

WorkWell Sussex

Evaluation report

August 2026



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Executive summary

Context

Musculoskeletal (MSK) and mental health conditions are a leading cause of economic inactivity in working-age adults, with many individuals either unemployed or off work due to their health (Department for Work and Pensions, 2024b).

The national WorkWell programme aims to deliver evidence-based, low-intensity work and health assessments to help citizens with health conditions or disabilities overcome barriers to employment. The Government launched a funded Vanguard initiative pilot programme in May 2024, of which NHS Sussex (as was) was not a part. However, further leadership funding aligned to the WorkWell initiative was made available to make progress in this area of enhancing health, work and skills integration and strategy development in all Integrated Care Systems across England.

NHS Sussex used its funding to commission Health Innovation Kent Surrey Sussex (KSS) to support the development and delivery of the WorkWell Sussex programme, who led on the discovery phase of the programme, and provided programme oversight and support to participating places.

Based on underlying health, demographics, and employment profiles, Crawley, East Brighton, and Hastings were selected to receive some funding and launch low-level WorkWell schemes with a neighbourhood approach.

As part of an initial discovery phase, Health Innovation published a [discovery report](#)

outlining the background and strategic context, and the findings of a deep dive in each of the three sites. This was accompanied by a [horizon scan](#) detailing the political, economic and social landscape affecting health-related inactivity.

Health Innovation KSS commissioned Unity Insights to conduct a rapid evaluation of the programme and provide strategic recommendations that facilitate prevention of MSK and mental health related work absences, acting as a proof of concept to ultimately support the implementation of a WorkWell service in Sussex.

Future WorkWell and wider health and employment support could therefore be considered as part of a broader population health, prevention, early intervention, and inequalities agenda.

This evaluation has been achieved through the implementation of bespoke quantitative data collection methods, interviews with the participating sites, case studies from citizens, and a high-level economic review, that are detailed within this report.

Findings and discussion

How was WorkWell implemented and delivered across local areas? What factors influenced the delivery, engagement, and effectiveness of the programme?

Delivery models varied across localities, but all used locally tailored approaches to meet population needs and improve engagement. East Brighton generated the highest referral volume (46%), followed by Crawley (35%) and Hastings (19%).

Strong partnerships, trusted referral routes, flexible person-centred support, and ongoing adaptation were key enablers of implementation and engagement.

Short delivery timescales, limited awareness, capacity pressures, and operational challenges constrained implementation and the ability to demonstrate longer-term impact.

How does access to WorkWell vary by service user demographics?

WorkWell Sussex reached citizens from a range of backgrounds, including a substantial proportion living in more deprived communities. Of the 48 referrals, 31% were from the two most deprived IMD deciles, rising to 36% among those with a known IMD score. All referrals from these two deciles came through East Brighton, suggesting that its community-based model was particularly effective in reaching Core20 populations.

Women accounted for 69% of referrals, while White British citizens represented 63% of the cohort. The prominence of White British citizens suggests that some minority ethnic communities may not have been reached in proportion to local need, particularly in

diverse areas such as Crawley. Referral methods also appeared to shape the demographic profile of each site. East Brighton's offer reached more younger citizens, women and people from deprived areas, while Hastings' repeat fit note approach engaged an older population with more established health-related work absence. Women also appeared more likely than men to remain engaged through to follow-up.

The pilot should not be judged simply in terms of overall referral numbers, but in relation to equitable access for populations most likely to experience health-related work inequalities. The findings suggest that neighbourhood delivery models, trusted community settings and locally tailored referral routes can improve engagement with underserved communities, while also highlighting the need for future programmes to monitor and respond to differences in access and engagement across deprivation, ethnicity, gender and other population characteristics.

To what extent does WorkWell change health and employment outcomes?

Qualitative findings identified examples of citizens moving into work, completing training, volunteering, accessing job trials and becoming more ready to engage with employment. The three delivery models supported different stages of progression. Crawley's structured coaching model supported active jobseekers, East Brighton combined confidence-building with direct employer links that led to job trials and paid roles, and Hastings focused on job retention and return to work through occupational therapy and support with reasonable adjustments. Patient-reported outcome

measures also provided early evidence of improved self-efficacy and wellbeing, supporting a return to employment.

How might WorkWell impact patient-reported experiences?

WorkWell was associated with improved work-related confidence and several aspects of mental wellbeing. Average confidence in managing health and staying in work when difficulties arose increased from 4.54 to 5.83 out of ten, a statistically significant improvement; however, respondents from the Crawley site scored, on average, below 5, suggesting that there was still a lack of confidence in managing their health and staying in work. Managing your own health and wellbeing also saw a modest increase from 2.57 to 2.83 out of 5.

Short-Warwick-Edinburgh Mental Wellbeing Score (SWEMWBS) results also saw average total scores increase from 17.56 to 22.48, with statistically significant increases across 6 of the 7 domains.

These changes are consistent with WorkWell's personalised approach, which combined practical goal setting, service navigation, employment support and help with wider barriers such as benefits, finances, childcare and digital access. Trusted community relationships, longer private appointments, occupational therapy and access to practical opportunities may all have contributed to improved confidence and self-efficacy.

What is the economic value of WorkWell?

The economic modelling estimated first-year benefits of £146k, producing a net present

value of £105k and a benefit-cost ratio of 3.54. This suggests that every £1 invested could generate approximately £3.54 in wider social value. Sensitivity analysis produced a mean benefit-cost ratio of £3.65, with an estimated range of £2.95 to £4.43 per £1 invested. Most of the estimated benefit, £130k, came from increased economic output associated with citizens entering or remaining in work, whilst the remainder related to estimated health-related quality-of-life gains. These findings should be treated as modelled potential value rather than realised financial savings. Employment outcomes were estimated using evidence from a comparable programme and assume sustained employment for one year.

Recommendations

The following recommendations were suggested:

- To improve consistency whilst retaining responsiveness to local needs, establish a clear core WorkWell model with flexibility for local tailoring, leveraging existing relationships between VCSEs.
- To improve employment, health, and wellbeing outcomes, provide multidisciplinary, person-centred support that addresses wider barriers to work.
- To increase access to employment opportunities and job retention, strengthen employer engagement and support for workplace adjustments.
- To better understand long-term impact and value, implement consistent

outcome monitoring and follow-up beyond the pilot period.

- Use local partners such as Health Innovation KSS to explore further innovations that may support citizens and services realise the greatest potential in the WorkWell model.

Conclusion

WorkWell Sussex should be viewed as a proof of concept for locally tailored, neighbourhood-based health and employment support rather than a definitive test of long-term impact. The programme demonstrated that support can be successfully delivered through trusted community and primary care settings, drawing on local relations and assets to bring together health, employment and wider social support around citizens' needs. Evidence suggests this approach can improve wellbeing, confidence, and progression towards employment, training, and wider community participation. However, the relatively short delivery and follow-up period means that longer term evaluation is needed to understand whether these outcomes – including work readiness, job entry, and job retention – are sustained over time. Future delivery should retain local flexibility whilst strengthening referral pathways, implementation support, and longer-term outcome monitoring to maximise impact.

Introduction

Context

Musculoskeletal (MSK) and mental health conditions are a leading cause of economic inactivity in working-age adults, with many individuals either unemployed or off work due to their health (Department for Work and Pensions, 2024b). In 2025, a total of 155,097 fit notes were issued across Sussex for diseases of the musculoskeletal system and connective tissue or mental and behavioural disorders (NHS England, 2026).

Across Brighton and Hove, Hastings, and Crawley, unemployment rates are reported to be 6.0%, 5.6% and 3.6%, respectively, compared to a national average of 4.5% (nomis, 2025).

Unemployment is linked to increased rates of depression, anxiety, and suicide, whilst returning to work is associated with improved self-esteem, physical health, and mental health, as well as reduced psychological distress; supportive, secure, high-quality, well-managed jobs provide the greatest benefit to general health (Department for Work and Pensions, 2025). There is a cyclical relationship between employment and health, whereby employment and positive health outcomes reinforce one another, as do unemployment and negative health outcomes. Further, employment delivers economic benefits generated by increased productivity, tax revenue, and local economy stimulation. Improved health also generates primary economic savings through a reduction in healthcare service utilisation, with health and employment positively feeding back into one another.

Two of the six key labour market challenges identified include (Department for Work and Pensions, 2024c):

- High levels of economic inactivity, particularly among those with health conditions or low skills.
- Prevalence of insecure, low-quality, and poorly paid jobs.

The government launched a target to increase the total employment rate to 80%, equivalent to two million more people in work. Therefore, ways to increase the total employment rate in the context of these labour market challenges must be sought.

WorkWell

WorkWell is a funded initiative through which public sector organisations could apply for a portion of a £57 million fund, aimed at delivering evidence-based, low-intensity work and health assessments to help individuals with health conditions or disabilities overcome barriers to employment (Department for Work and Pensions, 2023). The initiative places strong emphasis on early intervention, targeting not only individuals who have already left employment but also those

at risk of losing their jobs. Grant applicants retain considerable autonomy over the design of their local WorkWell programmes; however, most adopted a similar approach that includes identifying and referring users, assessing their needs and prioritising support, developing personalised plans for engagement with services (such as physiotherapy and counselling), and measuring the impact of interventions (Figure 1). Referral criteria for WorkWell can be found in 'Appendix A: Recommended referral criteria for WorkWell'.

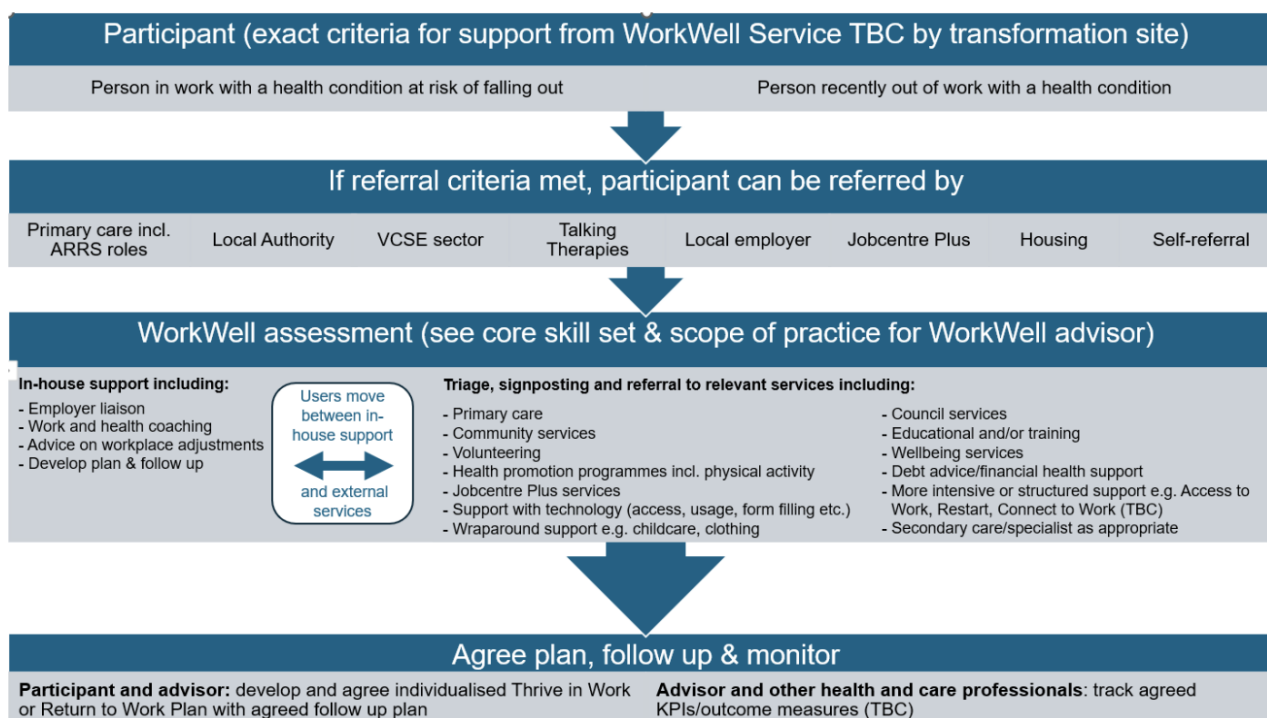


Figure 1: The typical user journey for an individual engaging in WorkWell in Sussex, adapted from the typical user journey provided in the WorkWell prospectus.

NHS Sussex was not part of the initial Vanguard initiative pilot programme, but developed a WorkWell pilot as part of their further leadership funding each ICB received for WorkWell. As part of horizon scanning activities, three localities were identified and launched low-intensity WorkWell schemes based on their underlying health, demographic, and employment profiles (Table 1; Health Innovation Kent Surrey Sussex, 2025).

Table 1: The three localities that WorkWell was piloted within and how, alongside relevant demographic, employment, and health factors.

Locality	Demographics	Employment context	Health context	WorkWell delivery model
Crawley	Large inland town with a highly diverse population, including higher proportions of residents identifying as Muslim (9.7%) and Hindu (5.1%) than the England averages (6.7% and 1.8%, respectively).	Elevated levels of unemployment linked to MSK conditions.	Lowest levels of physical activity in Sussex, alongside wider indicators of unhealthy lifestyles and higher prevalence of CVD.	Began as an MSK-focused primary care model in one PCN. Expanded to all PCNs, wider long-term conditions, multiple referral routes, and proactive community outreach.
East Brighton	Diverse urban population. The East neighbourhood contains eight of Brighton and Hove's 34 Core20 deprived areas, with 22.1% of residents living within these areas.	High levels of unemployment linked to mental health issues and one of the highest rates of economic inactivity in Sussex.	Long elective care waiting lists and multiple indicators of deprivation.	Implemented as a community-based pilot through the Crew Club, in close partnership with PCN staff where an Occupational Therapist and Health & Employment focused social prescriber co-located on a weekly basis to the community setting for joint delivery. Referrals were generated primarily through trusted local networks and on-site engagement.
Hastings	Predominantly White, middle-aged population.	Elevated levels of unemployment linked to both	Highest levels of deprivation in Sussex.	Implemented through a primary care-led model,

Locality	Demographics	Employment context	Health context	WorkWell delivery model
		MSK conditions and mental health issues.		evolving from self-referral, GP promotion, and EMIS searches to proactive identification through repeat fit note reviews and care coordinator outreach.

Purpose of the report

Unity Insights were commissioned by Health Innovation KSS to undertake a rapid qualitative, quantitative, and economic evaluation of the three NHS WorkWell Sussex pilots. The purpose was to produce a report that would inform local direction and funding decisions for future WorkWell initiatives developing across Sussex, as well as to provide strategic recommendations for wider implementation across with a view to prevent MSK- and mental health-related work absences. The current report depicts the findings of the evaluation.

Method

Evaluation approach

As part of the evaluation, a logic model workshop was completed to identify impacts, outcomes, and metrics for measurement. The outcome of the logic model can be found in 'Appendix B: Logic model' and was used to create the evaluation questions.

Evaluation questions

The evaluation questions were as follows:

PROCESS AND IMPLEMENTATION

- How was WorkWell implemented and delivered across local areas? What factors influenced the delivery, engagement, and effectiveness of the programme?

IMPACT

- How does access to WorkWell vary by service user demographics?
 - a. To what extent does WorkWell change health and employment outcomes? How do employment outcomes change, based on different delivery mechanisms?
 - b. How might WorkWell intervention components impact on patient-reported experiences (in other words, shifts in confidence, understanding of health-employment links, and self-efficacy)?

ECONOMIC

- What is the economic value of WorkWell?

- c. Do citizens enrolling onto the WorkWell programme realise quality-adjusted life year gains by improving the management of their conditions and improving wellbeing?

To answer the evaluation questions, a mixed-methods approach was used to bring together evidence on programme reach, implementation, citizen outcomes and economic value. The evaluation included demographic and health inequalities analysis, patient-reported outcome measures, qualitative interviews and case studies, and high-level health economic modelling. Findings from these methods were triangulated to provide an overall assessment of how WorkWell was delivered, who it reached, the outcomes associated with participation and its potential wider value.

Demographic and health inequalities analysis

WorkWell aims to help individuals overcome barriers to gaining or sustaining employment and reduce the impact of health inequalities on *Core20PLUS* citizens. The guidance set out in the NHS *Core20PLUS5* approach to reducing health inequalities whilst focusing on individual engagement and outcomes (NHS England, 2021) for WorkWell was explored.

A data collection template was developed by Unity Insights and shared with WorkWell leads, to be returned to Unity Insights on a monthly basis. Data was collected on citizen age group, gender, ethnicity, IMD, highest education level, disability, and whether English was their first language. This demographic data was analysed using frequency distributions and statistical testing, where appropriate, to compare citizen outcomes by demographics.

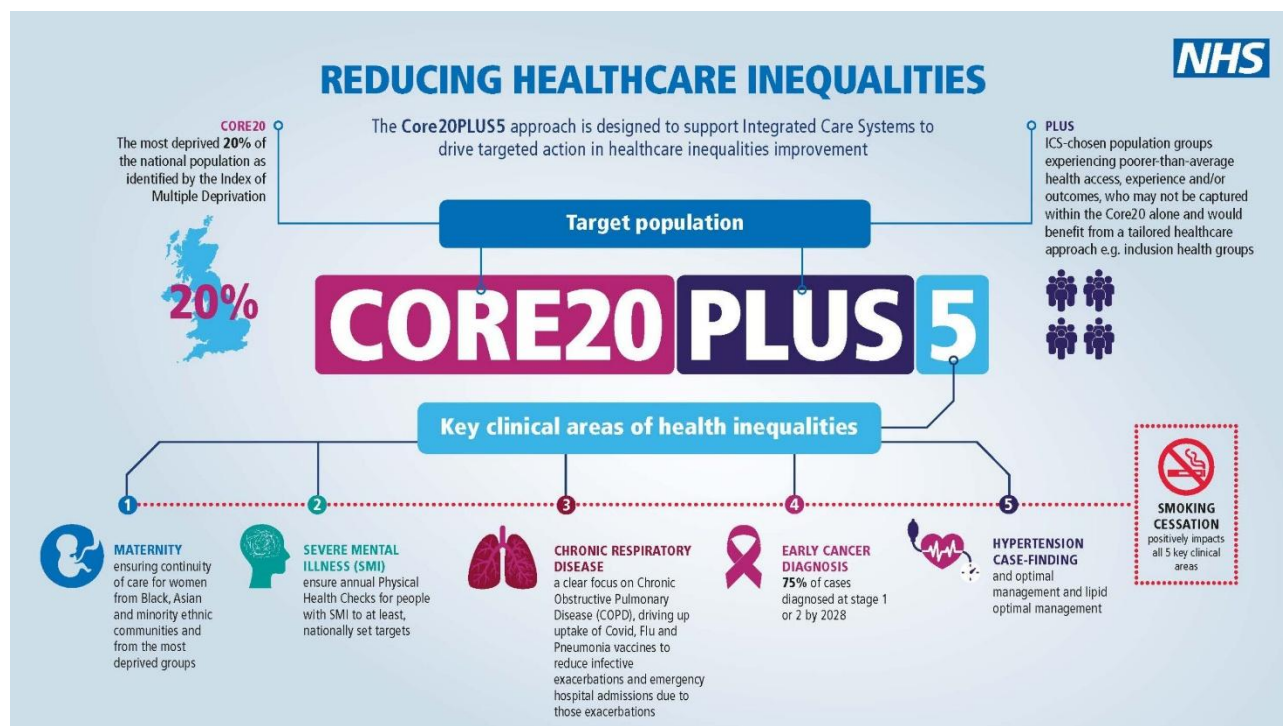


Figure 2: The Core20PLUS5 approach.

ASSUMPTIONS AND LIMITATIONS

- Citizens recorded on the spreadsheet without an onboarding date are assumed to be referrals that never initiated WorkWell support.
- Citizens with follow-up self-efficacy and Short-Warwick-Edinburgh Mental Wellbeing Scale results are considered to have successful complete support.
- Postcodes, where provided, have been used to acquire the latest 2025 Index of Multiple deprivation scores.

Patient reported outcome measures

As part of the original logic model workshop session, various patient reported outcome measures used by services were explored to understand which scales were already used. Scales to measure a citizen's mental wellbeing and self-efficacy were desired for this evaluation. This activity found that the Short Warwick-Edinburgh Mental Wellbeing Scale was used by several services as business-as-usual.

Patient Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS) scores

The Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS) is a seven-item self-report measure of mental wellbeing, derived from the longer 14-item Warwick-Edinburgh Mental Wellbeing Scale, which was designed to monitor positive mental health and evaluate mental health promotion initiatives at population level. It asks respondents to rate positively worded statements about their thoughts and feelings:

- *“I’ve been feeling optimistic about the future”*
- *“I’ve been feeling useful”*
- *“I’ve been thinking clearly”*
- *“I’ve been feeling relaxed”*
- *“I’ve been dealing with problems well”*
- *“I’ve been feeling close to other people”*
- *“I’ve been able to make up my own mind about things”*

Each statement is scored on a 1 to 5 Likert scale:

- 1 = None of the time
- 2 = Rarely
- 3 = Some of the time
- 4 = Often
- 5 = All of the time

The Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS) was completed by citizens during the initial onboarding to WorkWell Sussex, and again approximately eight weeks following their first engagement to monitor their mental wellbeing. Eight weeks was agreed upon by members of the WorkWell Sussex programme board members following advocacy from WWS NHS Sussex ICB representatives with significant experience of MSK services and follow-up completion rates of patient surveys. Responses were analysed using descriptive statistics and statistical tests, where appropriate.

Patient reported self-efficacy outcomes

In addition to SWEMWBS, two additional self-efficacy questions were provided to citizens at baseline and follow-up. Various self-efficacy frameworks were reviewed as an outcome of the logic modelling workshop session; however, colleagues at NHS Sussex ICB advised of two self-efficacy questions that had been used as part of previous programmes of work within the ICB. The self-efficacy questions asked were:

- *“How confident are you that you can manage your health and stay in work, even when things get difficult?”* (1 = Not confident at all; 10 = Completely confident)
- *“How would you rate your ability managing your own health and wellbeing?”* (1 = Not able; 2 = A little bit able; 3 = Quite able; 4 = Very able)

The self-efficacy questions followed the same expectations as the SWEMWBS questions with regard to completion at baseline and follow-up. Responses were analysed using descriptive statistics and statistical tests, where appropriate.

Assumptions and limitations

- It was assumed that respondents were a representative sample of all citizens who engaged with WorkWell.
- Hastings were unable to produce follow-up surveys for their citizens because of delayed programme implementation and data quality issues.
- Whilst services made best efforts to meet the eight-week follow-up requirement, due to the nature of the service provided, some follow-up surveys were conducted at a later date. All but one follow-up surveys from Crawley and East Brighton have been accepted for the analysis.
 - The one excluded survey is due to the follow-up survey having no accompanying baseline data.
- Strict guidance on methods to capture that citizens' baseline and follow-up surveys was not given and was at the discretion of each of the service providers.
- Statistical tests have been used to evidence the change in patient reported outcomes measures; however, it is accepted that the overall sample size is small and could be affected by power, meaning the analysis may be less able to detect genuine differences where they exist.

Qualitative analysis

Staff interviews

Semi-structured staff interview questions were developed with the project team and interviews (45 to 60 minutes long) were conducted by Unity Insights between April 2026 and June 2026. The following staff roles were interviewed from each locality:

- Crawley
 - Project manager ($n = 2$)
 - One interviewee convened task and finish groups, liaised with stakeholders, chaired groups, and attended board meetings.
 - One interviewee provided direct support to individual referrals, alongside managing appointments and administrative tasks.
 - First contact practitioner lead ($n = 1$)
 - This interviewee saw patients early in their MSK journey and delivered physiotherapy within a primary care setting.
- East Brighton
 - Project manager and social prescriber ($n = 1$)
 - This interviewee set up systems and processes, completed data reporting, and delivered the health and employment social prescribing element, alongside weekly delivery at the Crew Club and building links with skills, employment, and health services across the city.
 - Occupational therapist ($n = 1$)
 - This interviewee attended the Crew Club weekly to provide informal, optional support to individuals attending the lunch club, offering conversations and ongoing contact where needed.
 - Crew Club manager ($n = 1$)
 - This interviewee welcomed citizens into the space, completed initial sign-ups and triage, understood individuals' needs, and created a warm, trusted environment that enabled open conversations about the significant barriers citizens faced in relation to work.
- Hastings
 - Project manager ($n = 1$)

- This interviewee was a point of contact within the project board and oversaw the delivery team. They led team meetings and resolved problems, including any issues escalated to them.
- Occupational therapist ($n = 1$)
 - This interviewee received referrals, set goals with referred citizens, and provided tailored, work-focused occupational therapy support. They also supported employers to understand citizen barriers to work and make practical adjustments.
- Occupational therapist assistant ($n = 1$)
 - This interviewee triaged referrals from GP surgeries and redirected individuals to other services where appropriate, without providing direct treatment.

Interviews were hosted on Microsoft Teams and recorded and transcribed using AI. Transcripts were then analysed using thematic and sentiment analysis to generate suitable themes.

ASSUMPTIONS AND LIMITATIONS

- The interview sample was assumed to be representative of all staff members involved in WorkWell Sussex. The exception was within the Hastings sample, which did not include a verbal interview with the project manager; however, they were able to provide written responses to the semi-structured questions.

Case studies

Case studies were gathered to capture programme participants' experiences of engaging with WorkWell. Localities were invited to complete case studies in collaboration with participants, focusing on their experience of the programme and the support they received. In total, six case studies were collated, comprising three from East Brighton and three from Crawley.

ASSUMPTIONS AND LIMITATIONS

- Hastings was unable to provide case study examples, meaning that insights from this locality were limited.
- The case study sample was assumed to be representative of all participants involved in WorkWell Sussex.

High-level health economic modelling

A cost-benefit analysis was undertaken to estimate the key costs and benefits associated with the WorkWell sites in monetary terms. The analysis adopts a societal perspective, considering the wider effects on the public sector, employers and citizens, rather than focusing solely on the organisation funding or delivering the programme. Although the findings are expressed in monetary terms, they do not always represent direct changes to budgets. For example, an existing member of staff may spend time supporting WorkWell citizens without the organisation incurring additional recruitment costs. However, this still represents an economic cost because that staff member's time could otherwise have been used for other activities. This is known as an opportunity cost.

WorkWell may also generate benefits that have an economic value but do not create additional cash for an organisation. For example, improvements in citizens' health and wellbeing can be valued using measures such as Quality-Adjusted Life Years (QALYs), while support that helps someone remain in work may generate wider productivity benefits. Similarly, preventing a hospital attendance or reducing demand on primary care may allow existing healthcare resources to be used elsewhere, but it may not result in an immediate reduction in expenditure. These are referred to as non-cash-releasing benefits.

Financial modelling, by comparison, generally focuses on the perspective of a specific budget holder and includes only costs and benefits that directly affect its income and expenditure. The costs and benefits identified within the WorkWell cost-benefit analysis should therefore be interpreted as estimates of wider economic and social value, rather than as direct cash savings or financial returns to any single organisation.

Scenario analysis

A single scenario has been presented as part of the health economic modelling conducted:

- **Scenario 1: Estimated net return of WorkWell Sussex** estimates the economic value based on actual WorkWell Sussex participation and baseline employment statuses combined with employment outcomes and additionality assumptions from comparable literature, offset by the known lump sum funding received by each WorkWell Sussex pilot site.

Benefit streams

BENEFIT STREAM 1: GROSS VALUE ADDED (GVA)

Gross value added represents the additional economic output generated when WorkWell supports citizens to enter employment or remain in work. It is therefore primarily a benefit to the wider economy, although the value is ultimately shared between citizens, employers and government. The ONS reports regional GVA, with an average of £39.2 across the three local authorities, then later uplifted with inflation.

To estimate the number of additional hours worked, figures reported by the Sheffield Hallam University on the ‘*Working Well*’ programme have been used and applied to the data collected within the WorkWell Sussex programme. Sheffield Hallam University reported that in 2022, 25% of people exiting the Working Well programme (having been unemployed on entrance to the programme) were in employment at exit. Further, 50% of participants who entered the programme as employed left the programme as employed. An additional impact analysis by Sheffield Hallam found that 33% to 35% of positive job outcomes would not have happened without Working Well support (hereby referred to as the ‘*additionality factor*’). These figures were applied to the known employment status of individuals engaging with WorkWell Sussex to estimate the likely number of people now in employment because of WorkWell Sussex support.

The number of hours worked annually was calculated using a blended rate between the average number of hours worked by part-time and full-time staff, as reported by the Office for National Statistics. Figure 3 depicts how benefit stream 1 was calculated.

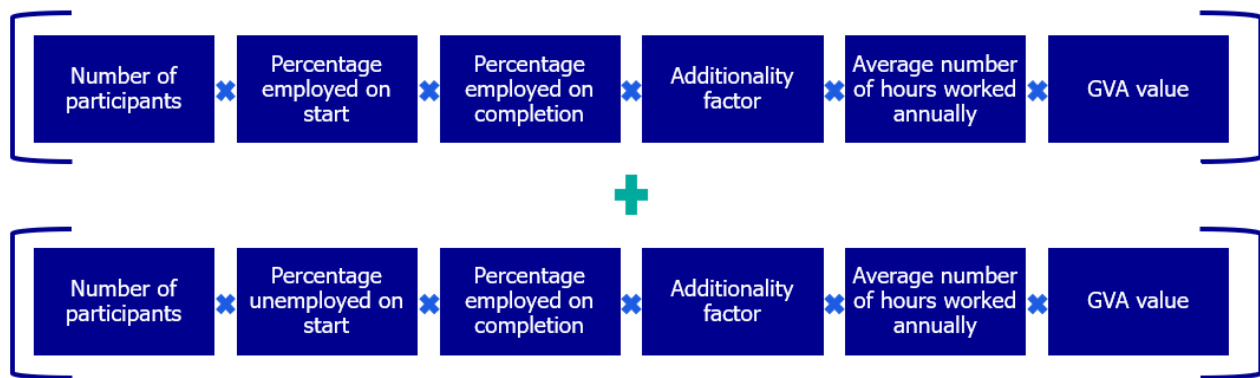


Figure 3: Demonstration of GVA benefit stream calculations.

BENEFIT STREAM 2: INCREASE IN QALYS

Quality-adjusted life years (QALYs) provide a standardised way of measuring improvements in health by combining quality of life with the length of time for which that level of health is experienced. One QALY is equivalent to one year lived in full health. QALYs typically sit on a range of 0 to 1, where 1 QALY is considered as one full year of perfect health, whilst 0 is considered deceased. An improvement in health utility of 0.1 that is maintained for one year would generate 0.1 additional QALYs.

Throughout the WorkWell Sussex programme, delivery staff collected Short Warwick–Edinburgh Mental Wellbeing Scale (SWEMWBS) responses at baseline and follow-up. As SWEMWBS measures mental wellbeing rather than health utility, the results cannot be used directly to calculate QALYs. A published mapping tool developed by Keetharuth et al. (2024) has therefore been used to convert citizens’ responses to estimated Recovering Quality of Life Utility Index (ReQoL-UI) values. The tool uses responses to the seven SWEMWBS questions, alongside age and sex, to estimate each citizen’s health utility at baseline and follow-up.

The difference between the baseline and follow-up utility values represents the estimated change in each citizen's health-related quality of life. This improvement has been converted into QALYs, with the resulting QALY assigned a monetary value for inclusion within the cost-benefit analysis. NICE applies a cost-effectiveness range of £25,000 to £35,000 per additional QALY when assessing health technologies. To maintain prudence, the lower end of this spectrum (£25k) has been used for assessing the monetary value of QALY gains during the WorkWell Sussex project. Figure 4 depicts how benefit stream 2 was calculated.



Figure 4: Demonstration of increase in QALYs benefit stream.

Cost streams

For this high-level health economic analysis, a single cost stream has been incorporated into this analysis. The additional time contributed by colleagues from NHS Sussex ICB and Health Innovation Kent Surrey Sussex has been considered pump primed and excluded from the model.

COST STREAM 1: SITE FUNDING

Each WorkWell site received £12,000 in funding to establish and deliver the pilot within its local area. This funding has been included within the cost analysis as the core programme investment required to initiate delivery, covering the resources and activities needed to set up and operate the pilot at each site.

Assumptions and limitations

- The £12,000 awarded to each site was assumed to capture the full cost of initiating and delivering the WorkWell pilot, with no additional unfunded staff time, overheads or in-kind contributions included unless separately identified.
- Employment outcomes achieved through WorkWell were assumed to be consistent with those reported for the Working Well programme.
- The additionality rate reported for the Working Well programme was assumed to be applicable to WorkWell Sussex.

- Citizens entering or remaining in employment were assumed to work the average annual number of hours, based on the national balance of full-time and part-time employment.
- The GVA generated through employment was assumed to be equivalent to the latest national average GVA per hour worked.
- No allowance was made for displacement, whereby one citizen gaining employment may reduce employment opportunities for another person.
- Changes in SWEMWBS scores were assumed to represent genuine improvements in mental wellbeing rather than differences in questionnaire completion.
- The published SWEMWBS to ReQoL-UI mapping tool was assumed to provide an appropriate estimate of health utility for the WorkWell population.
- Mental health-related QALY gains were assumed to be experienced by all WorkWell participants and maintained for 12 months.

UNMODELLED BENEFIT STREAMS

A potential reduction in healthcare resource utilisation was identified as an important additional benefit of WorkWell, particularly through fewer GP appointments and reduced reliance on repeat fit notes. By addressing health, employment and wider social barriers in a coordinated way, WorkWell may reduce the need for citizens to repeatedly seek support from primary care or other healthcare services.

At the outset of the evaluation, it was anticipated that one site would provide data on a cohort of citizens receiving repeat fit notes. This would have enabled analysis of changes in healthcare resource utilisation before and after engagement with WorkWell. Following delays in launching the project, and changes in site personnel, it has been deemed that this analysis is no longer possible. As a result, this benefit cannot be quantified or included within the cost-benefit analysis and should be regarded as a potential unmodelled benefit.

Optimism bias

Optimism bias (OB) is defined as, “*the tendency for a project’s costs and duration to be underestimated and/or benefits to be overestimated*” (Mott MacDonald, 2002) as found by historical UK government reviews on public sector procurement. To account for these ‘*optimistic*’ estimates, the model applies OB correction factors in response to the level of uncertainty in the data or assumptions used within the model.

Unity Insights’ approach to optimism bias is presented in *Appendix D: Health economic optimism bias application*. This is an adaptation of the model created by the Greater Manchester Combined Authority (GMCA) Research Team (formerly New Economy; HM Treasury et al., 2014). The GMCA

model is featured in the supplementary guidance of HM Treasury's *Green Book* and offers a robust and prudent approach to economic analysis (HM Treasury, 2022). In addition to the optimism bias factors applied at the benefit and cost stream level, a further factor of 15% was applied to reduce the benefits and increase the costs. This additional factor was included as an extra level of prudence to ensure that the model does not misrepresent the impact of the intervention.

GDP deflation adjustment

A real Gross Domestic Product (GDP) deflator was applied that removes the general effects of inflation and presents costs and benefits included within the appraisal in '*real*' base year prices rather than in nominal prices (such as the first year of the project). Within this appraisal, a GDP deflator of 2% has been used to convert nominal to real values. Various rates were applied depending on data that was sourced from the Office for Budget Responsibility forecast (Office for Budget Responsibility, 2022) and The Green Book (HM Treasury, 2022).

Discounting

Discounting is a technique that enables the comparison of costs and benefits on a consistent basis and accounts for the concept of '*social time preference*' (in other words, it allows costs and benefits that occur at different time periods to be compared on a "*present value*" basis). Discounting was applied to all future costs and benefits and is not applied retrospectively.

A discount rate of 3.5% is applied to benefits to deflate outcomes to real terms and reflect the changing value of healthcare within GDP (HM Treasury, 2022). For social outcome streams linked to welfare or utility values (such as QALYs), a discount rate of 1.5% was applied as this excluded the change in expected growth per capita over time and only considered health and life effects.

Sensitivity analysis

A degree of uncertainty in the estimates of the model is accounted for by using sensitivity analysis. It is important to note that the sensitivity differs from optimism bias in that it is applied on each individual assumption or input in the model, rather than by benefit or cost stream as in the case of optimism bias. Unity Insights used a Monte Carlo simulation to conduct the sensitivity analysis. This modelling technique simulates the impact of the expected variance in key variables on the output of interest, in this case the net present value return on investment. Further details on how this was applied are included in 'Appendix C: Health economic sensitivity analysis methodology'.

Results

Quantitative analysis

Referrals

Figure 5 displays the number of referrals recorded by each WorkWell Sussex pilot site. Across the three sites, a total of 48 referrals were recorded. East Brighton accounted for the largest proportion of referrals, with 22 referrals representing just under half of the total cohort (46%). Crawley received the second highest number of referrals, with 17 referrals (35%), while Hastings received nine referrals (19%).

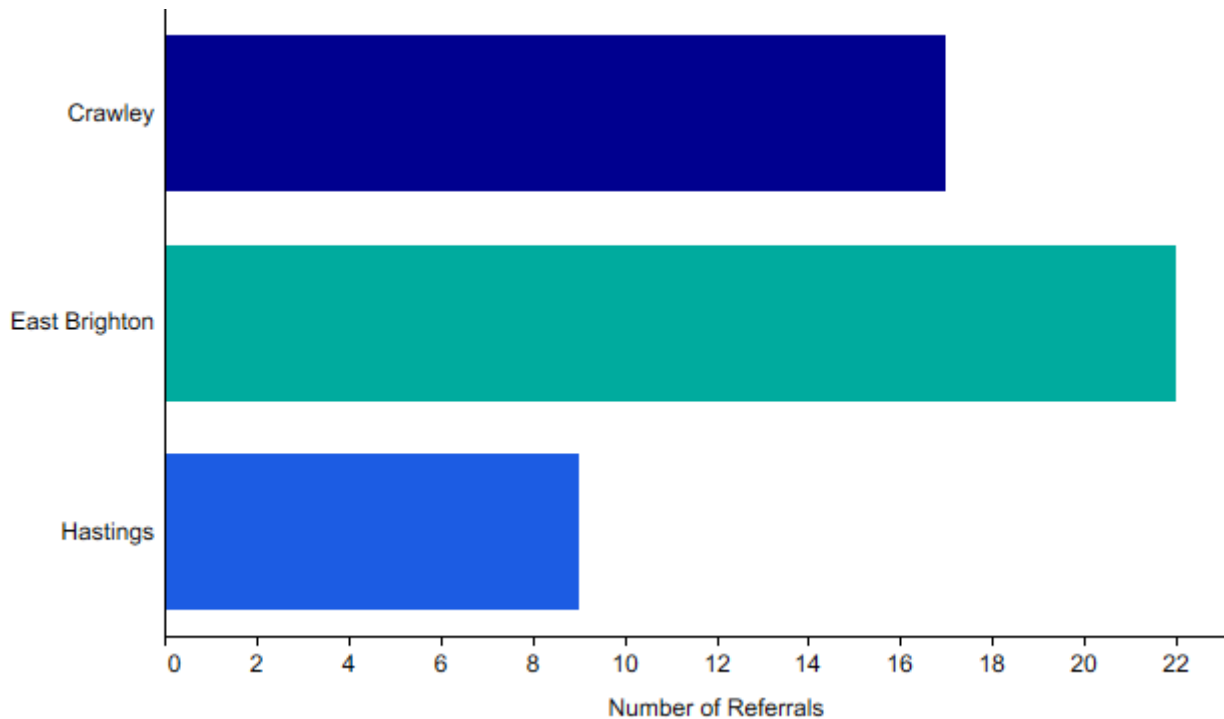


Figure 5: Referrals by WorkWell Sussex pilot site.

Figure 6 displays the number of citizens onboarded onto WWS per month, alongside the cumulative running total. Across the period shown, a total of 39 citizens were onboarded. Onboarding activity began with four citizens in December 2025, increasing to nine citizens in January 2026, before reducing slightly to six citizens in February 2026. The highest monthly volume was recorded in March 2026, when 15 citizens were onboarded, representing 39% of the total cohort. A further five citizens were onboarded in April 2026, bringing the cumulative total to 39

citizens by the end of the period shown. Overall, the trend indicated a gradual build-up in onboarding activity during the early months of the pilot, with a notable increase in March 2026, coinciding with the initial onboarding of citizens within the Hastings pilot site.

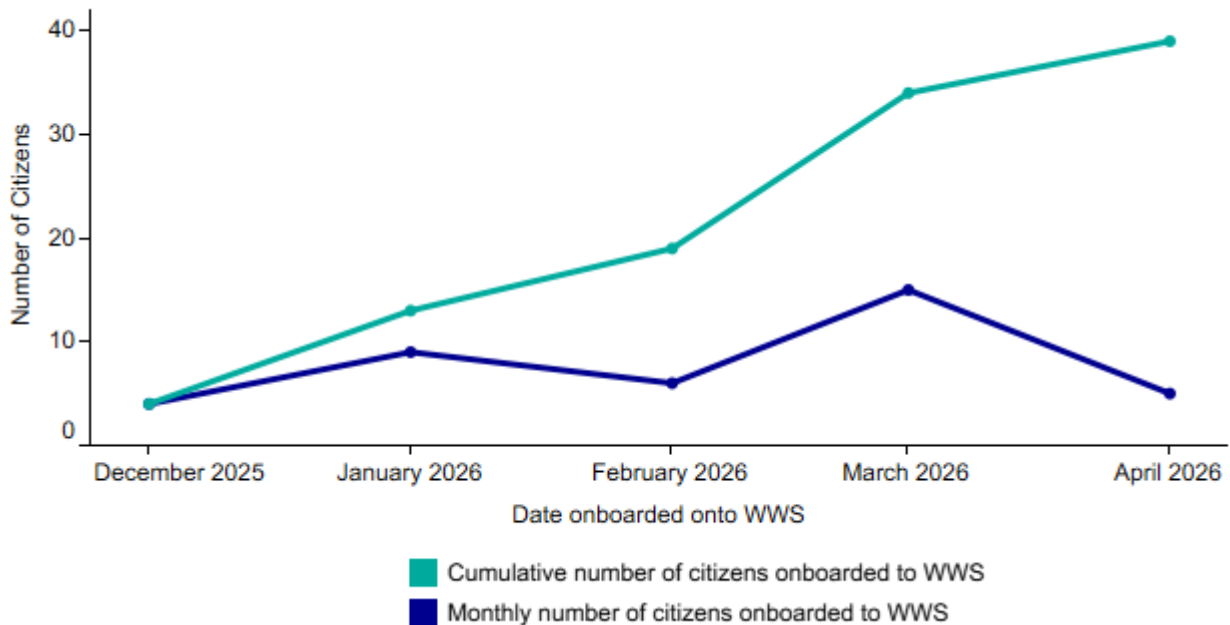


Figure 6: WorkWell Sussex citizens onboarded over time, December 2025 to April 2026.

Citizen demographics

Figure 7 displays the recorded ethnicity of citizens referred into WorkWell Sussex, split by pilot site. Across the total cohort of 48 referrals, the largest group was White British, with 30 citizens representing 63.5% of all referrals. A further 18 citizens were recorded across all other recorded ethnicity categories, equivalent to 37.5% of the total cohort and 32% of those with a known ethnicity recorded. These included Any other white background ($n = 4$), Other ethnic group ($n = 4$), Black, Black British, Caribbean, or African ($n = 3$), Asian or Asian British ($n = 2$), and Mixed or multiple ethnic background ($n = 1$). Ethnicity was unknown for four citizens, all of whom were referred through the Hastings site. Most White British referrals were recorded in East Brighton ($n = 16$), followed by Crawley ($n = 9$) and Hastings ($n = 5$).

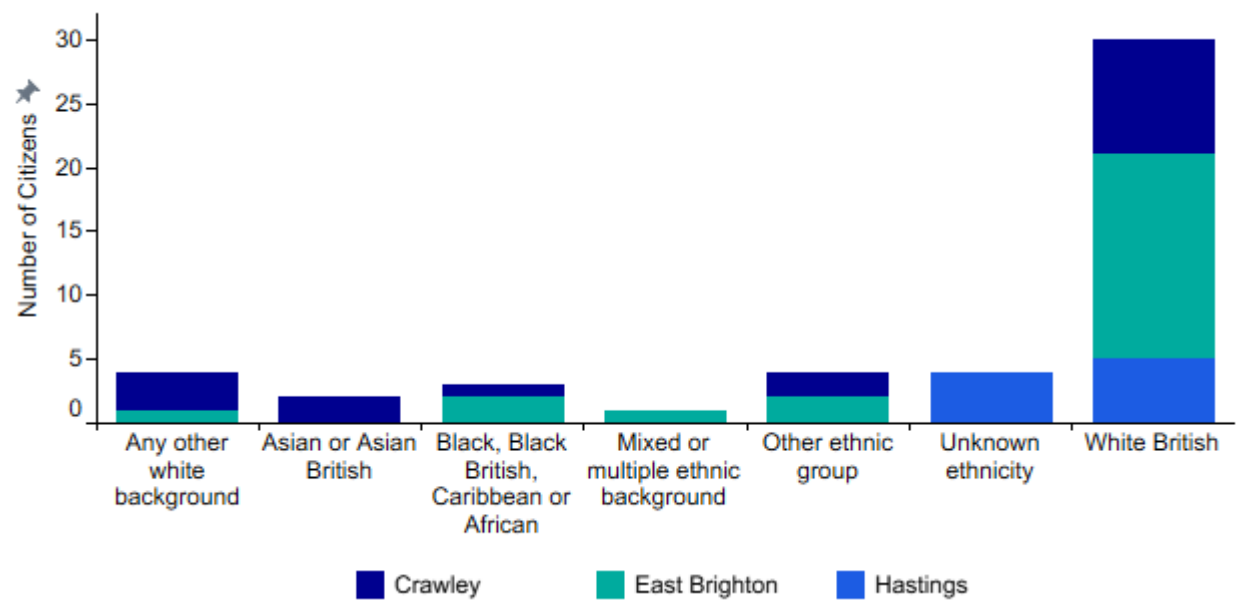


Figure 7: Ethnicity of citizens referred into WorkWell Sussex by pilot site.

Figure 8 displays the recorded IMD score of citizens referred into WorkWell Sussex, split by pilot site. Across the total cohort of 48 referrals, the largest group was recorded in IMD score 1 (most deprived), with 14 citizens representing 29.2% of all referrals.

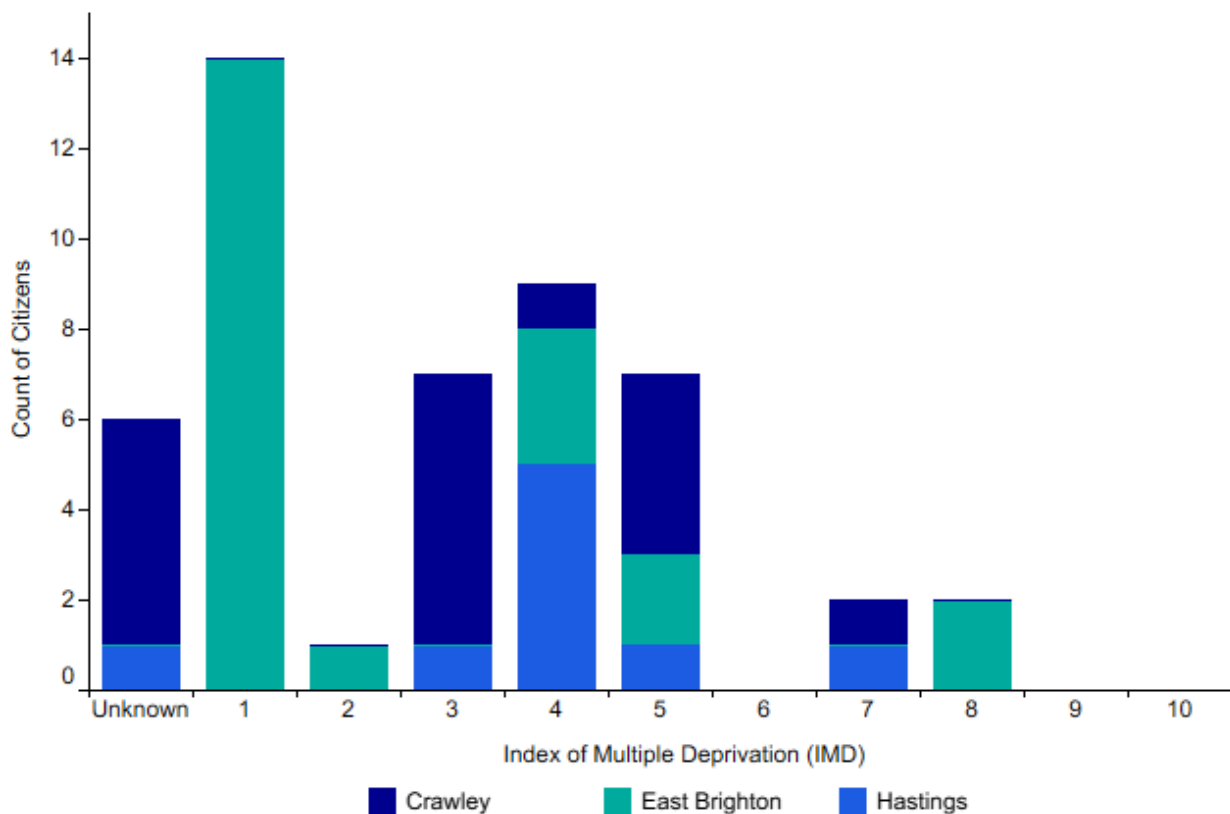


Figure 8: IMD profile of citizens referred into WorkWell Sussex by pilot site.

When combined, IMD scores 1 and 2 accounted for 15 referrals, representing 31% of all referrals and 36% of referrals with a known IMD score. This suggests that a substantial proportion of citizens referred into the pilot were from areas with the highest levels of recorded deprivation.

All citizens recorded in IMD score 1 and 2 were referred through East Brighton, accounting for all CORE20 referrals, whilst Crawley referrals were more concentrated in the unknown, IMD score 3 and IMD score 5 categories. Hastings referrals were most commonly recorded in IMD score 4, slightly higher than Hastings' average IMD score. Overall, the chart suggests that the pilot reached citizens across a range of deprivation profiles, with a substantial proportion of referrals coming from lower IMD scores.

Figure 9 displays the recorded gender of citizens referred into WorkWell Sussex. Across the total cohort of 48 referrals, just over two-thirds were female, with 33 female citizens representing 69% of all referrals. The remaining 15 referrals were male, representing 31% of the cohort. The greatest disparity between gender referrals was witnessed in East Brighton, with a significantly larger proportion of the referrals being female.

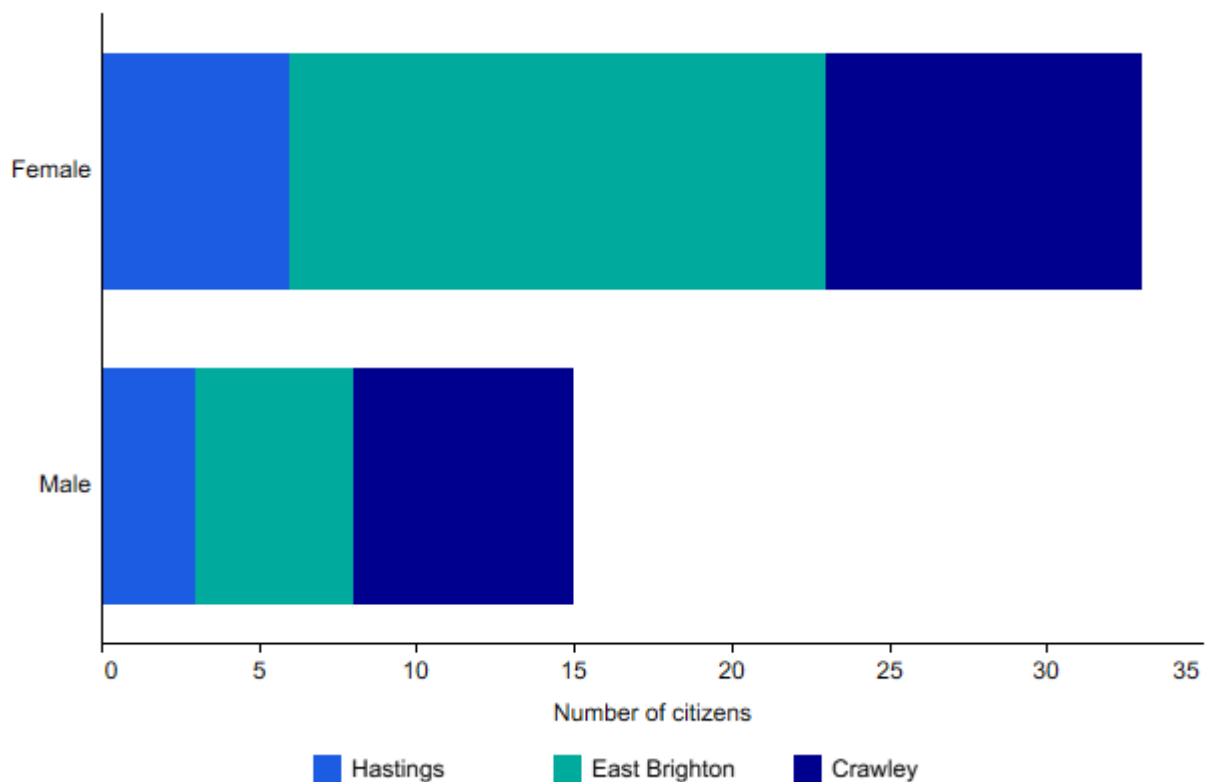


Figure 9: Gender of citizens referred into WorkWell Sussex.

Figure 10 displays the recorded age profile of citizens referred into WorkWell Sussex, split by pilot site. Referrals were distributed across a broad age range, from younger citizens through to those aged 65 and over. The largest age group was 55 to 59 years, with eight citizens representing 20% of those shown. There were also notable numbers of citizens aged 25 to 29 and 35 to 39, with six citizens in each group. Overall, just under a third of citizens with age recorded were under 30 years old (29%; $n = 12$), while a similar proportion were aged 55 and over (32%; $n = 13$). This suggests that the pilot reached citizens across both younger and older working-age groups, although findings should be interpreted descriptively due to the small cohort size.

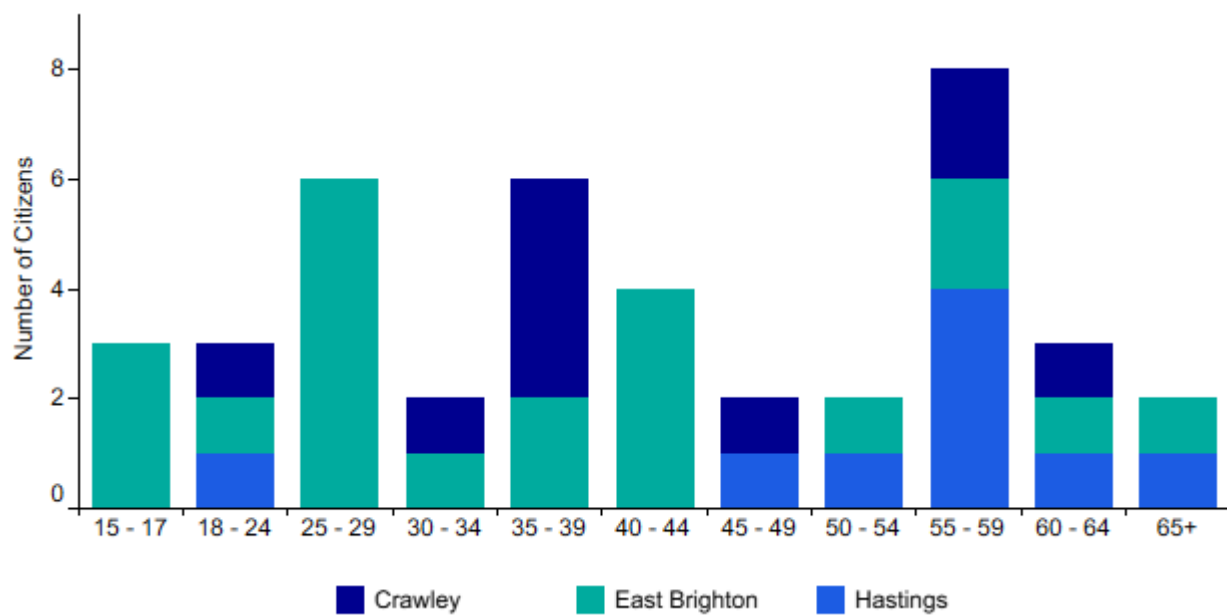


Figure 10: Age profile of citizens referred into WorkWell Sussex by pilot site.

Site-level patterns varied, with East Brighton accounting for most referrals among younger age groups, particularly those aged 25 to 29, while Hastings had the highest number of referrals in the 55 to 59 age group. Given the small number of referrals within some age categories, these findings should be interpreted cautiously; however, it is expected that the referral methods of each site have heavily influenced the age profile of the programme.

Figure 11 displays the recorded employment status of citizens referred into WorkWell Sussex, split by pilot site. Across the total cohort of 48 referrals, the largest group was citizens recorded as economically inactive, with 21 citizens representing 44% of all referrals. A further 13 citizens were unemployed and looking for work, representing 27% of the cohort. Combined, these two groups accounted for 34 referrals, equivalent to 71% of all referrals and 81% of referrals with a known employment status recorded.

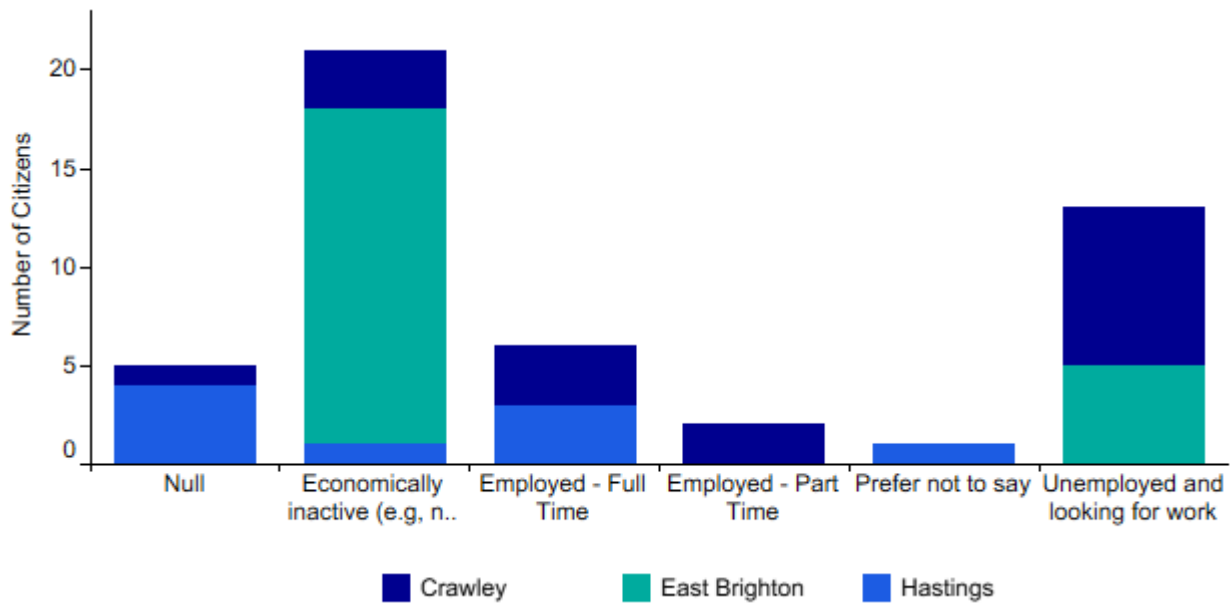


Figure 11: Employment status of citizens referred into WorkWell Sussex by pilot site.

Smaller numbers of citizens were in employment at the point of referral, with six recorded as employed full-time and two as employed part-time. East Brighton accounted for most economically inactive referrals, whilst Crawley accounted for the largest number of referrals from citizens who were unemployed and looking for work.

Figure 12 displays the recorded highest educational level of citizens referred into WorkWell Sussex, split by pilot site. Across the total cohort of 48 referrals, the largest group was citizens with fewer than five secondary education qualifications at GCSE, O-Level or equivalent level, with 15 citizens representing 31% of all referrals. This was followed by citizens with A-Level or College Diploma qualifications (21%; $n = 10$), those with an undergraduate degree (13%; $n = 6$), and those with a postgraduate master's degree (8%; $n = 4$). Smaller numbers were recorded as having no qualifications ($n = 2$), apprenticeships ($n = 2$), or five or more secondary education qualifications at GCSE, O-Level or equivalent level ($n = 1$). Educational level was recorded as Null for seven citizens, while one citizen preferred not to say.

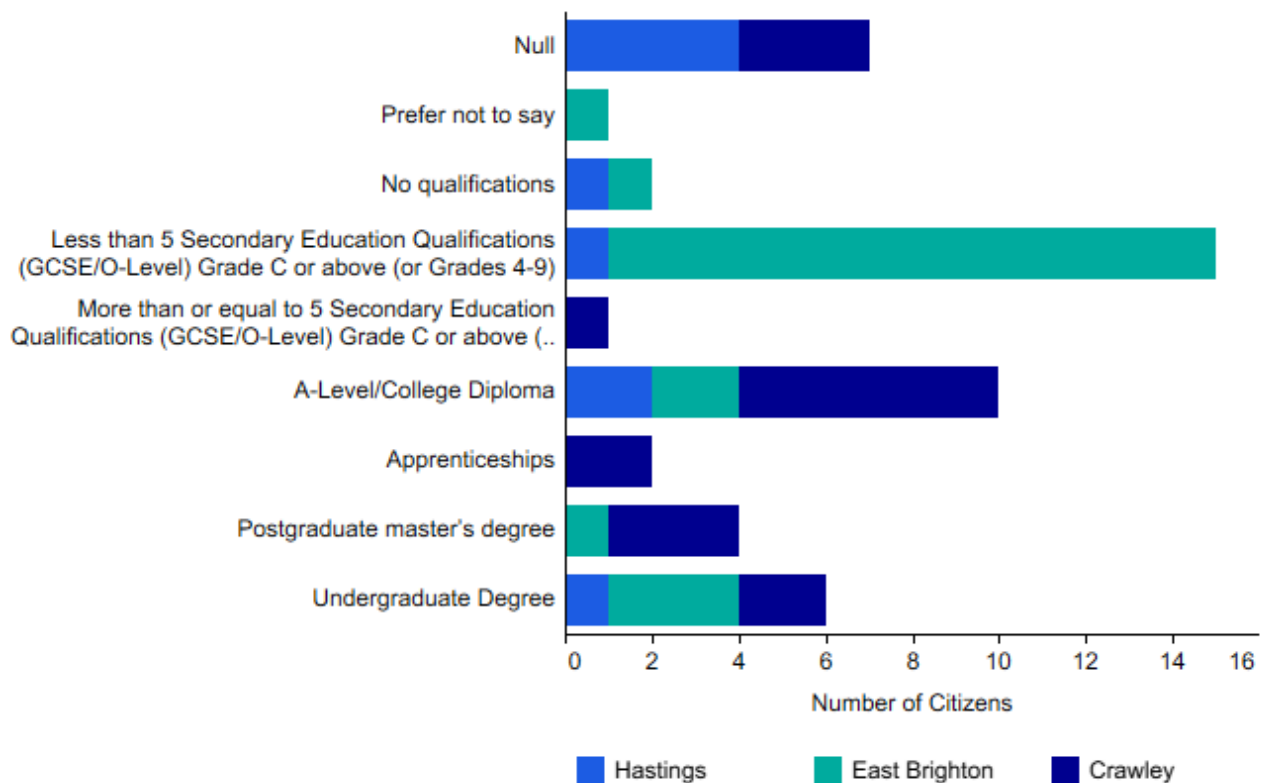


Figure 12: Highest educational level of citizens referred into WorkWell Sussex by pilot site.

Figure 13 summarises the language profile of citizens referred into WorkWell Sussex. Most citizens were recorded as having English as their first language, accounting for 32 of the 48 referrals (67%). Despite this, over a quarter of the cohort were recorded as not having English as their first language (27%; $n = 13$), indicating that the pilot engaged a notable group of citizens for whom English was an additional language. A further three records had a Null response.

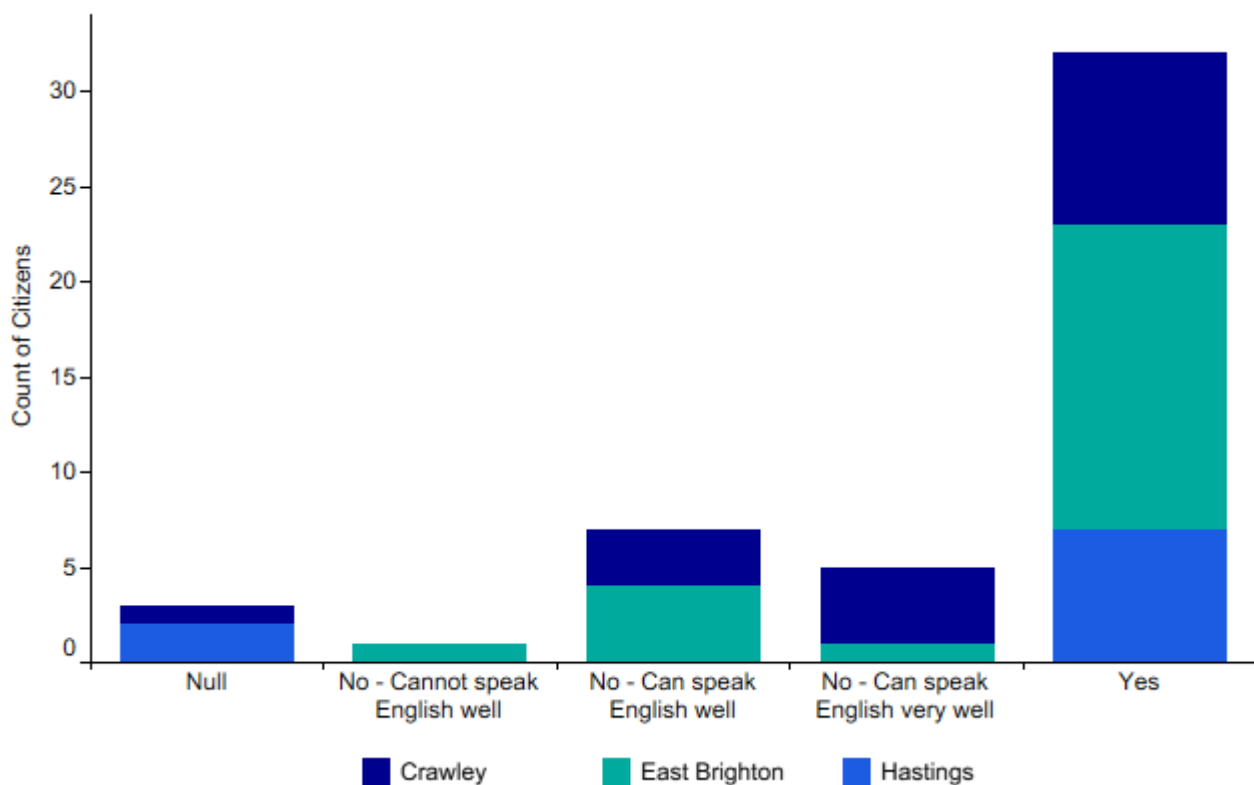


Figure 13: English as first language among citizens referred into WorkWell Sussex by pilot site.

Among citizens whose first language was not English, the majority were recorded as being able to speak English well or very well ($n = 12$). Only 1 citizen was recorded as unable to speak English well. East Brighton accounted for most referrals among citizens whose first language was not English, suggesting some variation in the language profile of referrals across the three pilot sites.

Self-reported outcomes: Short-Warwick-Edinburgh Mental Wellbeing Scale

A total of 27 citizens had both a baseline and follow-up Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS) assessment recorded, enabling change in wellbeing score to be assessed over time (Table 2). Of these, eight citizens were from Crawley, representing 30% of the matched SWEMWBS cohort, while 19 citizens were from East Brighton, representing 70%. No citizens from Hastings had both baseline and follow-up SWEMWBS scores available within this cohort.

Table 2: Citizens with matched baseline and follow-up SWEMWBS assessments by pilot site.

Site	Number of citizens with baseline and follow-up results
Crawley	8
East Brighton	19
Hastings	0
Total	27

Gender of referrals to WorkWell Sussex were majority female, notably however; the number of follow-up responses from male participants (50%; $n = 6$) is disproportionately lower than that of female participants (78%; $n = 21$).

It was agreed that citizens would complete their follow-up SWEMWBS assessment at approximately the eight-week point after their baseline assessment. Across citizens with both baseline and follow-up scores recorded, the average time between assessments was 9.5 weeks. This was slightly longer in East Brighton, where the average interval was 10.2 weeks, compared with 7.8 weeks in Crawley (Table 3).

Table 3: Average time between baseline and follow-up SWEMWBS assessments by pilot site.

Site	Average weeks between baseline and follow-up SWEMWBS assessments by pilot site
Crawley	7.8
East Brighton	10.2
Hastings	-
Overall	9.5

Matched SWEMWBS data indicate an improvement in wellbeing between baseline and follow-up (Table 4). Among the 27 citizens with paired assessments, the average item response score increased from 2.51 at baseline, to 3.21 at follow-up, representing an average increase of 0.70 points per item. As each SWEMWBS item is scored out of a maximum of five, this equates to a 14% improvement against the maximum possible item score. This corresponded to an increase in the average total SWEMWBS score from 17.56 to 22.48, a mean gain of 4.93 points.

Table 4: Average SWEMWBS scores at baseline and follow-up by pilot site.

Site	Average individual response score			Average total score		
	Baseline	Follow-up	Difference	Baseline	Follow-up	Difference
Crawley	1.96	2.52	0.55	13.75	17.63	4.93
East Brighton	2.74	3.50	0.77	19.16	24.53	3.88
Overall	2.51	3.21	0.70	17.56	22.48	4.93

A paired *t*-test indicated that the increase in SWEMWBS scores between baseline and follow-up was statistically significant ($p < 0.001$), suggesting that the improvement observed in the matched cohort is unlikely to be due to chance.

In Crawley, the average response score increased by 0.55 points, equivalent to an 11.0 percentage-point improvement against the maximum possible item score, whilst East Brighton saw the average response score increase by 0.77 points, equivalent to a 15% improvement. The boxplot (Figure 14) also shows an upward shift in the distribution of total SWEMWBS scores at follow-up, with higher median and upper-range scores compared with baseline. While individual scores continued to vary, the overall pattern suggests a positive change in self-reported mental wellbeing among citizens with paired SWEMWBS assessments.

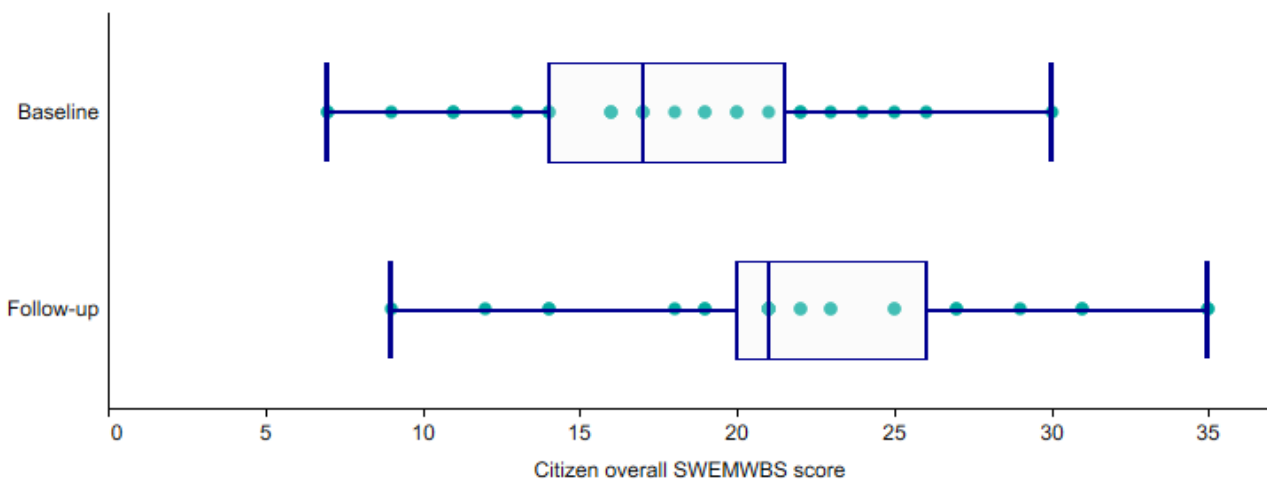


Figure 14: Distribution of total SWEMWBS scores at baseline and follow-up.

Table 5 shows changes in average SWEMWBS item scores across each of the seven wellbeing domains. Improvements were seen across all domains, with the largest increase observed for feeling optimistic about the future, which rose from 2.26 at baseline to 3.30 at follow-up. This

represented an average increase of 1.04 points, equivalent to a 20.8 percentage-point improvement against the maximum possible item score of five.

Table 5: Changes in average SWEMWBS item scores across each of the seven wellbeing domains.

Domain	Baseline	Follow-up	Difference	<i>p</i> -value
Optimistic for the future	2.26	3.30	1.04	$p < 0.001$
Feeling useful	2.33	3.15	0.81	$p < 0.001$
Feeling relaxed	2.26	2.93	0.67	$p = 0.003$
Dealing with problems well	2.44	3.19	0.74	$p < 0.001$
Thinking clearly	2.67	3.19	0.52	$p = 0.002$
Feeling close to people	2.67	3.44	0.78	$p = 0.002$
Able to make up my own mind	2.93	3.30	0.37	$p = 0.110$

Other notable gains were seen for feeling useful, which increased by 0.81 points, and feeling close to people, which increased by 0.78 points. Scores also improved for dealing with problems well, feeling relaxed and thinking clearly, with gains ranging from 0.52 to 0.74 points. The smallest improvement was observed for being able to make up one's own mind, which increased by 0.37 points, equivalent to a 7.4 percentage-point improvement.

The statistical testing results indicate that improvements were statistically significant across six of the seven domains. The only domain that did not show a statistically significant change was being able to make up one's own mind ($p = 0.11$). Overall, the domain-level results suggest that the strongest changes were concentrated in future optimism, perceived usefulness and social connectedness.

Further analyses explored whether changes in SWEMWBS scores varied by citizen demographics. No statistically significant differences were identified across these subgroup analyses. These results should be interpreted with caution, as the number of citizens within each subgroup was very small, limiting the ability to detect meaningful differences.

Self-reported outcomes: Self-efficacy measures

SUMMARY

A total of 24 citizens had both baseline and follow-up responses recorded for the self-efficacy questions and were included in the analysis (Table 6). Five Crawley citizens had completed the follow-up self-efficacy questions; however, one of these citizens was missing a baseline score for one of the measures and was therefore removed from the analysis.

Table 6: Citizens with matched baseline and follow-up self-efficacy assessments by pilot site.

Site	Number of citizens with baseline and follow-up results
Crawley	4
East Brighton	19
Hastings	0
Total	23

The self-efficacy measures asked citizens to rate their ability to manage their own health and wellbeing, and their confidence in managing their health and staying in work when things become difficult. These questions were used to explore whether citizens reported changes in confidence and perceived ability to self-manage between baseline and follow-up.

Table 7 summarises changes in the two self-efficacy measures between baseline and follow-up. For the question on citizen ability to manage their own health and wellbeing, the overall average score increased from 2.57 to 2.83, representing a mean increase of 0.26 points on the four-point scale. This equates to a 7% improvement against the maximum possible score. Despite this, the change was not statistically significant ($p = 0.137$). Citizens from the Crawley site in fact reported a decrease in their perceived ability to manage their own health and wellbeing; although this is reported from a small sample size, with one individual's follow-up score being one point less than their baseline, resulting in this decrease.

Table 7: Average self-efficacy scores at baseline and follow-up by pilot site.

	Managing your own health and wellbeing			Manage your health and stay in work, even when things get difficult		
Site	Baseline	Follow-up	Difference	Baseline	Follow-up	Difference
Crawley	2.75	2.50	-0.25	3.40	4.40	1.00
East Brighton	2.53	2.89	0.37	4.84	6.21	1.37
Overall	2.57	2.83	0.26	4.54	5.83	1.29

For the question on confidence in managing health and staying in work when things get difficult, the overall average score increased from 4.54 to 5.83, representing a mean increase of 1.29 points on the 10-point scale. This is equal to a 13% improvement against the maximum possible score. This change was statistically significant ($p = 0.016$), indicating a measurable improvement in citizens' confidence to manage their health and remain in work. Despite this, it should be noted that respondents from Crawley's follow-up scores failed to break the five-point threshold, suggesting that their overall confidence in managing their health and remaining in work was net unconfident.

Further analyses explored whether changes in self-efficacy scores varied by citizen demographics, but no statistically significant differences were identified across these subgroup analyses.

MANAGING YOUR OWN HEALTH AND WELLBEING

Figure 15 shows changes in citizens' self-reported ability to manage their own health and wellbeing between baseline and follow-up. The number of citizens reporting that they were "*quite able*" increased from 8 at baseline to 12 at follow-up, while the number reporting that they were "*not at all*" able reduced from 3 to 0. The number of citizens reporting that they were "*very able*" remained stable at 4.

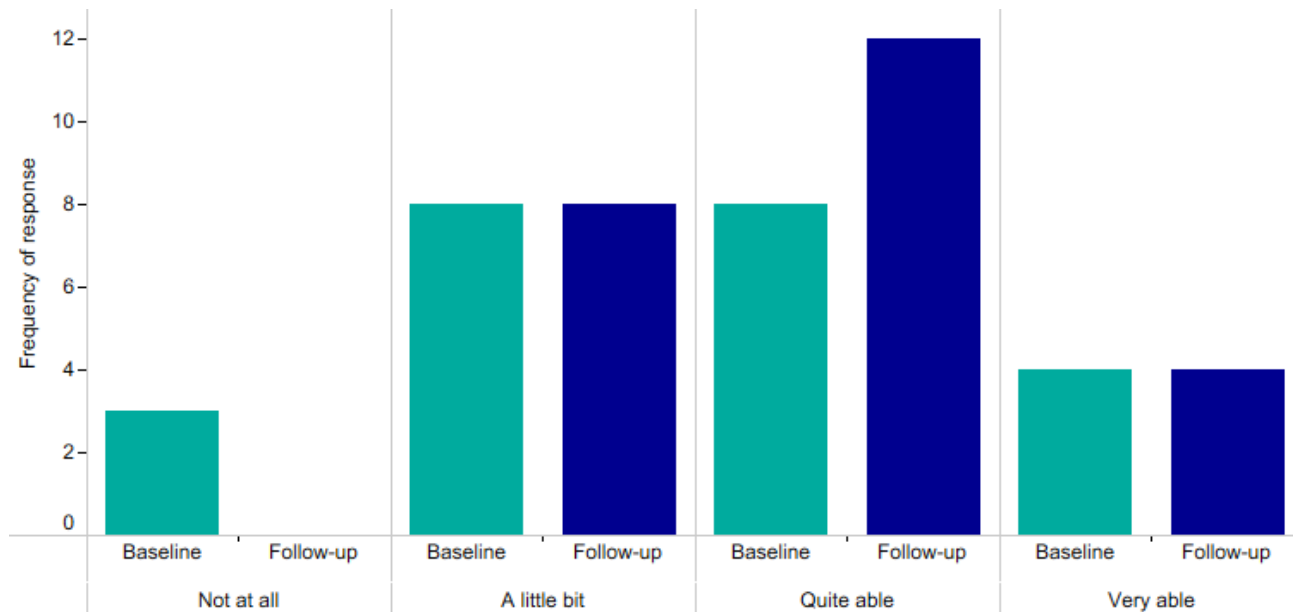


Figure 15: Ability to manage own health and wellbeing at baseline and follow-up.

When combining the two most positive response categories, 12 citizens at baseline reported being either “quite able” or “very able”, compared with 16 citizens at follow-up. This suggests a positive shift in self-efficacy among citizens who completed the measure.

MANAGE YOUR HEALTH AND STAY IN WORK, EVEN WHEN THINGS GET DIFFICULT

Figure 16 shows a positive shift in citizen confidence in managing their health and staying in work when things become difficult. At baseline, responses were concentrated around lower to mid-range scores, with the most common score being 3 out of 10. By follow-up, responses were more evenly distributed across the higher end of the scale, with increased numbers of citizens scoring 7, 8, and 10.

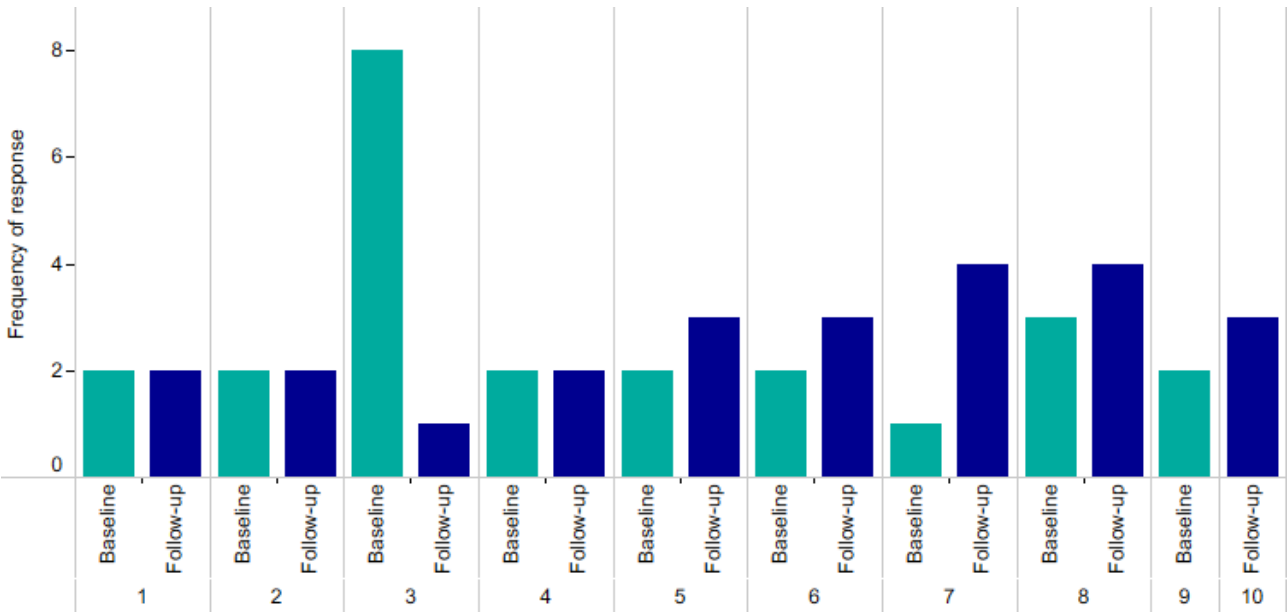


Figure 16: Confidence in managing health and staying in work at baseline and follow-up (1 = Not confident at all; 10 = Completely confident).

The proportion of citizens scoring seven or above increased from 25% at baseline to 46% at follow-up. At the same time, the proportion scoring between 1 and 4 reduced from 58% to 29%. The average confidence score increased from 4.54 at baseline to 5.83 at follow-up, representing an average improvement of 1.29 points on the 10-point scale. Overall, this suggests an improvement in citizen perceived confidence to manage their health and remain in work, although a smaller group continued to report low confidence at follow-up.

Qualitative analysis

Interview findings summary

A summary of the findings from the interviews conducted with WorkWell staff is detailed in Table 8. More findings from qualitative analysis can be found in ‘Appendix E: Qualitative insights’.

Table 8: A summary of the findings identified within the qualitative interviews with WorkWell staff members across the three localities.

Locality	Implementation approach	Key success factors	Key challenges
Crawley	Multi-agency model developed through a task and finish group involving PCNs, DWP, employment services, MSK partners, and wellbeing leads. Initially targeted MSK patients in one PCN before expanding eligibility and referral routes.	- Strong partnerships and local networks broadening eligibility and introducing multiple referral routes improved uptake - Proactive outreach in community settings and Jobcentres - Holistic, person-centred support delivered through longer one-to-one appointments - Strong cross-site learning through steering group participation	- Limited awareness at launch due to restricted promotion - Service was initially difficult to explain to referrers and citizens - Short delivery timeframe - Some gaps in specialist advocacy support - Accessibility limitations of early materials - Managing referral closure and expectations as the pilot ended
East Brighton	Community-based model delivered through the Crew Club, a trusted local community venue. Relational, informal, and citizen-led approach focused on building local capacity and connecting citizens to wider support.	- Trusted and familiar setting reduced barriers to engagement - Flexible, relationship-based support - Strong local knowledge and connections to employers, services, and community opportunities - Moving to an open drop-in model	- Initial uptake was slow - Early delivery location limited visibility and engagement - Capacity pressures emerged as demand increased - Sustainability concerns beyond the funded period - Short delivery timescale limited

Locality	Implementation approach	Key success factors	Key challenges
		improved visibility, uptake, and accessibility • Effective support for people experiencing mental health-related barriers	opportunities to develop the model further and provide more intensive support • Locality-based delivery may not have reached all residents equally
Hastings	Primary care-led model focused on identifying citizens through EMIS searches, repeat fit notes, and occupational therapy-led support. Referral processes evolved into more proactive identification linked to routine primary care contacts.	• Proactive identification methods linked to repeat fit notes improved engagement • Reached individuals who may not otherwise access support • Strong occupational therapy contribution • Continuity of support regardless of referral route • Established links with VCSE organisations, DWP, and other services supported onward referrals	• Low uptake from initial referral approaches • Limited clarity around roles, processes, and data requirements • GP engagement was variable • Identification processes were resource-intensive and difficult to scale • Communication challenges affected both staff and citizen engagement • Limited infrastructure and staffing to sustain delivery long term • Short reporting timelines made it difficult to demonstrate meaningful outcomes

WorkWell set up and implementation over time

CRAWLEY

WorkWell in Crawley was established as a pilot through the Integrated Neighbourhood Team leadership group. A task and finish group was set up, involving partners from PCNs, DWP, employment services, MSK partnership, and workplace wellbeing colleagues. This group collectively shaped the model, which was built iteratively rather than fully designed in advance.

Implementation evolved quickly once delivery began. To manage the scope of the small pilot and avoid overwhelming demand, referrals were initially restricted to individuals with MSK conditions in a single PCN, with a particular focus on one GP practice due to staff expertise. Despite this, uptake was described as slow at this stage, with referrals characterised as a steady but manageable “*slow trickle*”. This approach was soon recognised as too narrow, prompting expansion to include people with a wider range of long-term health conditions, coverage across all PCNs, and the introduction of multiple referral routes. These included self-referrals (which became the most common route, often driven by visibility through posters and GP websites), as well as referrals from GPs, other services, the Department for Work and Pensions, and wider primary care networks. Outreach activity, including attendance at community events, job fairs, Employ Crawley events, and Jobcentre Plus, further supported awareness, although structural barriers meant Jobcentre referrals were not always straightforward. Interviewees emphasised that expanding referral pathways was essential to increasing uptake, while also noting that higher volumes, particularly through self-referrals, could require additional capacity and support.

Following referral, citizens were contacted by the project lead and offered up to six one-hour sessions focusing on work needs, barriers to employment, wider issues such as health, childcare, or benefits, and realistic goal-setting. The emphasis was not solely on returning to work, but on supporting citizens to move towards where they wanted to be, whether that involved training, volunteering, career change, or stabilising other aspects of their lives.

EAST BRIGHTON

WorkWell in East Brighton was implemented through the Crew Club, in close partnership with PCN staff where an Occupational Therapist and Health & Employment focused social prescriber co-located on a weekly basis to the community setting for joint delivery. An initial steering group process explored different delivery options and ultimately selected a community-based model that best reflected local need. Early proposals, including a health hub model for citizens with multiple fit notes, were scaled back due to funding constraints. The Crew Club was chosen because “*the crew club manager presented a compelling argument about ... generational worklessness*” and the value of an existing trusted community space. WorkWell was delivered over six months, with a deliberate focus on building local capacity so that elements of the offer could continue beyond the funded period. The PCN project manager supported this by providing organisational and employment-focused capacity building to the host organisation, helping strengthen local delivery capability.

Delivery was informal, relational, and citizen led. Citizens were initially triaged on site and supported through open conversations about their ambitions, experiences, transferable skills, and

barriers to work, whether physical, mental, or skills based. Action plans were co-produced at a pace that suited the citizen, without pressure to meet fixed timelines. The Health & Employment focused social prescriber supported person-centred action planning, linking citizens with relevant health, skills and employment services, as well as wider support addressing determinants of health. Occupational therapy support was used selectively for individuals with more complex needs, with therapeutic conversations helping citizens identify and manage significant barriers to employment. Funding was used flexibly to support delivery, including equipment such as laptops, room hire, and small incentives, as well as to strengthen links with employers and peer support networks.

Referral routes were primarily community-based, with around two thirds of individuals engaging through the Crew Club itself, including those already attending or known to staff. Informal engagement, such as conversations during activities like lunch clubs, also played an important role, supported by local promotion through social media, posters, and GP advertising. In contrast, relatively few referrals came via health services or social prescribing routes, despite efforts to engage a wider network including physiotherapists, mental health staff, job centres, and voluntary sector groups.

Uptake was initially described as slow, but increased as the programme gained traction, particularly after delivery moved into a more open and accessible setting. This shift, alongside a move away from traditional clinical referral routes towards more community-based, relationship-driven approaches, was seen as key to improving engagement. As demand grew, capacity became a concern, with periods of high demand, including queues at sessions, and a shared view that any further increase in referrals would require additional staffing or protected time.

HASTINGS

WorkWell was introduced in Hastings as part of a tender created by a PCN clinical director and federation chair. However, there were delays to implementing WorkWell due to an unexpected medium-term illness of one of their core project members. Hastings was noted to have a high level of unemployment, so the project's implementation was considered a "*natural development*".

WorkWell was initially implemented through a primary care-led identification and triage model, where citizens were identified through EMIS searches targeting citizens with MSK and mental health conditions, as well as those with repeat fit note issuance. These searches produced large volumes of potential candidates but resulted in low uptake rates, contributing to the modest uptake, which interviewees noted was lower than expected given the wider eligible population.

Over time, multiple referral routes were introduced. This included self-referrals via PCN websites and advertisements on GP practice TV screens, alongside GP referrals encouraged through clinical leadership; however, these approaches also generated limited engagement. The project manager noted that engaging GP practices was limited as this relied on sites recognising the value of the programme. Upon reflection, they noted they should have been clearer with GP practices about the requirements to engage with the programme: "*although many, I think, could see benefits, where the pilot was finding its way, the uncertainty and lack of ease for practices transpired into lower engagement than I would have wanted.*"

Delivery shifted towards more proactive and embedded identification processes. Criteria were broadened to include all working-age adults, and the model evolved into a more targeted approach linked to repeat sick note requests within those with MSK or mental health needs. Care coordinators monitored when repeat fit notes were due and proactively contacted patients, offering referral into WorkWell. This led to improved engagement and an influx of referrals, although activity remained concentrated within a relatively narrow group and largely within a single GP practice. Interviewees noted that while this approach was effective for some, it raised questions about whether individuals with other needs, such as MSK or mental health conditions not captured through this route, were being reached, and highlighted that many potentially eligible individuals may not yet be referred or engaged. The project manager noted that these carefully designed searches could identify likely patients but must be tailored across GP practices due to coding differences and would require sufficient local patient knowledge. The project manager noted that, upon reflection they *“would also have put more resources into developing the operational plan for identifying and engaging patients.”*

Citizens identified through the route selected typically had complex, multiple needs and were all off sick but motivated to remain in, or return to work, making them well suited to occupational therapy input. The project manager noted that they expected patients to be distributed amongst mental health, social prescribing, occupational therapy, and physiotherapy. Despite this, occupational therapy was identified as the area that almost all patients were required to engage with, emphasising the need for this role within WorkWell.

To encourage active participation, telephone triage was introduced to better explain the service, clarify expectations, and confirm suitability. Despite these adaptations, interviewees reported ongoing challenges engaging some citizens, with not all those off sick from work choosing to take up the offer. The project manager highlighted that engagement required multiple mechanisms and a careful strategy, particularly to avoid contact being perceived as threatening in relation to fit notes. Overall, aligning referral processes more closely with routine citizen contact points, such as sick note reviews, was found to be more effective than earlier approaches, although further work may be needed to broaden reach and increase uptake. The project manager also noted that once WorkWell becomes embedded in clinician culture, GPs and other staff members may be able to identify and discuss the programme more routinely. However, this culture takes time to build.

Aspects of delivery that worked well and challenges to delivery

Across the three localities, delivery worked best when WorkWell was embedded in trusted local systems and relationships, with flexible, person-centred support helping staff respond to complex health, employment, and wider social needs. In Crawley, strong partnerships, expanding referral routes, and longer, more private sessions supported engagement, while in East Brighton, a trusted community setting, relational delivery, and strong local knowledge helped lower barriers and connect citizens to wider support. In Hastings, the programme showed value in reaching people who may not otherwise have accessed help, particularly through more proactive referral methods linked to routine primary care contact. However, common challenges included the short delivery timeframe, which limited awareness-raising, relationship-building, continuity, and the opportunity to demonstrate outcomes. Additional barriers included limited pre-launch communication, capacity and sustainability concerns, difficulty explaining the offer clearly, and operational issues such as

data collection requirements, inconsistent internal communication, and the accessibility of materials or locations.

CRAWLEY

In Crawley, strong local networks and existing relationships were a key enabler of delivery, with staff highlighting the value of knowing local communities and professionals and maintaining engagement through conversations and workshops to build partnerships. Despite this, the short delivery window and limited pre-launch promotion made it difficult to raise awareness early on: “*if we hadn’t had [staff member] to ask people to refer, I don’t think we would’ve had anyone referred*”. One manager said they could not advertise before launch because the project was not open to referrals and were asked to delay while other WorkWell sites set up, despite being ready to start. A healthcare professional felt this time could have been used to raise awareness among citizens and staff without implying immediate access to support. Earlier communication and clearer guidance may have supported stronger initial engagement.

Staffing and capacity were generally seen as sufficient to support consistent delivery, and participation in the WorkWell steering group enabled useful cross-site learning that informed local improvements, including to referral routes. At the same time, embedding the service within existing systems required considerable effort through meetings, training, and internal communications to build understanding and confidence among referral partners.

Expanding referral pathways, including GP referrals, self-referrals, and engagement with job centres, improved reach. This engagement was further strengthened through in-person presence, with staff attending and sitting within job centres to support identification and referral, helping to navigate data sharing barriers. Strong collaboration within the project team, alongside relevant expertise and flexibility, also helped bring services together effectively. Nonetheless, the model could be difficult to explain to both referrers and citizens because of its flexible, personalised nature, so clearer communication had to develop over time.

The delivery model itself was seen to work well: experience in social prescribing supported staff to address complex, holistic needs, and longer, more private sessions helped build trust and open discussion about barriers to employment. Interviewees suggested that the additional time and privacy enabled conversations that participants might have been reluctant to have elsewhere, particularly where there were anxieties about benefits of DWP involvement. This approach was noted to reduce pressure on citizens and created space for open conversations that might not occur in more time-limited or compliance-driven settings. Despite this, there were limits to the scope of support available. Although WorkWell was presented as offering advocacy for people in work, staff did not always have the knowledge to provide this in complex cases. This sometimes resulted in onward referral to services such as Citizens Advice, which could delay access to timely support. Public-facing materials were also initially only available in English, which may have reduced accessibility for some groups.

“When you’re in a private meeting room ... once they’d kind of sussed out what it was all about, they opened up a lot more and people shared things that were really important to them and were massive barriers to employment that they probably wouldn’t share with their work coach”

- Project manager interviewee, Crawley

Finally, the short timeframe created ongoing operational pressures, including the need to close referrals early so enrolled citizens could complete the programme and challenges in managing expectations as the service ended. This reinforced the importance of clear communication about timelines to both referrers and citizens to avoid frustration and protect the reputation of the service.

EAST BRIGHTON

In East Brighton, delivery worked best when the programme was based in a trusted community setting where people already felt comfortable, helping to lower barriers to engagement and build relationships naturally over time. Interviewees described the Crew Club as a safe, warm and familiar environment where people were already attending for other reasons, in contrast to more formal settings such as the health hub, where conversations about health and work were seen as less likely to occur. Despite this, visibility mattered: early delivery in a smaller, more private room limited awareness and uptake. While intended to offer confidentiality, this space was sometimes perceived as intimidating, particularly when only a few people were present, and the need to enter a separate room could act as a barrier, especially for those experiencing mental health challenges. Moving into a more accessible hall shifted delivery towards an open drop-in format, improving engagement and uptake. Despite this, being based in one part of the community could still limit reach, particularly for residents less likely to attend local venues or leave home: *“people at the top end of Whitehawk don’t tend to travel to the middle or bottom end of Whitehawk and the same with the bottom end”*.

Another strength was staff’s strong understanding of local support and their ability to connect people to employers, services, and opportunities. For example, they signposted to organisations such as the WEA, provided support with PIP-related advice via St Luke’s Advice, and used laptops to help develop CVs and identify free courses. They also identified opportunities for younger people through routes raised in conversation. This work drew on existing relationships and helped build networks that could continue beyond the formal WorkWell period. At the same time, this depended on significant effort, wider professional support, and limited resources such as funding, raising questions about capacity and sustainability once the programme ended.

More broadly, the model benefited from being flexible, relational, and citizen-led within a trusted community environment, allowing support to be tailored to individual needs and strengthening links between employment, health, and local support networks. This approach was particularly important for people experiencing mental health-related barriers, who could be reluctant to engage in more formal settings. Despite this, the short delivery period limited how far this approach could be developed and reduced opportunities to provide more intensive practical support, such as on-site help using laptops so citizens could complete longer courses.

Operationally, continuity and routine were also important, particularly for people who benefited from regular structure, meaning breaks in delivery such as half term could reduce attendance. The limited timeframe also created challenges in managing expectations as the programme neared its end, reinforcing the importance of building lasting knowledge, networks, and connections so that support could continue in some form beyond the funded period, instead of becoming another

programme that provides support for vulnerable people for an allotted period of time and then ends.

HASTINGS

In Hastings, delivery was supported by the programme's ability to reach individuals who may not otherwise have accessed support, while maintaining continuity with existing approaches regardless of referral route. Engagement was strongest among older participants, and letters appeared more effective than telephone contact. Existing relationships with VCSE organisations, DWP and other providers also supported onward connection where citizens needed wider support. Once citizens were identified and engaged in the pathway, the clinical team was felt to work well with them, although the project manager noted it remained unclear whether this translated into employment outcomes.

Local context influenced delivery. The absence of a central community hub and the dispersed nature of smaller community hubs in Hastings made it harder for the programme to establish a visible presence and for individuals to navigate support, although promotion through one GP practice helped increase awareness to some extent.

WorkWell was noted by both interviewees to be introduced with limited clarity for frontline staff, with the project manager noting there was confusion over which parts of the project frontline staff had full control over and which parts were mandatory. They received an email with an '*information pack*', however were unclear on what they had to do with the documents. They attended a meeting about WorkWell for half a day, where limited reference was made to the pack that was provided, the data the site had to gather, and what staff should be asking citizens.

Interviewees questioned whether managers understood the intention and requirements to deliver WorkWell appropriately. One healthcare professional instigated two meetings to align their collective understanding of WorkWell. Following the first meeting, they considered themselves to be aligned on expectations, however the agreed plan changed. When asked how much communication the healthcare professional had with their manager, they noted that originally, they did not have daily communications due to their manager's capacity, however, now have more regular meetings as they have both recognised issues with delivering WorkWell. The project manager reflected that the desire to remain flexible may have contributed to a lack of clarity for individuals working within the system, and that roles and responsibilities would need clearer resourcing in any future WorkWell model.

Clinical coding searches were resource-intensive, as coding varied across GP practices and required experienced care coordinators and local patient knowledge to distinguish suitable referrals from misleading records. If scaled, the project manager felt additional care coordinator and administrative resource would be needed to guide citizens through the pathway, as current clinical staff could not sustain the administrative workload long term. The pilot was manageable because existing clinicians' time was repurposed, but this was not viewed as sustainable at a larger scale. Overall, the project manager felt the main area for development was how to identify and engage the right group of citizens within primary care.

One interviewee noted that the name “*WorkWell*” did not always translate clearly in practice. They therefore modified materials and descriptions into more user-friendly formats, removing the name of the programme, in an effort to improve understanding and engagement. This was particularly important where contact related to fit notes, as engagement needed to feel supportive rather than threatening or linked to removal of certification. Due to communication errors, another staff member adjusted the letter to include mention of WorkWell and further detail around the programme. Following this, a WhatsApp group was created to aid communication.

Interviewees raised the importance of including those who are implementing WorkWell on the ground in initial project set up. One staff member noted that funding was held back as the correct data had not been collected. They noted that they were told “*months down the line there’s all these other questions we should’ve asked, but no one told us earlier*”. The questions that the occupational therapist had to ask citizens were mental health related, which was suggested to be difficult to ask citizens early on. Asking other questions, such as education level, could also impact citizen engagement with WorkWell due to the sensitive nature. To mitigate this, a questionnaire was developed to collect the same data in a more approachable format.

Issues with the data capture sheet were noted by both healthcare professional interviewees. For example, there were limitations in the drop-down and selection functionality; the dropdown only went to 11 rows, so they could not add any more citizens to the list after this. The wording of disabilities was noted to be inappropriate; conditions had been inappropriately combined into one category. There was also no option for citizens to not answer the question.

Meaningful change for citizens often took longer than reporting timeframes allowed, particularly where appointments were spaced several weeks apart (every three to four weeks). One healthcare professional noted that eight weeks was too soon to see a change in citizen outcomes. Further, one healthcare professional noted that employers would repeatedly ask questions to stall acceptance of adjustments, delaying the process for citizens further.

“Many of the learning points ... have been things which did not work, but ... these are ... valuable... in helping us design a map for the future”

- Project manager interviewee, Hastings

Impact of WorkWell on citizens

Across localities, a key area of impact was enabling individuals to begin or continue a journey towards employment, including by building the confidence and readiness needed to take earlier steps towards work, training, volunteering, or wider participation. In Crawley, this included tangible outcomes such as moving into work, completing training, or engaging in volunteering, with interviewees highlighting improvements in skills and confidence, particularly through structured opportunities like IT courses. In East Brighton, interviewees emphasised that progress was not always immediately reflected in employment outcomes, but could be seen in citizens leaving the

house, attending community activities, engaging with support, and building confidence to consider courses or other next steps.

A shared theme was the value of tailored, individualised support. In both areas, interviewees noted that the programme allowed citizens to access opportunities and support that may not otherwise have been available, whether through formal pathways such as training or more informal relationship-led engagement. This included helping individuals identify next steps, build confidence, and better understand their own goals. In East Brighton, this was particularly important for citizens experiencing mental health-related barriers to leaving home or engaging with services. Interviewees described WorkWell as helping people start a journey by supporting them to attend community settings, continue attending groups such as lunch clubs, and build the confidence to access nearby learning opportunities. One interviewee noted they were just “*scratching the surface*” with their engagement, suggesting benefits may develop further over time.

Factors influencing how citizens engage with WorkWell

Engagement was influenced by a range of personal, social, and contextual factors across both Crawley and East Brighton, with several common themes emerging alongside some locality-specific insights.

Interviewees highlighted the impact of individuals’ wider life circumstances on engagement. In Crawley, an employability and healthcare professional noted that some individuals disengaged at different stages, often due to having competing priorities or complex personal situations that took precedence. Similarly, in East Brighton, interviewees reported that personal pressures could affect continued participation, with some individuals discontinuing involvement due to having “*a lot going on*.”

Mental health and emotional readiness were also important influences, particularly in East Brighton, where one employability and healthcare professional noted that some individuals found it difficult to engage in conversations about work and health, leading in some cases to disengagement or the need for alternative approaches such as telephone appointments. Concerns around stigma and anxiety about engaging with employment support, including fears about the potential impact on benefits, also affected engagement, requiring staff to build trust and clearly communicate the supportive nature of the programme.

Across both sites, variation in motivation and willingness to engage was evident. In Crawley, some individuals did not attend initial appointments or stopped responding without explanation, suggesting that not all referrals translated into active engagement. Despite this, in East Brighton, one employability and healthcare professional noted that most individuals who attended did engage well once initial barriers were overcome, “*giving it a good go*.”

Finally, there was some evidence from Crawley that when individuals did engage, this could lead to positive outcomes, including improvements in wellbeing, although interviewees noted that capturing these changes depended on the timing of follow-up measures.

Recommendations for successful implementation

CRAWLEY

Recommendations included:

- Engage with communities early and proactively by going into community settings such as libraries, job centres, and places of worship to raise awareness of WorkWell and build trust.
- Ensure the referral process is clear and accessible to ensure citizens understand the WorkWell offering, including raising awareness early. Providing case studies or examples was recommended by interviewees in Crawley to improve understanding and support informed decision-making.
- Include a broad eligibility criteria and multiple referral routes from the outset to maximise reach and avoid restricting access through narrow initial targeting.
- Build strong local partnerships (including across primary care, employment support, and the DWP) and understand what each organisation can offer to support coordinated delivery and shared learning.
- Use of a holistic approach to ensure support is tailored to each individual's needs. This includes focusing on citizens moving closer to employment (focusing on needs such as housing, childcare, finances, and fit notes), rather than into employment.
- Use of a multi-skilled team, consisting of work coaching and social prescribing skills, to ensure staff are adequately equipped to work with citizens with complex needs. In particular, skills to allow staff to directly advocate for citizens with employers, as this was a gap in delivery for Crawley.
- Participation and establishing learning networks across sites enabled shared learning and continuous improvement.

EAST BRIGHTON

Recommendations included:

- Take a person-centred approach, where conversations are not driven solely by employment outcomes, but where individuals are, their life circumstances, and what support they need. Active listening was seen as crucial to this process, alongside creating a safe space for individuals to explore their thoughts and feelings.
- Build flexibility into delivery, including remote or phone-based options, to engage people who may not be ready or able to attend in person.
- Include a consistent presence of WorkWell within familiar, trusted community environments to build trust and visibility so support reaches people where they already are, rather than expecting them to seek it out.

- Further ensuring WorkWell staff are seen as approachable and consistent, so individuals recognise staff and feel comfortable initiating conversations.
- Raising awareness of WorkWell early was important to build recognition and uptake over time. Branding and messaging should be carefully considered.
- Use of a multi-skilled team was highlighted, including occupational therapy staff, employability support, and community knowledge, to contribute towards a more holistic understanding of citizen needs. This team must be motivated to support the local community.
- Understanding the local community and its barriers, such as groups who may be less likely to engage, was seen as essential. This allowed outreach approaches to be developed accordingly, such as through phone-based support or more proactive engagement models.
- Interviewees noted that future models should consider additional support for younger people, particularly those not in education or employment, to prevent longer-term disengagement. Younger citizens approached WorkWell, however were unable to receive help from the programme due to their age so were referred elsewhere.

HASTINGS

Recommendations included:

- Prioritise building a very clear plan and pathway first, ensuring all necessary organisations are engaged with the plan. This would ensure all staff involved in delivery share a clear and consistent understanding of the programme's purpose, processes, and expectations from the outset. This includes GP practice staff who may refer staff to WorkWell; these individuals must be able to understand and remember WorkWell to discuss referral with eligible patients.
- Promoting WorkWell through accessible channels such as GP surgery screens was seen as a practical way to increase awareness. Despite this, more targeted and personalised approaches to communication, rather than reliance on standard messaging systems, were encouraged to improve engagement.
- Ensure that the correct infrastructure is in place in terms of staff resourcing. A care coordinator was noted to be a crucial aspect of successful delivery.
- Engagement approaches should prioritise reassurance and clarity of WorkWell's purpose. Citizens should be informed that WorkWell is there to support them, rather than monitor or impact their benefits. Using plain language, avoiding jargon, and taking time to listen were seen as essential for building trust and encouraging participation. The name of the programme itself was considered less important than how it is described in practice.
- Make communication simple, clear, and user-friendly for citizens and staff. For example, data collection should be presented in a questionnaire format that could be completed

alongside having a conversation with a citizen, making it easier to engage individuals. Internal communication with staff should be streamlined, with clear guidance on requirements, avoiding multiple emails or complex documentation.

- Listen to and validate individuals' experiences, particularly for conditions such as chronic pain, fatigue, or fibromyalgia that may be poorly understood or not visibly apparent.
- Use multidisciplinary support, including occupational therapy, to help individuals communicate their needs, request reasonable adjustments, and feel less isolated in navigating workplace challenges.
- WorkWell staff should be transparent about the scope and timeframe of the service to citizens. Clearly communicating the duration of support helps manage expectations and avoids disengagement if the programme ends unexpectedly from the participant's perspective.
- Gathering regular feedback from participants, for example through follow-up conversations or patient involvement groups, was recommended to help refine delivery and ensure the service meets local needs.

Case studies

Seven WorkWell Sussex case studies are presented on the following pages.

WorkWell Crawley case study: Citizen A

Background

Citizen A had been unemployed for 14 years following a workplace accident and other complex health conditions. They were experiencing ongoing health challenges and lacked the confidence to re-enter the workforce after such a prolonged period of unemployment.

Onboarding and engagement

The Department for Work and Pensions offered the individual an opportunity to meet with a WorkWell Coach to explore alternative approaches to job searching and options for upskilling. A WorkWell coach met with Citizen A on three occasions to understand their needs and provide support with applying for courses and volunteering opportunities. Citizen A had previously been referred to courses they felt were unsuitable; however, the coach took time to listen and ensured that recommendations were aligned with their goal of securing employment in administration. This personalised approach had a positive impact on motivation and overall outcomes. Citizen A's health condition meant there were extended periods before they were able to complete tasks, enrol on courses, or attend sessions. Given that WorkWell supports individuals with health-related needs, it is important to recognise that a longer period of support may be required before measurable improvements in wellbeing are observed.

Outcomes and reflections

Citizen A reported feeling more informed about their options and the range of courses available to them as a Universal Credit claimant. As a result, they enrolled on a course offering tutor support and access to a local centre to complete their modules. Increased confidence in their abilities also encouraged them to take up volunteering opportunities. Citizen A felt that WorkWell provided more in-depth and personalised support than the Jobcentre, with course recommendations that aligned more closely with their future goals. This support also encouraged them to step outside their comfort zone and move closer to re-entering the workplace.

WorkWell Crawley case study: Citizen B

Background

Citizen B was a single mother experiencing back pain and low mood, while also adjusting to the pressures of recently moving into temporary accommodation after losing her private rental. She was working 15 hours per week due to her health and wider circumstances, but wanted to increase her hours. Despite this, a lack of childcare support and the wider instability of her situation left her feeling overwhelmed.

Onboarding and engagement

Citizen B was onboarded to WorkWell Sussex to receive support with finding work that better suited her health needs and personal circumstances. She was also looking for wider practical support to help manage the pressures she was experiencing around housing, childcare and wellbeing. Citizen B was supported through four one-to-one appointments, where the focus was first on her immediate needs around housing, childcare, health and wellbeing before exploring employment changes. She received guidance on local support options and was referred to Employ Crawley for more in-depth employment support. Despite this, some support could not be accessed immediately, including school transport and childcare-related financial support, which delayed her ability to increase her working hours.

Outcomes and reflections

Following engagement with WorkWell Sussex, Citizen B felt listened to and supported, which helped reduce some of the pressure she was experiencing and allowed her to think more clearly about her options. Although immediate changes were limited, she was able to develop a plan around working hours and childcare that could support greater financial stability over time. Reflecting on her engagement with WorkWell Sussex, Citizen B felt more positive about the options available to her, even though not all issues had been resolved. She felt better able to manage the challenges she was facing and reassured that support was available as changes progressed over time.

WorkWell Crawley case study: Citizen C

Background

Citizen C had been signed off work due to an injury and additional health concerns, including a back condition and a recent diagnosis of fibromyalgia. At the time, Citizen C was awaiting medical appointments and physiotherapy. She also had ADHD and was working to manage her diagnosis and mental health alongside challenges within her current workplace. Citizen C found it challenging to communicate with their employer following a change in management and felt that her employment situation was adding further pressure to her health.

Onboarding

Citizen C was experiencing challenges with their employer and wanted to better understand their employment rights. They were also seeking a role more suitable for their health needs, potentially exploring self-employment.

Engagement

The WorkWell coach met with Citizen C on six occasions and maintained contact via email between appointments. The coach took an approach tailored to Citizen C's preferences, allowing time to work through each area of support. This pacing and approach had a positive impact on Citizen C's proactivity, as support was addressed in manageable stages, helping to avoid feelings of being overwhelmed.

Outcomes

Citizen C received support from Citizens Advice regarding HR matters and employment rights, which increased their confidence in managing their employment situation and future options. They also received guidance on their benefit entitlements and how these may change if they pursue self-employment.

Citizen C's confidence further improved following enrolment in a wellbeing course with a local charity supporting women to build confidence. They also enrolled in a business start-up course to begin exploring self-employment, which they felt aligned with their future goals. In addition, Citizen C developed a better understanding of their fibromyalgia diagnosis by joining a peer support group and benefitted from connecting with others in similar circumstances.

Citizen C found it challenging to communicate with their employer. Although advocacy support had been advertised as part of WorkWell, the limited availability of this support meant that external, over-the-phone assistance was required.

"I would highly recommend WorkWell... I am truly grateful for the coach's support; she has made a lasting difference in helping me move forward with confidence."

Reflections

Citizen C reported being connected to local services they had not previously been aware of, with the WorkWell coach making referrals on their behalf and acting as a bridge between them and other support systems. Following the first session, Citizen C felt reassured and confident that the support would be beneficial. The programme helped them move from a position of fear and uncertainty about the future to feeling more confident in their next steps.

WorkWell East Brighton case study: Citizen D

Background

Citizen D experienced significant mental health challenges, including work-related stress and potential undiagnosed neurodiversity, which affected daily life through fluctuating energy levels, poor concentration, and headaches that limited sustained computer-based work. They had been signed off work for five months and subsequently resigned from a care agency role following a workplace dispute and loss of trust in their employer. During this period, Citizen D was unemployed and facing financial difficulties, alongside declining confidence and worsening mental health. Personal factors, including experiences of childhood trauma and strained family relationships, further influenced their wellbeing and ability to re-engage with employment.

Onboarding

The citizen was referred to WorkWell by their GP surgery's Social Prescribing Team and was able to engage through a familiar community setting, reducing anxiety around participation. At the point of referral, their main barrier was difficulty accessing suitable employment, particularly roles involving prolonged computer use, despite their high level of qualification.

Engagement

The citizen received a combination of peer support, social prescribing, and practical work-based experience through WorkWell. This included an initial work trial in a community kitchen, which helped refine their employment goals, alongside referrals to talking therapies, an ADHD service, and wider support for skills, confidence, and wellbeing. Support was delivered through a mix of in-person sessions and flexible remote contact (telephone and email), with regular appointments providing structure and continuity. Therapeutic conversations and a consistent support routine were particularly effective in building confidence, identifying barriers, and developing a clear action plan, while financial pressures and competing commitments occasionally limited attendance, requiring adaptation to maintain engagement.

Outcomes

The citizen successfully secured an initial role in a local café but found the level of responsibility overwhelming, leading them to leave the position; however, ongoing in-work support from WorkWell enabled them to re-engage and refine their employment goals. This support contributed to them securing a second role with a larger organisation, where they remained in employment six weeks later.

**“It’s nice to know about services out there
that can help me... I feel more hopeful for the
future”**

Reflections

The citizen reflected positively on their experience of WorkWell, highlighting the importance of having consistent support and a trusted space to discuss their challenges. They particularly valued the combination of emotional support and practical guidance with job searching, as well as increased awareness of available services, which gave them a greater sense of choice and hope for the future.

WorkWell East Brighton case study: Citizen E

Background

Citizen E was managing multiple long-term conditions, including Generalised Anxiety Disorder, depression, ADHD, and fibromyalgia, which significantly impacted daily life. She described experiencing persistent self-critical thoughts and a sense of being “stuck,” which affected her confidence and overall wellbeing. Due to these health challenges, alongside caring for her daughter, she had not been in employment for several years. Her home environment was described as “chaotic” at times, with difficulties maintaining routines such as getting her child to school, further impacting daily functioning.

Onboarding

The citizen engaged with WorkWell through the Crew Club, where they had previously participated in other activities, and chose to take part after learning about the programme through staff. They engaged with WorkWell as they were motivated to build a positive routine, manage their anxiety more effectively, and develop the confidence and skills needed to support a return to employment.

Engagement

Citizen E received holistic, person-centred support through WorkWell, beginning with an initial assessment delivered by a familiar staff member. They were supported to identify transferable skills, explore their goals, and address barriers, which informed a personalised Journey to Work Plan with structured weekly actions across employment, health, and daily life. Support included guidance on accessing education, volunteering, and CV development, alongside referrals and activities to improve physical and mental health. Delivery was primarily through regular, informal drop-in sessions, which helped establish a manageable routine and sustained engagement. The familiar, non-judgemental environment and consistent support were particularly effective in building confidence, although anxiety in busy settings and a need for more intensive support at times limited outcomes.

Outcomes

As a result of WorkWell, the citizen experienced notable improvements including reduced anxiety, improved mood, and increased confidence, supported by a medication review and structured self-management strategies. They developed greater independence and control in daily life, including establishing routines, attending peer support groups, and improving organisation. Confidence and self-efficacy increased over time, enabling them to engage more actively with services and community activities, such as attending Connect to Work sessions and travelling independently.

“It was really helpful to be shown options of what my future could be... just because I can’t do a full week’s work doesn’t mean I can’t find work that will fit my current needs”

Reflections

Citizen E noted that identifying and valuing transferable skills gained through life experience, alongside breaking down future goals into achievable steps, was the most impactful element in improving their confidence and helping them see employment as a realistic and attainable outcome.

WorkWell East Brighton case study: Citizen F

Background

Citizen F was a young man living independently and volunteering at a local community centre. He viewed himself as managing a disability rather than a specific health condition and was registered on the learning disability register, alongside managing ADHD and autism. These experiences affected his confidence and, at times, contributed to feelings of loneliness, isolation and low mood.

Onboarding

Citizen F first heard about WorkWell Sussex through attending the Crew Club lunch club. At the point of onboarding, he was interested in exploring future employment opportunities and wanted practical support with accessing an ID card, understanding employment and benefits, and building the confidence and skills needed to progress from volunteering into wider opportunities in the city.

Engagement

Citizen F found WorkWell Sussex accessible because it was delivered from a local community centre that he already attended regularly. This helped him feel more comfortable and confident from the outset, particularly as he had previously found similar services difficult, formal or unsafe. He was offered regular weekly meetings with a Health and Employment-focused Social Prescriber, where he explored his interest in catering and his ambition to work in a café or restaurant in Brighton city centre. Together, they developed a step-by-step action plan, including applying for an ID card, registering with a local adult education college for courses in confidence and communication, IT and cookery, and exploring apprenticeship options.

Through this support, a two-year apprenticeship in a city café was identified and discussed as a potential next step. Citizen F felt the most helpful aspect of the support was being able to explore different options with advice and guidance, although he would have benefited from more practical support between sessions, such as help making initial contact with mainstream services or attending the Adult Education Centre for the first time.

Outcomes

Through WorkWell Sussex, Citizen F was supported to recognise his transferable skills and see that he had more experience to offer than he initially thought. This helped build his confidence, which had been a key barrier to progressing towards employment. With time to explore his options and support to prepare for next steps, he felt able to apply for a paid role that became available at the community centre and was successful in securing the position.

“The regular weekly contact gave me confidence and hope that I haven’t been written off, I felt like I had a chance”

Reflections

Reflecting on his experience, Citizen F described feeling less isolated and more confident to become involved in everyday life. He valued being able to speak freely in sessions and felt the questions were clear and easy to understand, unlike some previous experiences with services. Knowing the people delivering WorkWell Sussex through the lunch club also helped him feel comfortable and supported throughout his engagement.

WorkWell Hastings case study: Citizen G

Background

Citizen G was off sick from their full-time role at a company that provides car parts to local repairers, following respiratory failure which resulted in hospitalisation and a significant period of rehabilitation. They also had Guillain-Barré syndrome, an acute ST segment elevation myocardial infarction, and bursitis of the ankle and foot. These conditions had a substantial impact on daily life, including washing and dressing, going to the gym, and being able to work. Citizen G was particularly concerned about whether they would be able to manage the physical demands of their role, including heavy lifting and repeatedly using a staircase, and was also worried about the impact their absence was having on colleagues.

Onboarding

Citizen G was referred to WorkWell because they were keen to return to work but were unsure how they would manage this safely and sustainably. At the point of referral, their main barriers were uncertainty about their physical capacity, concern about returning too quickly, and needing support to communicate their needs clearly with their employer.

Engagement

Citizen G worked with an Occupational Therapist from Hastings and St Leonards Primary Care Network, who supported them to explore their concerns about returning to work and the practical adjustments that might be needed. The support focused on understanding the impact of their health conditions, identifying suitable options for a phased return, and considering whether returning full time or part time would be most appropriate. The Occupational Therapist also provided an Allied Health Professionals Health and Work Report, which helped Citizen G explain their needs to their employer. This combination of occupational therapy advice, return-to-work planning, and support with employer communication was particularly important in helping Citizen G take a more considered approach to their recovery and employment.

Citizen G's main challenge was recognising the importance of taking time to build up activity gradually, both at home and in relation to returning to work. They initially struggled to see the long-term benefit of pacing and of having an appropriate phased return that included suitable timing and lighter duties. This was particularly important because they were motivated to return to work quickly and were conscious of the pressure their absence might place on colleagues. Through WorkWell support, Citizen G was encouraged to take a more balanced view of recovery and to consider how a rushed return could increase the risk of further absence. The phased return and discussion of part-time working helped address these barriers by creating a more manageable and sustainable route back into employment.

Outcomes

As a result of WorkWell Hastings, Citizen G was supported to return to work on a phased basis, initially working half days. They were able to be open and honest with their employer, who was supportive, and the AHP Health and Work Report helped communicate what adjustments were needed. The support enabled Citizen G to understand the importance of pacing their recovery and avoiding a return that could have negatively affected their physical or mental wellbeing. Citizen G also considered the benefits of returning on a part-time basis, which was an option they had not previously thought about but felt could support their longer-term health and wellbeing. Although their employer could not accommodate the initial request not to work on Fridays, both parties reached an amicable and achievable compromise.

Reflections

Overall, WorkWell helped Citizen G feel more supported and better prepared to return to work in a way that protected their health and wellbeing. The most valuable element was the practical occupational therapy support, including the AHP Health and Work Report, which helped them communicate effectively with their employer and agree a realistic phased return.

High-level health economic modelling

Scenario 1: Estimated benefits of WorkWell Sussex

Table 9 displays the health economic results for Scenario 1, estimating the potential benefits derived by combining the known number of citizens onboarded to WorkWell Sussex, their employment status on onboarding, their self-reported outcome measures, and published literature from reputable sources estimating employment outcomes and QALY gains. The social return within the first year of the pilot estimates a positive return, culminating in an NPV of £105k returned to the wider society.

Table 9: Estimated economic return for WorkWell Sussex. Please note that figures were rounded to the nearest £1k and therefore may not sum correctly.

Estimated WorkWell Sussex return (£, net present value in 2025 figures)		Year 1
Benefits		
<i>Increase in gross value added</i>		£110k
<i>Increase in QALYs</i>		£36k
Total benefits		£146k
Costs		
<i>Site funding</i>		£41k
Total costs		£41k
Net present value		
Total NPV		£105k (£53k to £201k)
BCR		3.54

Monte Carlo sensitivity analysis was conducted on this scenario to estimate the potential range in which the net return of WorkWell Sussex may lie. Figure 17 demonstrates the 90% confidence intervals and mean benefit-cost ratio following the simulation. The mean benefit-cost ratio for the simulation was reported to be 3.65, marginally higher than the base case (3.54), due to prudent reporting of QALY gains using the lower estimate of the QALY range in the base case. A BCR of 3.54 means that for every £1 invested, an estimated £3.54 is returned to wider society.

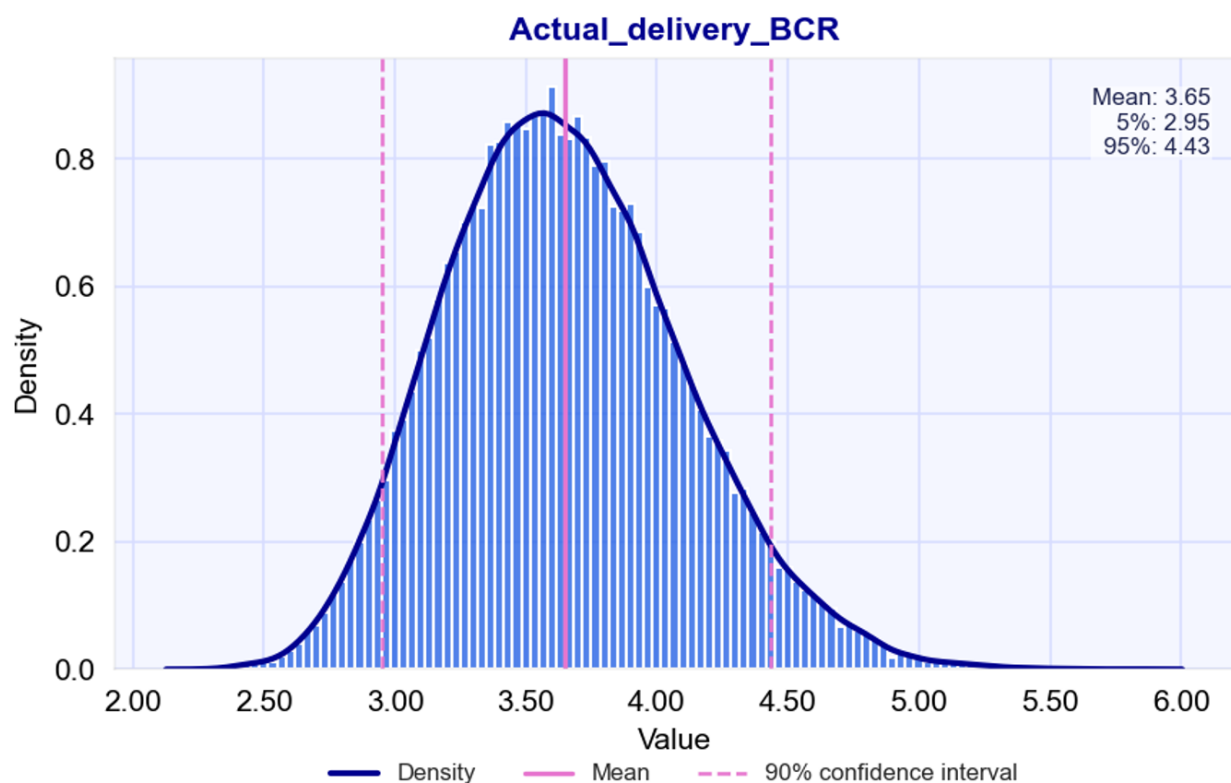


Figure 17: Estimated benefit-cost ratio following Monte Carlo sensitivity analysis. At a 90% confidence interval, the estimated return may be between £2.95 and £4.43 for every £1 invested.

Discussion

Process and implementation

How was WorkWell implemented and delivered across local areas? What factors influenced the delivery, engagement, and effectiveness of the programme?

LOCAL ADAPTATION SHAPED IMPLEMENTATION AND REACH

WorkWell was implemented differently across the three localities, reflecting local needs, existing infrastructure, and available partnerships rather than a single standardised model. This flexibility enabled each site to tailor referral pathways, workforce models and delivery settings to its local

context, which appeared important for implementation and engagement. East Brighton delivered WorkWell through the community-based Crew Club model and generated the highest number of referrals, accounting for 22 referrals, or 46% of all referrals. In contrast, Hastings adopted a primary care-led approach linked to repeat fit note reviews and occupational therapy support, generating the lowest number of referrals, with nine referrals, or 19% of the total. Crawley initially implemented a PCN and MSK-focused model, which subsequently expanded across all PCNs and to wider long-term conditions, generating 17 referrals, equivalent to 35% of all referrals. These differences suggest that local adaptation supported relevance and responsiveness, but also that local infrastructure, partnership maturity, and referral route design influenced reach and effectiveness. Future WorkWell programmes may benefit from retaining a clear core model while allowing sufficient flexibility for local tailoring.

All three sites adapted their delivery models in response to lower-than-expected initial uptake, suggesting that flexibility and iterative learning were important to implementation, engagement, and effectiveness. Crawley broadened eligibility beyond MSK conditions and a single PCN, East Brighton moved delivery into a more open and accessible community setting, and Hastings shifted from EMIS searches and self-referral to proactive identification of individuals receiving repeat fit notes. Interviewees consistently reported that engagement improved following these changes, indicating that sites quickly learned which referral approaches were most effective for their local populations and adjusted delivery accordingly. Future WorkWell programmes should therefore build in opportunities for ongoing adaptation, learning, and quality improvement, so delivery can respond to emerging evidence about what works in each local context.

Local population demographics and context influenced how WorkWell was implemented and which groups the programme reached across each locality. East Brighton accounted for all referrals from IMD categories 1 and 2, likely reflecting the higher levels of deprivation within the local area, and also generated a greater number of younger referrals, particularly among those aged 25 to 29 years. In contrast, Hastings generated more referrals among citizens aged 55 to 59 years, suggesting that differences in population profile, existing infrastructure, delivery setting, and referral routes shaped access to the programme. These findings indicate that delivery models alone did not determine reach; rather, engagement was also influenced by how well each model aligned with the characteristics and needs of the local population. Local demographic and deprivation profiles should be considered when designing delivery models, ensuring referral routes, outreach approaches, and engagement strategies are tailored to the communities they aim to reach.

A key learning from WorkWell Sussex is that “place” was not simply the geographical location of delivery, but a determinant of how the model needed to work. Each neighbourhood had different patterns of need, different community assets, different levels of trust in statutory services, and different referral infrastructures. East Brighton’s community-led model was effective in reaching citizens from deprived communities through a trusted local venue, while Hastings’ primary care-led approach showed the potential value of identifying people at risk of long-term absence through repeat fit notes. Crawley demonstrated the value of multi-agency partnership working and broader referral routes. This suggests that strategic commissioning should define the core purpose, outcomes, and minimum service components of future WorkWell or health and employment support, while allowing each neighbourhood to select the delivery route most suited to its local population and assets.

PARTNERSHIP AND REFERRAL INFRASTRUCTURES SHAPED DELIVERY AND ENGAGEMENT

Strong local partnerships and existing networks were critical enablers of WorkWell implementation, shaping how effectively sites established referral routes, engaged citizens, and embedded delivery within local systems. Crawley benefited from a multi-agency task and finish group involving PCNs, DWP, employment services, and MSK partners, East Brighton built delivery around an existing trusted community organisation yet developed a broad network of relationships with employment support groups within the area, whilst Hastings relied heavily on GP practices and care coordinators to identify eligible participants. These examples suggest that existing relationships reduced the implementation burden, supported referral generation, and helped sites adapt delivery in response to local learning.

Trusted community and healthcare relationships were important drivers of citizen engagement, suggesting that WorkWell was more effective when delivered through familiar settings and credible local contacts. In East Brighton, most referrals were generated through trusted community networks and the Crew Club, which also produced the largest referral cohort overall, with 22 referrals, and accounted for all Core20 referrals, with all citizens recorded in IMD 1 and 2 referred through this site. In Hastings, engagement improved when referrals became linked to routine fit note reviews, indicating that trusted healthcare touchpoints could also support participation when community-based infrastructure was less established. These findings suggest that trust, accessibility, and local credibility reduced barriers to engagement and helped WorkWell reach groups that may not have accessed traditional employment services.

MULTIDISCIPLINARY WORKING AND INTEGRATION WERE CORE ENABLERS OF DELIVERY

WorkWell was most effective when it operated as an integrated, multidisciplinary offer rather than as a standalone employment service. Citizens often presented with overlapping barriers, including health conditions, low confidence, financial pressures, caring responsibilities, benefits concerns, workplace issues, and limited access to training or digital resources. No single professional group could address this range of need. The strongest models combined elements of social prescribing, occupational therapy, employability support, community knowledge, care coordination, and links to primary care and wider services. Future delivery should therefore formalise the multidisciplinary nature of the offer, including clear routes into occupational health, physiotherapy, mental health support, social prescribing, welfare advice, employment rights advice, and community-based support.

OPERATIONAL AND CONTEXTUAL FACTORS CONSTRAINED PERFORMANCE

Short implementation and delivery timescales constrained WorkWell's effectiveness across all sites by limiting the time available to raise awareness, build relationships, embed referral pathways, and demonstrate outcomes. Interviewees across localities described difficulties generating early engagement and establishing referral processes within the short pilot period, while the timing of implementation also affected evaluation data collection. This was particularly evident in Hastings, where delays to programme implementation and data collection processes meant no matched follow-up outcome data were available, compared with eight matched SWEMWBS follow-up

responses from Crawley and 19 from East Brighton. These findings suggest that the full potential of WorkWell may not have been realised or captured during the evaluation period, particularly where sites had less time to optimise delivery, engage citizens, and evidence change.

Clear implementation planning, communication, referral infrastructure, and operational systems influenced how effectively WorkWell was delivered, engaged citizens, and demonstrated outcomes across localities. This was particularly evident in Hastings, where challenges with role clarity, operational planning, communication, and data collection processes coincided with the lowest referral volume, with nine referrals, and no matched follow-up outcome data available. In contrast, Crawley and East Brighton contributed all matched SWEMWBS follow-up data and appeared better able to evidence outcomes, although both sites also reported that substantial effort was needed to build awareness among referral partners and embed referral pathways. These findings suggest that implementation factors shaped not only delivery processes, but also the extent to which citizens could be recruited, engaged, retained, followed up, and included in outcome measurement. Future WorkWell implementation should therefore include structured onboarding, clearer guidance, standardised reporting processes, and early support to develop referral pathways and partner awareness, recognising that programme effectiveness depends on both the quality of support provided and the operational systems required to deliver and evidence that support.

SUMMARY

The findings suggest that successful WorkWell implementation depended on balancing a common set of core principles with local flexibility. While delivery models varied considerably across localities, positive outcomes were observed across all approaches. The strongest influences on delivery, engagement and effectiveness were partnership working, trusted referral pathways, person-centred support, and the ability to adapt delivery in response to local learning. At the same time, short delivery timescales and operational challenges limited opportunities to embed referral processes, collect outcome data and fully realise programme benefits. Taken together, these findings suggest that future WorkWell programmes should retain flexibility for local tailoring while providing more consistent implementation support, referral infrastructure and performance monitoring arrangements.

Impact

How does access to WorkWell vary by service user demographics?

The demographic findings suggest that WorkWell Sussex reached citizens from a range of backgrounds. 37% of referrals were from non-White-British ethnic groups, 27% did not have English as their first language and 31% of all referrals were from the two most deprived IMD deciles. White British citizens remained the largest ethnic group, accounting for 30 of the 48

referrals, or 63% of the overall cohort. When citizens with an unknown ethnicity are excluded, White British citizens represented more than two-thirds of referrals with a recorded ethnicity.

The prominence of White British citizens is notable in the context of the local areas selected for the pilot. Crawley was identified partly because of its diverse population, including higher proportions of Asian, Asian British, Black, Black British, Caribbean or African residents than the national average (Office for National Statistics, 2022). It raises the possibility that some minority ethnic communities were not reached to the extent that might have been expected given the local population profile. Recruitment and communication arrangements may have contributed to this pattern. Crawley staff reported that public-facing materials were available only in English. This may have limited awareness among people who did not speak English as a first language, particularly those less confident reading written English or navigating health and employment services without assistance. While most citizens whose first language was not English were recorded as speaking English well or very well, spoken English proficiency does not necessarily mean that standard English-language promotional materials are equally accessible. Recruitment materials also need to reflect how different communities understand health, employment, disability and public services. Standard written information may be less effective than communication through trusted community leaders, faith organisations or cultural associations; therefore, Crawley staff's recommendation to undertake proactive outreach in community settings such as places of worship (in addition to typical settings such as libraries and job centres) is particularly relevant.

The East Brighton model provides some evidence that trusted community-based delivery can improve access for populations that may be less likely to engage through formal clinical routes. East Brighton accounted for all referrals from the two most deprived IMD deciles and most referrals from citizens whose first language was not English. Its approach relied heavily on existing relationships, informal conversations and a consistent presence within the Crew Club.

Another key point identified within the pilot relates to the gender of citizens participating, and their ongoing engagement with the programme. Women accounted for 69% of referrals, indicating a potential difference in access. This may reflect successful engagement with women experiencing substantial work and health needs, but it may also suggest that men were less likely to recognise the service as a potential avenue. A point previously made regarding the messaging of the WorkWell support package and the WorkWell brand is again pertinent here. The available follow-up data also suggest that women were more likely than men to remain engaged to the point of completing follow-up self-reported outcome measures, with substantially more women providing matched follow-up responses. This may indicate a gender difference not only in initial access, but also in continued participation and completion of the programme.

The referral and engagement methods used by each site appear to have influenced the demographic profile of those who took part, creating a degree of self-selection. In East Brighton, delivery through the Crew Club and its existing activities, including lunch clubs, may have been more accessible and appealing to younger women and mothers who were already using the venue. This may help explain both the younger age profile and the higher proportion of women referred through the site. In Hastings, the original intention was to engage a younger population, but the early referral approaches generated limited uptake. The later shift towards proactive contact through repeat fit note reviews was more successful but ultimately reached an older group with more established health-related work absence. These findings suggest that demographic

reach was shaped not only by local population need, but also by where the service was based, which existing groups used those settings and how citizens were identified and approached.

Overall, the pilots reached a diverse cohort, including citizens from deprived communities and people for whom English was an additional language; however, the predominance of White British citizens, particularly within areas selected partly because of their ethnic diversity, suggests that more intentional approaches may be needed to reach minority ethnic communities. Attention should also be paid to the gender case mix and ages at sites in the future to ensure that access is equal to all with less self-selection. These findings demonstrate that referral routes and delivery settings are not neutral; they actively influence who accesses support. Future WorkWell models should therefore use population intelligence to design proportionate referral and outreach approaches, ensuring that delivery is intentionally configured around communities experiencing the greatest risk of health-related economic inactivity.

To what extent does WorkWell change health and employment outcomes?

Person-centred, holistic support appeared to underpin WorkWell's effectiveness across localities by addressing the wider barriers that influence employment readiness and health outcomes, rather than focusing solely on work outcomes. Across sites, support extended beyond employment needs to include wellbeing, confidence, skills, housing, childcare, and financial concerns, reflecting the complex circumstances many citizens faced.

HOW DO EMPLOYMENT OUTCOMES CHANGE, BASED ON DIFFERENT DELIVERY MECHANISMS?

The three delivery models appeared to support different forms and stages of employment progression, reflecting the employment status, needs, and distance from the labour market of each of the implementation sites. Employment outcomes were not collected at a consistent follow-up point, as agreed during the project logic modelling workshop due to pushback that the programme would struggle to capture employment outcomes, and because the project was at the mercy of local job markets. Therefore, comparisons between sites are primarily based on qualitative evidence.

Crawley recruited a comparatively large number of citizens who were unemployed and actively looking for work. Its structured one-to-one coaching model was therefore well placed to support practical employment goals. Staff described examples of citizens completing IT courses, developing new skills and progressing towards or into employment.

Hastings increasingly focused on citizens receiving repeat fit notes who remained connected to employment or wished to return following sickness absence. These citizens often required support with functional barriers, occupational therapy and reasonable adjustments. The Hastings model may therefore be more relevant to job retention, reduced sickness absence and sustainable return to work than to new job entry. Its employment benefits may take longer to materialise, particularly where employers delay decisions about adjustments or citizens require several appointments before they are ready to return.

East Brighton engaged a larger economically inactive population, including citizens experiencing mental health difficulties, low confidence and social isolation. Some progress was therefore reflected in earlier-stage outcomes, such as leaving the house, attending community activities and engaging with support. The achievements of the Crew Club were not limited to these outcomes. Its existing links with local employers, particularly a high-street chicken restaurant, provided an informal (in other words, avoiding interview) yet direct route into employment opportunities. Through this relationship, it is understood that several citizens secured job trials and some subsequently obtained paid roles. This represents important evidence that a trusted community-based model can support both improvements in work readiness and employment outcomes.

The restaurant relationship illustrates a particular strength of the Crew Club model. Staff were able to draw on established local credibility and employer connections to move citizens from informal conversations and confidence-building into real workplace opportunities. Job trials may have offered citizens who lacked recent experience, qualifications or confidence an opportunity to demonstrate their capabilities outside typical recruitment processes. This suggests that community organisations can act not only as trusted gateways for citizens, but also as champions for residents to employers. The experience also indicates that employer relationships should be treated as a core element of delivery rather than as an optional onward referral. The Crew Club's connection produced opportunities that may have been difficult to access through generic online job searches or standard signposting alone. Future community-based delivery should therefore invest in developing a network of local employers willing to offer supported applications, workplace visits, job trials and suitable roles; however, these relationships should not rely entirely on the personal contacts of individual staff members as this could limit sustainability.

The findings support the development of complementary pathways rather than the adoption of one uniform delivery model if future WorkWell models are to provide support to a broad spectrum of citizens. A trusted community organisation can engage citizens who are distant from formal services and use local employer relationships to convert increasing confidence into job trials and employment. Structured coaching can help active jobseekers address work-related barriers and pursue training or work (voluntary or paid). Primary care-linked occupational therapy can support people at risk of leaving employment or returning after sickness absence. A future Sussex model should connect these approaches through shared referral arrangements, allowing citizens to access the pathway most appropriate to their starting point.

How might WorkWell intervention components impact on patient-reported experiences, i.e. shifts in confidence, understanding of health-employment links, and self-efficacy?

The emerging evidence indicates that WorkWell Sussex was associated with improvements in mental wellbeing and work-related confidence. Amongst citizens with matched SWEMWBS assessments, average wellbeing scores increased by 4.93 points, with statistically significant improvements across six of the seven domains. The largest changes related to optimism about the future, feeling useful and feeling close to other people. Confidence in managing health and staying in work when things became difficult also increased significantly, from an average of 4.54 to 5.83 out of ten. By comparison, the more general measure of ability to manage health and wellbeing

improved only slightly and was not statistically significant. This pattern suggests that WorkWell Sussex may have had a stronger effect on citizens' confidence to manage the interaction between health and employment than on their ability to manage their condition.

There was variation in outcomes reported between sites. East Brighton recorded improvements in both self-efficacy measures, whereas Crawley's average score for managing health and wellbeing decreased from 2.75 to 2.50 on the four-point scale. This reduction reflected one participant reporting a lower score at follow-up and should therefore be treated cautiously. Nonetheless, it indicates that improvements were not experienced uniformly by all citizens.

Additionally, Crawley's average confidence in managing health and staying in work when difficulties arose increased from 3.40 to 4.40. Although this represented improvement, the follow-up average remained within the lower half of the response range. This suggests that, on average, Crawley citizens remained relatively unconfident about their ability to manage their health and sustain employment when circumstances became difficult. The findings therefore indicate that short-term support may have improved confidence without fully overcoming health barriers experienced by this group. This appears consistent with the support provided, which focused on practical goal setting, service navigation, employment barriers, training, workplace communication and wider personal issues.

These findings align closely with the domain-level SWEMWBS findings - improved optimism may reflect clearer goals and a more apparent pathway forward. Feeling useful may have been strengthened through training, volunteering, skills development or renewed consideration of employment. Increased closeness to others is consistent with peer support and participation in the community initiatives, such as the Crew Club. Improvements in dealing with problems and thinking clearly may reflect action planning, navigation and practical problem-solving.

The increase in work-related self-efficacy is particularly important because employment-specific confidence is associated with later return-to-work outcomes. A systematic review of workers with MSK or psychological injuries found consistently positive associations between self-efficacy and return to work, with stronger relationships when self-efficacy measures were closely focused on work and job behaviour (Black et al., 2018). Other studies have found that high or increasing return-to-work self-efficacy is associated with less subsequent sickness absence (Skagseth et al., 2021).

The overall change in general health-management-related self-efficacy should therefore be recognised, alongside the decrease observed in Crawley. It is unfortunate that matched scores from Hastings could not be obtained, for their focus on supporting individuals with repeat fit notes to remain in work would be much more closely aligned to this self-efficacy measure in comparison to the delivery model of Crawley and East Brighton. Improvements in health confidence and self-efficacy should be viewed as important intermediate outcomes within the pathway to sustainable employment rather than as endpoints in themselves. For many citizens, particularly those facing complex health and social barriers, increased confidence may represent the first step towards work readiness, community participation and future employment. Longer-term follow-up will be important to understand whether these gains are sustained and translate into durable health and employment outcomes.

Economic

What is the economic value of WorkWell?

The economic model estimates total first-year benefits of £146k against costs of £41k, producing a net present value of £105k and a benefit-cost ratio of 3.54. The Monte Carlo analysis produced a mean ratio of 3.65 and a 90% simulation interval of approximately £2.95 to £4.43 returned for every £1 invested. On these assumptions, WorkWell Sussex has a positive potential social return.

The result should be described as modelled potential value rather than realised value. Approximately £110k of the £146,000 benefit, around 75%, is attributed to GVA. The economic case is therefore largely driven by estimated employment outcomes rather than by the observed wellbeing changes. These employment outcomes were not measured among Sussex citizens. They were estimated using outcome and additionality assumptions from Working Well Early Help, where evaluation estimated that approximately 33% to 38% of positive job outcomes would not have occurred without the programme (Sheffield Hallam University et al., 2022). The use of average annual working hours and national GVA per hour may also overstate value if citizens initially enter part-time, insecure or lower-productivity work, or understate it if employment is sustained for several years; however, the utilisation of optimism bias, other deflationary measures and sensitivity analysis within the model attempts to mitigate as much risk as possible.

It should also be recognised that this was a relatively short pilot, with part of the funded period used to establish delivery models, develop referral pathways and recruit citizens. As services became more established, several sites reported increasing referral and engagement activity. If this continued over a longer delivery period, greater citizen throughput could potentially improve the economic return by spreading elements of programme set-up and delivery across a larger cohort. However, this potential effect has not been modelled and should not be assumed within the current estimates.

From a cost perspective the model includes site funding but excludes central programme management, ICB and Health Innovation KSS input, in-kind staff contributions, facilities, administration and the costs of onward services. Staff interviews indicate that implementation required substantial partnership activity, search development, communication and repurposed clinical time. There may also have been additional provider costs or opportunity costs that were not captured within the high-level model. A longer-running programme could therefore benefit from greater delivery efficiency, but a more complete assessment of costs could also increase the estimated cost of provision. These effects may operate in opposite directions.

Considering this, the BCR ratio of 3.54 should be treated as an illustrative estimate of the economic value of WorkWell Sussex. In comparison, Department for Work and Pensions Health-led Employment Trials (2024) demonstrates a mean estimate of 2.32 for every £1 invested when accounting for economic benefits; however, this is almost entirely generated from improvement in health utilities, not productivity benefits.

DO CITIZENS ENROLLING ONTO THE WORKWELL PROGRAMME REALISE QUALITY-ADJUSTED LIFE YEAR GAINS BY IMPROVING THE MANAGEMENT OF THEIR CONDITION AND IMPROVING WELLBEING?

Utilising SWEMWBS outcomes and mapping these to health utilities (Keetharuth et al., 2024) provides an estimated £41k of benefit from improved health-related quality of life, supported by the statistically significant improvement in SWEMWBS. Qualitative evidence across staff interviews and patient case studies also suggests that citizens experienced improved optimism, confidence, social connection and ability to take practical steps.

The limitations are that the mapping of SWEMWBS to health utilities introduces uncertainty and the model assumes that wellbeing improvements were caused by WorkWell and maintained for twelve months. To make estimations more prudent, a value of £25,000 per QALY was applied. This is comparatively lower than other organisations: the £25,000 to £35,000 threshold range used by NICE, and the £70,000 willingness to pay threshold within *The Green Book* (2026).

The site recommendations may help strengthen future QALY gains. Consistent and trusted support, flexible access, validation of citizens' health experiences, occupational therapy input and clearer pathways to practical assistance may improve wellbeing and reduce disengagement from the intervention. The appropriate conclusion is that WorkWell Sussex likely generated health-related quality-of-life gains among some matched respondents, but the duration of those gains remains uncertain.

Recommendations

Establish a clear core delivery model, whilst retaining local flexibility

A clearer core delivery model will be needed as WorkWell is rolled out more widely to ensure consistency in the support available to citizens and to enable the programme's collective impact to be understood. The three Sussex pilots demonstrated the value of local adaptation but also showed that different delivery models can lead to variation in referral routes, eligibility, staffing, data collection, and outcomes. This was manageable across three sites, but further expansion without a shared model risks creating substantial variation in the support available by area.

Consistency should not mean a single rigid delivery model using the same organisations or structures in each area. The evaluation has shown that there is a clear role for different local approaches, including community-led delivery, coaching-based support, and primary care-linked models. These models appear to reach different groups of citizens, from those who are socially isolated or distant from formal services to active jobseekers, people at risk of leaving work, or people returning to work after sickness absence. Future delivery should therefore retain enough flexibility for localities to build on existing community organisations, trusted relationships, and local assets.

Provider collaboratives could also be brought into future planning to ensure that WorkWell and wider health and employment support can respond to more complex cases. Provider collaboratives could help define escalation routes, clarify access to specialist advice, and support interfaces between neighbourhood-based delivery and clinical pathways.

Therefore, future WorkWell models should operate around a consistent core framework that sets out the minimum expectations for delivery, whilst including locally tailored delivery routes. This would allow each locality to use the assets already present in its neighbourhoods, while avoiding excessive variation in the citizen offer. In practice, this would mean defining the core elements that all WorkWell localities must provide, while allowing local partners to decide how that support is best delivered within their community. Mechanisms should be developed for ongoing adaptation, learning, and quality improvement, so delivery can respond to emerging evidence about what works in each local context – akin to the Programme Boards hosted by NHS Sussex for the WorkWell Sussex programme.

Provide multidisciplinary, person-centred support with stronger employer involvement

WorkWell Sussex demonstrated that positive employment outcomes are most effectively achieved through a holistic approach that addresses the wider factors affecting people's ability to work, including health, wellbeing, finances, benefits, and social circumstances. Future models should retain this integrated offer by combining coaching and social prescribing with access to specialist support such as occupational therapy, welfare advice, employment rights guidance, and other relevant services.

The pilots also highlighted the importance of employer engagement as a core component of delivery rather than simply an onward referral route. Trusted community organisations were able to act as a bridge between citizens and local employers, helping people access informal conversations, supported applications, workplace visits, job trials, and paid roles through more flexible and supportive recruitment processes. This was particularly valuable for citizens facing barriers such as low confidence, health conditions, limited recent work history, or gaps in qualifications. Future WorkWell and health and employment programmes should develop strong local employer networks, including employers committed to offering job trials, reasonable adjustments, flexible roles, and opportunities for people returning to work after illness, enabling more direct matching of citizens to suitable opportunities and supporting sustained employment outcomes.

Evaluation, monitoring, and continuous improvement

Future delivery should be underpinned by a shared outcomes and evaluation framework across Sussex, while allowing localities to determine the most appropriate delivery route for their population, assets, and referral infrastructure. This would preserve local flexibility while enabling consistent assessment of reach, engagement, impact, inequalities, and longer-term value across places.

Data collection processes should be designed with frontline staff and citizens so that they are proportionate and accessible, with time taken by project teams to explain the purpose and functionality of data collection template. The framework should track the full citizen journey, including referral source, onboarding, engagement, retention, demographic reach, deprivation profile, work-related confidence, wellbeing, employment status and job retention, sickness absence, fit note patterns, onward referrals, employer engagement, citizen experience, and movement towards training, volunteering, job trials, or other meaningful activity. Including these wider indicators is important because progress towards work may be incremental, particularly for citizens experiencing complex health, social, or economic barriers. The commissioners of WorkWell should invest greater emphasis on reviewing healthcare and employment outcomes through platforms such as the NHS secure data environments, or through data sharing agreements with HMRC, reducing the burden on delivery teams to capture this information through custom forms.

The WorkWell pilot primarily assessed outcomes during and shortly after engagement with the programme. As a result, there is limited evidence on whether improvements in wellbeing, work readiness, employment, and health were sustained over time. Future evaluations should include follow-up assessments at six and twelve months to understand longer-term impacts, this would provide a more complete understanding of programme effectiveness and longer-term value.

Earlier identification and intervention

Future WorkWell delivery should explore how local systems can identify people at risk of long-term work absence earlier, drawing on a combination of fit note data, repeat sickness certification, referrals from primary care, MSK services, mental health services, occupational therapy, social prescribing, and employment support pathways. The Hastings model demonstrated the potential value of proactive identification through repeat fit note monitoring, while also highlighting practical challenges relating to data quality, coding variation, and workforce capacity. Future programmes should test whether risk stratification approaches can enable earlier intervention for people with emerging MSK or mental health needs before short-term absence progresses to long-term worklessness.

Consider how innovation can help

Local partners like Health Innovation KSS are well placed to support future development through an innovation support role: identifying promising models, supporting local partners to test them in real-world settings, evaluating implementation and outcomes, and helping spread learning across places. The WorkWell Sussex programme has generated practical learning about what may need to be standardised at system level and what should remain locally determined. Future work should therefore distinguish between strategic commissioning functions, such as defining outcomes, governance, eligibility, evaluation, and data requirements, and place-based delivery functions, such as choosing trusted settings, referral routes, local partners, and employer engagement approaches.

Conclusion

WorkWell Sussex demonstrated that relatively small-scale, neighbourhood-based investment can support locally responsive approaches for people facing health, employment, and wider social barriers. The three pilots built on different local assets, relationships and infrastructure rather than delivering a single uniform model. Early findings suggest promising benefits, including improved wellbeing, greater confidence in managing health in relation to work, and examples of citizens progressing towards employment, training, volunteering, job trials, and wider community participation. Economic modelling also suggested potential positive social value, although this should be interpreted as modelled value rather than a realised financial return.

The evaluation also highlighted important learning for future delivery models. Engagement was strongest where services were visible, trusted, and embedded in local relationships, including through community organisations, GP practices, care coordinators, occupational therapists, employers, and local partners. Despite this, the short delivery period limited mobilisation, adaptation, and understanding of longer-term outcomes, including whether employment gains were sustained. Overall, WorkWell Sussex provides a useful proof of concept for neighbourhood-based work and health support. Future delivery should build on this learning through a more consistent longer-term model, while preserving local flexibility and relationships.

How this learning can inform future work – Health Innovation KSS

WorkWell Sussex provides an important proof of concept for place-based health and employment support. The programme demonstrated that trusted local settings, locally tailored referral pathways, multidisciplinary working, and strong relationships with employers and community partners can support citizens facing complex health, employment, and social barriers. While the evaluation was undertaken over a relatively brief period and should therefore be viewed as early learning rather than definitive evidence of long-term impact, it provides valuable insight into the practical delivery of integrated health and employment support at neighbourhood level. It also positions WorkWell Sussex not only as an employment support pilot, but highlights the opportunity to include it as part of a wider prevention, population health, and inequalities approach to supporting people before health-related barriers become entrenched.

The context for future delivery has evolved since the programme was commissioned and evaluated. Following the formation of NHS Surrey and Sussex and the national rollout of WorkWell across all Integrated Care Systems, future delivery is being shaped by national programme requirements, but the learning from WorkWell Sussex remains highly relevant. The evaluation highlights the value of flexible, locally tailored approaches that connect health, employment, and wider community support around citizens' needs. It also demonstrates the importance of strong referral pathways, effective partnership working, employer engagement, and robust approaches to identifying and supporting people at risk of falling out of work due to health conditions. These findings can help inform the implementation and continuous improvement of WorkWell across

Surrey and Sussex, supporting local areas to deliver national objectives while retaining the flexibility required to respond to the needs, assets, and opportunities within individual communities.

This learning may also be of wider relevance to other areas implementing WorkWell nationally, particularly those seeking to strengthen integration between health, employment, local government, voluntary sector partners, and employers in support of improved health and work outcomes.

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Appendices

Appendix A: Recommended referral criteria for WorkWell

Eligibility Criteria

- Aged 18 to 64 years old and 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 (for example, housing, caring responsibilities, digital exclusion)

Appendix B: Logic model

WorkWell Sussex: Logic model

A logic model workshop was hosted with participants attending from each NHS Sussex WorkWell site: Crawley, East Brighton, and Hastings. Additionally, representatives from Health Innovation KSS and Sussex ICB were present. During the day, the participants were asked to consider the inputs, activities, outcomes and impacts likely to be derived through the implementation of the WorkWell. The table below provides a summary of the discussions of the workshop to understand the impacts and outcomes service users, the healthcare and VCSE system, and the public, employers and wider community. Each site's project proposal has been incorporated to achieve as thorough a model as possible.

	Impacts	Outcomes
Service users	Improved service user wellbeing & confidence	- Increased service user confidence - Increased service user motivation - Improved service user self-efficacy - Improved service user mental wellbeing (SWEMWBS) - Reduction in healthcare attendance - Reduction in MH and MSK issues
	Greater work readiness & retention	- More service users entering volunteering, training and employment pathways - Service users at risk of dropping out of work sustaining employment - Reduced risk of prolonged unemployment for participants
	Improved navigation and access	- Improved navigation of local services - Reduced stigma around accessing employer support - Reduction in digital exclusion for service users - Greater trust by service users in local community offers (i.e Crew Club)
Healthcare & Support Systems	Improved early intervention and prevention	- Reduced repeat fit note requests among participants - Reduced reliance on primary care for non-medical employment issues - Reduced excess healthcare resource utilisation (GP appointments) following completion of course
	Integration and System Learning	- Improved referral criteria across services - Sustainable referral pathways - Improved communication between healthcare services and VCSE
	More equitable and inclusive systems	- Targeted support for deprived areas to improve health and employability offerings - Reduced health and wealth inequalities through ongoing monitoring and evaluation of services
Public, employers and wider community	Larger workforce and economic activity	- Reduced avoidable work loss across Sussex - Reduced dependency on welfare and benefits (fit notes) - Increased productivity for employers
	Integration and system learning	- Sustainable and scalable WorkWell models continued in the community - Joined up health and employment support

WorkWell Sussex: Logic model

Inputs	Activities / Outputs
£12,000 pilot funding per site - Local VCSE partners (Crawley Community Action, Trust for Developing Communities, Crew Club) - Primary Care Networks and staff (GPs, physiotherapists, occupational therapists, social prescribers, health coaches) - Community venues (Crew Club, Crawley hubs, Marlborough House) - Digital resources (laptops) - Service user engagement and lived experience input - NHS Sussex oversight and governance	- Deliver 1:1 personalised coaching (Crawley) - Provide peer support and navigation to local services (Crawley) - Map service user journeys and referral pathways (Crawley) - Run job club sessions in trusted venues (East Brighton) - Provide digital inclusion support with laptops and connectivity (East Brighton) - Deliver OT-led "Work Readiness Plans" (East Brighton) - Train a peer "WorkWell Champion" (East Brighton) - Co-produce an employment resource pack - Identify citizens with fit notes via EMIS searches (Hastings) - Amend fit note process with signposting templates (Hastings) - Deliver joint multidisciplinary clinics (Hastings: FCP, OT, Health Coach, Social Prescriber) - Provide outreach for those unable to attend clinics (Hastings) - Host group sessions for citizens with shared needs (Hastings) - Hold stakeholder engagement events (all pilots) - Collaborate across NHS, VCSE, DWP, and councils to align pathways (all pilots)
Assumptions and Risks	
- Limited funding (£12k per pilot) may constrain delivery capacity - Reliance on in-kind contributions (e.g., OTs in East Brighton, PCN staff in Hastings) could stretch already pressured services - Staff turnover in VCSE or PCNs, or winter pressures, may reduce continuity - Digital equipment (East Brighton) may be insufficient or underused. Community venues (Crew Club, Crawley community hubs, Marlborough House) are accessible and trusted by participants. - Difficulty recruiting and engaging 25–35 suitable participants in a short timeframe - Recruitment pathways do not work as intended (for example, they do not identify economically inactive MSK citizens) - Dropouts and disengagement due to inconsistent service provision or poor service matching - Varying delivery models make for a challenging evaluation of the umbrella project (WorkWell) - Cross-agency collaboration will reduce duplication and enable smoother referral pathways - Small cohorts can still produce meaningful learning and system insights - Participants' journeys and feedback will provide enough evidence to inform scaling - Experiences do not vary substantially by recruitment pathway - VCSE/community champions will have the trust and credibility needed to engage participants effectively - Data sharing is managed securely, and will be effectively captured and shared with independent evaluators for analysis	

Appendix C: Health economic sensitivity analysis methodology

The below represents an example of how the Monte Carlo sensitivity analysis is run. Please note all figures used in this example do not represent actual WorkWell Sussex outcomes.

Step One: Allocation of ranges

Variables of interest are given base-case values (or mean estimates), and an expected range. The range given to each assumption is dependent on the confidence grading applied seen in Table 10.

Table 10: Unity Insights' sensitivity confidence grades.

			Data Source											
			Confidence grade		Formal service delivery contract costs		Practitioner monitored costs		Costs developed from ready reckoners		Costs from similar interventions elsewhere		Cost from uncorroborated expert judgement	
					Figures derived from local stats / RCT trials		Figures based on national analysis in similar areas		Figures based on generic national analysis		Figures based on international analysis			
					1		2		3		4			
Age of Data	< 2 Years	1	1.1	10%	2.1	10%	3.1	15%	4.1	20%	5.1	25%		
	2 - 3 Years	2	1.2	10%	2.2	15%	3.2	20%	4.2	25%	5.2	25%		
	3 - 5 Years	3	1.3	15%	2.3	20%	3.3	25%	4.3	25%	5.3	30%		
	5 - 10 Years	4	1.4	20%	2.4	25%	3.4	25%	4.4	30%	5.4	35%		
	> 10 Years	5	1.5	25%	2.5	25%	3.5	30%	4.5	35%	5.5	40%		

The example in Table 11 demonstrates the quality-of-life adjustment factor and life expectancy.

Table 11: Example of a sensitivity range allocation.

Variable	Sensitivity Grading	Range Applied	Lower range estimate	Base-case / mean estimate	Upper range estimate
Quality of life adjustment factor	2.4	+/- 25%	0.420	0.565	0.70
Life expectancy (years)	4.4	+/- 30%	4.41	6.30	8.19

Step Two: Allocation of a distribution shape

All data has a shape to its distribution. If there is equal likelihood of any value within a range being drawn, then a rectangular distribution can be used (so called because a graph of the probability of any specific value being drawn would appear to be a rectangle). If there is a lower likelihood of a value at the extreme ends of the range being drawn, then a triangular distribution could be used.

If there is reason to believe the distribution meets the statistical qualities required to be defined as normal, Poisson, etc, then these can be applied. In this study, we have generally applied triangular distributions as this best reflects the ranges used and diminishing probabilities of more extreme ends. Where a different distribution has been used, it is expressly noted in the text.

Step Three: Random selection of values within the range

The model selects at random a value for each variable from within the range between the upper and lower estimate and calculates the outcome from each draw, considering the distribution shape selected and therefore the probability of any value being drawn.

Step Four: Repetition

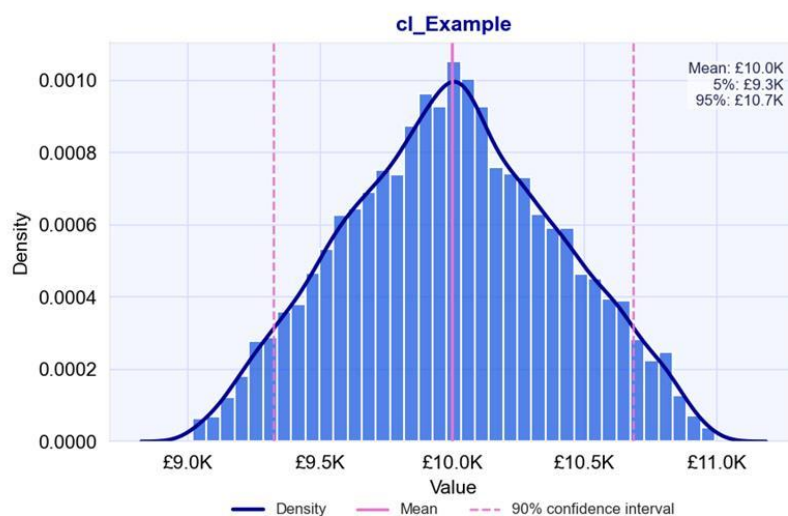
Five draws are given in

Table 12, using a rectangular distribution. These deliver estimates lying between £40,500 and £105,000. The draw is repeated thousands of times. In this evaluation we use 10,000 runs as standard.

Table 12: Example of random variation within the Monte Carlo simulation.

Variable	Draw 1	Draw 2	Draw 3	Draw 4	Draw 5
Quality of life adjustment factor	0.45	0.50	0.55	0.60	0.70
Life expectancy (years)	4.5	5.0	5.5	6.0	7.5
Quality of Life Year monetary value	£20,000	£20,000	£20,000	£20,000	£20,000
Benefit (lives saved * value of lives saved)	£40,500	£50,000	£60,500	£72,000	£105,000

Creating 10,000 estimates allows the creation of a distribution of possible outcomes from the draws made. From this distribution we can then compute the range within which we expect 90% of the observations from the draws to fall. This is called the 90% confidence interval, illustrated in Figure 18.

**Figure 18: Illustration of sensitivity analysis.**

The source for many of the data inputs in the model may also include a confidence interval, such as if the source is an academic study. In these cases, the confidence interval from the data source is used to provide the maximum and minimum ranges for the data input in the sensitivity analysis. Where no confidence interval is provided, the quality of the data is graded in a similar way to optimism bias to express the degree of certainty that Unity Insights has in the estimates.



Appendix D: Health economic optimism bias application

Table 13: Unity Insights' optimism bias confidence grades.

			Data Source											
			Confidence grade		Formal service delivery contract costs		Practitioner monitored costs		Costs developed from ready reckoners		Costs from similar interventions elsewhere		Cost from uncorroborated expert judgement	
					Figures derived from local stats / RCT trials		Figures based on national analysis in similar areas		Figures based on generic national analysis		Figures based on international analysis			
					1		2		3		4			
Age of Data	< 2 Years	1	1.1	0%	2.1	10%	3.1	15%	4.1	25%	5.1	40%		
	2 - 3 Years	2	1.2	5%	2.2	10%	3.2	15%	4.2	25%	5.2	45%		
	3 - 5 Years	3	1.3	10%	2.3	15%	3.3	20%	4.3	30%	5.3	50%		
	5 - 10 Years	4	1.4	15%	2.4	25%	3.4	30%	4.4	40%	5.4	55%		
	> 10 Years	5	1.5	25%	2.5	30%	3.5	40%	4.5	50%	5.5	60%		

Appendix E: Qualitative insights

Inappropriate referrals

CRAWLEY

In Crawley, inappropriate referrals were not always evident at the point of referral, with one employability and healthcare professional noting that suitability often became clearer during subsequent appointments once individuals felt more comfortable sharing their circumstances. Some referrals were found to involve individuals with more severe mental health needs than the programme was designed to support, requiring more specialist or tailored provision. It was also highlighted that the quality and level of detail provided in referrals varied considerably across referral partners, such as GPs and physiotherapists, which could make it more difficult to assess suitability at the outset and suggested a need to refine the referral form.

Where individuals were identified as unsuitable, they were typically signposted or referred on to more appropriate services, with ongoing contact sometimes maintained to support engagement and ensure successful transition. At a system level, inappropriate referrals were discussed within working group meetings and redirected accordingly. More broadly, one manager indicated that even where individuals were not ready to move into employment, alternative forms of support were identified, such as volunteering opportunities or financial guidance, to ensure they could still benefit from support.

EAST BRIGHTON

In East Brighton, one employability and healthcare professional stated that they had not encountered notable inappropriate referrals, while another noted this “rarely happens.” A manager similarly reflected that there is almost always some form of support that can be offered, even if it is not directly aligned to employment. Where individuals were not suitable for formal WorkWell support, this was typically due to eligibility or scope. For example, younger individuals still in school could not be formally supported through the programme; however, staff engaged them informally through conversations in the Crew Club, offering guidance on next steps despite the absence of appropriate referral pathways. There were also cases where individuals were already receiving adequate support elsewhere, or where their immediate needs were outside the remit of WorkWell, such as requiring primarily emotional support or an opportunity to talk rather than employment-focused assistance. In practice, these situations were managed flexibly, with staff providing informal support where possible, offering signposting, or identifying alternative sources of help. In some cases, limitations were due to logistical factors, meaning that while needs were recognised, there was limited scope to intervene further within the programme.

HASTINGS

In Hastings, inappropriate referrals were typically related to individuals’ readiness or ability to engage with employment support. One interviewee noted that some individuals, although technically eligible, were not well enough to work due to the severity of their symptoms. This

included individuals already moving through formal processes such as the capability route with the Department for Work and Pensions, or those with complex or long-term health conditions and no intention of returning to work. There were also cases where individuals remained in work but were physically unable to continue in their roles, often repeatedly going off sick, and were therefore more suitable for alternative forms of support. In these instances, individuals were referred on to more appropriate services, such as specialist employment support programmes. A second interviewee similarly highlighted that some individuals were progressing through limited capability for work-related activity routes and therefore were not appropriate for WorkWell at that stage. Where referrals were considered unsuitable, they were managed through onward referral to more appropriate pathways, ensuring individuals could still access relevant support aligned to their needs. aligned to their needs.

