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McCluskey, Serena

Telephonic support to facilitate return-to-work: what works, how and when?

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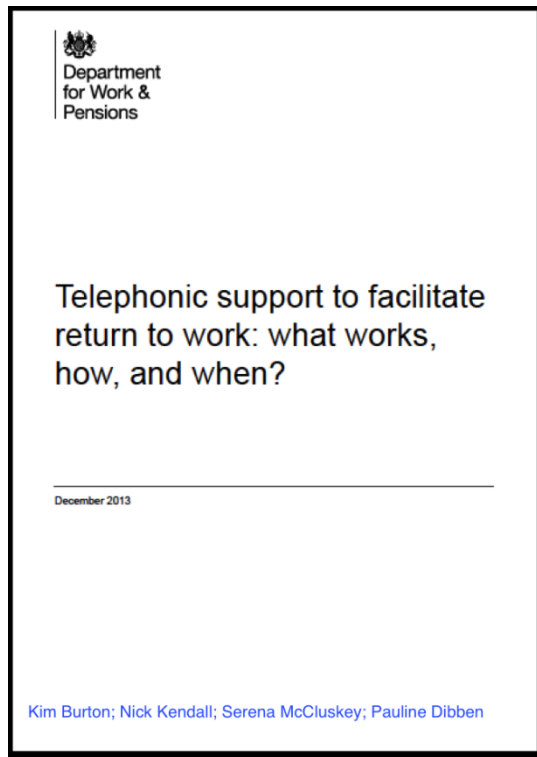
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Dr Serena McCluskey



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Rationale for review

- There is a clear need for more focused, evidence-based and coordinated services for people with common health problems in the early stages of sickness absence who are struggling to return to work.



Health at Work Service

- This will provide occupational health advice and support for employees, employers and GPs to help people with a health condition to stay in or return to work.
- There are 2 elements to the service:
 - assessment – once the employee has reached, or is expected to reach, 4 weeks of sickness absence they will normally be referred by their GP for an assessment by an occupational health professional, who will look at all the issues preventing the employee from returning to work
 - advice – employers, employees and GPs will be able to access advice through a phone line and website

Telephonic support



- Potential to provide targeted delivery of the right support to the right people at the right time
- Routine practice (RCN, 2006)
- Ease of access, shortened waiting times, efficiency (CSP, 2010)

Managing sickness absence

- Telephonic methods for managing sickness absence and return to work have become common practice within occupational health service provision and the health insurance sector
- Widely used by workers' compensation systems internationally
- Most often incorporated into a case management approach

Business considerations

- Cost-containment
- Maintaining a competitive advantage
- Delivery of high-quality and truly effective service

Concerns

- Telephone vs face-to-face consultation
- Individual nature of health concerns
- Effectiveness via 'call centre'
- Safety and acceptability
- Who does what, to whom, and when?



Scope of the review



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for people with common health problems, are telephonic occupational and related assessments effective in identifying biopsychosocial obstacles to work participation, and are telephonic interventions effective in overcoming those obstacles?

- **Best Evidence Synthesis**, six key steps
 - Develop working definitions for the project.
 - Search and select – scientific literature search (n=83), grey literature (n=28), and relevant professional practice (n=10).
 - Extract data (8 tables).
 - Generate evidence statements (10 statements).
 - Grade strength of evidence (4 levels).
 - Synthesise evidence (12 key messages).

1. Our working definitions

- **Common Health Problems**
 - musculoskeletal
 - mental health (mild to moderate)
 - stress complaints
- **Telephonic support**
 - telephonic assessment and triage
 - telephonic information and advice
 - telephonic (non-clinical) intervention
 - telephonic case management

2. Literature search

- Six strategies
 1. Formal search of electronic databases (e.g. Medline, Cochrane)
 2. Internet searching
 3. Hand searching of relevant journals, reports, documents
 4. Personal databases
 5. Grey literature
 6. Practice exemplars

Practice exemplars/UK professional standards



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5 Boroughs Partnership NHS Foundation Trust;
Buckinghamshire Healthcare NHS Trust;
Colchester Hospital Foundation Trust;
Isle of Wight Health Trust;
Leicestershire Fit for Work Service;
NHS Lanarkshire/University of Glasgow;
RehabWorks;
Swiss Re

- *BSI, 2010*
- *CMSUK, 2005*
- *UKRC, 2009*
- *VRA, 2013*

Table A.1 Evidence grading system to support evidence-based statements about the effect of telephonic support

Evidence grade	Definition¹
*** Robust	Generally consistent findings provided by multiple peer-reviewed studies or data from multiple well-documented prospective practice exemplars.
** Adequate	Findings provided by a single peer-reviewed study, evidence-based guidance, or data from a single well-documented prospective practice exemplar.
* Vulnerable	Based on limited data from a single practice exemplar, or on professional or commercial consensus, or on inconsistent findings provided by multiple peer-reviewed studies.
⁰ Indirect	Consistent findings provided by peer-reviewed studies of non-telephonic support that are conceptually transferable to the telephonic environment, or telephonic interventions beyond the anticipated scope of the service that are similarly transferable.

¹ The definitions represent minimum requirements.

Key findings



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- Assessment and triage
- Case management
- Information and advice
- Return to work
- Aspects of implementation

Assessment and triage



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There is robust evidence that telephonic approaches can be suitable for assessing clients' needs and can compare favourably to face-to-face methods. The assessment can be used to make decisions about allocation to appropriate care through a triage process.

- the approach used to assess and manage common health problems telephonically must complement the type of problem (e.g. musculoskeletal or mental health), but the underlying principles are the same for all.
- When telephonic approaches yield inferior results, the most likely reasons are inadequate (training in) telephonic or clinical skills, poor service design and implementation, and poor adherence. It is crucial that the telephonic personnel (including clinically-trained staff) receive focused training and support that is reviewed on a regular basis, and facilitated by standardised protocols.

Case management



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There is robust evidence that telephonic case management can support people with common health problems through care pathways, monitor progress and facilitate return to work. It can contain overall costs by reducing delays and optimising referrals.

- The overall effectiveness of the case management process is well established in a variety of settings and for a range of clients, where telephonic first contact is the norm. Nevertheless, careful service design and practitioner training is required to avoid duplication of services through over-escalation to face-to-face assessments.
- Specific advantages of telephonic case management include reducing delays, integrating intervention components, optimising referrals, coordinating stepped care and communicating between the key players. This fits well with a stepped-care model: delivering just what's needed, when it's needed.
- Telephonic approaches are unsuitable for clients with communication problems and those with complex pre-existing medical conditions in addition to their current common health problem: assessment and triage can identify these cases and move them to a face-to-face approach.

There is adequate evidence that relevant information and advice, including self-management techniques, can be effectively delivered by telephone.

- Information and advice in a case management context is seen as a necessary, but not sufficient, part of the overall intervention package.
- Delivery of relevant information by telephone contact can encourage and enhance self-management of common health (and other) problems.
- In respect of occupational outcomes, telephonic delivery of work-focused information and advice is useful to orient the person towards return to work, thus helping to set expectations and aiding decisions about how and when to return.



There is robust evidence (notably from practice exemplars) that telephonic interventions can facilitate return to work. Effective approaches incorporate evidence-based concepts of vocational rehabilitation: identifying obstacles to work participation; developing a return- to-work plan; providing work-focused information; coordinating the key players (person – workplace – worker). These can all be facilitated telephonically, and the main aspects are:

- ensuring return to work is asked about in every case
- promoting self-management approaches as soon as appropriate
- demedicalising common health problems wherever possible
- having a monitoring process to avoid serial ineffective treatment
- integrating line managers into the return-to work-plan
- facilitating early referrals into the service

Aspects of Implementation



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- There is acceptable evidence that telephonic approaches can be delivered safely using personnel with appropriate skills, training and governance.
- There is robust evidence that telephonic approaches (if suitably conducted) are generally accepted by service users, and are associated with high levels of satisfaction that equal or exceed those for face-to-face approaches. In addition, telephonic approaches are generally acceptable to health professionals.
- There is robust evidence that a biopsychosocial perspective is appropriate for managing common health problems, from both clinical and occupational perspectives. Telephonic approaches based on biopsychosocial principles can lead to cost-benefits and be cost-effective for clinical and occupational outcomes.
- There is robust evidence that timing is important to achieve desired occupational outcomes: early intervention is consistently associated with a timely return to work.

Conclusions



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- Telephonic approaches using assessment and triage, along with coordination of the key players, can be effective at reducing the number of sickness episodes, the number of days lost and the overall cost of a case/claim. Unnecessary healthcare can be reduced, without compromising client satisfaction.
- The important caveat is that this applies when services are well designed and implemented, and are staffed by professionals who have appropriate training and support.

Review Outcome and Impact

Health and Work Service specifications (Feb 2014):

- *Delivery Method* - Research has indicated that assessments, case management and work focussed interventions can successfully be delivered on the phone, with face-to-face assessment as appropriate.



Considerations

- Central to enhancing return-to-work outcomes is that work is seen as a health outcome;
- Work participation is the principal focus for the service;
- Clients are helped to devise a practical and feasible RTW plan;
- There is coordinated action with the workplace.

The future

- More research is needed – *but it works in the real world*



A cautionary tale!

<http://youtu.be/I3IxMQsazAM>