Health Innovation
Kent Surrey Sussex

NHS Sussex WorkWell Discovery

NHS
Sussex

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About this report

Announced at the Spring Budget 2023, WorkWell is a joint initiative by the Department for Work and Pensions (DWP) and the Department of Health and Social Care (DHSC), launched as part of the UK Government's strategy to reduce health-related economic inactivity. This report covers the results of a discovery phase to support the implementation of a WorkWell service in Sussex and was commissioned by NHS Sussex.

It is split into five sections:

Executive summary, background and strategic context

Executive summary

The WorkWell Discovery Phase across transformation sites in Hastings, East Brighton, and Crawley reveals a strong consensus among stakeholders that a locally embedded, person-centred model is essential to address the complex interplay between health and employment. Across all three sites, individuals with mental health and musculoskeletal (MSK) conditions face significant barriers to work, including long waiting lists, digital exclusion, fragmented referral pathways, and inconsistent support from employers. Despite these challenges, there is a wealth of existing service provision and a strong appetite for innovation, co-production, and system integration.

Stakeholders from primary and community care health providers, and Voluntary, Community, and Social Enterprise (VCSE) sectors emphasised the importance of embedding WorkWell within trusted community settings, and aligning it with existing services such as social prescribing, Talking Therapies, and MSK pathways. This underscores the existing efforts to tackle the primary divers of economic inactivity - mental health in younger adults and MSK conditions with older adults. They highlighted the need for flexible, culturally sensitive delivery models that accommodate fluctuating health conditions and non-linear journeys into employment. There was also a call for clearer communication of the WorkWell offer, who it is for, and how it would fit with existing services, acknowledging that those in work and those out of work would need different types of support. Consideration of sustainability from the outset is crucial, and it was felt that the development of shared outcome frameworks to track impact across sectors would help demonstrate the value of integrated support and inform future investment.

The findings underscore the potential of WorkWell to act as a connector across fragmented systems, working to clear pathways for specific cohorts to avoid duplication and fill gaps. WorkWell can also provide much needed support for individuals who are not in crisis but not yet work-ready. To succeed, WorkWell must be designed with sustainability, equity, and local ownership at its core. It should prioritise early intervention and the use of digital tools to support this pathway where appropriate, with a call for a cultural shift around the use of fit notes as an enabler to this work to provide timely support. Opportunities were also flagged for more of a focus on employer engagement, education, and support to create inclusive workplaces. With the right transformation and alignment, WorkWell can significantly improve employment outcomes for those managing physical and mental health conditions and reduce health inequalities across Sussex.

Background and strategic context

The Sussex WorkWell programme is a locally driven initiative aligned with the Government's broader ambition to reduce economic inactivity to employment, particularly among individuals with health-related barriers, as outlined in the Get

Britain Working (GBW) white paper.[1] The Government aims to increase employment to an 80% rate, equivalent to over two million more people in work. Six key labour market challenges have been identified, including:

- High economic inactivity, especially among people with health conditions, carers, and those with low skills.
- Poor school-to-work transitions for young people.
- Insecure, low-quality, and low-paying jobs.
- Barriers faced by women with carer responsibilities.
- Labour and skills shortages affecting employers.

Each local area, bringing together stakeholders including local authorities, the Department for Work and Pensions (DWP), VCSE organisations, and the local NHS Integrated Care Board (ICB), is expected to develop its own Get [Place] Working plan by September 2025, tailored to local needs.[2] With plans in place for Sussex to become a Mayoral Combined County Authority in 2026, existing local authorities are working towards a Sussex-wide plan supported by local implementation plans.

Links between health and employment

There is a growing recognition of the link between health and employment. The recently published Get Britain Working Green Paper highlights how "Good work can be protective of health and prevent issues from occurring".[3] It builds on a comprehensive review of over 400 scientific studies commissioned by the DWP, which concluded that: "Work is generally good for physical and mental health and well-being. Worklessness is associated with poorer physical and mental health and well-being."[4]

Key findings include:

- Unemployment is linked to increased rates of depression, anxiety, and suicide.
- Returning to work improves self-esteem, general and mental health, and reduces psychological distress.
- The quality of work matters—supportive, secure, and well-managed jobs are most beneficial.

Integrated Community Teams and the prevention and health inequalities agenda

Integrated Community Teams (ICTs) are an ideal vehicle to support the shift from 'sickness to prevention' working with communities and key partners.

Wider determinants of health are often interlinked. For example, someone who is unemployed may be more likely to live in poorer-quality housing with less access to green space and have less access to fresh, healthy food. This means some groups

[1] Get Britain Working White Paper
[2] Guidance for Developing local Get Britain Working plans (England)
[3] Get Britain Working Green Paper
[4] Waddell, G., & Burton, A. K. (2006). Is work good for your health and well-being? London: The Stationery Office.

and communities are more likely to experience poorer health than the general population. These groups are also more likely to experience challenges in accessing care.

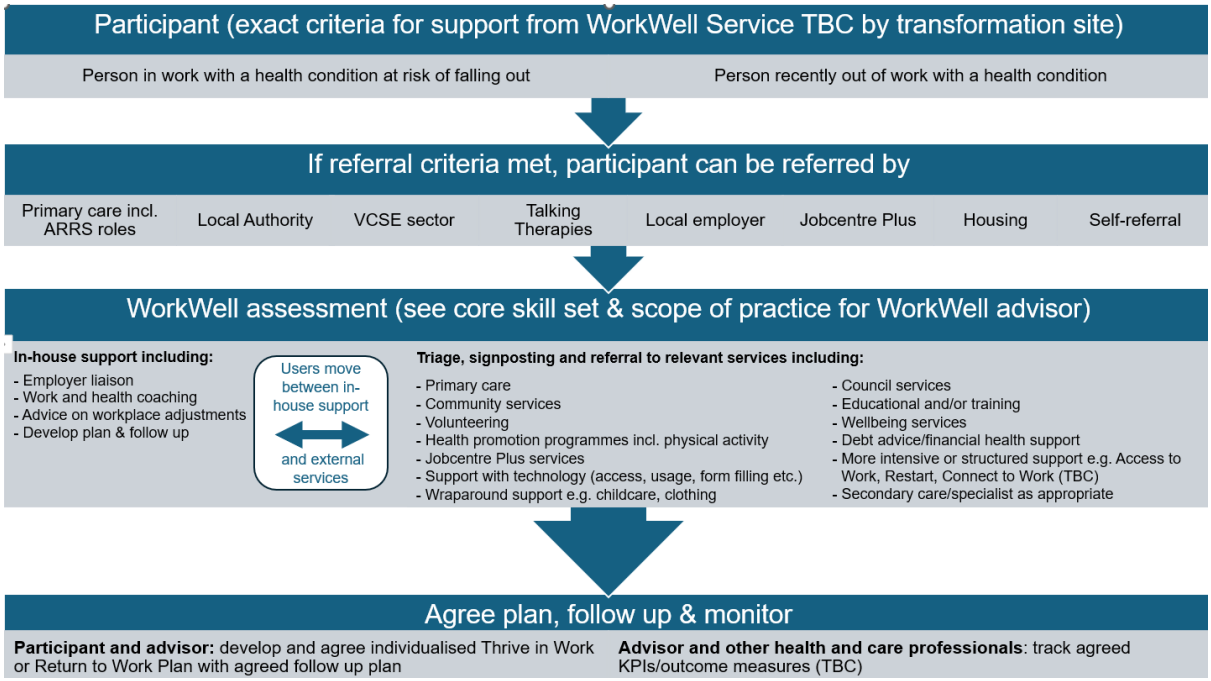
The ICTs are an ideal opportunity for deeper collaboration in our local communities and neighbourhoods to deliver a joined-up approach to prevention, including taking action to address the building blocks of good health – a good home, employment, education and social connections and a sense of community

WorkWell is an example where NHS Sussex will be working closely with Integrated Care Teams on the wider determinants of health. The key to unlocking this is through early intervention i.e. to stop people falling out of work due to health conditions.

WorkWell Vangaurds

The WorkWell Vanguard initiative was a pilot program launched by the Government in May 2024 to integrate health and employment support at the local level. Its focus is to help people with long-term health conditions or disabilities start, stay, and succeed in work by offering early intervention and a personalised approach offering a joined-up support package. Backed by £64 million, the initiative is being trailed in 15 local areas or 'Vanguards', including Surrey and Frimley, where services have been co-designed by local authorities, ICB's, and Jobcentres. These Vanguard sites are currently testing innovations like reforming the fit note process, and a WorkWell Toolkit is forthcoming (date TBC) to offer national guidance on integrating health and employment support.

The WorkWell prospectus provided a typical user journey and an overview of some key potential components of a generic local system intervention. Sites should tailor their own support based on local needs and resources. However, through the information gathered during the Deep Dive interviews conducted in Sussex we have adapted the typical user journey for local use, as shown below (find a larger version in Appendix 1). Please note the figure below provides a general guide informed by our deep dive interviews; relevant pathways and referral criteria are intended to be developed at each transformation site based on their interpretation of the findings and local priorities and resources.



We have also drafted recommended referral criteria for WorkWell, which you can find in Appendix 2.

WorkWell leadership funding

In addition to the initial funding of WorkWell Vanguards, further leadership funding aligned to the WorkWell initiative was made available to make progress in this critical area of enhancing health, work and skills integration and strategy development in Integrated Care Systems across England. NHS Sussex was awarded funding and partnered with Health Innovation Kent Surrey Sussex to undertake an initial Discovery programme to understand how a WorkWell service could be developed and implemented in Sussex.

WorkWell in Sussex: Programme structure and governance

WorkWell in Sussex is structured around five Work Packages (WPs), each designed to build a comprehensive understanding of the local landscape and support the development of integrated services.

Work Package 1 is focused on **project initiation, governance, and data analysis to identify initial transformation sites**. A Programme Board, led by NHS Sussex ICB, was set up in March 2025 to provide the governance structure for this work.

Identifying sites for WorkWell transformation was guided by the following considerations:

- Sites needed to be contrasting within Sussex i.e. focused on a coastal town, coastal city or inland/rural town/city, to have distinct demographics and be generalisable to similar demographics across Sussex.
- Sites need to be in East, West and Brighton & Hove local authorities, to provide an understanding of how WorkWell can best integrate with existing

service provision and other initiatives focussing on reducing economic inactivity across the region.

- Sites selected would ideally cover the same footprint as one of the 13 new Integrated Community Teams (ICTs), given the shared objective of WorkWell and ICTs for integrated, joined up services across organisations within communities. Sites should be generalisable across Sussex.

Initial discussion and analysis of health, employment, and demographic data provided a list of options, such as Brighton and Hove, Arun, Adur, Crawley, Hastings, Worthing and Eastbourne. Key metrics were selected and analysed to provide indicators for the level of need for health and employment support integration in each locality, that would incorporate the relevant services across organisations and within communities (see Appendix 3 for a summary table of these metrics). This led to the selection of **East Brighton**, **Hastings** and **Crawley**.

In summary:

East of Brighton & Hove was selected because:

- It is a coastal city with a diverse population and high levels of unemployment related to mental health[5] as well as having one of the highest levels of overall economic inactivity for Sussex. This is likely to be impacted by one of the longest elective care waiting lists currently in England.[6] The East neighbourhood includes eight out of the 34 CORE20 deprived areas in Brighton and Hove, with 22.1% of its residents living in those areas.[7]

Hastings was chosen because:

- It is a coastal town with a predominantly white, middle-aged demographic, with high MSK and mental health related unemployment and the highest levels of deprivation in Sussex.[8]

Crawley was chosen because**:**

- It is a large inland town with a significant non-white population with a higher percentage of residents who state they are Muslim (9.7%) or Hindu (5.1%) compared to England average (6.7%/1.8%).[9] It also has high levels of unemployment related to MSK conditions[5] and the lowest levels of physical activity for Sussex, alongside other indicators of unhealthy lifestyles and the prevalence of cardiovascular disease (CVD).[9]

The Data Pack section of this report provides detail on the public health data supporting the decision to focus on these sites, together with detail on the public health and economic inactivity data for respective local authorities (i.e. West Sussex

[5] Based on employment support data for 2019 supplied by NHS Sussex
[6] Data from NHS Model Hospital
[7] Details on the Core20PLUS5 approach to inform action to reduce inequalities available here
[8] Hastings ICT Data Pack
[9] Crawley ICT Data Pack

for Crawley, East Sussex for Hastings and Brighton and Hove Unitary Authority for East Brighton.

Work Package 2 comprises a **Deep Dive** report that documents the discovery phase of WorkWell in Sussex, through a detailed qualitative investigation of the three transformation sites.

Work Package 3 will provide NHS Sussex ICB with a **Horizon Scan** that covers a review of evidence, innovative programmes and activity elsewhere from which to learn, and consider how these might relate to the Sussex populations of focus, whether that might be health condition (mental health, MSK) or demographic. It will adopt the 'PEST' methodology exploring the Political, Economic, Social, and Technological factors at play in the context of work and health integration.

We have engaged with WorkWell regional leads at DWP and Office for Health Improvement and Disparities (OHID) and secured participation in the South East (SE) Work and Health Community of Practice Network Meetings. This has enabled us to engage with Vanguards (including Surrey and Frimley) who are currently developing a WorkWell Implementation Toolkit, alongside sharing best practice and evaluation methodologies.

The Horizon Scan will include:

1. A summary of new government initiatives, such as those outlined in the recent Get Britain Working white paper (including Connect to Work).[1,10]
2. An understanding of the implementation and success of other WorkWell initiatives.
3. A review of potential funding pots and opportunities to help sustainability and fund further activity/evaluation.
4. A technology horizon scan will provide details of a selection of innovations that may align with the WorkWell programme. This includes digital technology that can support the pathway, including (i) support for an individual or (ii) support for providers and workforce, through identification, case management, integration and shared records. The focus will be on those who are in work, but at risk of falling out of work, or have fallen out of work for up to a year or less.

[10] **Connect to Work** is a government-funded employment program in England and Wales designed to support individuals with disabilities, health conditions, or complex barriers to employment

WP4 and **WP5** will focus on transformation site planning and mobilisation, implementation and evaluation. Local task and finish groups established in each pilot area will ensure place-based leadership and coordination to support planning, implementation and delivery.

Methods

This WP2 report draws on qualitative data collected during the WorkWell Discovery Phase across the three selected transformation sites: Hastings, East Brighton, and Crawley. The aim was to explore local perspectives on the barriers to employment for individuals with mental health and musculoskeletal (MSK) conditions, and to help inform the design of a locally embedded WorkWell service.

Participants were recruited through early stakeholder engagement at system-wide meetings and via recommendations from initial contacts. While not exhaustive, the sample included a broad cross-section of professionals and community members across health, employment, local authority, and the VCSE sector. Participants from the Integrated Community Team Delivery Board also provided feedback on the WorkWell proposals during a presentation at their regular meeting.

In total, **80 participants** contributed to the three deep dives:

- **East Brighton**: 26 participants
- **Hastings**: 33 participants
- **Crawley**: 21 participants

Each site included individuals with lived experience of health-related barriers to employment, as well as professionals in roles spanning clinical care, social prescribing, employment support, and community development. Data collection methods included one-to-one interviews, focus groups, and written responses. In Crawley, Community Panel members also contributed insights through group discussions and follow-up interviews. Furthermore, a focus group of primary care clinicians was convened in East Brighton, and additional perspectives were gathered from a system wide NHS Sussex ICT Delivery Board meeting, as well as through engagement with emerging local ICT leadership groups, and community oversight groups.

Interviews were guided by a semi-structured questionnaire, aligned with the aims of the deep dive and the WorkWell model. Topics included service integration, referral pathways, digital access, funding, and user journeys. Interviews were conducted via Microsoft Teams or in person, with transcripts analysed using the Framework Analysis approach[11]. Microsoft Copilot M365 was used to support coding and thematic analysis, with all outputs cross-checked against source material to ensure accuracy and fidelity to participants' views.

[11] Ritchie, J., & Spencer, L. (1994). Qualitative data analysis for applied policy research. In A. Bryman & R. G. Burgess (Eds.), Analysing Qualitative Data (pp. 173–194). London: Routledge

Summary of recommendations and actionable steps

1. **Agree local leadership and bring together 'task and finish' groups for each transformation site**
   - Review Deep Dive Report for the relevant transformation site, alongside the accompanying data pack to help inform planning, implementation, and delivery of a WorkWell service and associated evaluation framework.
   - With the oversight of task and finish groups at each transformation site, the planning, implementation and delivery needs to be informed by the multiple stakeholders represented in this review, and the available data for each locality.
   - The recommendations for each site may be considered a 'long list' from which each site can prioritise the focus and operational aspects of WorkWell based on local capacity, existing infrastructure, service configuration, and available funding.

2. Embed WorkWell in trusted community settings

- Co-locate WorkWell services in community hubs (e.g. established community organisations or settings, libraries, food banks, GP surgeries).
- Use drop-in models and peer-led groups to reduce stigma and waiting times.
- Leverage existing VCSE networks to build trust and engagement.

"Basing social prescribers in community settings…it takes a focus away from their medical conditions and what they can't do and brings it into the more active space of 'I'm engaged in my local community'. I think the medicalisation of it removes some of the possibility." VCSE Organisation CEO, East Brighton Deep Dive

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3. Clarify the WorkWell offer & avoid duplication

- Develop a clear service charter outlining eligibility criteria, scope, and benefits.
- Map existing services and establish formal referral protocols and pathways
- Communicate through stakeholder briefings, community events, and materials translated into different languages.

"How much of this sort of support is already being picked up by social prescribing? …you know, we want to make best use of our resources, and we don't want them being sort of duplicated." Social Prescriber, East Brighton

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4. Strengthen referral pathways & fit note integration

- Embed referral prompts into the fit note process.

- Train GPs and Allied Health Professionals (AHPs) on WorkWell criteria and workplace adjustments.
- Enable self-referral and community-based referral options.

> *"People are coming to us to be signed off. But GPs don't like getting into debates and making people distressed by telling them they've got to work, so therefore that's where the conversation ends, and they get signed off sick." GP, Hastings*

5. Address gaps for "middle-ground" clients

- Identify "middle-ground" clients – those who are not in crisis but not yet work-ready.
- Provide light-touch coaching, peer support, and volunteering pathways as steps towards employment readiness.
- Coordinate with integrated neighbourhood mental health teams.

6. Support digital inclusion

- Offer hybrid (digital + in-person) service models to include support for those who struggle with digital platforms and transactions.
- Include a 'self-serve' platform where possible to support early intervention.
- Partner with libraries and VCSEs for digital skills training and device access.
- Use the Sussex Digital Inclusion Framework to guide implementation.

> *"People need something a bit more human and need something from a person who is able to really understand the nuance of the specifics – if I'd said, oh, there's an app, you know, I don't think that's going to work. But if I can put them in touch with a real human being that they can sit down with... that will be preventing them from kind of moving on with the things that they want to move on with. So digital is limited there." Crawley VCSE Organisation CEO*

7. Invest in workforce development

- Train staff involved in delivering WorkWell services in motivational interviewing techniques (and other core skills, as per the Core Skill Set and Scope of Practice for WorkWell Provider(s) in Appendix 3).
- Recruit individuals with lived experience to enhance relatability and trust.
- Promote shared learning across sectors, for example, deliver training to the voluntary and housing sectors together as they bring different perspectives to user pathways and support offers.

8. Engage employers & promote inclusive workplaces

- Develop toolkits and host roundtables to educate employers on MSK and mental health adjustments.
- Share success stories to reduce stigma and encourage inclusive hiring.
- Collaborate with Department for Work and Pensions (DWP) and Jobcentre Plus for employer engagement.

> *"Hastings is a town full of small employers and, very frequently, the employers don't know what their responsibilities are. They often don't do the right thing by their employees." Hastings CAB Advisor*

9. Track outcomes with shared, light-touch metrics

- Use existing tools, e.g. HubSpot CRM, ReQoL-10, and SWEMWBS, where appropriate.
- Balance quantitative data with qualitative stories and case studies.
- Align with NHS and DWP reporting requirements where possible.

10. Align with local & national policy

- Integrate with Changing Futures Sussex, Get Sussex Working, ICB priorities, and Local Skills Improvement Plans.
- Seek co-commissioning opportunities and pooled funding models.

11. Use WorkWell as a system connector

- Lead service mapping and gap analysis.
- Coordinate cross-sector planning and delivery.
- Facilitate shared governance and accountability structures.

Recommendations by stakeholder group

Formal employment support services (DWP, Jobcentre Plus, Employ Crawley)

- Embed WorkWell referral prompts into Universal Credit online journals and fit note processes.
- Co-locate WorkWell services in Jobcentres and Employ Crawley Hubs.[12]
- Share caseload insights to support early identification of clients with health-related barriers.
- Promote employer engagement through joint events and toolkits on workplace adjustments.

VCSE community organisations

- Offer WorkWell drop-in sessions in community venues (e.g. food banks, libraries, community and family centres supporting young adults).
- Provide peer-led support, volunteering pathways, and digital inclusion training as part of WorkWell.

[12] Employ Crawley Hubs

- Collaborate on shared referral protocols and processes for direct and clear handovers.
- Use storytelling and lived experience to co-design and evaluate WorkWell services.

GPs and allied health professionals (AHPs)

- Use fit notes as a referral trigger to WorkWell, especially for mental health and MSK conditions.
- Train AHPs (e.g. Occupational Therapists (OTs), physiotherapists) to issue enhanced fit notes with functional assessments.
- Integrate WorkWell referral options into primary and community care electronic patient record systems (SystmOne /EMIS) templates.
- Participate in joint training to understand the employment-health link.

Clinicians supporting mental health and MSK conditions

- Refer patients to WorkWell early in their treatment journey, especially those at risk of falling out of work.
- Collaborate with WorkWell services to develop return-to-work plans.
- Share outcome data (e.g. IAPTUS, ReQoL-10) to support evaluation.[13],[14]
- Advocate for co-location of WorkWell within clinical and community settings.

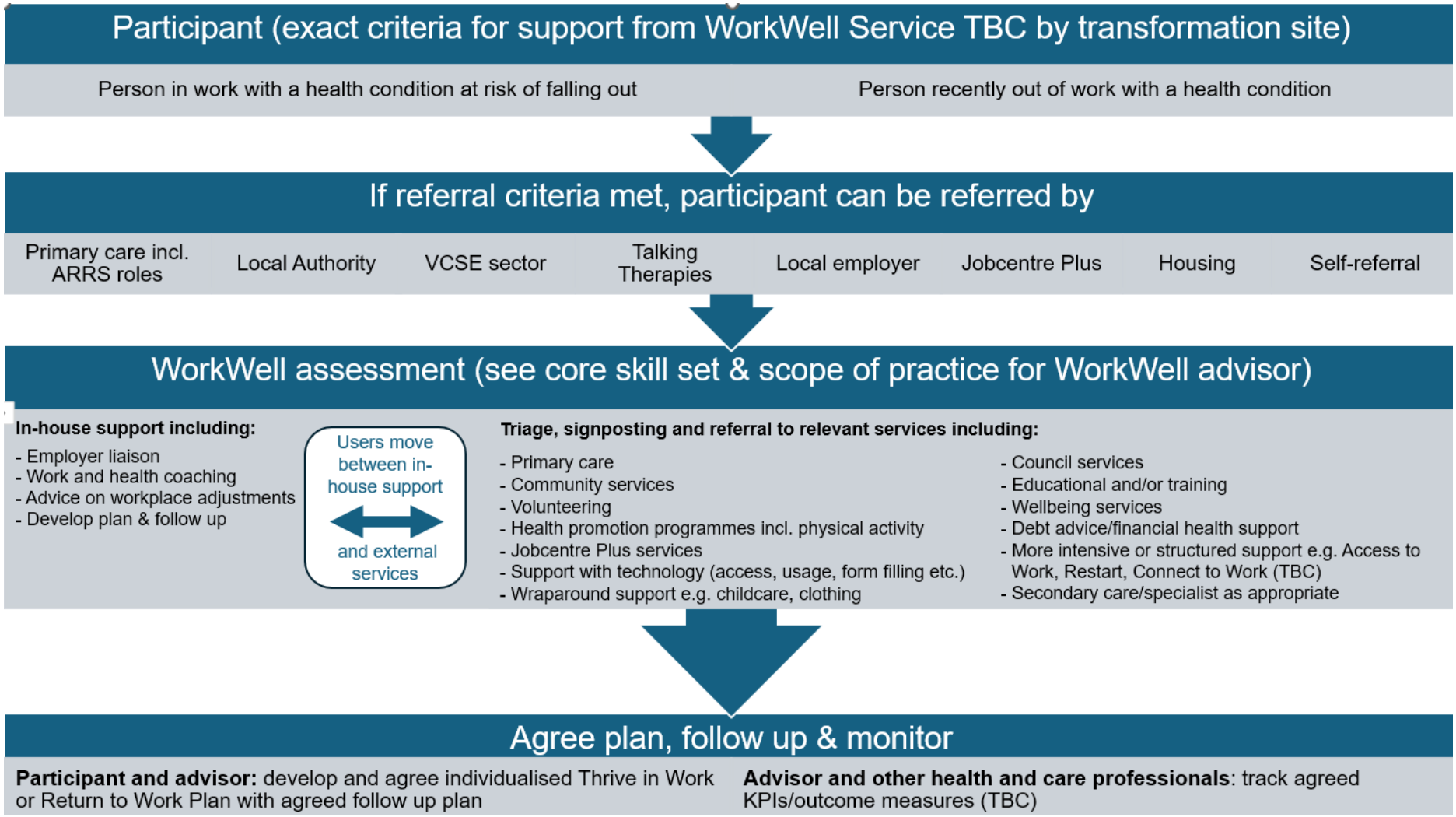
Limitations

This analysis is based on qualitative data from a non-exhaustive sample of stakeholders across three sites, who kindly gave up their time to respond to our outreach. While diverse, the participant pool may not fully represent all relevant perspectives, particularly from employers, housing providers, and some VCSE organisations. Additionally, much of the public health data is only available at local authority level, limiting insight into intra-area disparities (e.g. within East Brighton). These limitations highlight the need for ongoing engagement and more granular data collection.

[13] A cloud-based electronic patient record (EPR) system specifically designed to support psychological therapy services, particularly those within Talking Therapies program.
[14] the Recovering Quality of Life – 10-item tool, a brief questionnaire designed to assess the quality of life in individuals with mental health conditions. It is part of the broader ReQoL (Recovering Quality of Life) suite, developed by researchers at the University of Sheffield and funded by the UK Department of Health.

Appendices

Appendix 1: Typical user journey for local use



Appendix 2: Recommended referral criteria for WorkWell

Based on the DWP WorkWell Prospectus Vanguard guidance and the views of participants in the deep dive interviews, a proposed WorkWell referral might comprise the following:

Eligibility Criteria:

- Aged 18–64 either:
    - Out of work (unemployed or economically inactive) for less than a year and requiring health-related support to move into sustainable employment, or
    - In work and either off sick or struggling to fully participate in work due to a health condition
- Experiencing barriers related to mental health or MSK conditions
- Resident in or registered with a GP/Jobcentre Plus within the WorkWell footprint.

Referral Sources:

- Self-referral
- GP or other primary care provider
- Jobcentre Plus or DWP Work Coach
- VCSE or community organisation
- Employer (with consent).

Priority Groups:

- Individuals with two or more fit notes in the past year
- Those recently off work due to mental health or MSK conditions
- People with fluctuating or long-term conditions affecting work readiness
- Individuals facing multiple disadvantages (e.g. housing, caring responsibilities, digital exclusion).

Appendix 3: Metrics to inform choice of WorkWell Sites

Location/ICT	Brighton & Hove	Hastings	Crawley	Arun	Worthing	Eastbourne
Geography	Coastal City	Coastal Town	Inland town	Coastal/Rural area	Coastal Town	Coastal Town
MH ESA Claim % (& rank in Sussex)[1]	58 (1ST)	52 (2ND)	49 (4TH)	49 (4TH)	52(2ND)	50 (3RD)
MSK ESA Claim % (& rank in Sussex)	10 (5TH)	13 (2ND)	14 (1ST)	11(4TH)	11 (4TH)	13 (2ND)
Demographic (Co-Pilot Summary)	Predominantly young adults, diverse, multiethnic	Predominantly middle-aged & White	Predominantly working age, significant Asian population	Predominantly older, White	Predominantly middle-aged White, Asian	Predominantly older, White, Asian
% Unemployment rate (national av: 3.3) [2]	4.8	6.1	3.8	4.3	3.4	4.4
% Economically Inactive (national av:21.6)	19.5	16	14.1	16.9	12.3	17.6
% physically active [3]	73	62	51	64	61	61
Av. IMD Decile for LSOA areas [4]	5.56	3.22	5.49	5	6.3	5.978

[1] ESA data by region and condition provided by NHS Sussex May 2018
[2] Nomis - Official Census and Labour Market Statistics (Oct'23-Sept'24)
[3] Active Lives Small Area Estimates Tool | Sport England
[4] English indices of deprivation 2019 - GOV.UK

Appendix 4: Core skill set and scope of practice for WorkWell provider(s)

The Deep Dive reports have drawn upon a wide range of professional perspectives from stakeholders involved in various aspects of employment support and healthcare provision that help individuals to return to or stay in work. From these interviews, a core skill set, and scope of practice is indicated below.

Core Skills:

- Motivational interviewing and coaching
- Culturally competent practice, including awareness of trauma-informed approaches
- Knowledge of employment rights and workplace adjustments
- Understanding of mental health and MSK conditions
- Digital literacy and ability to support clients with digital tools
- Partnership working and referral coordination.

Scope of Practice:

- Provide 1:1 support to individuals with health-related employment barriers
- Develop personalised action plans and support return-to-work journeys
- Liaise with employers to facilitate workplace adjustments
- Keep abreast of local service provision and develop networks
- Refer to and coordinate with health, VCSE, and statutory services
- Deliver support in community settings and via digital platforms
- Track outcomes and contribute to service evaluation

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Data analysis

Executive summary

The Sussex WorkWell programme is designed to address economic inactivity driven by health-related barriers to employment, particularly mental health and musculoskeletal (MSK) conditions.

Across Sussex, economic inactivity due to long-term sickness is higher than in neighbouring regions, particularly in East Sussex, which also shows one of the highest fit note issuance rates for the region.

The data pack highlights that while Brighton and Hove, East Sussex, and West Sussex each face distinct challenges, their respective WorkWell transformation sites – East Brighton, Hastings, and Crawley – exhibit concentrated deprivation and health inequalities that indicate the need for targeted intervention.

Brighton and Hove, whilst younger and more diverse than the national average, faces high levels of deprivation in specific wards such as Moulsecoomb and Bevendean. This area reports elevated rates of educational and health deprivation, low full-time employment, and high child poverty. Despite a relatively strong employment rate citywide, the gap in health outcomes and economic participation remains significant in East Brighton.

Hastings, part of East Sussex, is one of the most deprived local authorities in England. It exhibits high rates of long-term health conditions, mental health challenges, and musculoskeletal issues. Employment rates are significantly below the national average, and the employment gap for those with health conditions is among the highest in the region. The town also faces acute housing pressures and high rates of homelessness, further compounding health inequalities. These indicators highlight the need for integrated, place-based interventions that address both health and socio-economic determinants.

Crawley, while economically active and demographically younger, presents a contrasting picture. It has the highest ethnic diversity compared to other Sussex Integrated Community Team (ICT) footprints, with a strong employment rate, including among those with long-term health conditions. However, it also experiences high levels of housing overcrowding, benefit dependency, and child poverty. Health inequalities are pronounced, with significant intra-borough disparities in deprivation. Despite better than average employment and health indicators, the area's challenges in education, housing, and crime suggest a need for targeted, community-specific strategies.

The Sussex context

The Department for Work and Pensions (DWP) has recently published data on economic inactivity across England,[15] which is a key target the UK Government is addressing through the WorkWell initiative and wider Get Britain Working Strategy.[16]

It defines economic inactivity as those not in employment and who have not been seeking work within the last four weeks and/or are unable to start work within the next two weeks, including individuals who are long-term sick or disabled, students, retired (before state pension age), caring for family, temporarily sick or discouraged from seeking work.

Economic inactivity is distinct from those unemployed, who are actively seeking and available for work. The data goes down to Local Authority level but is not available to Integrated Community Team (ICT) or similar smaller footprints. However, it does illustrate how Sussex compares against regional and national figures. In terms of economic inactivity of working age population, Sussex sits between Surrey and Kent & Medway, at 4.9%.

The table in Figure 1 highlights that Sussex has a higher proportion of working age people economically inactive due to physical health conditions, including MSK, CVD, diabetes, respiratory, allergies and more. Furthermore, one can see mental health condition prevalence figures are closer to Kent and Medway than Surrey.

It is worth stating at this point that the Get Sussex Working plan is currently in development and is due to be published in the Autumn (exact date TBC). This will provide more up to date data, and detail local area delivery plans around health, skills and work.

[15] Official Statistics Gov.UK: Keep Britain Working
[16] Get Britain Working White Paper

Fig 1: Economic inactivity, mental health and physical health condition prevalence nationally and across the South East

Local Authority	Population (aged 16-64)	Economically inactive – short or long-term sick	(%)	Physical health condition*	(%)	Mental health condition†	(%)	Disabled‡	(%)
National	43,060,175	3,027,429	7	9,192,675	21.3	4,123,293	9.6	10,436,636	24.2
West Sussex	525,007	26,153	5	119,945	22.8	52,293	10	118,749	22.6
Brighton & Hove	213,797	8,631	4	46,226	21.6	20,971	9.8	58,851	27.5
East Sussex	333,087	19,180	5.8	76,088	22.8	32,360	9.7	84,042	25.2
Sussex	1,071,891	53,964	4.9	242,259	22.4	105,624	9.8	261,642	25.1
Kent	987,742	55,317	5.6	202877	20.5	94,142	9.5	226034	22.9
Medway	183,768	10,213	5.6	35,850	19.5	20,318	11.1	43,472	23.7
Kent & Medway	1,171,510	65,530	5.6	238,727	20	114,460	10.3	269,506	23.3
Surrey	757,048	33,811	4.5	146,391	19.3	59,418	7.8	146,888	19.4

*'Physical health condition' includes: difficulty in seeing or hearing; severe disfigurement; skin conditions; allergies; stomach, liver kidney or digestive problems; epilepsy; progressive illness not included elsewhere; problems or disabilities connected with arms, hands, legs, feet, back or neck; chest or breathing problems incl. asthma and bronchitis; heart, blood pressure or blood circulation problems and diabetes.

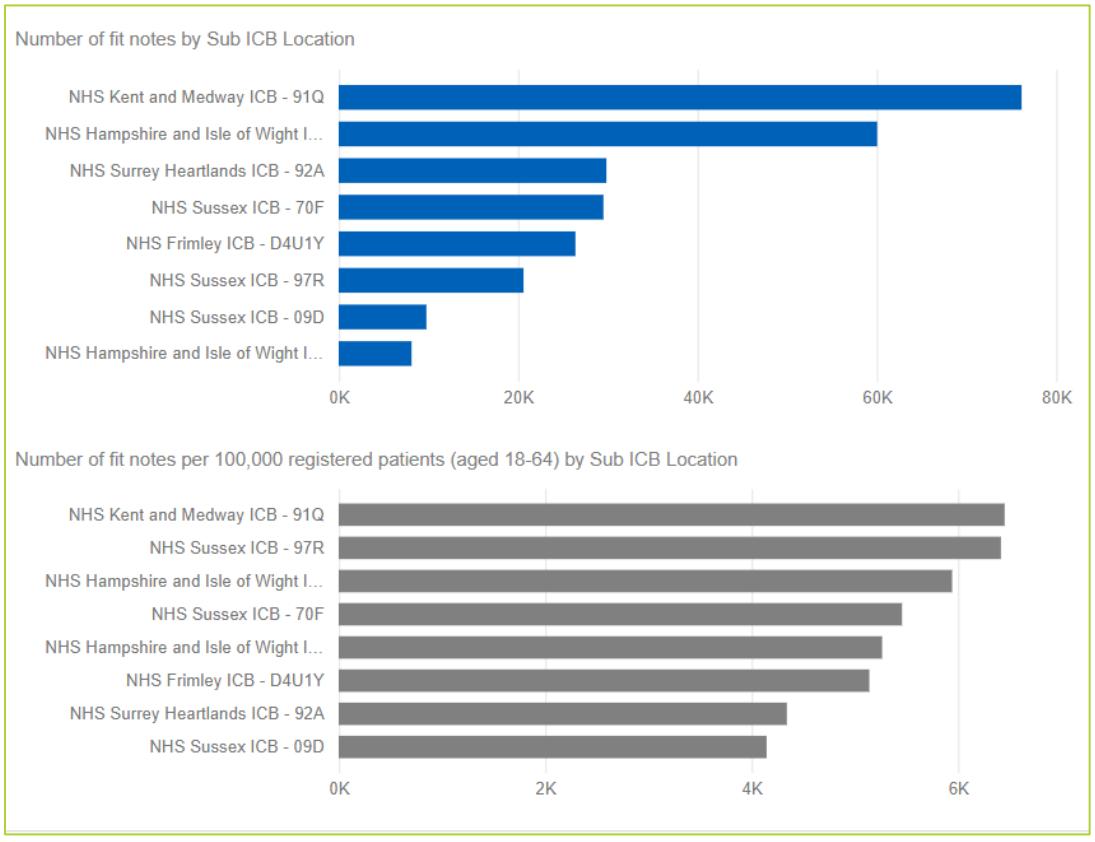
†'Mental health condition' includes: mental illness, or suffering from phobia, panics or other nervous disorders and depression, bad nerves or anxiety; severe or specific learning difficulties and autism.

‡Disabled: Government Statistical Service (GSS) Harmonised Standard definition of disability, in line with the Equality Act 2010 (EA) core definition

A pivotal moment in an individual's journey from work to economic inactivity is the issuance of a fit note by a GP or allied health professional (AHP) that indicates whether a person is fit for work or may be fit with adjustments. It is used in the UK to support sick leave, benefit claims, and workplace accommodations. Fit notes are typically required after seven days of absence from the workplace due to illness and can help guide discussions between employers and employees about returning to work.

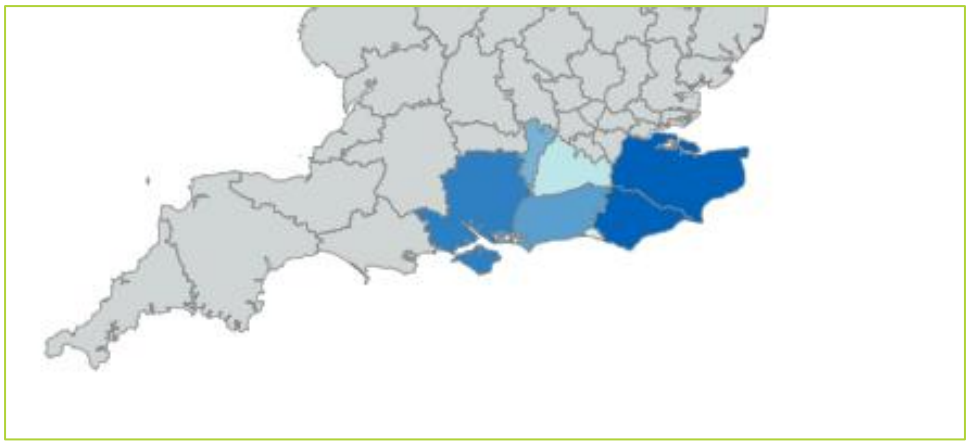
Data from the Office for Health Improvement and Disparities (OHID) fit note dashboard[17] below illustrates that East Sussex (97R) has the second highest fit note issuance rate (per 100,000 of the population) for the eight sub locations featured across the South East followed by West Sussex (70F) and Brighton and Hove (09D).

Fig 2: Number of fit notes and fit note issuance across the South East per 100,000 registered patient map



[17] OHID Fit note dashboard

Heat map of fit note issuance per 100,000 population South East



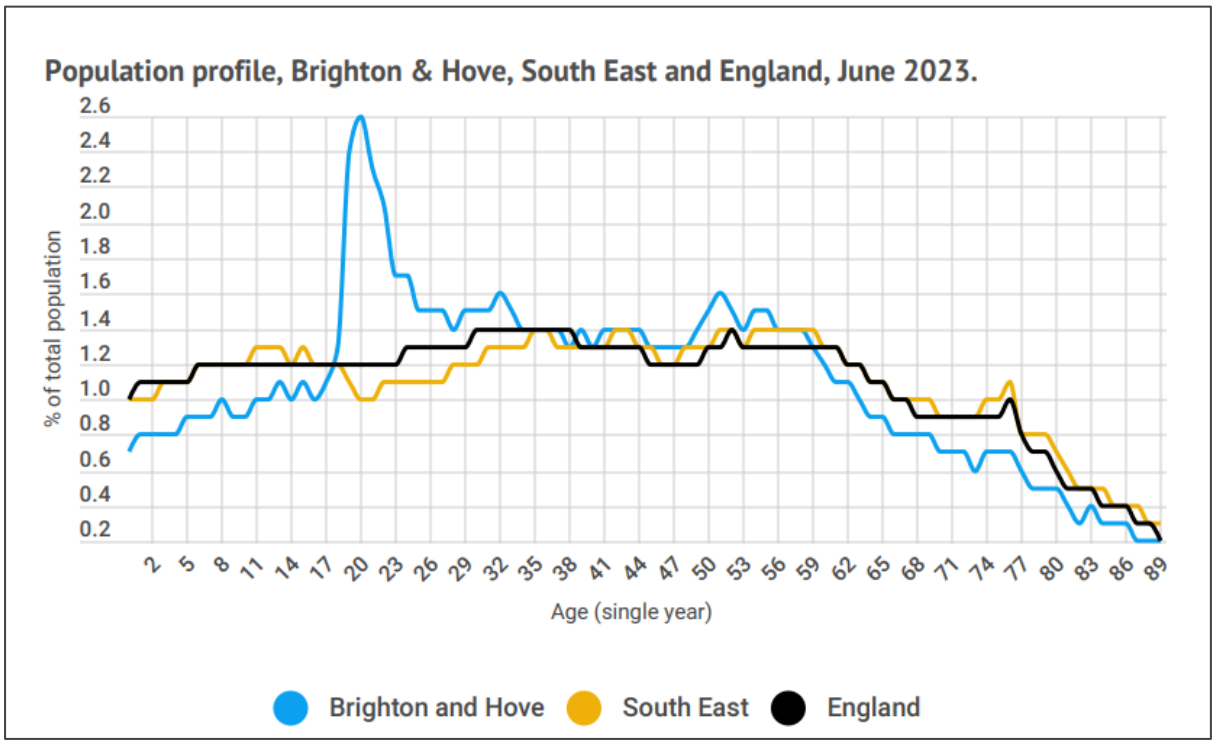
Source: OHID Fit note dashboard

Brighton and Hove

Population profile

According to its Joint Strategic Needs Assessment (JSNA)[18], Brighton and Hove has a younger age structure than England. In 2023, it was estimated that 40,800 people (15%) were aged 0 to 15 years old, more than two thirds (73%, 203,700 people) aged 16 to 66 years old, one in ten (11%, 29,600 people) were aged 67 to 84 years old and 5,400 people (2%) were aged 85 years or older.

Fig 3: Brighton and Hove age profile (Source: Brighton & Hove JSNA)



[18] Brighton and Hove JSNA

Demographic and social characteristics

Residents of Brighton and Hove are more likely than across England, to be:

- Ethnic minorities: 1 in 3 people
- LGBTQ+: 1 in 6 adults
- Transgender: 1 in 100 adults
- Never married/in a civil partnership: almost 2 in 3 adults.

Between 2011 and 2021, the total population has decreased by 0.8%, in contrast to the national picture that shows an increase over the same period of 6.6%.

Housing and economic context

Housing cost is a significant issue in Brighton and Hove, with those on the lowest 25% of earnings requiring 12.2 times their earning to afford the lowest 25% of housing prices, compared to 7.4 times across England.

Education and employment

Brighton and Hove faces persistent inequalities in education and employment outcomes, particularly among disadvantaged groups. Despite a highly educated population overall, with a large proportion of residents holding degree-level qualifications, there are significant attainment gaps for children and young people from low-income households and ethnic minority backgrounds. Employment levels are generally strong. However, insecure and low-paid work remains a concern, especially in sectors such as hospitality and care.

Brighton and Hove public health profile

Based on the latest data from the Public Health Outcomes Framework for Brighton and Hove[19], several key health indicators reveal a mixed picture in the area. Data below is drawn from several different time periods (as detailed in the tables for each measure), which are the latest available data published on the Framework.

Life expectancy

Life expectancy at birth is 78.8 years for males and 83.6 years for females, closely aligning with England averages (79.3 and 83.2 respectively).

[19] Public Health Outcomes Framework (Brighton & Hove)

Healthy life expectancy

Healthy life expectancy is 60.6 years for males and 61.5 years for females, suggesting a notable gap between lifespan and healthy lifespan, again aligning with national levels (61.5 and 61.9 respectively).

Measure	Year	B&H Male	B&H Female	England Male	England Female
Life expectancy at birth (years)	2023	78.8	83.6	79.3	83.2
Healthy life expectancy at birth (years)	2021-2023	60.6	61.5	61.5	61.9

Mental Health Indicators

- The percentage of adults in contact with secondary mental health services living in stable and appropriate accommodation is 74%, which is significantly better than the national average of 58%.
- The percentage of adults in contact with secondary mental health services and on the Care Plan Approach (aged 18 to 69) in paid employment is 10%, compared to the England figure of 9%.
- Emergency hospital admissions for intentional self-harm (2023/24) are at 161.8 per 100,000, significantly higher than compared to the England figure of 117 per 100,000.

Measure	Year	B&H Adults	England Adults
Adults in contact with secondary mental health services living in stable and appropriate accommodation (%)	2021	74	58
Adults in contact with secondary mental health services and on the Care Plan Approach (aged 18 to 69) in paid employment (%)	2021	10	9
Emergency hospital admissions for intentional self-harm (per 100,000)	2023-2024	161.8	117

Musculoskeletal (MSK) Problem Indicator

The percentage reporting a long-term MSK problem stands at 13.6% in adults over 16 compared to a regional figure of 18.4%.

Measure	Year	B&H Adults	England Adults
% reporting a long-term Musculoskeletal (MSK) problem in adults over 16	2023	13.6	18.4

Employment and Health Indicators

- The percentage of people in employment is 79%, higher than that for England overall at 75.7%.
- The percentage of the population with a physical or mental long term health condition in employment (aged 16 to 64) is 66.2, slightly better than the England figure of 65.3.
- The employment gap[20] between the employment rate for those with long-term physical or mental health conditions and the employment rate in the general population is at 8.8%, slightly better than the England average of 10.4%.
- The percentage of working days lost due to sickness absence lies at 1.2% aligned to the figure for England 1.2%.
- The percentage of 16- to 17-year-olds Not in Education, Employment or Training (NEET) or whose activity is not known stands at 5%, compared to 5.4% for England.

Measure	Year	B&H Adults	England Adults
% of people in employment	2023-2024	79	75.7
% of the population with a physical or mental long term health condition in employment (aged 16 to 64)	2022-2023	66.2	65.3
Gap in the employment rate between those with a physical or mental long-term health condition (aged 16 to 64) and the overall employment rate	2022-2023	8.8	10.4
Sickness absence: % of working days lost due to sickness absence	2021-2023	1.2	1.2
% 16- to 17-year-olds Not in Education, Employment or Training (NEET) or whose activity is not known	2023-2024	5	5.4

[20] This indicator is used to measure inequality in access to employment for people with long-term health conditions. A larger gap suggests that people with such conditions face greater barriers to employment, which can include discrimination, lack of workplace accommodations, or insufficient support services.

Other Metrics of Note for WorkWell: Youth Crime and Homelessness

- Youth Crime and Homelessness: First time entrants to the youth justice system stand at 198 per 100,000, significantly higher than the national average of 143.
- Homelessness: households in temporary accommodation is 12.3 per 100,000, significantly higher compared to 4.6 for England.

Measure	Year	B&H Adults	England Adults
First time entrants to the youth justice system (per 100,000)	2023	198	143
Homelessness – households in temporary accommodation (per 100,000)	2023	12.3	4.6

Health Inequalities in Brighton and Hove

Life Expectancy and Deprivation

The inequality in life expectancy at birth between the most and least deprived areas in Brighton and Hove is highest for males (9.4 years) than for females (6 years), but both are lower compared to the England figures of 10.5 years for men and 8.3 years for women.

Measure	Year	B&H Male	B&H Female	England Male	England Female
Inequality in life expectancy at birth between the most and least deprived areas (years)	2021-2023	9.4	6	10.5	8.3

Geographic Distribution of Deprivation

Several neighborhoods in Brighton and Hove rank among the 20% most deprived areas in England. The highest concentrations of deprivation are found in the Whitehawk, Moulsecoomb and Bevendean, and Hollingdean areas. Additional pockets of deprivation are located along the coast to the west of the city and in Woodingdean. These areas face multiple challenges across domains such as income, employment, education, health, and housing. This distribution reflects the broader socio-economic disparities within the city and underscores the importance of targeted interventions to address community needs[21].

[21] Brighton & Hove City Council plan 2023 to 2027/ Brighton & Hove demographics

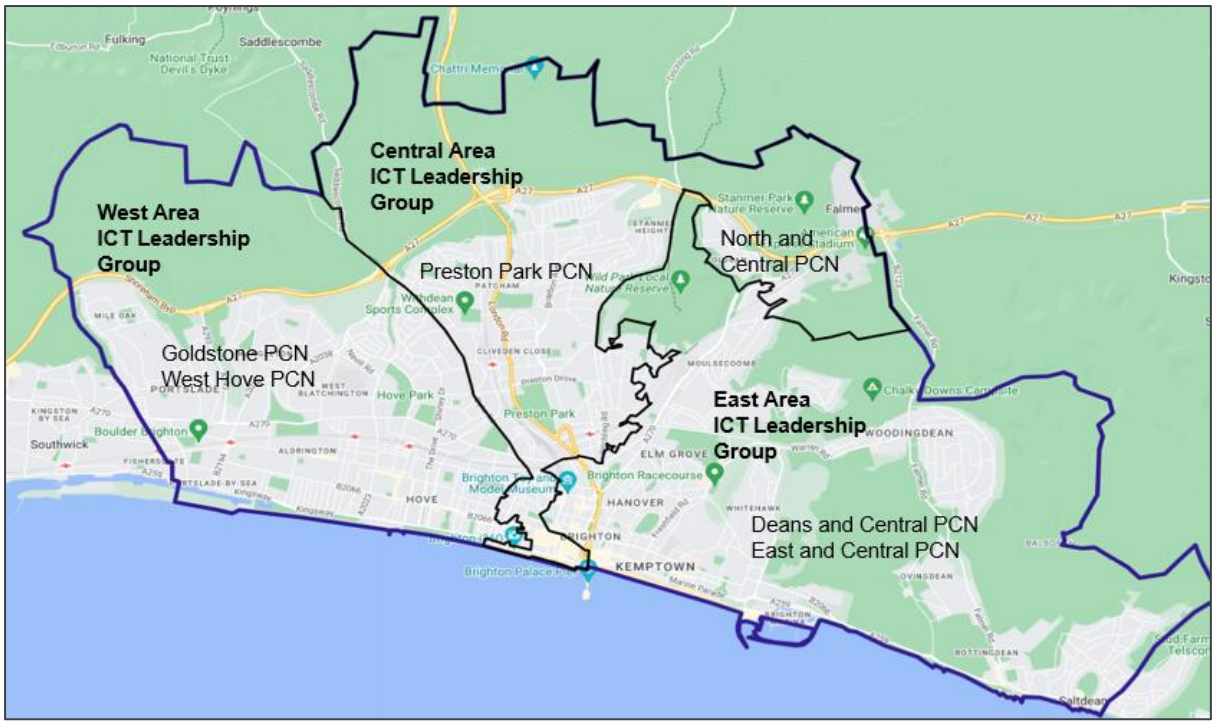
East Brighton WorkWell transformation site and ICT leadership group

East Brighton ICT Leadership Group is one of three groups that make up the wider Brighton and Hove ICT footprint and has been the focus for the East Brighton WorkWell Transformation Site.

Previously, East Brighton was one of three separate ICT's that covered the Brighton and Hove area, but in 2025 this arrangement was modified. There are now three ICT Leadership Groups, with their own governance structures, that report into one Brighton and Hove ICT, effectively a hub and spoke model.

The footprints for each of the three Leadership groups are provided below for reference:

Fig 5: Brighton and Hove ICT Leadership Groups



Source: Trust for Developing Communities, email correspondence

It is important to note a high percentage of public health data is only available at Brighton and Hove level, which limits the granularity and insights available specific to East Brighton. However, Moulsecoomb and Bevendean, a large ward within the footprint – produced a Neighbourhood Action Plan[22] in 2018 with data to highlight health and employment issues of interest. For example:

- Of the 18,500 population, 79% of people in the ward live in an area of educational deprivation compared to 20% in England.

[22] Moulsecoomb and Bevendean Neighbourhood Action Plan

- 60% live in areas ranked in the most deprived 20% of England according to the Indices of Multiple Deprivation 2015.
- 49% of the community are living in health deprivation 'hotspots' compared to 20% for England.
- Only 23% people aged 16-74 are in full-time employment, compared to 39% across England.
- 39% of children are living in poverty compared to 19% in England.

Data is available for 2019-2023 for the similar geographical footprint of the East Brighton ICT (the precursor to the East Brighton ICT Leadership Group) through their ICT data pack[23] that provides further indicators of social and health inequalities, particularly for mental health, including:

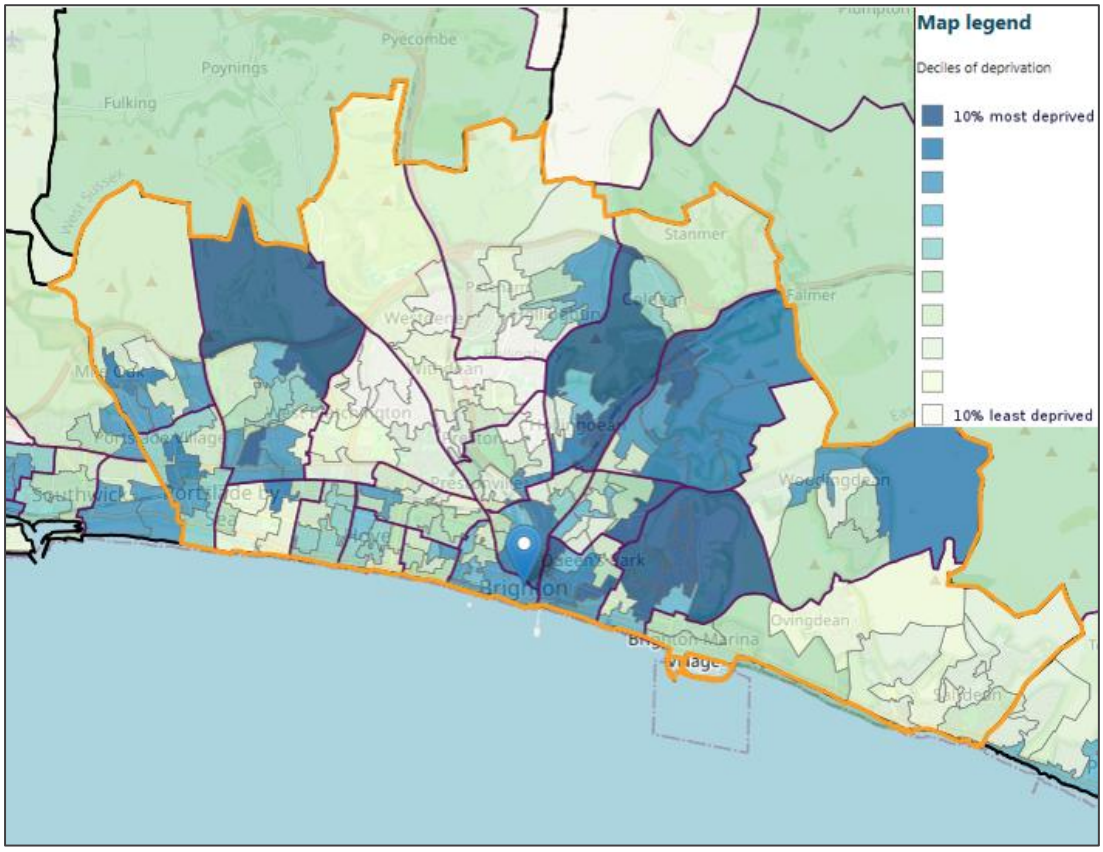
- 22.1% of people lived in the most deprived areas in England, compared to the average 19% for England (2019).
- 18.7% of older people lived in poverty compared to the average 14.2% for England (2019).
- 299.6 emergency hospital admissions for self-harm rate per 100,000 (2021/22) compared to the England figure of 163.9 for the same period.
- 36.1 % of adults with serious mental illness were taking up a physical health check compared to 58.5% in England in 2022/23.
- 28.5% of people gave a high anxiety score compared to 22.6% in England (2021/222).

Deprivation Across East Brighton

The Indices of Deprivation 2019 and 2015 Interactive Map[24] enables a map view of the Lower Super Area Output (LSOA), which typically contains 1,000 to 3,000 people or 400 to 1,200 households, with Index of Multiple Deprivation superimposed. Brighton and Hove LSOA (O27A) is ranked 8,856 out of 32,844 LSOAs in England, where 1 is the most deprived LSOA. This is amongst the 30% most deprived neighbourhoods in the country.

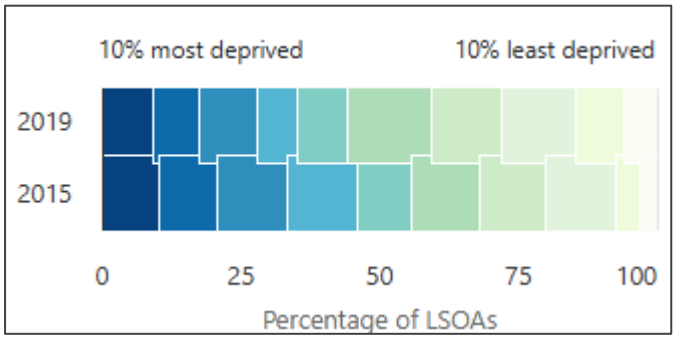
[23] Brighton & Hove East Integrated Community Team Population Profile Pack 2023
[24] Indices of Deprivation 2019 and 2015 Interactive Map – OpenDataCommunities

Fig 6: Brighton and Hove LSOA Index of Multiple Deprivation Map



Source: Indices of Deprivation 2019 and 2015 Interactive Map – OpenDataCommunities

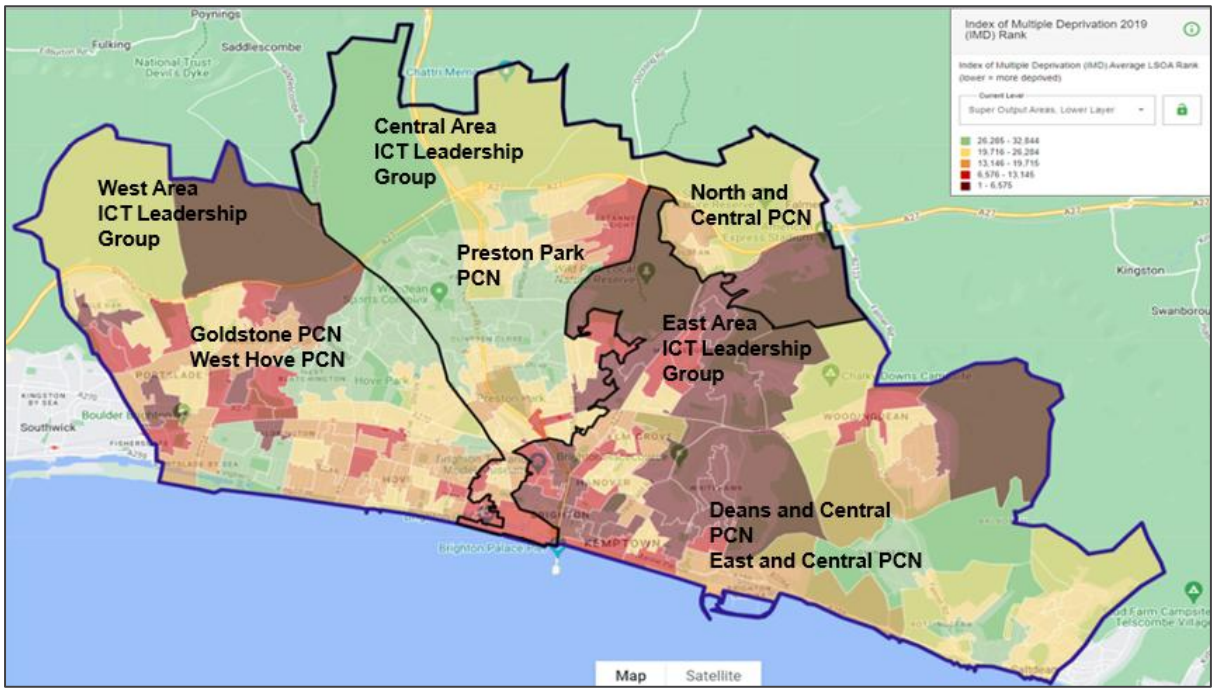
The map tool below provides comparison with 2015 data and indicates some marginal improvements in deprivation levels over this time with slightly fewer areas within the lowest IMD deciles in 2019.



Source: Indices of Deprivation 2019 and 2015 Interactive Map – OpenDataCommunities

This similar map, provided by the Trust for Developing Communities using the Brighton Public Health Insight tool[25], highlights how the elevated levels of deprivation in the area correspond to the area covered by the East Brighton ICT Leadership Group and WorkWell Transformation Site.

Fig 7: Brighton and Hove ICT Leadership Group boundaries and deprivation levels



Source: Trust for Developing Communities, email correspondence

East Sussex

Population Profile

According to the East Sussex Joint Strategic Needs Assessment (JSNA)[26], East Sussex has an older age structure than England overall. The population was estimated at 550,720 in mid-2022, a 4% increase since 2012, primarily driven by internal migration from within the UK. In contrast to Brighton and Hove, East Sussex has a significantly higher proportion of older residents and fewer people in younger age groups, particularly those aged 20–39 years.

The county has a lower proportion of residents from ethnic minority backgrounds compared to England. The population is predominantly White British/Northern Irish, and the diversity seen in urban areas like Brighton and Hove is less pronounced in East Sussex.

Demographic and Social Characteristics

Residents of East Sussex are more likely than the national average to:

[25] Brighton Public Health Insight tool
[26] East Sussex JSNA

- Be aged 65 and over, reflecting the county's appeal as a retirement destination.
- Live in rural or semi-rural areas, with implications for access to services and transport.
- Experience health inequalities that vary significantly by district, for example, Hastings is among the 20 most deprived local authorities in England, while Wealden is among the 100 least deprived[27].

Between the 2011 and 2021 Censuses, the population of East Sussex increased by approximately 3.7%, rising from around 526,700 to 546,000 residents. This growth was primarily driven by internal migration, particularly among older age groups, reflecting the county's continued appeal as a retirement destination. While the overall growth rate was modest compared to some other regions, it varied across districts, with Wealden and Lewes experiencing more significant increases, while Hastings saw relatively little change[28].

Housing and Economic Context

The East Sussex JSNA outlines a complex housing and economic landscape shaped by affordability challenges, demographic shifts, and broader economic pressures. Housing affordability remains a key concern, with a significant gap between local incomes and house prices, particularly affecting younger and lower-income households.

The JSNA also notes a shortage of suitable housing for older people and those with complex needs, which places additional pressure on health and social care services.

Economically, East Sussex faces structural challenges - including lower-than-average productivity and wages - compounded by the ongoing impacts of the cost-of-living crisis and public service funding constraints, according to the East Sussex Council Plan[29].

These factors contribute to inequalities across East Sussex, reinforcing the need for integrated planning across housing, health, and economic development to support resilient and inclusive communities.

Education and Employment

Based on the East Sussex JSNA, education and employment in the county reflect both progress and persistent challenges. The JSNA highlights disparities in educational attainment, particularly among disadvantaged groups, and emphasises the need for targeted support to improve outcomes for children and young people, especially those with Special Educational Needs and Disabilities (SEND).

East Sussex Public Health Profile

[27] State of the County: Focus on East Sussex
[28] ONS/Census change over time data, England and Wales: 2011 to 2021
[29] East Sussex Council Plan

Based on the latest data from the East Sussex Public Health Outcomes Framework[30] the area demonstrates a generally strong public health profile, though some indicators highlight areas for improvement. Data below is drawn from several different time periods (as detailed in the tables for each measure) which are the latest available data published on the Framework.

Life Expectancy

- Males: 80.2 years
- Females: 83.7 years

These figures are slightly above the England averages of 79.3 and 83.2 years respectively.

Healthy Life Expectancy

- Males: 61.8 years
- Females: 62.2 years

These are slightly better than the England averages of 61.5 and 61.9 years respectively, though they indicate a significant portion of life may be spent in poor health.

Measure	Year	E Sx Male	E Sx Female	England Male	England Female
Life expectancy at birth (years)	2023	80.2	83.7	79.3	83.2
Healthy life expectancy (years)	2021-2023	61.8	62.2	61.5	61.9

[30] Public Health Framework: East Sussex

Mental health indicators

- The percentage of adults in contact with secondary mental health services living in stable and appropriate accommodation is 74%, significantly better than the national average of 58%.
- The percentage of adults in contact with secondary mental health services and on the Care Plan Approach in paid employment (aged 18–69) is 13%, above the England average of 9%.
- However, in contrast, emergency hospital admissions for intentional self-harm stand at 192.7 per 100,000, significantly higher than the England average of 117 per 100,000.

Measure	Year	E Sx Adults	England Adults
Adults in contact with secondary mental health services living in stable and appropriate accommodation (%)	2021	74	58
Adults in contact with secondary mental health services and on the Care Plan Approach (aged 18 to 69) in paid employment (%)	2021	13	9
Emergency hospital admissions for intentional self-harm (per 100,000)	2023-2024	192.7	117

Musculoskeletal (MSK) problem indicator (2023)

- Percentage of adults reporting a long-term MSK problem is 22.5%, higher than the Southeast regional figure of 17.4% and the England average of 18.4%.

Measure	Year	E Sx Adults	England Adults
% reporting a long-term MSK problem in adults over 16	2023	22.5	18.4

Employment and health indicators

- The percentage of people in employment (2023/24) is 75.2%, compared to 75.7% for England.
- Percentage of the population with a physical or mental long term health condition in employment (aged 16 to 64) is 56.5%, markedly lower than for England (65.3%).
- The employment gap between those with long-term physical or mental health conditions and the general population is 16.6%, significantly higher than the England average of 10.4%.
- The percentage of working days lost due to sickness absence is 1.1% compared to 1.2% in England.
- The percentage of 16–17-year-olds Not in Education, Employment or Training (NEET) or whose activity is not known (2023/24) is 6.3%, higher than the England average of 5.4%.

Measure	Year	E Sx Adults	England Adults
% of people in employment	2023-2024	75.2	75.7
% of the population with a physical or mental long term health condition in employment (aged 16 to 64)	2022-2023	56.5	65.3
Gap in the employment rate between those with a physical or mental long term health condition (aged 16 to 64) and the overall employment rate	2022-2023	16.6	10.4
Sickness absence: % of working days lost due to sickness absence	2021-2023	1.1	1.2
% 16- to 17-year-olds Not in Education, Employment or Training (NEET) or whose activity is not known	2023-2024	6.3	5.4

Other Metrics of note for WorkWell: youth crime and homelessness

- First-time entrants to the youth justice system: 127.7 per 100,000, lower than the national average of 143.
- Homelessness – households in temporary accommodation: 4.7 per 100,000, closely aligned with the England average of 4.6 per 100,000.

Measure	Year	E Sx Adults	E Sx Adults
First time entrants to the youth justice system (per 100,000)	2023	127.7	143
Homelessness – households in temporary accommodation (per 100,000)	2023	4.7	4.6

Health inequalities in East Sussex

Life Expectancy and Deprivation

The inequality in life expectancy at birth between the most and least deprived areas in East Sussex is males at 8.4 years and females at 7 years, lower than the figure for England (males 10.5 and females 8.3 years respectively).

Measure	Year	E Sx Male	E Sx Female	England Male	England Female
Inequality in life expectancy at birth between the most and least deprived areas (years)	2021-2023	8.4	7	10.5	8.3

Geographic distribution of deprivation

The geographic distribution of deprivation across East Sussex reveals significant spatial inequalities, with the highest levels of deprivation concentrated in coastal and urban areas. As noted earlier, Hastings is among the 20 most deprived local authorities in England, while Wealden is among the 100 least deprived. This uneven distribution underscores the importance of place-based approaches to public health and social policy, targeting resources and interventions where they are most needed.

Hastings WorkWell and ICT transformation site

Population profile

Through analysis of the Public Health Outcomes Framework data for Hastings[31], it is clear the town has significant public health challenges. Hastings has a younger age profile than much of East Sussex, but also some of the highest levels of deprivation in the county. It is consistently ranked among the 20 most deprived local authorities in England, with persistent socio-economic inequalities impacting health outcomes.

The population is more urbanised compared to other parts of East Sussex, with a higher proportion of residents living in areas classified among the most deprived 20% nationally. This contributes to increased demand for health and social care services and greater exposure to risk factors associated with poor health.

Demographic and social characteristics

Residents of Hastings are more likely than the national average to:

- Live in deprived urban neighbourhoods.
- Experience long term health conditions and mental health challenges.
- Be affected by low income, unemployment, and housing insecurity.

Housing and economic context

Hastings has a higher rate of children living in low-income families than the national average:

- 18.8% of children live in absolute low-income households (2022-2023) compared to 15.6% in England.
- 23.2% live in relative low-income households (2022-2023) compared to 19.8% in England.

Housing affordability and quality remain key concerns, with a significant proportion of households in temporary accommodation and a growing need for supported housing[32].

Hastings public health profile

There is not as much comparable data at district level compared to local authority through the Public Health Outcomes Framework. The following tables replicate the data provided at Local Authority level where data is available or similar (i.e. Life Expectancy at 65 instead of 'Healthy Life Expectancy' for Local Authorities). Data below is drawn from several different time periods (as detailed in the tables for each measure) which are the latest available data published on the Framework.

[31] Public Health Outcomes Framework: Hastings
[32] ONS Data for Hastings

Life expectancy

Life expectancy at birth is slightly poorer for males at 77.2 years compared to England at 79.3 years, and similarly for females at 81.6 years compared to England at 83.2 years.

Healthy life expectancy at 65

Life expectancy, particularly is poorer compared to England figures:

- Males: 17.3 years (England 18.8)
- Females 19.8 years (England (21.3)

Measure	Year	Hastings Male	Hastings Female	England Male	England Female
Life expectancy at birth (yrs)	2023	77.2	81.6	79.3	83.2
Life expectancy at 65 years	2023	17.3	19.8	18.8	21.3

Mental health indicators (2023/2024)

Emergency hospital admissions for self-harm indicate a significant issue comparing the figure of 269.7 per 100,000 to 117 per 100,000 for England.

Measure	Year	Hastings Adults	England Adults
Emergency hospital admissions for intentional self-harm (per 100,000)	2023-2024	269.7	117

Musculoskeletal (MSK) problem indicator (2023)

The percentage of adults reporting a long-term MSK problem stands at 26.7%, significantly higher than for England (18.4%).

Measure	Year	Hastings Adults	England Adults
% reporting a long-term MSK problem in adults over 16	2023	26.7	18.4

Employment and health

- The employment rate for Hastings is 68.7%, noticeably lower than for England (75.7%).
- The gap in the employment rates between those with a physical or mental long term health condition (aged 16 to 64) and the overall employment rate 18.1%, significantly higher than the England average of 10.4%.
- Sickness absence: the percentage of working days lost due to sickness absence is at 1%, just below England (1.2%).
- The percentage of the population with a physical or mental long term health condition in employment (aged 16 to 64) is 55.6%, noticeably lower than for England (65.3%).

Measure	Year	Hastings Adults	England Adults
% of people in employment	2023-2024	68.7	75.7
Gap in the employment rate between those with a physical or mental long term health condition (aged 16 to 64) and the overall employment rate	2022-2023	18.1	10.4
Sickness absence: % of working days lost due to sickness absence	2021-2023	1	1.2
% of the population with a physical or mental long term health condition in employment (aged 16 to 64)	2023-2024	55.6	65.3

Other metrics of interest to WorkWell: homelessness

Homelessness – households in temporary accommodation – stands at 12.3 per 100,000, significantly higher than for England (4.6 per 100,000).

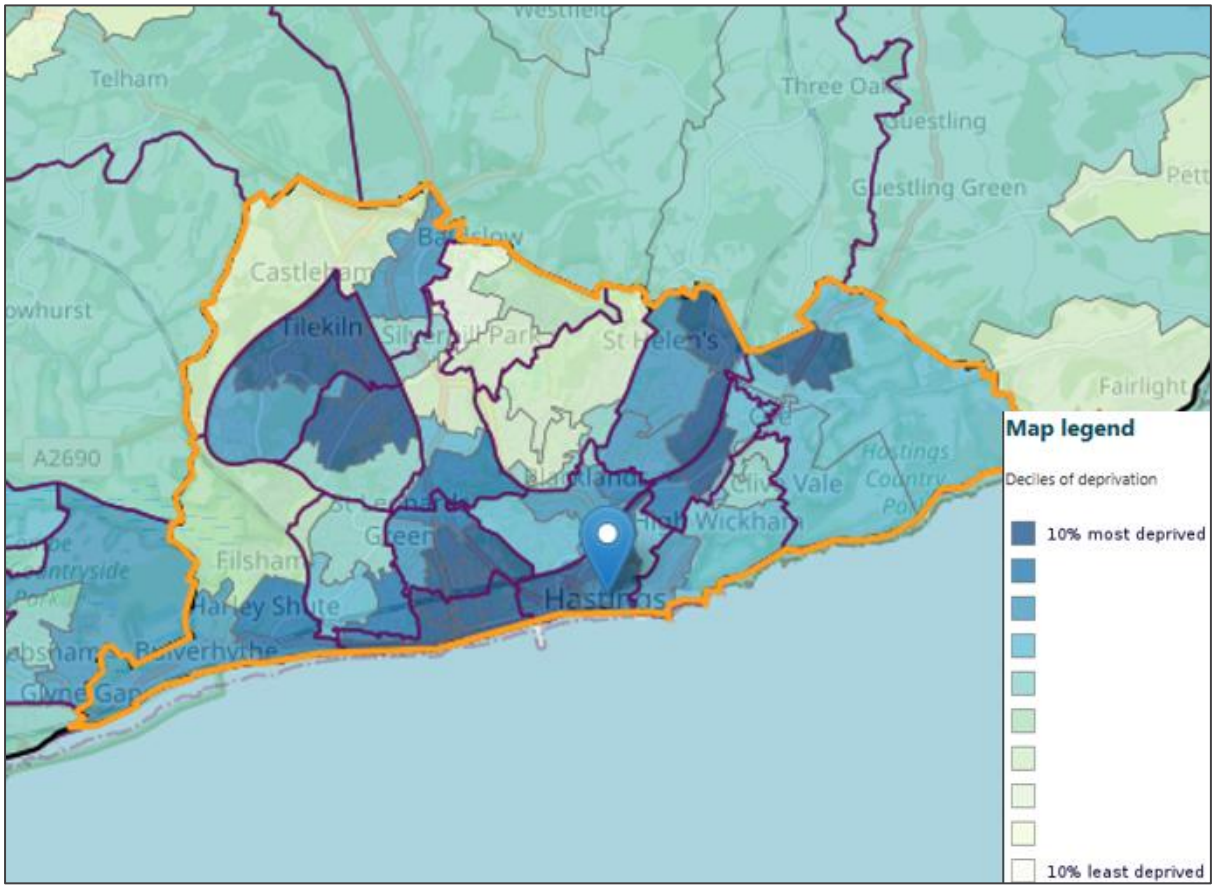
Measure	Year	B&H Adults	England Adults
Homelessness – households in temporary accommodation (per 100,000)	2023	12.3	4.6

Health inequalities in Hastings

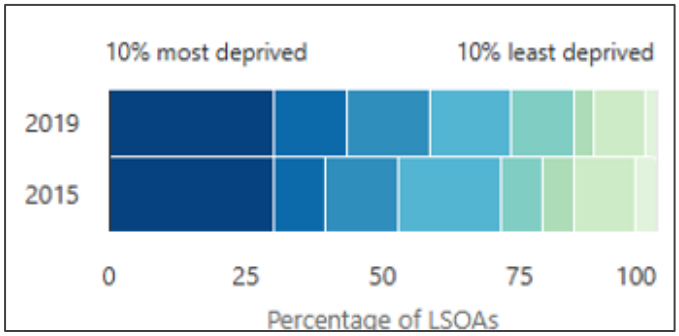
The Indices of Deprivation 2019 and 2015 Interactive Map enables a map view of the Lower Super Area Output (LSOA), which typically contains 1,000 to 3,000 people or 400 to 1,200 households, with Index of Multiple Deprivation superimposed.

In 2019, Hastings LSOA is ranked 3,452 out of 32,844 LSOAs in England, where 1 is the most deprived. This places it among the 20% most deprived neighbourhoods in the country. The map highlights the elevated levels of deprivation in the area covered by Hastings WorkWell Transformation Site compared to neighbouring inland areas.

Fig 9: Hastings LSOA index of multiple deprivation map



Source: [Indices of Deprivation 2019 and 2015 Interactive Map – OpenDataCommunities]



This map tool provides comparison with 2015 data, indicating a deterioration in deprivation levels over this time, with more areas within this LSOA falling within the lowest IMD deciles in 2019.

[Indices of Deprivation 2019 and 2015 Interactive Map – OpenDataCommunities]

West Sussex

Population profile

According to the West Sussex Joint Strategic Needs Assessment (JSNA)[33], this local authority area has a relatively older age structure compared to the national average. The population was estimated at approximately 882,000 in mid-2022, with growth driven by internal migration, particularly among older age groups. Unlike Brighton and Hove, West Sussex has a lower proportion of residents in the 20–39 age range and a higher proportion aged 65 and over, reflecting its appeal as a retirement destination.

The county is less ethnically diverse than England overall. The majority of residents identify as White British, with ethnic minority communities more concentrated in urban areas such as Crawley whilst rural areas remain less diverse.

Demographic and social characteristics

Residents of West Sussex are more likely than the national average to:

- Be aged 65 and over – reflecting the county's popularity among retirees.
- Live in rural or semi-rural areas – which can impact access to healthcare, education, and transport.
- Experience varying levels of deprivation – with Crawley and coastal towns like Bognor Regis and Littlehampton showing higher levels of need, while areas like Horsham and Mid Sussex are among the least deprived.

Housing and economic context

The West Sussex JSNA highlights a mixed housing and economic picture. Housing affordability remains a concern, particularly for younger households and key workers, due to high property prices relative to local incomes. There is also a growing need for accessible and supported housing for older adults and those with complex needs.

Economically, the county faces challenges related to productivity and wage disparities, especially in coastal and rural areas. The cost-of-living crisis and pressures on public services have further exacerbated inequalities. These dynamics underscore the need for integrated planning across housing, health, and economic development to support inclusive growth and community resilience.

Education and employment

The JSNA identifies both strengths and challenges in education and employment across West Sussex. While overall employment rates are slightly above the national average, there are notable gaps for individuals with long-term health conditions and disabilities. Educational attainment varies significantly by area, with disadvantaged pupils and those with Special Educational Needs and Disabilities (SEND) requiring

[33] West Sussex JSNA

targeted support to improve outcomes. The proportion of 16–17-year-olds Not in Education, Employment or Training (NEET) is significantly higher at 16.4% than the national average (5.4%), highlighting a key area for intervention.

West Sussex public health profile

Based on the latest data from the Public Health Outcomes Framework[34] West Sussex demonstrates a generally positive public health profile, though some indicators highlight areas for improvement. Data below is drawn from several different time periods (as detailed in the tables for each measure) which are the latest available data published on the Framework.

Life expectancy (2023)

- Males: 80.4 years
- Females: 84.6 years

These figures are aligned with the England averages of 79.3 and 83.2 years, respectively.

Healthy life expectancy (2021–2023)

- Males: 63.8 years
- Females: 64.9 years

These are slightly above the England averages of 61.5 and 61.9 years, indicating a modest gap between lifespan and healthy lifespan.

Measure	Year	W Sx Male	W Sx Female	England Male	England Female
Life expectancy at birth (Yrs)	2023	80.4	84.6	79.3	83.2
Healthy life expectancy at birth (Yrs)	2021-2023	63.8	64.9	61.5	61.9

[34] Public Health Outcomes Framework: West Sussex

Mental health indicators

- The percentage of adults in contact with secondary mental health services living in stable and appropriate accommodation is 72%, significantly better than the national average of 58%.
- The percentage of adults in contact with secondary mental health services and on the Care Plan Approach in paid employment (aged 18–69) is 12%, above the England average of 9%.
- Emergency hospital admissions for intentional self-harm stand at 127.2 per 100,000, higher than the England average of 117 per 100,000.

Measure	Year	W Sx Adults	England Adults
Adults in contact with secondary mental health services living in stable and appropriate accommodation (%)	2021	72	58
Adults in contact with secondary mental health services and on the Care Plan Approach (aged 18 to 69) in paid employment (%)	2021	12	9
Emergency hospital admissions for intentional self-harm (per 100,000)	2023-2024	127.2	117

Musculoskeletal (MSK) problem indicator

The percentage of adults reporting a long-term MSK problem is 18.9%, similar to the England average of 18.4% and the South East regional figure of 17.4%.

Measure	Year	W Sx Adults	England Adults
% reporting a long-term MSK problem in adults over 16	2023	18.9	18.4

Employment and health indicators

- The percentage of people in employment is 76%, compared to 75.7 % for England.
- The percentage of the population with a physical or mental long term health condition in employment (aged 16 to 64) is 74.3%, markedly higher than for England 65.3%
- Employment gap between those with long-term physical or mental health conditions and the general population is 4.6%, significantly lower than for the England average of 10.4%.
- Sickness absence: the percentage of working days lost due to sickness absence is 2.6% significantly higher than for England (1.2%).
- 16–17-year-olds Not in Education, Employment or Training (NEET) or whose activity is not known is 16.4%, significantly higher than England average of 5.4%.

Measure	Year	W Sx Adults	England Adults
% of people in employment	2023-2024	76	75.7
% of the population with a physical or mental long term health condition in employment (aged 16 to 64)	2022-2023	74.3	65.3
Gap in the employment rate between those with a physical or mental long term health condition (aged 16 to 64) and the overall employment rate	2022-2023	4.6	10.4
Sickness absence: % of working days lost due to sickness absence	2021-2023	2.6	1.2
% 16- to 17-year-olds Not in Education, Employment or Training (NEET) or whose activity is not known	2023-2024	16.4	5.4

Other metrics of note for WorkWell: Youth crime and homelessness

- First-time entrants to the youth justice system: 83.5 per 100,000, significantly lower than the national average of 143 per 1000,000.
- Homelessness – households in temporary accommodation: 3.8 per 100,000, compared to 4.6 per 100,000 for England.

Measure	Year	W Sx Adults	England Adults
First time entrants to the youth justice system (per 100,000)	2023	83.5	143
Homelessness – households in temporary accommodation (per 100,000)	2023	3.8	4.6

Health inequalities in West Sussex

Life Expectancy and Deprivation

The inequality in life expectancy at birth between the most and least deprived areas in West Sussex is:

- 6.7 years for males
- 6.2 years for females

This indicates less inequality for men and women compared to 10.5 years for men and 8.3 years for females in England.

Measure	Year	W Sx Male	W Sx Female	England Male	England Female
Inequality in life expectancy at birth between the most and least deprived areas (years)	2021-2023	6.7	6.2	10.5	8.3

Geographic distribution of deprivation in West Sussex

In West Sussex, deprivation is unevenly distributed across the county. While areas such as Horsham and Mid Sussex are among the least deprived, other parts—particularly Crawley and coastal towns like Bognor Regis and Littlehampton—exhibit higher levels of need. These more deprived areas face challenges related to income, employment, education, and access to services. Crawley shows significant intra-borough disparities, with some neighbourhoods ranking among the most deprived 20% nationally, while others fall within the least deprived quintiles. This spatial variation underscores the importance of place-based interventions tailored to the specific needs of each locality within West Sussex.

Crawley Work Well and ICT transformation site

Population profile

Crawley is home to approximately 118,500 residents, reflecting an 11% population growth since 2011—significantly higher than the national average of 6.6%. This growth is driven by both natural increase (more births than deaths) and international migration. The population is relatively young, with 25% under the age of 20 and only 13% aged 65 or older, compared to 18% nationally. The area has a diverse ethnic composition, with 38% of residents from ethnic minority backgrounds, the highest among Sussex ICTs[35].

Demographic and social characteristics

Crawley has a lower proportion of residents with disabilities or recorded as providing unpaid care compared to England, but this might be reflective of cultural differences centred around the role of unpaid caring. It also has a higher proportion of residents identifying as Muslim or Hindu. Despite a relatively young and diverse population, Crawley faces notable health inequalities. Life expectancy is similar to the national average, but the gap between the most and least deprived areas is significant, especially for men - 7.8 years for men and 2.7 years for women. The area also reports higher rates of obesity, smoking, and physical inactivity, contributing to a greater burden of long-term conditions like diabetes.

Housing and economic context

Crawley experiences considerable housing pressure, with nearly 7% of households overcrowded, the highest rate among Sussex ICTs. The ratio of house prices to earnings is high, making home ownership unaffordable for many. Economically, Crawley has a higher percentage of working-age residents claiming benefits and a higher rate of children in low-income households than the national average. Crime rates—including violent crime and anti-social behaviour—are also elevated. Educational outcomes are below average, with an Attainment 8[36] score of 43.9, compared to 48.7 nationally[20].

Public health profile for Crawley

There is not as much comparable data at district level compared to local authority through the Public Health Outcomes Framework[37]. The following tables replicate the data provided at local authority level where data is available or similar metrics appear in both.

Life expectancy (2023)

Male figures align with the England figures of 79.3 for men and 83.2 years for women:

- Males: 79.3 years

[35] Crawley ICT Data Pack
[36] Attainment 8 is a measure used in England to assess the average achievement of pupils at the end of Key Stage 4 (typically age 16, after GCSEs). It calculates a score based on performance in eight qualifications including maths and English
[37] Public Framework Output: Crawley

- Females: 83.6 years

Healthy life expectancy at 65 (2023)

Both male and female figures align with the England averages of 18.8 and 21.3 years.

- Males: 18.5 years
- Females: 21.8 years

Measure	Year	Crawley Male	Crawley Female	England Male	England Female
Life expectancy at birth (years)	2023	79.3	83.6	79.3	83.2
Life expectancy at 65	2023	18.5	21.8	18.8	21.3

Mental health indicators

Emergency hospital admissions for intentional self-harm for 2023/24 are 126.6 per 100,000, notably higher than the England figure of 117 per 100,000.

Measure	Year	Crawley Adults	England Adults
Emergency hospital admissions for intentional self-harm (per 100,000)	2023-2024	126.6	117

Musculoskeletal (MSK) problem indicator (2023)

Percentage of adults reporting a long-term MSK problem stand at 14.9% significantly lower than for England (18.4%).

Measure	Year	Crawley Adults	England Adults
% reporting a long-term Musculoskeletal (MSK) problem in adults over 16	2023	14.9	18.4

Employment and health indicators

- The percentage of people in employment (2023/24) is 79.9%, higher compared to 75.7% for England.
- Sickness absence: the percentage of working days lost due to sickness absence (2021-2023) is 0.7%, so better performing compared to the England figure of 1.2%.
- The percentage of the population with a physical or mental long term health condition in employment (aged 16 to 64) is 83.6% significantly higher than the England figure of 65.3%.

Measure	Year	Crawley Adults	England Adults
% of people in employment	2023-2024	79.9	75.7
Sickness absence: % of working days lost due to sickness absence	2021-2023	0.7	1.2
% of the population with a physical or mental long term health condition in employment (aged 16 to 64)	2023-2024	83.6	65.3

Other Metrics of note for WorkWell: homelessness

Homelessness – households in temporary accommodation (2023/2024): 9.6% significantly higher than for England: 4.6%

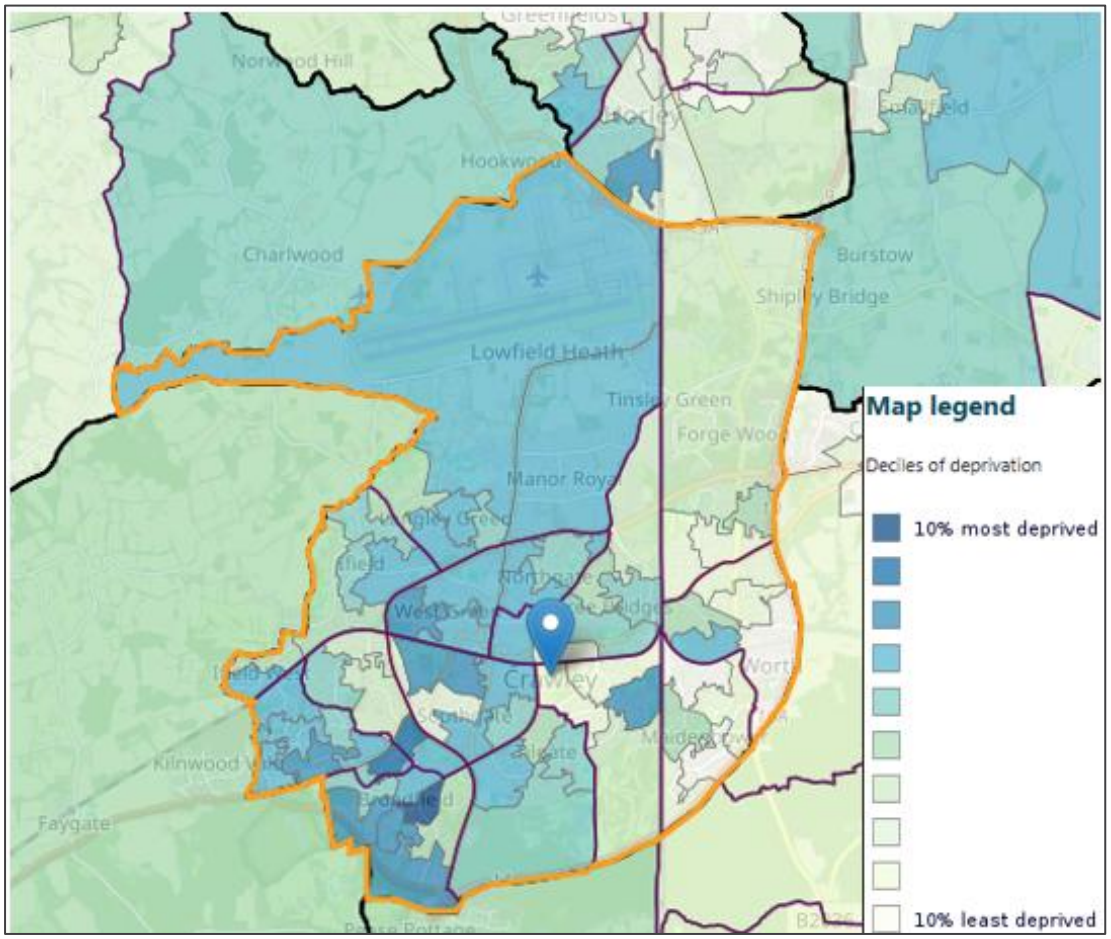
Measure	Year	Crawley Adults	England Adults
Homelessness – households in temporary accommodation (per 100,000)	2023	9.6	4.6

Health inequalities in Crawley

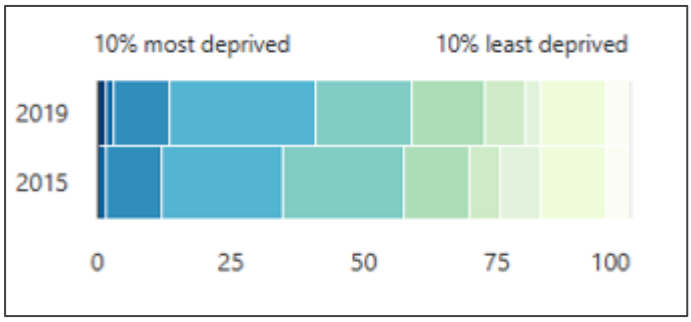
Crawley exhibits notable disparities in deprivation levels across its neighbourhoods, as highlighted by the English Indices of Deprivation 2019. While some areas of Crawley fall within the least deprived quintiles nationally, others, particularly in the wards of Broadfield, Bewbush, and West Green, rank among the most deprived 20% in England. These intra-borough inequalities reflect variations in income, employment, education, health, and access to services. Index of Multiple Deprivation (IMD) data underscores the need for targeted interventions to address these disparities and improve outcomes for the most disadvantaged communities

The Indices of Deprivation 2019 and 2015 Interactive Map[38] enables a map view of the Lower Super Area Output (LSOA), which typically contains 1,000 to 3,000 people or 400 to 1,200 households with Index of Multiple Deprivation superimposed. Fig 11. below of LSOA Crawley 009D ranks among the 20% least deprived areas in England.

Fig 11: Crawley LSOA Index of Multiple Deprivation Map



Source: [Indices of Deprivation 2019 and 2015 Interactive Map – OpenDataCommunities]



The map tool provides comparison with 2015 data, indicating a deterioration in deprivation levels over this time with more areas within this LSOA within the lowest IMD deciles in 2019:

Source [Indices of Deprivation 2019 and 2015 Interactive Map – OpenDataCommunities]

[38] [Indices of Deprivation 2019 and 2015 Interactive Map – OpenDataCommunities]

Limitations

The data is drawn from multiple sources with varying timeframes and geographic resolutions, which limits direct comparability. Some of the public health data is only available at the Local Authority level, masking intra-area disparities particularly for East Brighton. These limitations highlight the need for more granular, real-time data to inform effective, localised interventions.

Deep dive: East Brighton

Executive summary

This deep dive into stakeholder perspectives on establishing a WorkWell service in East Brighton reveals a strong consensus on the need for a locally embedded, holistic, and flexible model that addresses the complex interplay between health and employment. The focus of this deep dive is centred around support for those with mental health and musculoskeletal (MSK) conditions.

Views from partners across the Voluntary, Community and Social Enterprise (VCSE), health, and local government sectors emphasised the importance of integrating and embedding WorkWell into existing and established services such as social prescribing, MSK and Talking Therapies pathways, and community hubs. The findings highlight the diversity of roles already supporting employment and wellbeing, the need to consider how health barriers affect an individual's ability to engage with support services, and how these change over time. Participants stressed that the critical role of trust, relevance to the community being served, and community-based delivery. However, challenges to transforming services in line with the aims of WorkWell were identified. These included digital exclusion, long waiting lists, fragmented and disjointed referral pathways, and inconsistent data collection. Funding instability and the risk of duplicating existing services were also noted as key concerns.

Despite these challenges, there is a clear appetite for innovation and co-production of a new WorkWell pathway for citizens of East Brighton. Stakeholders proposed a range of practical solutions, including reforming the production of fit notes, supporting digital inclusion, and embedding services in trusted local venues. The WorkWell model is seen as a valuable opportunity to bridge gaps identified between health and employment support. To succeed, the transformation site must be strategically aligned with local systems, avoid being perceived as a short-term initiative, and be designed with sustainability, equity, and community ownership at its core. The insights gathered provide a robust foundation for shaping a WorkWell service that is both impactful and resilient in the context of East Brighton's unique needs.

Introduction

East Brighton is one of three sites selected as part of a WorkWell 'Discovery Phase' for NHS Sussex. Sites were chosen based on key metrics, data points, and qualitative insights (full data packs are available in section 2).

East Brighton was selected due to its high levels of deprivation, complex health inequalities, and significant barriers to employment, particularly among residents with mental health and MSK conditions. The area includes some of the most deprived wards in Brighton and Hove, with entrenched socio-economic challenges that contribute to poor health outcomes and economic inactivity. These challenges are compounded by digital exclusion, fragmented referral pathways, and inconsistent access to support services.

Stakeholders described East Brighton as a community with deep-rooted needs but also strong local assets. There are active VCSE organisations, such as the Trust for Developing Communities and the Crew Club, which provide trusted, community-based support. However, participants highlighted that many services are underfunded, short-term, and disconnected, making it difficult for residents to navigate support systems. Waiting lists for mental health and MSK services are long, and digital barriers further limit access to help.

The local economy was described as fragile, with limited employment opportunities, especially for those with health conditions. Many residents face multiple, intersecting barriers, including poor housing, low confidence, and a lack of employer understanding around workplace adjustments. Despite these challenges, there is a strong appetite for innovation and co-production. Stakeholders expressed enthusiasm for a WorkWell model that is embedded in trusted community settings, avoids duplication, and is designed with sustainability and equity at its core.

Stakeholders noted the presence of several active networks and community groups that could support user engagement. Ongoing initiatives such as the Changing Futures Sussex programme and the Connect to Work scheme offer opportunities for alignment and integration. It is recommended that all relevant data, insights, and existing service evaluations be reviewed as part of the next steps in planning and implementing WorkWell in East Brighton.

Participants

Code	Organisation
BPH1	Brighton & Hove City Council Public Health
BVC1	Trust for Developing Communities
BVC8	Trust for Developing Communities
BHCC2	B&H City Council (Skills Partnership)
BVC3	Community Works
BHCC2	Brighton & Hove City Council (Supported Employment)
BPCN1	Deans and Central PCN (Operations)
BVC4	Together Co
BDWP1	Department for Work & Pensions
BDWP2	Department for Work & Pensions
BP1	Station Practice & East Brighton PCN (Pharmacy)
BGP1	St Peters Medical Centre (GP)

BPCN1	Central Brighton PCN (Benefits Advice)
BLG1	B&H City Council (Employability)
BVC5	Trust for Developing Communities
BVC6	Trust for Developing Communities
BVC7	Brighton East PCN & ARCH Healthcare (Outreach)
BCC1	Crew Club
BCC2	Crew Club
BCC3	Crew Club
BTTEA	Sussex Community Foundation Trust (Talking Therapies Employment Advice)
BLE1	Lived Experience
BGP2	Wellsbourne Clinic GP
SxMSKSCFT1	Sussex MSK Health (Clinical)
SxMSKH2	HERE (Strategy & Innovation)
SxMSKCFT2	Sussex Community Foundation Trust (Clinical Leadership)

Methods

In total, 26 participants contributed to the study via deep dive interviews. This included a focus group with primary care clinicians, three participants who shared their lived experience of mental health conditions, and one additional lived experience participant who responded to the interview questions via email. Full details on the methods used for this report are provided in the overall report introduction sections.

Findings

1. Roles and responsibilities of participants

Stakeholders interviewed occupied a diverse range of roles, from strategic leadership to frontline delivery. They included one East Brighton resident with current lived experience of mental health challenges in the workplace [BLE1] and three system stakeholders who shared additional views from their personal experiences of health barriers to work. Stakeholder roles were often hybrid, combining community engagement, health facilitation, and employability support. For example, roles in partnership development and coordination across the VCSE sector or leading on external health engagement and neighbourhood-based community development.

Roles were often embedded within local systems. For instance, social prescribers operating across multiple GP practices, acting as bridges between clinical and community support. Meanwhile, colleagues from DWP work closely with NHS

employers and local job centres to support individuals with complex barriers to employment.

The diversity of roles reflects the complexity of the local landscape, but equally there are established services in place to support a WorkWell pathway. Many stakeholders wore multiple hats—balancing strategic oversight, community trust-building, and direct service delivery. This multiplicity is a strength but also highlights the need for clear coordination and role clarity in any future WorkWell implementation to avoid overlap and duplication.

2. Familiarity with the WorkWell pathway

Familiarity with the WorkWell model varied across stakeholders. Some, particularly those in health and social prescribing roles, recognised WorkWell as an extension of existing approaches, and noted similarities with social prescribing and health coaching roles [BPH1]. Others, like the Trust for Developing Communities (TDC) team, saw WorkWell as closely aligned with their employability support model, particularly the "Finding Your Way" course [BVC1].

However, some stakeholders expressed concern about potential duplication. Social prescribers emphasised the importance of ensuring WorkWell complements rather than overlaps with existing services

> "How much of this sort of support is already being picked up by social prescribing? …You know, we want to make best use of our resources, and we don't want them being sort of duplicated." *[BVC4]*

There was also a call for clearer communication about the WorkWell model's unique value proposition, particularly its focus on employment outcomes and integration with clinical pathways. This perspective underlined the importance of carefully considering appropriate KPI's and evaluation metrics for WorkWell when setting up transformation sites.

The lived experience participant was less familiar with the formal WorkWell pathway but intuitively understood its goals. They emphasised that unless employers and health services align around a shared agenda, even the best-designed WorkWell journey would fall short:

> "Based on my experience, if both employer and health services do not come together with an agreed agenda to support people to attend work it really does not matter how good the proposed WorkWell user journey is thought out." *[BLE1].*

3. Thoughts on the typical user journey

Stakeholders generally supported the WorkWell user journey but highlighted several areas for improvement. A recurring theme was the importance of flexibility and personalisation. For example, a representative from the Crew Club [BCC1], emphasised the need for safe, informal spaces where users can engage at their own pace. Both the TDC and the Crew Club demonstrated the route from voluntary work to employment offered an exemplar of a flexible pathway to employment for those initially overwhelmed by health barriers:

> ”People who have suffered depression where they haven't left the house for ages come here by a social worker for our family support, we welcome them in, they use all our facilities then they often start doing some voluntary work when their child went to school… we kind of build them up along the way which is really positive and it gives everybody a chance. It starts you thinking oh if I can volunteer, this could potentially become a job you know.” *[BCC1]*

TDC’s model of employability services allows users to access different levels of support with 1:1 coaching, a structured ‘Finding your way’ course and drop-in events to promote engagement with clients whose readiness for support might vary depending on their health barriers [BVC1].

In this context, several participants stressed the need for WorkWell to cater for non-linear pathways into employment. Many users face fluctuating mental health, alongside housing instability, or caregiving responsibilities. A rigid pathway could alienate those most in need. The WorkWell journey must therefore accommodate setbacks and re-engagement.

Integration with existing touchpoints—such as food banks, GP surgeries, and community hubs—was seen as essential. Embedding WorkWell within familiar settings increases trust and accessibility. Furthermore, stakeholders warned against over-medicalising the journey. The emphasis should be on empowerment, not diagnosis, and some felt this suited co-location in the community rather than medical settings [BVC3].

> ”Basing social prescribers in community settings…it takes a focus away from their medical conditions and what they can't do and brings it into the more active space of ‘I'm engaged in my local community’. I think the medicalisation of it removes some of the possibility.” *[BVC3]*

4. Funding

Funding emerged as a critical concern across all stakeholder groups. Many services that align with WorkWell principles are currently funded through short-term grants or transformation site schemes. For example, Community Works previously hosted a European Social Fund project ‘Roots’ aimed at getting those furthest from the workplace into work using community-based delivery partners, which ended post-Brexit, leaving a significant gap in local employment support resources [BVC3]. TDC’s employability hubs also lost funding in April 2025 [BVC 5,6].

This instability undermines continuity and trust. Stakeholders emphasised the need for long-term, sustainable funding that supports both core staffing and flexible delivery. There was also concern about the administrative burden of fragmented funding streams, which can pull organisations away from frontline work.

Some participants supported aligning WorkWell with existing strategic funding frameworks, such as the Changing Futures programme or NHS Sussex priorities. Others advocated for co-commissioning models that bring together health, local authority, and VCSE partners to pool resources and reduce duplication [BVC1], as implicit in the formation of ICTs.

5. Referral pathways for mental health and MSK conditions

Referral pathways for individuals with mental health and musculoskeletal conditions vary significantly across East Brighton, often depending on the service provider and the strength of local partnerships.

MSK conditions

To access MSK services, patients can self-refer or be referred by GPs or physiotherapists. NHS services are primarily provided by Sussex MSK Healthcare in partnership with Social Enterprise HERE. These services often include an assessment of work and social history, with treatment plans tailored to individual needs [SxMSKSCFT1]. Clinicians integrate work-related discussions into initial assessments and treatment planning. HERE also provides ‘Care Navigators’ who may refer to local Social Prescribing services and other organisations that might

provide employability support services. The MSK Triage process is outlined in their 2024 Integrated Triage Manual and summarised as follows:[39]

Referral Entry: Patients can enter via self-referral, GP, or First Contact Practitioner.

Triage Team: Advanced Practitioners review and assess referrals.

Screening & Categorisation:

- Red flag screening for urgent issues
- Categorisation into routine MSK, complex cases, or pain management.

Dual Pathway & On-Hold: Some patients may follow multiple paths or be placed on hold.

Outcomes:

- Physiotherapy
- Advanced Practitioner assessment
- Pain Management Services
- Pain Management Programme (PMP)
- Secondary care referral
- Redirect to referrer.

Patient-facing information on this process and the services available can be found at www.sussexmskhealth.co.uk.

Participants from MSK services acknowledged that the integration of employment support into these MSK pathways is less formalised than in mental health services, with no standardised approach described in these interviews.

Mental health conditions

Sussex Partnership NHS Foundation Trust has oversight for NHS provision of Primary Care level mental health services operating through the Brighton and Hove Wellbeing Service. Services offered include free and confidential support, including Talking Therapies (formerly known as Improving Access to Psychological Therapies or IAPT) counselling, and wellbeing support for adults (18+) and children and young people requiring help with anxiety, depression, stress and low mood. Referral may be through the following pathways:

- Self-Referral – via online form or phone
- GP/Health Professional Referral – through your local surgery
- Assisted Referral – with help from a friend, family member, or support worker
- Social Prescribing – via link workers in GP practices

[39] Sussex MSK Partnership Central – Integrated Triage Manual

Alongside statutory services, the VCSE sector is also active in this area with services aimed at combatting key mental health risk factors such as loneliness and isolation and supporting with employment advice to help people stay in employment or return to work. MIND in Brighton and Hove offer peer support groups, counselling, mental health advocacy and community outreach services focussed on empowering individuals and reducing stigma. Together Co offers befriending, social prescribing and volunteer support. Another example is Southdown Housing which offers a range of services and support networks, including free educational courses and workshops, as well as specialist employment support.

Mental health services specifically include employment advisers embedded within Talking Therapies. The advisors offer one-to-one support to help individuals manage work-related challenges, return to employment after sickness, or explore new career paths. They assist with CVs, job applications, workplace adjustments, and understanding of employment rights, all while supporting mental health recovery and wellbeing.[40]

DWP work coaches

The DWP also plays a role in referrals to mental health and MSK services, particularly through work coaches who triage clients based on need. However, the scale of caseloads (up to 200 clients per coach) limits the depth of support [BDWP1&2]. There is a clear opportunity for WorkWell to work closely with DWP alongside local mental health and MSK services, to support referral pathways into services, and vice versa, so that these services make use of the WorkWell offer, and links to appropriate community resources that support employability.

Non-clinical support for individuals with mental health & MSK conditions

Social prescribers or Community Connectors, such as those at Together Co, Southdown Housing and TDC, receive referrals from GPs and other healthcare professionals and self-referrals. They offer non-clinical support that includes wellbeing, housing, and employment advice [BPCN1], [BVC4]. However, waiting lists for social prescribing can be up to six weeks, which delays access to support [BPCN1], [BVC4].

Connect to Work

For individuals with more complex mental health needs and, more likely to be receiving secondary care mental health services for diagnosed mental health conditions the new government-funded supported employment programme Connect to Work is currently being rolled out across Sussex[41]. It is said to be designed to help individuals facing complex barriers to employment find and sustain meaningful work using standardised models of Supported Employment, such as Individual Placement Support (IPS) and Supported Employment Quality Framework (SEQF), for eligible

[40] www.brightonandhovewellbeing.org/eaiapt
[41] Connect to Work: Grant Guidance for England - GOV.UK

and suitable participants, to ‘place, train and maintain’ competitive employment within the delivery area.

Perceptions of mental health and MSK referral pathways in East Brighton

Perceptions of referral pathways across the Brighton WorkWell stakeholder network reveal a strong preference for informal, trust-based, and community-embedded approaches. For example, [BVC1 & BVC8] emphasised that referrals are often made through word-of-mouth and face-to-face contact, with trust being a critical factor in whether individuals engage and follow through. This sentiment is echoed by [BGP2], who described a low-barrier, inclusive referral process that prioritises early engagement and connection over formal criteria. Similarly, [BVC3] noted that onward referrals typically go to trusted local partners and gave examples of East Brighton Trust and the Care Coaches Programme in primary care, reinforcing the importance of local familiarity and continuity. In contrast, [BPH1] and [BDWP1&2] highlighted systemic challenges, such as the complexity of digital systems like EMIS, which hinder seamless referrals and create confusion about available services. These insights suggest that while formal referral mechanisms exist, effective pathways are those that are simple, relational, and embedded in local knowledge and networks, rather than overly reliant on digital or bureaucratic systems.

6. Patient outcomes data

Data collection on outcomes that might tie together health, and employment was regarded as patchy and often limited to basic metrics such as attendance or number of sessions. For example, the DWP collects health-related data at the front end but does not track outcomes over time [BDWP1,2]. Similarly, social prescribing services report outcomes monthly, focusing on needs identified and referrals made, but struggle to measure long-term impact due to the variability of cases [BPCN1], [BVC4].

To improve our understanding of the links to Health and Employment, one Public Heath employee expert highlighted the potential of using fit note data and the Brighton and Hove Insight Tool to evaluate changes in employment and health outcomes at a granular level [BPH1].[42] Furthermore, their Health Counts survey published in June’25 combined with census-based data with more recent survey data to highlight demographic, socio-economic and other changes over the last five years, alongside ward maps illustrating variations across Brighton and Hove in measures including: happiness and anxiety, experience of living in care as a child/young person, percentage of adults who are unpaid carers, general health and disability, falls and pain and alcohol and drug use.[43] These resources could be key to understanding the issues associated with economic inactivity in East Brighton wards, which in turn could inform WorkWell service design and focus.

[42] Brighton and Hove Insight Tool
[43] Health Counts Survey

TDC uses a combination of case studies and quantitative metrics to track outcomes, such as employment, volunteering, and training [BVC1]. However, there was a shared concern that excessive measurement could undermine trust and engagement, particularly in informal or peer-led settings like the Crew Club:

> "We have a lot of people come through the door which we track, like charities want information on the share shop - how many people we fed in a week etc., but personally I think you need to be open and you know just welcoming and like comfortable place to be go back to, not formal." *[BCC1]*

7. Digital aspects of service delivery

Digital inclusion is a significant challenge in East Brighton. More generally, it is estimated 24% of people who are out of work lack basic digital skills.[44]

In East Brighton, some service users lack access to reliable internet or devices, relying instead on mobile phones with poor connectivity [BLE1]. This digital divide affects their ability to engage with services, complete forms, or access online resources. It can also reinforce stigma, when those who struggle with digital tools are often perceived as "difficult" or "out of touch" [BLE1].

To address this, several organisations have implemented creative solutions. TDC provides tablets, SIM cards, and digital training in different languages [BVC1]. They also run digital inclusion sessions in partnership with Age UK and the Good Things Foundation [BVC5,6]. Together Co supports clients to use the NHS app and offers face-to-face help with digital tasks [BPCN1], [BVC4].

In this context, it is worth highlighting the Digital Inclusion Framework, which emerged out of a collaboration between University of Sussex and NHS Sussex, supported by the Health Innovation Kent Surrey Sussex.[45] This has been used across NHS Sussex to help ensure health care services consider inclusion in any digital transformation.

Despite these efforts, systemic barriers and challenges remain, particularly with regard to how individuals might be referred to employment support services from primary care. The electronic patient record systems used in primary and community care (e.g. EMIS, SystmOne) were considered too inflexible and cumbersome for seamless referrals to a WorkWell service, and there is a lack of cohesion in digital infrastructure across services [BPH1], [BDWP1,2]. Simplifying referral processes and

[44] Digital Nation | The UK's Digital Divide | Good Things Foundation
[45] Digital Inclusion framework

investing in digital literacy were considered essential for the success of a WorkWell model.

One GP cautioned against the over-reliance on digital platforms particularly for those in more overwhelming stages of mental health conditions:

> "When someone is quite stuck, who can be disillusioned and not trusting in the health service anymore, not opening their curtains in the morning, not leaving their house ever, ordering food in-that takes a person to engage them". *[BGP1]*

8. Data on links between health and employment

Participants indicated data collection in this area is still underdeveloped. The DWP reports that around 50% of their clients have health-related barriers to work, but this data is not tracked longitudinally [BDWP1]. Similarly, MSK services ask about work status during assessments but do not routinely report on employment outcomes [SxMSKSCFT1].

TDC's use of HubSpot Customer Relationship Management (CRM) system, provides the functionality for more structured tracking of client journeys, including employment outcomes, language skills, and training uptake [BVC5,6]. However, based on our interviews, this level of data sophistication is not generally widespread across other services.

There is a clear opportunity for WorkWell to lead on developing a shared outcomes framework that captures the interplay between health and employment across services.

9. Experience supporting mental health and/or MSK return to or remain in Work

Stakeholders across East Brighton bring a wealth of experience in supporting individuals with mental health and MSK conditions to return to or remain in work. This experience spans clinical, community, and voluntary sectors.

For example, the team at TDC has been delivering employability support for over five years, including one-to-one coaching and group-based interventions like the "Finding Your Way" course [BVC1]. Their approach is holistic, combining confidence-building, skills development, and peer mentoring.

Clinicians routinely explore how pain and physical limitations affect employment, and tailor interventions accordingly [SxMSKSCFT1,2], [SxMSKH2]. However, they note that MSK issues often mask deeper social or psychological challenges, requiring a more integrated support model such as the Changing Futures platform (see section

15). As detailed above, HERE offers Care Navigators who can signpost to relevant support agencies in these circumstances.

> "We have that initial conversation with the patient that was important to them. It's rarely MSK condition they've been referred for. But often these other things are popping up for them, such as their mental health or their finance or their work or their childcare issues. So that's very much part of what we do within the organisation."
> *[SxMSKSCFT1]*

During interviews with staff at the Crew Cub, the Whitehawk-based Encounter Wellness service was mentioned.[46] This service is a collaboration between local NHS GPs and complementary therapists to offer physical and psychological rehabilitation to those who have tried NHS treatments and remain in need. Their phased model, addressing medical, psychological, and social needs, offers an example for how WorkWell could support those furthest from the labour market and help them towards employment through 3 distinct phases of support.

A representative [BGP2] outlined an initial stage for patients experiencing chronic pain. These patients are often dependent on strong medications, feel isolated by their condition or disillusioned with formal health services. At Encounter Wellness, they might receive wellness treatments like gentle massage for pain to develop engagement and build trust, or medical and complementary therapies to help sleep. In a second phase, they help the individual to explore how their condition is affecting them and what other things might be contributing to their pain, particularly any psychological component. This might include exploring what their views on work are, or whether there is an 'illness identity' that they are holding onto for a "very good reason that they're not going to let go of unless they are given a better alternative". Over seven sessions, "they progress to art therapy or movement therapy, which can be more challenging, and then we might see whether they are up for the garden or craft group. And then there is the third more proactive phase that would build confidence to return to work or even develop their own business selling what they make on Etsy or how to do tax returns or a gardening enterprise" [BGP2].

10. Common needs for those with mental health conditions in employment or needing support returning to work

Mental health conditions present a complex array of barriers to employment, and stakeholders emphasised the need for tailored, flexible support. Common needs include:

[46] Encounter Wellness

- Anxiety, stress and energy management: symptoms such as panic attacks, fatigue, and brain fog were cited by a participant with current lived experience [BLE1] and stakeholders with previous lived experience.
- Confidence and motivation: many individuals lack the self-belief to re-enter the workforce, particularly after long periods of isolation or illness [BCC1,2,3], [BVC6,5].
- Supportive environments: group activities can be daunting, and one-to-one or peer-led models are often more effective [BPH1, [BCC1], however these can be challenging to fund [BGP2].
- Holistic care: mental health cannot be addressed in isolation. Housing, financial stress, and social isolation all contribute to poor mental wellbeing [BVC1], [BGP2].

Services like Mind, South Down, Together Co, Community Works, TDC, Encounter Wellness and the Crew Club offer mindfulness, counselling, and creative therapies that help individuals manage symptoms and build resilience. The support these services offer may be key to effective early intervention for a typical WorkWell service user in the context of long waiting lists for talking therapies and inconsistent employer support [BGP1], [BLE1].

11. Common needs for those with MSK conditions in employment or needing support returning to work

MSK conditions often intersect with a high prevalence of manual labour occupations, and among those living in areas of deprivation, aging demographics, and long-term health conditions. Stakeholders identified several recurring needs:

- Pain management: chronic pain affects sleep, mobility, and concentration, making sustained employment difficult [BLE1], [SxMSKSCFT1].
- Workplace adjustments: simple changes, like flexible hours or ergonomic equipment, can make a significant difference but are not always offered or understood by employers [BVC3].
- Self-management support: for example, peer-led MSK groups have the potential to replicate diabetes support groups, which have been effective in building confidence and reducing reliance on clinical services [BVC1].
- Recognition of broader determinants: MSK-related absence is often driven by social issues such as poverty, addiction, or housing instability [SxMSKSCFT1].

There is a strong case for embedding MSK support within a broader WorkWell framework that addresses both physical and social barriers to work.

12. How services support typical Workwell users

Many existing services already support individuals who would benefit from a WorkWell focus, albeit in fragmented ways. For example:

- TDC offers employability coaching, digital inclusion, and community-based peer support, often co-located with food banks and GP surgeries [BVC1].
- The Crew Club provides a safe, informal space where young people and families can access support, build confidence, and transition into volunteering or employment [BCC1].
- Together Co delivers social prescribing that directly supports return to work and includes emotional, practical, and community-based support, often for clients with mental health or MSK conditions [BPCN1], [BVC4].

We should note, that we did not undertake a full semi-structured interview with a representative from the Changing Futures Sussex programme, but our engagement identified the service as highly relevant to the focus of WorkWell.[47] Changing Futures is part of a national £91.8 million programme aimed at improving outcomes for adults facing multiple disadvantages, such as homelessness, mental health issues, substance misuse, domestic abuse, and involvement with the criminal justice system. In Sussex, the programme brings together public services and voluntary sector partners to deliver person-centred, coordinated support. It focuses on transforming local systems to reduce crisis demand, improving service integration, and empowering individuals to stabilise and improve their lives.

Common to all these service providers are links to volunteering, which may be used as a route to helping people back into work.

Interview participants from VCSE organisations emphasised the importance of building trust with the communities they served, flexibility, and cultural relevance. They often serve as the first point of contact for individuals who more formal support systems have failed to engage. However, stakeholders noted that without a dedicated employment focus, these services can only go so far. These observations indicate that a more focused approach to economic inactivity that brings together existing support services in trusted community settings, should be a key focus of WorkWell in East Brighton. This might involve additional training and/or guidance from a forthcoming DWP WorkWell Toolkit.

Drawing on the findings of this report, and the skills and experience outlined as core to delivering a WorkWell initiative, the key skill set, scope of practice and recommended referral criteria for a WorkWell provider have been drafted and are available in the main Sussex report.

13. Waiting lists and their impact on service user pathways

Waiting lists are a significant barrier to timely support, particularly for mental health and MSK services. Social prescribing services also often have waiting times of up to

[47] Social Care | Changing Futures Sussex

six weeks, which can delay access to essential non-clinical support [BPCN1], [BVC4]. This delay is especially problematic for individuals with fluctuating mental health, who may disengage before receiving help.

MSK services report even longer waits - up to 12 weeks for routine physiotherapy and 21 weeks for pain and spine services [SxMSKSCFT 2]. During these periods, patients are often in need of interim support and some services offer signposting or digital tools like the GetUBetter app to bridge the gap.[48]

In contrast, community-based models, like the Crew Club and TDC, avoid formal waiting lists by offering drop-in sessions and group-based support [BCC1], [BVC1]. Interviews indicated these models provide immediate, light-touch engagement, which participants believed can prevent deterioration and build trust.

14. Stakeholders referral processes

Referral pathways are diverse and often informal, relying heavily on local knowledge and trust. Social prescribers receive referrals from GPs, VCSE's and health and social care professionals, and in turn refer clients to a wide range of services, including housing, benefits, and employment support [BPCN1], [BVC4]. However, the effectiveness of these referrals depends on the availability and awareness of local resources.

Organisations like TDC and the Crew Club act as signposting hubs, connecting individuals to food banks, housing support, and training opportunities [BVC1], [BCC1]. These organisations often serve as the first point of contact for individuals with complex needs, using informal conversations and community events to identify and address issues.

Despite these strengths, there is a lack of cohesion across the system. Stakeholders noted that many people do not know what services are available or how to access them [BPH1], [BDWP1,2]. This feedback indicates that: (i) simplifying referral processes, (ii) maintaining a constantly updated database of trusted support organisations and (iii) improving communication between services should be key priorities for the WorkWell model.

15. Success stories and impact reports

While formal impact reports are limited, stakeholders shared numerous anecdotal success stories that highlight the effectiveness of community-based support. For example, the Crew Club has seen young people who first engaged through youth activities later return as volunteers or staff members [BCC1]. These stories demonstrate the long-term value of creating safe, supportive environments.

[48] GetUBetter

TDC tracks outcomes such as employment, volunteering, and training through a combination of case studies and quantitative metrics [BVC1]. Their use of HubSpot CRM offers functionality for structured data collection and reporting [BVC5,6].

Social prescribing services also collect feedback to assess the impact of their support, although measuring outcomes remains challenging due to the wide range of needs and interventions [BPCN1], [BVC4], and so the evidence base for social prescribing always remains a challenge. There was a shared recognition that qualitative data—stories, testimonials, and lived experience—are just as important as quantitative metrics in evaluating success.

16. The fit note process and return to work

The fit note process is widely seen as inadequate for supporting return-to-work planning. Stakeholders criticised the binary nature of fit notes, which often fail to capture the complexity of an individual's condition, or the adjustments needed for a successful return to work [BGP1], [BLE1]. GPs are frequently overburdened and lack the time or training to explore work-related issues in depth.. This conversation from a focus group of primary care staff neatly encapsulates these challenges whilst also offering pointers to improve the process:

"It [the fit note] doesn't ask me for a long narrative on what the person can do and can't do in various situations, and then the person who's receiving it, the employer just sees a diagnosis. They don't know how that diagnosis is affecting the person... So again, mental health problems – what does that mean in terms of what?...What adjustments can I make? How can I enable this person to work? There's no clue for either party what that is. So, if we were thinking completely blue sky thinking, I would be saying: take diagnosis away from it and put in function, but then you need people who can assess function. And that's not necessarily me. What that needs is a very holistic space, a motivational interview-based conversation." *[BGP1]*

"So, it's improving communication by doing that, because actually you're giving the employer a list of things the patient can do rather than saying here's the blanket fit note, I'm going to give you some really nebulous diagnosis. You don't understand, and then you can't make adaptation. So, we're both imprisoning each other in the same bit of misinformation, aren't we?" *[BP1]*

Some services have begun to address this gap. For example, occupational therapists at health hubs are now issuing fit notes, which helps to relieve pressure on GPs and provides a more holistic assessment [BVC3]. However, this practice is not yet widespread.

There is strong support for reforming the fit note system to include more detailed descriptions of symptoms and recommended adjustments. This would help employers better understand the needs of returning employees and reduce stigma around conditions like anxiety and chronic pain [BLE1], [BPH1]. A focus for a WorkWell service could be to address these challenges by improving primary care awareness and onward referral to WorkWell and other local employment support services. One approach could be via a case finding exercise based on fit note data, and integration with electronic patient records for an easy-to-use referral system to such services. Lessons from WorkWell Vanguards such as Frimley may be used alongside a WorkWell Toolkit, which is forthcoming from the DWP in these efforts.

17. Wider challenges to supporting people back to or staying in work

Stakeholders identified a wide range of systemic, structural, and cultural challenges that hinder efforts to support individuals in returning to or staying in work. These include:

- Employer attitudes: Many employers are inflexible or lack understanding of reasonable adjustments. Mental health conditions, in particular, are often met with scepticism or seen as a financial burden [BLE1], [BVC3].
- Occupational health limitations: Occupational health services could focus on more creative or low-cost adjustments that could make a significant difference [BVC3].
- Benefits trap: Fear of losing financial stability prevents many from transitioning off benefits, especially in areas with high housing costs like East Brighton [BVC3], [BCC1].
- Intersectionality: Individuals often face multiple, compounding barriers, such as poor housing, digital exclusion, and language barriers, which require coordinated, multi-agency responses [BVC1]
- Funding instability: Short-term funding cycles disrupt service continuity and undermine trust. Employability hubs and community support programs are particularly vulnerable [BVC5,6].

These challenges underscore the need for a holistic, integrated approach that addresses the broader determinants of health and employment. WorkWell must be designed with flexibility, sustainability, and equity at its core.

18. Gaps and opportunities for the Workwell programme

While stakeholders were generally supportive of the WorkWell concept, several gaps and missed opportunities were identified:

- Lack of employer engagement: the current model does not sufficiently involve employers in co-designing return-to-work plans or understanding the value of reasonable adjustments [BGP1].
- Over-medicalisation: there is a risk that WorkWell could replicate the overly clinical approach of some existing services, rather than focusing on empowerment and community integration [BVC3], [BGP1].
- Inconsistent integration: the degree to which services might easily integrate with WorkWell varies widely. Some areas have strong links between Primary Care Networks (PCNs), VCSEs, and DWP, while others operate in silos [BPCN1], [BVC4], [BDWP1,2].
- Limited focus on preventative support: stakeholders emphasised the importance of early intervention and ongoing monitoring, particularly for those with long-term conditions [BLE1].

Addressing these gaps will require co-production with local communities, clearer communication of the WorkWell offer, and stronger alignment with existing services and strategies.

19. Ideas and innovations for WorkWell

Stakeholders offered a wealth of ideas to enhance the design and delivery of WorkWell in East Brighton, for example:

- Community-based delivery: Services should be embedded in trusted local venues, food banks, and GP surgeries. This increases accessibility and builds trust [BCC1], [BVC1].
- Flexible engagement: Drop-in models, peer-led groups, and informal support can prevent disengagement and reduce waiting times [BVC1], [BCC1].
- Digital inclusion: Providing access to devices, data, and training, especially in multiple languages, can bridge the digital divide and support engagement [BVC5,6].
- Fit note reform: Expanding the role of allied health professionals in issuing fit notes and improving the quality of information provided can support better return-to-work planning [BVC3], [BPH1].

These ideas reflect a strong appetite for innovation and a deep understanding of local needs. By incorporating these insights, WorkWell can become a transformative model for health and employment support in East Brighton.

Conclusion

The East Brighton Deep Dive reveals a vibrant yet fragmented ecosystem of services supporting individuals with mental health and MSK conditions in their journey to remain in or return to work. While there is a wealth of experience and commitment across the VCSE, health, and statutory sectors, systemic challenges—such as long waiting times, digital exclusion, inconsistent referral pathways, and

funding instability—undermine the effectiveness of current support. Stakeholders consistently emphasised the need for a holistic, community-embedded WorkWell model that builds on existing assets, fosters trust, and integrates employment support into familiar, accessible settings. With strong local appetite for innovation and co-production, and alignment with national policy priorities, there is a clear opportunity to transform service delivery through low-cost, high-impact changes that prioritise sustainability, equity, and user involvement and empowerment. Feedback from participants in this report suggests a user pathway that builds upon existing resources and networks which need to work more closely to address the aim of WorkWell to reduce economic inactivity in East Brighton.

Recommendations and actionable steps

The following recommendations have been made with the knowledge of the limited funding available to support a WorkWell service in East Brighton. The emphasis is therefore on building on the strengths of the services already working in this space by transforming and focussing on existing resources. These recommendations do, however, act as a long list of recommendations that would support delivery of a successful programme, that will need to be prioritised based on local priorities, funding, time and the resources available.

1. Embed employment support in trusted community settings

Actions:

- Co-locate advisors with a WorkWell remit in venues like the Crew Club, Robert Lodge Health Hub, food banks, and GP surgeries.
- Use drop-in models and peer-led groups to reduce waiting times and increase engagement.

Why it works: Embedding WorkWell into trusted community settings and existing networks builds on trust, avoids duplication, and ensures continuity of care. It leverages local knowledge and infrastructure, making the programme more sustainable and accepted.

2. Streamline and standardise referral criteria and pathways

Actions**:**

- Develop a shared, clear referral criteria and protocols across PCNs and GP Practices, MSK and mental health services, DWP, and VCSEs to focus on priority cases (for example: under a year unemployed, mental health and/or MSK health conditions, 2 fit notes in a year etc.).
- Use simple, low-tech digital tools to track referrals and outcomes.

Why it works: Clarifying referral criteria and improving referral pathways ensures early intervention, especially for those at risk of falling out of work. Improves coordination without requiring new infrastructure.

3. Reform the fit note process locally

Actions:

- Train allied health professionals (e.g., OTs, physiotherapists) to issue fit notes.
- Transformation site should consider developing a “fit note plus” template that includes suggested workplace adjustments. Whilst there is no official template in existence, a greater focus on measures that could support return to, or staying in, work might support better links between work and health. These could include prompts to explore:
    - Phased return to work
    - Amended duties
    - Altered hours
    - Workplace adaptations.

Why it works: Potential to reduce GP burden and improve return-to-work planning. Fit notes are a key touchpoint and can be leveraged to connect people to support sooner.

4. Enhance digital inclusion using existing resources

Action: Work closely with existing resources in this area – for example

- Repurposing unused devices and partnering with VCSE organisations and libraries for digital skills training.
- Offer SIM cards and data packages through existing funding streams (e.g., Good Things Foundation).
- Use the Sussex Digital Inclusion Framework to inform all digital aspects of WorkWell service delivery, which has been used across NHS Sussex to help ensure health care services consider inclusion in any digital transformation.

Why it works: Increases access to online services and reduces exclusion.

5. Use lived experience to co-design services

Actions:

- Engage with Community Panels and GP Patient Participation Groups for lived experience guidance to shape WorkWell delivery.
- Use storytelling and testimonials to inform service design and employer engagement.

Why it works: Supports equality, and ensures services are relevant and inclusive

6. Align with national and local policy

Actions:

- Map WorkWell to Sussex and National priorities around Health and multiple disadvantages as outlined in the 'Changing Futures Sussex' programme.
- Seek co-commissioning opportunities through alignment to shared objectives in Sussex's Get Britain Working and Local Skills Improvement Plans.

Why it works: Supports integration, increases sustainability and avoids duplication.

7. Support employers with low-cost adjustments

Actions:
Supported by local DWP/Jobcentre Plus services:

- Develop a local employer toolkit with guidance on MSK and mental health adjustments.
- Host employer roundtables to share success stories and build buy-in.

Why it works: Reduces stigma and improves recruitment and retention of staff with health conditions.

8. Track outcomes using simple, shared metrics

Actions:

- Use tools to track employment outcomes, balanced with the need to minimise administrative tasks for both service users and providers.
- Consider using tools already in use by existing services.
- Focus on light-touch metrics (e.g., return-to-work rates, confidence scores) to avoid overburdening staff and deterring engagement.

Why it works: Demonstrates impact without excessive bureaucracy or formality.

Note: the additional Horizon Scan report provides examples of digital platforms that may be considered to support case management and evaluation.

By implementing these recommendations, WorkWell can become a transformative service that not only supports individuals back into work but also strengthens the broader health and wellbeing infrastructure in East Brighton.

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Deep dive: Hastings

Executive summary

The WorkWell Programme has been broadly welcomed by stakeholders across health, employment, and community sectors in Hastings and East Sussex. Participants recognised the value of a structured, person-centred pathway that integrates support for individuals with mental health and musculoskeletal (MSK) conditions. Many services already support similar cohorts and deliver comparable interventions, such as coaching, signposting, and holistic care. However, there is a strong consensus that WorkWell must align with existing provision, avoid duplication, and clearly define its unique offer to be effective.

Key challenges identified include fragmented referral pathways, inconsistent integration between health and employment services, and limited capacity across the system. Fit notes are often underutilised as a referral trigger, and MSK needs are frequently overlooked. Digital exclusion, short-term funding, and employer stigma further complicate efforts to support people back into work. Participants emphasised the importance of trust, continuity, and flexibility in service delivery, alongside better data sharing and outcome tracking to demonstrate impact.

To succeed, WorkWell must embed itself within trusted local networks, co-locate with existing services, and invest in joint training and communication. It should focus on filling gaps, particularly for “middle-ground” clients – those who are not in crisis but not yet work-ready – and act as a connector across sectors. With sustained funding, strategic alignment, and a commitment to co-production, WorkWell has the potential to enhance system-wide collaboration and improve outcomes for individuals facing health-related barriers to employment.

Introduction

Hastings is one of three sites selected as part of a WorkWell ‘Discovery Phase’ for NHS Sussex. Sites were selected using key metrics and data points and other sources of information (data packs can be found in section 2).

Hastings was selected as it is a coastal town with a predominantly white, middle-aged demographic, with the 2nd highest mental health & MSK claim levels and the highest levels of deprivation in Sussex. The data pack further underpins the choice of Hastings as a transformation site. It is consistently ranked among the 20 most deprived local authorities in England, with persistent socio-economic inequalities impacting health outcomes. This contributes to increased demand for health and social care services and greater exposure to risk factors associated with poor health.

Throughout the interviews, it was stressed by several participants that it is a very challenging landscape in Hastings. While the data shows that there are high levels of deprivation, participants highlighted that the realities of this make it very hard for people on the ground. There are two shared prosperity areas (Broomegrove and Downs Farm estates), issues with drug and alcohol misuse and widespread cuts to core local services [HCAB1], [HVC1,4], [HLG1], [HSC].

It was described as a low paid micro economy [HVC2] with limited jobs, lots of seasonal work, few large employers with many Small and Medium Enterprises

(SMEs), many of which lack robust Human Resource and Occupational Health functions to adequately support their staff [HCAB1], [HCC1].

The area is, however, seemingly quite well connected in areas and very engaged with an active Voluntary Community and Social Enterprise (VCSE) sector. The participants in this deep dive spoke of partnership working and gave many examples of organisations they work with or refer to. There is the well-established and active Skills East Sussex (SES) Board and the developing ICT Management and Planning Group.

While there was frustration that previously funded programmes had ceased (e.g. the Work and Health programme) [HVC1], there are newer opportunities (e.g. Connect to Work). There is no ICT community panel in Hastings, but it was said that there are several other groups and networks where user input can be sought [HICB4].

Participants mentioned stakeholder and service mapping exercises, market research, programme evaluations and events for specific programmes. There are also other pieces of work in development, such as the Coastal Navigators Network pilot and Get East Sussex Working plans. It is therefore suggested that all relevant information is shared and reviewed as part of agreeing who will lead, plan and implement this work.

Participants

Code	Organisation
HVC1	Sussex Community Development Association (SCDA)
HVC2	Hastings Voluntary Association
HCC1	East Sussex County Council (Employability and Skills)
HCC2	East Sussex County Council (Commissioning/IPS)
HICB2	NHS Sussex (Commissioning)
HICB1	NHS Sussex (Commissioning)
HVC3	Sussex Community Development Association (Employability)
HTP1	Sussex Council of Training Providers
HGP	High Glades medical Centre (PCN lead)
HCC3	East Sussex County Council (Employability and Skills)
HLG1	Hastings Borough council (Physical Activity)
HLG2	Hastings Borough Council (Shared Prosperity)
HICB3	NHS Sussex (People and Communities)
HICB4	NHS Sussex (People and Communities)
HVC4	Hastings Voluntary Action
HDWP1	Department for Work & Pensions
HDWP2	Department for Work & Pensions

HHWC	Integrated Family Healthcare Ltd (Health & Wellbeing Coach)
HOT1	High Glades Medical Centre (OT)
HSC	Southdown Housing Association (Operations/Social Prescribing)
HVC5	Southdown Housing Association (Operations/Social Prescribing)
HCAB1	Citizens Advice/Hastings Community Network
HVC6	Fellowship of Saint Nicholas/Hastings Community Network

Methods

In total, 22 participants contributed to the study via deep dive interviews. Additionally, feedback has been included from attending the Hastings Integrated Community Team (ICT) Management & Planning Group (MPG) and the Skills East Sussex (SES) Board. Further details on the methods applied in the deep dive are provided in the main introduction to the deep dive report.

Findings

1. Roles and responsibilities of participants

Participants across the system represent a diverse range of roles, from strategic commissioners and clinical leads to frontline practitioners and voluntary sector coordinators. These include those managing employment and skills programs [HCC1], overseeing social prescribing [HSC], and leading integrated care strategies [HICB2]. Many are embedded in local systems, such as Primary Care Networks (PCNs), ICBs, or community-based organisations, and bring a wealth of experience in supporting people with complex needs.

Several participants operate within or alongside statutory services, including local authorities and the NHS. For example, some lead on commissioning mental health and employment support services, while others manage operational delivery of employment programs, like the now ceased Work and Health programme, or the recently commissioned Connect to Work programme. This blend of strategic and operational perspectives provides a comprehensive view of the challenges and opportunities in integrating health and employment support.

Others work in the voluntary and community sector, delivering grassroots services such as food networks, wellbeing hubs, and supported employment [HVC4,5,6]. These roles often involve direct engagement with service users and provide critical insights into the lived experience of those navigating the system. Their work is often underpinned by short-term funding and a need for strong local partnerships.

Several participants also bring clinical expertise, including occupational therapists [HOT1], GPs [HGP], and health coaches [HHWC], who support individuals with long-term conditions, mental health challenges, and MSK issues. Their roles often involve motivational interviewing, lifestyle coaching, and liaison with employers, highlighting the importance of clinical input in employment pathways.

2. Familiarity with the WorkWell pathway

Familiarity with the WorkWell pathway varied among participants. Some had direct experience with similar models and several participants recognised elements of the WorkWell approach within existing or previous initiatives [HCC1], [HVC3,5]. For example, the pathway was seen as echoing the principles of social prescribing and integrated care models already in place [HICB3,4], [HVC6]. Others, particularly those in clinical or commissioning roles, were aware of the concept but had not encountered the WorkWell programme specifically [HGP], [HOT1], [HICB1].

A few participants, particularly those in strategic roles, saw the WorkWell pathway as an opportunity to formalise and scale up existing good practice. They suggested that with the right alignment and stakeholder engagement, WorkWell could enhance coordination and fill gaps in the current landscape [HCC2], [HVC1,3]. However, they also cautioned that this would require investment in awareness-raising and training across sectors.

3. Thoughts on the typical user journey

Participants broadly supported the structure of the WorkWell user journey, recognising that it reflects many principles already present in local practice—particularly the emphasis on early engagement and holistic, person-centred support for individuals with complex needs [HVC3,5,6]. The journey was seen as a helpful framework for coordinating services, provided it remains adaptable to individual circumstances.

Some felt the pathway aligns well with existing models, especially where employment specialists and social prescribers are embedded in primary care or community settings [HCC1], [HVC3,5]. There are also similarities with existing processes and organisations around multidisciplinary in-house support through the Jobcentre [HDWP1,2].

It was flagged however, that GPs are often not a key referral route in practice, with referrals more commonly coming from housing officers, community connectors, or self-referrals [HGP], [HVC6]. This highlights the need for the pathway to reflect the diversity of local referral mechanisms. Where primary care is the main referral point, there are still inconsistencies as different surgeries use services to varying degrees [HHWC].

Additionally, the pathway may not fully account for the fragmented nature of local services. In some areas, integration is strong; in others, siloed working and inconsistent communication persist [HICB1], [HLG2], [HVC4], [HCAB1], [HDWP2]. The model must be flexible enough to adapt to these varying contexts.

Several concerns were raised about potential duplication or disconnection from existing services. Many of the functions described—triage, coaching, signposting—are already delivered by existing roles such as social prescribers, health and wellbeing coaches, mental health practitioners, work coaches and community connectors [HSC], [HVC4,6], [HCAB1]. Social housing organisations also deliver employment and skills opportunities to people in the town [HCC3], [HICB1]. This further highlights the need for clearer communication and integration with current systems. Trust and relationships were seen as critical and simply adding a new

service or role won't work unless it is embedded within existing networks and partnerships [HVC3,4,5].

Participants also questioned the clarity and scope of the WorkWell offer. There is a need to clearly define who the service is for, what it provides, and how it complements existing provision [HICB1,2], [HVC1,3]. The support needed to someone in-work will also differ to the support needed to someone out of work [HVC1]. Without this clarification, the service risks overpromising or underdelivering.

Capacity was also a big concern. Many services, including debt advice, financial health, welfare benefits advice and housing support, are overstretched or inaccessible, with cuts across the board. Introducing a new pathway or signposting without available capacity would increase pressure [HVC2,5,6] and risks creating false hope and disengagement [HCAB1].

> "The Work and Health programme is now closed and there is no equivalent programme nationally to support people who have health issues into employment, so while this social prescribing pathway might create a plan for somebody, there are no formal programmes to refer people on to." *[HVC1]*

Integration of services seems to vary, with some areas reporting strong alignment, particularly where models like Individual Placement Support (IPS) are already in place [HVC3,5], [HCC2]. These areas benefit from established referral mechanisms and collaborative relationships.

However, in other areas, integration is limited. Employment specialists and VCSE providers are not always linked into health services, leading to fragmented support [HVC1,6]. Participants called for clearer referral pathways, shared protocols, and co-location of services to improve integration [HVC2,3], [HGP].

Joint training and shared understanding were highlighted as enablers of integration. Barriers include digital exclusion, inconsistent communication, and lack of awareness of available services. True integration must go beyond structure—it must foster mutual understanding, shared goals, and a commitment to person-centred care [HICB3], [HOT1], [HVC6].

4. Funding

Funding sources across the WorkWell ecosystem are diverse and often fragmented. Many services rely on a mix of funding streams from the NHS, Department for Work and Pensions (DWP), public health, Local Authority, grants and additional sources such as the UK Shared Prosperity Fund (UKSPF) [HCC3], [HVC1]. This patchwork of funding can support innovation and flexibility but also creates instability and short-termism, particularly for voluntary sector providers who often have to source their own funds and have a strong presence in Hastings.

Several participants highlighted the challenges of sustaining services when funding is tied to short-term projects or competitive bidding cycles. For example, some employment and wellbeing programs have been forced to scale back or close due to the end of European Social Fund (ESF) support or reductions in local authority budgets [HVC3,4,6]. This has a direct impact on the continuity of care and the ability to plan long-term interventions.

Citizens Advice in Hastings operates entirely on project-based funding, with no core funding available, despite being in one of the most deprived areas in the country. This severely limits their ability to meet rising demand [HCAB1].

Many other local services have seen funding cuts and are now underfunded, or have long waiting lists, which will have a direct impact on the WorkWell pathway. It risks becoming a signposting service into a system that lacks the capacity to respond [HCAB1] and without investment in services, the pathway could fail to deliver meaningful outcomes [HVC6].

Others noted that while NHS funding supports some roles, such as health coaches, occupational therapists, and social prescribers, these are often limited in scope or capacity [HOT1], [HHWC]. There is also variation in how resources are allocated, which can lead to unequal access to services across different areas. Participants called for more consistent and strategic investment in integrated health and employment support.

A few participants emphasised the importance of aligning WorkWell with existing funding streams to avoid duplication and maximise impact. This includes leveraging town deals, regeneration funds, and community safety budgets where appropriate [HICB1], [HLG2]. However, they also warned that without dedicated and sustained funding, the WorkWell pathway risks becoming an unsustainable offer.

5. Referral pathway for mental health and MSK conditions

Referral pathways for individuals with MSK conditions seemed quite consistent but varied for mental health services, depending on entry route and needs of the patient. Many participants reported receiving referrals from a mix of sources, including Jobcentre work coaches, housing officers, social prescribers, and voluntary sector partners [HVC1], [HVC3,5]. In some cases, self-referral is also possible, particularly in community-based or digitally enabled services [HVC6].

MSK conditions

The East Sussex MSK Community Partnership (ESMSK) was launched in December 2024 and acts as an NHS referral management service, offering pathways and services for the care and treatment of patients with MSK conditions across East Sussex[49]. It commissions a network of local clinicians and support organisations to provide seamless, all-round care for patients, as per the pathway below:

[49] East Sussex MSK Community Partnership

Referral entry: Patients can enter via self-referral, GP, a First Contact Practitioner, physiotherapy providers or a clinician at East Sussex Healthcare NHS Trust.

Triage team: Patients referrals are clinically triaged by a specialist team to determine the best care pathway for their individual needs and situation.

Outcomes:

- For many people the first step might involve an appointment with a physiotherapist or an advanced practitioner. They will work with the patient to get the right diagnosis, discuss treatment options and help the patient choose the option best suited to their needs.
- Onward referrals will be made as required for:
    - Specialist treatment
    - Surgery
    - Pain management.

It was acknowledged that there is no formalised integration of employment support into this pathway.

First Contact Practitioners
First Contact Practitioners (FCPs) operate in general practice and offer patients access to an expert physiotherapist at their very first contact in their GP practice. In Hastings, these roles are directly funded by the PCN from independent providers. The PCN uses a mixed employment model with some practices employing their own FCPs internally, allowing for a balanced distribution of FCPs across practices and ensuring that every practice has access to one. It is noted that the PCN is currently reviewing their FCP capacity in line with its Additional Roles Reimbursement Scheme (ARRS) budget and NHS England's evolving policies [HGP].

FCPs address appropriate primary care needs, and patients with ongoing MSK symptoms can be referred or can self-refer to community MSK services. It was flagged however that this pathway could miss the ideal window of opportunity to support any patients with early risk factors of stopping work due to their MSK presentation.

Mental health conditions

Sussex Partnership NHS Foundation Trust has oversight for NHS provision of mental health services in Sussex for adults, children and those in crisis, among other groups.

Talking therapies and employment support
Health in Mind is an NHS Talking Therapies service delivered by Sussex Partnership NHS Foundation Trust across East Sussex, part of the national NHS Talking Therapies programme, providing courses and other types of therapies that help with stress, anxiety and low mood. Employment support follows the full IPS model, including job search, in-work support, and employer engagement and is for those with more severe or complex mental health conditions. Referral may be through the following pathways:

- Self-Referral – via online form or phone
- GP/Health Professional Referral – through your local surgery
- Assisted Referral – with help from a friend, family member, or support worker
- Social Prescribing – via link workers in GP practices

Talking Therapies professionals provide multiple services using different approaches to support people as appropriate, including mindfulness, cognitive behavioural therapy, guided self-help, counselling and more. Users receive one-to-one support with a personalised 'journey to work' plan and time-unlimited in-work support for them and their employer.

IPS Light Touch is available for people receiving NHS Talking Therapies for common mental health conditions like anxiety or depression. Integrated with therapy sessions, Southdown provide light-touch employment support and referrals come directly from Health in Mind.

Work in Mind is a one-to-one employment support offer delivered by Southdown employment specialists, to help people progress towards their work aspirations, overcome any barriers they are facing and help people manage their mental health in the workplace. Referrals come directly from Health in Mind.

Employment advisors and work coaches
In addition to the employment support services mentioned above, Southdown also has employment specialists that work in the community offering flexible, person-centred support. These employment specialists will also refer to Southdown Social Prescribers if a client is also struggling with housing, debt, loneliness, or other social issues (and vice versa).

DWP Employment Advisors or Work Coaches are primarily based in Jobcentre Plus offices supporting people receiving Universal Credit, Jobseeker's Allowance, or Employment and Support Allowance and can refer clients to external employment support programmes. Disability Employment Advisors (DEAs) offer tailored support for people with health conditions or disabilities and people can be referred to a DEA via an existing work coach, those on Universal Credit can send a message through their online journal, or someone can be referred directly from a Jobcentre Plus office. It was flagged, however, that many people suitable for the WorkWell offer won't be on Universal Credit and therefore won't be accessing the Jobcentre [HVC1].

Southdown has started running drop-ins with the Jobcentre DEAs to show clients how they can work together to reach their goals [HSC], which also highlights the work of DEAs.

An issue was flagged around charitable/volunteer organisations as they often contact DEAs to say they have a customer that would benefit from DEA support but, because of GDPR, the Jobcentre has to advise them to tell their customer to voice these needs in the Jobcentre directly or via the online portal, adding in an additional step for someone in need of support [HDWP1,2].

Since the Deep Dive interviews took place, the Connect to Work programme[50] has now launched in East Sussex and will be supporting people in Hastings who have mental health and physical health obstacles to access employment. A range of providers including Southdown, SCDA, Littlegate, CXK, People Matter and Palladium will employ Employment Specialists who will support economically inactive people in Hastings with 12 months of bespoke support with accessing and sustaining work locally. The Employment Specialists will also be able to support those whose work is at risk due to regular absence on health grounds, (i.e. those in receipt of fit notes), for a period of three months, to help them sustain their roles.

Additional roles and support for individuals with mental health & MSK conditions

Social prescribers sit within primary care and community venues across Hastings and Rother [HCC2]. The social prescribers can receive referrals from and refer people to Southdown Employment Specialists if a client expresses a desire to return to work, find a job, or explore volunteering or training.

Southdown commission three of the social prescribers known as Community Connectors based in Hastings, St Leonards and Rother, connecting people to non-clinical community support for housing, debt, loneliness and wellbeing activities.

Southdown also employ community-based Mental Health Support Coordinators (MHSCs) in Hastings as part of a multidisciplinary team that includes GPs, mental health professionals, and social prescribers, embedded in the Emotional Wellbeing Service model, to ensure users get the most appropriate support [HCC2].

The Emotional Wellbeing Service (EWS) aims to bridge the gap between primary care and specialist mental health services and is based in GP surgeries across East Sussex, delivered in partnership with the PCN. It offers short-term support for emotional and mental wellbeing providing information, advice, and guidance tailored to individual needs. Referrals are usually made by a GP or other healthcare professional, and it will refer on to Health in Mind, the Community Connectors, specialist mental health services or relevant voluntary sector organisations. It was unclear how much support is provided around employment specifically.

Health and Wellbeing Coaches are employed by the PCN and based in practices or out in the community (e.g. One You East Sussex). They offer personalised coaching around improving people's broader health and wellbeing. Its practice-based coaches host various support and wellbeing groups, e.g. managing pain. While people can self-refer to the groups, referrals to the coaches come from GPs, social prescribers, or other professionals. It was noted that referral numbers vary depending on the route [HHWC].

An Occupational Therapist is embedded within GP practices as part of the PCN. They work alongside GPs, social prescribers, mental health support coordinators, and health and wellbeing coaches and help with managing fatigue, pain, or anxiety, returning to or staying in work (often around access or reasonable adjustments), developing coping strategies and routines and improving independence and quality of life. Referrals are made through the GP [HOT1].

[50] Connect to Work: Grant Guidance for England - GOV.UK

Key delivery partners

There are a few key partners across the patch that deliver (or have delivered) programmes of work supporting people with health conditions stay or return to work. These include:

1. **East Sussex County Council**

The council funds or co-funds several relevant services and has a very active employment and skills team. They also fund One You East Sussex – delivered by Thrive Tribe – a specialist health and wellbeing service.

ESTAR is one of the Employment and Skills sub-teams that provide support to vulnerable adults (18+), helping them build the skills and confidence to search for work. They:

- Deliver Level Up, an extension to the Moving on Up programme, which initially supported residents living in supported and temporary accommodation to secure an apprenticeship or employment, and permanent housing, but now supports young people who are NEET and economically inactive people.
- Oversee the Homeless Prevention Employment Service (HPES), which supports those that are homeless or at risk of homelessness into work.
- Now also oversee the new DWP Connect to Work programme (see above).

The Employment and Skills Team also includes the Adult Learning Team, which oversees Skills Bootcamps – 16-week courses to train people in technical skills leading into employment or to upskill those without a Level 3 qualification who are in work.

East Sussex County Council has also overseen the multi-agency Skills and Employment East Sussex Board for the last decade, in place to coordinate Employment and Skills work in the County. NHS Sussex has a seat on this Board to support links with health. The Board has several working groups including the Health and Social Care Task Group, the Adult Learning Network and the ESTAR Employability Forum.

2. **Sussex Community Development Association (SCDA)**

SCDA have vast experience developing and delivering welfare to work programmes and support for those disadvantaged in the labour market. Examples include the nationally funded DWP Work and Health Programme (where referrals had to come through the Jobcentre) and the ESF/National Lottery Community Fund funded Building Better Opportunities programme (where referrals came from OT and other key links) – both having now come to an end nationally. They also coordinate several advice providers

3. **Southdown**

Southdown is a major provider of community-based mental health and employment support across Sussex. They offer employment support integrated with NHS Talking Therapies and their employment advisors work alongside therapists to help clients find or stay in work, using a "light touch" IPS model (see above).

The wider VCSE sector

Alongside statutory services, the VCSE sector is very active in and around Hastings, with services aimed at combating key mental health risk factors such as loneliness and isolation. Whilst the following is not an exhaustive list, below are some providers mentioned during the participant interviews.

Organisation/service	**Role/offer**
One You East Sussex	Health and wellbeing service from East Sussex County Council.
Fellowship of St Nicholas	A charity that aims to provide effective and professional caring action without discrimination for children, young people and families suffering the effects of poverty, disadvantage, neglect and abuse. Support moving people towards work. Partner with the PCN to deliver a few needs-led services, including Health & Wellbeing Coaching.
Active Hastings	Partnership between East Sussex County Council and Hastings Borough Council. Partner with the PCN with Sports Champions to help the local community to move more. Have a GP link worker who gets referrals from practices and signposts on. Run Men: Mind and Muscle.
East Sussex Recovery Alliance (ESRA)	Support people in Hastings and Rother to live free from addiction and support for long-term recovery. Work to build confidence, develop skills, and create connections that support education, employment, and career opportunities.
Little Gate Farm	Find paid jobs for adults with learning disabilities and autism across East Sussex, giving them all the support they need to learn the role, adapt to their new workplace and become a real asset to their employer. Using an approach called ‘job carving’.
Hastings Voluntary Action	Infrastructure organisation for the not-for-profit sector in Hastings. Not a delivery partner. Developed the Support and Employment Forum. Held a Connecting the Connectors conference for providers to discuss appropriate referrals between primary care or social prescribing and other services. Host the Ageing Network and the Food Network, including social supermarkets. Will signpost to JCP.
UOK	A partnership of 20 community services working together to support good mental health and wellbeing across Sussex, led by Southdown.
East Sussex College Group	Support work for apprentices and apprenticeships Employment specialists can refer in.
Brighton Housing Trust	Delivers East Sussex Floating Support Service provides short-term housing-related floating support vulnerable people, aged 16+, who require support to live independently, including preventing homelessness, managing a tenancy, money management and accessing healthcare.

Change Grow Live	A charity supporting people who want to make a change in their lives. Take a holistic approach to find the right treatment and care options whether it's physical health, mental wellbeing, lifestyle or relationships. Includes guidance on drug and alcohol misuse.
Eggtooth	Wellbeing service for children, young people, parents and professionals, offering mental health support. Partnered with the PCN to provide funding to support neurodiverse young people in their care and to promote the inclusion of the young LGBTQ+ community in Hastings.
Seaview Project	Helps marginalised people with addiction problems, mental health issues, ex-and at-risk offenders and rough sleepers achieve personal growth and fulfilment.
IC24 Hastings Primary Care Hub	A service based in the town centre delivered by a team of Advanced Nurse Practitioners providing appointments for a range of minor illnesses.
Sussex Council of Training Providers (SCTP)	The training provider network for Sussex – a membership organisation. A lot of their members deliver the back to work provision through the DWP, i.e. pre-employment support. Also provides NEET provision as well. Hold termly pre-employment meetings.
East Sussex Wellbeing at Work	A free initiative designed to help local employers improve the health and wellbeing of their workforce. Funded and delivered by Public Health at East Sussex County Council.
Access to Work	A national government scheme that provides practical and financial support to help people with a disability or health condition start or stay in work. Long waiting lists.
Restart Scheme	Helps long-term unemployed people to start working. Provides a wide range of support options, including skills training, job application and interview preparation, financial help, online tools and health and wellbeing support. Nationwide scheme provided by Reed in Partnership in Hastings with the DWP.
Arts on Prescription	Social prescribing that connects people with creative activities to support their mental health and overall wellbeing. Instead of – or alongside – traditional treatments. Offered by Southdown as part of its UOK East Sussex wellbeing services.

Perceptions of mental health and MSK referral pathways in Hastings

For MSK conditions, while the overarching pathway is clear, referrals often depend on the visibility of services and the awareness of referring professionals. Some participants highlighted that MSK needs are under-identified in the community, particularly when services lack physical presence in GP practices or when patients are not actively seeking work [HOT1], [HVC2]. Others noted that MSK referrals are more likely to come through structured programs like pain clinics or physiotherapy services, which are not always well-integrated with employment support.

Several participants noted that GPs are often not the primary referral route – even within primary care – despite their central role in health systems. Instead, referrals often come from other primary care staff such as nurses, receptionists, or ARRS roles, who may have more time to engage with patients and understand their broader needs [HCC1], [HICB4], [HHWC]. This reflects a shift toward more distributed models of care and the importance of non-clinical staff in identifying support needs.

There is clearly a lot of relevant activity going on in Hastings, but, with the busy VCSE sector and challenges around high levels of deprivation and funding cuts, participants stressed the need of raising awareness among all staff across the board about referral options and eligibility criteria. They also called for better use of fit notes and digital tools to trigger referrals at key points in the care journey [HGP], [HVC5,6], potentially missing opportunities to support patients with signs of stopping work due to their MSK presentation or mental health. Without clear and consistent pathways, individuals with mental health and MSK conditions risk falling through the cracks or being referred too late for effective intervention.

6. Patient outcomes data

Participants reported a mixed picture regarding the availability and quality of outcomes data. Some services, particularly those funded through NHS England or DWP, are required to report on specific metrics such as job outcomes, referral volumes, and engagement rates [HVC5], [HCC3]. This data is often used to monitor performance and inform commissioning decisions, though they may not always capture the full impact of the service.

Others noted that while data is collected, it is often fragmented or not routinely shared across systems. For example, social prescribing services may track referrals and client characteristics, but not employment outcomes [HSC], [HVC4]. Similarly, some employment programs collect “softer” intelligence—such as confidence levels or wellbeing improvements—but lack standardised tools for measuring these outcomes [HVC3,6].

A few participants highlighted the use of specific tools for data collection, such as the use of wellbeing scales (e.g., Warwick-Edinburgh Mental Wellbeing Scale), Customer Relationship Management (CRM) systems, or monthly PCN reports [HLG1], [HHWC]. These tools can provide valuable insights into client progress and service effectiveness, but their use is not consistent across the system. There is also a need for better integration of health and employment data to understand the links between the two.

Several participants emphasised the importance of capturing long-term outcomes, including job retention, health improvements, and reduced reliance on statutory services – the data shouldn’t stop once someone is in work. They called for a more joined-up approach to data collection and evaluation, with shared indicators and feedback loops across health, employment, and community services [HICB1], [HVC1], [HVC2]. Without this, it is difficult to demonstrate the full value of integrated Digital delivery has become a core component of many services, particularly since the COVID-19 pandemic. Several participants reported that appointments, workshops, and coaching sessions are now routinely offered online [HCC1], [HSC],

[HHWC]. This has increased accessibility for some clients, especially those with mobility issues or anxiety, but also introduced new challenges related to digital literacy and engagement.

Digital exclusion remains a significant barrier, particularly for older adults, people with low incomes, and those with limited English or literacy skills. Participants noted that many clients lack access to devices, reliable internet, or the confidence to use digital tools effectively [HVC4,6], [HOT1]. Some services have responded by offering digital skills training, loaning devices, or maintaining face-to-face options for those who need them. One key issue is completing forms online. Even if people do have access to a phone, it is hard to complete lengthy forms on a small screen for benefits or a job application that might not be compatible with that device [HOT1]. Form Filling Friday was a previous offer from Hastings Voluntary Action, which was unfunded, but they are still asked about the offer [HVC4].

Digital tools are being used to support service delivery and coordination, for example, the Joy platform is being used to manage social prescribing, but its use is inconsistent [HGP]. Others use CRM systems to monitor engagement and outcomes. Some organisations use social media as their main method to promote services and share updates [HLG1], [HVC3].

Participants emphasised the need for a hybrid approach that balances digital and in-person support. While digital tools can increase reach and flexibility, they are not suitable for all clients or all types of support, especially with the cohorts of people that a WorkWell pathway is trying to reach. Services must be designed with user preferences in mind and include options for those who are digitally excluded or need face-to-face interaction [HVC1,2,5].

> "The majority of the time we like to be face-to-face when we're supporting people. We meet people in well-being centres or outside spaces, not in their houses, because we're trying to encourage them to come out into the community. But we acknowledge that some people can't." *[HSC]*

In this context, it is worth highlighting the Digital Inclusion Framework, which emerged out of a collaboration between University of Sussex and NHS Sussex, supported by the Health Innovation Kent Surrey Sussex.[51] This has been used across NHS Sussex to help ensure health care services consider inclusion in any digital transformation.

8. Data on links between health and employment

Participants reported varying levels of access to data linking health and employment outcomes. Some services, particularly those involved in IPS or DWP-funded programs, collect structured data on employment status, health conditions, and

[51] Digital Inclusion framework

service engagement [HCC2], [HVC3,5]. This data is often used to track progress and report to funders, though it may not always be shared across systems or used for strategic planning.

Others noted that while anecdotal evidence and internal monitoring suggest links between health and employment, formal data collection is limited. For example, social prescribing services may record mental health diagnoses or MSK issues, but not consistently track employment outcomes or job retention [HSC]. Similarly, some employment services collect data on barriers to work but not on health improvements over time.

A few participants highlighted the potential of primary care data, such as fit note issuance or long-term condition registers, to inform employment support strategies. However, they also acknowledged challenges around data sharing, consent, and system interoperability [HGP], [HOT1], [HICB1], [HDWP1]. Without integrated data systems, it is difficult to build a comprehensive picture of how health and employment interact at the population level.

There was strong support for developing shared indicators and outcome frameworks that span health and employment domains. Participants suggested that WorkWell could play a role in coordinating data collection and evaluation across partners, helping to demonstrate the value of integrated support and inform future investment [HVC1,2,3]. It was also flagged that there is likely to be client turnover when an initial offer or even a job placement might not be right and the person comes back into the system, so this needs to be considered, especially when thinking about evaluating the role of a WorkWell coach [HCC2].

9. Experience supporting mental health and/or MSK return to work

Participants reported extensive experience supporting individuals with mental health conditions in returning to or staying in work. Many services, particularly those delivering IPS or community-based employment support, regularly work with clients experiencing anxiety, depression, or neurodivergence [HVC3,5,6]. These services often provide tailored coaching, employer engagement, and in-work support to help individuals manage their conditions while pursuing employment.

In contrast, experience with MSK conditions was more variable. Some participants noted that MSK needs are less frequently addressed in employment support settings, often due to a lack of clinical expertise or integration with physiotherapy and pain management services [HVC1], [HOT1]. Where MSK support is provided, it tends to focus on pain management, mobility, and workplace adjustments, often in collaboration with occupational therapists or primary care teams.

Jobcentre advisors regularly liaise with employers to discuss workplace adjustments and support individuals with health-related barriers to work [HDWP1]. However, the Jobcentre often face barriers in collaboration with healthcare professionals, partly due to perceptions of the DWP [HDWP1,2], [HGP]. It was also reported that DWP Key Performance Indicators (KPIs) can be misaligned with those of primary care, making partnership working even harder [HOT1].

Several participants emphasised the overlap between mental health and MSK conditions, particularly in cases where chronic pain contributes to low mood or where mental health challenges exacerbate physical symptoms [HHWC], [HGP], [HCC2]. This highlights the need for integrated approaches that address both physical and psychological barriers to work. Some services have begun to explore this through joint clinics or co-located teams, though these models are not yet widespread.

There was also recognition that many clients with mental health or MSK conditions are not engaged with formal health services and may require outreach or peer-led support to access help. Participants stressed the importance of building trust, offering flexible engagement options, and providing holistic support that goes beyond clinical treatment to include housing, benefits, and social connection [HVC2,3,5], [HCAB1].

10. Common needs for those with mental health conditions in employment or needing support returning to work

Participants consistently identified confidence-building as a foundational need for individuals with mental health conditions seeking to return to or remain in work. Many clients experience anxiety, low self-esteem, or fear of failure, which can prevent them from engaging with employment services or pursuing job opportunities [HVC3,5,6]. Services often address this through motivational coaching, peer support, and gradual exposure to work-related activities.

Another common theme was the need for emotional support and someone to listen. Participants emphasised that many clients benefit from having a consistent, trusted relationship with a coach, advisor, or peer mentor who can help them navigate challenges and build resilience [HVC4], [HHWC], [HVC2]. This relational approach is particularly important for individuals who have experienced trauma or social isolation.

The need for additional practical support can also not be underrated. This cohort often need help with job applications, interview preparation, transport and even clothing [HCC1], [HVC1,6].

Participants noted that mental health conditions also often intersect with financial stress, housing insecurity, and other social determinants of health, requiring a holistic and coordinated response [HCAB1]. Services that can address these needs in one place or through strong partnerships are more likely to succeed.

> "I know there's elements of training and things like that to get people back to work, but to get more people into work, we have to better understand why they're not working – what is really stopping them. The challenge being that often the person doesn't know how to articulate it and they need someone to help." *[HOT1]*

Finally, stigma remains a significant barrier. Several participants reported that clients are reluctant to disclose mental health conditions to employers or fear being judged or dismissed [HGP], [HVC3]. There is a need for more employer education, flexible

working arrangements, and supportive workplace cultures that recognise and accommodate mental health needs.

11. Common needs for those with MSK conditions in employment or needing support returning to work

Participants noted that individuals with MSK conditions often require tailored physical support, including pain management and mobility aids, can be overlooked in employment support services [HVC3], [HOT1]. Where MSK support is provided, it is often through collaboration with occupational therapists or physiotherapists, though such integration is not yet widespread.

Fatigue and flare-up management were also highlighted as key concerns. Clients with chronic MSK conditions such as arthritis or fibromyalgia may struggle with energy levels, consistency, and physical endurance, making traditional work environments challenging [HHWC], [HOT1], [HVC2]. Participants emphasised the importance of flexible working arrangements, phased returns, and supportive employers who understand the fluctuating nature of these conditions.

Another common issue is the delay in accessing treatment or diagnosis. Several participants reported that clients are often stuck on long waiting lists for physiotherapy or pain clinics, which can delay their return to work or lead to deterioration in their condition [HVC3,4,6]. This highlights the need for faster access to clinical support and better coordination between health and employment services.

Finally, participants stressed the psychological impact of MSK conditions. Chronic pain and reduced mobility can lead to isolation, depression, and loss of identity [HVC1,5], [HGP]. Addressing MSK needs, therefore, requires a holistic approach that includes emotional support, peer networks, and confidence-building alongside physical rehabilitation.

12. How services support typical Workwell users

Many participants described their services as already supporting the same cohort targeted by WorkWell, particularly individuals with low-level mental health needs, long-term conditions, or those facing multiple barriers to employment. Services such as social prescribing, IPS, and community-based employment programs routinely provide coaching, signposting, and practical support to help people move closer to work [HVC3,5].

Support often includes motivational interviewing, confidence-building, and help navigating complex systems such as benefits, housing, and healthcare. Participants emphasised the importance of holistic, person-centred approaches that address the full range of needs a client may have—not just employment readiness [HVC2,6], [HHWC]. This aligns closely with the WorkWell model, suggesting strong potential for integration.

Several services also offer structured pathways into training, volunteering or job trialling, designed to support employer recruitment needs and provide progression routes for clients. These include skills bootcamps, apprenticeships, and supported employment placements, often delivered in partnership with local colleges, employers, or voluntary sector organisations [HVC1,3], [HCC3], [HTP1]. Participants

noted that WorkWell coaches should be familiar with these opportunities and able to refer clients appropriately.

Finally, participants highlighted the value of peer support and community engagement in sustaining progress. Services that offer group activities, buddy systems, or co-located support were seen as particularly effective in helping clients build confidence and maintain motivation [HSC], [HLG1], [HVC5]. Embedding WorkWell within these existing networks could enhance its reach and impact.

We should note that we did not undertake a full semi-structured interview with a representative from the Changing Futures Sussex programme, but our engagement identified the service as highly relevant to the focus of WorkWell.[52] Changing Futures is part of a national £91.8 million programme aimed at improving outcomes for adults facing multiple disadvantages, such as homelessness, mental health issues, substance misuse, domestic abuse, and involvement with the criminal justice system. In Sussex, the programme brings together public services and voluntary sector partners to deliver person-centred, coordinated support. It focuses on transforming local systems to reduce crisis demand, improving service integration, and empowering individuals to stabilise and improve their lives.

Drawing on the findings of this report, and the skills and experience outlined as core to delivering a WorkWell initiative, the key skill set, scope of practice and recommended referral criteria for a WorkWell provider have been drafted and are available in the main Sussex report.

13. Waiting lists and their impact on service user pathways

Waiting lists were reported by several participants, generally due to high demand and limited staffing. For example, some GP-linked services such as occupational therapy or health coaching reported wait times of up to two months for initial appointments, with follow-ups delayed due to caseload pressures [HOT1], [HHWC]. This can significantly impact a service user's momentum and motivation, especially when they are ready to engage.

In contrast, some employment-focused services, particularly those with recent funding expansions, reported minimal or no waiting lists. For instance, the "light-touch" IPS services and short-term interventions like Health in Mind were able to maintain quick turnaround times, often under two weeks [HVC3,5]. These services emphasised the importance of maintaining flow and responsiveness to keep clients engaged.

Participants noted that long waits can lead to disengagement, especially for individuals with fluctuating mental health or MSK conditions. Clients may lose confidence, experience deterioration in their condition, or face additional barriers such as housing instability or benefit sanctions during the wait period [HVC1,2,6]. This underscores the need for interim support or check-ins to maintain engagement.

[52] Social Care | Changing Futures Sussex.

Some services have developed strategies to manage waiting lists more effectively, such as triaging based on urgency, offering group sessions while clients wait for one-to-one support, or using peer mentors to provide interim contact [HSC], [HVC3]. Participants suggested that WorkWell should consider similar approaches to ensure that users are not left unsupported during critical transition periods.

14. Stakeholders referral processes

Referral to other services is a core function across nearly all participants' roles. Most described well-established pathways to a range of support, including housing, mental health, financial advice, training, and volunteering opportunities [HVC3,4,6]. These referrals are often based on a holistic assessment of the client's needs and are facilitated through strong local networks and partnerships.

Some services operate within formal referral frameworks, such as those linked to the PCN or funded through DWP or commissioned contracts. These often use digital platforms or CRM systems to track referrals and outcomes, ensuring accountability and continuity of care [HHWC], [HVC1,5]. Others rely more on informal networks and personal relationships, particularly in the voluntary and community sector, where trust and local knowledge are key [HVC2,6].

Participants emphasised the importance of targeted handovers rather than blanket referrals. This means taking time to explain the next service to the client, sometimes accompanying them to appointments or following up to ensure engagement [HSC], [HVC4,6]. This approach helps build trust and reduces the risk of clients falling through the cracks, especially those with complex or fluctuating needs.

There were also calls for better coordination and shared referral protocols across sectors. Some participants noted that services are not always aware of each other or may duplicate efforts due to poor communication [HICB1], [HLG2], [HVC3]. By ensuring that WorkWell is closely aligned with existing programmes and structures, there is the opportunity for this work to support the streamlining of referral pathways and create a more joined-up system.

15. Success stories and impact reports

While formal impact reports were not widely shared, many participants referenced anecdotal success stories and positive outcomes from their work. These included clients who had moved from long-term unemployment into sustained work, often after receiving holistic support that addressed both health and social needs [HVC3,5,6]. Such stories were seen as powerful evidence of what integrated, person-centred approaches can achieve.

Some services, particularly those funded through NHS England or DWP, are required to report on outcomes such as job entries, retention rates, and wellbeing improvements. These metrics are often used to demonstrate value to funders and support continued investment [HVC5], [HCC2]. However, participants noted that these reports may not capture the full impact of their work, especially the "softer" outcomes like increased confidence, reduced isolation, or improved self-management of health conditions.

Participants also highlighted the importance of qualitative feedback from clients. Many services collect testimonials, case studies, or satisfaction surveys to understand what works and where improvements are needed [HVC1,4], [HHWC]. These insights are often used to refine service delivery and advocate for additional resources or policy changes.

There was a shared view that WorkWell should prioritise capturing and sharing success stories to build momentum and demonstrate impact. Participants suggested that this could include both quantitative data and personal narratives, ideally co-produced with service users. Doing so would help to humanise the pathway, inspire confidence among stakeholders, and support the case for long-term investment [HVC2,3,6].

16. The fit note process and return to work

Participants shared a range of experiences with the fit note process, often highlighting its limitations in supporting return-to-work conversations. Several noted that GPs tend to issue fit notes readily, sometimes without exploring alternative options such as phased returns or workplace adjustments [HICB2], [HGP], [HDWP1]. This was attributed to time pressures, lack of training, or discomfort in challenging patient expectations.

Some services, particularly those with clinical staff like occupational therapists, reported more proactive involvement with fit notes. These professionals often work with clients to understand their capabilities and liaise with employers to facilitate adjustments [HOT1], [HHWC]. However, they also noted that they are not always included in the fit note process, which limits their ability to influence outcomes.

There was a strong consensus that fit notes could be used more effectively as a trigger for support. Participants suggested embedding referral prompts into the fit note process, such as automatic signposting to WorkWell or related services when a note is issued for mental health or MSK reasons [HVC1,3,5]. This would help ensure timely intervention and reduce the risk of being off or out of work long term.

> "Thinking about where a work and health coach might sit, the question is, where is this entrenchment of people being signed off sick happening? It's in the GP practices. People are coming to us to be signed off. But GPs don't like getting into debates and making people distressed by telling them they've got to work, so therefore that's where the conversation ends, and they get signed off sick. But if we're trying to move people out to another service, which is essentially voluntary for the patient, it sounds like it needs to be wherever people will be interfacing for their sick notes." *[HGP]*

Finally, participants emphasised the need for cultural change around fit notes. They called for more education for both clinicians and clients about the purpose of fit notes and the possibilities for staying in or returning to work with the right support

[HVC2,6]. Without this shift, fit notes may continue to act as a barrier rather than a bridge to employment.

17. Wider challenges to supporting people back to or staying in work

Participants identified a range of systemic and structural challenges that hinder the wider network's ability to support people into or to remain in work. A major issue is the fragmentation of services and lack of coordination between health, employment, housing, and social care systems [HICB1], [HVC3,6]. This often results in duplicated efforts, missed referrals, and clients falling through the cracks, particularly those with complex or multiple needs. The number of jobs available in Hastings is also really low, which can have a wider impact, especially if people keep trying for jobs and get knocked back [HDWP2].

Funding instability and workforce capacity were also frequently cited. Many services operate on short-term grants or project-based funding, which limits their ability to plan long-term or retain experienced staff [HVC2,4,6]. This is especially problematic in areas like Hastings, where demand is high, and the voluntary sector plays a critical role in service delivery. Participants stressed that without sustained investment, even the best-designed pathways will struggle to deliver impact.

Cultural and attitudinal barriers also persist. They noted that clients themselves may fear stigma or lack the confidence to disclose their needs or request adjustments. Some employers also remain hesitant to hire individuals with health conditions, particularly mental health or fluctuating MSK issues, due to perceived risks or lack of understanding [HVC1,5], [HGP]. Participants called for more employer engagement, education, and support to create inclusive workplaces.

> "Hastings is a town full of small employers, and very frequently, the employers don't know what their responsibilities are. They often don't do the right thing by their employees." *[HCAB1]*

Finally, participants highlighted the impact of broader socioeconomic factors such as housing insecurity, digital exclusion, and benefit system complexity. These issues can undermine progress and make it difficult for individuals to focus on employment goals [HVC3,4,6]. Addressing these challenges requires a whole-system approach that goes beyond employment support to tackle the root causes of being out of work and health inequality.

18. Gaps and opportunities for the WorkWell programme

Participants offered a range of reflections and suggestions to strengthen the WorkWell Programme. As discussed, a common theme was the importance of aligning WorkWell with existing services and structures – such as the Skills and Employment East Sussex Board – to avoid duplication. Many emphasised that the programme should build on what already works locally—such as social prescribing, IPS approaches, and community-based employment support—rather than creating parallel structures [HSC], [HVC1,3,6].

Some spoke about whether this would be a reactive pathway or if it could have a proactive element, taking a risk-stratified and informed approach to target those who are known and identified to be not working for health reasons [HICB2], [HGP]. They stressed that it will be important to clarify the user groups and be mindful of the boundaries of the offer for both healthcare professionals and users alike [HICB2], [HICB4].

Several participants highlighted the need for clearer communication and engagement strategies. They suggested that WorkWell should be introduced through joint training sessions, stakeholder briefings, and community events to ensure buy-in from all sectors, including GPs, Jobcentres, housing teams, and voluntary organisations [HVC2,4,5], [HICB4]. This would help clarify roles and referral routes, reduce confusion, and foster collaboration.

“Connecting the Connectors” are events held in Hastings with the aim of bringing frontline workers together to better connect the system and encourage more collaborative working and were flagged as a way to work towards a “no wrong door” approach – where a client’s needs are met by the right provider, irrespective of where they enter the pathway [HVC4].

There were also calls for addressing gaps in the current system, particularly for “middle-ground” clients who are not in crisis but not yet work-ready. Participants noted that these individuals often fall between services, which can lead to longer term unemployment – they require flexible, tailored support that bridges health and employment [HCC2], [HGP], [HVC5].

It was flagged that mental health services will be moved into the soon-to-be-established integrated neighbourhood mental health teams, which will mean a joining up of mental health with physical health and other aspects and might be an opportunity to embed the WorkWell pathway [HSC], [HVC2], [HCC2].

Finally, participants stressed the importance of long-term investment and system-wide integration. They warned that without sustained funding, strong governance, and alignment with broader health and wellbeing strategies, WorkWell risks becoming another short-lived initiative rather than a transformative system change. Several suggested that WorkWell could play a convening role—mapping services, identifying gaps, and coordinating efforts across sectors to create a truly joined-up system [HICB1], [HVC3,6], [HTP1].

Conclusion

The WorkWell Programme presents a timely opportunity to enhance integration between health and employment services in Hastings. Stakeholders across sectors recognise the value of a structured, person-centred approach to supporting individuals with mental health and musculoskeletal conditions. However, for WorkWell to succeed, it must be embedded within existing systems, clearly differentiated from current services, and supported by sustainable infrastructure.

Recommendations and actionable steps

The following recommendations have been made with the knowledge of the limited funding available to support a WorkWell service in Hastings. The emphasis is therefore on building on the strengths of the services already working in this space by transforming and focussing on existing resources. These recommendations do, however, act as a "long list" of recommendations that would support delivery of a successful programme, that will need to be prioritised based on local priorities, funding, time and the resources available.

1. Embed WorkWell within existing local systems

Actions:

- Map existing services and identify integration points.
- Co-locate those delivering WorkWell with trusted VCSE and health partners.
- Establish joint referral protocols and care plans.
- Attend and contribute to local forums and events.

Why it works: Embedding WorkWell into existing networks builds on trust, avoids duplication, and ensures continuity of care. It leverages local knowledge and infrastructure, making the programme more sustainable and accepted.

2. Clarify and communicate the WorkWell offer

Actions:

- Develop a clear service charter outlining eligibility, scope, and benefits.
- Create referral guides and flowcharts for all professionals.
- Host stakeholder briefings and community events.

Why it works: Clear communication reduces confusion, improves referrals, and sets realistic expectations. It helps professionals and users understand how WorkWell complements – not competes with – existing services.

3. Strengthen referral pathways and fit note integration

Actions:

- Embed referral prompts into the fit note process.
- Train GPs and primary care staff on WorkWell referral criteria.
- Enable clear self-referral and community-based referral options.
- Promote use of digital tools to trigger timely referrals.

Why it works: Improving referral pathways ensures early intervention, especially for those at risk of falling out of work. Fit notes are a key touchpoint and can be leveraged to connect people to support sooner.

4. Address gaps for "middle-ground" clients

Actions:

- Design flexible support for those not in crisis but not work-ready.

- Offer light-touch coaching, peer support, and confidence-building.
- Provide access to volunteering, training, and job trialling.
- Coordinate with new integrated neighbourhood mental health teams.

Why it works: This group often falls through the cracks. Tailored, non-clinical support bridges the gap between health recovery and employment readiness, improving long-term outcomes.

5. Invest in joint training and cross-sector collaboration

Actions:
- Deliver joint training for health, employment, and VCSE staff.
- Develop shared language and goals through co-production.
- Use forums and events to build relationships across all sectors.

Why it works: Shared understanding fosters collaboration and reduces siloed working. It builds a culture of mutual respect and coordinated care, essential for integrated delivery.

6. Improve data sharing and outcome tracking

Actions:
- Develop shared indicators across health and employment.
- Review use of CRM systems to track referrals, engagement, and outcomes.
- Collect both quantitative data and qualitative stories.
- Align data collection with NHS and DWP reporting requirements.

Why it works: Robust data demonstrates impact, supports funding bids, and informs service improvement. Shared metrics enable system-wide learning and accountability.

7. Tackle digital exclusion with a hybrid delivery model

Actions:
- Offer both digital and face-to-face service options.
- Include digital skills training and device loans in the pathway.
- Maintain in-person drop-ins and community-based support.

Why it works: A hybrid model ensures accessibility for all, especially those with low digital literacy. It respects user needs and reduces barriers to engagement.

8. Secure sustainable and aligned funding

Actions:
- Align WorkWell with Integrated Care Board and Local Authority Priorities e.g. the local Get Britain Working plan.
- Develop a long-term investment case using outcomes data.
- Explore options for pooled budgets across health and employment sectors.

Why it works: Sustainable funding enables long-term planning, staff retention, and consistent service delivery. It reduces reliance on short-term projects and enhances system stability.

9. Engage employers and promote inclusive workplaces

Actions:
Supported by local DWP/Jobcentre Plus services:

- Provide employer training on mental health and MSK conditions.
- Promote employer responsibilities and reasonable adjustments.
- Develop employer toolkits and peer learning networks.
- Highlight success stories of inclusive hiring.

Why it works: Employer engagement reduces stigma and increases job opportunities for people with health conditions. It builds a more inclusive local labour market.

10. Use WorkWell as a system connector and convenor

Actions:

- Lead service mapping and gap analysis.
- Coordinate cross-sector planning and delivery.
- Facilitate shared governance and accountability structures.

Why it works: Positioning WorkWell as a connector maximises its strategic value. It helps align fragmented services and fosters a “no wrong door” approach.

By implementing these recommendations, WorkWell can become a transformative service that not only supports individuals back into work but also strengthens the broader health and wellbeing infrastructure in Hastings.

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Deep dive: Crawley

Executive summary

This report presents a comprehensive analysis of stakeholder perspectives on the potential establishment of a WorkWell service in Crawley. Drawing on insights from a diverse range of professionals across health, employment, voluntary, and community sectors, the findings reveal strong support for a locally integrated, person-centred employment support model. Stakeholders consistently emphasised the importance of addressing mental health and musculoskeletal (MSK) conditions in tandem with employment readiness, highlighting the need for flexible, culturally sensitive, and accessible services. The WorkWell model is seen as a valuable addition to the existing ecosystem, provided it complements rather than duplicates current services.

Key themes emerging from the data include the necessity of outreach beyond GP settings, the importance of cultural sensitivity and ensuring appropriate in-reach to community settings, the value of lived experience and peer support, and the importance of sustained engagement post-employment.

Challenges identified include digital exclusion, fragmented funding, and inconsistent awareness of existing services. Stakeholders also stressed the need for employer education, better integration across sectors, and simplified referral pathways. The report concludes that a well-implemented WorkWell service could significantly enhance employment outcomes and wellbeing in Crawley, particularly for those with complex health and social needs.

Introduction

Crawley is one of three sites selected as part of a WorkWell 'Discovery Phase' for NHS Sussex. Sites were chosen based on a combination of key metrics, local intelligence, and stakeholder insights (data packs are available in section 2).

Crawley was selected due to its unique socio-economic profile, high levels of health-related economic inactivity, and the presence of complex barriers to employment, particularly among individuals with mental and musculoskeletal (MSK) conditions. Furthermore, whilst Crawley specific data was not available when compiling the accompanying data pack, it is noteworthy that West Sussex has a significant issue regarding 16- to 17-year-olds not in Education, Employment or Training (NEET) at 16.4% compared to the England figure of 5.4%[53]. Crawley's diverse population, combined with structural challenges in the local labour market and fragmented service provision, makes it a compelling site for transformation.

Stakeholders described Crawley as a place with strong community assets but also significant gaps in service integration and accessibility. While there are well-established services across the NHS, Local Authority, and the Voluntary, Community and Social Enterprise (VCSE) sectors, these are often siloed, underfunded, or difficult to navigate. Digital exclusion, cultural and linguistic barriers, and long waiting times for mental health support were repeatedly cited as key obstacles. Additionally, the reduction in social prescribing capacity in primary care, and the limited availability of sustained employment support were seen as critical issues.

Despite these challenges, there is strong support for the WorkWell model, particularly its emphasis on holistic, person-centred support that bridges health and

[53] Public Health Outcomes Framework: West Sussex

employment. Stakeholders welcomed the opportunity to co-produce a service that is culturally inclusive, community-embedded, and responsive to local needs. There is a clear appetite for innovation, including simplified referral pathways, digital inclusion initiatives, and employer engagement strategies.

The presence of an active Community Panel and a range of collaborative networks provides a strong foundation for user engagement and co-design. Existing programmes such as Connect to Work and Changing Futures Sussex offer opportunities for alignment and integration. It is recommended that all relevant data, service evaluations, and stakeholder insights be reviewed as part of the next phase of planning and implementation for WorkWell in Crawley.

Participants

Code	Organisation
CDWPDEA	Department for Work and Pensions
CGP	Coachmans Surgery (GP)
CICB	NHS Sussex (Programme management)
CLG1	West Sussex County Council (Economy Team)
CLG2	Employ Crawley (Operations)
CVC1	Crawley Community Action (Leadership)
CVC2	Crawley Community Action (Social Prescribing)
CPCN	Alliance for Better Care/PCN (Project Management)
CVC3	Brighton Housing Trust/Pathways (Operations)
CTTWP	Psychological Wellbeing Practitioner
CMSK1	HERE (Care Navigation)
CMSKLE	HERE (Lived Experience)
CTTES	Talking Therapies (Employment support)
CCP1	Community Panel (Community Leadership)
CCP2	Community Panel (Community Event Organiser)
CCP3	Community Panel (Neurodiversity Leadership)
CCP4	Community Panel (Leadership, Diversity)
CCP5	Community Panel (Scribe)
CCP6	Community Panel (Volunteer & Nurse)
CCP7	Community Panel (Volunteer and Social Activism)
CCP8	Community Panel (Education/Diversity)

Methods

In total, 21 participants contributed to the study. Full details on the methods used for this report are provided in the overall report introduction sections. Data collection in Crawley included one Community Panel focus group, including three people who subsequently participated in individual follow-on interviews. Four participants shared lived experience of mental health and MSK health barriers to employment.

Findings

1. Roles and responsibilities of participants

Stakeholders interviewed for this analysis represent a diverse cross-section of Crawley's health, employment, and community support landscape. Their roles span NHS services, local authority employment programmes, voluntary and community sector organisations, and primary care networks. This diversity provides a rich and nuanced understanding of the opportunities and challenges associated with implementing a WorkWell service in Crawley.

For example, [CTTES] is an Employment Advisor embedded within the Talking Therapies service, supporting those with mild to moderate mental health conditions. Their role involved providing employment-related advice and signposting, often in parallel with psychological treatment. Similarly, [CPCN] serves as a Primary Care Network (PCN) Development Manager and previously worked as a social prescriber, offering a dual perspective on both clinical and community-based support. [CLG2], working with Employ Crawley, oversees employment pathways and coordinates with local services, while [CVC1] and [CVC2] represent voluntary sector organisations focused on social prescribing and community engagement.

Other roles include [CDWPDEA], a Department for Work and Pensions (DWP) Disability Employment Advisor embedded in GP surgeries; [CTTWP], a Psychological Wellbeing Practitioner delivering low-intensity CBT; and [CMSK1], a Care Navigator supporting patients with complex needs. These roles collectively illustrate the breadth of existing support and the potential for WorkWell to act as a connector and enhancer of current services. Importantly, many stakeholders already operate in integrated or co-located models, suggesting a strong foundation for WorkWell to build upon.

2. Familiarity with WorkWell pathway

Stakeholders demonstrated varying degrees of familiarity with the WorkWell pathway, with many drawing parallels to existing services such as social prescribing, Talking Therapies, and employment support programmes. Several participants noted that while the WorkWell model was not entirely new in concept, its structured integration of health and employment support offered a more focused and potentially impactful approach.

For instance, [CTTES] recognised similarities between WorkWell and their current role within Talking Therapies, particularly in terms of signposting and supporting patients with employment-related concerns. However, they noted that WorkWell appeared to offer more intensive and sustained support, which could fill existing gaps. [CPCN] echoed this view, describing WorkWell as ‘‘not dissimilar from things that exist already,’’ but acknowledged its more targeted focus on employment outcomes.

Others, such as [CLG2], were familiar with the Reasonable Adjustments process and saw WorkWell as a natural extension of existing employment pathways, particularly for individuals who are nearly work-ready. [CDWPDEA] had direct experience with WorkWell through the Vanguard programme in Surrey and highlighted the benefits of embedding employment support within GP surgeries - a model already partially in place in Crawley.

Some stakeholders, like [CVC1] and [CVC2], were less familiar with the formal WorkWell pathway but intuitively understood its aims and expressed support for its principles. They emphasised the importance of ensuring WorkWell complements rather than duplicates existing services, particularly in a landscape already rich with community-based support.

Overall, while familiarity with the specific branding and structure of WorkWell varied, there was a strong conceptual alignment with its goals. Stakeholders broadly welcomed the idea of a service that bridges health and employment, provided it is well-integrated, clearly communicated, and responsive to local needs.

3. Thoughts on the typical user journey

Stakeholders provided a range of insights into the typical user journey envisioned for the WorkWell service, with many drawing comparisons to existing pathways and highlighting both opportunities and potential pitfalls. A recurring theme was the importance of a holistic, person-centred approach that addresses the root causes of unemployment, particularly where these intersect with mental health and MSK conditions. Participants in the Community Panel were keen to stress that health issues may be symptoms of deeper social and economic problems, and that addressing these root causes can improve health and support return to work.

[CTTES] described the WorkWell journey as reminiscent of a previous Fit for Work initiative, emphasising the need for early intervention to prevent deterioration in mental health and reduce pressure on statutory services. They noted that many users benefit from even a single conversation that helps them feel less overwhelmed and more confident in navigating their employment options. [CPCN] highlighted the importance of link workers who engage users with support and then step back, allowing individuals to take ownership of their journey.

[CVC1] and [CVC2] emphasised the need for WorkWell to align with existing community-based models, such as motivational interviewing and volunteer pathways, particularly for individuals who are not yet work-ready. They stressed that the journey should be flexible and responsive, owned by the person and allowing for gradual progression based on individual strengths, readiness and confidence.

> “The motivational interviewing approach with people is about understanding the motivations that people might have and then working to kind of support people to make positive lifestyle changes based around the things that are that are, you know, most motivating to the individuals. So, the plan that we work with people on, is their plan. And we help people to realise it.’ *[CV2]*

[CLG2] added that the journey to work is as important as the job outcome itself, and that services should support users through each stage, from confidence-building to job applications.

Several stakeholders, including [CDWPDEA] and [CTTWP], noted that the WorkWell journey should include sustained support post-employment, recognising that the first few months in a new role are often the most challenging. Others, such as [CMSK1], advocated for community-based delivery models that reduce stigma and increase accessibility, particularly for marginalised groups:

> “It's really important that the services based in the community and that it's not in a DWP sort of situation I feel, and also it's important that it's not health centre based, that it's a community focus to support people into areas where they may feel uncomfortable going.”

Overall, stakeholders supported a user journey that is proactive, empowering, and tailored to individual needs. They cautioned against overly clinical or bureaucratic models and called for a service that builds trust, fosters independence, and integrates seamlessly with the broader support ecosystem in Crawley.

4. Funding

Stakeholders provided a detailed overview of the funding structures that currently support employment and health-related services in Crawley, offering valuable context for the potential integration of a WorkWell service. A key theme was the fragmented and often short-term nature of funding, which can hinder service continuity and long-term planning.

[CLG2] explained that Employ Crawley is funded through the local economic development team, with additional support from Sussex Partnership Trust and the Department for Work and Pensions (DWP). This multi-source funding model enables flexibility but also requires careful coordination to avoid duplication and ensure sustainability

[CVC2] and [CVC3] highlighted the challenges faced by voluntary and community sector (VCSE) organisations, which often rely on short-term grants and are vulnerable to funding cuts. For example, [CVC2] and [CGP] noted that Crawley’s social prescribing team has recently significantly reduced due to funding constraints,

despite high demand for their services. [CMSK1] echoed this concern, emphasizing the need for stable, long-term investment to support preventative and community-based approaches.

> "I think you know sometimes these amazing projects come to life and they start off as pilot sites and a lot of times you know the funding runs out. Even though that all the evidence is there that it's the most, you know, one of the most amazing things that it's really supported, that it's made a massive difference to a lot of people."

[CTTES] and [CTTWP] described NHS-funded roles within Talking Therapies, where employment advisors are embedded but limited to working with patients currently in treatment. This restriction, driven by funding criteria, can exclude individuals who might benefit from employment support but are no longer receiving therapy. [CICB] added that funding for Integrated Community Teams (ICTs) is being used to support multi-agency collaboration, which could provide a useful framework for WorkWell integration here:

> "[WorkWell] fits in into that quite nicely because it is that multi agency partnership. You know, let's look at that space and understand what the, the challenges and the needs are and how we can collectively respond to that."

Overall, stakeholders agreed that WorkWell must be underpinned by secure, multi-year funding to ensure its success. They recommended aligning WorkWell with existing strategic priorities—such as the West Sussex Economic Strategy and ICB transformation plans—to maximise funding opportunities and embed the service within the broader health and employment ecosystem.

5. Referral pathways for Mental Health and MSK Conditions

MSK conditions

To access MSK services, patients can self-refer or be referred by GPs or physiotherapists. NHS services are primarily provided by Sussex MSK Healthcare in partnership with social enterprise HERE. These services often include an assessment of work and social history, with treatment plans tailored to individual needs [SxMSKSCFT1]. Clinicians integrate work-related discussions into initial assessments and treatment planning. HERE also provide 'Care Navigators' who may refer into local Social Prescribing services and other organisations that might provide employability support services. The MSK Triage process is outlined in their 2024 Integrated Triage Manual and summarised as follows[54]:

[54] Sussex MSK Partnership Central – Integrated Triage Manual

2. **Referral Entry**: Patients can enter via self-referral, GP, or First Contact Practitioner (FCP).
3. **Triage Team**: Advanced Practitioners review and assess referrals.
4. **Screening & Categorisation**:
    - Red flag screening for urgent issues
    - Categorisation into routine MSK, complex cases, or pain management.
5. **Dual Pathway & On-Hold**: Some patients may follow multiple paths or be placed on hold.
6. **Outcomes**:
    - Physiotherapy
    - Advanced Health Practitioner assessment
    - Pain Management Services
    - Pain Management Programme (PMP)
    - Secondary care referral
    - Redirect to referrer.

Patient facing information on this process and the services available can be found at sussexmskhealth.co.uk.

Participants from MSK services acknowledged that the integration of employment support into these MSK pathways is less formalised than in mental health services, with no standardised approach described in interviews with MSK professionals

Mental health conditions

In Crawley primary care-level mental health support, specifically talking therapies, is delivered through NHS West Sussex Talking Therapies, part of the national NHS Talking Therapies programme (formerly known as Improving Access to Psychological Therapies, IAPT), with oversight from Sussex Community Foundation Trust. This service supports adults aged 18 and over who are experiencing mild to moderate anxiety, depression, or related conditions. It also offers specialist support for individuals with long-term physical health conditions such as diabetes, COPD, and long Covid. Therapy is delivered by qualified clinicians and includes a range of options such as Cognitive Behavioural Therapy (CBT), counselling, and guided self-help, available via face-to-face, telephone, or online sessions. Referrals consist of:

- Self-Referral – via online form or phone
- GP/Health Professional Referral – through your local surgery
- Assisted Referral – with help from a friend, family member, or support worker
- Social Prescribing – via link workers in GP practices

Alongside statutory services, the VCSE sector is active in this area with services aimed at combatting key mental health risk factors such as loneliness and isolation. Whilst the following is not an exhaustive list, four established providers in the VCSE sector are:

1.Crawley Wellbeing
A free, council-run service that offers lifestyle advice and emotional wellbeing support to adults. It provides one-to-one sessions, group workshops, and signposting to local services, helping individuals manage stress, anxiety, and low mood.

2. Staying Well Crawley (run by Richmond Fellowship)
Staying Well is an out-of-hours mental health crisis prevention service for adults aged 18 and over. It offers a safe, supportive space for people experiencing emotional distress, providing immediate support and helping to reduce the need for emergency services.

3. Mind in West Sussex
Mind in West Sussex delivers a range of community-based mental health services, including peer support, wellbeing groups, and one-to-one emotional support. Their services are designed to promote recovery, reduce isolation, and empower individuals to manage their mental health.

4. Community Roots (via Pathfinder West Sussex)
Community Roots is a network of local VCSE organisations working together to provide mental health and wellbeing support. In Crawley, this includes services such as advocacy, housing support, and recovery-focused activities tailored to individual needs.

Unfortunately, we were unable to carry out semi-structured interviews with representatives from these organisations.

[CTTES] explained that individuals can also self-refer to Talking Therapies if they have a GP in West Sussex, with referrals also coming directly from GPs and other professionals. Once assessed, patients may be referred to employment advisors if they meet the criteria for mild to moderate mental health support. However, they noted that support is only available while patients are actively engaged with the therapy service, limiting continuity.

[CVC3] described a broader referral network for Pathfinder and Be OK mental health services in the VCSE sector, which includes GPs, midwives, physiotherapists, Citizens Advice, and self-referrals. These services accept clients without formal diagnoses and offer step-up and step-down support across primary and secondary care. [CVC2] emphasised the importance of removing GP gatekeeping, advocating for open-access referral models that empower individuals to seek help directly.

DWP employment advisors and work coaches

[CDWPDEA] highlighted the role of Disability Employment Advisors (DEAs) embedded in GP surgeries, who receive referrals from GPs and First Contact Practitioners (FCPs). These referrals are not limited to individuals with disabilities but include anyone with a health condition affecting their ability to work. DEAs also participate in MSK community appointment days, offering on-the-spot support.

The DWP also plays a role in referrals to mental health and MSK services, particularly through work coaches who triage clients based on need. Whist DWP caseloads were not recorded for Crawley, we understand from our Deep Dive in East Brighton that the level of caseloads per coach can reach up to 200, which limits the depth of support. There is a clear opportunity for WorkWell to work closely with

DWP, local mental health & MSK services to support referral pathways to services, and vice versa, so that these services make use of the WorkWell offer, and links to appropriate community resources that support employability.

Connect to work

For individuals with more complex mental health needs and more likely to be receiving secondary care mental health services for diagnosed mental health conditions, the new government-funded supported employment programme Connect to Work is currently being rolled out across Sussex. It is said to be designed to help individuals facing complex barriers to employment find and sustain meaningful work using standardised models of Supported Employment, such as Individual Placement Support (IPS) and Supported Employment Quality Framework (SEQF) approaches, for eligible and suitable participants, to 'place, train and maintain' competitive employment within the delivery area.[55]

Perceptions of mental health and MSK referral pathways in Crawley

Stakeholders described a variety of referral pathways for individuals with mental health and MSK conditions, reflecting the complexity and fragmentation of the current system. While multiple entry points exist, there is a strong consensus that clearer, more coordinated pathways are needed, particularly if WorkWell is to be effectively integrated.

[CMSK1, CPCN, CVC1] noted that social prescribers and care navigators often act as informal referral hubs, connecting individuals to a range of services based on their needs. However, [CVC1] also pointed out that many residents are not registered with GPs or are reluctant to disclose social issues in clinical settings, creating barriers to access:

> "In a very culturally diverse place like Crawley, there are a significant number of people who aren't even registered with GPs. There are a significant number of people in different ethnic communities that would never dream of going to talk to their GP about issues around social needs. They would consider that to be an inappropriate use of the GP's time, but nonetheless they need, you know, they need support with them and without getting that support in a timely manner, you know, issues will escalate. Stress will become more acute and then that will eventually manifest in the kind of clinical problems that they will then present at GP for."

Overall, stakeholders called for WorkWell to adopt a flexible, multi-channel referral model that includes self-referral, professional referral, and community-based outreach. This approach would help ensure that individuals with mental health and MSK conditions are not missed and can access timely, appropriate support.

[55] Connect to Work: Grant Guidance for England - GOV.UK

6. Patient outcomes data

Stakeholders reported a range of approaches to capturing patient outcomes, reflecting the diversity of services involved in supporting individuals with health and employment needs. While some services use structured tools and digital systems, others rely on qualitative feedback and case studies. Across the board, there was a shared recognition of the importance, and challenge, of evidencing impact in a meaningful way.

[CTTES] described the use of the IAPTUS system within Talking Therapies, which includes a dedicated employment episode for each patient. This system records appointment details, time spent, and outcomes, including job attainment, benefit changes, and retention. It also tracks sickness absence, providing a useful link between health and work status. However, [CTTES] noted that while data is collected, it is not always analysed or used to inform service development.

[CVC3] used the ReQoL-10 tool to measure quality of life at multiple points during the support journey (e.g., initial, 4th, 6th, and 10th sessions). Practitioners interpret responses to identify incongruence and tailor support accordingly. [CVC2] employed the Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS), observing that around 80% of clients showed improved wellbeing on this scale. However, they acknowledged cultural mismatches and language barriers that can affect the accuracy of these tools.

[CPCN] and [CVC1] reported using wellbeing scales and feedback forms to track progress, though they emphasised the difficulty of capturing complex, non-linear journeys through quantitative metrics alone. [CLG2] tracked job outcomes and interventions using a simple spreadsheet, focusing on the journey to work rather than just job placement. [CDWPDEA] noted that while DWP collects data on transitions into work, training, and education, the analysis is often limited and lacks depth. Several stakeholders expressed a preference for case studies and narrative accounts, which they felt better captured the nuanced impact of their work. They cautioned against over-reliance on numeric indicators, which may not reflect the full value of support provided—particularly for individuals with complex needs. For example:

> "I appreciate that we need to collect data and evidence, but I'm a big believer in case studies. I feel that case studies are a better picture of the patient journey. Of where they started, the middle bits and where they've ended up. And also, what impacts the intervention has had, getting people with lived experience to actually come and talk to you and tell you about how that interventions you know impacted on them." [CMSK1]

In summary, while data collection is widespread, there is a need for more consistent, culturally sensitive, and outcome-focused evaluation methods. WorkWell could play a valuable role in standardising and enhancing outcome measurement across services, helping to build a stronger evidence base for integrated health and employment support.

7. Digital aspects of service delivery

Digital inclusion is a significant challenge in Crawley. More generally, it is estimated 24% of people who are out of work lack basic digital skills[56]. Digital access and literacy emerged as both an enabler and a barrier in the delivery of services relevant to WorkWell. Stakeholders highlighted a range of digital tools and practices currently in use, while also emphasising the persistent challenges faced by digitally excluded populations, particularly older adults, low-income groups, and those with limited English proficiency.

[CTTES] noted that while many clients are comfortable with digital communication, others—especially older individuals—struggle with internet access or confidence. In such cases, advisors often read out phone numbers or suggest visiting libraries, where staff can assist with job searches or volunteering opportunities. [CVC2] and [CVC3] described similar experiences, with volunteers and community partners helping clients navigate basic digital tasks such as email access and document uploads.

[CPCN] and [CMSK1] praised Crawley Library's underutilised digital support groups, which offer training on using computers, accessing emails, and saving documents. These services are seen as vital for bridging the digital divide, though awareness and uptake remain limited. [CMSK1] also referenced digital literacy lessons provided through Care Navigation, including how to book GP appointments online.

[CTTWP] described a flexible digital model within Talking Therapies, offering communication via phone, video, email, or letter. Clients can complete questionnaires online or on paper, ensuring that lack of internet access does not become a barrier to care. [CVC3] added that remote sessions have reduced no-show rates and improved efficiency, though digital exclusion remains a concern for some clients.

Despite these efforts, stakeholders agreed that digital solutions alone are insufficient. [CVC1] cautioned that information giving often needs the human touch ‘’and that many clients require face-to-face interaction to build trust and engagement”. They cited an example of a service user they had just encountered trying to help her son with employment issues:

> *“*People need something a bit more human and need something from a person who is able to really understand the nuance of the specifics – if I'd said, oh, there's an app, you know, I don't think that's going to work. But if I can put them in touch with a real human being that they can sit down with now, because it won't just be one thing, it'll be a kind of an interplay between different experiences and things that have happened to people that will be preventing them from kind of moving on with the things that they want to move on with. So digital is limited there.”

[56] Digital Nation | The UK's Digital Divide | Good Things Foundation

[CDWPDEA] acknowledged the value of digital tools but emphasised the need for blended approaches that combine technology with personal support.

In this context, it is worth highlighting the Digital Inclusion Framework, which emerged out of a collaboration between University of Sussex, NHS Sussex, and Health Innovation Kent Surrey Sussex. This has been used across NHS Sussex to help ensure health care services consider inclusion in any digital transformation.[57]

In summary, while digital tools enhance flexibility and reach, WorkWell must account for digital exclusion in its design. Stakeholders recommended co-locating digital support with employment services, leveraging community assets like libraries, and ensuring that all digital offerings are complemented by accessible, in-person alternatives.

8. Data on links between health and employment

Stakeholders provided a range of insights into how their services collect and interpret data on the relationship between health and employment. While some organisations have structured systems for tracking outcomes, others rely more heavily on qualitative feedback and anecdotal evidence. Across the board, there was a shared recognition that better data integration could strengthen the case for services like WorkWell.

[CDWPDEA] confirmed that the DWP tracks transitions into work, training, and education, with weekly reports submitted to leadership. However, they acknowledged that the data is often limited in scope and lacks the depth needed to fully understand the health-employment link. [CLG2] similarly tracked job outcomes and interventions using a spreadsheet, focusing on the journey to work rather than just final employment status.

[CVC3] used the ReQoL-10 tool to assess quality of life, while [CVC2] employed the SWEMWBS scale to measure mental wellbeing. Both tools provide quantitative data that can be linked to employment outcomes, though stakeholders noted challenges with cultural relevance and language barriers:

> "We often have conversations with people where they, you know, it's clear that the kind of concepts around that are that are being questioned in the test and not necessarily ones that they're familiar with or not necessarily ones that have kind of pre-eminence in their cultural mindset." *[CVC2]*

[CICB] emphasised the importance of combining quantitative data with lived experience narratives to capture the full impact of support services.

[CMSK1] and [CVC1] highlighted the value of case studies and client stories in demonstrating the connection between health and employment. They argued that

[57] Digital Inclusion Framework

while numbers are important, they often fail to capture the complexity of individual journeys—particularly for those with multiple barriers to work.

In summary, while data collection practices vary, there is a clear opportunity for WorkWell to enhance and standardise outcome tracking across services. Stakeholders recommended developing a shared framework for measuring the impact of employment support on health, incorporating both quantitative metrics and qualitative insights.

9. Experience supporting mental health and/or MSK return to work

Stakeholders shared extensive experience in supporting individuals with mental health and MSK conditions to return to or remain in work. Their insights underscored the importance of tailored, person-centred approaches that address both clinical and social determinants of health.

[CTTES] described working with patients experiencing mild to moderate anxiety and depression, often linked to workplace stress or long-term sickness absence. Their role involved helping clients navigate conversations with employers, requesting reasonable adjustments, and building confidence to re-enter the workforce. They emphasised that even a single, well-timed conversation can significantly shift a person's outlook and readiness to work:

> "So, some patients, it might just be one phone call, and they're then sort of confident, you know, they feel like I've got a bit of a plan, maybe it was just they were a bit overwhelmed with their situation, couldn't really think of a way forward. So just having that discussion can be really helpful. And then they do have the confidence to kind of move forwards, and they don't need a follow up call."

[CDWPDEA] estimated that mental health conditions account for around 80% of the cases they support. They highlighted the lack of mental health resources in Crawley compared to other areas like Brighton, which has prompted the introduction of additional training for Disability Employment Advisors. [CVC3] and [CVC2] also reported high volumes of clients with mental health needs, often presenting with anxiety, depression, or low self-esteem. Their services focus on motivational interviewing, peer support, and gradual re-engagement with community activities.

For MSK conditions, [CTTWP] and [CMSK1] noted that pain management and employer attitudes are key barriers. [CMSK1] emphasised the need for flexible work environments and employer education to support sustained employment. Clients with chronic pain conditions often face scepticism from employers, particularly when flare-ups lead to unpredictable absences.

> "With musculoskeletal and you know things like fibromyalgia; people can have flare ups. So, it's knowing that if they're going to go through all of that process, that whole journey, will there be an employer at the end that is actually going to be accepting of them phoning up sick a lot." *[CTTWP]*

[CICB] and [CPCN] described integrated care models that support both mental health and MSK clients through multidisciplinary teams. These models include health coaching, wellbeing programmes, and social prescribing all of which contribute to improved work readiness. [CLG2] added that post-COVID changes in the local job market, particularly at Gatwick Airport, have created new challenges for clients with health conditions, including stricter security clearance requirements and reduced job availability.

In summary, stakeholders bring a wealth of experience in supporting mental health and MSK return-to-work journeys. Their insights reinforce the need for WorkWell to offer flexible, sustained, and holistic support that bridges clinical care, employment services, and community resources.

10. Common needs for those with mental health conditions in employment or returning to work

Stakeholders consistently identified a range of common needs among individuals with mental health conditions who are either seeking to return to work or remain in employment. These needs span emotional, practical, and systemic domains, underscoring the importance of a holistic and flexible approach within the WorkWell model. These needs were put succinctly by one stakeholder:

> "How much are they really wanting to get back into work, you know, especially if they've had so many barriers beforehand, it's just going to be, you know, the resilience is going to be down, their confidence is going to be down. Especially if they've been told before that they can't do the job or, especially with mental health, if they're so, you know, low esteem, it's going to be really hard to kind of get back into work." *[CTTWP]*

[CTTES] emphasised that many clients are unaware of their rights or the support available to them. Common needs include help with disclosing health conditions to employers, requesting reasonable adjustments, and navigating workplace dynamics. Clients often require reassurance, confidence-building, and practical support, such as drafting emails or understanding the Access to Work scheme. [CTTES] noted that even small interventions can significantly reduce anxiety and empower clients to take proactive steps.

[CTTWP] reported that stress, anxiety, and depression are frequently linked to work-related issues. Clients often seek therapy not only for symptom relief but also to gain

clarity and confidence in making employment decisions. Younger clients, in particular, benefit from normalisation of their experiences and structured support to explore options.

> "Your brain isn't fully developed until you're 24, you know, so there are a lot of things that we have to do a lot of what we call normalising you know. So that's something that we do quite a bit you know people come in, they've got certain worries about something you know well that's absolutely normal. You know we're designed to worry."

[CVC2] and [CVC3] added that many clients initially lack motivation and self-belief, requiring gradual, trust-based engagement before employment becomes a realistic goal.

> *"*We already have those skills of building rapport building trusts of, you know, making it feel less like a bureaucratic process, like 'I'm going to guide you through what can be quite a complex process actually'. And you know, if you're struggling with mental health and employment, you know, you can, you know, really think, where do I even start?" *[CVC1]*

[CPCN] and [CMSK1] highlighted the role of social isolation and low self-esteem in preventing people from engaging with work. They stressed the importance of peer support, group activities, and community-based interventions that rebuild social confidence. [CLG2] noted that post-COVID anxiety and changes in the job market have exacerbated these challenges, particularly for those with long-term conditions or disrupted work histories.

[CDWPDEA] estimated that mental health conditions are the primary barrier for the majority of their clients. They emphasised the need for sustained, wraparound support that continues after employment begins, as well as employer education to reduce stigma and improve workplace accommodations. [CVC1] and [CVC2] echoed this, noting that many employers lack understanding of mental health needs and are ill-equipped to provide appropriate support.

In summary, individuals with mental health conditions require a combination of emotional support, practical guidance, and systemic advocacy to succeed in employment. WorkWell must be designed to meet these diverse needs through integrated, person-centred, and culturally sensitive approaches.

11. Common needs for those with MSK conditions in employment or returning to work

Stakeholders identified a range of needs specific to individuals with MSK conditions who are seeking to return to or remain in work. These needs often intersect with

mental health, pain management, and workplace accommodations, requiring a coordinated and empathetic approach.

As noted earlier, [CTTWP] and [CMSK1] emphasised that chronic pain conditions such as fibromyalgia, arthritis, and back pain frequently lead to either long-term or unpredictable short-term absence from work. Clients often struggle with fluctuating symptoms, which can make consistent attendance and performance difficult. [CMSK1] noted that many clients choose to live with pain rather than rely on medication, which can impair cognitive function and reduce employability. This trade-off highlights the need for flexible work arrangements and supportive employers.

[CDWPDEA] reported that MSK clients are regularly supported through large-scale community events, such as MSK appointment days at local leisure centres. These events provide opportunities for early intervention and direct referrals to employment support. However, they also noted that MSK support is generally more available than mental health support, creating an imbalance in service provision.

[CVC3] and [CVC2] described how MSK clients often experience isolation and reduced mobility, which can lead to secondary mental health issues. Their services focus on building confidence, promoting physical activity, and reconnecting individuals with community resources. [CVC2] added that many MSK clients are aged 50–60 and want to remain independent, but face ageism and physical barriers in the workplace.

> "Some have reached a certain age where they feel like they're not needed anymore. They're not wanted, that they can't bring anything to the table anymore and are not physically forced, but feel like they're forced to retire, for instance. So there's people aged, I don't know, 65 to 67 and over that want to continue working for a variety of different reasons, not necessarily just financially, you know, to have a sense of purpose or you know need to be active." *[CMSKLE]*

[CLG2] highlighted the structural challenges in Crawley's job market, particularly in sectors like aviation and logistics, where physical demands are high and accommodations are limited.

[CPCN] and [CICB] pointed to the importance of integrated care pathways that address both physical and emotional wellbeing. Programmes like ''Living Well'' support clients with chronic conditions by focusing on energy levels, sleep, and lifestyle changes, which can indirectly improve work readiness.

In summary, MSK clients require a combination of physical accommodations, emotional support, and employer engagement. WorkWell must be designed to offer flexible, person-centred solutions that recognise the complex and often invisible nature of chronic pain and its impact on employment.

12. How services support typical WorkWell users

Stakeholders described a wide range of services that already support individuals who would be considered typical users of the WorkWell programme—namely, those with health-related barriers to employment, particularly mental health and MSK conditions. These services span NHS, local authority, and voluntary sector provision, offering a strong foundation for WorkWell integration.

[CTTES] outlined how employment advisors within Talking Therapies support patients during treatment or while on the waiting list. Support includes one-to-one phone consultations, signposting to external services, and practical help with employment-related issues such as requesting reasonable adjustments or navigating workplace stress. Importantly, patients can re-engage with the service at any point during their therapy journey, ensuring continuity of support.

[CPCN] described the role of social prescribers and health and wellbeing coaches in addressing the broader determinants of health. These professionals help clients manage anxiety, depression, and isolation through referrals to community groups, wellbeing programmes, and practical support services. [CVC2] and [CVC3] added that their services focus on motivational interviewing, peer support, and confidence-building—key components for individuals not yet ready to return to work.

[CLG2] explained that Employ Crawley provides hands-on support with job searching, CV writing, and interview preparation. The service is co-located with libraries and foodbanks to maximise accessibility and reach. Clients are often signposted to mental health or wellbeing services before engaging in employment activities, ensuring that foundational needs are addressed first.

[CMSK1] and [CICB] emphasised the importance of community-based delivery models that reduce stigma and increase engagement. Their services include care navigation, peer support groups, and informal outreach in settings like supermarkets, faith and community centres. These approaches are particularly effective for reaching marginalised groups and those reluctant to engage with formal services.

[CDWPDEA] highlighted the value of embedding employment support within GP surgeries, where clients can be referred directly by clinicians or First Contact Practitioners. This model ensures early intervention and facilitates clear and comprehensive handovers between services.

We should note here we did not undertake a full semi-structured interview with a representative from the Changing Futures Sussex programme, but our engagement identified the service as highly relevant to the focus of WorkWell[58]. Changing Futures is part of a national £91.8 million programme aimed at improving outcomes for adults facing multiple disadvantage, such as homelessness, mental health issues, substance misuse, domestic abuse, and involvement with the criminal justice system. In Sussex, the programme brings together public services and voluntary sector partners to deliver person-centred, coordinated support. It focuses on transforming local systems to reduce crisis demand, improving service integration, and empowering individuals to stabilise and improve their lives.

[58] Social Care | Changing Futures Sussex.

In summary, existing services already provide many of the components envisioned for WorkWell. The opportunity lies in connecting these services more effectively, reducing duplication, and ensuring that users experience a seamless, supportive journey from health recovery to employment readiness.

Drawing on the findings of this report, and the skills and experience outlined as core to delivering a WorkWell initiative, the key skill set, scope of practice and recommended referral criteria for a WorkWell provider have been drafted and are available in the main Sussex report.

13. Waiting lists and their impact on service user pathways

Waiting times emerged as a significant factor influencing the effectiveness and accessibility of services for individuals with health-related employment barriers. Stakeholders described a mixed picture, with some services offering timely access while others face substantial delays, particularly for more intensive or specialist support.

[CTTES] reported that patients typically receive an initial assessment within two to three weeks of referral to Talking Therapies. However, the subsequent wait for treatment can vary widely depending on the type of therapy and patient availability. For example, those requiring face-to-face or evening sessions may wait considerably longer. While patients are contacted every three months during the wait, [CTTES] acknowledged that delays can impact motivation and mental health, potentially complicating their employment journey.

[CTTWP] provided more detailed figures, noting that Step 2 therapy has an average wait time of 8–8.5 weeks, while counselling waiting lists can be over 1 year. CBT wait times range from 8 to 26 weeks depending on the stage. To mitigate these delays, the service offers webinars and review calls and send text reminders to reassure clients they haven't been forgotten. However, [CTTWP] emphasised that short-term therapy models may not suit complex cases, and long waits can lead to disengagement.

In contrast, [CPCN] and [CMSK1] reported minimal or no waiting lists for services like Crawley Wellbeing and Care Navigation. These services offer more immediate, community-based support, which can be particularly valuable for individuals in crisis or those needing early intervention. [CVC3] noted a 4–8 week wait for Pathfinder assessments, with interim support provided through coping strategies and emotional literacy work.

[CVC2] and [CVC1] highlighted the importance of maintaining engagement during waiting periods. They use informal check-ins, peer support, and group activities to keep clients connected and motivated. [CLG2] added that employment support is often available while clients wait for clinical treatment, which can sometimes resolve work-related issues without the need for therapy.

In summary, waiting lists significantly shape the user experience and can either support or hinder progress toward employment. WorkWell should be designed to offer timely access, maintain engagement during delays, and provide interim support that keeps individuals on track toward their goals.

14. Stakeholders referral processes

Stakeholders described a well-established culture of cross-referral among services in Crawley, with many organisations actively signposting clients to complementary support. These referral pathways are essential for addressing the complex and interrelated needs of individuals with health-related employment barriers, making them a critical component of any future WorkWell model.

[CTTES] outlined a broad range of referral destinations, including the National Careers Service for CV and job application support, Citizens Advice for legal and benefits advice, and local unions for workplace disputes. They also refer clients to Employ Crawley for more intensive employment support, particularly for those with autism or complex needs. [CTTES] emphasised that referrals are tailored to the individual's situation and often include legal, financial, and wellbeing services.

[CPCN] and [CMSK1] described similar practices for accessing wider support, referring clients to services such as Crawley Wellbeing, food banks, and community groups. These referrals are often made through informal conversations and are designed to address immediate needs like housing, debt, or social isolation. [CMSK1] also highlighted the importance of peer support groups and motivational interviewing in preparing clients for employment.

[CLG2] explained that Employ Crawley works closely with other services, including the DWP, local councils, and voluntary organisations. They frequently refer clients to mental health services, especially when employment readiness is hindered by anxiety or depression. [CVC2] and [CVC3] added that their services often act as a bridge, helping clients access more specialised support once trust has been established.

[CDWPDEA] noted that DEAs refer clients to social prescribing services and other community-based support when non-work-related barriers are identified. This includes issues such as caregiving responsibilities, housing insecurity, or language barriers. [CVC1] emphasised the importance of culturally sensitive referrals, particularly for clients from minority communities who may face additional barriers to accessing mainstream services.

In summary, referral to other support services is a cornerstone of current practice in Crawley. WorkWell should build on this foundation by formalising referral pathways, ensuring clear and comprehensive handovers, and maintaining strong relationships across sectors to provide seamless, wraparound support for users.

15. Success stories and impact reports

While formal impact reports were not widely available among stakeholders, several shared anecdotal success stories and qualitative insights that illustrate the transformative potential of integrated health and employment support. These narratives highlight the value of sustained, person-centred interventions, an approach central to the WorkWell model.

[CTTES] recounted instances where clients, initially overwhelmed by workplace stress or long-term unemployment, regained confidence and re-entered the workforce after just a few targeted conversations. In some cases, resolving work-related issues through employment advice reduced the need for further

psychological therapy, demonstrating the preventative value of employment-focused interventions.

[CVC3] shared examples of clients who progressed from isolation and low self-esteem to active community participation and volunteering. These individuals often began with low expectations but, through consistent support and peer engagement, developed the confidence to pursue training or employment through relationships with their local communities:

> "We do a lot of graded exposure work, help people kind of connect with their communities again and employment as part of rebuilding up people's confidence and skills."

[CPCN] and [CMSK1] also highlighted the importance of community-based success, such as clients who reconnected with social networks, improved their wellbeing, and eventually re-entered the workforce. These stories often go undocumented but are critical indicators of long-term impact.

[CVC2] emphasised that even small milestones, such as attending a group session or completing a CV can represent major breakthroughs for clients with complex needs.

[CLG2] described how Employ Crawley tracks not only job placements but also the journey toward work. One client, for example, moved from long-term unemployment to part-time work after receiving support with interview preparation and confidence-building. The service's co-location with libraries and foodbanks helped reduce barriers and increase engagement, particularly among those facing financial hardship.

[CDWPDEA] noted that while DWP data is often limited to quantifiable outcomes, many success stories are shared informally among staff. These include clients who sustained employment after receiving workplace adjustments or who transitioned from benefits to full-time work with ongoing support from a Disability Employment Advisor.

In summary, while formal impact reporting is inconsistent, stakeholders provided compelling qualitative evidence of success. WorkWell should prioritise capturing and sharing these stories alongside quantitative data to build a robust case for its value and secure long-term support.

16. The fit note process and return to work

Stakeholders expressed a range of views on the fit note process, with many highlighting its limitations and the need for reform to better support individuals returning to work. The consensus was that fit notes are often used reactively and do not always reflect a holistic understanding of the individual's capacity or circumstances.

[CDWPDEA] noted that fit notes are frequently completed incorrectly, with GPs defaulting to ''not fit for work'' without exploring whether adjustments or phased

returns might be appropriate. They described a more progressive model used in some areas, where Patient Advisory Services review cases before GPs issue fit notes, encouraging a broader view of the patient's ability to work:

> "The GP won't issue a fit note until they've seen our patient advisory service. So that's because we want to look at the whole situation - right, you've got that health condition, well, you can't work at the moment, so that is about right. OK, but what can you do? Can you actually do anything at all, you know? And GP's do take that advice and say right; OK we're going to write the fit note correctly. We're going to make sure that it's not saying that you're going to be [off] long term."

[CTTES] and [CTTWP] observed that many patients request fit notes to manage stress or avoid difficult workplace situations. In some cases, the underlying issues are more social or psychological than medical. These stakeholders emphasised the importance of early intervention and employment advice to prevent unnecessary or prolonged absence from work.

[CVC1] and [CMSK1] highlighted the emotional and financial stressors that often go unspoken in GP consultations. They argued that fit notes can mask deeper issues such as caregiving responsibilities, housing insecurity, or lack of community support. [CMSK1] suggested that social prescribers and care navigators could play a greater role in uncovering these hidden challenges and supporting return-to-work planning.

[CGP], a local GP, expressed concern that the current system incentivises sickness rather than recovery. They noted that some patients prefer to remain off work due to financial pressures or lack of workplace support. They advocated for a more assertive, case-finding approach that links unemployment offices directly with primary care, reducing bureaucracy and promoting accountability.

There was an animated discussion around fit notes in the Community Panel where views expressed included:

- GPs should appreciate more the broader life issues like housing, finances, and caregiving that affect patients' wellbeing, but it's more the domain of social prescribers to help address these hidden challenges.
- Holistic GP consultations could improve outcomes.
- Many people avoid disclosing personal struggles to employers or GPs.
- Emotional and financial stressors often go unspoken in the GP fit note interaction.
- Sickness notes may often mask deeper caregiving responsibilities.
- Lack of community support for children with learning difficulties increases absenteeism.
- Good conversations with employees can reveal hidden challenges.

In summary, the fit note process is widely seen as a missed opportunity for proactive, person-centred support. WorkWell could enhance this process by embedding employment-focused conversations into primary care, training clinicians

on work-health links, and offering alternative pathways for individuals who are not fully ‘‘fit’’ but could return to work with the right support.

17. Wider challenges to supporting people back to or staying in work

Stakeholders identified a wide range of systemic, cultural, and practical challenges that hinder efforts to support individuals in returning to or staying in work. These challenges span across service design, employer engagement, funding, and the lived realities of service users, highlighting the complexity of the environment in which WorkWell must operate.

A recurring theme was the lack of understanding and flexibility among employers. [CTTES] noted that many employers are unaware of their responsibilities around reasonable adjustments or are unwilling to accommodate staff with health conditions. [CLG2] added that small employers often lack the resources to support individuals with fluctuating needs, while larger employers may be constrained by rigid HR policies.

[CDWPDEA] and [CVC3] emphasised the disparity between mental health and MSK support. While MSK services are relatively well-resourced, mental health support remains limited, especially in Crawley. This imbalance creates bottlenecks in the return-to-work process, particularly for individuals with anxiety, depression, or trauma-related conditions.

[CVC1, CGP1] and [CMSK1] highlighted cultural and linguistic barriers that prevent some communities from accessing support. For example, translation services are often inadequate, and individuals may rely on family members, sometimes children, to interpret sensitive information. This can erode trust and lead to miscommunication. [CGP] added that cultural norms around work, gender roles, and mental health can further complicate engagement, particularly among Asian and refugee communities.

Funding instability was another major concern. [CVC2] and [CGP1] noted that the social prescribing team in Crawley was substantially reduced recently due to budget cuts, despite high demand. [CICB] warned that NHS funding is increasingly restricted to specific conditions, threatening the sustainability of broad, community-based offers.

Finally, several stakeholders pointed to structural issues in Crawley’s economy. [CLG2] described how the town’s industrial estate is fragmented. [CVC3] added that service hours (typically 9–5) for support agencies exclude many working individuals, and there is a need for more out-of-hours support.

In summary, the challenges to supporting people back to or staying in work are multifaceted and deeply embedded. WorkWell must be designed with these realities in mind, offering flexible, culturally competent, and well-resourced support that bridges gaps across sectors.

18. Gaps and opportunities in the Workwell programme

While stakeholders were broadly supportive of the WorkWell model, they also identified several gaps and missed opportunities that could limit its effectiveness if not addressed. These insights offer valuable guidance for refining the programme to better meet the needs of Crawley’s diverse population.

One of the most frequently cited gaps was the risk of duplicating existing services. [CPCN] and [CLG2] warned that WorkWell could overlap with social prescribing and employment support already available through Employ Crawley and other local initiatives. Without clear differentiation and integration, there is a danger of ‘‘muddy waters’’ where clinical staff are unsure where to refer patients, leading to underutilisation or confusion.

Another key gap is outreach and visibility. [CTTES] and [CMSK1] noted that many individuals who could benefit from WorkWell are not engaged with GP services or are unaware of available support. This includes people who are not yet claiming benefits, those with limited English proficiency, and individuals from communities with cultural stigma around mental health or unemployment. [CVC1] emphasised the need for culturally inclusive outreach strategies, such as translated materials and community-based engagement.

Digital exclusion was also highlighted as a persistent barrier. [CVC2] and [CVC3] pointed out that many clients lack access to devices, internet, or digital literacy, which can prevent them from engaging with online services. While some support is available through libraries and community groups, it is often underutilised or insufficiently promoted.

Several stakeholders, including [CDWPDEA] and [CGP], identified a missed opportunity in the fit note process. They argued that GPs are not always equipped or incentivised to explore work-related issues, and that WorkWell could play a stronger role in embedding employment conversations into primary care. [CGP] also suggested that national policy changes such as conditional benefits or direct links between unemployment offices and health services, could enhance the programme’s impact.

Finally, [CICB] and [CVC3] noted that WorkWell must be flexible enough to adapt to local contexts and evolving needs. This includes addressing the unique challenges of Crawley’s neighbourhoods, supporting people in temporary accommodation, and responding to emerging health inequalities.

In summary, WorkWell has the potential to fill critical gaps, but only if it is clearly positioned, well-integrated, and responsive to the lived experiences of local residents.

19. Ideas and innovations for WorkWell

Stakeholders offered a wide range of creative and practical ideas to enhance the design and delivery of the WorkWell programme in Crawley. These suggestions reflect a deep understanding of local needs and a desire to see WorkWell succeed as a flexible, inclusive, and integrated service.

A recurring theme was the importance of **visibility and accessibility**. [CVC3] proposed launching WorkWell through community mailing lists, forums, and presentations to raise awareness. [CMSK1] suggested using informal community hubs—such as libraries, supermarkets, and places of worship—for outreach and engagement. [CTTES] and [CPCN] recommended setting up WorkWell stands at job fairs, shopping centres, and health events to reach people who may not engage with traditional services.

Several stakeholders emphasised the need for **simplified referral processes**. [CPCN] advocated for self-referral options via GP websites and social media, noting that long forms and complex procedures deter many users. [CLG2] supported the idea of embedding WorkWell referral links into existing digital platforms, such as local authority websites and community apps.

Cultural inclusivity was another key area for innovation. [CVC1, CCPC 3-6] and [CMSK1] recommended designing culturally specific activities to reach in to seldom heard groups, such as women-only groups and using translated and appropriately nuanced wellbeing materials to engage underserved communities. [CVC2] suggested co-producing services with community leaders to ensure relevance and trust.

On the **digital front**, [CMSK1] proposed developing a mobile app (e.g., MOTIF) that allows users to track daily wellbeing using customisable metrics. This could help users monitor progress and stay engaged between appointments. The Horizon Scan that accompanies this report highlights a range of other apps and platforms that could support this function. [CVC3] added that digital tools should be complemented by in-person support to avoid excluding those with limited access or skills.

Training and workforce development were also highlighted. [CTTWP] and [CICB] recommended offering motivational interviewing training to all WorkWell staff, ensuring a consistent, person-centred approach. [CICB] also suggested mapping waiting list support pathways for each transformation site, enabling WorkWell to provide interim support and reduce drop-off.

Finally, [CGP] proposed more assertive outreach models, including conditionality (e.g., linking benefits to engagement with WorkWell) and direct collaboration between unemployment offices and primary care. While potentially controversial, these ideas reflect a desire to ensure that no one falls through the cracks.

In summary, stakeholders envision WorkWell as a dynamic, community-rooted service that is easy to access, culturally responsive, and digitally enabled, while maintaining a strong human touch.

Conclusion

This stakeholder analysis reveals strong support for the introduction of a WorkWell service in Crawley, grounded in a shared recognition of the link between health and employment. Stakeholders across sectors—including health, employment, voluntary, and community services—see WorkWell as a timely and necessary intervention that could bridge existing gaps, enhance integration, and improve outcomes for individuals with mental health and MSK conditions.

The findings highlight both the strengths of the current ecosystem and the challenges that WorkWell must navigate. While many services already provide elements of what WorkWell proposes, there is a clear opportunity to unify these efforts under a coherent, person-centred model. Success will depend on WorkWell's ability to be flexible, culturally responsive, and well-integrated with existing pathways. If implemented thoughtfully, WorkWell has the potential to significantly improve employment outcomes, reduce health inequalities, and contribute to a more resilient and inclusive local system.

Recommendations and actionable steps

The following recommendations have been made with the knowledge of the limited funding available to support a WorkWell service in Crawley. The emphasis is therefore on building on the strengths of the services already working in this space by transforming and focussing on existing resources. These recommendations do, however, act as a long list of recommendations that would support delivery of a successful programme, that will need to be prioritised based on local priorities, funding, time and the resources available.

1. Clarify Positioning and Avoid Duplication

Actions:

- Clearly define WorkWell's unique role in the local ecosystem.
- Map existing services and establish formal referral protocols to prevent overlap.

Why it works: Clear positioning ensures efficient use of limited resources and avoids confusion for service users, aligning with WorkWell's aim to streamline support and reduce fragmentation in health and employment services.

2. Enhance Accessibility and Outreach

Actions:

- Enable self-referral through GP websites and community platforms.
- Use community venues (e.g., libraries, supermarkets, places of worship) for outreach.
- Develop culturally inclusive materials and translated resources.

Why it works: Reducing barriers to access, especially for underserved or marginalised groups – helps reach those most at risk of falling out of work, supporting WorkWell's goal of early intervention and inclusive service delivery.

3. Strengthen Integration with Primary Care

Actions:

- Embed WorkWell coaches in GP surgeries and community health hubs.
- Train clinicians on the health-employment link and fit note reform.
- Promote clear and comprehensive handovers between clinical and employment services.

Why it works: Integrating employment support into healthcare settings leverages trusted relationships and normalises the work-health link, which is central to WorkWell's model of holistic, joined-up care.

4. Support Digital Inclusion

Actions:

- Offer blended digital and in-person support.
- Partner with libraries and community groups to deliver digital literacy training.
- Explore development of a wellbeing tracking app for user engagement.

Why it works: Digital tools expand reach and flexibility, while inclusion efforts ensure no one is left behind—key to WorkWell's ambition to provide equitable, scalable support.

5. Invest in Workforce Development

Actions:

- Provide motivational interviewing training for WorkWell staff.
- Recruit staff with lived experience to enhance relatability and trust.

Why it works: Skilled, empathetic staff build trust and engagement, especially among individuals with complex needs, supporting WorkWell's emphasis on personalised, empowering support.

6. Monitor Outcomes and Share Impact

Actions:

- Use a mix of quantitative tools (e.g., ReQoL-10, SWEMWBS) and qualitative case studies.
- Regularly review data to refine service delivery and demonstrate value.

Why it works: Continuous learning and evidence-sharing demonstrate value to funders and stakeholders, helping to sustain and improve the service in line with WorkWell's data-driven approach.

7. Secure Sustainable Funding

Actions:

- Align WorkWell with Integrated Care Board and Local Authority Priorities, e.g. the local Get Britain Working plan.
- Explore multi-year funding models and cross-sector investment.

Why it works: Long-term, integrated funding ensures stability and allows for strategic planning—critical for embedding WorkWell as a core part of the local health and employment ecosystem.

By implementing these recommendations, WorkWell can become a transformative service that not only supports individuals back into work but also strengthens the broader health and wellbeing infrastructure in Crawley.

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