio 2.05, 95% CI 1.22 to 3.45).	No significant difference in improvement in stress-related symptoms over 12 months.	No
Beemster et al. (2021)	A health-focused vocational rehabilitation programme with an additional ~10-hour work module consisting of case management by an RTW coordinator (involving discussion of barriers to RTW, creation of an RTW plan, provision of information about work-related legislation and a workplace visit).	Employees with MSK pain on full- or part-time sick leave.	RCT; control group participated in the same vocational rehabilitation programme as the treatment group, but did not receive the work module.	Netherlands	No statistically significant difference in odds of RTW at discharge from programme. Odds of RTW at 6-month follow-up significantly higher than in control (OR 1.7, p=0.04).	Not analysed.	No

Article (study name)	Model name and description	Target population	Study design and control/comparison condition	Country of study	Employment outcomes	Health and well-being outcomes	Cost-benefit analysis? (If yes, see Table 6 for details)
Arends et al. (2013)	'SHARP-at work': a problem-solving intervention begun when employees were ready to RTW to prevent recurrent sickness absence, with guidance provided by occupational physicians.	Employees returning from sickness absence due to common MH issues.	Cluster RCT; control group received care as usual from an occupational physician following an evidence-based guideline for treatment of sick-listed workers with MH problems. This included one consultation after RTW.	Netherlands	Incidence of recurrent sickness absence over 12 months: 39% vs 62% for control (mean effect difference: 24%, 95% CI: 3% to 45%); +55 days to recurrence vs control (95% CI: 3 to 106 days).	Not analysed.	Yes
Vlasveld et al. (2013)	Collaborative care, with an occupational physician as case manager. The model included a psychological intervention aimed at teaching problem-solving skills, manual-guided self-help, a workplace intervention and antidepressant medication if desired by the participant.	Employees on sickness absence for 4-12 weeks due to major depressive disorder.	RCT; control group received care as usual (which could involve treatment from their company's occupational physician).	Netherlands	No significant difference in time to full RTW.	Statistically significantly shorter time to response (-2.8 months, $p<0.05$). No significant difference in time to remission or depressive symptoms as a continuous measure.	No (but cost-effectiveness discussed in Goorden et al. (2014))

Article (study name)	Model name and description	Target population	Study design and control/comparison condition	Country of study	Employment outcomes	Health and well-being outcomes	Cost-benefit analysis? (If yes, see Table 6 for details)
Rebergen, Bruinvels, Bezemer et al. (2009)	Guideline-based care from an occupational physician, involving an activating approach, time-contingent process evaluation, cognitive behavioural principles (stress inoculation training, graded activity and enhanced problem-solving capacity) and work-related interventions if relevant.	Police officers on sick leave due to MH problems.	RCT; control group received usual care (minimal involvement from the occupational physician, easy referral to a psychologist).	Netherlands	No statistically significant difference in time to full RTW or productivity loss.	Not analysed.	No, but cost-effectiveness discussed in Rebergen, Bruinvels, van Tulder et al. (2009)
Skisak et al. (2006)	Shell Oil Company's disABILITY Management Program (DMP), involving case management from the fourth day of absence.	Shell employees on sick leave.	QED; comparison group was composed of business units that did not use the DMP.	United States	A 10% reduction in sickness absence vs an 8% increase in the comparison group (statistical significance not reported).	Not analysed.	Yes

Article (study name)	Model name and description	Target population	Study design and control/comparison condition	Country of study	Employment outcomes	Health and well-being outcomes	Cost-benefit analysis? (If yes, see Table 6 for details)
Lerner et al. (2015)	A work-focused intervention conducted by telephone, providing care coordination, cognitive behavioural therapy (CBT)-based strategy development and work coaching and modification over eight 50-minute sessions.	Employees with depression and work limitations.	RCT; the control group received usual care (which could involve care provided by their study site or through an Employee Assistance Programme (EAP)).	United States	44% improvement in at-work productivity loss compared to 2 weeks before baseline, vs 13% improvement in control; 53% fewer absence days, vs 13% fewer in control; scores on four Work Limitations Questionnaire scales improved 44% to 47%, significantly more than in control ($p<0.001$ for all differences in change).	Mean Patient Health Questionnaire-9 depression severity score: 51% reduction vs 26% reduction in control ($p<0.001$ for difference in change).	Yes

4.1.1. Many caseworker models appear to be effective for employment and/or health outcomes, particularly when implemented in countries where usual care is less developed

As Table 5 shows, while caseworker models do not always outperform usual care (i.e. the support that workers would normally receive as a matter of course), many appear to improve workers' employment and/or health outcomes. In all but three of the 14 studies summarised in Table 5, the caseworker model was statistically significantly more effective than usual care for at least one employment or health outcome. This includes all five of the studies carried out in the UK (Bergman et al. 2022; Brown et al. 2015; IES 2023b; McCluskey et al. 2006; Wynne-Jones et al. 2018).

Except for Bergman et al. (2022), all the studies included in Table 5 measured at least one employment outcome. Of these 13 studies, nine found that caseworker support led to a significant improvement in at least one of the employment outcomes measured. Interestingly, three of the four studies that did not find improved employment outcomes were conducted in the Netherlands (Oostrom et al. 2010; Rebergen, Bruinvels & Bezemer et al. 2009; Vlasveld et al. 2013). In the Netherlands, usual care (the control condition) is of comparatively high quality. For example, all employees in the Netherlands have regular meetings with their company's occupational physician during periods of sick leave (ArboNed 2025). For this reason, the models from the Netherlands generally involved a specific intervention being delivered on top of the care already provided by the occupational physician. Models trialled in the Netherlands therefore arguably had to clear a higher bar to be shown to be more effective than care as usual, which may explain why studies from the Netherlands were more likely than studies conducted elsewhere to find no effect of caseworker support on employment outcomes.

Two employment outcomes were measured in several studies: the time taken to RTW from a period of sickness absence and the total days of sickness absence over the study period. The five studies that measured total days of sickness absence all found a positive effect: caseworker support significantly reduced the number of days of sick leave study participants took (Brown et al. 2015; Bültmann et al. 2009; Lerner et al. 2015; Skisak et al. 2006; Wynne-Jones et al. 2018). However, of the five studies that measured time to RTW (McCluskey et al. 2006; Oostrom et al. 2010; Rebergen, Bruinvels & Bezemer et al. 2009; Skarpaas et al. 2019; Vlasveld et al. 2013), only one (McCluskey et al. 2006) concluded that caseworker support accelerated RTW. This finding is unexpected, suggesting that caseworker support is more effective at reducing total days of sick leave than at shortening specific periods of absence. However, once again, a more likely explanation is that three of the five studies that measured time taken to RTW were conducted in the Netherlands, where usual care (the control condition) is more comprehensive than in many other countries.

Seven of the 14 studies in Table 5 measured health outcomes. The measures used were very varied, including a range of indicators of health and well-being. Findings were mixed. Four of the seven studies found no effect for the majority of health- and well-being-related outcomes measured (Bültmann et al. 2009; Oostrom et al. 2010; Vlasveld et al. 2013; Wynne-Jones et al. 2018): two found a small but statistically significantly positive effect on quality of life (Bergman et al. 2022) or well-being (IES 2023b), while one found a sizeable effect on depression severity (Lerner et al. 2015). This variation in models'

effectiveness for health outcomes may reflect the different emphasis that different models place on improving workers' health rather than simply their employment outcomes.

In summary, most caseworker-led support models appear to outperform usual care, leading to better employment and/or health outcomes for workers than they would achieve without this support. However, Table 5 suggests that caseworker models tend to be more effective for employment outcomes than for health outcomes: employment outcomes improved in a majority of the studies included in Table 5, while health outcomes improved in only a minority of studies. Moreover, the quality of usual care in the country where a study was conducted may have played a role in determining whether the study found a positive effect. As noted above, studies conducted in countries such as the UK, where provision of early-intervention support for workers is relatively underdeveloped, were more likely to find that caseworker support was effective than studies conducted in, say, the Netherlands.

4.1.2. Isolating the effect of providing a caseworker is not straightforward.

In many of the models outlined in Table 5, the provision of a caseworker was just one element of a broader intervention. For instance, various models required caseworkers to deliver a specific guideline-based intervention, with the content of these interventions varying between models. Some models also provided faster access to medical treatment, as in the case of Working Health Services Scotland (Bergman et al. 2022). Determining which elements of a model – the caseworker, the nature of the specific intervention, swifter access to treatment or other factors – are contributing most to the model's effect is difficult. Skarpaas et al. (2019) exploited variation in the implementation of Norway's national 'Rapid-RTW' programme to explore this question. All participants in the Rapid-RTW programme received either occupational rehabilitation, assessment and follow-up services from the social security system, or medical treatment. However, due to differences in implementation across sites, only some programme participants were assigned a caseworker to coordinate and tailor the services they received. Skarpaas et al. (2019) found no significant difference in the time taken to RTW between the caseworker group and the no-caseworker group. However, despite their efforts to control for confounders such as pain severity, the authors note the possibility that the caseworker group had more complex health issues than the comparison group, which would have delayed their RTW despite their caseworker's support. Skarpaas et al.'s findings are therefore inconclusive.

Fundamentally, however, this study's focus is not specifically on the effect of providing a caseworker. Caseworkers will always be operating within a broader model that determines the type of support they offer. Arguably, what matters most (and what Table 5 captures) is the effectiveness of this broader model, which may include several different interventions. In Section 4.3, we return to the question of what this broader model should look like and the components it should include.

4.2. Cost-benefit analysis

The previous section presented impact evidence from 14 studies of caseworker models. A number of these studies also included an economic evaluation that aimed to determine the benefit-cost ratio (BCR) or return on investment of the model being tested. Table 6 presents a summarised version of the outcomes of these economic evaluations. For comparability across models, it includes only the seven models for which

the original authors provided sufficient data to calculate a BCR. All costs and benefits are reported per participant (rather than per programme).

Table 6. Summary of model costs and benefits

Model (study report)	Estimated benefits per participant	Estimated costs per participant	Estimated BCR (lower bound; upper bound)	Practitioners	Limitations of the economic analysis
Vocational Advice Intervention, trialled in SWAP (Wynne-Jones et al. 2018)	Employment and productivity benefits: £748 Health benefits: not included	£15	49:1 (25:1; 49:1)	Healthcare professionals (3 physiotherapists, 1 nurse)	*Benefits highly uncertain and likely underestimated:* health benefits not included. Underlying impact analysis lacks statistical significance. *Costs likely underestimated:* the lower bound of the BCR may be more realistic (it includes training and mentoring costs).
EASY (Brown et al. 2015)	Employment and productivity benefits: £43 Health benefits: not included	£38	1.14:1 (1.14:1, 1.56:1)	Occupational health professionals, supported by non-clinical call handlers	*Benefits likely underestimated*: Health benefits not included. *Costs are likely overestimated*: costs should fall over time. *BCR likely underestimated* due to underestimated benefits and overestimated costs.
IPS-Lite, trialled in Health-Led Trials (in-work sub-group only) (IES 2023a)	Not possible to disaggregate employment vs health benefits. Direct financial benefits: £41 Economic benefits: £4,803	£2,116	2.32:1 (1.26:1, 4.18:1) (for the economic case; not including minor financial benefits)	IPS employment specialists	*Benefits are highly uncertain*: they are calculated comprehensively but range widely (£2,613–8,646 per participant). *BCR highly uncertain:* sensitivity analysis suggests a 13% probability of not breaking even in the reference scenario.

Model (study report)	Estimated benefits per participant	Estimated costs per participant	Estimated BCR (lower bound; upper bound)	Practitioners	Limitations of the economic analysis
Coordinated and Tailored Work Rehabilitation (Bültmann et al. 2009)	Employment and productivity benefits: £8,700[9] Health benefits: £464	£1,550	~6:1	Multidisciplinary team (occupational physician, occupational physiotherapist, chiropractor, psychologist), with social workers as caseworkers	*Benefits likely underestimated:* benefits do not include value of improved quality of life. *BCR not subject to sensitivity analysis:* no upper and lower bounds reported; no further sensitivity analysis undertaken.
Shell DisABILITY Management Program (Skisak et al. 2006)	Employment and productivity benefits: ~£101 Health benefits: not included	~£22	More than 4:1	Two full-time case managers, supported by nine location nurses	*Degree of certainty of benefit estimates is unclear:* no information on upper/lower bounds or statistical significance. Benefits and BCR likely underestimated: health benefits not included.
SHARP-at work (Arends et al. 2013)	Employment and productivity benefits: none Health benefits: not included	£1,186	No overall economic benefit.	Occupational physicians	*Costs likely overestimated:* the intervention's cost could drop significantly if each occupational physician treats multiple workers, but a sensitivity analysis using the lower cost did not change the BCR results. *Benefits likely underestimated*: health benefits are not included.
Work-focused intervention (Lerner et al. 2015)	Employment and productivity benefits: £3,880 Health benefits: not included	£627	6.19:1	Masters-level counsellors	*Degree of certainty of benefit estimates is unclear:* no information on upper/lower bounds or statistical significance. Benefits and BCR are likely to be underestimated: health benefits are not included.

4.2.1. The economic benefits of effective caseworker models generally outweigh their costs

All but one of the models set out in Table 6 appear to have positive BCRs, including all three models trialled in the UK (Brown et al. 2015; IES 2023a; Wynne-Jones et al. 2018). Where models' BCRs are

[9] Non-GBP currencies were converted using the exchange rate at the time of the relevant trial report's publication.

positive, they vary greatly in magnitude, from a possible 49:1 for the model trialled in the Study of Work and Pain (SWAP) (Wynne-Jones et al. 2018) to 1.14:1 for the Early Access to Support for You (EASY) model (Brown et al. 2015).

However, these ratios are not easily comparable. First, the methods used to generate them varied considerably. In many cases, the evaluators included only employment and productivity benefits in their analysis and not health and well-being benefits. Although the evaluators did calculate benefits comprehensively, their estimated BCRs remained relatively uncertain. For instance, the Health-Led Trials of IPS-Lite estimated the programme's benefits at between £2,633 and £8,690 per in-work participant, leading to uncertainty in the BCR calculated for IPS-Lite (IES 2023a). In some cases, this uncertainty stemmed from the nature of the underlying impact findings. In the case of SWAP, for example, the confidence intervals for the impact findings underpinning the economic evaluation were extremely wide, limiting the reliability of the economic analysis (Wynne-Jones et al. 2018).

It is also worth noting again that the studies that generated data on the models' impacts, costs and benefits were conducted in very different contexts. The costs and economic benefits of a caseworker model are likely to vary considerably between the UK, the rest of Europe and the United States. In other words, a model originally trialled in, say, the Netherlands is likely to produce different costs and benefits if transferred to the UK context. As mentioned in the previous section, the quality of usual care in the Netherlands is relatively high, which suggests that the economic benefits of adding caseworker support to usual care are likely to be smaller than they would be in the UK.

Despite the difficulty of comparing different models' costs and benefits, the overall picture shown by Table 6 is positive: the benefits of caseworker support often outweigh the costs. Moreover, the benefits of the models included in Table 6 were likely underestimated in many cases: a majority of the economic evaluations underpinning the data in Table 6 did not attempt to estimate the models' health or well-being benefits, for instance.

4.3. Components of effective models

The findings presented so far in this chapter provide evidence for the effectiveness and BCRs of specific caseworker models. This section moves beyond specific models to explore the components that tend to make a model successful. None of the studies included in our evidence review directly address this question, using designs that would help disentangle the effects of different components of caseworker models. However, taken together, the evidence review findings point to several elements typically present in effective models and absent in less effective ones, as discussed in this section.

4.3.1. Caseworker support provided earlier in a sickness absence may be more effective than support provided later

All of the caseworker models included in our evidence review are defined as 'early-intervention' in the sense that they are intended for workers who are still working or on short-term sickness absence, rather than for unemployed people or those on long-term sickness absence. However, some models intervene earlier in workers' trajectories than others, enabling tentative conclusions about when caseworker interventions should take place.

There is relatively strong evidence for the effectiveness and economic benefits of several very early-intervention models that assign employees with health issues a caseworker while they are still actively working or within their first two weeks of sickness absence. Five studies included in our evidence review meet these criteria,[10] and all appear to have improved workers' employment outcomes and yielded a positive BCR (Brown et al. 2015; IES 2023b; Lerner et al. 2015; Skisak et al. 2006; Wynne-Jones et al. 2018). That said, not all studies found that intervening as early as possible was optimal. For instance, the vocational advice intervention trialled in SWAP was significantly more successful for participants who had been absent for more than ten days than for those absent for fewer than ten days (Wynne-Jones et al. 2018).

While it is difficult to pinpoint precisely how early is optimal based on the available evidence, intervening later (after workers have been on sick leave for at least a month) appears less likely to be effective. Vogel et al. (2017) conducted a systematic review and meta-analysis of RTW coordination programmes to improve RTW for workers on sick leave. All 14 studies included in the review targeted workers who had been on sick leave for at least a month. Of these, four studies targeted workers who had been absent for at least three months. The review therefore includes studies of several models that we would not classify as early intervention. The meta-analysis of these studies found no benefit of RTW coordination programmes for RTW outcomes at either short-, long- or very-long-term follow-up.

4.3.2. Strong caseworker-client relationships predict successful RTW

There is some evidence that good relationships between caseworkers and their clients are associated with better RTW outcomes. For instance, Feuerstein et al. (2003) studied a group of federal workers in the United States with work-related MSK conditions, randomising half to receive standard case management according to Department of Labor guidelines and the other half to receive more personalised 'integrated' case management. The treatment group was significantly more satisfied with the care they received than the control group; in turn, higher satisfaction levels predicted faster RTW and reduced symptom severity at six-month follow-up.

Two studies of different subsets of the same Australian cohort reached similar conclusions (Black et al. 2017; Lane et al. 2018). Black et al. (2017) studied 357 workers with MSK or MH conditions and found that workers who rated their contact with their caseworker as 'low-stress' were significantly more likely to have high RTW self-efficacy (i.e. more positive perceptions of their ability to RTW, which the authors note is associated with more positive RTW outcomes). Lane et al. (2018) analysed data from 632 workers. They reached a slightly more ambiguous conclusion: that low-stress interactions with caseworkers were non-significant four months after workers became unwell, but nearly doubled the odds of RTW six months later.

Taken together, the findings from Feuerstein, Lane and Black suggest that higher-quality, lower-stress interactions with caseworkers are associated with faster RTW, particularly for workers who have been on sick leave for longer periods.

[10] However, note that only some participants in SWAP (Wynne-Jones et al. 2018) and the Health-Led Trials (IES 2023b) were still actively working when enrolled in the trial.

4.3.3. Tiered or targeted caseworker support models enable more efficient use of resources

Most workers on sickness absence will eventually RTW, even without support. For instance, analysis of UK government statistics suggests that, in 2024, 94% of workers who spent a month or less on sick leave returned to work, as did 88% of workers with a 3–6-month period of sickness absence (DWP & DBT 2025). Therefore, providing intensive caseworker support to all workers on sick leave would be an inefficient use of resources. Nonetheless, it could help accelerate or sustain RTW, even among workers who would have returned without it.

A more efficient option is to provide tiered support. Several existing and proven caseworker models take this approach, increasing the intensity of support over time according to clients' needs (Brown et al. 2015; Sowden et al. 2019). For instance, clients in EASY receive a brief telephone call on days one and three of their absence, but are only assigned a caseworker on day ten (Brown et al. 2015). Similarly, the intervention trialled in SWAP begins with a phone call, with subsequent calls, face-to-face appointments and workplace visits taking place only where necessary (Sowden et al. 2019).

Another efficient option is providing targeted support, i.e. giving caseworker support only to those workers most likely to benefit from it. Several criteria could be used to identify the subset of workers most likely to benefit. One example is workers' desire for support, as there is some evidence that caseworker models tend to work best for clients most motivated to engage with them. The participatory workplace intervention trialled in Van Oostrom et al. (2010) had no overall effect on RTW. However, it was highly effective among employees who intended to RTW despite experiencing symptoms. The latter returned to work after an average of 55 days, compared to 120 days for employees who intended to RTW but did not receive the intervention.[11]

Workers with both MSK conditions and either MH conditions or psychosocial risk factors for RTW are another subset for whom caseworker support seems particularly effective. For example, an Australian trial (Nicholas et al. 2020) studied workers with soft-tissue injuries who were assessed as being at high risk of delayed RTW. The (non-randomised) control group received usual (stepped) care. In contrast, the treatment group received a psychological assessment and comprehensive protocol (known as Work Injury Screen Early, or WISE) to address obstacles to RTW, coordinated by an RTW coordinator. At the two-year follow-up, the mean number of lost workdays in the treatment group was less than half that in the control group, representing a substantive statistically significant result. A UK study comparing two treatment pathways for people with MSK conditions (one case-managed and the other not) reached a similar conclusion: Bergman et al. (2022) found that participants with the poorest MH at baseline experienced the greatest improvements to their overall health as a result of support from the case-managed pathway.

[11] A similar effect was noted in the evaluation of the UK Work and Health Programme (aimed at people who were out of work, and therefore not an early-intervention model as we define it). The programme's outcomes were generally more positive for voluntary participants who freely chose to engage with the programme than for mandatory ones. Several employment outcomes only reached statistical significance for voluntary participants (Kantar Public et al. 2024).

In short, both tiered and targeted support are likely to be more efficient than providing intensive support to all workers. Tiering is perhaps the more equitable option, ensuring all workers receive some support rather than leaving some entirely without it. However, as demonstrated above, targeting support to worker subgroups most likely to benefit is a viable, evidence-based alternative.

4.3.4. Maintaining a clear focus on RTW is likely to improve outcomes

Most models considered in our evidence review, both effective and ineffective, focused on RTW and the workplace to some degree. This focus could involve several activities facilitated by the caseworker, such as creating RTW plans, collaborative problem-solving to overcome barriers to RTW, communication with employers or line managers and workplace visits.

Some evidence suggests that focusing on the workplace benefits RTW. For instance, a synthesis of systematic reviews by Cancelliere et al. (2016) found that multidisciplinary interventions involving the workplace and other stakeholders (but not necessarily caseworkers) were associated with positive RTW outcomes. Similarly, a systematic review by Franche et al. (2005) found moderate-to-strong evidence that contact among workers, their workplaces and other involved parties (such as healthcare providers) tends to accelerate RTW.

However, few studies have compared the outcomes of a work-focused caseworker intervention against those of a non-work-focused caseworker intervention. One exception is Lane et al. (2018), who examined the effects of caseworkers' interpersonal and functional activities on RTW outcomes in a prospective cohort study of workers with MH and MSK conditions in Australia. They found that having an RTW plan in place doubled the odds of a worker achieving sustainable RTW four months after becoming unwell (although the effect of the RTW plan was not statistically significant six months later). This finding suggests a link between an early RTW focus and rapid RTW.

Conversely, some evidence cites a lack of focus on the workplace as an explanation for the apparent ineffectiveness of a caseworker model. As discussed above, for example, Skarpaas et al. (2019) compared outcomes for participants in Norway's rapid-RTW programme assigned a caseworker with outcomes for those not assigned a caseworker. The authors suggest that one reason participants assigned a caseworker did not RTW faster was that healthcare services provided a caseworker who largely coordinated healthcare provision in this case, with little focus on coordination with the workplace.

5. Delivery realities and system constraints

This chapter examines how early-intervention caseworker-led support operates in practice, focusing on the delivery realities and system constraints identified through stakeholder interviews and the appraisal workshop. It explores how models are implemented on the ground, the operational challenges providers and partners face and the factors that enable or hinder effective delivery at scale. Rather than assessing impact or effectiveness, our emphasis is on feasibility, integration and sustainability, drawing on practitioner, employer, insurer and commissioner perspectives to understand what is realistically deliverable within current systems.

The findings presented in this chapter are based primarily on qualitative evidence gathered through informant interviews and workshop discussions, as described in Chapter 2. While these insights do not provide a comprehensive picture of all delivery contexts, they offer a detailed and practice-oriented understanding of the constraints shaping early-intervention caseworker support in the UK and inform the assessment of policy components and model design in subsequent sections.

5.1. Experiences of providers and delivery partners

Stakeholders across publicly funded, voluntary and insurer-led programmes agreed that the effectiveness of early-intervention support is shaped not only by the model itself, but crucially by how it is delivered. This section explores the practical realities of delivery, highlighting five recurring themes: the importance and challenges of early engagement; fragmented referral pathways; uneven employer involvement; workforce pressures and role ambiguity; and the influence of local system maturity on what can be achieved in practice.

5.1.1. Early engagement is critical, but difficult to achieve consistently.

Consistent with the evidence review presented in Chapter 4, providers emphasised the timing of engagement as one of the strongest determinants of impact. Interviewees often described their most successful cases as those in which support began while individuals were still at work or within the first days of sickness absence. Early contact was seen to reduce escalation, maintain attachment to the workplace and limit the intensity and duration of support required later.

One insurer-led provider described how this logic has shaped their delivery model:

> *'We've got to the point in our evolution that some groups will come to us now before someone's even been off work and we're willing to help them at that stage because we know early intervention is a key part of what we do. Getting involved early is a key*

> *factor in our case management approach … You need to be finding a way to engage people as early as possible… at the initial point of absence or dropping out of work while they're still motivated*'[12]

Similarly, one longstanding third-sector provider described their core purpose as preventing work absence and supporting workers at an early stage, with most referrals coming via primary care and many clients still in work or off sick for only a short period. They considered this approach central to achieving better employment outcomes and avoiding prolonged absence.

Despite this shared emphasis on early intervention, informants also highlighted that existing delivery and referral arrangements often make early engagement difficult in practice. Referral routes are frequently triggered only once sickness absence has become established or when a formal claim or benefit process is underway. Several stakeholders characterised this as services engaging 'too late in the journey', when health, confidence and work relationships have already deteriorated, and problems have already become more complex and entrenched.

While some models report having developed mechanisms to intervene very early – particularly insurer-led or long-standing local programmes – many continue to face barriers that limit their ability to do so consistently. These include funding triggers tied to absence or claims, reliance on overstretched gatekeepers and referral processes that do not align well with frontline workflows.

One delivery partner explained that their services were historically 'targeted to be working with absentees who were already off work', meaning that teams had to 'find them at the GP surgeries [where] everyone would have been going for a fit note.'[13] This pattern was echoed in descriptions of clients accessing support only after repeated, unsuccessful attempts to resolve issues elsewhere: '[we're] seeing many people for the same problem, not got anywhere… and then they hear about us.' The same interviewee noted that referral processes must align with gatekeeper capacity and workflow, observing that 'GPs just don't want to do online referrals,' implying that system design choices can directly constrain how quickly (and how reliably) people are routed into support.

5.1.2. Referral pathways are often fragmented and difficult to navigate

Providers described referral pathways into early-intervention caseworker support as fragmented, inconsistent and difficult to navigate, varying widely by locality, programme design and institutional boundaries. Entry points include GP referral, Jobcentre referral, employer referral and self-referral, but providers widely saw reliance on any single route as problematic and fragile. As one interviewee summarised, 'I do feel it's very disjointed,' while another referred to 'a very complex … landscape of provision.'[14]

Importantly, fragmentation is not only structural but often person-dependent. Access to support was described as hinging on the awareness, confidence and discretion of individual gatekeepers – such as particular GPs, Jobcentre advisers or employers – rather than on consistent system design. This situation

[12] Stakeholder Interview (SI)1.

[13] SI2.

[14] SI3, SI4.

leads to uneven access and fragile referral pathways, with similar individuals experiencing very different journeys depending on whom they encounter first.

This disjointedness was framed not simply as a logistical issue, but as a broader system-alignment problem, reflecting the fact that different parts of the system operate under different logics and priorities. As one stakeholder put it, 'You've got to have lots of different pieces of the puzzle aligned.'[15] Another interviewee noted that health services, employment services, employers and insurers often 'do not speak the same language', resulting in weak coordination and unclear ownership of work-related risk.

These misalignments were considered particularly acute at the public-private interface, where limited coordination and uncertainty about when to intervene, what support is available and where responsibility lies can leave individuals without a clear or timely route into help. As one interviewee observed, 'There's a lack of joining up of that public-private network… and so you have the employee who just falls through the gap.'[16]

In this context, system navigation itself is a core function of effective caseworker support, rather than a supplementary task. One provider described their role explicitly as 'helping them to navigate services – probably not as clear as it could be.'[17] Without this navigational function, individuals are often left to move between services that are poorly connected or, in some cases, actively incompatible.

Capacity constraints in primary care and the wider NHS further compounded referral challenges. Reliance on GP referral alone was frequently cited as a bottleneck, with interviewees noting that primary care is under significant pressure. Delays in accessing healthcare – particularly mental-health services – were seen as directly delaying work-focused support. As one stakeholder explained, 'If you're waiting six to eight months, twelve months to get access to CBT, then you're not going to call occupational health for a really long time.'[18]

Against this backdrop, stakeholders advocated for multiple, parallel routes into support, rather than sequential or exclusive pathways. Services that enabled self-referral and employer referral alongside clinical routes were viewed more positively, as they reduced dependence on any single gatekeeper and improved resilience. As one interviewee illustrated this:

> *'[we] have a more multimodal referral basis… we've got referral from primary care, secondary care, voluntary community sector organisations and self-referral. So we cast the referral net wider. …A no wrong front door approach… make[s] sure that any member of the public can walk into a provider… and we make sure that we get them to the right place.'*[19]

Informants also highlighted the value of co-located or embedded roles, such as advisers based in GP practices or integrated within clinical teams, which were seen as reducing friction and enabling earlier

[15] SI3.

[16] SI3.

[17] SI4.

[18] SI3.

[19] SI5.

engagement without adding burden to clinicians. As one interviewee explained, 'Rather than being a third party who's thrown into the mix, we are able to build on an established relationship.'[20]

5.1.3. Working productively with GPs requires extensive engagement

GPs are a major source of referrals in many publicly-funded caseworker models. Interviewees emphasised the importance of continuous engagement with GPs to promote caseworker services, e.g. through in-person visits to GP surgeries, encouraging GPs to visit delivery sites or providing an introduction to local caseworker services in formal GP training. One option for enabling close collaboration with GPs was to co-locate caseworker services in GP surgeries, making it easy for GPs to simply 'send them [clients] down the corridor.'[21] However, as one interviewee noted, this can become difficult or impossible for larger, scaled-up services. For instance, if a service has a detailed registration process that involves the client showing ID, registration will likely need to take place at a separate time to a GP appointment.

Several interviewees discussed encouraging GPs and other healthcare professionals to refer to the service by offering medical treatment alongside caseworker support. This method was seen as highly attractive to both GPs and clients, enabling them to skip long waiting lists for treatment such as physiotherapy and counselling. As one provider said: 'You can have a service without the therapies, but I think the therapies do seem to be the big selling point.'[22] However, providers also felt that this approach had downsides. As mentioned above, interviewees felt it tended to attract clients who simply wanted quicker access to treatment and who were not really interested in receiving caseworker support. Some providers found this discouraging: for instance, the same provider also noted that 'sometimes it feels like the service in its full glory isn't fully accessed.'[23]

5.1.4. Employer engagement is essential but uneven

Stakeholders were almost unanimous in emphasising employer engagement as a critical determinant of successful early-intervention support. Across delivery settings, informants stressed that many barriers to sustained RTW are located in the workplace itself, including job design, line management practices, flexibility and workplace culture. As one provider put it, 'You need good employer engagement.'[24]

Caseworkers were described as playing a vital intermediary role, translating health needs into practical workplace adjustments, facilitating conversations between employees and managers and helping reduce conflict or misunderstanding. Effective caseworker-led support depends on active liaison with employers and line managers, rather than focusing solely on the individual. One private provider explained that, from a vocational rehabilitation perspective, 'the relationship with the workplace and the line manager is a key point… we might give all the treatment in the world to an individual, but if the line manager is not educated or on board with that, that can sometimes be a barrier.'[25] This same provider described

[20] SI4.

[21] SI2.

[22] SI2.

[23] SI2.

[24] SI4.

[25] SI1.

employer contact as a first step in their delivery process rather than an optional add-on: 'We will talk to the employer in the first instance… we liaise, we get information from the employer.'

However, while informants saw employer engagement as essential in principle, they consistently described it as highly uneven in practice. While larger employers with established HR functions, occupational health provision or insurance-funded rehabilitation were generally considered better positioned to engage proactively, engagement with small SMEs was described as more challenging, often due to limited awareness, capacity or confidence. One provider explained that engagement depends less on formal contracts than on 'making sure [employers] are aware of this service and feel comfortable using it.'[26] Another warned that this can create a two-tier system in which access to early intervention depends heavily on employer size and resources.[27]

Despite the emphasis on employer involvement, there was broad agreement that expecting employers or line managers to act as de facto case managers is unrealistic, particularly for SMEs. Informants emphasised the need for clearer expectations, practical tools and accessible external support to enable employers to play a constructive role. One interviewee was explicit about the need to distinguish caseworkers' and line managers' roles: 'This is not about upskilling line managers… because it's the separation between the line manager and the case manager that makes it work.'[28] Caseworkers were therefore viewed as essential intermediaries, bridging the gap between clinical advice and workplace implementation.

International evidence reinforces this picture. Interviews with stakeholders in Australia and the Netherlands highlighted that employer engagement and responsibility are often positioned as central to early-intervention and RTW frameworks, but that employer capacity to fulfil this role varies sharply. One interviewee described a system that 'relies on a huge responsibility of the employer and the employee themselves', noting that larger organisations are generally better equipped to manage this responsibility through in-house occupational-health expertise. In contrast, smaller employers must rely on external provision, which is 'not very feasible all the time.'[29] For small employers, the financial and operational risks associated with long-term sickness absence were described as severe, with one stakeholder explaining that in very small firms a single prolonged absence can 'mean bankruptcy of your company.'[30]

Another stakeholder observed that larger employers are more likely to understand how to navigate work-and-health systems, whereas 'the small and medium [employers] only deal with a claim when they get one… and they don't actually have the skills and don't understand the system.'[31] In such cases, smaller employers were described as more reliant on external support, often 'welcom[ing] having an independent person to help them guide them through the process.'[32] Interviewees also noted that some systems attempt to compensate for uneven employer capability by embedding clearer positive employer duties, including

[26] SI1.

[27] SI4.

[28] SI1.

[29] SI6.

[30] SI6.

[31] SI7.

[32] SI7.

obligations to maintain employment relationships and provide suitable work accommodations during recovery.[33]

5.1.5. Workforce pressure, role ambiguity and caseloads shape what is deliverable

Workforce conditions were considered core determinants of what early-intervention models can realistically deliver. Several stakeholders reported persistent difficulties recruiting and retaining staff with the hybrid skill set required for these roles, combining health literacy, employability expertise, employer engagement and strong relational skills. As one provider put it, 'Staff recruitment and retention can be an issue at times, because this field isn't really professionalised.'[34] Others noted that pay structures, particularly for work coaches and employment advisers, are often 'too low' and 'uncompetitive', making it difficult to attract or keep 'really good people.'[35] Informants emphasised that the effectiveness of caseworker support depends less on adherence to fixed protocols and more on capability, judgement and adaptability.

The caseworker role itself was described as broad, hybrid and emotionally demanding. Caseworkers were expected to 'hold the whole picture' for clients, providing emotional support, practical problem-solving, employer liaison, coordination with healthcare and navigation of welfare and social-support systems. One interviewee summarised this as 'wrap-around support… using that kind of motivational interviewing coaching approach… [and] if they've got any issues with the employer… we could either speak to an employer… [and] might pull in support around debt, parenting… whatever is needed.'[36] Crucially, informants stressed that effective delivery relies on caseworkers' ability to build trust with individuals, understand their circumstances over time, and adapt support as needs evolve rather than delivering a fixed sequence of interventions. They saw this relational continuity as particularly important for individuals with fluctuating health conditions or complex personal situations.

While interviewees widely viewed this breadth and flexibility as a strength, they also identified them as a major source of strain. Several providers noted that, in practice, caseworkers often compensate for gaps between services, effectively 'holding everything together' for individuals navigating fragmented systems. Without clear role boundaries, supervision and escalation routes, this expectation was seen as placing significant pressure on staff and limiting effectiveness.

A recurring concern was role ambiguity, particularly around the boundary between coaching and clinical support and around when – and how – cases should be escalated to specialist services. Many informants observed that practitioners typically enter these roles from either a health or employability background and that capability gaps arise when cross-disciplinary training and supervision are limited. Informants widely considered short-term or one-off training insufficient to address this challenge. Instead, they emphasised the importance of sustained supervision, peer learning and access to multidisciplinary expertise to support caseworkers in exercising judgement and managing complex cases safely.

[33] SI7.

[34] SI2.

[35] SI4.

[36] SI2.

Interviewees also highlighted the emotional load associated with the work. Caseworkers may 'not [be] delivering clinical advice… but clients get really, really distressed and they are often the first line.'[37] Providers described using group meetings with therapists to help staff 'offload' and maintain well-being, noting that 'staff need to feel well supported… their well-being needs to be put first.' [38] Combined with the absence of formal clinical boundaries, interviewees considered this emotional exposure a key reason for the importance of structured supervision and reflective practice.

Interviewees also cited caseload pressure as another key risk to both service quality and staff well-being, describing caseloads as highly variable and difficult to predict. They reported that some cases resolve quickly with light-touch support, while others require intensive, long-term engagement. This variability makes capacity planning challenging and increases the risk that complex cases dominate practitioner time. Interviewees referenced evidence from established models, such as IPS, showing that high caseloads reduce the ability to build relationships, engage employers and provide follow-up, undermining outcomes and increasing burnout. Additionally, where performance is narrowly judged on short-term outcomes, stakeholders noted a risk that providers may prioritise less complex cases, reducing the time available for trust-building, employer engagement and system navigation for those with greater needs.

5.1.6. Local context strongly influences delivery

Providers and delivery partners also noted that variation in local system maturity strongly shapes what is achievable. In areas where relationships between health services, employment support, local authorities and voluntary-sector organisations were well established, caseworkers were better able to coordinate support, make timely referrals and adapt provision to individual circumstances. Stakeholders repeatedly stressed that effective delivery depends on building on what already exists locally, rather than imposing a uniform model. As one interviewee put it: 'Each individual local delivery team area has its own set of interventions… based on what was already existing at place… place comes first, and place takes primacy, and you build on what is already there.'[39] These local ecosystems were described as enabling collaboration, trust and innovation, allowing caseworker-led support to function as intended.

By contrast, interviewees described delivery in areas with weaker local infrastructure, fragmented governance or limited partnership working as far more fragile. In such contexts, caseworker support often depended heavily on informal networks, individual goodwill or personal relationships rather than on embedded system processes. Where these informal arrangements were absent or disrupted, coordination became difficult, and services were harder to sustain or replicate. Local variation in system maturity also affects referral routes and access. Some areas were described as having developed broader, more integrated referral pathways, while others remained constrained by narrow entry points.

Hyperlocal ownership and scrutiny were also described as enabling collaboration and accountability. One commissioner described how locally commissioned and locally run teams create 'a sense of ownership,

[37] SI2.

[38] SI2.

[39] SI5.

scrutiny and support' that strengthens delivery and accountability.[40] Interviewees viewed such locally embedded arrangements as fostering responsiveness and trust. In contrast, larger regional footprints could dilute oversight and make services harder to sustain: 'I often wonder … how would things have gone if we'd had a different commissioning footprint … if we'd had fewer teams then we … could have had more resilience … better value for money … better retention.' [41]

A recurring message across interviews was that early-intervention caseworker support is not a 'plug-and-play' model. While national frameworks and manuals provide useful guidance, effective delivery depends on local integration, relationships and capacity. One interviewee reflected that even with a fully manualised model and detailed guidance, success ultimately depends on 'getting the right person in post' and ensuring 'deep integration.'[42] As a result, scaling provision nationally was seen to require a combination of clear national frameworks and expectations, alongside sufficient flexibility for local adaptation.

5.2. Systemic enablers and barriers

The delivery experiences outlined in Section 5.1 highlight that both local factors and broader structural conditions influence provider performance. This section examines these systemic enablers and barriers, focusing on five recurring themes:

- The impact of short-term funding
- The absence of coordinated national messaging
- Challenges in evidencing outcomes
- The complexity of working with GPs
- The ongoing lack of professionalisation within the field of caseworker support.

5.2.1. Limited and/or fixed-term funding creates numerous challenges for providers

The advantages and disadvantages of different funding models for caseworker services were a common theme in interviews. Some providers we spoke to had relatively long-term, continuous funding for their service; others were delivering their service under a fixed-term contract. Interviewees consistently felt that short-term funding was detrimental to the quality of caseworker services. The uncertainty of not knowing whether further funding would be forthcoming was described as 'really hard to manage', impacting a range of practical decisions such as when to start wrapping up a service (and when to inform referrers of this).[43] Interviewees also noted that this uncertainty affects service design, making it unclear whether to design programmes for the short or long term. Conversely, providers with long-term funding found it valuable for ensuring continuity and effective planning.

[40] SI4.

[41] SI4.

[42] SI4.

[43] SI2.

Interviewees also highlighted the impact of funding models and pay structures on recruitment, retention and service development. As one provider explained, 'The funding is only for a year, 18 months … by the time I recruited a new member of staff and got them up and running, it really wouldn't be worthwhile … there's no continuity. And then people just fall off a cliff edge.'[44] Several reported difficulties attracting high-quality applicants to work under fixed-term contracts. One interviewee described this challenge clearly: 'What we need is longer-term, more certain, more secure money… we want to be able to tell people that they can build a career with us… [but] successive rounds of relatively short-term funding made that quite difficult to say.'[45] One interviewee also discussed significant discrepancies across providers' pay structures, noting the problems that this caused for retention when skilled caseworkers (or indeed whole teams of caseworkers) left lower-paying providers for higher-paying ones. At the same time, providers who offered stable, appropriately compensated positions for their caseworkers tended to report that recruitment and retention were not issues for their services.

5.2.2. A lack of centralised messaging requires individual providers to shoulder the burden of promoting their services

Providers described engaging in a wide range of activities to promote their caseworker service. These included marketing campaigns (particularly targeting sectors struggling to retain staff due to poor health or well-being), engaging liaison officers to reach out to potential referrers (such as GPs and employers), face-to-face networking to raise awareness, and delivering well-being training sessions for employers to spread the word about their service. Several interviewees reported that they would like to see more national support for these efforts and clearer messaging from governments about the benefits of caseworker support. They felt that this would increase public confidence in and take-up of caseworker services. As one informant put it, 'I think the messaging […] is best coming from a health board or government […] I think there should be some centralised messaging and centralised branding that, I think, gives confidence.'[46]

5.2.3. Demonstrating the impact of caseworker services on job retention rates is challenging

Several providers discussed the difficulty of demonstrating that their services were effective in keeping people with health conditions in work. They described having high-quality data on effectiveness as vital for understanding the service's performance and demonstrating its impact to commissioners, particularly for new or pilot services. However, they saw two main issues standing in the way: the lack of suitable metrics for measuring success and the challenges of following up with participants after they left the service.

Interviewees considered it more difficult to measure the success of models aimed at people in employment than of those aimed at the unemployed or economically inactive, for which the obvious metric is employment rates upon leaving the programme. As one interviewee put it for in-work support models, 'an

[44] SI8.

[45] SI4.

[46] SI2.

outcome is that nothing happens': an employee remains employed.[47] For participants who are employed but currently on sick leave, one possible metric is time taken to RTW. However, as one interviewee noted, using RTW rates as a measure of success can incentivise providers to cherry-pick relatively simple cases and avoid investing time and effort in more complex cases that are less likely to yield rapid RTW.

Interviewees also described collecting endpoint data on participant outcomes as challenging. One established caseworker service provider noted that participants tended to 'disappear', leaving the service as soon as they started to feel better.[48] This problem was particularly acute for caseworker services that also provided treatment, such as access to physiotherapy or counselling. As one interviewee reported, some participants accessed the service simply to avoid long NHS waiting lists for MSK or MH treatment, and tended to drop out of the service as soon as they had received it.[49]

5.2.4. There is little consensus among stakeholders on the kind of caseworker support that should be delivered, by whom and with what training

Stakeholders typically had strong views on who should provide caseworker support and what this support should look like. A key area of disagreement was whether caseworker models should be delivered by healthcare professionals and incorporate medical treatment. Some (particularly interviewees from healthcare or vocational rehabilitation backgrounds) argued that caseworkers with a healthcare background were better able to assess and respond to potential threats to clients' health, support clients with complex medical conditions, win clients' respect and work productively with GPs and other healthcare professionals ('speak clinician', as one interviewee put it).[50] Others, particularly interviewees from employment support backgrounds, felt that caseworkers with healthcare backgrounds tended to over-medicalise clients' issues and were less likely to provide holistic support that accounted for clients' non-medical barriers to RTW.

It was also clear that different providers are encouraging their caseworkers to access different types of training and qualification. These included formal qualifications from institutions such as the Institute of Employability Professionals and the International Disability Management Standards Council, as well as a variety of in-house professional development opportunities aiming at developing relevant skills, such as motivational interviewing. In other words, while providers were ensuring their caseworkers received ample professional development opportunities, there appeared to be no single source of relevant training or professional qualifications for 'work and health' caseworkers.

This lack of agreement on what caseworker support should look like and fragmented professional development pathways both suggest a field that, as one stakeholder put it, 'isn't really professionalised.'[51] This assessment aligns with the findings of chapter 3 of this report, which noted the considerable diversity of caseworker backgrounds and roles, as well as the lack of dedicated qualification routes. Professionalisation of the field would likely require a consensus on the nature of the caseworker role and

[47] SI4.

[48] SI8.

[49] SI2.

[50] SI8.

[51] SI2.

the training and skills required to do it well. This consensus-building process could take positions that most stakeholders appear to agree on as a starting point. For instance, the majority of interviewees felt that, regardless of the caseworker's background, having some form of clinical supervision or oversight in place was important for both clients' safety and caseworkers' well-being.

5.3. Appraisal of policy components and implications for practical model design

Building on the workforce mapping exercise (Section 3.3), the evidence review (Chapter 4) and stakeholder insights on delivery (Sections 5.1 and 5.2), this study developed and appraised a longlist of policy options aimed at strengthening early-intervention caseworker-led support to prevent health-related job loss and support sustainable RTW. The longlist was developed iteratively using evidence from these sources and appraised through a facilitated stakeholder workshop, which tested proposed policy components and specific actions against delivery realities and system constraints. We subsequently refined findings through discussion with the RAG, with the full longlist and detailed appraisal presented in Annex C.

This section does not seek to identify a single preferred model or set of actions. Instead, it structures and synthesises the policy landscape, drawing out what the appraisal exercise reveals about the feasibility, acceptability, scalability and sustainability of different approaches in practice. The policy components discussed here are not mutually exclusive, and stakeholders consistently emphasised that combinations of interventions are likely to be more effective than individual measures implemented in isolation.

5.3.1. Overview of policy components assessed

For this appraisal, we grouped individual actions into six broad policy areas. These reflect the real-world delivery issues discussed earlier in the chapter and the different stages from being in work to sustained RTW:

1. Enhancing publicly funded work-and-health support, particularly by scaling existing provision (e.g. WorkWell).
2. Building a skilled and sustainable caseworker workforce, including capability frameworks, caseload standards and multidisciplinary support.
3. Implementing tiered, flexible models of support that match intensity to need and allow escalation over time.
4. Strengthening employer responsibilities and engagement in sickness absence and RTW processes.
5. Using financial incentives to encourage employer investment in retention and workplace health, particularly for SMEs.
6. Leveraging Group Income Protection (GIP) insurance to support early intervention and rehabilitation.

These areas target different actors and system levers. While some focus primarily on public provision and workforce capacity, others focus on employer behaviour or private-sector mechanisms. Stakeholders

recommended viewing these areas as complementary rather than competing and emphasised that effective system reform will likely require coordinated action across several of them.

5.3.2. Cross-cutting insights from the appraisal

Standardisation is necessary but must allow for local adaptation

A consistent message from the appraisal was that greater clarity and consistency are needed, particularly as provision scales nationally. Participants broadly supported the development of a national core service specification covering assessment, case management processes, employer engagement, follow-up and outcomes to address current variation in quality and practice. However, there was equally strong resistance to rigid, one-size-fits-all models. Workshop participants emphasised that effectiveness depends on alignment with local systems, echoing our interview findings. As a result, the appraisal favoured a modular or principles-based approach that combines a clearly defined core with explicit scope for local tailoring. This balance was considered essential to both acceptability and scalability.

Early intervention and follow-up are widely supported components

Actions towards making early intervention the default, including earlier referral points and proactive engagement while individuals are still in work, were among the most strongly supported options across all appraisal criteria. Stakeholders viewed early engagement as both feasible and scalable, provided referral pathways are widened and gatekeepers supported. Similarly, there was strong consensus on the importance of continued follow-up beyond initial return-to-work or stabilisation to prevent relapse and churn. Follow-up was portrayed as low-cost, highly acceptable to users and practitioners, and critical to preventing relapse, repeated absences, and loss of momentum. Continued, light-touch follow-up was considered a practical way to reinforce earlier investment and stabilise outcomes at scale.

Workforce capacity and role clarity are prerequisites for scale

Workforce-focused actions received some of the strongest and most consistent support in the appraisal. Establishing a national caseworker capability framework, clear caseload and supervision standards and structured entry routes from adjacent professions were all considered essential enablers of quality and scale.

Participants repeatedly emphasised that scaling without addressing workforce pressures risks diluting effectiveness and increasing burnout.

Employer engagement must be built in, not assumed

The appraisal reinforced Section 5.1.3's findings that employer engagement is indispensable but uneven. This unevenness reflects structural differences in employer capacity that any future system must be designed around rather than work against. Three structural patterns emerged consistently across the stakeholder consultations and appraisal workshop. First, employer capability is shaped less by size than by the maturity of pre-existing organisational practice. Employers with established HR functions, occupational health provision or insurance-funded rehabilitation are generally better placed to engage early and constructively. Such markers of maturity are more common in larger organisations, but capability does not map neatly onto size. Second, SMEs face a distinct set of constraints beyond limited resources. Many lack HR or OH infrastructure, leaving line managers to manage sickness without

training, supervision or organisational backing, while being disproportionately exposed to the financial and operational risks of prolonged absence. Third, awareness and information flow are persistent barriers, even where employer-funded support is in place. Stakeholders noted wide variation in how quickly employers activate available services, often reflecting limited awareness of what is on offer or internal policies that delay activation rather than the absence of provision.

These structural patterns have direct implications for policy design. Stakeholders strongly supported actions embedding employer liaison as a core caseworker function, supported by tools, training and clear role boundaries. At the same time, the appraisal highlighted caution around policies that impose additional responsibilities on employers without adequate support, particularly on SMEs. Participants considered graduated responsibilities, pooled support mechanisms and external provision to be more feasible and acceptable than blanket obligations. The appraisal also highlighted the importance of carefully designing financial incentives: stakeholders noted the risk that subsidies reward employers already engaged while failing to change the behaviour of those not doing so, emphasising that any incentives must be conditional on demonstrable engagement rather than passive eligibility.

Tiered and flexible delivery models increase efficiency and sustainability

The appraisal strongly supported the use of tiered or stepped-care models, which match support intensity to need and are adjustable over time. Participants viewed this approach as both fair and efficient, focusing limited specialist capacity where it adds most value. Flexible delivery channels, such as combining digital, group-based and face-to-face support, were also widely supported as a means of improving reach without over-stretching the workforce. However, this has practical implications for workforce and service design: expected caseloads should vary according to the intensity, complexity and delivery mode of support provided. Caseworkers primarily delivering low-intensity support, such as brief telephone contact, digital check-ins or group-based sessions, might be able to hold larger caseloads than those providing intensive one-to-one support for complex cases.

Some options require further testing before wider adoption

Not all policy options were deemed equally ready for large-scale implementation. Participants considered measures such as new outcome metrics focused on prevention, financial incentives for employers, pooled insurance arrangements and expanded use of insurer data promising but insufficiently developed. Stakeholders emphasised the need for piloting, evaluation and iterative refinement before national adoption to mitigate unintended consequences and ensure value for money.

Drawing together the cross-cutting insights from the appraisal of policy components, Box 2 summarises the key implications for designing and embedding early-intervention, caseworker-led support in practice, regardless of the specific delivery model.

Box 2. Summary of implications for model design

- National frameworks should specify core functions and standards, while allowing flexibility in their implementation locally, recognising variation in system maturity and delivery contexts.
- Models should assume variable employer capability and build in structured support for employer engagement rather than relying solely on employer initiative.
- Workforce development, role clarity and supervision should be treated as foundational infrastructure, not downstream implementation issues.
- Matching intensity to need rather than providing uniform support to all users is likely to facilitate scalability.
- A phased approach combining immediate 'no-regret' actions with targeted testing of more complex reforms will likely be most effective.

Source: RAND Europe, based on the appraisal workshop.

6. A roadmap to effective caseworker support in the UK

Previous chapters set out the scale and persistence of health-related job loss in the UK, reviewed the international and UK evidence on early-intervention caseworker support, and identified the design features that distinguish effective offers from ineffective ones. This final chapter consolidates those findings into a practical roadmap for policymakers, employers and insurers, asking:

- Why does this matter, and what would success look like?
- What does effective early-intervention caseworker support look like in practice?
- Who should deliver what?
- How can this support be scaled across the UK?
- What should different actors do next?

6.1. Why this matters: the case for action

Effective early-intervention caseworker-led support, delivered at scale, has the potential to make a measurable contribution to a significant economic and social challenge currently facing the UK: the steady attrition of people from the labour market when health problems are not identified and addressed early enough. This section sets out the costs associated with current provision levels, the outcomes a more effective system could be expected to deliver and features of the current policy context that make this a timely moment to act.

The case for action is substantial and detailed in Chapter 1. Over 8 million working-age people in the UK report a work-limiting health condition, and over 300,000 people each year leave their jobs and end up out of the workforce entirely with work-limiting health conditions. Poor workplace health and economic inactivity due to ill health cost the UK economy an estimated £150–300bn a year, with incapacity-related benefit spending forecast to rise sharply over the remainder of the decade in the absence of reform (DWP & DBT 2026a). The findings of this study indicate that current provision reaches only a small proportion of the in-work population at risk of leaving employment. Publicly funded provision is variously constrained by geographical footprint, eligibility criteria or a focus on those already out of work rather

than those at risk of leaving work.[52] Access to employer-led interventions tends to be determined by employer size, sector and insurance status rather than by clinical need.[53]

The evidence reviewed in this study suggests that a well-designed system of early-intervention caseworker-led support, delivered at sufficient scale, could be expected to deliver benefits across three domains. Each is principally a function of acting earlier with the in-work population than is currently the norm:

- **Faster and more sustainable RTW where absence has occurred**: for those who do take time off, several experimental and quasi-experimental evaluations of caseworker-led vocational rehabilitation have found reductions in total sickness leave taken relative to usual care (see Section 4.1.1). Caseworker models may also be beneficial for health outcomes: UK-specific evidence from Working Health Services Scotland reports that a case-managed approach resulted in 'significantly greater change' in health outcomes compared to routine care (Bergman et al. 2022).
- **Job retention and reduced flow onto long-term sickness benefits:** by interrupting the trajectory from in-work health problem to prolonged absence, early intervention reduces progression onto long-term sickness benefits. The Health-Led Trials reported positive effects on employment outcomes at 12 and 21 months for in-work participants receiving IPS-Lite in the Sheffield City Region (IES 2023b). International evidence from Denmark and the Netherlands points in the same direction (Høgelund & Holm 2006; Vilsteren et al. 2015).
- **Reduced pressure on the NHS, and broader productivity gains:** the SWAP trial showed that a vocational advice service in primary care led to significantly fewer days of work absence in the short term (Wynne-Jones et al. 2018). Providers such as Sheffield Occupational Health Advisory Service have reported reducing the number of GP appointments required by patients (DWP & DHSC 2023). Insurer interviewees reported that GIP-funded early intervention generates positive return on investment for both insurers and policyholders.[54]

The benefits to individuals extend beyond employment outcomes. Sustained employment is associated with improved physical and mental health, reduced social isolation and protection of household income (Batty et al. 2022; Kantar Public et al. 2024; Vilsteren et al. 2015; Waddell et al. 2008). Therefore, a more effective system would be expected to deliver gains both to individuals and to the wider economy, e.g. a higher proportion of the people currently at risk of leaving employment each year remaining, a faster and more sustainable RTW for those who do take time off, and, downstream, fewer people transitioning onto long-term health-related benefits.

Three features of the current policy context make this a timely moment to act. First, health-related worklessness has become a priority for current government policy, with the *Get Britain Working White Paper* and the *Keep Britain Working Review* placing employer responsibilities for health at work, access to occupational health and early intervention at the centre of the government's labour-market and welfare strategy. Second, the *Keep Britain Working Review* has set out a phased delivery architecture, including

[52] SI12; SI9.

[53] SI1; SI9; SI10; SI11.

[54] SI1; SI11.

Vanguard (years 1–3), Expansion (years 2–5) and General Adoption (years 4–7). This delivery is anchored in three proposed structures: a Healthy Working Lifecycle setting out shared standards for workplace health across the working life; a national Workplace Health Provision providing access to occupational health and vocational rehabilitation, particularly for SMEs; and a Workplace Health Intelligence Unit providing data, evaluation and oversight. Together, these structures will be designed to provide a framework for embedding scaled caseworker support. Third, delivery vehicles capable of supporting scaled provision are emerging, including the national rollout of WorkWell led through ICBs and ongoing industry exploration into mechanisms to extend GIP reach into the SME market. The policy question is therefore less about whether a system can be built from scratch and more about how components currently in development can be aligned, strengthened and integrated. The remainder of this chapter sets out what that process should look like in practice.

6.2. What effective early-intervention caseworker-led support looks like

This section sets out a design brief for effective early-intervention caseworker-led support, drawing on the evidence review and interview findings. It presents the core components of an effective offer, using illustrative user journeys to explore how these might play out in practice.

6.2.1. Core components of an effective offer

The evidence review and interviews converge on six core components that distinguish effective early-intervention caseworker-led support from less effective provision. These apply across settings, target populations and funding models:

1. **Early engagement, ideally measured in days, not weeks**: a strong predictor of successful case management across the evidence base is the speed with which support begins after a health problem emerges. Very-early-intervention models that assign employees with health issues a caseworker while they are still actively working (IES 2023b; Lerner et al. 2015; Wynne-Jones et al. 2018) or on or before their tenth day of absence (Brown et al. 2015; Skisak et al. 2006) show relatively strong evidence of effectiveness and economic benefits. By contrast, intervening later (after workers have been on sick leave for at least a month) is less likely to be effective (Vogel et al. 2017).
2. **A biopsychosocial, work-focused approach:** effective caseworker-led support addresses health, psychological and work factors together as 'interlinked systems' rather than treating them separately or sequentially (Shaw et al. 2024; Vilsteren et al. 2015; Waddell et al. 2008). Interviewees consistently emphasised that coordination with workplace accommodations is what distinguishes this provision from general healthcare or general employment support: the caseworker's job is to help the person stay in or return to sustainable work, not only to treat symptoms or find any job.[55]

[55] SI1; SI3; SI9.

3. **A skilled caseworker and manageable caseloads**: the caseworker-client relationship is the active ingredient in the model (Batty et al. 2022; Kantar Public et al. 2024). Interviewees across provider types described trust, continuity and the caseworker's ability to advocate for the client with employers, clinicians and benefits systems as central to outcomes.[56] Caseload size also matters, as effective intensive support requires manageable caseloads. For instance, fidelity benchmarks in IPS models indicate that optimal delivery is achieved with average caseloads below 15 clients per specialist, while caseloads above 41 substantially reduce the quality of employer engagement, follow-up and personalised support (IES 2023b). Higher caseloads risk reducing the model to mere signposting.
4. **Active employer liaison as a core function, not an optional extra**: effective models engage actively with the employer (via the line manager, HR or occupational health where present) to negotiate adjustments, phased returns and sustainable role changes (DWP & DHSC 2026b; Hanson et al. 2006; IES 2023b; Soler-Font et al. 2021). Interviewees were unanimous that this is one of the most skilled and time-consuming parts of the caseworker role, and one of the features most often missing from provision focused exclusively on the individual.[57] The Dutch system's explicit employer obligations create a structural requirement for this liaison (Høgelund & Holm 2006).[58]
5. **Follow-up beyond initial RTW:** sustainable RTW requires follow-up after the person is back at work and until achievement of a 'satisfactory outcome', not case closure at the point of return (Hanson et al. 2006). Provider interviewees and workshop participants stressed the importance of continued follow-up to prevent relapse and churn. However, some of them described follow-up as underfunded and often the first thing dropped under caseload pressure.[59]
6. **Tiered intensity proportionate to need**: not all workers on sick leave need intensive caseworker support. Efficient systems stratify by complexity, offering lighter-touch digital, telephone or group-based support for people with less complex needs and reserving intensive face-to-face appointments and workplace visits for those with complex or comorbid presentations (Brown et al. 2015; Sowden et al. 2019; Waddell et al. 2008). Another efficient option is providing targeted support, with caseworkers focusing on workers whose circumstances suggest they are most likely to benefit, such as those with comorbid MSK and MH conditions (Bergman et al. 2022; Nicholas et al. 2020). While some evidence suggests that outcomes may be better where participants are motivated to engage (Kantar Public et al. 2024; Oostrom et al. 2010), this does not imply that support should be restricted only to those who are easiest to engage. Rather, the core principle is to match the support's form and intensity to the individual's needs, circumstances and likely barriers to staying in or returning to work, meaning support is both equitable and more likely to achieve the best outcomes

[56] SI3; SI5; SI10.

[57] SI1; SI3; SI9; SI10; SI11.

[58] SI6.

[59] SI3; SI9.

6.2.2. What this looks like in practice: illustrative user journeys

The following three vignettes illustrate how the core components of effective support might play out across different contexts.[60] The three journeys illustrate the same six core components playing out in various ways: different entry routes (public referral, employer/insurer referral, GP referral), intensities (light-touch to intensive multi-disciplinary) and durations (weeks to months). What remains constant are early contact, a biopsychosocial work-focused approach, a skilled caseworker with an active employer liaison role and rapid access to treatment and follow-up beyond the initial RTW.

Box 3. User journey 1: Sarah – warehouse worker at a small logistics firm with acute back injury

Sarah is 47, works as a picker-packer for a 25-person logistics firm and lifts heavy items throughout her shift. She injures her back one Monday morning, and her GP signs her off for two weeks. Her employer has no occupational health provision and no GIP policy. Sarah's GP flags her as at risk of prolonged absence and refers her into a publicly funded caseworker service within the first week.

A caseworker contacts Sarah within three days, takes a biopsychosocial assessment and arranges rapid-access physiotherapy starting the following week. With Sarah's consent, the caseworker also contacts Sarah's line manager to discuss adjustments: a phased return on lighter duties and avoiding sustained lifting for four weeks. Sarah returns to work on reduced duties at week three and resumes full duties at week seven. The caseworker follows up at one and three months post-return; at the three-month follow-up, Sarah reports occasional stiffness but is managing, and the case is closed.

Box 4: User journey 2: Priya – office worker at a large employer who develops anxiety and depression

Priya is 34, works in a finance team at a 3,000-person company and has been struggling with low mood and sleep problems for several months while still at work. Her employer has a GIP policy with an early intervention pathway available before absence has occurred. Priya's line manager, who has received MH-awareness training, notices changes in her performance and has a supportive conversation. With Priya's consent, Priya's line manager refers her to the insurer's early-intervention service.

A vocational rehabilitation caseworker contacts Priya within two days, assesses her presenting issues and arranges a course of CBT starting the following week. The caseworker also works with Priya and her line manager to agree temporary adjustments: a reduced caseload, flexible start times and a fortnightly check-in, without Priya needing to take formal sick leave. Over eight weeks, Priya's symptoms improve; the adjustments are gradually stepped down. The caseworker follows up at three and six months.

[60] These user journeys are illustrative composites synthesised from provider accounts and published programme evaluations; they are not drawn from primary research with service users, which was outside the scope of this study. The names are fictional, with the details drawn from typical cases described by interviewees and evaluation case studies.

Box 5: User journey 3: Gareth – care worker with long-term MSK and MH comorbidity

Gareth is 56, has worked as a care worker for fifteen years and has chronic lower back pain compounded by caring responsibilities at home and increasing anxiety. He has had several short absences over the past year and is now signed off for six weeks. His employer, a mid-sized care provider, has no OH or GIP provision and instead refers Gareth to a publicly funded specialist caseworker service.

An initial caseworker assessment identifies physical, psychological and social factors, and a multi-disciplinary plan is agreed: physiotherapy, a short course of psychological therapy and benefits advice to address financial stress. The caseworker liaises with Gareth's employer over several weeks to negotiate a phased return on modified duties (day shifts only, no single-handed transfers) and to identify longer-term redeployment options within the organisation. RTW takes three months and is not linear; the caseworker re-engages twice when setbacks occur. Follow-up continues for six months after sustained return.

6.3. Who should deliver what: the roles of public services, employers and insurers

The architecture set out in Section 6.2 is unlikely to be delivered by any single actor. Effective early-intervention caseworker support requires engagement from several actors, including the public system, employers, employees and, where relevant, insurers, voluntary-sector organisations and community-based services. Each actor must make a distinct contribution at different points from the emerging health concern to sustained RTW. The current landscape is fragmented, characterised by uneven coverage, inconsistent standards, weak referral routes and people whose needs are not picked up by any single service.[61] A coherent system requires clarity on who does what and how different parts of the system connect, refer and share accountability.

Together with the current state of provision, international comparators and consultation with stakeholders, the evidence reviewed for this study points to a model in which public services provide the central gateway to a national, integrated work-and-health system in which a) employers carry primary responsibility for prevention, early identification and supported return for their own workforce and b) insurers extend specialist vocational rehabilitation capacity to those covered by GIP and analogous products.[62] Each actor has a primary role, but each also plays supporting roles at other stages of the pathway. Table 7 summarises this division.

[61] SI4; SI5; SI9; SI10; SI11; SI12.

[62] Note that individuals also play a key role in supporting their health and determining their employment trajectories. However, this study study focused on other stakeholders' roles.

Table 7. Division of roles across the early-intervention pathway

Stage	Main role	Supporting role
Prevention and early identification (before or at onset)	Employer: supportive management culture, line manager capability, early conversations.	Primary care: opportunistic identification. Insurers: pre-absence and stay-at-work pathways, where covered. Voluntary and community organisations: well-being, advice and community-based support.
Early intervention (first days to weeks)	Employer (where OH/GIP available). Publicly-funded caseworker service (WorkWell, local specialist provision).	Primary care: referral and clinical input. Insurers: GIP-funded caseworkers for insured population.
Active RTW (weeks to months)	Caseworker (insurer-funded, publicly-funded or employer-funded depending on route).	Employer: adjustments, phased return. Primary care: clinical continuity. Voluntary and community organisations: complementary support where relevant (e.g. debt, housing or well-being support).
Sustained return and follow-up (3–6 months post-RTW)	Caseworker: structured follow-up. Employer: ongoing adjustments review.	Primary care: flare-up management

Source: RAND Europe.

6.3.1. The role of the public sector and health system

Publicly led provision forms a core pillar of the system and a central gateway through which the working-age population accesses early-intervention support. In this context, the role of the public health system is not to deliver every element of support itself, but to provide the infrastructure through which support can be accessed, coordinated and quality-assured. Public services have the greatest potential to provide the reach, legitimacy and accountability needed to set national standards, coordinate provision across settings and guarantee access to support for the entire working-age population. The latter includes those whose employers do not provide OH or equivalent services, the self-employed, people working in SMEs, people who are out of work and seeking to return and people whose health needs exceed what their employer or insurer can reasonably provide.

Therefore, the public role is foundational rather than residual, with three interlocking functions:

- Standard-setter: the public system defines what good early-intervention support looks like, setting expectations for providers, overseeing or supporting accreditation arrangements and ensuring that provision delivered through any route (public, employer-funded or insurer-funded) meets a minimum specification grounded in evidence.
- System coordination: the system provides the referral architecture connecting primary care, employment support, vocational rehabilitation, and specialist clinical pathways, ensuring people do not have to navigate the system alone.

- First and last resort: public services ensure universal coverage for the working-age population, especially those without alternative access through employment-based or insurance-based arrangements.

These functions do not mean that we should understand all elements of support (including the caseworker role) as exclusively public. Depending on the nature of the need, the most appropriate support may be most appropriately provided through different routes. Some elements may sit naturally within public provision while others may be better delivered by employers, insurers, voluntary-sector organisations or community-based services. For example, debt advice, housing support or community-based well-being support might be most effectively delivered through voluntary or local community organisations. In contrast, workplace adjustments, management support and some rehabilitation inputs may be better funded or delivered through employers or insurers (where these routes exist). Therefore, the public system's distinctive role is less about exclusive delivery of support than about responsibility for ensuring that support is available, connected, and of sufficient quality across the whole system.

In practice, this points towards a system in which national and local public roles are complementary. National structures are best placed to set expectations, define minimum standards, support accreditation and provide overall coordination and accountability. Local systems are better placed to organise delivery, build referral relationships, integrate with existing services and tailor support to local population needs, employer landscapes and service ecosystems.

The emerging architecture of public early-intervention provision in the UK includes WorkWell and devolved provision such as the Working Health Services Scotland (WHSS) model delivered in Scotland and RCS in Wales. It is supplemented by programmes that offer support with both finding and staying in work, such as the NHS Talking Therapies programme (including its employment-advisory function), IPS for severe mental illness and IPS-AD for addiction. Several stakeholders also noted the value of local and regionally embedded models, which combine local knowledge, existing relationships with employers and primary care and the capacity to integrate across silos.[63] Together, this points towards a model that delivers support locally but within a clearer national framework of roles, standards and best practice. The *Keep Britain Working Review*'s proposals for a Workplace Health Provision framework and the creation of the Workplace Health Intelligence Unit (WHIU) can help formalise this standard-setting and coordinating role at national level (DWP & DBT 2026a).

6.3.2. The role of primary care

Primary care serves as the initial point of contact for many individuals experiencing health problems that affect their ability to work. It plays a critical role in identifying needs, initiating work-focused discussions, and referring individuals to appropriate support services.[64] Interviewees were clear that GPs should not

[63] SI5; SI8.

[64] Although primary care is part of the broader public service landscape, it is considered separately in this context due to its more specific role within the system.

become caseworkers, as they have neither the time, the vocational training nor the employer-facing capability to provide structured casework-led support.[65]

Primary care has an essential role in:

- Identifying people at risk of prolonged absence or job loss, including through work-focused conversations during routine consultations and, where relevant, utilising the fit note to facilitate conversations about work and recovery rather than solely as a certification tool.
- Referring and signposting people into appropriate caseworker-led services, such as WorkWell, local specialist provision and relevant insurer pathways.
- Providing clinical continuity during and after RTW, including managing medication, flare-ups and comorbidities.

This role is also likely to evolve as government reforms to the fit note system develop. In May 2026, DWP and DHSC announced four pilots at selected WorkWell sites to test alternatives to the current fit-note process, which was deemed not to be working as intended for patients, employers or clinicians (DWP & DHSC 2026a). The pilots will trial different models, including approaches in which GPs issue an initial fit note before referring people into a separate support service, and approaches that refer patients directly to a work-and-health support service without issuing a fit note.

The SWAP model illustrates one route for embedding work-focused support close to primary care without requiring GPs to take on the caseworker role themselves (Sowden et al. 2019; Wynne-Jones et al. 2018). More broadly, the evidence reviewed for this study points to the value of place-based early intervention support: provision organised around a defined locality that draws together primary care, community services, employment support and voluntary-sector resources to provide accessible, joined-up help. Co-location within GP practices is one expression of this, but it is difficult to achieve at scale given limited facility space. The neighbourhood health model offers an opportunity to embed work-focused support in community settings beyond the GP surgery, e.g. through accessible local venues such as community centres and libraries. Social prescribing link workers and other non-clinical roles, increasingly able to operate remotely, can complement this by providing one-to-one guidance and connecting people to community services, including caseworker support, through telephone or digital channels.

6.3.3. The role of employers

Employers are positioned to provide the first line of early intervention for their own workforce. Most people who develop a health problem that affects their capacity to work first disclose it, formally or informally, to their line manager or HR. The earliest and often most influential responses to emerging health concerns may therefore happen within the workplace, before absence begins or in its first days.[66]

Based on our evidence review, interviews and workshop discussion, an effective employer role should comprise five elements:

[65] SI2; SI3; SI9; workshop discussion.

[66] SI1; SI3; SI6.

- A statutory duty of care to their workforce, including a safe and supportive working environment, reasonable adjustments and active management of work-related health risks, applied proportionately to organisational size and context.
- A clear sickness management policy and process, with defined steps for supporting people struggling at work or recently absent.
- Line managers trained and supported to have early, supportive conversations about health and work, identify risk early and negotiate adjustments.
- Access to occupational health or equivalent clinical advice, whether in-house, through GIP or through commissioned external provision.
- A duty to engage actively in RTW planning, including agreeing adjustments, phased returns and, where necessary, redeployment.

Participants consulted repeatedly emphasised that employer maturity of practice varies enormously and is not a simple function of size.[67] Some large employers have limited internal capability, while some small employers manage health and work well. Policy and support should therefore be calibrated to maturity rather than just size.

6.3.4. The role of insurers

While GIP insurers and analogous providers currently fund some of the most intensive and earliest-intervening vocational rehabilitation in the UK, they reach only around 10% of the workforce, concentrated in large employers.[68] The evidence suggests that the insurer role should have the following main components:

- Early-intervention clinical and vocational rehabilitation for insured populations, triggered on absence notification or, increasingly, pre-absence.
- Case management for longer-term claims, with sustained engagement through complex RTW trajectories.

There is also growing interest in whether pooled arrangements could extend insurer-funded early intervention to employers below current underwriting thresholds. However, this remains at an exploratory stage, and interviewees flagged significant feasibility issues around underwriting, pricing and product design.

Therefore, the insurer role is best understood as extending specialist vocational rehabilitation capacity into the employer-funded part of the system, complementing public provision and expanding access to certain forms of support for covered populations. The public system's standards, accreditation and coordination functions apply equally to insurer-funded provision: the evidence-based components should be expected of any provider, regardless of funding route.

[67] SI1; SI3; SI10; workshop discussion.

[68] SI1; SI11.

6.3.5. Key policy choices and trade-offs

The evidence reviewed for this study does not point to a single blueprint for organising early-intervention caseworker support. Rather, it highlights a set of higher-level policy choices and trade-offs that policymakers will need to navigate, as outlined below:

- First, there is the question of how to balance public, employer-funded and insurer-funded provision. Public services are best placed to provide national coordination, standard-setting and access for those not otherwise covered. At the same time, employer and insurer provision can extend reach and specialist capacity for some groups, but risks uneven access if relied on too heavily.
- Second, there is a trade-off between national consistency and local flexibility: clearer national frameworks and minimum standards are needed to reduce fragmentation, but rigid uniformity would risk undermining responsiveness to local conditions and existing service ecosystems.
- Third, there is the question of employer and employee engagement. Employers are a critical route for early action, but their capacity is uneven, and improvement depends on aligning stronger expectations with practical support, particularly for SMEs. At the same time, employees need accessible and credible routes into support that do not depend solely on formal absence or GP contact.
- Fourth, there is the question of how to design funding and incentive mechanisms that encourage earlier intervention and wider access without generating excessive deadweight, duplication, or inequity.

Across these issues, the evidence suggests that the most effective approach is unlikely to lie at either extreme. Instead, it points towards a mixed system where a) public services play a coordinating and standard-setting role, b) employers, insurers, voluntary-sector organisations and other actors contribute through different routes, c) national frameworks provide coherence and minimum standards, and d) local systems retain flexibility over delivery. A central challenge for policymakers, therefore, is not just how to balance these roles but how to define them clearly, build cross-system acceptance of them, and ensure they cohere in practice.

6.4. Scaling effective support across the UK: challenges and how to overcome them

The components and role divisions set out in Sections 6.2 and 6.3 describe the design of an effective early-intervention caseworker system. The challenge is to deliver them at scale across a fragmented landscape, an uneven employer base, a stretched public-sector workforce and a funding environment that has struggled to sustain effective models beyond the pilot stage. This section examines four interlocking challenges to scaling: access and referral routes; workforce capacity and professionalisation; system coherence, monitoring and evaluation; and funding stability and incentive design.

6.4.1. Access and referral routes

The strongest evidence on what makes early-intervention support effective concerns timing: engagement is most effective before health-related work difficulties become entrenched and sickness absence becomes prolonged (Vargas-Prada et al. 2016; Waddell et al. 2008). RTW rates fall sharply with length of inactivity, from 94% for those out of work less than a month to 49% for those out of work for over a year (DWP & DBT 2025). However, current arrangements often intervene late across the UK, with difficult-to-navigate referral routes that depend on prolonged sickness absence, receipt of a fit note, benefit claims or the availability of a clinical or employer gatekeeper. As a result, many of those most likely to benefit from early support do not encounter the system in time, particularly those still in work but at risk of leaving.

The evidence points to the following practical responses:

- Make early, light-touch engagement the default first response, explicitly offering support during early sickness absence or when work-related risk is first identified rather than waiting until prolonged absence or exit. The evidence shows that brief check-ins, telephone contact and structured early conversations are effective and cost-efficient, with intensity being stepped up only where need is identified.
- Strengthen and normalise multiple access routes, including self-referral, employer referral, primary care referral and Jobcentre referral, alongside referral from specialist clinical services. Reliance on a single gatekeeper concentrates risk and produces person-dependent access, whereas systems with multiple complementary entry points achieve broader, more equitable reach.
- Promote local 'no wrong door' approaches, with clear signposting and navigation support built into caseworker roles – recognising that early access depends not only on timing and individual behaviour, but on the ability to help individuals move quickly and coherently across fragmented systems.
- Combine open access with more proactive approaches to identifying cohorts likely to benefit from early support, particularly among people still in work who are experiencing emerging health-related work difficulties. Targeting should be used to prioritise outreach and follow-up, not to restrict access. Emerging practice in some areas illustrates how this might be operationalised. For example, some systems use Fit Note receipt as a pragmatic proxy to identify individuals who might benefit from WorkWell-type support, while exploring whether broader indicators (such as work-limiting MSK or MH conditions) could support even earlier identification and engagement in the future.
- Develop digital self-help resources to complement caseworker-led support, particularly at the early, low-complexity end of the pathway. People with emerging health-related work difficulties who do not need structured caseworker input might still benefit from accessible information, signposting to local services and prompts to initiate conversations with line managers, HR or primary care. A centrally designed, quality-assured digital offer, signposted at points of natural contact with the system (for example, at fit-note receipt or at the end of the self-certification

period at day seven), could provide a universal early touchpoint that does not depend on caseworker capacity.

6.4.2. Workforce capacity and professionalisation

The effectiveness of caseworker-led support depends not only on what is offered but on who delivers it and under what conditions. Across the evidence reviewed, the quality of outcomes was consistently linked to manageable caseloads, continuity of relationship, clear role definition, structured supervision and the professional competence required to support sustainable RTW (Shaw et al. 2024). Interview evidence and the workshop appraisal reinforced this picture, with workforce-focused actions among the most strongly supported components across feasibility, acceptability, scalability and sustainability criteria.

While there is no shortage of workers with relevant skills, the current UK caseworker workforce and the wider pool of workers with related skills and roles from which it draws are fragmented, with many such workers tied up in other (critical) roles. Caseload expectations vary substantially across services, with no agreed national framework for the competencies, ethical standards or escalation routes that should govern the role. Moreover, work-and-health casework is not yet professionalised, with no clear pathways into casework, and provision of continuing professional development is provider-dependent.

Scaling effective provision will require sustained investment in workforce capacity and professionalisation. The practical priorities suggested by the evidence are:

- A national work-and-health caseworker capability framework defining core competencies, role boundaries, escalation routes and ethical standards while remaining flexible enough to accommodate different role profiles and delivery settings. This framework should focus on capabilities rather than protected titles, reflecting the diversity of entry routes into the workforce. It should support movement across settings while equipping practitioners for the specific context in which they work. Light-touch accreditation or recognised qualifications, building on existing professional registration routes where relevant, could support comparability across programmes and funding routes and reinforce the standard-setting role of public services described in Section 6.3.
- Investment in ongoing professional development, keyed to the capability framework, including training in building caseworker-client relationships, workplace adaptations, employer engagement and system navigation, alongside structured opportunities for supervision and peer learning to manage emotional load and judgement-based work.
- Support for communities of practice and peer-to-peer learning across programmes and sectors, recognising that much expertise in work-and-health casework is currently tacit and unevenly distributed and that caseworker effectiveness relies on judgement, reflection and shared learning as much as formal training. High turnover and poor retention undermine the development and transmission of this tacit expertise, as well as the quality of support.
- Funded transition and conversion pathways into caseworker roles from adjacent professions with scalable labour pools (e.g. employment advisers, social care and community roles, HR and coordination roles), building on existing skill sets rather than relying solely on new roles. This

should be supported by targeted training in health-related job retention, employer engagement and RTW planning.

- Explicit expectations for caseload size and supervision, drawing on evidence from established models such as IPS and recognising these as quality safeguards rather than discretionary management choices. These expectations should be embedded in commissioning and contract management rather than left to provider judgment.
- Multidisciplinary team models that give non-clinical caseworkers timely access to clinical advice and supervision rather than requiring all caseworkers to hold clinical qualifications. This point reflects evidence that effective support depends on access to expertise, not on over-medicalising the role.
- Improvements to the system-level visibility of the workforce, including mapping roles, skills and capacity across programmes, to support workforce planning, commissioning decisions and sustainable scale-up.

6.4.3. System coherence, monitoring and evaluation

As discussed in Section 6.3.5, a central policy trade-off is between national coherence and local flexibility, alongside the need to avoid fragmentation across different delivery models and funding routes. In practice, system fragmentation is a clear constraint on the effectiveness and scalability of early-intervention caseworker support, potentially leading to duplication of effort and individuals falling between services. The goal is therefore to produce a single, coherent framework of caseworker-led support that allows flexible implementation across different contexts while avoiding a difficult-to-navigate patchwork of provision or the development of a two-tier system (for instance, where private provision is higher quality than public).

Section 6.3 sets out a division of roles in which public services act as the standard-setter and central coordinator of the system. Realising this in practice requires four mutually reinforcing actions:

- Develop a clear and consistent national narrative that positions work retention and RTW as shared system outcomes, cutting across health, employment, employer and insurance policy domains. The priority should be on establishing a clear national framework of roles, core functions and minimum standards, while allowing flexibility in how these are implemented.
- Clarify roles, responsibilities and hand-offs across the sickness absence and RTW pathway, supported by national guidance or codes of practice rather than new statutory duties. Reducing ambiguity about who is expected to act, when and how would address one of the most persistent sources of friction in current provision.
- Encourage greater coherence in the way services are commissioned, arranged and governed across publicly delivered and insurer-delivered services, including aligned or joint arrangements where services span health, employment support and workplace intervention. This should prioritise reducing duplication and fragmentation while preserving local flexibility, which the evidence suggests is important for trust, accountability and responsiveness.

- Embed monitoring and evaluation into programme design from the outset, with realistic timelines and outcome frameworks that reflect the evidence base. Evaluation should assess not only effectiveness but delivery feasibility, resource use, workforce implications and equity of access. The wider point is that the current evidence base, although substantial, contains significant gaps on questions of greatest practical relevance to commissioners and policymakers, including how early is 'early enough', what level of light-touch support is sufficient, and which combinations of components work best for different groups. A coordinated approach to evaluation, with comparable outcome measures across services, would substantially strengthen the evidence base for future commissioning decisions.

6.4.4. Funding stability and incentive design

Funding arrangements and incentive structures are highly linked to model sustainability. The evidence reviewed for this study repeatedly identifies funding instability, short-termism, and fragmentation as principal reasons why effective models have struggled to scale or sustain their effects beyond the pilot stage. Fixed-term funding cycles can undermine workforce stability, limit investment in training and partnerships, and encourage cautious delivery models that prioritise short-term output over sustained outcomes.

Funding stability is an identified problem across all parts of the current system, although its sources and implications differ between publicly-, employer- and insurer-funded provision. While the evidence reviewed for this study does not point to a single preferred balance between these routes, it does provide a basis for differentiated roles for public services, employers and insurers within a coherent system. The practical priorities for funding and incentive design follow from the functions that such a system should perform: securing stable funding for those functions, regardless of the wider configuration of funding routes, and ensuring that provision delivered through public, employer or insurer routes meets the evidence-based standards set out in Section 6.3.

Incentives across the system are also frequently misaligned. The costs of intervention often fall on one actor while the benefits accrue elsewhere or happen over a different time horizon. This issue is particularly relevant for employers, especially SMEs, who may face short-term costs in supporting retention and RTW while not necessarily bearing the full long-term consequences if a worker becomes economically inactive. Stakeholders emphasised that financial incentives and private-sector mechanisms can play a useful role, but require careful design, conditionality and testing to avoid deadweight effects and widening inequalities between large employers and SMEs.

The evidence points to the following practical responses:

- Stable centralised funding is required for the functions that hold the system together, including standard-setting, coordination, workforce development, monitoring and provision for those not reached by employer or insurer routes. The current pattern of short-cycle, pilot-based commissioning is poorly suited to caseworker-led support given the relational and workforce-intensive nature of the work and the time required to build local partnerships, develop the workforce and accumulate tacit expertise. Longer funding horizons would support workforce retention, partnership development, and service learning, and reduce the inefficiencies associated

with repeated start-ups and wind-downs. The neighbourhood health approach proposed under the NHS 10-Year Plan offers one route to consolidating health and employment funding at the local level to support these functions.

- Funding and performance frameworks should align with prevention, job retention and sustained outcomes, rather than relying solely on short-term or binary return-to-work measures. Outcome frameworks should reflect different client journeys and starting points. For individuals on sickness absence, time to return and the sustainability of return are appropriate; for individuals still in work but struggling, measures of work functioning, retention, and the prevention of absence are likely to be more meaningful. Frameworks should be designed to minimise incentives for 'cherry-picking' easier cases and to encourage support for those with more complex needs.
- Economic evidence should be used to prioritise funding for early, light-touch and targeted interventions, recognising that several such models (e.g. SWAP, EASY, IPS-Lite, and the model discussed in Lerner et al. 2015) demonstrate positive benefit-cost ratios, even where impacts on single outcomes are modest. Funding decisions should recognise that many economic evaluations likely underestimate benefits by excluding health and well-being gains.
- Simplified and scaled support mechanisms are needed for SMEs, particularly for access to occupational health, caseworker support or vocational rehabilitation services, recognising that SMEs face higher relative risks from sickness absence and have more limited capacity to absorb costs or navigate complex systems. Such mechanisms could include enabling SMEs to access the same broad forms of support as larger employers through lower-cost pooled approaches that achieve economies of scale and may be government-backed, regulated or nationally coordinated. The pooled and simplified products discussed in Section 6.3.4 are one route; targeted public provision aimed specifically at the SME workforce is another.
- Employer-facing incentives should be carefully designed and conditional, linking any financial benefits (e.g. subsidies, tax reliefs, and statutory sick pay reimbursements) to demonstrable engagement with early intervention and RTW processes rather than to passive participation. International comparators offer relevant reference points. For example, the Netherlands gatekeeper protocol shows the use of structured obligations on employers to operationalise conditional engagement, and the Australian workers' compensation model illustrates how financial risk allocation can drive employer investment in early intervention. Although both are embedded in welfare and labour-market arrangements that differ from the UK and are not directly transferable, they indicate the range of design options available.
- Wider rollout should be preceded by piloting and evaluation of new funding and incentive mechanisms, including outcome frameworks, pooled insurance arrangements and employer incentives. Pilots should assess effectiveness, value for money, distributional impacts, workforce implications and unintended consequences. Funding and incentive arrangements should be reformed alongside the national expectations and guidance discussed in Section 6.4.3 to reduce uncertainty for providers and employers and support consistent implementation across diverse local systems.

6.5. Next steps

This section distils this chapter's analysis into practical next steps for four audiences: national policymakers, employers, insurers, and researchers/evaluators. Given the current state of provision and the roles different actors currently play, these suggested actions highlight what could realistically be pursued over different time horizons to strengthen provision, improve coherence and build capacity. In some areas, the evidence points more clearly to priority actions; in others, it leans towards a range of plausible options with different trade-offs, rather than a single preferred approach.

6.5.1. Next steps for policymakers

In the short term (first 12 months):

1. Work towards a national core specification for WorkWell that aligns with the six evidence-based core components outlined in Section 6.2.1, alongside a clear timeline for national coverage.
2. Support one or two vanguard sites to test the integrated model of early-intervention caseworker-led support outlined in this report, drawing together the core components, the division of roles and the scaling enablers within a single coherent local system. Candidate areas should be selected based on existing infrastructure, partnership maturity and prior experience of work-and-health programmes. From the outset, vanguard sites should be supported by independent evaluation aligned with the proposed Workplace Health Intelligence Unit to generate evidence informing wider national rollout.
3. Develop a national capability framework and supervision standards for work-and-health caseworkers, working with organisations such as the Institute of Employability Professionals and provider representatives, as part of broader efforts to support the professionalisation of work-and-health casework. Any such framework should align with the Healthy Working Lifecycle standard currently under development in light of the *Keep Britain Working Review,* and complement existing professional standards and accreditation schemes such as the Safe Effective Quality Occupational Health Service (SEQOHS).
4. Consider issuing statutory guidance or equivalent national guidance on employer sickness management and RTW planning with proportionate expectations by organisation size, organisational context and maturity. This approach should align with fit-note reform and the wider standards architecture emerging from the *Keep Britain Working Review*. This approach could be supported by short, easy-to-use tools and practical guides for organisations of different sizes, especially SMEs.
5. Develop a structured feasibility programme on pooled approaches to extending access to work-and-health support for SMEs, including but not limited to GIP-like models, working with the Association of British Insurers (ABI), insurers and other relevant stakeholders to explore potential models, delivery mechanisms and trade-offs.

6. Explore how employer incentives could support investment in workforce health within a future system, including assessing the potential effectiveness of different mechanisms, such as insurer-funded healthcare or other approaches – particularly for SMEs.
7. Build on the fit-note reform already underway, working with primary care representatives, the relevant Royal Colleges and the wider health system to test and refine different approaches that better support work-focused conversations and appropriate support routes.

In the medium term (years 1–3):

8. Work towards national rollout of WorkWell to an agreed core specification, with employer liaison and follow-up considered as core functions, building on evidence generated through Vanguard sites and aligned with the Healthy Working Lifecycle framework.
9. Transition towards longer-term and more sustainable funding arrangements for caseworker support where possible, including through wider health and work reforms such as those proposed in the NHS 10-year plan.
10. Build on the current government-funded line manager training for SMEs by evaluating its take-up, implementation and effects, including barriers to participation, and, if evidence of benefit emerges, considering how it could be refined and scaled.[69]
11. Explore outcome-linked incentives for employer health-and-work provision through piloting and evaluation.
12. Explore undergraduate and postgraduate training pathways and national standards for work-and-health caseworkers to help practitioners bridge the clinical-vocational divide and provide a more sustainable basis for workforce development.

In the long term (5–10 years):

13. Promote greater integration of existing provision (such as WorkWell, IPS for severe mental illness and addiction, local and devolved provision) within a more coherent work-and-health system, with clearer referral routes from primary care, Jobcentres and other relevant entry points.

6.5.2. Next steps for employers

In the short term (first 12 months):

1. Work towards securing senior management commitment to workforce health and retention as a strategic priority, recognising that this sets the tone for a supportive culture and can enable investment in workplace modifications and access to support.
2. Establish or update sickness management and RTW policies that are proportionate to organisations' size and maturity, and aligned with emerging codes of practice and the Healthy

[69] In December 2025, DWP announced government-funded occupational health training for 5,000 line managers in SMEs across England (DWP 2025a).

Working Lifecycle standard under development via the *Keep Britain Working Review*. These policies should address early communication, workplace adjustments, phased returns and follow-up, and include 'day one' or early contact protocols supported by a system of regular, sensitive engagement with absent employees.

3. Where not already implemented, begin collecting and reviewing basic management information on workforce health, presenteeism, and sickness absence. This includes tracking absence patterns, workplace adjustments and time to RTW. Such data collection enables a clearer understanding and management of support needs, risks and the effectiveness of employer responses over time.
4. Engage actively with caseworker services, whether insurer-funded, employer-funded or publicly funded, when planning adjustments and RTW. Review whether internal HR and line-management processes are configured to receive and act on caseworker recommendations.
5. Review dismissal and capability procedures to avoid prematurely dismissing workers on long-term sickness absence, ensure that reasonable adjustments and job redesign options have been fully considered, and seek independent caseworker input before decisions to dismiss within the first year of absence.

In the medium term (years 1–3):

6. Engage with sector bodies, trade associations and emerging Workplace Health Provision arrangements to stay abreast of developing standards, codes of practice and shared resources and to contribute employer perspectives to their development. This engagement will likely be the most efficient route to accessing tools and guidance proportionate to their size, particularly for SMEs.
7. Build health-and-work capability into existing line manager training and integrate it into core people-management processes (e.g. regular check-ins and one-to-ones), expecting and equipping managers to proactively raise health and well-being early. Draw on resources developed through sector codes of practice and the Workplace Health Intelligence Unit as these become available.
8. Develop more integrated data and information management systems that allow employers to analyse reasons for absence, workplace adjustments and the effectiveness of RTW interventions, thereby supporting continuous improvement. Monitoring should extend beyond the initial RTW.
9. Where feasible, at no later than six weeks, introduce more formal RTW planning co-produced between the worker and manager for absences likely to extend beyond two weeks. These plans could include specific goals, time-limited modifications to duties/hours and fixed review dates.
10. Review whether current job design, working arrangements and line-management practices are helping to create a more health-supportive workplace, particularly for workers with fluctuating or long-term health conditions, and use this to inform adjustments, phased returns and engagement with caseworker support where relevant.

11. Review OH and GIP coverage against the six core components set out in Section 6.2.1 and, where gaps exist, consider how to address these through procurement or, for SMEs, through emerging pooled arrangements as they become available.
12. Involve employees and worker representatives in designing and evaluating health-and-work policies to promote transparency, build trust and reflect the experience of those the policies aim to support.

In the long term (5–10 years):

13. For SMEs in particular, utilise both public and insurance-based available architecture to build stronger connections with local gateways or specialist providers. This approach enhances their capacity to navigate the system and access the expertise and resources that larger firms may be better placed to manage in-house.
14. Work with OH professionals and researchers to test and learn from different support models, helping build the evidence base on effectiveness and return on investment.

6.5.3. Next steps for insurers

In the short term (first 12 months):

1. Consider offering pre-absence early intervention pathways more routinely within GIP products, incorporating clear triggers and defined routes for employer and employee access. The primary objective is to implement stay-at-work interventions that commence as soon as a health concern is reported, rather than delaying action until an absence occurs.
2. Evaluate the potential for strengthening earlier notification triggers from employers to insurers in contexts where GIP is implemented, recognising that early interventions are generally the most effective, yet current notification practices differ significantly among policyholders.
3. Work with employer customers to embed GIP-funded early intervention more fully within their internal systems, processes and policies, including absence management practices and software, sickness absence policies, line manager guidance and HR escalation routes. The aim is to establish insurer-funded support as a more routine part of the employer response to emerging health concerns and early absence, thereby reducing reliance on individual awareness or discretion.

In the medium term (years 1–3):

4. Continue exploring collaborative options for extending access to GIP-like support for SMEs with the ABI, government and other relevant stakeholders while recognising the underwriting, pricing and delivery complexities involved.
5. Clarify how insurer-funded provision should link with publicly funded support, particularly in transition points where people move between systems, to preserve the continuity of the caseworker relationship and minimise avoidable gaps in provision.

In the long term (5–10 years):

6. Contribute, where feasible, to shared or centrally organised efforts to improve data and evidence on the effectiveness of work-and-health interventions, including through organisations such as the ABI, the proposed WHIU (Department for Work and Pensions and Department for Business and Trade 2025) and/or equivalent initiatives. Anonymised insurer outcome data could make a useful contribution to strengthening the wider evidence base.

6.5.4. Next steps for researchers and evaluators

Several important evidence gaps emerged from this study. Addressing them would provide a stronger foundation for future policy development and practice, as outlined below:

1. Prioritise evaluating WorkWell at scale, including outcomes beyond initial RTW, effects on retention and cost-effectiveness. The evaluation should synthesise findings from the WorkWell pilots and the national WorkWell evaluation to inform future decision making.
2. Conduct primary research with UK clients and caseworker services on their experience of caseworker-led support, as this was outside this study's scope and would strengthen the evidence base on what works for whom. Such research could help test the principles and components set out in this report in live delivery settings, informing future policy and commissioning decisions with evidence on what works in practice.
3. Generate more robust evidence regarding established local and regional services, as interview data indicate potential effectiveness, yet published outcomes data remain insufficient.
4. Evaluate new initiatives, such as employer-led provision, to better understand how feasibility and effectiveness vary across employer types, sizes and contexts.
5. Investigate the role of employer practice maturity as a predictor of effective sickness management, including what helps move employers up the maturity curve. Research in this area could examine the impact of peer learning among employers, such as sector-based networks, employer-to-employer mentoring or local place-based learning collaboratives, as a mechanism for accelerating maturity, especially among SMEs.
6. Conduct feasibility and cost-benefit analyses of pooled GIP arrangements for SMEs, utilising insights from ongoing industry exploratory studies.
7. Synthesise lessons from international experience in establishing nationwide caseworker support systems, particularly in the Netherlands and the Nordic countries. Comparative analysis should address both the functions of these systems and the processes by which they developed, including the sequencing of legislative, market and capability changes.

References

ABI (Association of British Insurers). 2026. 'Income Protection Insurance.' As of 12 August 2026: https://www.abi.org.uk/products-and-issues/choosing-the-right-insurance/income-protection/

ArboNed. 2025. *The Eligibility for Permanent Incapacity Benefit (Restrictions) Act*. As of 12 August 2026: https://www.arboned.nl/en/compliance-law/eligibility-for-permanent-incapacity-benefit-restrictions-act

Arends, Iris, Ute Bültmann, Willem van Rhenen, Henk Groen, & Jac J. L. van der Klink. 2013. 'Economic Evaluation of a Problem Solving Intervention to Prevent Recurrent Sickness Absence in Workers with Common Mental Disorders.' *PLOS ONE* 8 (8): e71937. As of 12 August 2026: https://doi.org/10.1371/journal.pone.0071937

Batty, Elaine, Richard Crisp, Jan Gilbertson, et al. 2022. *Working Well Early Help: Final Annual Report*. Sheffield Hallam University, Centre for Regional Economic and Social Research. As of 12 August 2026: https://www.greatermanchester-ca.gov.uk/media/6763/wweh-2022-annual-report.pdf

Beemster, Timo T., Coen A. M. van Bennekom, Judith M. van Velzen, Monique H. W. Frings-Dresen, & Michiel F. Reneman. 2021. 'Vocational Rehabilitation with or without Work Module for Patients with Chronic Musculoskeletal Pain and Sick Leave from Work: Longitudinal Impact on Work Participation.' *Journal of Occupational Rehabilitation* 31 (1): 72–83. As of 12 August 2026: https://doi.org/10.1007/s10926-020-09893-z

Bergman, Beverly P., Evangelia Demou, James Lewsey, & Ewan Macdonald. 2022. 'A Comparison of Routine and Case-Managed Pathways for Recovery from Musculoskeletal Disorders in People in Employment.' *Disability and Rehabilitation* 44 (17): 4648–55. As of 12 August 2026: https://doi.org/10.1080/09638288.2021.1912837

Black, Oliver, Malcolm R. Sim, Alexander Collie, & Peter Smith. 2017. 'Early-Claim Modifiable Factors Associated With Return-to-Work Self-Efficacy Among Workers Injured at Work: Are There Differences Between Psychological and Musculoskeletal Injuries?' *Journal of Occupational and Environmental Medicine* 59 (12): e257–62. As of 12 August 2026: https://doi.org/10.1097/JOM.0000000000001172

Brown, Judith, Daniel Mackay, Evangelia Demou, Joyce Craig, John Frank, & Ewan B. Macdonald. 2015. 'The EASY (Early Access to Support for You) Sickness Absence Service: A Four-Year Evaluation of the Impact on Absenteeism.' *Scandinavian Journal of Work, Environment & Health* 41 (2): 204–15. As of 12 August 2026: https://doi.org/10.5271/sjweh.3480

Bültmann, Ute, David Sherson, Jens Olsen, Carl Lysbeck Hansen, Thomas Lund, Jørgen Kilsgaard. 2009. 'Coordinated and Tailored Work Rehabilitation: A Randomized Controlled Trial with Economic Evaluation Undertaken with Workers on Sick Leave Due to Musculoskeletal Disorders.' *Journal of Occupational Rehabilitation* 19 (1): 81–93. As of 12 August 2026: https://doi.org/10.1007/s10926-009-9162-7

Burton, Kim, Nicholas Kendall, Serena McCluskey, & Pauline Dibben. 2013. *Telephonic Support to Facilitate Return to Work: What Works, How, and When?* Research Report No. 853. Department for Work and Pensions.

Cancelliere, Carol, James Donovan, Mette Jensen Stochkendahl, et al. 2016. 'Factors Affecting Return to Work after Injury or Illness: Best Evidence Synthesis of Systematic Reviews.' *Chiropractic & Manual Therapies* 24 (1): 32. As of 12 August 2026: https://doi.org/10.1186/s12998-016-0113-z

CMSUK (Case Management Society UK). 2009. CMSUK Standards of Practice and Best Practice Guidelines. Sutton.

Commission for Healthier Working Lives. 2025. *Action for Healthier Working Lives*.

Creswell, John W. & Vicki L. Plano Clark. 2026. 'Designing and Conducting Mixed Methods Research.' 2 May. SAGE Publications Ltd. As of 12 August 2026: https://uk.sagepub.com/en-gb/eur/designing-and-conducting-mixed-methods-research/book269004

DBT (Department for Business and Trade). 2026. *National Minimum Wage and National Living Wage Rates.* As of 12 August 2026: https://www.gov.uk/national-minimum-wage-rates

Demou, Evangelia, Judith Brown, Kaveh Sanati, Mark Kennedy, Keith Murray, & Ewan B. Macdonald. 2016. 'A Novel Approach to Early Sickness Absence Management: The EASY (Early Access to Support for You) Way.' *Work* 53 (3): 597–608. As of 12 August 2026: https://doi.org/10.3233/WOR-152137

DWP. 2013. *Telephonic Support to Facilitate Return to Work: What Works, How, and When?* Research Report No. 853. DWP. As of 12 August 2026: https://assets.publishing.service.gov.uk/media/5a74a1eb40f0b616bcb18131/rrep853.pdf

———. 2025a. 'Press release: Drive to tackle workplace sickness with small business occupational health training.' As of 12 August 2026: https://www.gov.uk/government/statistics/the-employment-of-disabled-people-2024

———. 2025b. 'The Employment of Disabled People 2024.' November 5. As of 12 August 2026: https://www.gov.uk/government/statistics/the-employment-of-disabled-people-2024

DWP & DBT (Department for Work and Pensions & Department for Business and Trade). 2025. *Keep Britain Working Review: Discovery*. London. As of 12 August 2026: https://www.gov.uk/government/publications/keep-britain-working-review-discovery/keep-britain-working-review-discovery

———. 2026a. 'Keep Britain Working: Final Report.' GOV.UK. As of 12 August 2026: https://www.gov.uk/government/publications/keep-britain-working-review-final-report/keep-britain-working-final-report

———. 2026b. 'Survey of Employees and Self-Employed Workers, 2024 to 2025.' As of 12 August 2026: https://www.gov.uk/government/publications/survey-of-employees-and-self-employed-workers-2024-to-2025/survey-of-employees-and-self-employed-workers-2024-to-2025

DWP & DHSC. 2023. 'WorkWell Prospectus: Guidance for Local System Partnerships.'

———. 2026a. 'Press release: broken fit note system to be overhauled.' DWP and DHSC. As of 12 August 2026: https://www.gov.uk/government/publications/workwell/workwell-prospectus-guidance-for-local-system-partnerships

———. 2026b. 'WorkWell Prospectus: Guidance for Local System Partnerships.' DWP and DHSC. As of 12 August 2026: https://www.gov.uk/government/publications/workwell/workwell-prospectus-guidance-for-local-system-partnerships

Feuerstein, Michael, Grant D. Huang, Jose M. Ortiz, William S. Shaw, Virginia I. Miller, & Patricia M. Wood. 2003. 'Integrated Case Management for Work-Related Upper-Extremity Disorders: Impact of Patient Satisfaction on Health and Work Status.' *Journal of Occupational and Environmental Medicine* 45 (8): 803. As of 12 August 2026: https://doi.org/10.1097/01.jom.0000079091.95532.92

Franche, Renée-Louise, Kimberley Cullen, Judy Clarke, et al. 2005. 'Workplace-Based Return-to-Work Interventions: A Systematic Review of the Quantitative Literature.' *Journal of Occupational Rehabilitation* 15 (4): 607–31. As of 12 August 2026: https://doi.org/10.1007/s10926-005-8038-8

Frederick, Donald E., & Tyler J. VanderWeele. 2019. 'Supported Employment: Meta-Analysis and Review of Randomized Controlled Trials of Individual Placement and Support.' *PLOS ONE* 14 (2): e0212208. As of 12 August 2026: https://doi.org/10.1371/journal.pone.0212208

Gaillard, Aurélie, Hélène Sultan-Taïeb, Chantal Sylvain, & Marie-José Durand. 2020. 'Economic Evaluations of Mental Health Interventions: A Systematic Review of Interventions with Work-Focused Components.' *Safety Science* 132 (December): 104982. As of 12 August 2026: https://doi.org/10.1016/j.ssci.2020.104982

Gazzillo, Anna, Myriam Vriend, & Christopher Rocks. 2024. 'Labour Market Flows and Health Annex 1 of Towards Healthier Working Lives: Interim Report of the Commission for Healthier Working Lives.' The Health Foundation, Commission for Healthier Working Lives, October 3. As of 12 August 2026: https://www.health.org.uk/sites/default/files/2024-10/Annex%201%20Labour%20market%20flows%20and%20health_0.pdf

Gloster, Rosie, Rosa Marvell, & Clare Huxley. 2018. *Fit for Work: Final Report of a Process Evaluation*. Research Report No. 959. Department for Work and Pensions. As of 12 August 2026: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/716867/fit-for-work-final-report-of-a-process-evaluation.pdf

Goorden, Maartje, Moniek C. Vlasveld, Johannes R. Anema, et al. 2014. 'Cost-Utility Analysis of a Collaborative Care Intervention for Major Depressive Disorder in an Occupational Healthcare Setting.' *Journal of Occupational Rehabilitation* 24 (3): 555–62. As of 12 August 2026: https://doi.org/10.1007/s10926-013-9483-4

Grant, Maria J., & Andrew Booth. 2009. 'A Typology of Reviews: An Analysis of 14 Review Types and Associated Methodologies.' *Health Information & Libraries Journal* 26 (2): 91–108. As of 12 August 2026: https://doi.org/10.1111/j.1471-1842.2009.00848.x

Hanson, Margaret A., Kim Burton, Nicholas A. S. Kendall, Rebecca J. Lancaster, & Adele Pilkington. 2006. *The Costs and Benefits of Active Case Management and Rehabilitation for Musculoskeletal Disorders*. Research Report No. 493. Health and Safety Executive.

Høgelund, Jan, & Anders Holm. 2006. 'Case Management Interviews and the Return to Work of Disabled Employees.' *Journal of Health Economics* 25 (3): 500–519. As of 12 August 2026: https://doi.org/10.1016/j.jhealeco.2005.07.007

IES (Institute of Employment Studies). 2023a. *Health-Led Employment Trial Evaluation: 12-Month Outcomes Report: Economic Evaluation*. DWP research report no. 1036. As of 12 August 2026: https://assets.publishing.service.gov.uk/media/64baa8fa06f78d000d742703/health-led-employment-trials-economic-evaluation-report.pdf

———. 2023b. *Health-Led Trials: Evaluation Synthesis Report*. DWP research report no. 1025. Department for Work and Pensions. As of 12 August 2026: https://www.gov.uk/government/publications/health-led-employment-trials-evaluation/health-led-trials-evaluation-synthesis-report

Kantar Public, ICF (International Classification of Functioning, Disability and Health) & BPSR (Bryson Purdon Social Research). 2024. *Work and Health Programme Evaluation: Synthesis Report*. DWP research report no. 1044. As of 12 August 2026: https://www.gov.uk/government/publications/work-and-health-programme-evaluation-synthesis-report/work-and-health-programme-evaluation-synthesis-report

Lane, Tyler J., Rebbecca Lilley, Sheilah Hogg-Johnson, Anthony D. LaMontagne, Malcolm R. Sim, & Peter M. Smith. 2018. 'A Prospective Cohort Study of the Impact of Return-to-Work Coordinators in Getting Injured Workers Back on the Job.' *Journal of Occupational Rehabilitation* 28 (2): 298–306. As of 12 August 2026: https://doi.org/10.1007/s10926-017-9719-9

Lerner, Debra, David A. Adler, William H. Rogers et al. 2015. 'A Randomized Clinical Trial of a Telephone Depression Intervention to Reduce Employee Presenteeism and Absenteeism.' *Psychiatric Services* 66 (6): 570–77. As of 12 August 2026: https://doi.org/10.1176/appi.ps.201400350

McCluskey, Serena, Kim Burton, & Chris J. Main. 2006. 'The Implementation of Occupational Health Guidelines Principles for Reducing Sickness Absence Due to Musculoskeletal Disorders.' *Occupational Medicine* 56 (4): 237–42. As of 12 August 2026: https://doi.org/10.1093/occmed/kql003

NHS England. 2026. 'NHS Workforce Statistics - January 2026.' Data tables. Leeds. As of 12 August 2026: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/january-2026#

Nicholas, M. K., D. S. J. Costa, S. J. Linton et al. 2020. 'Implementation of Early Intervention Protocol in Australia for "High Risk" Injured Workers Is Associated with Fewer Lost Work Days Over 2 Years Than Usual (Stepped) Care.' *Journal of Occupational Rehabilitation* 30 (1): 93–104. As of 12 August 2026: https://doi.org/10.1007/s10926-019-09849-y

Nightingale, Madeline, Kankan Zhang, Andy Perkins et al. 2025. *Evaluation of Individual Placement and Support (IPS) in Community Drug and Alcohol Treatment Services*. RR-A3950-1. Santa Monica, Calif.: RAND Corporation. As of 12 August 2026: https://www.rand.org/pubs/research_reports/RRA3950-1.html

ONS (Office for National Statistics). 2023. 'Rising Ill-Health and Economic Inactivity Because of Long-Term Sickness, UK: 2019 to 2013.' Office for National Statistics. As of 12 August 2026: https://www.ons.gov.uk/employmentandlabourmarket/peoplenotinwork/economicinactivity/articles/risingillhealthandeconomicinactivitybecauseoflongtermsicknessuk/2019to2023

———. 2024. 'Employment in the UK: December 2024.' As of 12 August 2026: https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/bulletins/employmentintheuk/december2024

———. 2025. 'Annual Survey of Hours and Earnings (ASHE).' As of 12 August 2026: https://www.ons.gov.uk/surveys/informationforbusinesses/businesssurveys/annualsurveyofhoursandearningsashe

———. 2026a. 'INAC01: Economic Inactivity by Reason (Seasonally Adjusted).' As of 12 August 2026: https://www.ons.gov.uk/employmentandlabourmarket/peoplenotinwork/economicinactivity/datasets/economicinactivitybyreasonseasonallyadjustedinac01sa

———. 2026b. 'Labour Demand Volumes by Standard Occupation Classification (SOC 2020), UK.' As of 12 August 2026: https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/datasets/labourdemandvolumesbystandardoccupationclassificationsoc2020uk

Onumonu, Marvin. 2025. '72% of GIP Claimants Returned to Work in 2024 – GRID.' *Workplace Journal.* As of 12 August 2026: https://workplacejournal.co.uk/2025/05/72-of-gip-claimants-returned-to-work-in-2024-grid/

Oostrom, Sandra H. van, Willem van Mechelen, Berend Terluin, Henrica C. W. de Vet, Dirk L. Knol, & Johannes R. Anema. 2010. 'A Workplace Intervention for Sick-Listed Employees with Distress: Results of a Randomised Controlled Trial.' Original Article. *Occupational and Environmental Medicine* 67 (9): 596–602. As of 12 August 2026: https://doi.org/10.1136/oem.2009.050849

RCS (Regional Collaboration Service). 2026. 'In-Work Support Service Referral.' As of 12 August 2026: https://rcs-wales.co.uk/in-work-support-service-referral/

Rebergen, D. S., D. J. Bruinvels, P. D. Bezemer, A. J. van der Beek, & W. van Mechelen. 2009. 'Guideline-Based Care of Common Mental Disorders by Occupational Physicians (CO-OP Study): A Randomized Controlled Trial.' *Journal of Occupational and Environmental Medicine* 51 (3): 305–12. As of 12 August 2026: https://doi.org/10.1097/JOM.0b013e3181990d32

Rebergen, D. S., D. J. Bruinvels, M. W. van Tulder, A. J. van der Beek, & W. van Mechelen. 2009. 'Cost-Effectiveness of Guideline-Based Care for Workers with Mental Health Problems.' *Journal of Occupational and Environmental Medicine* 51 (3): 313. As of 12 August 2026: https://doi.org/10.1097/JOM.0b013e3181990d8e

Shaw, Elizabeth, Michael Nunns, Stuart G. Spicer, et al. 2024. 'What Is the Volume, Quality and Characteristics of Evidence Relating to the Effectiveness and Cost-Effectiveness of Multi-Disciplinary Occupational Health Interventions Aiming to Improve Work-Related Outcomes for Employed Adults? An Evidence and Gap Map of Systematic Reviews.' *Campbell Systematic Reviews* 20 (2): e1412. As of 12 August 2026: https://doi.org/10.1002/cl2.1412

Skarpaas, Lisebet Skeie, Lise Aasen Haveraaen, Milada Cvancarova Småstuen, William S. Shaw, & Randi Wågø Aas. 2019. 'The Association between Having a Coordinator and Return to Work: The Rapid-Return-to-Work Cohort Study.' *BMJ Open.* Health Services Research. February 1. As of 12 August 2026: https://doi.org/10.1136/bmjopen-2018-024597

Skisak, Christopher M., Faiyaz Bhojani, & Shan P. Tsai. 2006. 'Impact of a Disability Management Program on Employee Productivity in a Petrochemical Company.' *Journal of Occupational and Environmental Medicine* 48 (5): 497. As of 12 August 2026: https://doi.org/10.1097/01.jom.0000201844.33193.81

SOHAS (Sheffield Occupational Health Advisory Service. 2022. 'Sheffield Occupational Health Advisory Service.' As of 12 August 2026: https://www.sohas.co.uk/

Soler-Font, Mercè, José Maria Ramada, José Maria Montero-Moraga, et al. 2021. 'What Is Meant by Case Management for the Return-to-Work of Workers with Musculoskeletal Disorders? A Scoping Review.' *Work: A Journal of Prevention, Assessment & Rehabilitation* 70 (4): 1069–87. As of 12 August 2026: https://doi.org/10.3233/WOR-205172

Sowden, G., C. J. Main, D. A. van der Windt, K. Burton, & G. Wynne-Jones. 2019. 'The Development and Content of the Vocational Advice Intervention and Training Package for the Study of Work and Pain (SWAP) Trial (ISRCTN 52269669).' *Journal of Occupational Rehabilitation* 29 (2): 395–405. As of 12 August 2026: https://doi.org/10.1007/s10926-018-9799-1

Tu, Trinh, Kelly Maguire, & Theebika Shanmugarasa. 2021. *Sickness Absence and Health in the Workplace: Understanding Employer Behaviour and Practice*. DWP research report no. 981. DWP. As of 12 August 2026: https://www.gov.uk/government/publications/sickness-absence-and-health-in-the-workplace-understanding-employer-behaviour-and-practice/sickness-absence-and-health-in-the-workplace-understanding-employer-behaviour-and-practice-report

Vargas-Prada, Sergio, Evangelia Demou, Drushca Lalloo, et al. 2016. 'Effectiveness of Very Early Workplace Interventions to Reduce Sickness Absence: A Systematic Review of the Literature and Meta-Analysis.' *Scandinavian Journal of Work, Environment & Health* 42 (4): 261–72. As of 12 August 2026: https://doi.org/10.5271/sjweh.3576

Vilsteren, Myrthe van, Sandra H. van Oostrom, Henrica CW de Vet, Renée-Louise Franche, Cécile RL Boot, & Johannes R. Anema. 2015. 'Workplace Interventions to Prevent Work Disability in Workers on Sick Leave.' *Cochrane Database of Systematic Reviews* 2015, Issue 10. As of 12 August 2026: https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD006955.pub3/full

Vlasveld, Moniek C., Christina M. van der Feltz-Cornelis, Herman J. Adèr et al. 2013. 'Collaborative Care for Sick-Listed Workers with Major Depressive Disorder: A Randomised Controlled Trial from the Netherlands Depression Initiative Aimed at Return to Work and Depressive Symptoms.' Workplace. *Occupational and Environmental Medicine* 70 (4): 223–30. As of 12 August 2026: https://doi.org/10.1136/oemed-2012-100793

Vogel, Nicole, Stefan Schandelmaier, Thomas Zumbrunn, et al. 2017. 'Return-to-Work Coordination Programmes for Improving Return to Work in Workers on Sick Leave.' *Cochrane Database of Systematic Reviews* 2017 (3). As of 12 August 2026: https://doi.org/10.1002/14651858.CD011618.pub2

Waddell, Gordon, Kim Burton, & Nicholas AS Kendall. 2008. *Vocational Rehabilitation: What Works, for Whom, and When?* TSO; Vocational Rehabilitation Task Group. As of 12 August 2026: https://assets.publishing.service.gov.uk/media/5a7ccd8bed915d6b29fa8c2b/hwwb-vocational-rehabilitation.pdf

Whitworth, Adam, Susan Baxter, Jane Cullingworth, & Mark Clowes. 2024. 'Individual Placement and Support (IPS) beyond Severe Mental Health: An Overview Review and Meta-Analysis of Evidence around Vocational Outcomes.' *Preventive Medicine Reports* 43 (July): 102786. As of 12 August 2026: https://doi.org/10.1016/j.pmedr.2024.102786

Wynne-Jones, Gwenllian, Majid Artus, Annette Bishop et al. 2018. 'Effectiveness and Costs of a Vocational Advice Service to Improve Work Outcomes in Patients with Musculoskeletal Pain in Primary Care: A Cluster Randomised Trial (SWAP Trial ISRCTN 52269669).' *PAIN* 159 (1): 128. As of 12 August 2026: https://doi.org/10.1097/j.pain.0000000000001075

Annex A. Procedures of the evidence review

Table A.1 Key search terms by topic

Support models & programmes	Support roles & delivery functions	Employment retention / Job loss prevention	Health-related conditions	Inputs / Outcomes / Impacts
Accelerators	Care coordinator	Back to work	Absent worker(s)	Benefit(s)
Biopsychosocial model	Case management	Career redirection	Absenteeism	Capacity
Community-based Employment Support	Caseworker	Disability employment support	Anxiety	Caseload management
Condition Management Programme	Clinical concierge	Early intervention	Arthritis	Cost(s)
Connect to Work	Employment advisor	Employment barriers	Autoimmune conditions	Cost-Benefit Analysis / CBA
Fit for Work	Employment coach / Work coach / Job coach	Employment support	Barriers	Cost-effectiveness
Health-led employment trial	Employment specialist	Functional capacity evaluation	Burnout	Cost-utility
Healthy Working Lives	Health coach	Health benefits	Cancer	Effective referral(s)
Individual Placement and Support / IPS	Job retention advisor	Health management	Chronic condition	Effective*
Jobcentre Plus	Keyworker	Health risk assessment	Chronic fatigue	Employer engagement
Peer mentoring	Occupational case manager	Job loss	Chronic illness	Engagement with GP
	Peer mentor	Job maintenance	Chronic pain	Feasibility
		Job/work reintegration	Comorbidities	Funding/funding mechanisms

Support models & programmes	Support roles & delivery functions	Employment retention / Job loss prevention	Health-related conditions	Inputs / Outcomes / Impacts
Peer-to-peer	Rehab* case manager	Job/work retention	Depression	Health-work integration
Return to work	Return to work coordinator/manager/adviser)	Labour market reintegration	Disability	Impact(s)
Rework		Occupational health	Health challenges	Intervention
Self-management programme		Occupational therapy	Health-related	Outcome(s)
Service delivery model		Prevent*	Inflammatory condition	Presenteeism
Step care approach		Proactive support	Injury	Productivity
Tiered support/intervention		Reasonable adjustments	Long COVID	Qualifications
Trailblazers		Reduce absence	Long-term absence	Return on investment / ROI
Vocation Fit		Reduce presenteeism	Long-term conditions	Scalability
Vocational rehabilitation		Remain in work	Long-term sick leave	Skills
Workforce model		Sick leave reduction	Major illness	Stakeholder collaboration
WorkWell		Sickness absence	Menopause	Success factor(s)
		Social insurance	Mental health	Training
		Social support	Mental illness	Value for Money / VfM
		Stay at work	Musculoskeletal	Workplace happiness
		Supported employment	Occupational injury	Workplace relations
		Sustainable employment / job sustainability	Physical health	Workplace satisfaction
		Welfare-to-work	Poor health	Workplace well-being
		Work capability	Post-COVID	Workforce capacity
		Work psych* assessment*	Post-Traumatic Stress Disorder/ PTSD	
		Work readiness	Post-viral	
		Work retention	Sciatica	

Support models & programmes	Support roles & delivery functions	Employment retention / Job loss prevention	Health-related conditions	Inputs / Outcomes / Impacts
		Work return	Sickness absence	
		Workforce re-entry	Stress	
		Workplace accommodation	Work capacity limitations	
		Workplace adjustments	Work-limiting health condition	
		Workplace health	Work-related ill health	

Source: RAND Europe.

Table A.2 Inclusion and exclusion criteria

Included in the review	Excluded from the review
Literature on early-intervention caseworker-led models that aim to improve workforce health and/or prevent health-related job loss.	Literature unrelated to caseworker-led models or employment retention in a health context.
Academic and grey literature, empirical research and evidence syntheses.	Commentaries, media articles.
UK (incl. devolved nations and regional examples, such as Leicestershire, Nottinghamshire, Cornwall, Manchester prevention programmes) and relevant international comparators (e.g. Sweden, Denmark, the Netherlands, Australia, Canada and the United States – specific states: Michigan, Detroit).	Studies from contexts not relevant or transferable to the UK.
English language sources.	Sources published in languages other than English.
Studies published between 2005 and 2025.	Studies published earlier than 2005.

Source: RAND Europe.

Table A.3 Data extraction template

Topic	Data to extract
General information	Source Full reference Short reference (author-date) URL Title Abstract Publication type, e.g. journal article, book chapter, thesis, evaluation, government report, policy paper Geographical focus Relevance rating (high=explicit caseworker model; moderate=partial fit; peripheral=context-related only) Data sources/methodology Sector(s) or setting(s), e.g. health care, workplace, insurance, community, social care, others
Study design	Research design, e.g. RCT, quasi-experimental, difference-in-differences, pre-post, mixed methods, qualitative, economic evaluation, impact evaluation, statistical analysis, case studies, comparative study Key methodological information, e.g. sample size, measured outcomes, effect size, attrition rates, main limitations Quality appraisal (levels 1–5)

Topic	Data to extract
Model description	Model or intervention name and type (e.g. bio-psycho-social model, supported employment) Overall objective(s) Caseworker type and role and other stakeholders involved ('who'), e.g. OT, nurse, employment advisor, psychologist, clinician, etc. Target population(s) ('to whom'), e.g. MSD, mental health, cancer, cardiac, multi-condition, age group, gender, socio-economic group Stage of job-loss risk targeted ('when'), e.g. still employed, off sick, post-diagnosis, post-RTW Delivery setting ('where'), e.g. workplace, primary care, job centre, online Delivery mode ('how'), e.g. face-to-face, digital, hybrid, workplace-based, multi-agency Key components/activities ('what'), e.g. information on assessment, individualised plan, employer engagement, liaison & referrals to GP and other services, follow-up, duration and intensity Integration with other services, e.g. links to occupational or public health, employment services, employers, social care, multi-disciplinary teams, drug and alcohol treatment services Funding and governance, e.g. NHS service, social insurance, municipality, research trial Policy or system context
Workforce	Training and competencies required, e.g. qualifications, specific training, guidance Provider organisations, e.g. NHS, Jobcentre Plus, local authority, private, non-profit Roles
Outcomes, measurement and effect magnitude/significance	Health outcomes (e.g. fatigue, pain scores, psychological distress, quality of life) Employment outcomes (e.g. RTW rate, time to RTW, job retention at X months, sustained employment) Productivity and work outcomes (e.g. productivity/performance, work ability index, absenteeism, presenteeism, workplace happiness/satisfaction, reduced staff turnover) Economic and systemic outcomes (costs and resources required, benefits, cost-benefit ratios, cost-effectiveness ratios, reduced benefit claims, etc) Other outcomes (e.g. participant satisfaction, equality-related outcomes, social inclusion)

Topic	Data to extract
Feasibility and scalability	Facilitators and enablers Barriers and challenges Resources and costs Operational feasibility (any notes on model simplicity, workforce capacity requirements, regulatory environment) Scalability/transferability to UK (high, moderate, low, non-transferable and brief justification)
Other	Limitations of the study Snowball references

Source: RAND Europe.

Annex B. Interview topic guide

INTERVIEW TOPIC GUIDE: PRACTITIONERS AND DELIVERY PARTNERS

The purpose of this interview is to help us understand how early-intervention, caseworker-led support operates in practice: its key stages, delivery processes and your experiences in designing or implementing this type of support.

- The interview will take approximately **60 minutes**. Your participation is optional and you can withdraw from the interview at any point.
- Is it OK to **turn on the recording** for the interview? I will only do this with your permission.
- Have you had a chance to read the information we shared with you in advance of the interview, including the **privacy notice**? *As a reminder, summarise information:*
  - **Voluntary**. You don't have to take part and don't have to answer anything you don't want to.
  - **Anonymous**. Your personal details will not be disclosed to third parties at any stage of the process. Data from this interview will be analysed and may be used in the final report that may be published. The analysis will be written up in such a way that it will not be feasible to identify any individual.
  - **Recorded**: the interview will be recorded (with your permission) and notes made. The recording will be used for the sole purpose of conducting the analysis.

Do you have any questions before we start?

BACKGROUND & CONTEXT

Could you briefly describe your role and organisation and how it connects to keeping people in or returning them to work?

How does your organisation fit within the wider landscape (public sector, private insurer, local authority, third sector, employer, etc.)?

Who are your main clients and how do they usually access or get referred to your service? [Prompt about health- or work-related issues their clients typically have (e.g. mental health, musculoskeletal, chronic conditions, long-COVID, cancer, menopause-related)]

UNDERSTANDING THE MODEL: 'WHO GIVES WHAT TO WHOM?'

What is being delivered? (Describe the key elements or services of your support model: advice, coordination, vocational rehabilitation, coaching, sign-posting, etc.)

What does 'early intervention' mean in your context?

Who delivers it? Tell us about the caseworkers or equivalent staff, their roles, training and supervision.

Who receives the service? Are criteria defined by health condition, work status, employer referral, or something else?

How quickly after a person's health issue arises does support usually begin and how long does it last?

Which services do caseworkers refer clients on to? Who provides these services?

What makes the support most effective when it works well? Conversely, what tends to make it less effective or unsustainable?

What key features make this model different to other models?

Are there existing schemes or pilots you see as good or poor examples and what can be learned from them?

DELIVERY REALITIES, PARTNERSHIPS and ENABLERS/BARRIERS

How is your service organised and funded (e.g. core funded, outcome-based, per person, or mixed)?

What does coordination with other services look like in practice (e.g. GPs, ICBs, occupational health, Jobcentre Plus, employers, insurers, or voluntary organisations)?

What incentives, obstacles, or practical constraints shape collaboration and referrals between services?

How do information sharing and data protection factors influence delivery?

Do you include any digital or remote elements (e.g. online assessment, self-help portals)? If so, what has worked or not?

How easily could your approach be adopted elsewhere and what local factors keep it going or make replication difficult?

WORKFORCE CAPACITY, SKILLS AND COMPETENCIES

What kinds of backgrounds do your caseworkers come from (clinical, vocational, social work, coaching, etc.)?

What qualifications, competencies, or training do they require or receive?

How do recruitment, retention and supervision work? Where are the pinch-points?

What conditions (staffing levels, guidance, caseloads) need to be in place for effective caseworker delivery?

How could a coherent national competency framework or typology for caseworkers look, in your view?

OUTCOMES, MONITORING AND EVIDENCE

How do you currently measure or define success (e.g. job retention, return to work, well-being, reduced absence)?

What data or evaluation evidence is available on your programme or on comparable initiatives?

What are the main evidence gaps; what do we not know that we would need in order to gauge impact or cost-benefit?

Are short-term success measures adequate, or do you think longer follow-up (e.g. 12 months +) is needed?

COSTS, BENEFITS AND ECONOMIC IMPACTS

We're also aiming to understand the costs and benefits of early-intervention caseworker-led support – especially for employers and the wider system.

- What is the approximate **cost of delivery** – ideally, average cost per individual supported, if known? Alternatively, what is the total programme cost and how many individuals have been **helped or reached** through your programme to date?
- Have you collected or observed any data on reductions in absenteeism, staff turnover, or improvements in employment tenure following participation?
- Based on your experience, what do you think are the **broader benefits** of these interventions for individuals and for employers? What benefits do you think it has for the health system or exchequer?
- Do you have any insight into **drop-out rates (**for example, how many participants leave employment or disengage from caseworker support before completing the programme)?

(Prompt: If precise figures aren't available, ask participants to share estimates or examples of how they track these outcomes)

INTEGRATION, POLICY AND SCALABILITY

How could effective early-intervention caseworker support be better integrated into the wider health, employment and social systems?

What commissioning or funding changes would most enable sustainability (e.g. co-commissioning, colocation, pooled budgets)?

What would be realistic 'quick wins', that is, things that could be implemented within a year? And which changes are longer-term system shifts?

Which actors (public, private, insurers, voluntary) should play which roles in funding or delivery at scale?

What risks or unintended effects do you foresee if models are scaled nationally?

FINAL REFLECTIONS AND RECOMMENDATIONS

If you could advise national decision makers today, what two or three actions would most improve early-intervention, caseworker-led support?

What innovations or promising ideas (in the UK or abroad) should be tested or expanded next?

Are there any groups currently underserved who would particularly benefit from improved early caseworker support?

INTERVIEW CLOSE

Is there anything else you'd like to add that we have not had a chance to discuss?

Do you have any questions for us?

THANK YOU

Annex C. Longlist of model components and specific actions

This annex presents a longlist of model components and specific actions identified through the evidence review and stakeholder consultation as potentially relevant to effective early-intervention, caseworker-led support. These components were subjected to a structured, qualitative appraisal to support comparative assessment and sense-checking, rather than to produce definitive rankings.

The appraisal drew primarily on a facilitated exercise conducted during the stakeholder workshop and was informed by subsequent discussion at the third meeting of the RAG in March 2026. Together, these discussions provided an opportunity to test emerging findings against delivery realities and system constraints, drawing on practitioner, policy and sector expertise.

Each component and action was assessed against four criteria:

- Feasibility (F): the extent to which the proposed action could be implemented within the current institutional arrangements, organisational processes, workforce capacity and policy environment.
- Acceptability (A): the likelihood that the proposed action would secure buy-in, or encounter resistance, from key stakeholders, including policymakers, commissioners, service providers, employers and professional groups.
- Scalability (Sc): the potential for the proposed action to be expanded beyond pilot settings and implemented at regional or national scale.
- Sustainability (Su): the extent to which the proposed action could be maintained over time, considering funding requirements, workforce implications and alignment with existing systems.

Following the workshop and RAG discussions, the research team undertook an analytical synthesis of the qualitative input and assessed each component against the four criteria using a simple, indicative scoring system:

‘+’: there is evidence suggesting the criterion is likely to be met;

‘=’: evidence is mixed, limited, or largely anecdotal;

‘–‘: there is evidence suggesting the criterion is unlikely to be met;

‘?’: there is insufficient evidence to make an assessment.

These scores are intended to support comparative reflection and prioritisation, rather than to imply precise measurement or definitive judgements. They should be interpreted as indicative and context-dependent and as a complement to more detailed analysis presented in the main body of the report.

Table C.1 Assessing model components and specific actions

Policy component 1: Enhance efforts to scale up existing publicly-funded work & health support (in particular the WorkWell national expansion)					
Specific action	F	A	Sc	Su	Narrative assessment
Define a national **core service specification** for WorkWell (and similar programmes) covering assessment, case management processes, employer engagement, follow-up and outcomes - while explicitly allowing local tailoring beyond this core.	=	=	+	+	*Partial support.* Stakeholders had conflicting views: several noted the disadvantages of the wide variation between different WorkWell pilots ('apples vs courgettes'), but one stakeholder felt that competency standards for practitioners were more important than establishing rigid models that lock practitioners into a process-focused rather than human-centred approach.
Make **early intervention** (e.g. 2–6 weeks of absence or earlier where risk is identified) the default, by raising awareness of the benefits of early intervention among referrers, especially primary care teams and employers.	+	+	+	+	*Strongly supported.* Broad consensus that intervening early in sickness absences is crucial and feasible. Scaling early-access nationally is achievable but requires engagement with GPs and employers (some established organisations such as RCS Wales do this with considerable success). One stakeholder felt that intervening too early risked wasting resources on people who would have returned to work anyway.
Emphasise **employer liaison** to avoid pitfalls of previous programmes, positioning employer engagement as a core caseworker function (supported by tools, training and clear role boundaries).	+	+	+	+	*Strongly supported.* Stakeholders saw employer liaison as vital and noted programmes which do it well (IPS) and less well (Fit for Work). It was seen to be feasible, with one stakeholder pointing out that evidence exists on best practice. However, another stakeholder noted that caseworkers themselves may not be best placed to liaise with employers and suggested creating a specialist role with this remit. Another stakeholder made the point that caseworker services could generate valuable data for employers about health risks in their workplaces.
Strengthen the **'no wrong door' referral model**, with simple, well-signposted routes from primary care, employers and self-referral; supported by co-location and embedded roles (e.g. Workplace Health Champions) where feasible.	+	+	+	+	*Not discussed in detail.* Stakeholders provided examples of strong referral routes (e.g. co-location in GP surgeries over many years leading to excellent GP uptake of the service). One stakeholder noted that having multiple referral routes is now common (including within WorkWell) and avoids over-reliance on GPs to refer patients into programmes. Another stakeholder felt that actually offering treatment as part of the programme is a 'big sell' for GPs.
Require **follow-up** beyond initial return to work (or stabilisation in work) to prevent relapse and churn.	+	+	+	+	*Strongly supported.* Two stakeholders felt this point was particularly important, although one noted that follow-up is not always required.
Develop outcome measures that capture prevention and job retention, not only job entry or RTW milestones	?	?	?	?	Not discussed.

Policy component 2: Build a skilled caseworker workforce					
Specific action	F	A	Sc	Su	Narrative assessment
Establish a national Work & Health **caseworker capability framework** defining core competencies, role boundaries, escalation routes and ethical standards, with optional accreditation layered on over time.	+	+	+	+	*Supported*. One stakeholder felt that a capability framework would be essential to protect practitioners (e.g. by establishing role boundaries to avoid non-clinical practitioners feeling they have to handle clinical cases, and by defining the 'subtle skills' that caseworkers require). Two stakeholders noted that clear role boundaries and escalation routes would help to ensure caseworker well-being and avoid burnout, helping to ensure a sustainable workforce.
Create **funded conversion and transition pathways** into Work & Health casework from adjacent professions (nursing, physiotherapy, occupational therapy, HR, rehabilitation), rather than relying on wholly new roles.	?	?	?	?	*Not discussed*. However, stakeholders have expressed support for this idea in interviews.
Set **clear caseload guidelines** and supervision requirements to ensure quality and prevent burnout. Clearly define what caseworkers are responsible for, what they are not responsible for and when/how cases are escalated to clinical, safeguarding, or specialist services.	+	+	?	+	*Strongly supported*. Defining maximum caseloads was seen as feasible and highly acceptable: without these safeguards, quality drops and staff burnout. However, one stakeholder warned that scaling up programmes can often lead to compromises on caseloads being made, which can negatively affect workforce well-being and potentially reduce programme sustainability. Two stakeholders pointed out the importance of providing non-clinical caseworkers, particularly with supervision and support in referring cases on to clinical services where needed.
Pair non-clinical 'work coaches' with clinical advisors in a team to cover the full spectrum of needs. This multi-disciplinary approach ensures that complex cases get expert medical input while maintaining a work focus.	+	+	?	+	*Supported*. Some stakeholders expressed strong support for this option, highlighting its potential to bridge the divide between clinical and non-clinical support and protect both service users (who can be referred on to clinicians where needed) and caseworkers themselves (who can refer cases requiring clinical help on rather than tackling them themselves). However, one stakeholder emphasised the need to avoid medicalisation of cases where it is not necessary, pointing to the negative effects of overcare on both health and employment outcomes.
Embed **communities of practice**, peer learning and shared problem-solving as a funded, expected component of Work & Health delivery (could be facilitated by a national coordinating body or similar).	?	?	?	?	Not discussed.

Policy component 3: Implement a tiered support model					
Specific action	F	A	Sc	Su	Narrative assessment
Implement a **tiered support model** that determines intensity of support according to need. All users should receive some form of help, with intensity flexing over time. Use early assessments to categorise cases into tiers, for example: **Tier 1:** self-help, digital tools, group or brief check-ins for low-risk cases; **Tier 2:** structured one-to-one caseworker support (often remote) for intermediate cases; **Tier 3:** intensive face-to-face case management and multidisciplinary input for complex, high-risk cases.	+	+	?	?	*Supported*. Several stakeholders responded positively to the idea of tiered support. One stakeholder queried whether effective screening tools existed, while another suggested that service users should perhaps be able to self-select into particular tiers.
Use a structured, evidence-informed **screening tool to stratify risk** at intake (for instance, based on psychosocial risk factors or presence of co-morbidities), with explicit mechanisms for stepping up or stepping down as circumstances change.	+	+	?	?	*Supported*. As above, stakeholders were broadly supportive of this option, although questions were raised as to which tools would be used for screening and the possibility of self-selection into tiers.
Ensure **flexible delivery channels**: e.g. digital platforms or group workshops for lower tiers and in-person multidisciplinary teams for higher tiers. This maximises reach (many can get basic support) while focusing expert time on those who need it most.	?	+	?	?	*Supported*. The discussion only briefly touched on this point; one stakeholder responded positively to the idea.

Policy component 4: Strengthen employer responsibilities in sickness management ('gatekeeper' model elements inspired by the Netherlands)					
Specific action	F	A	Sc	Su	Narrative assessment
Introduce **statutory process duties** on employers during sickness absence, requiring timely planning, engagement and review. For example, mandate a 'RTW Plan' after a defined period (e.g. 4–6 weeks of absence), developed jointly by the employer, employee and a caseworker or occupational health professional.	+=	=	+	+=	*Partial support* (with caveats & flexibility). Could be feasible to implement – many larger employers already engage in formal RTW planning around this timeframe, although several participants felt waiting 4–6 weeks may be too late and suggested requiring action earlier when appropriate. Acceptability is an open question – stakeholders agree employers should actively manage sickness cases, but the policy should allow earlier intervention for certain cases and not be one-size-fits-all. Scalable as a general expectation (especially if paired with templates and guidance for SMEs). Sustaining such a duty long-term is likely if it is seen as reasonable: making early RTW planning a standard practice will help reduce prolonged absences and is aligned with broader policy goals to improve retention.
Introduce **graduated employer responsibilities** for occupational health and sickness management, scaled by employer size and capacity, with pooled or publicly supported models for SMEs.	+	+=	+	+	*Supported.* Feasible and necessary to ensure fairness – obligations can be adjusted by employer size (e.g. small businesses could meet requirements by using external services or pooled schemes). Highly acceptable – stakeholders agree that treating a ten-person firm differently from a 10,000-person firm is fair and will reduce resistance (SMEs will not face unrealistic burdens). Scalable – this approach could bring small employers on board by giving them accessible support options (like subsidised external occupational health) instead of expecting internal expertise, enabling nationwide adoption of strengthened responsibilities. Sustainable – proportional duties are more likely to be maintained long-term: small employers can comply without undue hardship, and large ones are capable of meeting higher standards, ensuring the policy's durability.
Explore extending employer financial responsibility during sickness absence in a limited and conditional way, explicitly linked to engagement with reintegration processes and access to support.	=	-	+	?	*Cautiously considered.* Directly increasing employers' statutory sick pay period or obligations (as in the Dutch system) was not broadly supported unless carefully designed to be fair. Stakeholders leaned toward using financial incentives: e.g. only imposing extra costs on employers who do not participate in RTW efforts (and potentially rewarding those who do). Such a conditional approach could be scalable as a nation-wide 'nudge' (encouraging all employers to invest in keeping people in work). However, the long-term sustainability of this idea is uncertain – it would need to be introduced gradually and proven effective to avoid backlash or unintended effects.

Policy component 4: Strengthen employer responsibilities in sickness management ('gatekeeper' model elements inspired by the Netherlands)					
Specific action	F	A	Sc	Su	Narrative assessment
Establish a clear statutory framework (akin to the Dutch **'Gatekeeper Act'**) that outlines employer, employee and caseworker duties during sick leave, such as regular occupational health assessments, work adaptations and exploring alternative roles if needed.	+	=	?	?	*Partial support* (with caveats & flexibility). Developing a comprehensive UK sickness absence framework is feasible – the group suggested starting with a Code of Practice or guidelines (detailing expected steps for all parties) and potentially enshrining key elements in law over time. Stakeholders supported the idea of a clear framework in principle. However, to increase acceptability, they recommended beginning with guidance and encouragement (backed by support and incentives for employers) and only moving to legislation once the ground has been prepared. A framework is scalable – it creates a consistent national standard for absence management, which can be introduced universally (with education and possibly incentives to aid compliance). It also enhances sustainability: by institutionalising best practices (and updating them as needed), it provides a stable, long-term structure for managing sickness absences that aligns with wider policy goals (e.g. recommendations from the Mayfield Review).
Pair any strengthening of employer duties with a clear **employee right** to timely work and health support during sickness absence.	?	?	?	?	Not discussed.

Policy component 5: Financial incentives for employers to invest in health & retention ('nudge' approach – subsidies, tax breaks, recognition)					
Specific action	F	A	Sc	Su	Narrative assessment
Introduce **targeted tax incentives** for employers who demonstrate effective sickness management behaviours (e.g. early RTW planning, use of accredited occupational health/caseworker services). The UK government has explored tax breaks for employer-provided occupational health as part of the 'Occupational Health: Working Better' consultation in 2023.	+	=	?	?	*Partial support.* Technically feasible to implement via the tax system, but stakeholders were uncertain about impact. Acceptability is uncertain – employers would welcome tax relief, but the group worried it could mainly reward those already doing good sickness management without changing others' behaviour (a 'deadweight' effect). Scalability and sustainability are questionable unless tied to demonstrable improvements: if incentives do not yield clear results (e.g. better retention outcomes), they might not be continued. The consensus was that any tax breaks must be tightly linked to real performance (to ensure they genuinely 'nudge' new action) to be justified.
Provide **free, standardised line-manager training** on health-related absence and retention, prioritised for SMEs and sectors with high sickness absence.	+	+	+	+	*Strongly supported.* Feasible – government has already begun funding thousands of free training spots for SME managers and creating a standardised curriculum is straightforward. This was one of the most enthusiastically received ideas: line managers are critical to successful returns and many currently lack the skills, so offering free training (especially to small businesses) is widely seen as a 'quick win.' It is easily scalable via online modules or workshops delivered by existing training providers and should be an ongoing effort (not one-off) for lasting cultural change. As long as it continues to be funded and refreshed, it is a sustainable investment in building employers' capability to support staff health.
Scale up and simplify **occupational health and caseworker subsidies for SMEs** into a single national programme, with clear eligibility, minimal admin and rapid access. For example, building on the 2023 pilot offering 80% subsidised occupational health support for SMEs, make this a national programme so that cost is not a barrier for SMEs to access occupational health or case management for their staff.	+	+	+	+	*Strongly supported.* Stakeholders consistently highlighted cost and administrative burden as the main barriers preventing SMEs from engaging with occupational health or caseworker support. Existing pilots offering subsidised occupational health were viewed positively but criticised for being fragmented and short-term. A single, simple national scheme was seen as feasible (building on existing pilots), highly acceptable to SMEs and scalable if delivered through trusted intermediaries (local authorities, chambers of commerce, ICB partnerships). Sustainability depends on stable funding but was viewed as realistic given strong employer demand and clear prevention benefits.

Policy component 5: Financial incentives for employers to invest in health & retention ('nudge' approach – subsidies, tax breaks, recognition)					
Specific action	F	A	Sc	Su	Narrative assessment
Develop a voluntary '**healthy work' accreditation scheme or kitemark** that signals good practice, provides practical tools (e.g., model policies for sickness absence, mental health, flexible work) and supports continuous improvement.	=	=	?	?	*Mixed support.* Some stakeholders saw value in a visible, positive signal that rewards good practice and helps employers benchmark themselves, particularly larger employers and those already engaged in well-being agendas. Others were sceptical, noting that accreditation schemes risk becoming symbolic, bureaucratic, or dominated by employers already performing well. Scalability and sustainability were not clearly discussed, and stakeholders stressed that any kitemark would need to be tightly linked to practical support and measurable behaviours to avoid limited impact.
Offer **partial Statutory Sick Pay reimbursements for SMEs** that engage proactively in approved return-to-work programmes or caseworker support.	=	=	?	?	*Cautious interest, but under-developed.* The idea of offsetting employer costs to encourage early engagement was mentioned positively in principle, especially for SMEs, but stakeholders did not explore this in depth. Questions were raised about complexity, administration and risk of gaming. While potentially feasible and acceptable if tightly targeted, there was no clear consensus on how such a mechanism would scale or be sustained without unintended consequences.

Policy component 6: Leverage Group Income Protection insurance for early intervention					
Specific action	F	A	Sc	Su	Narrative assessment
Work with the insurance industry to develop and formalise standard early-intervention practices that already exist within GIP, including early notification of absence and rapid deployment of rehabilitation support.	+	+	+	+	*Strongly supported*. Insurers and delivery partners confirmed that early intervention is already embedded within many GIP products, but inconsistently applied. Formalising expectations and minimum standards was seen as feasible and acceptable, particularly if developed collaboratively with the industry. Stakeholders viewed this as scalable across existing policies and sustainable, as it aligns with insurers' commercial incentives to reduce claim duration and improve RTW outcomes.
Support the development of **pooled or collective GIP arrangements for SMEs** (e.g. via chambers of commerce, sector bodies, or umbrella schemes). This could expand coverage beyond the ~10% of the workforce currently covered by GIP.	=	+	+	=	*Mixed support*. Stakeholders viewed pooled or collective GIP models (e.g. via chambers of commerce, sector bodies, or umbrella schemes) as conceptually attractive, but operationally complex. Particularly, challenges were mentioned around underwriting and pricing, adverse selection, governance of pooled schemes and identifying trusted intermediaries to host or manage them.
Improve **alignment** between insurer-provided rehabilitation and public work and health systems through shared principles, referral pathways and RTW planning. Explicitly position GIP-based early intervention as additional to publicly funded work and health support, not a replacement, to avoid a two-tier system.	+	+	+	+	*Strongly supported*. There was broad consensus that insurer-led rehabilitation should complement, not duplicate or displace, public provision. Stakeholders supported shared principles, referral pathways and RTW planning to avoid fragmentation or a two-tier system. This was seen as feasible through guidance and partnership agreements, acceptable to insurers and public actors and scalable nationally. Sustainability was viewed positively, as alignment reduces duplication and improves system efficiency.
Leverage GIP providers' **outcome data and service experience** (where available) to inform standards, workforce models and evaluation of early-intervention case management.	=	+	=	=	*Generally supported, with data-sharing constraints*. Stakeholders recognised the value of insurers' large datasets and practical experience, but highlighted barriers around data comparability, confidentiality and incentives to share commercially sensitive information. Acceptability was relatively high in principle, but feasibility and scalability depend on governance arrangements, standardisation and trust. Sustainability would require ongoing collaboration and clear rules on data use.
If **tax or NI incentives** are used to promote GIP, condition them on demonstrable early-intervention and rehabilitation engagement, not simply holding a policy.	?	?	?	?	Not discussed.

Source: RAND Europe.