Date: 30th June 2017

Subject: Creating a transformational, whole population Working Well system

Report of: Councillor Peter Smith, Portfolio Lead for Health & Social Care and Councillor Sean Anstee, Portfolio Lead for Employment, Skill & Apprenticeships

PURPOSE OF REPORT

This paper sets out a joint proposal across the GM Health and Social Care Partnership and the GM Combined Authority to develop a whole population approach to work and health.

The paper describes a whole population approach to Working Well, prioritising development of a GM Working Well Early Help model, alongside the existing GM Working Well (Work and Health)

The purpose of this report is to gain support for the development of an integrated work and health system for Greater Manchester (GM) and to update on progress in the commissioning of the GM Working Well (Work & Health) Programme.

RECOMMENDATIONS:

The Combined Authority is asked to:

Note that the GM Working Well brand is expanding to encompass a whole population approach to work and health

Agree the priorities proposed for the development of a GM Working Well (Early Help) Programme

Support the proposal for four key areas of focus for the working age population
Agree the proposed stages of delivery

Note and support the progress to date on Working Well (Work & Health Programme)

CONTACT OFFICERS:

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Risk Management – see paragraph
Legal Considerations – see paragraph
Financial Consequences – Revenue – see paragraph
Financial Consequences – Capital – see paragraph

BACKGROUND PAPERS: N/A

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GREATER MANCHESTER HEALTH AND SOCIAL CARE
STRATEGIC PARTNERSHIP BOARD

Date: 30 June 2017
Subject: Creating a transformational, whole population Working Well system
Report of: Cllr Lord Peter Smith & Cllr Sean Anstee

PURPOSE OF REPORT:

The purpose of this report is to gain support for the development of an integrated work and health system for Greater Manchester (GM) and to update on progress in the commissioning of the GM Working Well (Work & Health) Programme.

RECOMMENDATIONS:

The Strategic Partnership Board is asked to:

- Note that the GM Working Well brand is expanding to encompass a whole population approach to work and health
- Agree the priorities proposed for the development of a GM Working Well (Early Help) Programme
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1. Context

1.1 Greater Manchester Leaders have set an ambitious vision statements in relation to both work and skills and population health.

**Work & Skills Strategy 2016 – 2019**: Our ambition is to create an integrated eco-system, which has the individual and employer at its heart, and that better responds to the needs of residents, business and contributes to the growth and productivity of the GM economy.

**Greater Manchester Population Health Plan 2017 – 2021**: To achieve the greatest and fastest improvement to the health, wealth and wellbeing of the 2.8 million people who live in Greater Manchester

1.2 Leaders recognise that there is a co-dependent relationship between health and work: good quality work is good for health, and economic growth relies on a healthy, productive workforce. We know people with a long-term health condition are less likely to be employed in GM than elsewhere in the country. This is why the Work and Skills Strategy identifies integration of health commissioning with work and skill support as an objective, and the GM Population Health Plan has made employment a key priority within the ‘Living Well’ theme.

1.3 The evidence base for work as a health outcome is very strong, yet has received little priority to date from the health and social care system. There is clear evidence that unemployment is generally harmful to health, and leads to:

- Higher mortality;
- Poorer general health, long-standing illness, limiting longstanding illness;
- Poorer mental health, psychological distress, minor psychological/ psychiatric morbidity;
- Increased alcohol and tobacco consumption, decreased physical activity
- Higher rates of medical consultation, medication consumption and hospital admission
- Increased risk of fatal or non-fatal cardiovascular disease and events, and all-cause mortality, by between 1.5 and 2.5 times

One in seven men develop clinical depression within six months of losing their job, and prolonged unemployment increases the incidence of psychological problems from 16 per cent to 34 per cent, with major impacts on the individual’s family. Young people are particular at risk. Attempted suicides 25 times more likely for unemployed young men than employed young men, and mental health problems in general much higher amongst unemployed populations.

There is strong evidence that re-employment leads to improved self-esteem, improved general and mental health, and reduced psychological distress and minor psychiatric morbidity. The magnitude of this improvement is more or less comparable to the adverse effects of job loss. The exception to this can be young people, who are vulnerable to a ‘scarring’ effect - a bad early experience in the labour market can last for 20 – 30 years and restrict ability to progress. Young people who are not in education, employment or training (NEET) for a substantial period are less likely to find work later in life, and more likely to experience poor long-term health.

Staying in work is key to improving health outcomes in GM. National Institute for Health and Care Excellence (NICE) evidence indicates that those out of work with a health condition for 6-12 months have a 2% chance of returning to work, with those out of work for 24 months more likely to die than ever returning to work.
The strength of this evidence base needs to be viewed within the context of Greater Manchester’s ambitions to improve both health outcomes and inclusive economic growth. In Greater Manchester there are 225,000 people out of work and claiming benefits - more than the populations of Bury, Rochdale or Tameside. Of these, 61%, or 140,000 people, are claiming as a result of a health condition. Only 59.2% of GM residents with a long-term health condition or illness are in employment compared with the England average of 65.3%. The economic costs of sickness absence to GM is significant. Estimated annual cost of Statutory Sick Pay to Greater Manchester employers is estimated at nearly £90 million, and Occupational Sick Pay approaching £400 million\textsuperscript{viii} GM's economy is significantly less productive than it should be – there is a £10.2bn productivity gap with the national average. The key reasons are unemployment amongst working age residents, high levels of low skills and poor skills utilisation.

1.4 There is significant synergy across both strategies relating to work, skills and population health. Our challenge is to maximise opportunities for collective endeavour to deliver shared outcomes and priorities. To this end the GM Combined Authority and GM Health and Social Care Partnership leadership have formed a joint programme board to drive a system wide approach.

2. Extending Working Well towards a whole population approach

2.1 The current Working Well programmes have demonstrated that GM is able to trial successfully innovative approaches to addressing worklessness and poor health through locally commissioned and managed service design. The opportunity now is to expand the Working Well reach and build on the foundations that are place to create a transformation Working Well health and employment system that is able to enact positive change at scale to improve population health, address the worklessness challenge and increase productivity.

2.2 There is an opportunity to extend the programme across the employment life-cycle, which is demonstrated in the key areas of focus below.
3. Areas of Focus

3.1 Working Well (in work)

The objective is to create healthy GM workplaces which support workers to thrive, reduce sickness absence and increase productivity.

3.2 Working Well (early help)

The objective is to create a system that efficiently and effectively supports workers to retain employment when suffering from poor health or disability. This will reduce the flow of people leaving work and moving onto out-of-work benefits.

The principle of Early Help will also apply to those who have made a claim to benefit and a system of support will be developed to quickly address health needs and facilitate a return to the workplace. Within this theme we also need to ensure that the needs of young people, particularly those with health conditions and disabilities are addressed enable an effective transition to employment from school or college and that appropriate support is in place to make sure work is sustained.

3.3 Working Well (work & health programme)

The objective is to create a system that can support those with more complex needs, but have a reasonable prognosis of returning to work with personalised support within two years. This will be delivered through a dedicated keyworker service supported by an infrastructure of locally co-ordinated services. The primary outcome will be to facilitate a return to work, whilst also improving the employability, health and well-being for those who do not secure employment.

3.4 Working Well (care & support)
The objective is to create pathways to employment for those with more complex or enduring health conditions and also improving with quality of life for those for whom a return to work is not a realistic outcome.

4. Opportunities for Alignment

The four areas of focus align well with a number of strategic initiatives:-

4.1 Employer Engagement

*Employer Engagement and Public Service Leadership:* The Working Well programme is only deliverable by engaging and working positively with employers, particularly SMEs. There is also an opportunity for public services to lead by example, both in terms of supporting the health of the workforce and employment of local people. A GM Employment Charter would support the development of this theme.

*Apprenticeships:* There is an opportunity to use the apprenticeship levy to upskill the workforce and reduce the risk of people falling out of the workplace due to obsolete skills, as well as providing a structured pathway into work and career progression.

4.2 Priority population groups

*Ageing Hub:* Research has shown that there are real challenges to over 50s securing and maintaining employment. Working with businesses to support the development and retention of these assets, as well as developing bespoke pathways into employment, would be core elements of this work.

*Mental Health:* As a cause and effect of sickness absence and long-term worklessness, poor mental health is a shared priority which can be addressed as part of the GM Mental Health Strategy. There are opportunities to align employment support for people with mild to moderate and severe mental illness within the overall programme.

*Learning Difficulties:* A consistent approach to providing opportunities for people with learning difficulties and disabilities will be a priority area of focus, working closely with the Adult Social Transformation Programme. Opportunities for development include supported employment, apprenticeships and traineeships.

*Carers:* working closely with the Adult Social Care Transformation Programme, work is now underway to identify the approaches GM should take to ensure that Carers are able to remain in the workforce and/or supported to return to the workforce.

4.3 System Infrastructure

*Local Care Organisations (LCOs):* LCOs can anchor delivery vehicles, designed to meet the specific needs of their individual localities, providing a co-ordinated service offer, aligned with place-based initiatives. Prevention and early intervention, including the integration of social prescribing models and community support is a core component of delivering a sustainable health and care system. Supporting people to remain in and return to work is a key part of this.

*Place-based Initiatives:* Although much of the focus of PBI has been on supporting vulnerable residents, which will be absolutely critical to the success of Working Well, there is an
opportunity to take a very localised approach within each place to employer engagement and support for SMEs and Micro businesses, in order to create healthy workplaces.

*Jobcentre Plus (JCP)*: JCP is an important delivery partner in all aspects of Working Well with considerable resources and influence in this area. There is an opportunity to build upon some of the successful joint working already underway in GM (Troubled Families/Universal Support Delivered Locally), particularly with LCO's to maximise our joint efforts.

*Academic Partnerships:* There is significant academic expertise across the GM Universities in relation to health and employment. A strong academic partnership is under development to ensure that the whole programme is informed by the best evidence and latest research, and opportunities for learning and research are maximised for mutual benefit.

5. **Design Principles for a whole population Working Well system**

There are a number of key design principles that will underpin the Working Well system, which will ensure delivery is:-

a) Person-centred  
b) Place-based with local accountability  
c) Asset-based, drawing on the strengths of individuals and local communities  
d) Provides consistency of offer and quality (but not necessarily standardised)  
e) Continually improving  
f) Driving efficiency through innovation and technology  
g) Reducing risk of duplication  
h) Data-driven

6. **Stages of delivery**

6.1 The scale of ambition should not be underestimated and a staged approach to delivering the four areas of focus will be taken.

6.2 Progress is already well underway in the development of a five-year £54 million Working Well (Work & Health Programme), which will support 22,500 people and will go live in January 2018. The next planned focus of activity is in the development of Working Well (Early Help), which will be expanded upon in this report. There are opportunities to make some progress in the remaining areas of focus, in particular through the Mayoral priority of developing a GM Employment Charter and also through progressing the development of a GM approach to supported employment, apprenticeships and traineeships.

6.3 A systematic approach will be taken to the Working Well programmes of activity, looking in particular at a range of key considerations including customers, services, delivery partners, outcomes, pricing mechanics and contract structuring. More details are provided in the annexes, with some examples of how they have been applied to WW (Work & Health Programme) and their potential application to WW (Early Help).

7. **Working Well (Early Help)**

7.1 There is a significant gap in early help for many people who are in work but at risk of falling out of the labour market, or newly unemployed, due to health conditions or other factors.
Intervening before people become long-term out of work with the associated impacts on health, wellbeing, financial security and cost to the public service system makes sense.

7.2 The priority area for Working Well Early Help is to design and test an effective early intervention service to prevent people from falling out of employment. Building an effective early intervention system will support the GM economy, health equity and health outcomes and reduce the pressure on the fiscal gap generated by out of work benefit claims. This work is being driven as a key priority within the GM Population Health Plan as part of the joint approach with the GMCA.

7.3 The economic costs of sickness absence to GM is significant. Estimated annual cost of Statutory Sick Pay to Greater Manchester employers is estimated at nearly £90 million, and Occupational Sick Pay approaching £400 million[iv]. Lost productivity costs to business by those in work but struggling to perform is unquantified.

7.4 Provision of occupational health and employee health and wellbeing support within GM is currently unmapped but variable across the conurbation, mainly the preserve of large organisations. The majority of GM businesses are micro or small businesses (<50 employees). There are approximately 85,000 of these businesses across GM (98% of the total number of businesses, employing an estimated 50% of total employees).[ix]

7.5 Staying in work is key to improving health outcomes in GM. National Institute for Health and Care Excellence (NICE) evidence indicates that those out of work with a health condition for 6-12 months have a 2% chance of returning to work, with those out of work for 24 months more likely to die than ever returning to work. Only 59.2% of GM residents with a long-term health condition or illness are in employment compared with the England average of 65.3%.

7.6 The model will primarily be designed for GM residents who work for Small and Medium-sized Enterprises (SME’s), or are self-employed, and have no access to occupational or employee health support. The objectives are to

- Reduce the number of days lost to sickness absence for those in employment
- Prevent GM residents with health conditions from leaving the labour market
- Support SME’s to retain employees and better manage health in the workplace
- Reduce time spent by clinicians on non-clinical work in primary care
- Support newly unemployed people with health conditions to access an enhanced health support offer to facilitate an early return to work

7.7 The first draft of the Project Brief for GM Working Well (Early Help) is attached as Annex 3. A mixed model of investment is proposed including Transformation Fund, Joint Work and Health Unit Innovation Funds, and European Social Funds. Detailed project design, including investment modelling, evaluation, engagement and sustainability planning is in progress.

8. Working Well (work & health programme): Update on Progress

8.1 For WW (WHP) a combination of Service Fee and Outcome Fee has been agreed as the pricing mechanism for the programme. The Service Fee will be fixed from the start at a value of 30% of the total estimated contract cost. This will be paid in equal monthly instalments and provides cashflow certainty for providers, which is helpful for smaller and third sector providers
either operating as tier one or as part of the supply chain. There are a number of minimum service standards (MSM) which must be delivered to satisfy the release of Service Fee payments, which avoids the risk of paying for nothing. If MSMs are not delivered there is the option to withhold payments, although persistent failure to meet standards could result in contract termination.

8.2 The Outcome Fee accounts for 70% of provider payments and consists of i) earnings and ii) higher earnings outcome measures. The policy drivers for GM’s programme are to increase productivity and entrepreneurship, therefore outcome payments are related to Real Living Wage earnings and self-employment. The ‘earnings’ outcome is payable when an programme participant has earned the equivalent of 16 hours x Real Living Wage x 26 weeks, which equates to £3,500 (rounded). This will be uprated in line with the Resolution Foundation on an annual basis in April. The outcome can be achieved over any period of a participant’s time on the programme (i.e. 21 months) and acknowledges that some people may require incremental steps to return to work and that some good work is better than none at all. The ‘higher earnings’ outcome premium is payable when a participant has earned £3,500 within a 26 week period and has been designed to incentivise providers to support participants into quality, well-paid employment. As part of the procurement process, bidders are being asked to specify what proportion of outcomes will be ‘higher earnings’. Self-employment outcomes will be payable at the ‘higher earnings’ premium to acknowledge the value GMCA places on increasing entrepreneurship.

8.3 In terms of contract structure the option taken has been for a single contract for the entirety of GM. However, this could be delivered by either a Prime provider with a number of sub-contracts or as a Joint Venture or consortium. The use of local small providers and VCSE organisations has been incentivised and is a key element of the social value weighting.

8.4 As with the current Working Well programmes, local delivery partners play a key role in the overall programme and their work will be co-ordinated through our network of Local Leads and Local Integration Boards. Service Users have also been part of the co-design process with over 100 engaged to date.

8.5 The first phase of the procurement process has now concluded and five organisations have been invited to submit their proposed delivery models. These will be assessed in June and it is likely that three organisations will be invited to a series of competitive dialogue meetings. These will be used to scrutinise proposals and shape final submissions. It is anticipated that contracts will be awarded in October.

9. Recommendations

The Strategic Partnership Board is asked to:

1 Note that the GM Working Well brand is expanding to encompass a whole population approach to work and health
2 Support the proposal for four key areas of focus for the working age population
3 Agree the priorities proposed for the development of a GM Working Well (Early Help) Programme
4 Agree the proposed stages of delivery
5 Note and support the progress to date on Working Well (Work & Health Programme)
## ANNEX 1 - Key Considerations

<table>
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<tr>
<th>Element</th>
<th>Consideration</th>
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| Customers       | - Who are the target customers  
- What are their key attributes  
- What are segmentation requirements/options (data or assessment led) |
| Services        | - Build on existing successful programmes  
- Develop menu of services  
- Integrated, place-based approach |
| Channels        | - Spectrum from face-to-face, telephony and self-serve digital  
- Accessible  
- Zero cost to user |
| Delivery Partners | - Accountability needs defining  
- Key role for VCSE and small providers  
- Contracts owned at local, GM or national level |
| Data            | - Complex relationship of data ownership and access  
- Role of GM Connect  
- Will require significant thinking |
| Organisation    | - Relationship between government, GM bodies and localities  
- Governance needs to be understood  
- Mapping of local delivery eco-system |
| People          | - Does capability and capacity exist for i) design and ii) delivery? At which geography?  
- Workforce development implications |
| Technology      | - Need to understand GM landscape  
- Potential requirements include: CRM tool, Invoicing and Payment tool, Contract Management system, Portals, real-time info, and Analytics capability |
| Location        | - Pan-GM / clusters / localities / estates?  
- Must be deliverable (and potentially commercially attractive)  
- Should support GM standards and local delivery model  
- Emphasis on physical locations for F2F channels |
| Fraud, error and debt | - Where are risks e.g. outcome payments?  
| | - What should be passed to providers? |

**ANNEX 2 – Pricing Mechanics**

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| **Service Fee** | - A fixed fee per period (e.g. monthly) against which SLAs can lead to service credits  
| | - Can be calibrated against some or all of fixed cost base  
| | - May be beneficial in allowing support of SMEs/VCSEs who cannot take as much cashflow risk as larger organisations |
| **Event Payment** | - One-off fee paid against a defined activity or milestone event. The events/payments may be either one-off (eg attachment), or recurring (eg engagement)  
| | - Automatically adjusts with level of clients in the system |
| **Progression Payment** | - Payments associated with demonstrating clients have been made progress towards finding/returning to work, even if they have not yet done so |
| **Output Fee** | - Additional fee available for the delivery of either soft or hard outputs  
| | - Could consider transformation milestones, client and employer feedback, integration improvements etc |
| **Outcome Fee (Payment by Results)** | - One off payments for delivery of outcomes e.g. quality job outcome  
| | - Can enable differentiated payments (by time and/or by client group) |
ANNEX 3 – GM Working Well Early Help Project Brief

POPULATION HEALTH PLAN – PROJECT BRIEF
Living well: Health and Employment

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<td>The GM Health and Employment Programme is a joint programme between the GM Health &amp; Social Care Partnership and the GM Combined Authority.</td>
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<td>It aims to create a system response along the continuum from ‘in work’ through to long-term worklessness, focusing on the following areas:</td>
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<td>An effective early intervention system available to all GM residents in work who become ill and risk falling out of the labour market or those newly unemployed who need an enhanced health support offer</td>
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<td>Better support for the diverse range of people who are long-term economically inactive to prepare for and find work</td>
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<td>Development to enable GM employers to provide ‘good work’, and for people to stay healthy and productive in work</td>
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<td>This project brief focuses on the first priority within the programme, developing a ‘GM Working Well Early Help Service’ to deliver an effective early intervention service to GM residents with health conditions, at risk of falling out of the labour market or newly unemployed.</td>
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<td>Jenny Osborne, Strategic Lead, Health and Employment, GM Health &amp; Social Care Partnership</td>
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1. BACKGROUND & RATIONALE

This project forms a core component of ‘Living Well’ within the Population Health Plan, to ensure that of more GM individuals and families are economically active, and remain so throughout their working lives.

The purpose of this project is to prevent people with health conditions who are in work but at risk from falling out of employment. It will primarily be designed for GM residents who work for Small and Medium-sized Enterprises (SME’s), or are self-employed, have no access to Occupational Health support or are newly unemployed.

Current state
No effective systematic support service to prevent people with health conditions falling out of work
Limited & variable access, and effectiveness of Occupational Health & Employee HWB support
NHS services can be disconnected from employment needs.
Increasing focus on employment within some health and social care services (eg. mental health, learning disability) but with no clear system offer – risk of duplication
Employers and line managers lack knowledge of how to manage employers who are sick or have long-term conditions.
National Fit For Work Service not meeting local need
Jobcentre Plus support for newly unemployed is disconnected from local health and wellbeing support

Future state
Integrated GM health and employment system which is effective in preventing people with health conditions falling out work, or rapidly returning if they become unemployed
Access to appropriate Occupational Health/Employee HWB support for all GM employees
GM health and care services can respond in an integrated & timely way to keep people in work
GM Employers, including SMEs support good quality work and workplace health

Policy context

National: The importance of ensuring fair employment and good work for all was identified as one of the six key policy objectives to tackle health inequalities within Professor Michael Marmot’s ‘Fair Society, Healthy Lives: A strategic review of health inequalities in England, 2010’.

The Government recently launched ‘Improving Lives: the Work, Health and Disability Green Paper’ released in October 2016 which recognises the importance of work for health. Priorities for action include closing the gap which exists in the employment rate between people living with a long-term condition or disability, and non-disabled people; and ensuring an effective occupational health offer for all people of working age.
A National Fit for Work Service was commissioned by the DWP in 2014. It has been widely acknowledged as ineffective, and not well utilised either by small employers, GPs or individuals. The Green Paper makes little reference to the national service but states a clear ambition to support health and employment services that are locally designed and delivered. We are working with the DWP/DH Joint Unit to understand the lessons learned, which will form part of the detailed analysis shaping the design of the GM service.

Greater Manchester: ‘Stronger Together’: Greater Manchester Strategy, and ‘Taking Charge’ - the GM Health and Social Care Strategic Plan, recognise the interdependence between good health and employment. GM Health and Social Care devolution presents opportunities to test an enhanced role for the health system in terms of health and employment-related support, aligned to Locality Sustainability and Transformation Plans and Public Service Reform programmes, both critical for sustainable delivery at scale. Our ambition is to bring the work and health systems far closer together for the benefit of GM residents.

Economic costs to GM: In terms of costs to business, around 140 million working days are lost to sickness absence each year across Britain – approximately 5 days per employee, representing 2.2% of all working time. The total annual cost of Statutory Sick Pay to employers is estimated to be some £1.5 billion, but on top of this employers pay an additional £6.9 billion per annum in discretionary Occupational Sick Pay. Apportioning this based upon working age population (and weighting to account for the higher proportion of working days lost to sickness absence in GM), the annual cost of SSP to Greater Manchester employers is estimated at nearly £90 million, and OSP approaching £400 million. Lost productivity costs to business by those in work but struggling to perform is unquantified.

GM access to occupational health support: Provision of occupational health and employee health and wellbeing support within currently unmapped but variable across the conurbation, mainly the preserve of large organisations. The majority of GM businesses are micro or small businesses (<50 employees). There are approximately 85,000 of these businesses across GM (98% of the total number of businesses, employing an estimated 50% of total employees). These businesses are unlikely to have any provision in place and will be largely reliant on individual employees accessing NHS services. NHS services cannot currently ensure flexible and timely access to services in order to support employees with a health condition to remain in work, for example due to waiting times for MSK services.

GM gap with national average: Staying in work is key to improving health outcomes in GM. National Institute for Health and Care Excellence (NICE) evidence indicates that those out of work with a health condition for 6-12 months have a 2% chance of returning to work, with those out of work for 24 months more likely to die than ever returning to work.

Some 59.2% of GM residents with a long-term health condition or illness are in employment compared with the England average of 65.3%. GM’s employment rate is 70.5% compared with 74% across England. The number of people out of work in GM (225,000) is broadly
equivalent to the entire population of Rochdale or Tameside. Of the 225,000 out of work, 61% (140,000) are claiming out of work benefits due to a health condition.

Building an effective early intervention system to support people to remain in the labour market will support the GM economy, health equity and health outcomes and reduce the pressure on the fiscal gap generated by out of work benefit claims.

**Evidence Base**

There is a strong case for early intervention to support people with chronic health conditions to remain in work and productive. The evidence base was sufficient for Government to fund a national service to try to address this, and for the Scottish Government to mainstream this provision within NHS delivery.

Evidence from The Work Foundation and Fit for Work Europe demonstrated a compelling economic case in October 2015 that effective interventions can

- Reduce sick leave and lost work productivity among workers with MSK disorders by 50%;
- Reduce healthcare costs;
- Reduce the risk of developing a co-morbid mental illness;
- Reduce disability benefit costs

Similar approaches are in place in other parts of the UK:

- **Scotland** has an NHS-led service available nationally to all people working in companies with under 250 employees, and the self-employed.
- **Sheffield** have a longstanding service of this type which is well used by GPs (Sheffield Occupational Health Advice Service), and are looking to expand across the City Region.
- **Nottinghamshire, Leicestershire** and **Derbyshire** all commission a Fit for Work service.
- **Manchester** has a small Fit for Work similar service which has 86% of GP practices regularly referring to it.

An evidence review and analysis of previous models and trials, and existing models will need to be conducted as part of the detailed design work for this programme.

### 2. OBJECTIVES

**Project Objectives:** To design and deliver a GM Working Well Early Help service for those with health conditions in work and at risk or newly unemployed, who have no current access to Occupational Health services, in order to:

- Reduce the number of days lost to sickness absence for those in employment
- Prevent GM residents with health conditions from leaving the labour market or enable a rapid return
- Support SME’s to retain employees and better manage health in the workplace
- Reduce time by clinicians spent on non-clinical work in primary care

**Optional additions to be explored**

- Test an alternative approach to the current Fit Note system within Primary Care
The longer term objective is that no GM resident should leave employment due to the effects of a health condition or disability without accessing professional advice and support them to remain in the labour market. If unemployed with a health condition, the support should come far earlier to enable a return to work. The five year ambition is to mainstream this support as part of the GM health and care system, via an examination of funding model options through the project.

Support for the Project Objectives within Localities has been strong. Salford, Oldham, Stockport, indicated in November 2016 that they wanted to be early adopters, and all other Localities have provided initial indications that they want to participate.

### 3. OUTLINE DELIVERY MODEL OR SCOPE AND DELIVERABLES (WHICHEVER IS MORE RELEVANT TO CHARACTERISE THE PROJECT)

#### Target population
Individuals who are self-employed and employees working for SME’s (>250 employees) where no occupational health provision is in place or is ineffective

#### Delivery model
Any service model will be co-designed with Locality partners and stakeholders, taking into account of expert advice and evidence, and learning from any services already in place locally. The areas below outline represent a starting point for this process.

**Offer to individuals - Outline Access criteria (subject to further co-design)**

- Simple referral via GP for employed people who have been off sick for two weeks and likely to be off for four weeks or more, and who require a biopsychosocial intervention to return to work as quickly as possible.
- Self-referral or via employer for those at work but struggling with health conditions and require an intervention to remain effective and productive in work. This is for those who cannot access appropriate health support via their employer - particularly includes those who are self-employed, or work for small and medium sized enterprises (SME’s)
- Referral via Jobcentre Plus for those newly out of work who need an enhanced health support offer to make a return to work.

**Offer to employers**

- Targeted Employer-facing offer to support improved workplace health practice, employee-retention where issues identified through GM WW (EH) service to individuals or approached from employer
Proposed features of the model

Biopsychosocial assessment, action planning and case management
Integration and co-ordination with local services, including social determinants support
Condition management advice and self-care
Rapid access to MSK and mental health treatments
HR and Employment advice
Feedback, advice and support to GPs – eg. fit note, partial duties
Employer-facing offer to support improved workplace health practice

Delivery method: A range of options need to be explored during the detailed design phase, including
- Whether the service could be NHS-led by extending or re-configuring current provision
- Commissioning via a GM level procurement exercise on behalf of participating Localities
- Channelling funding via an agreed outputs/outcomes framework to Localities who have existing services in place

Timelines and milestones

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Timeline</th>
<th>Key tasks</th>
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<tbody>
<tr>
<td>Agree the Mandate</td>
<td>Jan-Mar ‘17</td>
<td>• Population Health Plan published including a clear priority around work and health • Lead for Health and Employment appointed</td>
</tr>
<tr>
<td>Establish Infrastructure &amp; agree scope</td>
<td>Feb - April</td>
<td>• Programme Team in place • Joint Governance with GMCA established • Localities engaged • Project Brief produced • ‘As is’ mapping undertaken</td>
</tr>
<tr>
<td>Develop the detailed</td>
<td>May –</td>
<td>• Evidence review • PID development</td>
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</tbody>
</table>
| business case                          | Sept | • Stakeholder Engagement  
|                                      |      | • Detailed model design & specification development  
|                                      |      | • Procurement options appraisal  
|                                      |      | • Evaluation and CBA  
|                                      |      | • Information Governance and Data  
|                                      |      | • Equalities Impact Assessment  
| Funding and procurement              | June - Dec | • Procurement/funding plans in place  
|                                      |      | • Transformation Fund application &CBA produced and submitted  
|                                      |      | • Market testing  
|                                      |      | • Any Tender process commences  
| Implementation                       | June ’18 | • Contract Award /Funding agreement in place  
| Evaluation and Monitoring            | June 2018-2021 | • Evaluation specification and reporting requirements in place  
|                                      |      | • Contract monitoring and performance management  

**Workstreams:** the following workstreams will be needed, with nominated leads, to deliver to the timelines identified.

1. Project Management and Governance
2. Stakeholder Engagement & Communication
3. Detailed model design
4. Evaluation, CBA, Information Governance & Data
5. Investment, procurement and sustainability
6. Project Implementation

4. OUTLINE PROJECT OUTPUTS

The key outputs that the intervention is seeking to achieve are outlined below.

- Delivery of a service to 8,500 individuals over 3 years.
- Referral to attachment into service rate of 75% + (volume tbc)
- Rapid assessment and support following referral (within c. 3 days of referral) for 95%+
- In work at point of discharge from service rate of 80% +
- Remaining outputs will be developed during the design phase of the programme

5. KNOW FINANCIAL INFORMATION

The summary below indicates the information at May 2017 and will be subject to further refinement through the relevant project workstreams.

**Potential Cohort size:**

18
11,000 people, reaching 50% of the estimated eligible in work cohort 11,000. 3,500 newly unemployed, though further modelling needs to take place.

**Potential cost:** Approximately £8.5m over 3 years (based on initial modelling). Further costing work will draw on Scottish and Sheffield City Region experience.

**Funding Options:** Transformation Fund, Joint Unit Innovation Fund, European Social Fund

**Estimated public value:** Initial CBA is available from an evaluation of the Manchester Fit for Work service pilot, which was small scale but demonstrated return on investment. The gross five-year fiscal return on investment for Manchester’s In-work service was an estimated 1.25, payback (when the benefits begin to outweigh the initial investment) should be achieved in four years. The wider public value delivered by the Manchester service incorporates increased economic output and reduced costs to employers, along with softer social benefits related to improved individual well-being – the public value return on investment was estimated at £5.74 for the In-work service.

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**6. KNOWN RISKS**

High level risks to taking risks to taking the project forward.

1. Initial Cost Benefit Analysis demonstrates that the largest percentage of return on investment accrues to DWP in the form of savings to benefits and therefore not realised by GM.
2. Requirements to go to procurement following any successful Transformation Fund bid will result in shorter duration of service delivery and timescales to mainstream within existing commissioning arrangements.
3. Central Programme Team capacity and Locality capacity to meet development and delivery timescales.

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**7. KNOWN DEPENDENCIES & CONSTRAINTS**

This is a cross-cutting programme with dependencies and linkages across many strategic and operational areas within both the GM HSCP and the Combined Authority.

*Transforming Community Based Care and Support (TfT2)* – the programme’s central delivery mechanism is via GP referral in primary care. The programme has scope to test alternative models for Fit note issue and other demand reduction measures, and needs to integrate within local community offer. As such it needs to integrate with new models of care and development of Local Care Organisations, as part of the wider process within public service reform of integrating place-based services.

*Standardising Acute Hospital Care (TfT3)* – musculoskeletal disorders are the second biggest cause of sickness-related absence and worklessness – current MSK pathways are fragmented
across GM and there is weak alignment with employment programmes. Linking this programme with transformation plans and future commissioning frameworks for MSK will be a core part of sustainability plans for the GM FFW service.

*Learning Disability* – joint discussions with the GMHSCP LD Leads are underway to ensure cohesion with the workstream on Employment support for people with LD. In work support and retention has a key potential overlap with GM FFW service.

*Mental Health* – Work is a priority theme within the GM Mental Health Strategy. As the largest cause of both sickness-related absence from work and worklessness, joint discussions are now underway with the Mental Health Executives to ensure programme alignment, as with Learning Disability above. Emerging evidence from GM Working Well would suggest that transforming approaches within IAPT services could deliver better outcomes.

*GM Workforce development and culture change* – embedding routine enquiry regarding employment status and advocacy of work as clinical outcome requires both workforce training, and cultural change.

*IM&T requirements* – delivery of a GM WW (EH) service will require Information Governance leadership, information and financial flows to be identified and mapped, data-sharing agreements and specialist advice on how data systems may be adapted to integrate the service as part of primary care delivery.

*Commissioning requirements* – following an options appraisal any decision to procure the service across the GMHSCP and the GMCA will need to be resourced and supported

**Constraints**
Requirements to go to procurement following any successful Transformation Fund bid will result in shorter duration of service delivery and timescales to mainstream within existing commissioning arrangements.

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8. KEY STAKEHOLDERS

A full stakeholder plan will be developed as part of the project management alongside this brief. Below is a summary of stakeholders

**GM & National Partners**

*GM Provider Federation Board*
*GM Association of CCGs*
*GM Primary Care Advisory Group*
*GM Mental Health Strategy Executive*
*GM Voluntary Sector Reference Group*
GM Ageing Hub
GM Local Employment Partnership
GM Employer Organisations: Federation of Small Businesses, Chamber of Commerce, Academic Partners: Universities of Manchester, Salford, Manchester Metropolitan University, Connected Health Cities
Public Health England
Jobcentre Plus
DH/DWP Joint Work and Health Unit

Locality Level
Health & Wellbeing Boards
Economic regeneration / Work and Skills Boards and delivery teams
CCG & Local Authority Commissioners,
GP Provider Federations
Local Care Organisations
Local Employer engagement forums and delivery partnerships
Local Voluntary and Community Services
Local residents and experts by experience

9. NEXT STEPS

Project Plans will be developed and workstreams initiated as detailed in section 3.

REFERENCES
1. Is Work Good for your health and wellbeing? Gordon Waddell & A Kim Burton 2006,
2. Siegrist et al 2010
3. Royal College of Psychiatrists 2013
4. Paul and Moser 2009
5. Waddell & Burton, 2008
6. Audit Commission, 2010
7. Multiplier is based upon working age population data sourced from the Mid-Year Population Estimates, weighted using Labour Force Survey (LFS) data sourced from Public Health England’s Fingertips tool on the proportion of working days lost due to sickness absence in GM compared to England as a whole
8. Multiplier is based upon working age population data sourced from the Mid-Year Population Estimates, weighted using Labour Force Survey (LFS) data sourced from Public Health England’s Fingertips tool on the proportion of working days lost due to sickness absence in GM compared to England as a whole
11. Ibid, p.37
12. Office of National Statistics Local Business Count data, New Economy estimate for the total number if employees.
13. *Economics of Early Intervention* Fit for Work Europe, Professor Steve Bevan, October 2015.