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Working Well Early Help: annual report 2020

July 2020



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Executive Summary

Summary

Working Well Early Help (WWEH) is a health-led employment support programme for residents in Greater Manchester. It aims to support a return to sustained employment for individuals with a health condition or disability who have either recently become unemployed or taken medical leave from an existing job. WWEH centres on the principle that early intervention can prevent short-term absence from work turning into long-term unemployment. The model offers personalised, health-focussed and holistic support provided through a key worker approach to address the full range of barriers to employment.

WWEH targets workers in small- and medium-sized enterprises (SMEs) as a group that tend to have less access to occupational health support as well as individuals who have become unemployed in the last six months and who have a health condition or disability. Initially, the programme primarily targeted SME workers but has recently placed more emphasis on supporting the newly unemployed as part of efforts to address high levels of unemployment anticipated in the wake of the coronavirus (COVID-19) pandemic.

This annual report draws on programme monitoring data and interviews with stakeholders and participants to assess the effectiveness of WWEH and the outcomes it achieves. It shows that the programme has faced considerable challenges in generating referrals and converting these to starts. However, the service is largely valued by participants and several indicators show improvements in health and wellbeing outcomes and, to lesser extent, employment outcomes by the time participants leave the programme. Early evidence points to a 'WWEH effect' where programme interventions often contribute to positive change.

The evaluation

- This evaluation underpins the 'test and learn' approach of WWEH by examining the extent to which early intervention to support those with health conditions and disabilities facilitates a return to work. It is based on programme monitoring data collected on 950 participants; 31 in-depth stakeholder interviews with the WWEH Programme Office team (referred to hereafter as the Commissioner), Provider delivery team, referral partners (GPs and Jobcentre Plus staff), and local authority officers supporting the programme; and 18 interviews with programme participants. It covers the first 16 months of delivery from March 2019 until the end of June 2020.

Design and implementation

- Stakeholders highlighted a number of aspects of design that made WWEH **distinctive and innovative** including a health-led model, the focus on early intervention, rapid access to Cognitive Behavioural Therapy and physiotherapy, and support for both SME employers and employees.
- Perceived **limitations of design** included incorrect assumptions that all employees of larger organisations have access to good occupational health support; and an inability to support employees who are still working and not on medical absence but on the verge of leaving due to health conditions.

- There were several **implementation challenges** in this first phase of the programme including a delay in putting core provision (CBT and physiotherapy) in place; difficulties in establishing effective referral pathways; a lack of clear and consistent marketing materials; staff turnover; restructuring within the primary care system; and a lack of integration with other Working Well programmes to provide continual support as individuals move in and out of employment.

Referrals

- Meeting targets for referrals and starts **proved challenging** from the outset of the programme. Lower than expected volumes led to the original monthly targets being revised in November 2019 (referred to hereafter as the revised flightpath), although lifetime targets remain the same. Unless otherwise stated, all references to targets in this report refer to the revised flightpath rather than original targets.
- There have been issues with the way referrals from JCP and Employers have been recorded due to an unintentional misinterpretation of the contract definition of a referral by the Provider, with initial 'signposts' not captured in referral data to date. This means referral volumes and conversion rates to starts are not directly comparable with the GP pathway which has seen all referrals recorded accurately from the outset. Future analysis will rectify this by including JCP and SME 'signposts' within overall referral data to provide comparable figures across all three pathways.
- A total of 1,777 referrals had been made into the programme by the end of June 2020. This is equivalent to **16 per cent of the lifetime target** of 11,206 referrals by September 2021 and **66 per cent of the cumulative referral target** (the number of referrals expected to date from programme launch based on the revised flightpath). However, it is important to bear in mind that cumulative achievement against original targets before they were revised only stands at 31 percent, highlighting how referral levels are significantly below initial expectations.
- Current underperformance against the revised cumulative flightpath is largely, though not wholly, explained by **falling referrals** following lockdown in March 2020 combined with a steady increase in monthly targets. Other factors contributing to lower than expected referrals before the first COVID-19 lockdown include a lack of understanding of eligibility criteria among GP; unclear marketing materials; and issues with capacity, training and expertise among the Provider engagement team.
- It has proved particular **challenging to generate referrals from SMEs**. This was attributed to a range of factors including Provider capacity issues to undertake SME engagement activities; reticence to engage among both employees and employers; and challenges in harnessing existing business support infrastructure as a source of referrals.

Starts

- A total of 950 participants had started on the programme by the end of June 2020. This represents **9 per cent of the lifetime target** of 10,085 participants by September 2021.
By the end of June 2020, the programme had only achieved **39 per cent of the cumulative target** for starts (the number of starts expected to date from programme launch based on the revised flightpath). Some of this shortfall can be attributed to low volumes of referrals during the first COVID-19 lockdown. However, achievement against the revised cumulative flightpath up until the end of March 2020 only stood at 64 per cent, indicating **performance issues precede lockdown**. Moreover, cumulative performance against the original target is only 19 percent, highlighting how starts have fallen significantly behind initial expectations.
- Factors contributing to underperformance against targets for starts include low levels of SME referrals and the **low conversion rates** of referrals to starts (53 per cent against a target of 90 per cent).
- **Conversion rates are particularly low for the GP pathway**, with only 42 per cent of referrals joining the programme. This low conversion rate was attributed to individuals not responding to

contact; a ‘clunky’ referral system that does not fully capture personal details; ineligible referrals from GPs; and the promotion of self-referrals by GPs. A number of steps have been taken to address this and recent data shows improvement in the GP conversion rate.

The impact of the coronavirus (COVID-19) pandemic

- It is essential to consider the impact of the outbreak of the coronavirus (COVID-19) pandemic and subsequent first lockdown on 23 March 2020 given the profound effects this has had on the UK economy and society. The impacts of COVID-19 can be explored in three ways: programme performance, participant needs and programme response.

Programme performance

- Table 1 presents data on cumulative referrals and starts against the revised flightpath in the period before and after the introduction of national lockdown on 23 March 2020, as well as performance to the end of June 2020. Most of the significant national first lockdown measures remained in place at the end of reporting period for this annual report (30 June 2020). This is shown in Table 1 below:

Table 1: Cumulative referrals and starts

	Referrals			Starts		
	Actual	Target	% of target met	Actual	Target	% of target met
Performance to date						
Mar 19 – Jun 20	1777	2689	66.1	950	2420	39.3
Performance until lockdown						
Mar 19 – Mar 20	1497	1348	111.1	781	1213	64.4
Performance after lockdown						
Apr 20 – Jun 20	280	1341	20.9	169	1207	14.0

- Key points include:
 - **Referral volumes:** The programme has met two thirds (66 per cent) of its cumulative target of referrals to date (up until 30 June 2020). Some of this can be accounted for falling volumes of referrals once lockdown was introduced. The number of referrals peaked at 164 in February 2020 before falling to 81 in May 2020, and then increasing slightly in June 2020 to 95 referrals. Cumulative performance against targets fell to 21 per cent in the three months following lockdown.

Excluding the last three months of data after the introduction of lockdown, the programme achieved 111 per cent of the cumulative target by the end of March 2020. The drop in performance once lockdown data are included is undoubtedly at least partly a reflection of the impact of COVID-19. However, achievement against monthly targets has been falling consistently since January 2020. This indicates a more longstanding issue with referral volumes failing to keep up with rapidly rising monthly targets. Given this trend, it seems unlikely the programme could have ‘caught up’ with targets, even without the COVID-19 pandemic.
 - **Referral volumes by pathway:** Lockdown had a significant negative impact on monthly referrals from GPs and JCP, although Employer referral volumes increased slightly from a low base between April and May 2020. Despite this, volumes of GP and JCP referrals either exceed or come close to meeting cumulative targets to date (112 per cent for GP

referrals and 84 per cent for JCP referrals). Employer referral volumes are well below target, only achieving just over one tenth (11 per cent) of the cumulative target

- **Start volumes:** The programme has only met two fifths (39 per cent) of the cumulative target for participant starts to date. Some of this shortfall can be attributed to falling volumes of starts during lockdown. During the three months after lockdown, achievement against targets fell to 14 per cent. However, cumulative achievement against the target for starts up until the end of March 2020 still only stood at two thirds of expectations (64 per cent), indicating **performance issues that precede lockdown**.
- **Start volumes by pathway:** There are significant differences by referral routes. Lower than expected cumulative performance for JCP and GP starts can be explained largely by lockdown limiting the flow of referrals. Pre-lockdown data shows JCP comfortably reaching the cumulative target for starts (137 per cent) and GP achieving over three quarters (78 per cent) of target by the end of March 2020. However, Employer starts remained significantly below target at 14 per cent, indicating performance issues preceded the COVID-19 crisis.

Participant needs

- The outbreak of the COVID-19 pandemic might be expected to negatively impact upon participants health and wellbeing. However, **there is little evidence to date, however, of a ‘COVID-19’ effect in terms of increased levels of presenting needs or health issues** among participants joining after lockdown:
 - The post-lockdown cohort (those joining from 01 April 2020) are slightly more likely to report health management as a barrier to work than the pre-lockdown cohort (96 per cent against 91 per cent). However, other data on health problems does not indicate any notable differences in the numbers or types of health problems experienced by these two cohorts.
 - A bespoke ‘combined measure of need’ identifies participants with the highest level of presenting needs based on 15 indicators. Analysis shows that the post-lockdown cohort starting in April 2020 or later had slightly less need than the pre-COVID cohort as measured by the proportion of participants placed in the category of most need (24 per cent against 26 per cent). This suggests that those joining the programme after lockdown are not experiencing greater levels of need, despite wider evidence of poorer health and wellbeing among the general population¹.
 - Caution should be exercised in interpreting these trends as post-lockdown analysis is only based on three months of data and differences between pre- and post-lockdown cohorts may change as more data for the months after June 2020 becomes available.

Programme response

- WWEH was launched in relatively benign labour market conditions in March 2019 but this changed dramatically with the outbreak of the COVID-19 pandemic. Unemployment is now rising (4.8 per cent in the three months to September 2020)² and expected to continue to increase, especially once the Job Retention Scheme ends in March 2021.
- This downturn led to a decision to **provide additional focus within WWEH on engaging and supporting the newly unemployed with health conditions or disabilities**. This has three key implications:
 - The programme will soon begin to accept far higher volumes of referrals from JCP, up to a maximum of 500 per month. This is more than all JCP referrals to date (450 as of June 2020), significantly rebalancing the focus of the programme towards the out-of-work cohort.
 - Targets for the proportion of referrals and starts by referral pathway have been removed. Until now, GPs and Employers were expected to account for 40 per cent each, while JCP provided the remaining 20 per cent. Removing these enables a refocus towards supporting the newly unemployed through increased referrals from JCP.

- Ongoing labour market uncertainty due to the COVID-19 crisis and the potential challenges in placing unemployed participants has led to a decision to pay the Provider on the basis of cost of services delivered rather than payment-by-results for job outcomes. This is in line with other employment programmes in Greater Manchester and nationally.
- WWEH has **a potentially valuable role to play in supporting those most impacted by the COVID-19 pandemic** as the situation continues evolves. Potential responses and implications include:
 - The Programme may find itself increasingly working with participants with higher levels of need as monitoring data suggests those out of work tend to have more significant barriers to work, presenting needs and health issues than the in-work cohort. At the same time, a rise in unemployment may mean that those losing jobs are closer to the labour market than the current out-of-work cohort supported by WWEH. Either way, it will be **important to monitor levels of need among the newly unemployed and the capacity of the Provider to support this group**. This means accommodating both rising volumes of referrals and, potentially, the increased intensity of support this cohort require.
 - A weakening labour market and decline in vacancies may make it harder to support out-of-work participants to return to work. In this context, it **may be necessary for WWEH support and monitoring** to focus on whether the programme can help participants maintain or improve health, wellbeing and job-readiness in the meantime if employment prospects become more limited.
 - Finally, as already highlighted, the programme needs to **continually review the extent to which it targets and engages groups most likely to impacted negatively by the economic downturn**. This is particularly the case for young people are who less represented on the programme than other age groups, yet more likely to experience job loss during the pandemic as the most recent data shows³.

The profile of participants

- Health management is by far the most common barrier to work. Meanwhile, mental health conditions are the most common health issues faced by participants with over two fifths (43 per cent) reporting at least one mental health condition. This appears to validate the focus of WWEH on addressing health issues to support a return to employment.
- A bespoke 'combined measure of need' identifies participants with the highest level of presenting needs based on 15 indicators. It shows that one third (33 per cent) of those out of work have been assigned to the category of most need compared with one fifth (20 per cent) of those who are currently in work. This suggests that **out-of-work participants have the highest support needs**.
- Interviews show there is a **two-way relationship between health and work**. In some cases pre-existing health conditions contribute to a decision to leave work; in other cases the nature of work itself in terms of working conditions and relationships with other staff seems the cause of, or contributing factor towards, physical or, particularly, mental health conditions that shape decisions to leave jobs.

The effectiveness of support

- Stakeholders identified a number of **strengths of the WWEH model** including a range of expertise among VRCs; a health-focussed approach; a bespoke, structured and sequenced package of support; motivational interviewing and coaching techniques; fast-track access to CBT and physiotherapy; and a unique level of support to enable participants to negotiate a return to work with employers. **Limitations** identified included the lack of control over the timing and availability of external provision into which participants can be referred or signposted; a 'two tier' service that can create confusion and disappointment for those only entitled to the lighter-touch Advice (rather than Support) Service; and the inability to offer 'in house' legal and financial advice, which some frontline staff felt could be usefully incorporated to create a

comprehensive internal offer rather than signposting to external organisations as currently happens.

- Just under **half (48 per cent) of participants are satisfied with the service** against a target of 90 per cent based on a survey undertaken following discharge. However, dissatisfaction is almost entirely accounted for by recipients of the more limited Advice Service. One explanation may be that GPs are referring patients working for larger employers without explaining that they are not eligible for the full Support Service. Indeed GPs may not even ask about, or be aware of, employer size. Data indicates that GP referrals of patients working for larger organisations represents a sizeable group. To date, 101 patients referred by a GP had declined the service and worked for an employer with more than 250 employees. This represents 19 per cent of the 521 GP referrals who declined the service.
- At the same time, participants interviewed were **largely positive about the practical support received** in terms of structured, sequenced and tailored Return to Work Plans; guidance on negotiating a return to work with employers; the speed and ease of access to specialist CBT and physiotherapy support; and clinically-informed resources for use and reference to help manage health conditions. They also highlighted the **value of empathic support** from VRCs which created a 'safe space' to discuss difficult issues, while also boosting confidence and motivation.
- The small number of negative comments from participants tended to relate to the **lack of relevance** of support offered to their circumstances as individuals rather than issues with quality. However, there was a minority view that the programme did not deliver the level of employment-related support expected, which perhaps reflects the strong focus on addressing health issues.

Outcomes

- **Positive change was particularly evident in relation to health and wellbeing.** All relevant measures indicated that participants, on average, experienced improvements in their physical and mental wellbeing as well as their ability to manage health conditions during their time on the programme.
- Participant interviews also highlighted positive change in health and wellbeing outcomes including reduced stress and anxiety as well as better physical health. There was **evidence of a 'WWEH effect'** where participants experiencing positive change attributed this, to some degree, to WWEH interventions including the empathic and listening approach of VRCs as well as support in liaising with employers. At the same time, the importance of other sources of support external to the programme in shaping positive outcomes was also noted.
- Both programme data and interviews highlight **positive employment outcomes** around progress towards or into employment. Again, there was evidence of a 'WWEH effect' with participants experiencing positive change noting the importance of programme support in boosting confidence and motivation, providing a structured pathway back into work, and negotiating a return with employers.
- **In-work participants were much more likely to return to work by the point of discharge than out-of-work participants** (64 per cent compared with 21 per cent). The significantly higher proportion of the in-work group who return to work may reflect their closer proximity to employment and the lower levels of presenting needs, barriers to work and health conditions they report.
- Interviews suggested many participants **benefitted from a return to work.** Those taking up new jobs, often in different sectors from previous roles, reported improvements in health and wellbeing where hours were shorter or working conditions less onerous. However, a minority who went back to work reported feeling compelled do so for financial reasons or unsupported by employers to manage health conditions in the workplace.

Introduction

1.1. Evaluating WWEH

This is first annual report of the Working Well Early Help (WWEH) evaluation being undertaken by a team of researchers from Sheffield Hallam University and the University of Salford. This section presents an overview of the WWEH programme, a summary of relevant national and local policies and strategies, data on labour market trends, and a description of the evaluation methods.

1.2. The Working Well Early Help programme

Working Well Early Help (WWEH) is part of the wider family of Working Well programmes⁴ operating in Greater Manchester. They provide tailored employment support to help residents return to and stay in work, with each targeting a different section of the working-age population.

WWEH is an early intervention programme available to residents in all 10 local authority areas in Greater Manchester⁵. It aims to support a return to sustained employment for individuals with a health condition or disability who have either recently become unemployed or taken medical leave from an existing job. The full WWEH model of support is described in Section 4.

Until recently WWEH mainly targeted employees of small and medium-sized enterprises (SMEs) who do not tend to have access to the same level of occupational health support available to employees of larger organisations. The programme is also intended to advise and support employers on employment and health issues, helping them retain staff and better manage health in the workplace.

However, the outbreak of the coronavirus (COVID-19) pandemic and subsequent first lockdown on 23 March 2020 led to a decision to provide additional focus on engaging and supporting the newly unemployed with health conditions or disabilities. This reflects the likelihood that the size of, and level of need within, this group will increase as the economic impacts of the pandemic result in rising unemployment.

WWEH was established as a devolved response to the UK government's *Improving Lives*⁶ strategy and builds on long-standing recognition of the relationship between work and health. It was commissioned by the Greater Manchester Combined Authority (GMCA) and funded by the Greater Manchester Health and Social Care Partnership NHS Transformation Fund, the Work and Health Unit Innovation Fund, the Greater Manchester Reform and Investment Fund, and the European Social Fund.

WWEH began supporting clients in March 2019 and will run until July 2022, with the last referrals accepted in September 2021. The programme is expected to help 10,085 participants over its lifetime. MAXIMUS are the lead Provider with some elements delivered by Pathways Community Interest Company. A Programme Office

team with representation from GMCA and the Greater Manchester Health and Social Care Partnership (GMHSCP) provides oversight and strategic direction to WWEH.

WWEH shares many of the aims and ethos of programmes within the Working Well family:

- **Personalised and holistic support** to address the full range of barriers to employment underpinned by a key worker model (known as the Vocational Rehabilitation Caseworker (VRC) in WWEH).
- **Integration with local services** within delivery areas to enhance the 'ecosystem' of work, health and skills services and offer a seamless, co-ordinated and sequenced package of support to participants.
- **Partnership and governance** through the involvement of all key partners including nominated Local Leads from local authorities and GP Leads in each of the delivery areas.
- **Robust evaluation** to ensure wider application of successful delivery and outcomes and to identify key learning as part of a 'test and learn' approach.

1.3. Policy and strategy

National

WWEH's focus on early intervention to prevent ill health leading to long-term disengagement from employment aligns with a number of national priorities. The **positive relationship between good quality, stable employment and good physical or mental health** has been recognised in a series of recent national strategies and reports⁷. These highlight the need to better integrate health and employment systems. This recognises both the role that poor health can play as a barrier to sustained employment, as well as the contribution that employment makes as a principal social determinant of good health.

The 2017 *Improving Lives: the future of work, health and disability* white paper⁸ is the cornerstone of the UK's government strategy to help those with disabilities and long-term health conditions access employment. The paper lays out a vision of integrated local services across the welfare system, the workplace and the healthcare system. It identifies WWEH as a key part of the UK government's commitment to test local approaches to early intervention, system integration and more streamlined referral routes.

Realising the benefits of employment is not just about supporting those with health conditions or disabilities to access *any* job. The recent *Health Equity in England*⁹ report emphasises the importance of good quality work¹⁰ for positive health outcomes. It outlines concerns that some of the increase in employment rates since 2010 has been driven by the emergence of poor quality work, putting health equity at risk.

Greater Manchester

Greater Manchester has been at the forefront of the devolution of funding and powers to city regions by the UK government, with its first Devolution Agreement signed in 2014. Successive agreements have, among other things, devolved control of Greater Manchester's £6bn health and social care budget and key elements of employment support including the devolved Working Well Work and Health Programme.

WWEH is a central part of Greater Manchester's commitment to demonstrate that locally commissioned and managed services are more able to integrate and achieve

better outcomes for residents than national programmes. It supports a series of wider strategic commitments to integrate work, health and skills systems to enable individual with disabilities and health conditions to find and stay in work:

- The *Greater Manchester Population Health Plan*¹¹ identifies employment as a key priority in delivering better health outcomes for residents, recognising the strong association between worklessness and poor health and the need for prevention and earlier intervention.
- Integration of work and health provision is a core part of the *Greater Manchester Primary Care Strategy*¹² which articulates a vision of “a system that understands the relationship between health and the wider determinants of health, ensuring access to support to address issues such as employment... [is] as embedded as writing a prescription or making a referral to secondary care”.
- Work and health policies and initiatives increasingly feature in local growth strategies:
 - The *Greater Manchester Independent Prosperity Review* (2019)¹³ emphasised the link between poor physical or mental health and lower productivity and growth.
 - The *Greater Manchester Local Industrial Strategy* identified a need to “align skills and work activity with health and care and other public services... recognising the links between good physical and mental health, employment and productivity”.¹⁴
- WWEH supports a wider drive to develop a *Greater Manchester Model*¹⁵ built around integrated public services with a focus on preventative interventions designed to prevent need escalating while recognising and developing individual assets.

1.4. Labour market and employment trends

National

WWEH was launched in relatively benign labour market conditions in March 2019 but this changed dramatically with the outbreak of the COVID-19 pandemic in the UK in early 2020 and subsequent lockdown introduced on 23 March 2020.

The significant curtailment of economic activity under lockdown has yet to translate into rises in the UK unemployment rate which stood at 3.9 per cent in the last quarter (March to May 2020)¹⁶. This is explained by the Job Retention Scheme¹⁷ preventing job losses while many of those who have lost jobs did not start looking for work during lockdown.

Despite this, unemployment is predicted to rise steeply in the coming months. The average of recent forecasts in HM Treasury analysis¹⁸ suggests unemployment may reach 6.6 per cent in 2021. Moreover, a series of other economic indicators provide cause for concern:

- Between March to May 2019 and March to May 2020, total actual weekly hours worked in the UK decreased by 175.3 million, or 16.7 per cent, to 877.1 million hours. This was the largest annual decrease since estimates began in 1971.¹⁹
- In June 2020, 649,000 fewer people were in paid employment when compared with March 2020 according to experimental estimates based on real-time data from HM Revenue and Customs’ (HMRC’s) PAYE.²⁰

- Estimated vacancies in the most recent quarter for which data is available (April to June 2020) fell by 463,000 (58.1%) to 330,000 compared with the previous quarter (January to March 2020).²¹

Furthermore, the negative impacts of the pandemic on employment have not been experienced evenly, with particular sectors and groups most affected. Analysis by the Resolution Foundation²² shows that:

- Employees in customer-facing service sectors impacted by lockdown and social distancing requirements have been worst hit. 'Hospitality' has accounted for more furloughs, job losses and reductions in hours than any other sector with over two thirds of workers affected, followed by 'Non-food retail and wholesale trade' and 'Arts, entertainment and recreation' which have both seen around half of workers affected.
- The low paid and young have been most affected by the pandemic, largely because of their concentration in the worst hit sectors:
 - Two in five (42 per cent) of the lowest paid fifth of employees have been furloughed, or lost jobs or hours compared with just 15 per cent of the highest paid fifth of employees.
 - 44 per cent of 18-24-year-old employees have been furloughed, or lost jobs or hours compared with less than a quarter of employees in their forties.

Greater Manchester

Greater Manchester has been impacted by the economic fallout of the effects of the response to the COVID-19 crisis including lockdown, with data showing:

- **Furloughed staff:** 384,700 claims have been made to the Job Retention Scheme in Greater Manchester up until 30 June 2020.²³
- **Claimant count²⁴:** an 89 percent rise in the volume of claims between March and June as the lockdown took effect; there were 140,635 unemployment benefit claimants in June 2020. The ONS claimant rate for those aged 16-64 in Greater Manchester, as of June 2020, was 7.9 per cent compared to 6.4 per cent for England.
- **Job vacancy data** is available weekly at a Greater Manchester level from Labour Insight (a tool allowing analysis of online job postings) and provides an indication of how the labour market is functioning during the COVID-19 pandemic. Job vacancies have fallen sharply. In January 2020, there were about 8,000 jobs posted a week; by the end of May this had fallen to about 2,400 a week.

These national and local labour market conditions provide a challenging context for WVEH to operate in. Supporting those with health conditions to return and stay in work is likely to prove harder if, as predicted, job losses continue to rise while vacancies remain below pre-lockdown levels. Moreover, the impacts of the pandemic on physical and mental health and wellbeing could also increase levels of presenting needs and exacerbate health issues which require more intensive support to address.

At the same time, the COVID-19 crisis presents an opportunity for WVEH to play a valuable role in identifying and responding to the needs of residents and employers. The evaluation can support this by providing real-time insights into the experiences and circumstances of participants and the effectiveness of programme support during the pandemic.

1.5. Evaluation methods

The evaluation of WWEH was commissioned by GMCA and is being undertaken by a team of researchers from Sheffield Hallam University and the University of Salford. It seeks to address a gap in the evidence base on early intervention employment support and how health and employment services in local areas can be integrated and delivered locally. The evaluation underpins the 'test and learn' ethos of WWEH and will be used to shape the programme as it evolves, and inform future investment decisions in similar programmes and services both in Greater Manchester and nationally.

The evaluation explores the extent to which the programme fulfils its core objectives to provide support that:

- results in a higher proportion of people who return to work and are sustained in work than would otherwise have been possible without the service.
- improves health and wellbeing for participants.
- contributes to a reduction in the number of days lost to sickness absence for those in employment.
- reduces time spent by clinicians on non-clinical work in primary care.
- reduces health inequality within this cohort.

This annual report focuses on the first 16 months of delivery from March 2019 to June 2020. Accordingly, it has a strong focus on the initial implementation and delivery of WWEH, particularly in terms of the development and effectiveness of the three main referral routes (Employers (SMEs), GPs and Jobcentre Plus). It also reviews the support delivered and its perceived effectiveness as well as the key health and employment outcomes experienced by participants.

Most of the data presented in the report covers all 16 months of delivery until the end of June 2020 unless otherwise stated. Where relevant, data has also been analysed up until the end 31 March 2020 and after 01 April 2020 to capture pre- and post-lockdown trends. Only data showing differences between these two periods is presented.

The findings presented in this report draw on the following sources of data:

- **Client monitoring data** on 950 participants collected by the Provider at several points during the customer journey. It includes data on referrals and starts, reasons for ineligibility, interventions received, participant characteristics, presenting needs and barriers to work, and health and wellbeing as well as employment outcomes. Data is collected by Provider staff using a combination of bespoke questions, standardised health assessments and a post-programme Customer Satisfaction Survey.
- **31 in-depth stakeholder interviews** undertaken face-to-face or by telephone between November 2019 and March 2020 with key stakeholders including: the Commissioner team based within the organisations responsible for funding, commissioning and scrutinising performance (GMCA and GMHSCP); managers and frontline delivery staff in the Provider organisations (Maximus and Pathways); local authority staff supporting the programme; and GPs and Jobcentre Plus (JCP) Work Coaches referring into the programme. Interviews explored the design, implementation and delivery of the programme; the effectiveness of referral mechanisms; the quality of support delivered; and outcomes for programme participants.

- **18 in-depth participant interviews** undertaken face-to-face or by telephone between January and March 2020 with programme participants who had received at least three month's support from WWEH. Interviews explored a range of themes including: employment histories, reasons for leaving work, the process of referral onto WWEH, barriers to returning to employment, support received from the programme and its perceived effectiveness, and outcomes of support.

The cohort was split equally by gender with nine female and nine male participants. All participants were White British/White English with two exceptions (one White Other from EU country and one British Asian). Eight were over the age of 50, with another three in their late forties. Across the sample, there was a fairly even split between those who had been referred by Jobcentre Plus (10 out of 18) and those referred by their GP (8 out of 18).

A number of planned evaluation activities were scaled back or postponed due to a combination of lower than anticipated engagement of SMEs and the impact of the COVID-19 pandemic. Lockdown occurred during the middle of planned fieldwork and several planned interviews had to be cancelled.

Postponed activities will be resumed once circumstances allows but it is important to note that delays impacted upon data collection and the findings presented in this evaluation. Participant and stakeholder insights are inevitably more limited given fewer than expected interviews, both in terms of the range of themes covered and their representativeness.

Also, stakeholder interviews were mostly conducted with the Provider delivery team. Planned interviews with wider stakeholders including staff in local authorities, GP practices and JCP offices were mostly postponed. This has resulted in a focus on frontline delivery and implementation of the programme from the Provider's perspective. Planned case studies looking at issues around implementation, governance, partnership and integration with other services within three localities have not been possible. These themes will be addressed in future fieldwork.

Finally, it is important to note that the number of participants who have joined and completed the programme has been significantly lower to date than expected, as outlined in in Sections 2 and 3. For this reason, many stakeholders interviewed felt it was **too early to reflect in depth on outcomes and impact**. Material presented in this report should therefore be treated as emerging findings which may change in later phases of the evaluation as more data becomes available.

1.6. Report structure

The remainder of the report is structured as follows:

- Section 3 considers the **design and implementation** of WWEH in terms of the perceived need for WWEH and the degree of innovation within programme design; partnership and governance; and implementation challenges.
- Section 4 reflects on the implementation and effectiveness of **referral pathways**. It examines volumes of referrals and starts and reviews the key challenges in meeting performance expectations.
- Section 5 **profiles participants** joining the WWEH programme in terms of personal characteristics, barriers to work, health conditions, presenting needs, and self-reported levels of health and wellbeing. It also explores how health issues interact with experiences of work and shape decisions to leave work.

- Section 6 looks at the **support offered** by WWEH and the number and type of interventions delivered to date. It considers the perceived 'value-added' of the WWEH approach from the perspective of stakeholders before comparing this with the experiences and perceptions of participants.
- Section 7 considers **employment and health outcomes** experienced by participants between entry onto and discharge from WWEH. Interviews with participants and stakeholders provide further in-depth insights into change and programme impact in terms of the extent to which WWEH contributes to outcomes.
- Section 8 reviews the key points of **learning** to emerge from the evaluation and makes **recommendations** for how the programme could continue to develop to respond to emerging needs.

Design and implementation

2

Summary

The WWEH model has a number of distinctive and innovative elements. These combine to create a unique service that, in principle, addresses an unmet need for tailored support for SME employees, the self-employed and the newly unemployed with health conditions or disabilities. Partnership working to support implementation is effective at the Greater Manchester level but more varied within localities. Integration of health and employment systems is progressing although still in the nascent phase. Implementation challenges have been significant, particularly in terms of the roll out of the core offer and generating referrals. Steps are being taken to address this.

2.1. Introduction

This section considers the design and implementation of WWEH. A core rationale for the programme is that it addresses an unmet need for tailored employment support for SME employees, the self-employed and the newly unemployed with health conditions or disabilities. The logic is that early intervention reduces the risk of long-term unemployment.

Successful implementation and delivery are dependent on effective partnership working at both a strategic and operational level across Greater Manchester and within localities. A key element of the implementation phase was to build partnerships between the Commissioner team, Provider organisations (Maximus and Pathways), Local Leads within local authorities, referral partners and wider services within the GM ecosystem.

Partnership is intended to support integration across the employment and health systems to engage GPs and allied health professionals and facilitate a change in culture in terms of seeing work as a determinant of health and wraparound return-to-work support as an important element of the health offer.

This section draws on stakeholder interviews to explore these themes in terms of the perceived need for WWEH and the degree of innovation within programme design; partnership and governance; and implementation challenges.

2.2. Design and innovation

Stakeholders highlighted a number of aspects of design that made WWEH **distinctive and innovative** including:

- A **health-led model** focussed on addressing health conditions and wider social determinants of health to enable individuals to move back into work.
- The focus on **early intervention** to facilitate a quicker return to work and reduce the risk of long-term unemployment.
- **Rapid access to services (CBT and physiotherapy)** for which there are long waiting times on the NHS.
- **Support for both SME employers and employees** including advice and confidence building for programme participants to negotiate a return to work.
- A **direct pathway for participating GP practices** to refer in patients who are in receipt of a Fit Note to support a return to work.

These elements combined to create what was perceived to be **a unique service that meets a clear need** for a service for SME employees or the self-employed in particular without access to occupational health provision.

However, a small number of interviewees suggested there were **gaps in the logic and design** of the programme including:

- The assumption that all employees of larger organisations have access to good occupational health support was not always borne out:

“With more established companies and more where there’s a very robust support package in place, they are getting that support, but there’s a lot of patients that are working for supermarkets and other organisations...lower paid positions where they don’t seem to have that access”. (Provider)

- Intervention at the point of taking medical leave or becoming unemployed was not always early enough:

“We haven’t got a programme for people who are wobbling, for people who could go off work but they’re trying their hardest to stay in ...So should there be something about keeping people in work before they go off sick?”. (Local authority)

- A lack of alignment with other Working Well programmes to provide continual support as individuals move in and out of employment. This could mean, for example, that the longer-term unemployed supported to return to work through other programmes could be referred into WVEH if health conditions then force them to leave their new job.

2.3. Partnership and governance

At a programme management level, stakeholders regarded the programme as a **genuine and effective partnership** between GMCA and GMHSCP. The direct involvement of GMHSCP staff in running the programme demonstrated *“really strong health buy-in”* at both a strategic and operational level. Working Well’s **strength as a brand and political leadership** from GMCA was also critical in securing engagement from wider partners in the health sector.

At the same time, it was recognised that there are **challenges in building links across the employment and health systems**, particularly in terms of engaging ‘health champions’ within local health partner organisations. This partly reflected the role of designated Local Leads within each of the local authorities tasked with supporting implementation of WVEH and facilitating partnerships. Nearly all had an employment and skills remit which left them less well placed to broker relationships

with health partners. As one interviewee reflected, system integration between health and employment was still at an early stage:

“We know we want health and employment to be a thing but...there’s still cultural challenges between the local authority and the health system and how they work. It will form eventually and it will grow, but I think that’s still quite new”. (Local authority)

Another stakeholder suggested the Commissioner team could have done more to engage parts of the health system including musculoskeletal (MSK) and mental health services at a Greater Manchester level. This would have made it easier for Local Leads to develop links at a locality level given the limited time they had to broker relationships.

Other **factors which had made developing partnerships more challenging** included:

- Pressures on the **capacity of Local Leads** to support WWEH due to the impact of austerity and staffing cuts which left them with high workloads and competing priorities. Some acknowledged the very limited time they could allocate to partnership development within WWEH. There was also a minority view that WWEH funding may have been better spent rebuilding depleted capacity at locality level rather than *“parachut[ing]”* (Local Authority) in a Provider and creating new posts.
- **Turnover of key members of staff** within both the Commissioner and Provider teams during the implementation phase impacted on the ability of the Provider to build relationships with potential referral partners such as GPs.

Governance arrangements were seen as a vital part of partnership building. Stakeholders noted **the effectiveness of strategic governance arrangements at a Greater Manchester level** but suggested local governance arrangements were more variable. In some areas, there was a strong focus on WWEH and supporting implementation. Other areas, however, had placed less priority on the programme which made it harder to secure buy-in from partners:

“The GM side of things is very strategic and you would expect solid governance in a strategic function...but when you then bring that into a locality where there’s a mish mash of everything...I think there does need to be a lot more information and more focus on the programme”. (JCP)

2.4. Implementation challenges

In addition to issues with partnership and governance, a number of further implementation challenges in early phases of the programme were identified:

- Difficulties in establishing effective **referral pathways** (explored in full in Section 4).
- A **delay in implementing core elements of the offer**, with fast-track Cognitive Behavioural Therapy (CBT) and physiotherapy provision only coming on-stream several months after programme launch. This was as a critical shortcoming given it was a major ‘USP’ of the programme. It led some GPs to stop referring patients once they realised the key *“selling point”* of shorter waiting times than NHS provision had not materialised: *“By the time the offer did come in place...GPs had disengaged then, they were making referrals and patients weren’t getting seen...they felt like they’d been told a lie”* (Local authority).

- One Local Lead also noted that this gap in support made them reluctant to encourage referrals from Jobcentre Plus as other programmes including the Work and Health programme had a superior offer for the newly unemployed in the meantime. It also meant the Provider delivery team had to fall back on their own expertise to support clients directly using techniques such as motivational interviewing. One implication was that the offer to clients was not always consistent as it depended on the skills of their VRC, although other team members with complementary experience could be sometimes be called upon.
- A **lack of clear and consistent marketing materials** had compromised understanding and profile of the programme. Issues included a lack of clarity among stakeholders about eligibility criteria and how it differed from other Working Well programmes. This led the Provider to recruit an external communications and social media consultancy to help refine the messaging to both referral agencies and potential participants.
- **Staff turnover** among both the Commissioner and Provider teams at the point of launch and in the first year of delivery have led to discontinuities as those responsible for designing and delivering the programme were not always in post to ensure smooth implementation.
- **Restructuring within the primary care system** including the introduction of social prescribing services and primary care networks (PCNs) made it more challenging to implement WWEH. Social prescribing was seen to add ambiguity to the referral options for staff within primary care, as well as delays if referrals came through to WWEH via the social prescribing teams. Meanwhile, PCNs do not always overlap with the neighbourhood-based geographies of WWEH and additional GP Practices who were part of the PCN have required further engagement work. This created a need to be nimble in a *“really complex adaptive system”* (Provider).

Overall, there was sense that these implementation challenges had been significant and meant the programme had not yet reached its full potential. A number of steps have been taken to remedy issues including significant actions to boost referrals (see Section 4), engaging a communications and social media consultancy to improve marketing, and bringing the Provider team up to full strength. It will be important to monitor the impact of these actions as the programme evolves.

Referrals and starts

Summary

Meeting targets for referrals and starts has proved challenging, even allowing for a drop off in activity during lockdown. A multitude of factors explain lower than anticipated volumes of referrals and starts but key issues include difficulties in generating Employer (SME) referrals and the large proportion of GP referrals that fail to 'convert' into starts on the programme. Significant activity has been undertaken to boost referrals and targets and this appears to be bearing fruit. The decision to refocus activities towards supporting the newly unemployed in response to the COVID-19 crisis is also likely to see significant increases in referrals.

3.1. Introduction

The distinctive focus of WWEH on early intervention and supporting in-work participants is reflected in the three main referral pathways and targets established at launch. In-work participants were intended to make up 80 per cent of all referrals and starts, with GP practices and Employers each contributing half of the target. It was also expected that 80 per cent of this in-work cohort would be SME employees. Jobcentre Plus (JCP) would then provide the remaining 20 per cent of participants who, as newly unemployed clients, would make up the smaller out-of-work cohort.

Targets have also been also set for the volume of referrals and starts over the lifetime of the programme. This includes interim monthly targets to measure if performance is on track to achieve the lifetime target. Performance challenges during the first year of programme delivery meant that the original interim targets were revised in November 2019 to create a new flightpath profile. This reduced expectations of referral and start volumes in the earlier phase of the programme and increased them in the later phase to compensate. Lifetime targets remain unchanged.

To understand performance issues, we have shown referral and start volumes against both the 'original' targets and 'revised' flightpath for some of the key measures below. However, we have mostly reported against the 'revised' flightpath as this is currently how performance is being assessed. All references to targets relate to the revised flightpath unless clearly stated that it refers to the original target.

The onset of COVID-19 and subsequent lockdown has also seen expectations revised to position the programme to address the anticipated rise in unemployment. The programme will soon begin to accept far higher volumes of referrals from JCP, up to a maximum of 500 per month. This is more than all JCP referrals to date (450 as of June 2020, see Table 3.2) and will significantly rebalance the focus of the programme towards the out-of-work cohort.

This section draws on programme monitoring data and stakeholder interviews to reflect on the implementation and effectiveness of referral pathways. It begins with an overview of referral volumes before exploring reasons for lower than expected levels. It then considers the volume of starts and conversion rates in terms of the proportion of individuals referred who join the programme, as well as the challenges in meeting targets for starts.

It is important to note that referrals have been recorded differently for each of the three pathways as follows:

- **GP pathway:** A GP referral is an individual who has been referred to the programme directly from one of the cluster GP practices. They are logged as a referral immediately because consent is assumed through their GP consultation and information governance agreements are already in place with the clusters. Sufficient personal information is available to enable a referral record (Appian ID) to be created without Provider staff speaking directly to the individual.
- **JCP pathway:** JCP, or newly unemployed referrals, are initially signposted to the programme from JCP offices. Consent and eligibility are then confirmed before they are classed as a referral.
- **Employer pathway:** Employer referrals include individuals employed by Small and Medium Sized Enterprises (SMEs), including those self-employed. As with JCP referrals, individuals in this pathway are only classed as a referral once contact has been made and consent secured.

The key distinction is that individuals signposted by JCP or Employers may not be contactable, eligible or agree to take part once contacted and are not recorded as referrals. This 'drop off' is not captured in referral and start data below. By contrast, GP referral data does include those referred across before contact is attempted and those who subsequently can't be contacted, decline the service or prove ineligible. These differences result from a misunderstanding by the Provider of the contractual requirements around reporting referrals which should have included these earlier 'signposts' from JCP and SMEs before contact was made.

This complicates comparison and effectively means the GP conversion rate of referrals to starts is suppressed relative to the JCP or SME pathway because the 'quality' of recorded referrals is more mixed. Caution needs to be exercised therefore in interpreting the figures. The Commissioner, Provider and Evaluation teams have now taken steps to rectify this. Newly available data on JCP and Employer signposts has now been made available to the Commissioner and Evaluation team. Preliminary analysis of this data will be available from January 2021 and will provide a more accurate and consistent on-going picture of levels of referrals and conversion to starts across pathways.

The introduction of the first lockdown on 23 March 2020 impacted significantly on referrals and starts. This is reflected in the analysis below to ensure the programme is not unfairly judged against targets that were set before the pandemic.

3.2. Programme referrals

Cumulative referrals

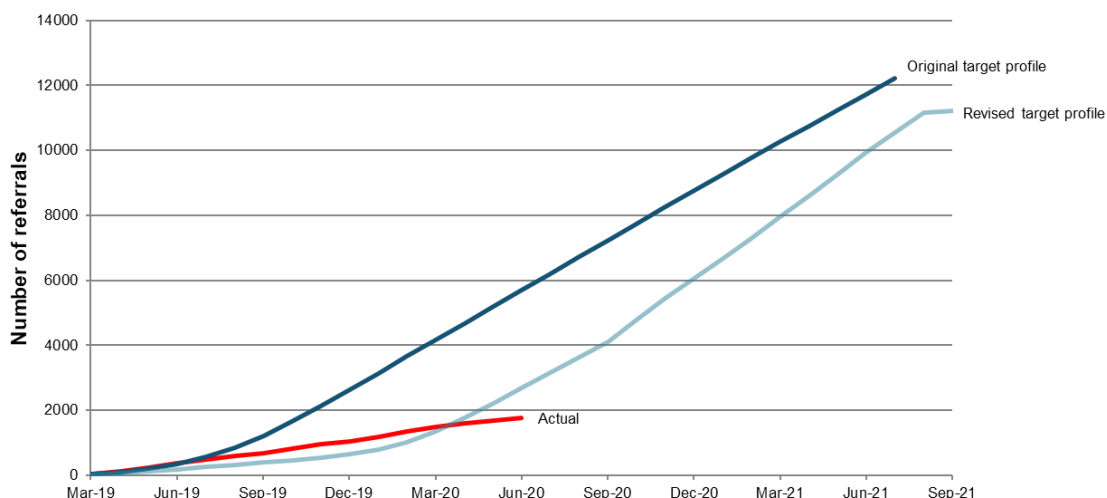
Cumulative referrals are all referrals received since programme launch in March 2019 until the latest point for which monitoring data is available. A total of 1,777 referrals had been made into WVEH by the end of June 2020 (Figure 3.1). This is equivalent to 16 per cent of the lifetime target of 11,206 referrals by September 2021 based on expectations that 90 per cent of referrals will be converted to starts as measured by

completion of one biopsychosocial assessment²⁵. However, the current referral to start conversion rate of 53 per cent is well below this. This means far more referrals will need to be made to hit the lifetime target for starts of 10,085.

The programme has significantly underperformed against ‘original’ referral targets, achieving only 31 per cent of the cumulative referral target to date. Indeed, the cumulative number of referrals has never exceeded the original cumulative target. There are several reasons for this underperformance which are explained in Section 3.3.

The ‘revised’ flightpath factors in early underperformance by reducing expectations in earlier months of delivery. Set against this measure, the programme has met two thirds (66 per cent) of its cumulative referral target to date. Underperformance is largely explained by falling referrals during lockdown at the same time as monthly targets continue to rise (Figure 3.2 below). Excluding the last three months after the introduction of lockdown, the programme achieved 111 per cent of the cumulative target by the end of March 2020. It must be remembered however that this level of overperformance is only possible because monthly targets were revised downwards to reflect early performance issues.

Figure 3.1: Cumulative referrals against lifetime target



Monthly referrals

Monthly referral volumes have ebbed and flowed since programme launch with a number of small peaks (Figure 3.2). The last six months of data presented in Table 3.1 show an increase from December 2019 to the highest monthly peak to date of 164 referrals in February 2020.

Referral volumes then fell each month from March 2020 before increasing slightly in June 2020 to 95 referrals, although this remains well below the February 2020 peak. Falling monthly referrals undoubtedly reflects the impact of lockdown as GP practices and JCP offices suspended many routine activities.

Current performance against the monthly referral target stands at 20 per cent in June 2020. While much of this can be explained by lockdown, data shows performance against targets has been falling consistently since January 2020. This indicates a more longstanding issue with referral volumes failing to keep up with rapidly rising monthly targets. Given this trend, it seems unlikely the programme could have ‘caught up’ with targets, even without the COVID-19 pandemic. However, these trends are likely to change following the decision to significantly increase referrals from JCP.

The 'original' target line shows how far and how quickly monthly referrals fell behind expectations from a very early phase after programme launch. Introducing the 'revised' monthly flightpath brought the programme back on track, but only until January 2020.

Figure 3.2: Monthly referrals against targets

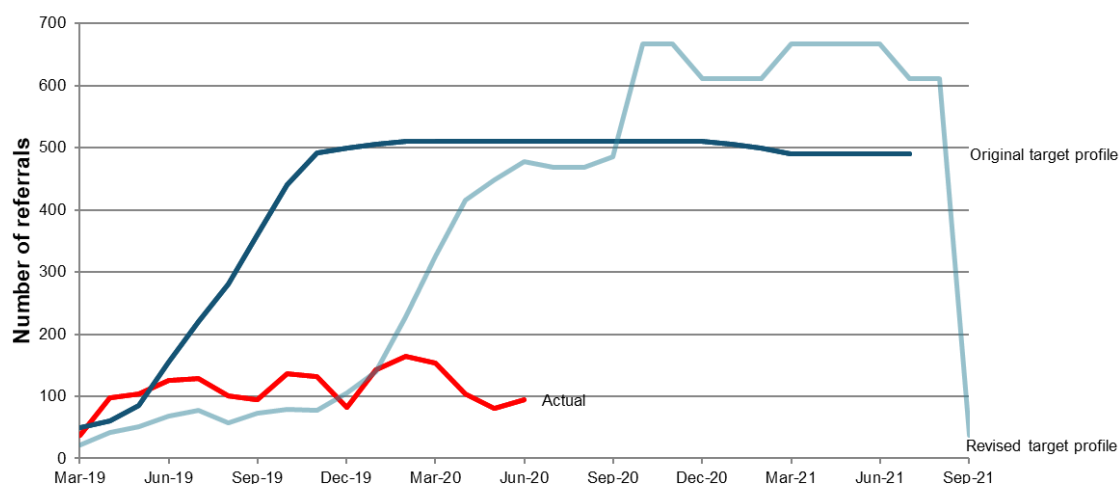


Table 3.1: Monthly referrals against targets

Month	Target	Actual	% of target achieved
Jan-20	139	142	102%
Feb-20	228	164	72%
Mar-20	326	154	47%
Apr-20	416	104	25%
May-20	448	81	18%
Jun-20	478	95	20%

Referrals by pathway

Referrals are sourced through three main pathways with GPs and Employers generating in-work referrals while JCP refer out-of-work clients (although the figures are not directly comparable due to recording issues discussed in Section 3.1):

- GPs:** One GP cluster (generally between four and six GP practices) in nine of the ten Greater Manchester boroughs (excluding Manchester) refer patients into WVEH. GPs or other practice staff refer directly using an online form. All GP referrals are intended to be in work but on medical leave with a Fit Note. Dedicated GP Engagement Officers (GPEOs) in the Provider team support GP practices to generate referrals.
- Employers:** SME employers can refer employees on medical leave with a Fit Note with their consent. SME employees as well as the self-employed with a health condition or disability limiting their work can also self-refer into the service. A team of Partnership Engagement Consultant (PECs) in the Provider team are responsible for developing links with SMEs and encouraging referrals.
- JCP:** Newly unemployed JCP clients who have worked in the last six months and for whom ill health or disability is a barrier to work can self-refer into WVEH. JCP

staff do not make direct referrals but provide information ('signpost') on WWEH to clients who then contact the programme directly. A dedicated PEC also regularly visits JCP offices and is available to talk to customers. One implication of the signposting and self-referral process is that JCP staff, unlike GPs, do not receive feedback on the support customers received and the outcomes experienced.

When WWEH was launched, it was expected that GPs and Employers would provide the majority of all referrals (40 per cent each) with the remaining 20 per cent sourced from JCP. This reflects the programme's original intention to focus on those in work but on medical leave.

Figure 3.3 shows the actual proportion of referrals to date by pathway has varied significantly from expectations. The GP pathway accounted for a significantly higher than expected proportion of referrals (68 against 40 per cent), while the proportion of JCP referrals has been slightly higher (25 per cent compared to 20 per cent). By contrast the proportion of referrals from Employers is far lower than expected (7 per cent compared to 40 per cent).

The first lockdown had a significant negative impact on monthly referrals from GPs and JCP, although Employer referral volumes increased slightly from a low base between April and May 2020 (Figure 3.4). Despite this, Table 3.2 shows volumes of GP and JCP referrals either exceed or come close to meeting cumulative targets to date (112 per cent for GP referrals and 84 per cent for JCP referrals). Employer referral volumes are well below target, only achieving just under one fifth (11 per cent) of the cumulative target. Pre-lockdown performance against cumulative targets for Employer referrals is still only 17 per cent.

Figure 3.3: Proportion of referrals by pathway

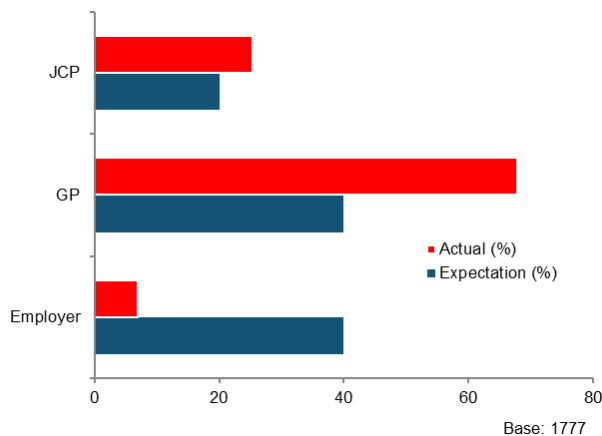


Figure 3.4: Monthly referral volumes by pathway

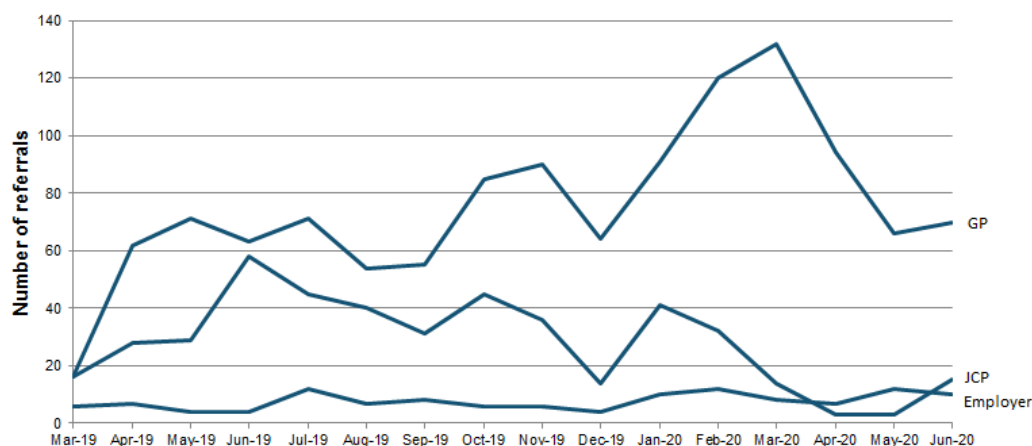


Table 3.2: Cumulative referrals against targets by pathway

Referral route	Total actual referrals	Cumulative referral target	% of cumulative referral target achieved to date (until end of June 2020)	% of cumulative referral target achieved before lockdown (until end of March 2020)
GP	1204	1076	112%	181%
Employer	123	1076	11%	17%
JCP	450	538	84%	159%
Total	1777	2690	66%	111%

3.3. Explaining referral volumes

Interviews with stakeholders provide some insights into referral volumes to date in terms of both good practice and challenges. This section looks firstly at overall referral volumes before presenting reflections on referrals via the three main pathways (although the figures are not directly comparable due to recording issues discussed in Section 3.1).

Overall referrals

Cumulative referrals since programme launch are currently at two thirds (66 per cent) of expected volumes at this point in the programme. Much of this can be attributed to the first lockdown but referral challenges were also evident before the COVID-19 crisis. The decision to revise monthly and cumulative targets in November 2019 reflected underperformance against original expectations. Monthly referral data (Table 3.1) also shows missed targets in February and March before the first full month of lockdown.

Stakeholders interviewed suggested a number of **reasons why referral volumes have been lower** than anticipated during this phase of the programme:

- Initial difficulties in **recruiting experienced staff** for engagement activities in competition with other employment support programmes. Ongoing issues with recruitment also meant a full engagement team was not finally in place until March 2020.

- Confusion among referral agencies and wider partners over **eligibility criteria** for different Working Well programmes. This stemmed partly from a **lack of clear and consistent marketing** in earlier phases of the programme.
- **Limited initial understanding of health issues** among some of the engagement team made it harder to promote WWEH's distinctive offer: *"At the start the team didn't have a good understanding of health and how to sell that and we're competing against other Working Well programmes"*. (Provider)
- **Variable capacity among Local Leads** to support the Provider to develop relationships with potential referral agencies and employers.

GP referrals

GP referral volumes to date are high relative to other referral pathways, accounting for over two thirds (68 per cent) of all referrals and comfortably meeting the cumulative revised flightpath by 112 per cent, although this only equates to 53 per cent of the original target. Analysis shows the overall performance against the revised flightpath is largely due to high numbers of referrals from a small number of participating GP practices. Of the 56 GP practices that have made any referrals, five practices alone account for 48 per cent of all referrals. One GP practice (Kearsley Medical Centre, Bolton) has made 14 per cent of all GP referrals over the course of the programme; this practice is responsible for nearly three quarters of all GP referrals in Bolton.

Where engagement with GPs has been effective in generating referrals, interviewees identified a number of **contributing factors** including:

- **supportive Local Leads** willing to broker engagement with GP practices.
- **committed and engaged GP practice staff** including:
 - **GP champions** with the commitment and energy to encourage colleagues to refer: *"You really need significant advocates to be able to get you a presence within the practice and the GPs to talk about the service and that's what worked well in Stockport and Bolton"*. (Provider)
 - practice managers able to support the Provider to access GPs
 - practice staff who can process referrals to reduce demands on GPs.
- **perseverance** among the Provider engagement team to establish contact and regular communication with GP practices.
- **fast track access to CBT and physiotherapy** support was *"a big selling point for the programme"* (Provider).
- **succinct and targeted feedback** evidencing the benefits of WWEH for patients also encouraged GPs to refer.
- GPs making **direct referrals** instead of encouraging self-referrals, even if the latter is seen as a way of empowering patients to self-manage health conditions.

At the same time, there have been difficulties in engaging some practices or individual GPs and securing referrals. Stakeholders identified a number of challenges including:

- the **perceived lack of capacity in the Provider engagement team** to undertake the intensive face-to-face work needed to secure GP buy in, even though the team has been at full strength since inception.
- **promotional materials** incorrectly stating eligibility criteria at the outset and a five-month delay in reissuing leaflets with the correct information.

- difficulties building **relationships** in some GP practices where there are high numbers of **non-permanent staff** (locums and trainees).
- accessing GPs where gatekeepers such as practice managers act as **“doctor blockers...and may not see the benefits of the service”** (Provider).
- the **excessive volume of feedback** on patient outcomes provided initially making it hard for GPs to digest and discern benefits that would encourage further referrals.
- a **lack of interest or involvement from GPs**, including many of the designated GP leads, due to factors including time pressures, a lack of understanding of eligibility criteria, competing priorities, and a reluctance to refer into a time-limited service: *“It’s hard for them to fully buy into a service if they don’t think it’s going to be there for the long run”* (Provider).
- a **lengthy nine-month delay in CBT and physiotherapy provision** being put in place deterred some GPs from using the service (see Section 3.3).
- **delays in rolling out ‘pop-up’ reminders of WVEH on GP systems** to encourage referrals and facilitate the process.
- WVEH being **“low down the list of priorities”** (Provider) in the context of wider restructuring of practices into Primary Care Networks.

A series of actions have also been taken to address many of these issues:

- **Ensuring physiotherapy and cognitive behavioural therapy provision is now in place** has helped to build trust and credibility: *“For those practices that were a little bit dissuaded...you have to build confidence, you have to go back...and we’ve seen new GPs referring into the service now”* (Provider).
- **Trialling triage** in GP practices in Stockport, Salford, Tameside and Oldham where GPEOs receive lists of patients receiving Fit Notes to contact directly. This reduces reliance on GPs or other practice staff to check eligibility and communicate the potential benefits of WVEH.
- **Condensing the volume of information provided in feedback to GPs.**
- **Working with CCGs and GP Federations** to facilitate better engagement with GPs.
- **Engaging other practice staff** including practice managers, receptionists, nurses and healthcare assistants to promote the programme and encourage referrals while reducing expectations of GPs.
- Running a **GP engagement event** in Bolton with the support of the GP Lead to clarify eligibility criteria and encourage referrals.
- **Expanding the number of GP practices** GPEOs are working with in Salford.
- **Working with** the social prescribing services operating in Salford (Wellbeing Matters) and Wigan to identify potential referrals.

This intensified engagement activity appears to have borne fruit. In Stockport the new triage approach was directly credited with increasing referrals: *“We’d suddenly gone from strength to strength”* (Provider). Moreover, steadily rising volumes of monthly GP referrals from 64 in December to 132 in March 2020 before the first full month of lockdown also indicates that renewed engagement activity is paying off.

Jobcentre Plus (JCP) referrals

JCP referrals to date account for just over a quarter of all referrals (27 per cent) and have met three quarters (84 per cent) of the cumulative target. This small shortfall against targets is mostly due to referrals almost ceasing in the first two full months of lockdown, with only six referrals made in total in April and May. At the same time, a steady increase in monthly targets has also widened the gap between actual and target referrals.

Stakeholders widely **regarded JCP as an effective and natural referral pathway** due to a number of factors including:

- the **natural alignment** of JCP priorities with WWEH as an employment programme.
- **established relationships** between GMCA, Local Leads and JCP helped the Provider gain access. Time spent **by the Provider developing good links** with JCP at the outset also secured buy in.
- a **tendency of JCP clients to self-refer** if suggested by Work Coaches because of *“fear of losing benefits”* (Provider) even though participation is voluntary.
- **recognition of the value of fast-track access** to physiotherapy and CBT to clients.
- **reducing the onus on clients to self-refer** by encouraging JCP staff to pass on details of potential referrals to the PEC so they can contact clients:

“The majority of people that we see have health conditions to do with mental health and the last thing they want to do is ring up somebody on an 0300 number and say I need help, it’s so much easier if [Work Coaches] say [WWEH] can give them a call”. (Provider)

At the same time, JCP staff and other stakeholders noted **challenges** in generating referrals including:

- **turnover in the Provider engagement team** increased the length of time required to develop relationships with frontline JCP staff.
- **lack of time** for JCP Work Coaches to discuss WWEH in short interactions with clients.
- **a shortage of eligible JCP clients** as most with health conditions had been out of work for longer than six months.
- **a tendency among some JCP staff and managers to prioritise and refer into the Work and Health programme²⁶ and other local provision** because of:
 - greater familiarity with the Work and Health programme which had been promoted heavily by service managers.
 - a preference to refer clients into intensive support seen as more appropriate for unemployed clients with health conditions.
 - a lack of feedback on client outcomes because of self-referral meant Work Coaches knew less about whether WWEH support worked compared with other programmes: *“It seemed to be a bit a bit of a black hole ... unless the individual came back themselves and spoke to the Work Coach we didn’t really know what had happened”* (DWP/JCP).

- the direct referral system for other programmes which was easier to use than the WWEH signposting process, which required Work Coaches to notify the WWEH team of potential referrals.

A small number of interviewees suggested **improvements** including:

- **revising communications materials** seen as “*too wishy-washy*” (DWP/JCP).
- **a renewed focus on promoting WWEH** including clearer communication of the value of its offer relative to other programmes: “*If you don’t put enough focus and priority on it it’s something that will get lost or slip to the bottom*” (DWP/JCP).

Employer referrals

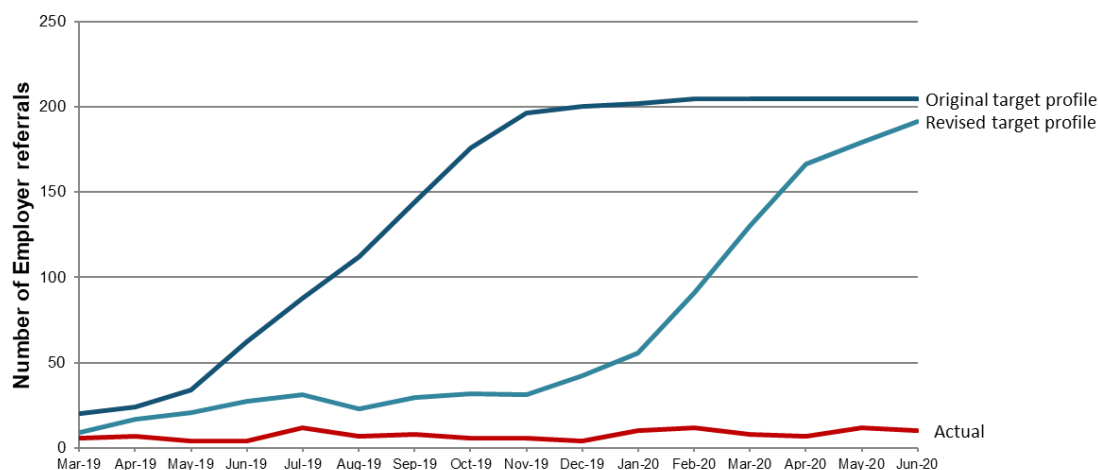
It was widely recognised that **Employer referrals have been lower than expected**. To date only 7 per cent (123) of referrals have come through this pathway against an expectation of 40 per cent. This is equivalent to 11 per cent of the cumulative target to date.

Stakeholders suggested a number of **reasons why SME referrals have not been as high as expected**:

- The **pool of potential participants may be small** as the lower levels of sick pay sometimes paid to SME employees means they are less likely to take medical leave.
- **Provider staffing issues** including personnel changes and periods of time with no PECs in place in some Localities have led to gaps in engagement activities.
- **Siloed working** has seen parts of the GM ecosystem such as the Growth Hub provide fewer SME contacts and referrals than expected.
- A perception among one interviewee that the Provider had **not fully harnessed the potential of existing employer support infrastructure**, networks and contacts: “*They were doing cold calling, they weren’t engaging with the local system*” (Local authority). At the same time there was a recognition that cuts in local authority funding for business support activities limited this potential.
- A **lack of willingness among employers** to engage with the programme because:
 - no staff are on medical leave when contacted.
 - involvement implies they are not providing adequate support for employees
 - of concerns that WWEH could signpost employees to advice on employment rights that could “*open up a can of worms*” (Provider).
- A **reluctance among employees** to engage because of fears that disclosure of health issues to their employer could mean they are “*treated differently and their rights will be impacted*” (Provider).
- **Challenges in working with business support networks** who often require payments to send out information to members.

The Provider has responded to low levels of referrals by significantly ramping up SME engagement activities. This has included extensive ‘cold’ calling and emails, SME engagement events, targeting specific sectors (care and logistics/warehousing), and joint visits to employer premises with local authority officers already working with SMEs e.g. environmental health officers. However, this additional activity generated few good additional leads to date, as Figure 3.5 shows.

Figure 3.5: Cumulative employer referrals



A number of **further improvements** were suggested, some of which have already been put in place:

- Enhancing the messaging to SMEs about **potential business benefits** such as reducing absenteeism and sick pay as well as increasing productivity. Work has started on this with the support of an external communications consultancy.
- Ensuring **on-going account management** so employers remain aware of WVEH and refer in as and when employees need support.
- Working with SMEs to **convey the message to employees that engagement with WVEH will not impact negatively** on their job or relationships with their employers.
- **Building the ecosystem around WVEH** by working with GMCA and business support programmes in Greater Manchester to better share SME information, contacts and referrals. Dialogue is already underway to support this.

3.4. Programme starts

Cumulative starts

A programme start is recorded when a participant completes a welcome call and initial health assessments. The lifetime target number of participants starting on the programme is 10,085 by September 2021. By the end of June 2020, 9 per cent of this target had been met (950 starts).

Figure 3.6 shows that cumulative starts have increased slowly but steadily since programme launch. However, the volume of starts has been lower than original targets in every month and currently stands at 19 per cent of the original cumulative target.

The introduction of the lower revised flightpath in November 2019 has still seen the gap between actual and expected starts widen. By June 2020 the programme had only achieved 39 per cent of cumulative revised flightpath starts. Some of this shortfall can be attributed to low volumes of referrals during the first lockdown. However, cumulative achievement against the revised flightpath for starts up until the end of March 2020 stood at 64 per cent, indicating **that performance issues precede lockdown**.

Prior to the lockdown, targets had been set for the proportion of in-work (80 per cent) and out-of-work (20 per cent) starts. To date, three fifths (59 per cent) of all programme

starts have been participants who are in work, indicating the programme has predominantly supported those on medical leave but not to the extent expected. These targets have now been removed to allow for a significant increase in out-of-work referrals from JCP.

Monthly starts

As with referrals, monthly starts have fluctuated since programme inception (Figure 3.7). Starts peaked at 85 in March 2020 before falling to 51 as lockdown took effect in April 2020 (Table 3.3). The subsequent two months saw small increases with 64 referrals made in June but this remains below pre-lockdown levels.

The last six months of data show that referral volumes have increasingly fallen behind steadily rising monthly targets since January 2020 (Table 3.3). Steep falls in the proportion of targets achieved between January and March 2020 predate lockdown, indicating the need for additional explanations for lower than expected starts.

The inclusion of the 'original' targets highlights performance issues from the outset, with volumes of starts below expected levels in every month since launch.

Figure 3.6: Cumulative starts against target

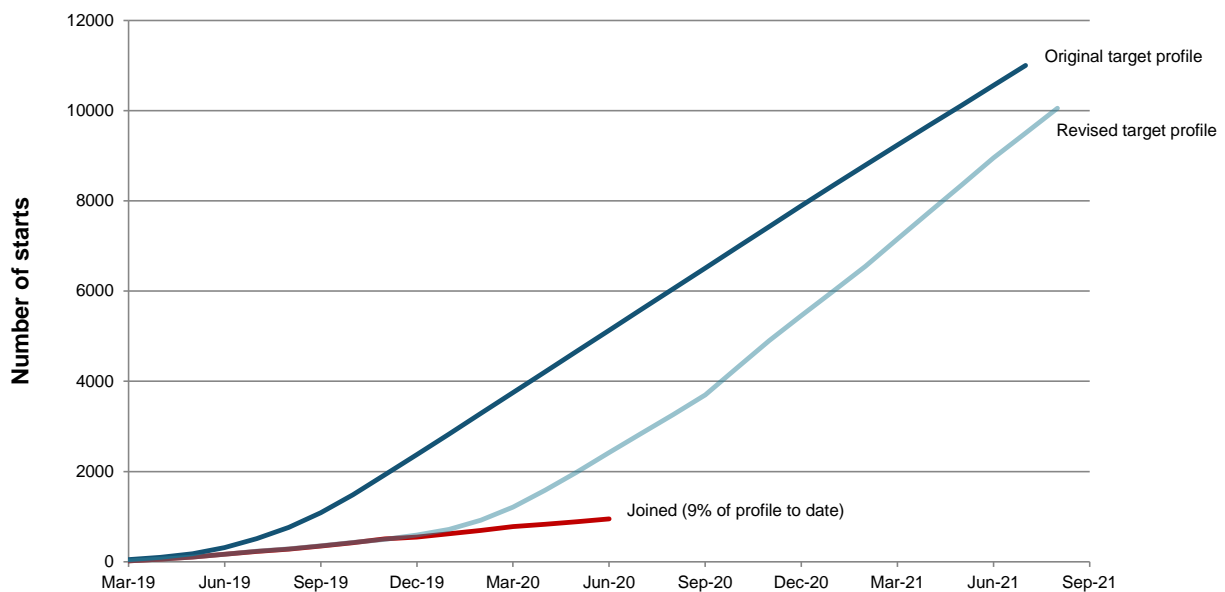


Figure 3.7: Monthly starts against target

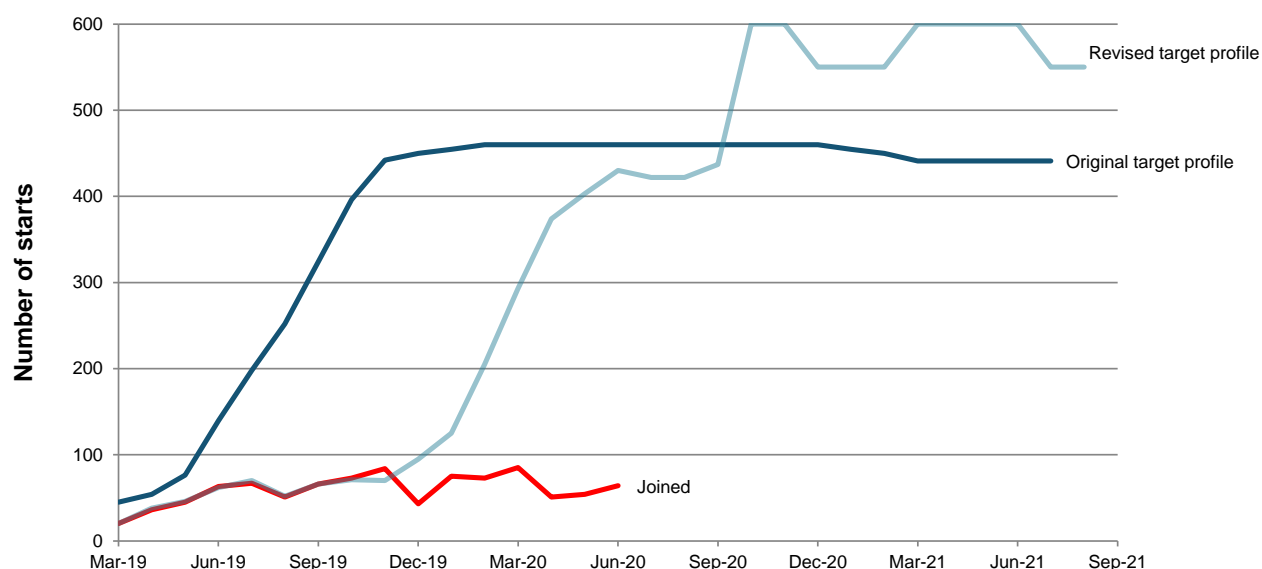


Table 3.3: Monthly starts against target (last six months)

Month	Target	Actual	% of target achieved
Jan-20	125	75	60%
Feb-20	205	72	35%
Mar-20	293	85	29%
Apr-20	374	51	14%
May-20	403	54	13%
Jun-20	430	64	15%

Starts by referral pathway

As with referrals, targets were initially set for the proportion of starts by referral route with GPs and Employers expected to account for 40 per cent each, while JCP provided the remaining 20 per cent. These targets have been removed during the COVID-19 crisis to enable a refocus towards supporting the newly unemployed through increased referrals from JCP.

Figure 3.7 shows that the proportion of starts from is higher than expected for from both the GP pathway (54 per cent compared to 40 per cent) and JCP pathway (37 per cent compared to 20 per cent). The proportion of starts from Employer referrals is far lower than expected (9 per cent compared to 40 per cent).

Performance against cumulative targets varies considerably by referral route as shown in Table 3.4 (although the figures are not directly comparable due to recording issues discussed in Section 3.1). By the end of June 2020, JCP starts had hit three quarters of the target (73 per cent) despite three months of lockdown when hardly any referrals have been made. By contrast, GP starts are only just over half of target (53 per cent) while Employer starts are less than one tenth of target (9 per cent).

Lower than expected performance for JCP and GP starts can be explained largely by lockdown limiting the flow of referrals. Pre-lockdown data shows JCP comfortably

reaching the cumulative target for starts (137 per cent) and GP achieving over three quarters (78 per cent) of the target by the end of March 2020. However, Employer starts remained significantly below target at 14 per cent, indicating performance issues preceded the COVID-19 crisis.

Figure 3.7: Proportion of referrals by pathway

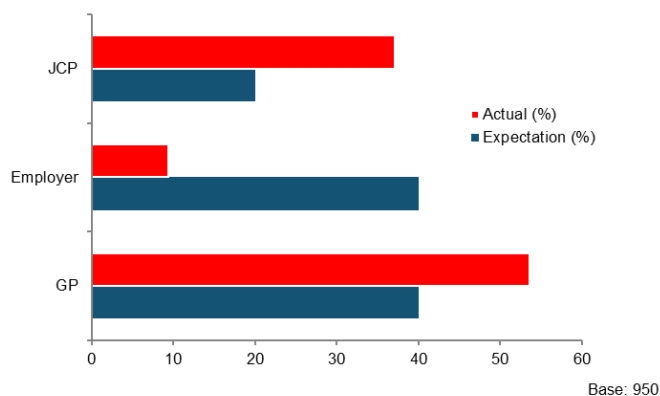


Table 3.4: Cumulative starts by pathway

Referral route	Total number of referrals	Total number of starts	Conversion rate of referrals to starts (%)	Target number of starts (until end of June 2020)	% of target number of starts achieved (until end of June 2020)	% of target number of starts achieved pre-lockdown (until end of March 2020)
GP	1204	509	42%	968	53%	78%
JCP	450	352	78%	484	73%	137%
Employer	123	89	72%	968	9%	14%
Total	1777	950	53%	2420	39%	64%

Conversion to starts

The conversion rate is a measure of the proportion of individuals referred into WVEH who join the programme as indicated by completion of at least one biopsychosocial assessment. The conversion rate currently stands at 53 per cent and has remained just over 50 per cent since programme launch against a target of 90 per cent. This has significant implications for the number of referrals needed for the programme to achieve lifetime targets for starts.

Monitoring data for all participants provides some indication of the primary reasons for the low conversion to start rate. Broadly this falls into two groups: participants being ineligible as they do not meet WVEH criteria or the service being declined (including those who cannot be contacted) once referred. Data shows those who decline the service are by far the largest group:

- **21 per cent are ineligible:** primary reasons for ineligibility within this cohort are that provision is not suitable for the participant and they are signposted to other provision (35 per cent); followed by the participant was not off work for more than two weeks (23 per cent).
- **79 per cent decline the service:** primary reasons for declining the service are that the individual referred cannot be contacted (53 per cent) or that individuals

decline support once contacted (37 per cent). Overall, individuals who cannot be contacted account for two fifths (42 per cent) of all programme referrals that are not successfully converted to starts.

Conversion rates for referrals vary considerably by referral route (Table 3.4). Around three quarters of individuals start on the programme where referred by JCP (78 per cent) or Employers (72 per cent). By contrast, only 42 per cent of GP referrals join the programme. However, it is important to note that referrals are currently captured differently for each pathway (see Section 3.1) so observed differences may be partially a reflection of recording criteria rather than actual performance. Planned analysis of JCP and SME signposts in coming months using newly available data will provide a more robust comparison.

This variation explains performance issues related to the number of starts achieved by pathways highlighted above. Most Employer referrals are successfully signed up to WVEH but the volume of referrals is too low to meet targets for starts. By contrast, GP referral volumes are high but the low conversion rate means the target for starts is missed by some distance. The reasons for a low conversion to start rate for GP referrals is explored below.

Explaining conversion to starts

Stakeholders identified **a number of reasons on why referrals are not always converted to starts across all pathways:**

- **Triage at referral stage** excludes those who state they do not want to go back to work despite the possibility that intentions could change with programme support.
- **A lack of clarity about criteria in early marketing materials** led to some ineligible referrals.
- The **lengthy referral and attachment process** serving the needs of the programme rather than participants, with multiple phone calls with different staff “*overwhelming*” and creating too many potential “*drop off points*” (Provider).
- A preference for **face-to-face support** leading some individuals to decline a predominantly telephone-based offer.
- **Limited IT skills or access to technology** prompting some to turn down a service with a significant component of online support.
- **A reluctance to divulge personal information** requested as part of mandatory assessments.
- **Improvements in health** or expectations of an imminent return to work negating the need for the service.
- Those eligible for the Advice Service turning down support because they **already had access to similar provision** through their employer.

Steps have been taken to address a number of these issues. Marketing materials have been significantly revised with the support of an external communications agency. VRCs also seek to accommodate individual needs by, for example, addressing a lack of IT skills by providing printed materials or not requiring an email address to sign up.

Stakeholders also reflected on why GP referral to start conversion rates were particularly low relative to the other two pathways (although these figures may not be directly comparable to other pathways due to recording issues outlined in Section 3.1):

- A “clunky” (Provider) referral system **making it difficult to contact individuals** due to incomplete information such as missing surnames, no GP name or practice information, and wrong telephone numbers.
- **Individuals not responding to contact** because incomplete referral information means the Provider cannot reach them by call, text or letter; or they do not recognise the ‘0300’ number the Provider calls on.
- GPs making **ineligible or inappropriate referrals** due to:
 - A tendency among a small number of GPs to just “*ping anyone through*” (Provider), particularly at the beginning of WVEH when promotional materials provided incorrect information on eligibility in terms of suggesting out-of-work patients could be referred.
 - A lack of understanding around eligibility criteria and the distinction between the Advice and Support Service. This can lead to patients working for larger employers declining the service when they realise they are not eligible for the full range of support.
 - **GPs not always informing patients** they had been referred which may lead some to not respond to ‘cold’ contact.
- **Promotion of self-referral** by some GP practices to encourage self-management of health conditions may have increased ineligible referrals.

The Provider engagement team have made **significant efforts to remedy many of these issues** including trialling a triage approach where GPEOs contact patients on Fit Notes (see above); sourcing missing contact information from GP practices; and using alternative methods (email and letter) where contact cannot be made by phone and text.

An enhanced referral form is also being rolled out in GP practices which should limit incorrect or missing information relayed to the Provider. However, this has been delayed by the time taken to get information security governance (ISG) agreements in place. One implication is that referring GPs can still not always be identified and contacted, either to source missing information or to ensure they understand referral criteria following ineligible referrals.

Finally, extensive and regular ‘conversion improvement’ meetings are now being held within the Provider team to identify and address reasons for ineligibility or service decline. This has highlighted the need to work more closely with GPs to ensure they are fully aware of eligibility criteria and inform patients both that they are being referred and what to expect in terms of contact from the Provider (e.g. that they will receive a call on an ‘0300’ number).

Encouragingly, these actions appear to be having a positive result with conversion rates across all three pathways improving in the last two months. In June, both Employer and JCP referrals had an 80 per cent conversion rate whilst the GP conversion rate increased to 63 per cent (compared to 42 per cent since programme start).

3.5. Referrals and starts by locality

There are a number of differences across Localities in terms of volumes of referrals and starts, referral source, and conversion rates:

- Since programme start, Stockport has been the leading source of referrals. Bolton, Oldham, and Tameside have also contributed a high number of referrals.

- There are key differences in referral source by district. Most areas primarily receive referrals through GPs although others such as Oldham and Wigan are more balanced in terms of the split between GP and JCP referrals. Manchester is an outlier with mainly JCP referrals but this is due to different referral structures which does not include a GP cluster due to the existence of separate local provision GPs can refer into.
- Manchester has the highest rate of conversion to starts (78 per cent), although this is the locality with the lowest number of referrals. Localities with the highest number of referrals convert around 50 per cent of referrals to starts.
- Since the first lockdown the number of referrals has decreased across all localities with the decreases largely proportional to the existing numbers of referrals by each locality.

Table 3.5: Referral and starts by locality

Locality	Total number of referrals	By referral source			Starts	Referral to Start conversion rate (%)
		GP	Employer	JCP		
Bolton	276	226	5	45	129	47
Bury	79	47	15	17	37	47
Manchester	58	3	8	47	45	78
Oldham	283	142	24	117	156	55
Rochdale	138	72	36	30	81	59
Salford	91	67	3	21	54	59
Stockport	391	360	5	26	201	51
Tameside	248	162	15	71	126	51
Trafford	124	76	7	41	71	57
Wigan	86	46	5	35	50	58
Total	1774	1201 ²⁷	123	450	950	54

Profile of clients

Summary

Health management features prominently as a barrier to work, validating the strong focus of the programme on supporting participants to manage health conditions. Mental health issues are particularly prevalent, affecting nearly a half of all participants. Standardised health assessment also show that life satisfaction and mental wellbeing are lower among participants on entry than the population as a whole. To June 2020 there is little evidence, however, of a 'COVID-19' effect in terms of increased levels of presenting needs or health issues among participants joining after lockdown, although it is too early to say whether this will stay the case as the pandemic evolves. Participant accounts highlight the close relationship between employment and health, with job quality a key factor shaping health, wellbeing and decisions to leave work.

4.1. Introduction

This section profiles the characteristics of participants joining the WVEH programme. It uses programme monitoring data collected through initial assessments to present information on personal characteristics, barriers to work, health conditions, presenting needs, and self-reported levels of health and wellbeing. The characteristics of participants who have the highest level of needs is then examined using a bespoke 'Combined Measure of Need' measure created for the evaluation.

The section concludes with insights from both stakeholder and participant interviews on health issues and how these interact with experiences of employment and shape decisions to take medical leave or leave jobs altogether.

4.2. Characteristics

Tables 4.1 and 4.2 shows the characteristics of individuals joining the programme by gender, age, ethnicity, education and occupation if in work. Key points include:

- 55 per cent of those joining so far are female; 44 per cent are male. There are significant gender differences by employment status on joining the programme. Nearly two thirds (62 per cent) of in-work participants are female while male participants make up a higher proportion of the out-of-work cohort (54 per cent).
- 85 per cent are White British, five per cent Asian/Asian British and 4 per cent Black/African/Caribbean/Black British.
- The programme has similar proportions of participants across all working-age groups except for 18-24-year olds. This cohort makes up a much smaller proportion of participants even after taking the narrower age range into account.

It will be important to ensure that the programme is targeting and engaging this group given the additional risks young people face of unemployment (see Section 1.4).

- 81 per cent of participants are educated to upper secondary (e.g. A-Levels) or post-secondary (e.g. college) level or above.
- The most common occupations for those in work on entry to the programme tend to be lower level occupations with the exception of 'Health and social welfare associate professional'.²⁸

Table 4.1: Characteristics of participants

Socio-demographics	%		
	In work	Out of work	All
Gender			
<i>Male</i>	38	54	44
<i>Female</i>	62	46	55
Age			
<i>18-24</i>	7	13	10
<i>25-34</i>	22	24	23
<i>35-44</i>	21	21	21
<i>45-54</i>	27	20	24
<i>55-64</i>	21	20	21
<i>65+</i>	1	1	1
Ethnicity			
White - British/Irish	86	82	85
Asian/Asian British	4	7	5
Black/African/Caribbean/Black British	2	5	4
White - Other	3	3	3
Mixed/Multiple	3	2	2
Other Ethnic Group	1	1	1
Education - Highest Qualification			
<i>Primary education or below</i>	0	1	0
<i>Secondary education (GCSE)</i>	18	14	17
<i>Upper secondary (A-levels)</i>	26	37	30
<i>Post-secondary (college, BTEC courses)</i>	27	32	29
<i>Undergraduate/Postgraduate</i>	28	15	23
<i>Not applicable</i>	1	1	1

Base: 948-950

Note: Columns may not sum to 100% due to rounding.

Table 4.2: Most common occupations (in-work participants only)

Top 4 occupations		%
1	Customer service occupations	16
2	Health and social welfare associate professional	10
3	Administrative occupations	10
4	Process, plant and machine operatives	7

Base: 577

4.3. Barriers to work and health problems

Information on barriers to work and health problems (classified as ‘primary’, ‘secondary’ or ‘other’) is collected from participants as part of initial assessments undertaken when joining the programme.

For those reporting barriers to work (Table 4.3), health management is by far the most common barrier for both in-work (96 per cent) and out-of-work (86 per cent) participants. Confidence, motivation, and family issues are also commonly reported barriers by both cohorts, albeit at far lower levels. The predominance of health management as a barrier to work validates the focus of WVEH on addressing health issues to support a return to employment. Of those reporting barriers to work, 28 per cent reported two or more barriers and 13 per cent indicated three or more barriers.

Mental health conditions are the most common health issues faced by WVEH participants (Table 4.4) with a fifth (21 per cent) experiencing ‘Depression or low mood’ and a further 13 per cent reporting ‘Anxiety disorders’. Problems with back is the most frequently reported physical health condition (12 per cent).

In total, nearly a third (29 per cent) of all participants overall report either ‘Anxiety disorders’ or ‘Depression or low mood’ as their primary condition. If those reporting these conditions as a secondary or other health conditions are also included, this total rises to 43 per cent.

Analysis was undertaken to see if there is a ‘COVID-19 effect’ where barriers to work or health problems faced by participants joining after lockdown (measured from 01 April 2020) are different to those joining before lockdown. There is no significant evidence for this. The post-lockdown cohort are slightly more likely to report health management as a barrier to work than the pre-lockdown cohort (96 per cent against 91 per cent). However, the data on health problems does not indicate any notable differences in the numbers or types of health problems experienced by these two cohorts.

Table 4.3: Most common barriers to work

<i>In work</i>	%	<i>Out of work</i>	%	<i>All</i>	%
Health Management	96	Health Management	86	Health Management	92
Confidence	6	Motivation	13	Confidence	8
Financial	6	Confidence	11	Motivation	7
Family	5	Family	8	Family	6
Motivation	4	Problem Solving & Decision Making	7	Financial	6

Base: 916

Table 4.4: Most common primary health problems

All	%
Depression or low mood	21
Anxiety Disorders	13
Problems with Back	12
Problems with Legs	3
Arthritis - Osteo	4

Base: 429

Interviews with stakeholders and participants provide further insights into the health issues faced. Frontline staff emphasised **the dominance of mental health issues as the main presenting need** among participants, most commonly in the form of stress, anxiety and depression. This is supported by the prevalence of ‘Depression or low mood’ and ‘Anxiety disorders’ in the analysis of health conditions presented above.

Moreover, the **number of participants with severe mental health or safeguarding issues was reported to be higher than expected**, with programme staff sometimes required to make referrals to alternative provision where support needs were too high. There is some evidence to support this in terms of levels of anxiety and depression among WVEH participants relative to the national population as whole as measured by standardised health assessments (see Section 4.5). However, there are no other obvious benchmarks against which to assess claim that there are particularly high levels of mental health needs among WVEH participants.

Staff also suggested physical health issues such as musculoskeletal problems were also common, albeit less so than mental health conditions, although the two were often experienced comorbidly: *“I believe all cases, even the ones that we’ve had that have been physical health have had a co-morbidity of anxiety or depression alongside it”* (Provider).

Participant interviews confirmed the accounts of stakeholders. In terms of health-related barriers to employment, a **diverse range of physical and especially mental health conditions** had contributed to participants leaving employment. This ranged from major surgery for physical health problems through to stress, anxiety and depression. Other contributing factors included alcohol dependency and bereavement.

Participant accounts also provided examples of comorbidity **where physical and mental health issues intersected**. For example, one female interviewee described how the impact of long-term physical health issues had led to a decline in her mental health over a two-year period. She indicated that she had gone back to work *“too early”* and struggled to cope, resulting in more time off, which had then exacerbated her low mood. Another interviewee with two separate and serious health conditions explained how this had intersected with mental health issues. Following discussion with his employer, he agreed it would be best to leave the job altogether to *“get sorted”*.

4.4. Presenting needs

All participants are asked to identify their level of need on entry to the programme against eight presenting needs (see Appendix A1 for full list). For each need, a series of factors are identified, and participants are asked to assess the extent to which these an issue on a scale from 0 to 6 where 6 indicates the greatest level of need.

Table 4.5 presents needs as mean scores indicating relative severity of need. Table 4.6 shows the proportion of participants reporting each of the presenting needs to capture prevalence. Those with scores of 5 or 6 have been classed as having 'severe' need; those with scores of 3 or 4 have been classed as having 'moderate' need. The data shows that:

- The highest mean scores are for 'Health' (3.87) followed by 'Coping and confidence' (3.83). 'Personal finances', 'Access to work' and 'Skills and qualifications' are also issues of need, especially for those out of work.
- 'Health' (27 per cent) and 'Coping and confidence' (26 per cent) are the needs most commonly reported as severe. Nearly half (48 per cent) of all participants reported either severe or moderate need on both measures.
- A total of 48 per cent report a 'severe' need on at least one measure. Of this group, 25 per cent report having a 'severe' need on 2 or more measures, and 9 per cent on 3 or more measures.
- Analysis of the pre- and post-lockdown cohorts indicates that there is no substantial difference between presenting needs.

Table 4.5: Presenting needs on entry to the programme (mean scores)

Presenting needs	Mean score on entry		
	In work	Out of work	Total
Health	3.86	3.88	3.87
Coping and Confidence	3.91	3.71	3.83
Personal finances	2.32	3.25	2.69
Access to Work	1.93	2.89	2.31
Skills and Qualifications	1.86	2.58	2.14
Housing	1.70	2.16	1.88
Caring and Family responsibilities	1.76	1.79	1.77
Alcohol and Drug Use	1.51	1.50	1.51

Base: 946-950

Table 4.6: Presenting needs on entry to the programme (prevalence)

Presenting needs	All (%)		
	Severe	Moderate	Severe or moderate
Health	27	35	61
Coping and Confidence	26	35	61
Personal finances	16	16	31
Access to Work	6	17	23
Skills and Qualifications	4	17	21
Housing	6	8	14
Caring and Family responsibilities	2	10	12
Alcohol and Drug Use	3	6	9

Note: Columns may not sum to 100% due to rounding.

Base: 946-950

It is possible to draw some comparison between the presenting needs for the WVEH programme against those in other similar Working Well programmes. However, it is not a perfect alignment due to differences in the presenting needs or 'issues' defined and monitored by the different programmes and the calculation of severity levels. Specifically, the WVEH programme classes need as severe when responses to

presenting needs score 5 or 6 (those scoring 3 or 4 were classed as having moderate need). In contrast, the Working Well Pilot and Expansion programmes report severity as those scoring between 4 and 6 on a 6-point scale²⁹.

Notably, however, when comparing the entry scores between WWEH and the Pilot programme it is apparent that similar patterns exist. 'Mental health' and 'Physical health' were the two issues with the highest proportion of participants classed as severe in the Pilot programme; while 'Confidence and self-esteem' had the highest proportion with severe need in the Expansion programme. This aligns with WWEH in which 'Health' and 'Coping and confidence' were the two presenting needs with the highest proportion of severity.

The extent of this need does appear to differ though with higher need for those on WWEH. 26 per cent of WWEH participants scored 5 or 6 (severe need) on entry in comparison with 27 per cent who scored between 4 and 6 for the Expansion programme. The lower threshold for achieving a 'severe' score on the Expansion programme suggests a similar proportion of participants may indicate a lower level of need.

4.5. Health and wellbeing

Participants are asked to assess their level of health using a series of standardised health assessments on entering the programme. The data collected from these assessments (Table 5.7) indicate that reported life satisfaction and mental wellbeing is worse than the national population (where benchmark data are available):

- The ONS score, which measures life satisfaction (scored between 0 and 10; 10 being completely satisfied), shows a mean score across all starts of 4.78. The national average is 7.70. A total of 44 per cent of WWEH respondents report a low score (0-4) compared with only 5 per cent of the UK population.
- The Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS)³⁰ gives a score between 7 (lowest mental wellbeing) and 35 (highest mental wellbeing). The mean score for across both groups is 18.58, which is below that for England (25.2). A score between 7-19 is considered low³¹: 15 per cent of the UK population fall in this range compared with 60 per cent of WWEH participants.
- The EQ-5D-5L looks at five dimensions (mobility, self-care, usual activities, pain/discomfort and anxiety/depression) and asks participants to rate their level of health based on the level of problems they are experiencing for each dimension. The mean score for all programme participants is 0.40; the further away from 1 the individual scores, the greater the extent of health issues they are experiencing.
- The EQ Visual Analogue score asks participants to rate their health out of 100 (where 100 is the best health score); the mean score is 54.04 for all participants.
- The out-of-work cohort report slightly lower levels of health and wellbeing on all indicators than the in-work cohort, which indicate greater challenges in supporting this group to return to work.
- Analysis of the pre- and post-lockdown cohorts indicates that there is no substantial difference in levels of health and wellbeing between these two groups.

Table 4.7: Health assessment scores

	Mean score on entry			
	In work	Out of work	Total	National average
ONS Score	4.81	4.75	4.78	7.70
SWEMWBS total score	18.28	19.05	18.58	25.2
EQ-5D-5L	0.39	0.43	0.41	N/A
EQ Visual Analogue score	53.06	55.54	54.04	N/A

Base: 950

4.6. Combined measure of need

The evaluation team have created a combined measure of need to identify participants with the highest level of need. This helps to understand the distribution of those with most need by referral pathway, locality and employment status. It can also be used to monitor outcomes for participants with the highest level of need.

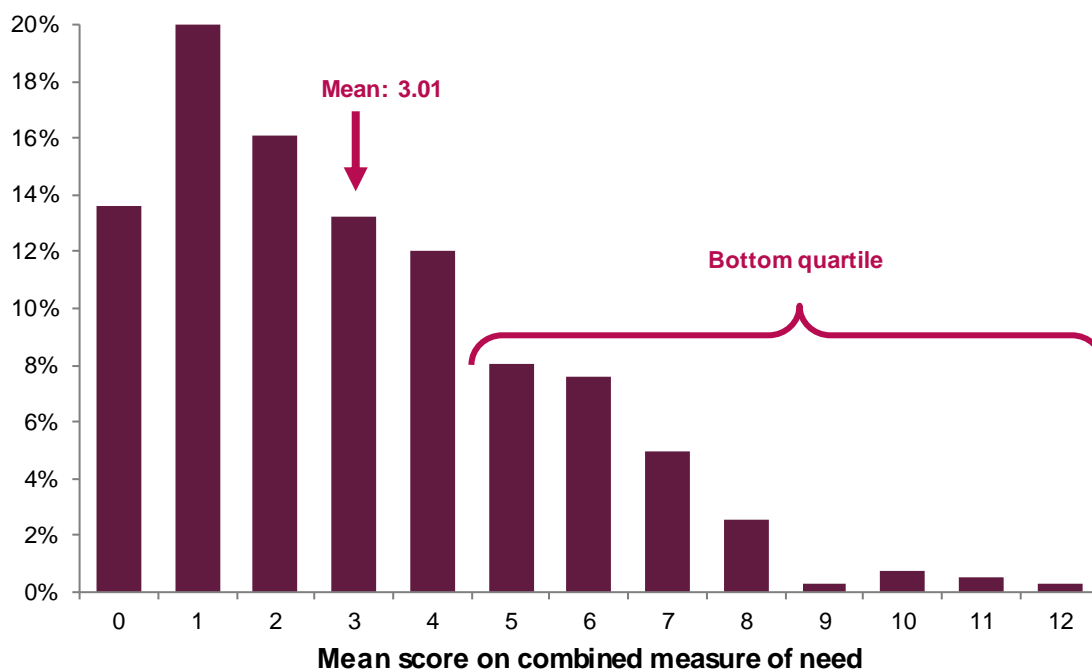
The combined measure draws on all eight presenting needs measures, four health assessments, and three other indicators: disability status, if currently in paid work and lack of basic skills. A full list is provide in Appendix A2.

The scores on these 15 measures are summed to produce the combined measure of need. Where a negative result for an individual measure is recorded (as defined in the second column of the table in Appendix A2), a value of 1 is assigned. The scores are then summed across the 15 measures, resulting in a combined score ranging from 0 to 15, with 0 representing the least need and 15 the greatest need. Each measure has been assigned the same weight.

Distribution of scores

The average (mean) score for participants completing the biopsychosocial assessments is 3.01 (lowest score 0 and highest 12) (Figure 4.1). This highlights that, on average, participants face multiple barriers to work. The analysis which follows focuses on those recorded as having the greatest need (those assigned a score above 5 and therefore placed in the bottom quartile on the combined measure).

Figure 4.1: Distribution of combined measure of need scores (All participants)

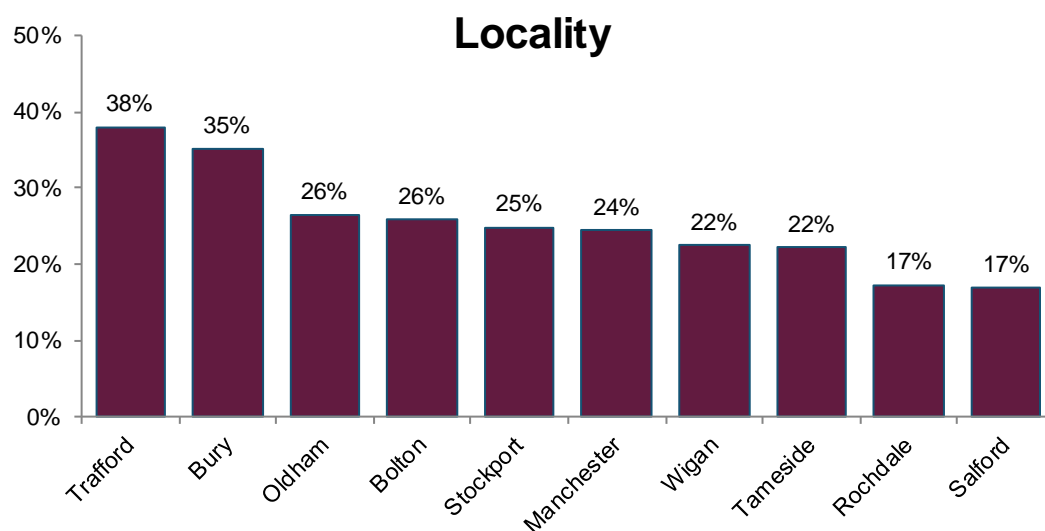


Base: 946

Analysis shown in Figure 4.1 indicates there are variations in the proportion of participants in the category of most need by:

- **Referral route:** A greater proportion of those signposted by JCP have been placed in the category of most need when compared to those referred by their GP or Employer (31 per cent compared to 22 per cent and 18 per cent respectively).
- **Employment status:** One third (33 per cent) of those out of work have been assigned to the category of most need compared with one fifth (20 per cent) of those who are currently in work.
- **Level of service:** A greater proportion of those accessing the Support Service have been placed in the category of most need compared to those accessing the Advice Service (28 per cent compared to 21 per cent).
- **Local authority area:** Figure 4.2 shows the area with the largest proportion of participants in the highest category of need (Trafford with 38 per cent) is over double that of the area with the smallest proportion (Rochdale and Salford with 17 per cent).

Figure 4.2: Proportion of participants in the highest category of need by locality



Variations by referral route and employment status are perhaps unsurprising. Those who are referred by JCP and out of work are likely to be further from the labour market and experience additional barriers than the in-work cohort.

The higher proportion of those with most need receiving the Support Service compared with the Advice Service (28 per cent compared to 21 per cent) appears to validate differential targeting and levels of service as those with highest needs are more likely to receive the most support. At the same time, it indicates that many of those receiving the Advice Service still have high levels of need.

Geographical differences in levels of need should continue to be monitored as it may indicate a need for additional support for residents in some areas as well as explain any observable variation in outcomes by area.

Analysis was also undertaken to see if there is a difference in levels of need among the pre-and post-lockdown cohort. It found that the post-lockdown cohort starting in April 2020 or later had slightly less need than the pre-COVID cohort as measured by the proportion of participants placed in the category of most need (24 per cent against 26 per cent). This suggests that those joining the programme after lockdown are not experiencing greater levels of need, despite wider evidence of poorer health and wellbeing among the wider population³².

4.7. The relationship between health and employment

Interviews highlighted the **close relationship between health and employment**. In some cases longstanding physical and mental health conditions may not have been triggered by employment but were identified as a primary barrier to returning to work. For example, stakeholders described participants reporting mental health issues associated with wider factors such as debt, household circumstances or adverse childhood experiences which impacted negatively on health and wellbeing and, in turn, on their current ability to sustain work:

“It’s more their environment, it could be problems with home life or work problems or debts, all these other side issues that affect their whole well-being”. (Provider)

“All I ever get is depression and anxiety or because of my past, my mum did this or something’s happened to them in their childhood and now I’d say they’re in their 40s and they’re struggling to keep a job down”. (Provider)

In other cases, **work itself was seen as the cause of, or contributing factor towards, physical or, particularly, mental health conditions** that shaped decisions to take sickness absence or leave jobs altogether. Stakeholders identified overwork, bullying, difficult relationships with management and co-workers, and legal issues as contributory factors to leaving work for some participants. This is illustrated by one participant who detailed the negative impact of overwork on their mental well-being

“[Work] contributed to the anxiety and depression, very short-staffed, [I was] effectively doing the job of three people and didn’t feel like I was getting any support or help”. (Participant)

Negative experiences of work may be linked to the nature of employment and the occupations and sectors in which participants predominantly worked. A significant number described employment histories characterised by **intermittent, short-term or insecure roles** such as employment in call centres, security, driving, warehousing and social care. However, the sample was diverse and also included those with skilled roles such as finance, engineering and biochemistry.

Some participants who had left work altogether viewed this decision as voluntary; others had **felt coerced by employers to leave**. Indeed, three had subsequently pursued cases in employment tribunals which, in itself, had generated considerable stress and anxiety.

One implication of these findings is that the extent to which work triggers or worsens health conditions may shape the type and degree of support needed. Participants whose health issues are not directly related to employment may primarily require help to manage conditions to prepare them for a return to work. For others where an existing job is a contributory factor to health issues, support in negotiating terms of employment or working conditions with employers may also be required. Where this is not possible, help in finding alternative and more suitable work could be needed.

Once individuals had left work for health reasons, the need to find new employment could then become an additional source of anxiety:

“Mainly work-related stress and anxiety and depression. [It] might be that somebody’s fallen out of work and it might be due to a bad relationship they had with that employer and then it’s causing more anxiety about seeking new employment”. (Provider)

Leaving work could also **become a source of anxiety in itself**, where it led to increasing financial pressures for both those on medical leave and the unemployed. One participant described significant anxiety at the prospect of their income being reduced after six months of medical leave: *“I were kind of suicidal, I thought how am I going to manage all this?”*. It was this crisis point that had prompted them to seek help from WWEH: *“I thought I’d better do something about it and that’s when I got in touch”*. One stakeholder also talked about the financial difficulties faced by the unemployed caused by the delay before receiving first payments for universal credit, identifying this as the *“biggest”* challenges participants face.

Motivations for joining WWEH included fast-track access to CBT or physiotherapy support, a need to address financial difficulties, and a concern to ensure any return to work was sustainable. For many, there was sense of welcoming any kind of support that might be able to help them in their current circumstances: *“I would explore any avenues; I was perfectly happy to speak to anyone that was saying that they might be able to help”* (Participant).

Referral agencies, especially GPs, played a key role in facilitating engagement:

“The GP...was trying to get me some sort of counselling and she said going through this route might be quicker”. (Participant)

“One of the things that my GP mentioned was people who end up being off work sick for six months or longer, there’s a very high probability that even if they do go back to work, they won’t stay in work just cos of how things work out...she said we want to get you back into work in plenty of time, but we also want to make sure that it’s done right”. (Participant)

This suggests the value in seeking to generate referrals through a trusted intermediary, despite the challenges in engaging GPs highlighted in Section 3.

Support offered and delivered

Summary

More participants have accessed the Advice Service than expected. This is due to higher than anticipated volumes of referrals from GPs of employees working for larger companies. It highlights the challenge of relying on external referral partners to observe priority eligibility criteria. Survey data suggests levels of satisfaction are mixed. Dissatisfaction may be largely accounted for by disappointment among those not aware at the point of referral that they are only eligible for the less intensive Advice Service. By contrast, participants interviewed were almost universally positive about WWEH with support valued even if it did not lead to identifiable outcomes.

5.1. Introduction

The WWEH model centres on personalised, health-focussed and holistic support provided through a key worker known as a Vocational Rehabilitation Worker (VRC) to address the full range of barriers to employment. Some aspects of support are delivered directly by the VRC who can also refer into a wider Expert Practitioner Network (EPN) commissioned to provide CBT and physiotherapy services, as well as into wider work, health and skills services in the Greater Manchester 'ecosystem'.

This section draws on programme documentation, programme monitoring data and interviews with stakeholders and participants to detail the WWEH offer and interventions delivered to date. It then considers the perceived value-added of the model from the perspective of stakeholders before comparing this with the experiences and perceptions of participants.

5.2. Support offer

WWEH provides personalised support and advice to help Greater Manchester residents with a disability or health condition who are on medical leave or newly unemployed return to work. Support is delivered by a team of seven VRCs who develop a package of support tailored to individual needs. It is mostly provided remotely by phone, text, videocall or email although face-face meetings can be arranged where requested.

The customer journey begins with referral onto the programme and completion of a biopsychosocial assessment (BPSA) based on a series of bespoke questions and standardised health assessments. These identify the multiple, interrelated issues impacting on participants' ability to move back into work. Assessments and discussions with VRCs are used to draw up a Return to Work Plan (RtWP) that details barriers, goals and interventions around three key themes: health and wellbeing, life and home, and work and skills.

There are two levels of service available:

- **Advice Service:** The Advice Service is offered to all in-work participants employed by large organisations (more than 250 employees) that are likely to have access to occupational health support already. This level of service provides a RtWP with a series of recommendations to support participants to access self-help tools or local services. VRCs may also refer or signpost them to other organisations for further advice or support. Recommendations can be shared with GPs or employers to inform reasonable workplace adjustments and treatment plans.
- **Support service:** The support service is available to participants who work for SMEs (fewer than 250 employees), are self-employed or who have become unemployed in the last six months. This group receive end-to-end support from VRCs for a maximum of 26 weeks with regular review of needs and goals in their RtWP. Participants receive a tailored package of services delivered through four main channels including a digital offer, and cutting across seven domains as outlined in Table 5.1.

Table 5.1: The WWEH Support Service offer

Delivery channel	Domain
<ul style="list-style-type: none"> ▪ VRCs provide direct, non-clinical support to participants e.g. coaching and motivation/confidence building support. ▪ Two in-house Health Practitioners (one Mental Health Practitioner and one Musculoskeletal Practitioner) provide clinical expertise for complex cases, deliver remote counselling and physiotherapy, and quality-assure the Expert Practitioner Network. ▪ Spot purchase of services from an Expert Practitioner Network (EPN) of local Providers provides clients with fast track access within five days to Cognitive Behavioural Therapy (CBT) and Physiotherapy. ▪ VRCs broker support for clients from the Greater Manchester Ecosystem of health, wellbeing, employment and training services in the locality e.g. employability provision, financial and debt advice, food banks. ▪ Digital support includes video consultations with VRCs and Health Practitioners, click-through to NHS Choices and local 'borough service directories', and access to <i>HealthWorksOnline</i> which currently hosts 550 self-help articles, videos and podcasts covering 27 topics of health/wellbeing (e.g. anxiety, healthy eating, money management and exercise). Digital content is available to Support and Advice Service participants for 12 months post-referral to promote self-help and drive sustainable outcomes. 	<ul style="list-style-type: none"> ▪ Health (e.g. CBT, vocational rehabilitation, physiotherapy, musculoskeletal workshops) ▪ Lifestyle/wellbeing (e.g. confidence and motivation sessions, healthy eating, mindfulness, weight management) ▪ Employment (e.g. CV preparation, interview preparation, job search techniques) ▪ Financial (e.g. debt screening, building financial capability, in-work benefit calculation) ▪ Social (e.g. personal interests and hobbies, social prescribing) ▪ Skills, Education & Training (e.g. ESOL, ICT workshop) ▪ In-Work Support (e.g. advice on reasonable adjustments including changes/adaptations, requesting flexible working hours/patterns, coping strategies)

5.3. Support delivered

Until the first COVID-19 lockdown the programme set targets for the proportion of in-work participants receiving the Support Service (80 per cent) and Advice Support (20 per cent). This was intended to focus delivery on SME employees and the self-employed as a group less likely to have access to occupational health support. Targets were not set for out-of-work participants who automatically receive the Support Service.

However, to date only 36 per cent of in-work participants have accessed the Support Service and 64 per cent the Advice Service (Figure 5.1). The higher than expected proportion of in-work participants accessing the Advice Service reflects the predominance of employees working for large organisations (66 per cent) among the in-work cohort (Table 5.2 below).

The tendency of in-work participants to work for larger organisations is explained by two factors. First, the programme has found it difficult to generate referrals from smaller local Employers (SMEs) on the scale envisaged (see also Section 3.3). Second, GPs consistently refer more patients working for larger employers than SMEs. Of all GP starts to date, 73 per cent (370 participants) have worked for large employers and 23 per cent (139 participants) for SMEs. This may reflect the tendency to ‘ping’ referrals across among GP practices rather than concern themselves whether patients match priority eligibility criteria.

Figure 5.1: Proportion of in-work cohort receiving Advice or Support Service

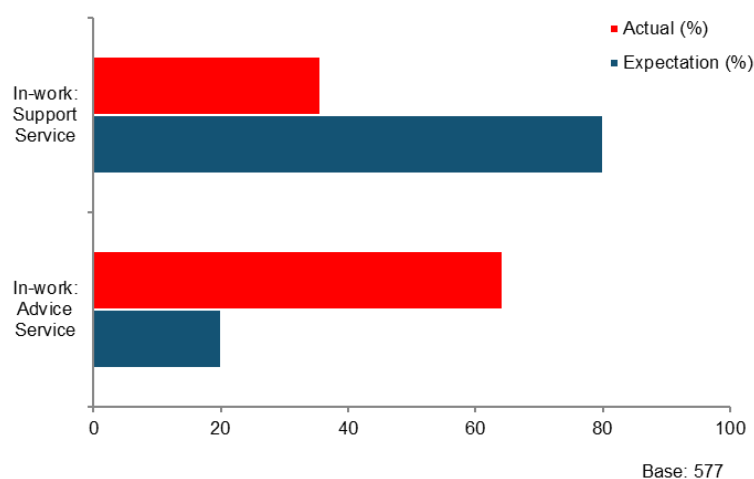


Table 5.2: Size of employer (in-work participants only)

Employer size	% of all in-work participants
0-10	5
10-50	10
50-250	14
250+	66
Self-Employed	7

Base: 577

Programme monitoring data on interventions either provided or advised (Figure 5.2) shows that the most common intervention is Vocational Rehabilitation, which has been provided to 83 per cent (690 participants) of those who have received an intervention.

'Coping strategies' (62 per cent), 'Mindfulness' (33 per cent), 'Cognitive Behavioural Therapy' (31 per cent) and 'Confidence and motivation session' (26 per cent) are also commonly provided or advised interventions. The predominance of interventions oriented towards addressing mental health and wellbeing further reflects the prevalence of needs and conditions as detailed in Section 4.

Figure 5.2: Interventions provided or advised



Base: 835

Almost half of programme participants have been provided or advised five or more interventions, while almost one quarter have been provided or advised seven or more interventions. The average (mean) number of interventions provided or advised is 4.6, illustrating the level of support, on average, each participant receives.

5.4. The WWEH approach

Interviews with stakeholders provide insights into the WWEH approach in terms of the nature of support provided to participants and which elements are most effective. The views of stakeholders including frontline delivery staff must, of course, be considered in combination with the perceptions and experiences of participants which are presented in the section which follow.

Frontline staff emphasised a number of aspects of the WWEH model that they felt added value for participants:

- **Personalised and responsive support** rather than 'off the shelf' provision.
- **A carefully sequenced and continually reviewed Return to Work Plan** which supports clients to manage health conditions and negotiate a return to work.
- **Fast track access to 'in-house' CBT or physiotherapy support** was seen both as a unique selling point and a valuable bridge to longer-term NHS provision:

"Everybody who comes through says I've been on a waiting list for weeks... it's massive, it's golden to be able to turn round to someone and say we can offer you this within two days, you can almost hear their voice change".
(Provider)

- A **health-focussed model** where health assessments trigger access to appropriate clinical advice and support that is often a prerequisite to returning to work.

“The health programme side of it is always a driving factor... you address what their physical or mental health needs are then the impetus would be for them to naturally go back into work. One can and does lead into another”. (Provider)

- A VRC team offering a **wide range of specialist and emotional support** including:
 - a **diverse range of skills and expertise** e.g. trauma-informed training.
 - **motivational interviewing and coaching techniques** focussed on identifying strengths and aspirations to build motivation, develop coping strategies, and encourage positive behaviour change: *“A lot of people...respond really well to...just having someone to listen to and someone to reframe things and help them”* (Provider).
 - a **safe and non-judgemental space** to talk about issues: *“I had someone who told me about their financial situation who said, ‘I’ve not told anyone about this, you’re the only one that knows this’, a safe space to talk”* (Provider).
 - an ability to communicate in clear, **non-clinical language**.
- A **focus on ensuring participants return to work at an appropriate point** to increase the likelihood of outcomes being sustained.
- A unique level of support to equip participants with the **knowledge and confidence to discuss health issues and negotiate a return to work** with employers.

At the same time, stakeholders identified some **limitations of the model**:

- While the ecosystem of external support is *“really rich”* (Provider), some stakeholders noted a **lack of control over timing and availability** means that support including skills and health condition management is not always accessible.
- There were concerns that a **‘two tier’ service can create confusion and disappointment** when individuals are not aware they only eligible for the Advice Service at the point of referral.
- Some **Advice Service clients are unable to receive appropriate clinical or occupational health support elsewhere** if their employer offer is insufficient or waiting lists for NHS health services are too long.
- There were **mixed views on the appropriateness of delivering WVEH as a predominantly telephone-based service**. Some suggested this could deter individuals from signing up if they felt uncomfortable talking from their own home; make it harder to identify safeguarding issues; and complicate delivering some forms of support such as help with writing job applications. Other stakeholders, including some with initial reservations, suggested experience showed clients were happy to communicate by phone or email and, in some cases, greater anonymity led clients to *“open up”* (Provider).
- The **six-month limit on support** was seen as insufficient to support individuals who had the most severe level of needs.

Finally, stakeholders also felt the programme could be improved by addressing **perceived gaps in the offer** by:

- **providing legal and financial advice services ‘in house’** or through formal referrals rather than signposting participants to external provision. Either option would enable VRCs to better understand and address legal and financial issues compared with the current signposting approach which provided no mechanism for feedback around needs, interventions and outcomes.
- **contracting rapid translation, interpreter and hearing services** that were not always available, not least because the Service Level Agreement in place sometimes required support to be delivered in a timeframe that precluded this. This option is currently being explored.

5.5. Effectiveness of support

Two sources of data provide insights into the perceived effectiveness of support among beneficiaries:

- A Customer Satisfaction Survey administered by the Provider by email to participants who have been discharged from the programme.
- Interviews with 18 programme participants.

Customer Satisfaction Survey results should be treated with caution as the sample is still very small (n=29) and is therefore not necessarily representative. Nonetheless, it is useful as it highlights issues with satisfaction related to the level of service received.

Just under half (48 per cent) of participants are satisfied with the service against a target of 90 per cent. However, dissatisfaction is almost entirely accounted for by recipients of the Advice Service (9 out of 10) as shown in Table 5.3. One explanation may be that may be that GPs are referring patients who are unaware that they are only eligible for the Advice Service because they work for a large employer, as already highlighted in Section 3.3. This leads to disappointment when they realise what level of support they are entitled to.

Table 5.3: Satisfaction levels with the WVEH service

	Advice	Support
Extremely satisfied	1	6
Satisfied	5	2
Neither satisfied or dissatisfied	3	2
Dissatisfied	5	1
Extremely Dissatisfied	4	0
Total	18	11

Further insights are provided by interviews with 18 participants which explored the support received and perceptions of service quality and value. Evidently, this is a small sample, with fieldwork cut short by the COVID-19 lockdown. Findings should not be seen as representative but nonetheless provide valuable illustrative data on the perceived benefits and limitations of the service, including the precise elements of support that were most valued.

Interviewees reported receiving a range of support including:

- **Employment-related support** such as job search preparation (CV writing, interview techniques), support with negotiating a return to work with employers

(e.g. signposting to ACAS for employment rights advice), and retraining or skills development.

- **Health-related support** such as CBT and physiotherapy, online resources to understand and self-manage conditions such as stress and anxiety, wellbeing and mindfulness activities, and guidance on physical exercise e.g. gym referrals, health coaching, and dietary advice.
- **Signposting to external provision including** alternative health therapies, legal advice around employment rights, housing support and financial advice.

A significant proportion of participants valued the support highly even if identifiable outcomes were not always significant. Descriptions such as “*very helpful*”, “*very good*”, “*really useful*”, “*really good*” and “*really reassuring*” appeared across a number of interviews.

Those with positive views of the service described it in ways that echoed the strengths of the model highlighted by stakeholders. They talked, respectively, of the **benefits of the ‘health-first’ approach as well as the emotional and motivational support provided by VRCs**:

- The **initial focus on health and well-being** provided comfort to participants who may have been deterred by a ‘work-first’ approach:

“[I] signed up because it did take into account your wellbeing...not just let’s get you straight into a job... it seemed like a really good support programme. It was thinking about how to get you to a point where you can sustain work, or even think about work”. (Participant)

- VRC support was valued as form of ‘**quasi-counselling**’ that benefitted participants through:

- the **listening and empathic skills of VRCs** which provided a safe and emotionally reassuring space for participants to discuss complex personal issues:

“They were just kind of therapeutic, beneficial chat...just chatting to somebody that was willing to give you a bit of time back and somebody who’s sympathetic to you”. (Participant)

“He was allowing me to cry it out...He listened and by the end of the time I had practical advice as well as an appointment for another call”. (Participant)

- **boosting confidence and motivation** for those taking steps to return to work: *“They made me feel that I needed to believe in me, that’s what he did and that mattered”.* (Participant)

WWEH was also seen to offer a range of valuable practical support which, again, corroborates the strengths of the model emphasised by stakeholders:

- **Structured, sequenced and tailored support** provided through Return to Work Plans:

“I was looking at the plan and going through and you could see how it was laid out...to aim for...such a date. Have you looked at this website? Have you tried these techniques? It gave me structure and I needed that at that time”. (Participant)

- **Advice and guidance on negotiating a return to work with employers** in terms of flexibilities (e.g. a phased return or flexible hours), ergonomic or workplace stress assessments, and reasonable adjustments. At least four participants noted offers by VRCs to liaise directly with employers but these did not appear to have been taken up. Advice on speaking to employers rather than direct liaison seemed the preferred form of support.
- The **speed and ease of access to specialist support** such as CBT compared with NHS provision.
- Online and offline materials to understand, and support self-management of, conditions such as anxiety were valued as **clinically-informed resources** that participants could refer back to when needed and might otherwise not have accessed: *“Sometimes I still go back to those downloads he gave me and if I’m having a stressful time I do still go back to that... it’s helped me a lot”* (Participant),

Where individuals declined support, it was evident that some still thought that the service was useful. For example, one participant mainly relied on friends, family and his GP but commended the WVEH approach:

“It’s something that’s been needed for a long time... contact with people who are in the situation I was in, worse or even lighter. I would like to see more people doing it and more investment in it.” (Participant)

Only three participants expressed **negative views about the support**. However, this was nearly always a reflection of the perceived lack of relevance rather than service quality per se: *“To be honest it was neither use nor ornament if I’m being brutally honest...[but] I can understand it being really, really helpful for some people”* (Participant).

That said, a small minority referred through JCP expressed a view that WVEH did not offer sufficient practical support with job search activities:

“[WVEH] didn’t give me any help applying. I did mention once I got a bit nervous actually at interviews and they said, ‘oh we could probably get you help for that’ and nothing ever happened”. (Participant)

This dissatisfaction perhaps suggests that those referred through JCP may have expected a higher level of employability support received than was available. Figure 5.4. also confirms that the most common interventions were health- rather than employment-focussed. However, the number of respondents’ views reported here is too small to draw definitive conclusions.

5.6. Support from other sources

It is important to consider other sources of support outside of WVEH, both to understand where participants access advice and guidance, and to consider the role of other services in contributing to any change experienced. Participants identified a number of formal and informal sources of support that they had found beneficial:

- **Health services** including hospital-based, secondary care services and primary care. GPs were often identified as **a key source of support**, both in terms of their ‘listening’ role and in facilitating access to provision such as counselling:

“[My GP] has been amazing, he supported me all through it. He did eventually get me on tablets, but he also got me meetings with a young lady in the surgery where I could talk and vent and I also had an online system where I could download formats for helping me cope”. (Participant)

- **Occupational support** from employers played a key role in some cases in enabling individuals to return to work. Support provided included adjustments to workstations, reduced duties, and discretionary use of more generous sick pay than statutory requirements. A number of those on medical leave reflected that their **workplaces had been very supportive**, including some in dispute with employers:

“As an employer they’ve been absolutely amazing to be honest, cos on paper I’ve not been there much over the five years... If it wasn’t for them I think I would have been in a lot worse place now.” (Participant)

At the same time, other participants were **more ambivalent about occupational health provision**. Two interviewees suggested, respectively, that their workplaces had either not embraced a culture of employee support - *“It’s never really been particularly embedded”* - or that its effectiveness was contingent on the attitude of individual line managers.

- **Family and friends** were a crucial source of informal financial, emotional and practical for some participants.
- **Jobcentre Plus and benefit services** elicited mixed views. While one participant was positive about support to access IT training, others were more sceptical about the value of help with job search which was seen as mechanical and ineffective: *“It was more a case of turn up, have you been looking for jobs?”* (Participant).
- **Voluntary work** accessed either through WVEH or independently was valued both as a source of work experience and for maintaining personal wellbeing and self-worth.
- **Self-help** was evident where individuals took steps independently to address issues and barriers to work. This mostly related to activities to improve health and wellbeing e.g. yoga, tai chi, dieting courses, swimming, and charity work. Some participants had also sought their own mental health support.

Outcomes

Summary

Presenting needs data and health assessments show consistent improvement in health and wellbeing outcomes for participants between joining and leaving the programme. Employment outcomes are also evident, although the level of change is less pronounced. There is clear evidence of a 'WWEH effect' where participants at least partly attribute programme support to beneficial outcomes. Returning to work can be a highly positive experience except where employees feel compelled to go back for financial reasons or unsupported by employers to manage health conditions in the workplace.

6.1. Introduction

WWEH provides a range of support that enables participants to return to existing jobs or take up new employment by addressing issues around health, employment and wider social determinants of health. The strong interrelationship between health and employment is seen to require a holistic response to address the full range of presenting needs.

Exploring outcomes experienced by participants provides a measure of the extent to which this underlying logic of the programme is validated. It is important to consider both outcomes in terms of change experienced and impact in the sense of the degree to which change can be attributed to WWEH support.

This section presents considers health and employment outcomes in turn. For each, programme monitoring data is used to identify change experienced by participants between entry onto and discharge from WWEH. Interviews with participants and stakeholders provide further insights into the nature of change and the extent to which WWEH contributes to outcomes. This provides an early qualitative assessment of impact, although it should be noted this is based on a small sample. More systematic assessment of impact will be undertaken at a later stage in the evaluation. The section concludes with an analysis of outcomes by subgroup.

6.2. Health outcomes

Health outcomes can be measured using two key sets of indicators – presenting needs and health assessments – and looking at change between entry onto and discharge from the programme.

Presenting needs

Of the eight presenting needs measures, one directly measures self-reported 'Health', while 'Coping and confidence' and 'Alcohol and Drug Use' capture further aspects of mental and physical wellbeing. An additional three presenting needs listed here are not directly related to health but could be considered social determinants of health ('Personal Finance', 'Housing' and 'Caring and Family responsibilities').

The data shows positive change against all six indicators. Table 6.1 indicates that there has been a decrease in the mean scores for all six measures, indicating a reduction in the level of need reported by participants. 'Health' and 'Coping and confidence' have experienced the greatest decreases.

Table 6.2 shows decreases in the proportion of participants experiencing severe or moderate need for all presenting needs listed. Particularly significant are falls in those with moderate or severe needs related to 'Health' and 'Coping Confidence' (33 percentage points in each cases).

Table 6.1: Presenting needs at entry and discharge (mean scores)

Presenting needs	Mean score		
	Entry	Discharge	Change
Health	3.98	2.86	-1.12
Coping and Confidence	3.70	2.65	-1.06
Personal Finances	2.83	2.46	-0.37
Housing	1.85	1.56	-0.30
Caring and Family responsibilities	1.62	1.39	-0.23
Alcohol and Drug Use	1.53	1.27	-0.25

Base: 158

Table 6.2: Proportion of participants with severe or moderate presenting needs

Presenting needs	Entry (%)		Discharge (%)		Change (%)	
	Severe	Moderate	Severe	Moderate	Severe	Moderate
Health	30	37	11	23	-19	-14
Coping and Confidence	27	30	9	15	-18	-15
Personal Finances	15	19	8	18	-7	-1
Housing	6	8	3	6	-3	-2
Caring and Family responsibilities	2	6	1	4	-1	-2
Alcohol and Drug Use	4	6	1	1	-3	-5

Base: 158

Health assessments

Comparing scores for standardised health assessments at entry and discharge also provides a measure of change in health and wellbeing outcomes among participants. Table 6.3 below shows the mean scores and proportion of participants experiencing positive change for all those who have been discharged from the programme to date.

Three additional assessments are included here in addition to those already described in Section 4.5:

- GAD7 is an assessment of Generalised Anxiety Disorder (GAD) with responses (ranging from “not at all” to “nearly every day”) collected across seven questions relating to feelings around anxiety. Responses generate a score between 0 and 21 where 21 is the highest level of anxiety. Scores of 5, 10, and 15 represent cut-off points above which mild, moderate, and severe anxiety is indicated respectively.
- PHQ9 is used to monitor the severity of depression and response to treatment. Responses ranging from “not at all” to “nearly every day” are gathered in response to nine questions relating to patient experience of problems linked to depression. Responses generate a score between 0 and 27 where 27 is the highest level of depression. Severity is indicated within ranges (None 0-4; Mild 5-9, Moderately 10-14, Moderately severe 15-19; Severe 20-27).
- The MSK-HQ (Musculoskeletal Health Questionnaire) assesses outcomes in patients with a variety of musculoskeletal conditions. It contains 14 items and measures the health status in patients with MSK conditions over the past two weeks, scored on a range of 0-56, with a higher score indicating better MSK-HQ health status.

Key findings include:

- There has been a positive change in mean scores across all health assessments, indicating, on average, self-reported improvements to health. This has closed the gap with national averages on the two indicators where benchmarks are available.
- It is also important to consider the proportion of participants experiencing positive change. The SWEMWBS measure saw most improvement with three quarters of participants (74 per cent) seeing improvements in their scores between entry and discharge. Around two thirds also reported improvements in their ONS score (67 per cent), EQ Visual Analogue score (67 per cent) and PAM score (63 per cent).
- Fewer participants experienced improvements in GAD 7 (48 per cent), PHQ9 (35 per cent) and MSK (29 per cent) scores. However, the smaller numbers completing these assessments means caution should be exercised in drawing definitive conclusions about which aspects of health have seen least improvement.
- Separate analysis shows that:
 - The proportion of WVEH participants experiencing a low ONS life satisfaction score (0-4) fell from 51 per cent to 17 per cent between entry and discharge (a fall of 34 percentage points).
 - The proportion of WVEH participants experiencing a low SWEMWBS (7-19) fell from 60 per cent to 21 per cent between entry and discharge (a fall of 39 percentage points).

Table 6.3: Change in health assessment scores

	Measure	Mean score			National average	% participant showing improvement in scores
		Entry	Discharge	Change		
SWEMWBS total score	Wellbeing	19.16	22.01	2.85	25.2	74
ONS score	Life satisfaction	4.72	6.50	1.78	7.70	67
EQ Visual Analogue score	Health	51.84	66.69	14.85	N/A	67
PAM total score	Health management	55.10	61.86	6.76	N/A	63
EQ-5D-5L score	Physical and mental health	0.42	0.55	0.12	N/A	53
GAD7	Anxiety	11.41	8.09	-3.32	N/A	48
PHQ9	Depression	11.00	9.35	-1.65	N/A	35
MSK-HQ	Musculoskeletal health	22.33	24.57	2.24	N/A	29

Base: 184 except for GAD7 (44), PHQ9 (23) and MSK-HQ (21).

Note: participants are only asked to complete GAD7, PHQ9 and MSK-HQ if they have indicated they are experiencing health conditions related to these assessments.

Participant and stakeholder insights

Most participants reported **improvements in physical or mental health**, and often both. These confirm some of the positive changes outlined in the health assessment data above. Many participants who returned to work from unemployment or medical leave noted **positive, albeit sometimes small, changes in mental health**, such as improved happiness, confidence, coping skills and sociability:

“[My] confidence is less than it used to be, but much more than it was in the last 18 months”. (Participant)

“[Work has] brought a bit of contentment back”. (Participant)

“[I’m] much more back to being sociable”. (Participant)

A smaller number of participants reported improvements in physical health: *“I feel as healthy as a horse”* (Participant). At the same time, it is important to note that many continued to struggle with their long-term physical or mental health conditions.

Positive changes were not just about direct improvements in health but acquiring the **‘tools and techniques’ to enable individuals to self-manage conditions**. For example, one frontline staff member cited an example where a participant was able to use condition management techniques to support another family member:

“She’d learnt some skills taught to her by the VRC but then felt empowered to use them with her son, so that’s where being able to self-manage is really crucial cos it’s being able to look after yourself”. (Provider)

While WWEH focussed on addressing health conditions to enable a return to work, one stakeholder stressed the value of improvements in health and well-being **regardless** of whether it led directly and immediately to a return to work:

“Sometimes in these programmes it is all about job outcomes but actually somebody might not have gone back to work but they might be in a lot healthier mindset than they were before...going back to work might not be the right avenue for that person at that time...they might go back to work in the future but they’re not ready to do so at the moment”. (Local authority)

WWEH impact on health outcomes

A key question is the extent to which health outcomes are additional to what would have happened without WWEH support. The evaluation is currently undertaking a systematic evaluation of impact that will report later on the scale and nature of impact. In the meantime, the analysis presented here provides illustrative examples of impact and the mechanisms which appear to contribute to change from the perspective of participants and stakeholders.

Some respondents identified a **direct and significant positive effect** of WWEH support on health or wellbeing:

“It’s taken a chunk out of the anxiety and stress”. (Participant)

“[Without WWEH] my depression would be big or bigger, yes. For sure I will be, broke down, now”. (Participant)

The complexity of participants’ health conditions and the range of professionals involved in supporting them makes it difficult to attribute improvements to any one single intervention. Nevertheless, most respondents experiencing some degree of positive change in health and wellbeing attributed at least part of this to the impact of WWEH support. Elements of the WWEH model seen to **contribute to positive change** included:

- A sense of **reassurance and comfort** that problems were neither insurmountable nor unique:

“It shows me that there’s people out there that are going through a lot of tough things like mental health or drug addiction, homelessness and just that in itself made me feel like I’m not alone”. (Participant)

- The support of VRC **was identified as leading to enhanced confidence and self-belief** that recovery from health conditions and an eventual return to work was possible:

“[The VRC] just made me feel like there was some light at the end of the tunnel. I’d got something to focus on instead of just focusing on all the bad things that had happened to me”. (Participant)

- **Structured support** was identified by two participants who were unemployed as enhancing wellbeing, which may be linked to addressing the loss of routine and meaningful activity often associated with unemployment. One noted how *“without that intervening thing I think I would have been a lot worse off”* and described the support as *“positive reinforcement”* (Participant).
- **Advice and guidance in liaising with employers** helped to alleviate stress and anxiety among some participants on medical leave: *“Somebody taking that pressure away and just saying we’re here, let us know what we can do, that really made a big difference”* (Participant).
- **Online resources** that were valued for supporting self-management of health issues as they could continue to be accessed after discharge.

Some respondents also attributed positive health and wellbeing outcomes benefits to the **combined impact of support** from WWEH and other sources. One interviewee who had accessed help through WWEH, GPs, an employer and a mental health service observed how: “*The whole is greater than the sum of the parts it seems, things seem to work together quite well*” (Participant).

At the same time, others suggested that forms of support external to WWEH had been the primary catalyst for change. One participant for instance attributed their health “*breakthrough*” to the intervention of a healthcare professional. Even where the catalyst for change was external to WWEH, though, programme support could still be valued. For example, one participant who attributed health improvements solely to time off work still expressed gratitude to WWEH key workers for listening to her while she was struggling with mental health issues.

6.3. Employment outcomes

Employment outcomes can be measured using two sets of indicators – presenting needs and employment status data – and looking at change between entry and discharge onto the programme. Again, the extent of impact and the interventions contributing towards positive change can be assessed using data from participant and stakeholder interviews.

Employability

Two of the presenting needs measures indicate changes in employability: ‘Access to work’ and ‘Skills and qualifications’.

Table 6.4 shows the results for participants discharged from the programme and who provided responses to the presenting needs questions at entry and discharge. It shows a small decrease in the mean score for the two employability indicators, indicating a reduction in the level of need reported by the participant.

Table 6.4: Presenting needs at entry and discharge (mean scores)

Presenting needs	Mean score		
	Entry	Discharge	Change
Access to Work	2.75	2.23	-0.52
Skills and Qualifications	2.30	1.77	-0.53

Base: 158

Table 6.5 below shows the change in the proportion of participants reporting either moderate or severe need at entry and discharge points. On both measures there are falls in the proportion of participants experiencing severe and moderate needs, with the proportion reporting moderate needs approximately halving between entry and discharge. The decreases in both mean scores and the proportion of participants experiencing need are not as large as those reported above for health-related outcomes above. However, employability needs were not as significant on either measure at the point of entry so the ‘headroom’ for positive change is smaller.

Table 6.5: Proportion of participants with severe or moderate presenting needs

Presenting needs	Entry (%)		Discharge (%)		Change (%)	
	Severe	Moderate	Severe	Moderate	Severe	Moderate
Access to Work	10	20	6	11	-4	-9
Skills and Qualifications	4	20	1	9	-3	-11

Base: 158

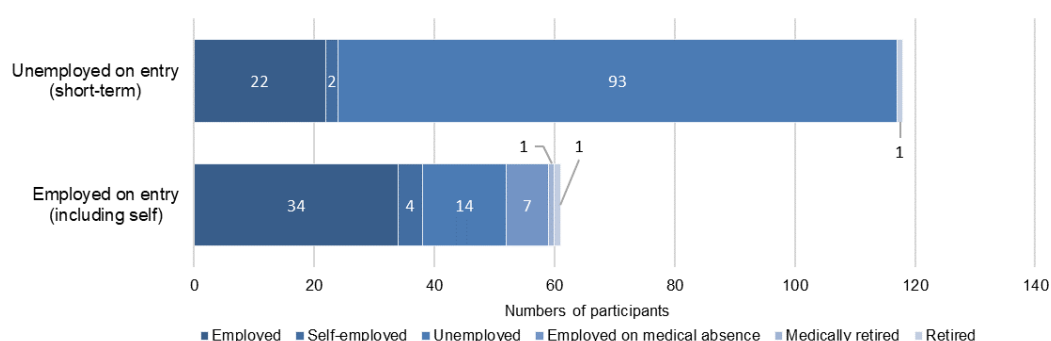
Return to work

A key measure of programme success is the extent to which WWEH supports a return to work. Figure 6.1 details participant employment status on discharge split by their status on entry (either unemployed or employed and on medical leave) for all participants who have completed discharge assessments to date. It shows that:

- A fifth of participants (21 per cent) who were unemployed on entry to the programme had found work at the point of discharge from the programme (24 out of 117 participants)³³. This is considerably lower than the target of 60 per cent for unemployed participants returning to work. Other Working Well programmes have achieved job entry rates of 24 per cent (the Expansion programme) and 13 per cent (Pilot programme) so WWEH falls in the middle of this range. Figures are not directly comparable due to different eligibility criteria. Both the Pilot and Expansion include participants who are, in theory, more distanced from the labour market by virtue of either being longer-term unemployed or in receipt of sickness and disability-related benefits.
- Nearly two thirds (64 per cent) of participants who were employed but on medical leave on entry had returned to work by the point of discharge (38 out of 59).³⁴ This is close to the target of 80 per cent for in-work participants returning to work.

The significantly higher proportion of the in-work group who return to work compared with the out-of-work cohort is likely to reflect their closer proximity to employment and the lower levels of presenting needs, barriers to work and health conditions reported earlier.

Figure 6.1: Change in employment status between entry and discharge



Base: 179

Participant and stakeholder insights

Interviews with 18 participants provide more in-depth insights into employment outcomes. Findings are presented by employment status at the point of interview among three different cohorts depending on whether were looking for work, returning to existing jobs, or taking up new employment.

Three case studies provide further detail of these three scenarios. They show how WWEH support is tailored to address individual needs and health conditions; the perceived effectiveness of support and how it interacts on with other forms of advice and guidance; and how positive employment outcomes differ depending on individual circumstances, work-readiness and expectations around a return a work.

Supporting insights from stakeholders are also provided where they add value in explaining participant outcomes. It is important to note, however, that many stakeholders felt it is **too early to reflect in depth on outcomes and impact** given the small numbers of participants who had completed the programme, especially in localities where they had been gaps in Provider team capacity. This data should be treated as emerging findings, therefore, and findings may change in later phases of the evaluation.

Looking for work

Six participants were newly unemployed and claiming benefits at the time of interview. Two were already seeking work or about to start job search after improvements to physical health. The other four did not consider a return to work possible until health issues had been resolved, highlighting the need for clear sequencing of support.

Some of these participants had taken **steps towards employment** including looking for voluntary work or retraining. Several participants described receiving support to improve CVs which was valued by one as “*a good thing*” because their existing CV was out of date.

For others in this cohort, **health issues precluded employment-focussed activities**. This included one individual encouraged both by JCP and WWEH staff *not* to consider work in the short term to support improvements in health and address on-going housing issues: “[WWEH] see it as though I'm not looking to go back into work just yet...they keep saying stop thinking about going back to work, you're off. And that's what the Jobcentre keeps saying to me” (Participant). This underscores the role WWEH can play in helping participants to identify an appropriate point to consider a return to work.

Stakeholders identified other beneficial outcomes for those looking for work. This included improvements in skills and a clearer sense of sectors and occupations which might be most appropriate given health conditions as the following example illustrates:

“It's not just about them returning to work [but] getting them...in the correct sector as well... [one participant] wants to go self-employed as a driver but...he's not got much people around him and he feels that might be bothering him with his anxiety and low mood. So I explored how he would feel driving maybe seven or eight hours a day and limited contact with people, would he feel comfortable with that, and I don't think he'd thought about it in that respect”. (Provider)

Case study 1: Looking for work

Jake is in his early thirties and had experienced mental ill health since adolescence, compounded by long-term alcohol misuse. Family bereavement had led to an extended period of medical leave from his job and although he tried returning work, deteriorating mental wellbeing led to further absence.

His GP signposted him to WWEH who developed a Return to Work Plan to reduce the risk of him leaving his job for good. This included offering to liaise with his employer; advice on activities to stabilise his mood such as attending a gym; and guidance on financial matters, housing, and diet. Jake highly valued this support: *“In a difficult time, it felt nice that there was a service that was actually trying to support me and actually help me stay in employment.”*

Ultimately, he felt unable to continue in his job, recognising the need to stabilise his health before re-entering the labour market. At the time of interview, he was claiming benefits and awaiting the results of a Work Capability Assessment. At the same time, he was volunteering at a local gym, attending addiction groups and engaging with other services.

Jake now has ambitions to change careers to become a personal trainer and plans to undertake training in support of this goal. He noted that his alcohol intake was reducing and his mental health is improving.

Although he endorsed WWEH, he reflected that the intervention of health services was probably a more significant factor in his recovery, having been supported by the alcohol adult community team, local NHS mental health services, various self-help groups and a very supportive GP. Nevertheless, he recognised that WWEH’s encouragement to attend the gym had steered him towards a possible new career.

Returning to existing jobs

Six participants had returned to their previous workplace. For some, this had been a positive step; for others the decision to return to work had been driven by necessity.

Among those for whom it was a **positive experience**, one participant described how a return to work after three months off due to stress had *“been going really well”* despite uncertainties beforehand: *“I wasn’t sure I was ready to go back [but] looking back on things...I went back at the right time...to get that push, albeit gentle was exactly the right thing”* (Participant). This illustrates the value of WWEH support in addressing uncertainties and concerns about going back to work.

Less positive experiences were reported by those who had felt **compelled to return to work for financial reasons**, including one individual given lighter duties but lower pay: *“If I didn’t have to do it, I wouldn’t do it”* (Participant).

Some interviewees also expressed concerns that **employers had not been supportive** or agreed adjustments to help manage health conditions. One participant suggested they were not allowed the regular breaks needed from a customer-facing role to manage their health condition. Another stated that WWEH advice for a phased return was financially unviable while suggestions for workplace adjustments e.g. lunchtime walks had been relevant but unlikely to find traction with their employer: *“Things I couldn’t do really but would have been beneficial...my employers are what they are, it was very difficult for me”* (Participant). Other interviewees remained concerned about the possibility and implications of taking sick leave in the future.

These mixed experiences of a return to work indicate that what might be measured as a positive employment outcome is not always *experienced* as such by participants. It may be necessary to review support provided following a move back into employment.

Case Study 2: Returning to work

Jeanette is in her early thirties and took medical leave from her administrative role due to a combination of physical and mental health conditions. She was referred to WWEH by her GP who had recommended it as a faster route to access counselling.

Jeanette wanted to return to work on a part-time basis but was apprehensive about her ability to cope, having unsuccessfully tried to go back on an earlier occasion. Her VRC helped her access a range of support including CBT, gym sessions, and information on mindfulness classes and self-management of her medical condition

Advice on employment rights enabled her to approach her employer with much greater confidence and knowledge about negotiating a return: *“The employer was asking me what hours can you do, and I didn’t have the answers but Working Well massively helped with guidelines”*.

WWEH also provided advice on reasonable adjustments, requesting flexible working hours, and ergonomic assessments, which fed into assessments carried out by her company’s Occupational Health team. This was contrasted with GP advice to take another month’s medical leave with no clear route back into work.

The empathy, accessibility and encouragement of the VRC was rated highly and improved her ability to cope: *“They would get back to me straight away if I had any problems, if I was worried or anxious about anything”*. By the time of interview, Jeanette had returned to her job and reported that her health conditions were being successfully managed: *“I’m in a good place now”*. At the same time, a supportive employer and NHS treatment was also credited with supporting her return to work.

Taking up new employment

Four participants had entered new employment, all of whom were extremely positive about the support they had received from WWEH.

Those taking up new jobs, often in different sectors from previous roles, reported **improvements in health and wellbeing** where hours were shorter or working conditions less onerous. One participant, for example, had swapped exceptionally long hours in a week in a hospitality chain for a part-time role in a café. Another participant who had taken medical leave from her previous job as a catering worker after collapsing with exhaustion from long hours had since found a new part-time role: *“I love it cos I only work Thursday, Friday, Saturday and it’s great money, they’re a great company to work for”* (Participant).

One implication is that supporting participants to find new roles may, in some cases, provide more scope for securing changes and flexibilities needed to address presenting issues than a return to an existing job. This confirms the stakeholder observation above about the importance of guiding participants into appropriate sectors.

Case Study 3: Taking up a new job

Paul is in his late fifties and worked in catering until a workplace accident saw him take medical leave. He felt let down by a lack of occupational support and was anxious about returning to a high-pressured role he believed to be a contributing factor to mental health issues he experienced.

During his time on medical leave, Paul's GP referred him to WWEH. The programme provided a wide range of practical and emotional support including phone numbers for local anxiety and stress groups; an offer of counselling once a month; putting him touch with JCP to develop a CV; and contacting ACAS on his behalf for guidance on employment issues.

Paul valued having a supportive voice at the end of the phone, with the consistency of a weekly, then fortnightly call supplemented by the knowledge that: *"I can phone [my VRC] any time I like, if I'm feeling stressed and anxious just give him a bell".*

After advice from ACAS and his VRC, Paul eventually left the post, taking his former employer to an industrial tribunal for payment of outstanding wages. At the time of interview, he was now in new part-time employment and enjoying the reduced hours and pressure. His levels of anxiety and stress had dropped, in part due to having a regular income, but also because of the supportive working environment, with the company positively promoting mental wellbeing.

WWEH Impact

A number of participants who had returned to work at the point of interview indicated that programme support had made a difference by identifying aspects of WWEH support that had directly contributed to moves into employment:

- **Structured and sequenced support** helped to map out a clear and achievable pathway back into employment. One respondent described, for example, how the RTWP combined with online resources and signposting to external support improved work-readiness and facilitated the transition into employment:

"It's helped me get back to work with some form of strategy, that's what it's done, cos after a couple of months I couldn't see me going, ever going back. Then slowly but surely I changed my mindset to maybe I could go back, maybe I could get a different role, to 'I think I'll go back'. Progression was slow but I made it in the end". (Participant)

- **Practical support with interview preparation** was attributed to one participant's successful job application: *"It helped immensely, I'm not sure I could have done it without them really because it's a long time since I've had interviews in the past"* (Participant).
- **Advice and guidance on negotiating a return to work** with employers was really significant in one case, especially as their GP could not offer this:

"It was massively important cos I didn't know what my guidelines were...what questions I needed to ask, and the GP didn't know either cos they say 'just don't go back to work', sign you off for another month, that doesn't really work with somebody who needs to get back to work". (Participant)

These participant insights further corroborate earlier reflections that the value of the WWEH model lies in the motivational capabilities of frontline staff, structured and sequenced support, and providing the tools and confidence to discuss a return to work with employers.

One way of measuring additionality is to consider look at whether WWEH facilitated a quicker return. This is measured formally as one of the programme's core outcomes. Participants who return to work and take part in a Customer Satisfaction Survey after discharge are asked if they have returned to work more quickly than they would have done without the programme's support. A third (33 per cent) of the 39 respondents agree that they had returned to quicker with programme support. This suggests the contribution of WWEH was limited, especially given a target of 95 per cent, although the sample is small and more data is needed to draw firm conclusions.

While participants spoke less about the speed of return to work, some frontline staff suggested that that WWEH had facilitated a **quicker return to work** than may otherwise have happened. This was attributed, in particular, to fast-track CBT or physiotherapy, or as the example below shows, having the knowledge and confidence to talk to employers about needs on their return:

“In some cases we’ve had interventions with employers that might have needed things like phased returns... making reasonable adjustments in the workplace and those can be very beneficial for people who never even knew that they could talk about things like that to their managers... So things like that do help people go back to work perhaps much quicker than they believed they might do”. (Provider)

Some stakeholders suggested WWEH support worked less well for some groups, including those further from the labour market, or with more severe presenting needs or health conditions. It was also considered less effective for newly unemployed participants who had little recent **experience of paid work** and required more intensive forms of support:

“You’ve done two weeks work somewhere, but you’ve not worked for six years before that, they’re the ones that seem to be more difficult to get back into employment, because ultimately they probably are long-term unemployed”. (Provider)

One implication outlined in the final quote is that potential benefits may not be fully realised during the short six-month timeframe of the programme, even if some progress is made.

Overall, there was **clear evidence to suggest that elements of programme support had contributed to positive employment outcomes** in some cases, particularly where participants had been supported to move from a stressful working environment to a new and less onerous role.

At the same time, half of interviewees identified positive outcomes but felt WWEH had played little or no role in change and considered it highly likely they would have experienced it without programme support. Nevertheless, **several of these participants still clearly valued WWEH support, particularly the personalised and empathetic approach, even if had not led to demonstrable change** or where help from other sources had more direct impact: *“Even if it wasn’t a lot of support that was put in place... there was understanding and empathy as well which goes a long way” (Participant)*. The value placed on support received was near universal across interviewees, regardless of whether it had led to observable change. It is important to remember, though, that findings are based on a small number of interviews and further

research with participants in subsequent phases of evaluation will provide a fuller picture of experiences and outcomes.

6.4. Outcomes by sub-group

Analysis of health and employment outcome shows some variations by subgroup. Table 6.6 below examines changes in the proportion of participants receiving a more positive result at discharge than entry on five of the core health assessments (ONS, SWEMWBS, EQ-5D-5L, EQ Visual Analogue score and PAM). Data suggests health outcomes tend to be better for those who:

- have been provided or advised **more interventions**.
- have been provided or advised **CBT**.
- **are not in the category of most need** on the combined measure of need (but only on the ONS, EQ-5D-5L and EQ Visual Analogue assessments).
- **were in paid work** (assumed on medical absence) **at the start of their engagement** compared to those who were out of work.
- are **female** compared with male participants (on all health assessments *except* the EQ-5D-5L measure).

Table 6.7 below examines employment outcomes achieved by sub-group. It shows that the proportion of participants who returned to work was higher for those who were:

- **provided or advised CBT**.
- **not placed in the category of most need** on the combined measure of need.
- were **in paid work** (assumed on medical absence) compared with those who were newly unemployed.
- **female compared to males**.

There is minimal difference, however, in the proportions achieving an employment outcome by number of interventions received.

Overall, the analysis of health and employment outcomes by sub-group indicates a correlation between positive change and the number or type of intervention(s), levels of need, employment status and gender. While this does not indicate causality, it highlights personal characteristics and features of programme support that should continue to be explored in terms of contribution to change.

Table 6.6: Outcome change: core health assessments (Base: 184)

	<i>More positive result recorded at discharge than on entry %</i>										
	Interventions			CBT provided /advised	CBT <i>not</i> provided /advised	Combined Measure of Need		In work	Out of work	Male	Female
	1-4	5+	7+			Bottom 25 percentile (most need)	Top 75 percentile				
ONS Life Satisfaction score	55	77	75	73	65	62	69	77	62	62	72
SWEMWBS total score	62	84	80	78	73	76	73	83	69	66	82
EQ-5D-5L	52	55	64	64	50	50	54	68	46	54	53
EQ Visual Analogue score	59	75	77	78	64	62	69	77	63	60	74
PAM Score	58	68	74	69	61	74	59	68	60	62	65

Table 6.7: Employment outcome³⁵ at discharge

	%
1-4 interventions	37
5+ interventions	34
7+ interventions	35
CBT provided/advised	43
CBT <i>not</i> provided/advised	33
Combined Measure of Need: Bottom 25 percentile (most need)	30
Combined Measure of Need: Top 75 percentile	37
In work	64
Out of work	20
Male	33
Female	38

Base: 177

Final reflections

7.1. Introduction

WWEH is a key part of the UK government's commitment to test local approaches to early intervention, system integration and more streamlined referral routes. A number of specific points of learning and potential improvement are highlighted throughout the report. This section provides some broader reflections on learning from the programme and how WWEH might evolve in response to challenges identified.

7.2. The WWEH model

There is strong support for the programme model with both stakeholders and participants highlighting the effectiveness of a health-focussed approach; a bespoke, structured and sequenced package of support; fast-track access to CBT and physiotherapy; and a unique level of support to enable participants to negotiate a return to work with employers.

At the same time, it highlighted potential gaps in support for two groups: those who are still working but 'wobbling' and at risk of leaving due to health conditions; and highly vulnerable individuals with severe needs, health conditions or safeguarding issues. It may not make sense to reconfigure WWEH to provide this support but there would be value in reviewing the current support available to these groups, and potential ways in which the Working Well family of employment support programmes could adapt to accommodate them.

7.3. Performance

Underperformance against targets has proved one of the biggest challenges to date. A series of remedial actions now have been undertaken by the Provider to address performance issues such as low SME referrals and the low conversion to start rate for GP referrals (although referral recording issues across pathways highlighted in Section 3.1 means comparisons with other pathways may be misleading). Early evidence suggests these are starting to pay off, at least in terms of GP referral to start conversion rates.

While essential to continually reflect on, and seek to improve, referral processes it is also **important to consider whether the targets themselves are feasible**. These could be reviewed once the outcomes of current remedial actions are evident. It will be important to learn from the experience of WWEH to ensure that future commissioning of employment programmes places sufficient onus on bidders to detail how proposed targets are both realistic and feasible, drawing on benchmarks from other interventions where appropriate.

In the remainder of the programme, it may make more sense to concentrate resources and capacity on delivery where the programme is already effective rather than focussing on improving elements such as SME referrals where there is sustained underperformance. This is already happening to some degree with the decision to provide additional focus on the newly unemployed.

7.4 GP referrals

Challenges in engaging GPs during the first phase of delivery of the programme reflect the complexities of working across multiple practices with different cultures and processes. Considerable efforts have been made to address a number of blockages and now appear to be leading to better quality referrals and fewer eligibility or attachment issues. With hindsight, earlier implementation of a continuous and systematic case-by-case review process of unsuccessful attachments may have been helpful.

One key point of learning is that **embedding the Provider in the referral process through triage within practices is crucial** to improving the quality of referrals. This can be even more effective where an engaged GP Lead is in place. Embedding Provider staff helps to make links with key staff, reduce demands on GPs and ensure patients receive timely and accurate information about the programme. Another aspect of learning is the challenge of relying on an external partner to adhere to, and to some extent 'police' eligibility criteria, with GPs currently referring far more employees of large organisations than expected. Further education and Provider triage working practices may help to address this, but there may be limits in the extent to which referral partners can be expected to recognise and respond to programme priorities.

Significant variation in referral levels across GP practices suggests **the programme should maybe prioritise working with more engaged GP practices** rather than continuing to pursue those that that have showed less commitment to date. Uniform levels of engagement across GP practices are unlikely to be achieved.

7.4. SME referrals

Persistently low levels of Employer (SME) referrals have been a key challenge for the programme despite the Provider investing considerable effort in engagement activities. A range of contributing factors are responsible for this including Provider capacity issues, reticence among both employees and employers to take part, and the challenges in harnessing existing support infrastructure as a source of referrals. It must also be remembered that the SME base is large and geographically dispersed which can make engagement activities costly and time consuming.

Efforts to engage SMEs should continue and be constantly reviewed and it will be important to monitor if current actions to refine messaging and develop better links with business support programmes and networks bear fruit. The recent decision to remove targets for the proportion of in-work and out-of-work participants to accommodate rising levels of unemployment will ease performance pressures to generate referrals through SMEs. This provides a valuable opportunity to **treat this pathway as a 'test and learn' component of the evaluation now that it is no longer expected to provide a large proportion of referrals**. It may be better to concentrate resource on supporting a small number of committed SMEs and understanding the experiences and outcomes of these activities rather than largely unsuccessful engagement activities that generate few 'warm' leads.

7.5. The relationship between work and health

WWEH has highlighted the close relationship between work and health. Workplace relationships and conditions shape both decisions to leave jobs and experiences of returning to work. One implication is that a positive employment outcome as measured by job entry will not necessarily be experienced as such by participants. This is particularly the case if they feel compelled to return to work for financial reasons or employers are not supportive in helping them manage health conditions in the workplace.

This highlights **the importance of continuous support after returning to work** as this is a challenging time for some. However, the time-limited nature of WWEH interventions may preclude the kind of on-going in-work support needed. Moreover, participant experiences show how outcomes are often shaped by the nature of work and employer practices which WWEH cannot always influence. Consequently, supporting participants to find new employment may, in some cases, provide more scope for securing changes and flexibilities needed to address presenting issues and manage health conditions than a return to an existing job.

7.6. Supporting COVID-19 recovery plans

WWEH has a potentially valuable role to play in supporting those most impacted by the COVID-19 pandemic. It has already been agreed that the programme will receive substantially higher volumes of out-of-work participants from JCP to help respond to anticipated rises in unemployment in the coming months. This shift in emphasis will occur within the original programme budget and duration.

Programme monitoring data suggests this may present additional challenges as those out-of-work tend to have higher barriers to work, presenting needs and health issues than the in-work cohort. At the same time, a significant rise in unemployment may mean that those losing jobs are closer to the labour market than the current out-of-work cohort supported by WWEH. Either way, it will be **important to monitor levels of need among the newly unemployed and the capacity of the Provider to support this group** both in terms of volumes of referrals and intensity of support required.

One further implication is that the short to medium-term likelihood of a weakening labour market and decline in vacancies (see Section 1) may make it harder to support out-of-work participants to return to work. In this context, it is appropriate that expectations of the proportion of in-work or out-of-work participants who find employment have been relaxed. Performance against employment targets continues to be monitored but with the understanding it will be hard to meet these in the current context. As the pandemic continues to develop, it will be important to continue **closely monitor health outcomes** to see if the programme can help participants maintain or improve health, even if employment remains a more distant prospect for some.

Finally, as already highlighted, the programme **needs to continually review the extent to which it targets and engages groups most likely to be impacted negatively by the economic downturn**. This is particularly the case for young people who are less represented on the programme than other age groups, yet more likely to experience job loss during the pandemic. Supporting vulnerable groups will reduce the risk of 'scarring' effects where long-term unemployment impacts on future employment and earning prospects.

Appendix 1: Presenting needs measures

Participants are asked to assess their level of presenting needs against eight themes on entry to and discharge from the programme. The eight themes and an example of scoring criteria for one theme (Housing) is detailed below.

Presenting Need 1: Housing

Aspects to consider: Access; affordability; suitability/adaptations; housing support:

0. I have an excellent housing situation, this is a strength.
1. I have a good housing situation and I only rarely have problems.
2. I have a good housing situation but I still need regular support.
3. I have an ok housing situation but I still need support to improve.
4. I have an ok housing situation but I need a lot of support to improve.
5. I don't have a good housing situation and I want to improve but don't know how.
6. I don't have good a housing situation but I am not thinking about making changes at the minute.

Presenting Need 2: Personal finances

Aspects to consider: Debt; Money management; Personal budgeting; Benefit entitlement.

Presenting Need 3: Caring and Family responsibilities

Aspects to consider: Childcare responsibilities; Lone parenthood; Care responsibilities for a friend or family member; Challenges in family life; Bereavement.

Presenting Need 4: Coping and Confidence

Aspects to consider: Problem Solving and Decision Making; Confidence building; Motivation; Personal circumstances.

Presenting Need 5: Skills and Qualifications

Aspects to consider: Basic/language skills; Educational attainment; Communication skills; Job specific skills and qualifications.

Presenting Need 6: Access to work

Aspects to consider: Lack of work experience; Transport to work barriers; Age discrimination; General state of local labour market; Criminal record.

Presenting Need 7: Health and Disability

Aspects to consider: Managing health conditions/disabilities (physical and mental); Extent health condition/disability affects ability to gain/retain employment.

Presenting Need 8: Alcohol and drug use

Aspects to consider: Alcohol consumption; Drug use; Addiction issues; Extent alcohol or drug use affects ability to gain/retain employment.

Appendix 2: Individual measures in the combined measure of need

Measures included:	Negative result:
Presenting needs:	
Health	Score of 5 or 6
Housing	Score of 5 or 6
Personal finances	Score of 5 or 6
Caring and Family responsibilities	Score of 5 or 6
Alcohol and Drug Use	Score of 5 or 6
Coping and Confidence	Score of 5 or 6
Skills and Qualifications	Score of 5 or 6
Access to Work	Score of 5 or 6
Health assessments:	
PAM Level of activation	Level 1
ONS Life Satisfaction score	Score of 0-4
EQ5D5L across the 5 dimensions	Combined score across the 5 dimensions in bottom quartile
SWEMWBS total score	Score in bottom quartile
Other indicators:	
Disability Status	Participant considers themselves to be disabled
Currently in paid work?	Participant is not in paid work
Participant lacks basic skills (defined as a qualification at Entry Level in Maths, English or ESOL)	Participant lacks basic skills

References

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- ¹ <https://www.health.org.uk/news-and-comment/blogs/emerging-evidence-on-covid-19s-impact-on-mental-health-and-health>
- ² <https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/unemployment>
- ³ Over the quarter, there has been a large decrease in the number of young people in employment, while unemployment for young people has increased. The increase in youth unemployment is linked to younger workers' tendency to work in industries that were worst affected by the pandemic, that is, accommodation and food service activities and arts, entertainment and recreation. Source: ONS (2020a) *Labour market overview, UK: September 2020*. <https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/bulletin/s/uklabourmarket/september2020#coronavirus-and-measuring-the-labour-market>
- ⁴ For a description and evaluation of the other Working Well programmes see <https://www.greatermanchester-ca.gov.uk/what-we-do/work-and-skills/working-well/>
- ⁵ The 10 local authority areas in Greater Manchester comprise Bolton, Bury, Manchester, Oldham, Rochdale, Salford, Stockport, Tameside, Trafford, Wigan.
- ⁶ DWP and DHSC (2017a) *Improving lives: the future of work, health and disability*. <https://www.gov.uk/government/publications/improving-lives-the-future-of-work-health-and-disability>
- ⁷ Department for Work and Pensions (DWP) and Department of Health and Social Care (DHSC) (2017b) *Thriving at work: The Stevenson / Farmer review of mental health and employers*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/658145/thriving-at-work-stevenson-farmer-review.pdf; DWP and DHSC (2017b) *Improving lives, op. cit.*;
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- ⁸ DWP and DHSC (2017a) *op cit.*
- ⁹ Institute of Health Equity (2020) *Health equity in England: The Marmot review 10 years on* <https://www.health.org.uk/sites/default/files/upload/publications/2020/Health%20Equity%20in%20England%20The%20Marmot%20Review%2010%20Years%20On%20full%20report.pdf>
- ¹⁰ Good quality work is described as “characterised by features including job security; adequate pay for a healthy life; strong working relationships and social support; promotion of health, safety and psychosocial wellbeing; support for employee voice and representation; inclusion of varied and interesting work; a fair workplace; promotion of learning development and skills use; a good effort–reward balance; support for autonomy, control and task discretion; and good work–life balance...Poor quality work is essentially work with the opposite of these features.” Institute of Health Equity (2020) *op cit.*, p61.
- ¹¹ Greater Manchester Health and Social Care partnership (2019) *Transforming the health of our population in Greater Manchester: Progress and next steps*. <https://www.gmhsc.org.uk/wp-content/uploads/2019/08/GMHSCP-Population-Health-Plan-FINAL-1.pdf>
- ¹² Greater Manchester Health and Social Care Partnership (2019) *Greater Manchester Primary Care Strategy 2019-2024*. <https://www.gmhsc.org.uk/wp-content/uploads/2019/11/07b-Appendix-2-to-PC-Strategy-GM-Primary-Care-Strategy-v20-HCB-31.01.2020-FINAL-v1.0.pdf>
- ¹³ Greater Manchester Independent Prosperity Review (2019) Reviewers' Report https://www.greatermanchester-ca.gov.uk/media/1826/gmis_reviewersreport_final_digital.pdf
- ¹⁴ HM Government (2019) *Greater Manchester Local Industrial Strategy*, June 2019. <https://www.greatermanchester-ca.gov.uk/media/2132/gm-local-industrial-strategy-web.pdf>
- ¹⁵ GMCA (2019) *The Greater Manchester Model: Our white paper on unified public services for the people of Greater Manchester*. https://www.greatermanchester-ca.gov.uk/media/2302/qtr_mcr_model1_web.pdf
- ¹⁶ <https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/unemployment>
- ¹⁷ The Job Retention Scheme went live on 20 April 2020 and provides grants to employers to cover 80 per cent of a furloughed employees wages up to £2,500 per month.
- ¹⁸ For the HMT Treasury analysis see HM Treasury (2020) *Forecasts for the UK economy: a comparison of independent forecasts*, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892791/Forecomp_June_2020.pdf. Additional analysis of unemployment counts based on these forecasts is

taken from: New Economics Foundation (2020) *Building A Green Stimulus For Covid-19 A Recovery Plan For A Greener, Fairer Future*. <https://neweconomics.org/uploads/files/green-stimulus-covid.pdf>

¹⁹ ONS (2020a) *Labour market overview, UK: July 2020*.

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²⁰ ONS (2020b) *Earnings and employment from Pay As You Earn Real Time Information, UK: July 2020*. <https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/bulletins/earningsandemploymentfrompayasyouearnrealtimeinformationuk/july2020#main-points>

²¹ ONS (2020a) op cit.

²² Resolution Foundation (2020) *The Full Monty: Facing up to the challenge of the coronavirus labour market crisis*. Sector figures are based on analysis of survey data commissioned by the Resolution Foundation and undertaken 6-11 May 2020 with a sample size of 6,005 working age adults. Data on impacts on the young and low paid are based on analysis of the ISER, Understanding Society survey (Base = all UK adults aged 18-65 who had an employee job prior to the coronavirus outbreak and provided information on their usual earnings prior to the coronavirus outbreak).

²³ UK Government (2020) *Coronavirus Job Retention Scheme statistics: July 2020 – data tables*, Table 5: CJRS Furloughed employments by country, region and Local Authority. <https://www.gov.uk/government/statistics/coronavirus-job-retention-scheme-statistics-july-2020>

²⁴ Includes Jobseekers Allowance plus the unemployment elements of Universal Credit.

²⁵ The expected number of referrals each month is based on the number of starts expected by month. For example, 430 starts were expected in June 2020, representing 4 per cent of the total 10,085 starts. Applying this same proportion by month and assuming 90 per cent target conversion rate creates a target 478 referrals in June 2020.

²⁶ The Work and Health Programme also supports individuals with health conditions and disabilities so some individuals could be eligible for either programme. However, the Work and Health Programme also has a focus on the supporting the long-term unemployed and this group would not be eligible for WHEH.

²⁷ Locality data is missing for three GP referrals, therefore the total sums to less than the 1,204 referrals reported elsewhere in this report.

²⁸ Examples jobs within these occupations include: Customer service: Call centre agents/operators, Customer care occupations; Health and social welfare associate professional: Nurses, Paramedics, Physiotherapists, Housing and welfare officers; Administrative occupations: Local government clerical officers and assistants, Pensions and insurance clerks, Library assistants/clerks, General office assistants/clerks; Process, plant and machine operatives: Road workers, Demolition workers, Handyman, Meat Processors.

²⁹ https://www.greatermanchester-ca.gov.uk/media/1360/working_well_2018_final.pdf

³⁰ Short Warwick Edinburgh Mental Well-Being Scale (SWEMWBS) © NHS Health Scotland, University of Warwick and University of Edinburgh, 2008, all rights reserved.

³¹ <https://warwick.ac.uk/fac/sci/med/research/platform/wemwbs/using/howto/>

³² <https://www.health.org.uk/news-and-comment/blogs/emerging-evidence-on-covid-19s-impact-on-mental-health-and-health>

³³ One participant who was unemployed on entry was retired on discharge and has therefore been excluded from the analysis of performance

³⁴ Two participants who were employed on entry were retired on discharge and have therefore been excluded from the analysis of performance

³⁵ Employment outcome = counted on either of the two programme employment outcomes (Returned to and sustained in work (sickness absence cohort) / Job starts (newly unemployed cohort)).

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