

Working Well Early Help Annual Report 2021

2021



Working Well Early Help

Annual Report 2021

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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. Initially, the programme primarily targeted workers in Small and Medium-sized (SME) workplaces. It has recently placed more emphasis on supporting the newly unemployed as part of efforts to address high levels of unemployment in the wake of the coronavirus (COVID-19) pandemic.

This annual report draws primarily on programme monitoring data and participant interviews to assess the effectiveness of WWEH and the outcomes it achieves. It shows that the programme continues to face considerable challenges in generating referrals and converting these to starts, with no likelihood in the time remaining that referral targets will be met. Nevertheless, it has experienced growing demand during the pandemic and consistently performs well in terms of the proportion of participants experiencing health and wellbeing improvements by the time they leave the programmes. Employment outcomes are more muted, which may reflect the severity of barriers to work among participants, as well as difficult labour market conditions during the pandemic. There is considerable evidence that work can be a contributing factor to poor health and wellbeing, raising important questions about how to improve job quality and employer practices.

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 2,686 participants; eight stakeholder workshops with the WWEH Programme Office team (referred to hereafter as the Commissioner), Provider delivery team, referral partners (Jobcentre Plus), and local authority officers supporting the programme; and 32 interviews with programme participants. It covers the first 26 months of delivery from March 2019 until the end of April 2021.

Referrals and starts

- **Meeting targets for referrals and starts has proved challenging** from the outset of the programme. Performance against cumulative targets stands around three fifths (62 per cent) of expectations to date for referrals and one third (35 per cent) for starts.
- A total of 5,345 referrals had been made into WWEH by the end of April 2021. This is equivalent to **48 per cent of the lifetime target** of 11,206 referrals by September 2021. The limited referral window left means it is not possible the programme will hit its lifetime targets for either referrals or starts in the time remaining.
- Despite these challenges, referral volumes during the pandemic have exceeded pre-pandemic levels, mainly because of a significant increase in referrals from Jobcentre Plus. This rising demand may be the result of increasing unemployment and the growing prevalence of mental health issues. Improvements in referral and start volumes during the third UK-wide lockdown

in 2021 also suggest the programme has become increasingly resilient to operating during periods of heightened COVID-19 restrictions.

- Current underperformance against referral targets may be partially explained by a range of factors including: competition from other employment support programmes; difficulties in maintaining relationships with GP practices and JCP practices during the pandemic; and on-going challenges in engaging SMEs employers.
- JCP has become the dominant referral pathway following the decision to refocus activities towards supporting the newly unemployed. Engagement with, and referrals from, SMEs remains significantly below expectations.
- A total of 2,686 participants had started on the programme by the end of April 2021. This represents **27 per cent of the lifetime target** of 10,085 participants by September 2021.
- Factors contributing to underperformance against targets for starts include very low volumes of SME referrals and the low conversion rates of referrals to starts (41 per cent against a target of 90 per cent). Low conversion rates may be partially explained by ineligible referrals from newly recruited JCP staff unfamiliar with WWEH; difficulties in assessing potential commitment among JCP clients remotely; and GP patients declining WWEH support once referred because of its perceived focus on a return to work which was not seen to prioritise their more immediate health needs.

Profile of participants

- **Mental ill health is the most common health issue among participants**, with 57 per cent of participants reporting a mental health problem as their primary health condition. 'Health management' was also by far the most common barrier to work reported.
- **Few participants report employment issues** ('Access to Work' or 'Skills and Qualifications') as a presenting need. Interviews show a small number of newly unemployed participants experienced employment barriers unrelated to health. This included issues with employability (interview technique and basic skills) and difficulties around the quality or quantity of jobs available during the pandemic.
- The **COVID-19 pandemic was a factor highlighted by some participants as contributing to both health and employment-related barriers to work**. This included being made redundant; limited vacancies in the job market; additional workplace pressures prompting medical leave; and wider social impacts on health and wellbeing such as the effects of social isolation.
- One implication is that WWEH programme is **operating in an increasingly challenging environment** where the pandemic has seen worsening health and wellbeing at precisely the same time as job opportunities have diminished.

Workplace experiences and health

- Wider research highlights the potentially positive relationship between good quality employment and good physical mental and mental health. However, it also shows that poor quality work can also contribute to ill health.
- Evidence from **the WWEH programme confirms the potentially harmful impact of poor work**. 'Health management' is the most common barrier to work among programme participants, with interviews suggesting it is often the relationship between negative workplace experiences and health that shapes decisions to take medical leave or leave work altogether.
- In many cases a range of workplace factors including overwork, bullying or harassment, difficult or dangerous working conditions, job insecurity, and poor management caused or aggravated ill health. Particularly striking was the way in which **the COVID-19 pandemic had created or exacerbated a series of work-related pressures that worsened health and wellbeing**. This was especially prevalent among interviewees working in the social care and healthcare sector.

- **Some interviewees indicated employers had been supportive** by recognising health conditions and making appropriate adjustments. It was more common, however, that interviewees reported a lack of support including failure to recognise health conditions, penalising medical leave and an unwillingness to make adjustments to facilitate a return to work.
- **Some Advice Service recipients were satisfied with work-based occupational health services but others reported it did not meet needs.** This questions the assumptions underpinning WWEH that employees in large companies do not need the full WWEH Support Service offer.

WWEH Support

- For some participants **the primary concern was to access support with a physical or, more commonly, mental health condition.** Employment was not always seen as an immediate priority, especially where health conditions are severe. This may impact on the ability of the programme to support some individuals to return to work.
- **Most participants were positive about WWEH programme** and valued a range of elements including: emotional support from VRCs; new insights into understanding and addressing needs and barriers; help in identifying the root causes of issues; impartial, external advice on returning to work; tools and techniques on managing health conditions and relationships with colleagues at work; and the ease and speed of access to support such as Cognitive Behavioural Therapy (CBT).
- **A smaller number of participants were less positive about the service.** For some, the key issue was the **inappropriateness of support for their personal circumstances**, especially given the challenging backdrop of the pandemic. Others were **concerned about the quality of the offer** itself for a range of reasons including the limited value of self-help resources; inadequate practical support with job search activities; a lack of direct liaison between the VRC and employer in one case; and the period of support being too short or contact too infrequent.
- It was noticeable that **recipients of the Advice Service tended to be more critical** of the less intensive and more self-directed nature of support received. The assumptions underpinning the design of this lighter touch offer within a two-tiered service are perhaps not always borne out. The Advice Service did not always meet levels of need and corresponding frequency and intensity of support required, particularly where participants working for larger organisations were reluctant to access occupational health services through their employer. That said, dissatisfaction with some aspects of the programme was also expressed by Support Service recipients, suggesting issues were not just related to the level of support received.

Outcomes and impact

- Programme monitoring data shows a high proportion of participants **experienced improvements in health and wellbeing outcomes** between joining and leaving the programme. Moreover, the proportion experiencing positive change in relation to anxiety, depression and physical health increased significantly during the pandemic compared with the pre-pandemic cohort.
- One explanation for improved health and wellbeing outcomes during the pandemic may be that personalised support and contact made a difference for a greater proportion of participants during a period of heightened anxiety and social isolation.
- A number of interviewees reported **positive health improvements**, particularly in relation to coping, confidence and mental wellbeing. Programme factors contributing to positive change included the empathetic approach of VRCs; tools and techniques to understand and manage health conditions; and referral into other services.
- Other participants were **less positive about changes experienced in health conditions** and it was not always clear the intensity or length of support was adequate for those with chronic,

severe or fluctuating conditions. In some cases, **concerns about COVID-19 appeared to impede health improvements.**

- **Employment outcomes were more mixed.** The proportion of those in work who returned to employment (66 per cent) remains relatively high but only a quarter of the newly unemployed (23 per cent) had moved into work on discharge from the programme. **While it was expected that employment targets would prove challenging during the pandemic, data clearly shows underperformance predates the pandemic.**
- **For some interviews, returning to an existing job was a positive experience but others reported negative outcomes** including a lack of support from employers and perceptions of job insecurity. Again, this highlights issues with job quality and potentially negative impacts on wellbeing or the sustainability of work.
- Aspects of WVEH support that contributed towards a return to work included guidance on how to manage health conditions and relationships with colleagues at work; encouragement to take up occupational health support; and being equipped with the knowledge and confidence to request adjustments.
- Qualitative impact assessment indicates that around **a half of positive health and wellbeing outcomes (53 per cent) and nearly two fifths of positive employment outcomes (39 per cent) can be attributed to WVEH support.**

1. Introduction

1.1. The evaluation

This is the second annual report¹ of the Working Well Early Help (WWEH) evaluation being carried out 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, key labour market trends, and evaluation methods.

1.2. The Working Well Early Help programme

Working Well Early Help (WWEH) is part of the wider family of Working Well programmes² 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 ten local authority areas in Greater Manchester³. It seeks to support a return to sustained employment for individuals with a health condition or disability who have either become unemployed within the last six months or taken medical leave from an existing job. The full WWEH support model is described in Section 4.

Until the outbreak of the coronavirus (COVID-19) pandemic 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 as 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.

The pandemic led to a decision to provide additional focus on engaging and supporting the newly unemployed with health conditions or disabilities as a response to concerns around rising levels of unemployment.

WWEH was established as a devolved response to the UK government's *Improving Lives*⁴ 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 (GMHSCP) 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 but referrals will only be accepted up until the end of August 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 in 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.

The programme has been live throughout the entirety of the COVID-19 pandemic to date. This evaluation therefore provides an important opportunity therefore to reflect on the extent to which WWEH offers timely and effective support during these challenging times.

1.3. Policy and strategy on work and health

National

WWEH's focus on early intervention to prevent ill health leading to long-term disengagement from the labour market aligns with a number of national priorities. The 2017 *Improving Lives: the future of work, health and disability* white paper⁵ remains the cornerstone of the UK's government strategy to help those with disabilities and long-term health conditions access work. 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. The UK government-commissioned *Thriving at Work*⁶ review on mental health and employers is also a central strategic framework for identifying how employees with mental health issues can be supported.

The rebalance of WWEH towards supporting greater numbers of newly unemployed also positions the programme to support UK government ambitions to protect, support and create jobs during and after the pandemic as outlined in its *Plan for Jobs*⁷. This on-going strategy has included additional funding to boost staff capacity at Jobcentre Plus offices and £2.9bn for the new Restart programme to help the longer-term unemployed.

Greater Manchester

Greater Manchester has been at the forefront of the devolution of funding and powers to city regions by the UK government. WWEH is a central part of Greater Manchester's commitment to demonstrate that locally commissioned and managed services are better able to integrate and achieve outcomes for residents than national programmes. It supports a series of wider strategic commitments⁸ to integrate work, health and skills systems to enable individual with disabilities and health conditions to find and stay in work. These strategies are detailed further in the previous *WWEH annual report 2020*⁹.

WWEH was introduced a year before the COVID-19 pandemic but is seen as a key element of Greater Manchester's short-term resilience and recovery plan¹⁰. Its potential contributions include supporting residents at a time when mental health

conditions are likely to increase in scale and severity, while also helping to tackle rising unemployment.

1.4. Labour market and employment trends

National

WWEH was launched in relatively benign labour market conditions in March 2019 but this changed with the outbreak of the COVID-19 pandemic in the UK in early 2020 and subsequent restrictions, including national and local lockdowns introduced since 23 March 2020. The latest UK labour market data¹¹ published by the Office for National Statistics (ONS) indicates that the national jobs market has deteriorated in the last 12 months. However, the extent of the downturn is perhaps not as great as feared at the outset of the pandemic, with signs of improvement in recent months against some indicators:

- **Employees:** The number of payroll employees increased in April 2021 for the fifth consecutive month but remains 772,000 below pre-coronavirus (COVID-19) pandemic levels (as measured in February 2020).
- **Unemployment:** The estimated UK unemployment rate in the quarter from January 2021 to March 2021 was 4.5 per cent; this is 0.8 percentage points higher than a year earlier but 0.3 percentage points lower than the previous quarter.
- **Vacancies:** In February 2021 to April 2021, there were an estimated 657,000 job vacancies, which is an increase of 8 per cent (48,400) compared with the previous quarter. However, this remains almost 128,000 below its pre-pandemic level in January 2020 to March 2020, with the worst affected industries being arts, entertainment and recreation, and accommodation and food service activities.

The rollout of the COVID-19 vaccine and rising consumer and business confidence has also seen **increasingly positive forecasts for unemployment**. The Office for Budget Responsibility (OBR)¹² has revised its unemployment estimates downwards, suggesting unemployment will peak at 6.5 per cent in Quarter 4 2021 (compared with previous estimates of a 7.5 per cent peak in Quarter 2 2021).

Growing optimism that the economic downturn will be less severe than expected does not negate the very real economic impacts of the pandemic for those affected. Some groups, areas and sectors have been hit particularly hard:

- **Overall trends:** Since February 2020, the largest falls in payrolled employment have been in the hospitality sector, among those aged under 25 years, and those living in London¹³.
- **Low paid workers:** Low paid workers have been three times as likely as higher paid workers to experience a negative impact on their work: in March 2021, 21 per cent of workers in the bottom weekly pay quintile had either lost their job or lost hours and pay due to the crisis, or were furloughed, compared to seven per cent of those in the top earnings quintile¹⁴.
- **Young workers (16-24):** Young workers account for two-thirds of the total fall in payrolled employment that occurred in the year to February 2021¹⁵.
- **Black and Minority Ethnic (BME) workers:** BME workers have been disproportionately impacted. The number of BME workers in employment fell by 5.3 per cent in the year between Quarter 3 2019 and Quarter 3 2020, compared to a fall of just 0.2 per cent in the number of white workers¹⁶.

Greater Manchester

Recent analysis by GMCA¹⁷ shows the on-going impacts of the pandemic in relation to unemployment, employment, furloughing and vacancies. It indicates some improvements in unemployment and vacancies that may provide tentative signs of an economic 'bounce back', but falling regional employment rates buck the more positive recent national trend.

- **Unemployment (claimant count):** 142,000 residents were in receipt of unemployment benefits in April 2021. This represents a slight fall of 2,000 since March 2021 but a rise of 90 per cent since March 2020.
- **Jobs and employment:** There were over 102,000 fewer jobs in the North West in January to March 2021 compared with the same period a year ago. The North West employment rate also fell from 75.8 per cent to 73.5 per cent over the year. Employment rates also fell by 0.2 percentage points between the two latest consecutive quarters (October to December 2020 and January to March 2021); this compares with a rise of 0.2 percentage points across the UK as a whole.
- **Furlough:** 137,000 Greater Manchester residents were furloughed on 30 April 2021 (11 per cent of those eligible). This represents a fall of 31,200 (19 per cent) from the end of March 2021.
- **Vacancies:** There are some signs of improvement in the jobs market with vacancy levels in Greater Manchester at 8,384 in the week ending 29 May 2021 – a rise of 13 per cent compared with vacancies in one of the last weeks before the first UK-wide lockdown (week ending 07 March 2020).

On-going risks in the Greater Manchester labour market include:

- an increase in unemployment when the Coronavirus Job Retention Scheme (CJRS) closes at the end of September 2021.
- high levels of business debt could eventually translate into increases in insolvencies and business failure.
- further COVID-19 restrictions in response to national or local outbreaks.

While labour market trends in Greater Manchester are perhaps not as challenging as forecast at the outset of the pandemic, conditions remain difficult and **outcomes achieved by WVEH must be seen in the context of a weaker labour market**. This annual report, therefore, is a reflection on how an employment programme designed before the pandemic can adapt to provide effective support in uniquely challenging circumstances. Moreover, as the recent *Build Back Fairer* report¹⁸ on health inequalities in Greater Manchester during the pandemic notes, this is a particular important juncture to understand and respond to the health-related challenges of the crisis:

Due to the pandemic, health and equity have been at the forefront of the national consciousness... and there is greater recognition of the importance and efficacy of public systems; these are essential features of successful action on health inequalities. The unfairness of economic and social arrangements, ethnic disadvantage and racism and the extent of health inequalities have been exposed and public and political appetite to remedy these may have increased.

1.5. Methods

This annual report focuses on the first two years of WWEH. Most of the data presented in the report covers the period from programme launch in March 2019 until the end of April 2021 unless otherwise stated. The findings presented in this report draw on four sources of data:

- **Client monitoring** data on 2,686 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.
- **32 in-depth participant interviews** undertaken by telephone between January and April 2021 with programme participants who had received at least three month's support from WWEH. This analysis does not include interviews reported in the *WWEH Annual Report 2020*.

Characteristics of the sample were identified by linking interviewees to programme monitoring data. Issues with the completeness of the dataset as well as challenges in linking interviewees to anonymised data means there are missing data for small number of variables in a few cases. Based on available data, the sample was broadly mixed by gender (18 male and 14 female) and age range (17 were aged 45 and under while 12 were aged over 45). The majority were White British (24) where ethnicity was stated with only one other ethnicity (Asian British) recorded in one case. Just under two thirds of participants were in work but on medical leave (20) on entry to the programme with the remainder (11) unemployed. Most interviewees accessed the full WWEH Support Service (22) with a smaller number receiving the Advice Service (7). Mental health was the predominant health condition (17) with only a small number reporting a physical health condition only (3) or both a physical and mental health condition (5).

- **Eight stakeholder workshops** with 34 unique attendees (some attended more than one workshop) undertaken by video conference call between November 2020 and May 2021. Attendees included the Commissioner team (GMCA and GMHSCP); managers and frontline delivery staff in the Provider organisations (MAXIMUS and Pathways); and Local Authority Leads and Jobcentre Plus staff.
- **Qualitative impact assessment** based on analysis of 38 in-depth participant interviews to provide an assessment of additionality. This estimates the extent to which outcomes would have been achieved without WWEH and how important WWEH interventions were to outcomes over and above the influence of other factors, interventions, or changes. The full method and findings are detailed in Appendix 4 and summarised in Sections 6.2 and 6.3.

A number of planned evaluation activities were scaled back or postponed due to the on-going impact of the COVID-19 pandemic. In particular, stakeholder interviews as part of five Locality case studies looking at issues around implementation, governance, partnership and integration with other services have been delayed. These will be carried out by summer 2021 and reported in future outputs. Accordingly, this evaluation **focuses mostly on analysis based on programme monitoring data as well as the perceptions and experiences of WWEH participants.**

1.6. Report structure

The remainder of the report is structured as follows:

- Section 2 examines volumes of **referrals and starts** and reviews the key progress and challenges in meeting performance expectations.
- Section 3 **profiles participants** joining the WVEH programme in terms of personal characteristics, health conditions, presenting needs, self-reported levels of health and wellbeing, and barriers to work.
- Section 4 is a themed section which looks specifically at the **relationship between workplace experiences and health**. It considers the way in which these experiences shape decisions to take medical leave or leave work altogether, as well as the extent and nature of support offered by employers to staff to remain in, or return to, jobs.
- Section 5 reviews the **support offered** by WVEH and the number and type of interventions delivered to date. It considers satisfaction with support from the perspective of participants.
- Section 6 considers **employment and health outcomes** experienced by participants between entry onto and discharge from WVEH. Interviews with participants provide further insights into change while qualitative impact analysis estimates the extent to which WVEH interventions contribute to outcomes.
- Section 7 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.

2. Referrals and starts

Summary

- Meeting targets for referrals and starts continues to remain challenging. That said, referral volumes during the pandemic have exceeded pre-pandemic levels. This rising demand may be the result of increasing unemployment and the growing prevalence of mental health issues.
- Improvements in referral and start volumes during the third UK-wide lockdown in 2021 suggests the programme has become increasingly resilient to operating during periods of heightened COVID-19 restrictions.
- JCP is now the dominant referral pathway following the decision to refocus activities towards supporting the newly unemployed. However, high proportions of JCP referrals fail to 'convert' to starts. This may be due to lower quality referrals by newly recruited JCP staff.
- GP referrals have increased in recent months which could reflect heightened pandemic-related anxieties over Covid-security in the workplace or job security.
- Employer (SME) referrals and starts remain consistently below target although recent community engagement activity to recruit SME employees outside workplaces shows promise.

2.1. Introduction

Referrals into WWEH are sourced through three main pathways:

- **GPs:** One GP cluster (generally between four and six GP practices) in nine of the ten Greater Manchester boroughs (excluding Manchester) refer patients into WWEH. 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 Note¹⁹. 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 Consultants (PECs) in the Provider team are responsible for engaging SME employers and employees.
- **Jobcentre Plus²⁰:** Newly unemployed JCP clients who have worked within the last six months and for whom ill health or disability is a barrier to work can self-refer into WWEH. JCP staff do not make direct referrals but provide information ('signpost') on WWEH to clients who then contact the programme directly. A dedicated PEC maintains regular contact with staff in JCP offices.

This section presents analysis for referrals and starts based on programme monitoring data up until the end of April 2021. Performance is shown against two sets of targets:

- **Original flightpath profile** targets show monthly and cumulative performance against targets agreed at programme launch.
- **Revised flightpath profile targets** were introduced in November 2019 in response to performance challenges during the first year of programme delivery. This reduced expectations of referral and start volumes in the earlier phase of the programme but increased them in the later phase to compensate. Lifetime targets remained unchanged.

Both targets are shown on charts but only the revised flightpath profile target (referred to hereafter as the 'target') is discussed in the text as this is currently the main measure of performance.

It should be noted that a change in the way that referrals were captured and recorded since December 2020 has resulted in a substantial increase in the number of referrals, mainly via the JCP pathway. This is shown on the charts below as the 'Actual (revised)' figure. Continuing to show referral data using the older reporting method ('Actual') permits comparison to see the extent to which changes reflect genuine shifts in the volume of referrals generated or simply the adjustment of reporting method.

For this reason, caution should be taken in looking at referral data over time, particularly when comparing referral data across pathways. JCP and Employer referrals were underreported prior to December 2020; GP referral data from this time is more accurate due to a different referral and monitoring system.

2.2. Referrals

Cumulative referrals

A total of 5,345 referrals had been made into WWEH by the end of April 2021 (Figure 2.1). This is **just over three fifths (62 percent) of the cumulative target** i.e. the number of referrals expected to date. The chart clearly shows that referrals have remained consistently below the cumulative target since March 2020. Referral volumes are currently around half (48 per cent) of the **lifetime target** of 11,206. It is unlikely that this target will be met given referrals will only be accepted up until the end of August 2021.

Figure 2.1: Cumulative referrals

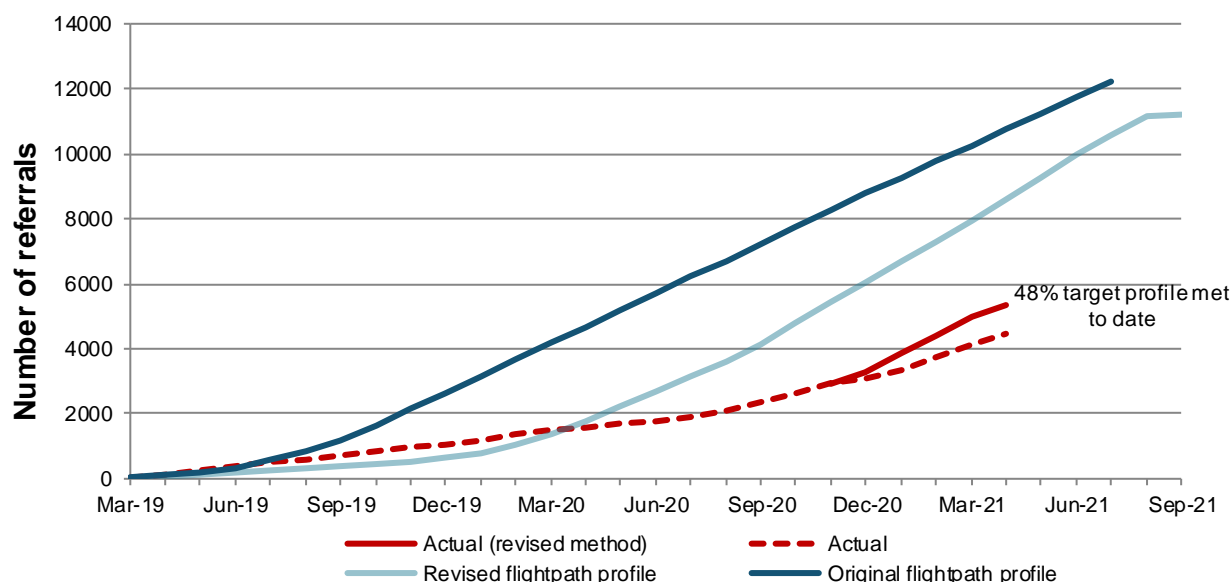


Table 2.1 compares referrals before the pandemic (up until 31 March 2020) and during the pandemic (after 01 April 2020). It shows volumes more than doubled across the two 13-month time periods from 1,497 to 3,848. Performance against original profile targets is better during the pandemic with the programme meeting nearly three fifths of the target (58 per cent) compared with just over one third before the pandemic (36 per cent).

Table 2.1: Referrals before and during the COVID-19 pandemic

	Referrals				
	Actual	Original profile	Revised flightpath profile	% of original profile achieved	% of revised flightpath profile achieved
Performance to date Mar 19 – Apr 21	5345	10752	8613	49.7	62.1
Performance before pandemic Mar 19 – Mar 20	1497	4168	1348	35.9	111.1
Performance during pandemic Apr 20 – Apr 21	3848	6584	7265	58.4	52.9

Monthly referrals

Figure 2.2 below shows there has been a significant increase in monthly referral volumes since the middle of 2020. A notable downturn in the months immediately after the introduction of the first UK lockdown in March 2020 was followed by a fairly consistent rise in volumes from May 2020 to reach a programme high of 623 in January 2021, exceeding both original and revised targets.

While the first lockdown saw a fall in referrals, volumes increased throughout the third lockdown introduced on 06 January 2021 with the programme either meeting or nearly

meeting in-month targets between January and March (Table 2.2). Monthly referrals now consistently exceed pre-pandemic levels.

Referrals fell sharply, though, in the last month from 576 in March (86 per cent of target) to 353 in April (53 per cent of target). However, stakeholders attribute this to a seasonal drop in JCP referrals due to staff taking leave over Easter alongside temporary IT disruption, with a subsequent bounce back anticipated.

Figure 2.2: In month referrals

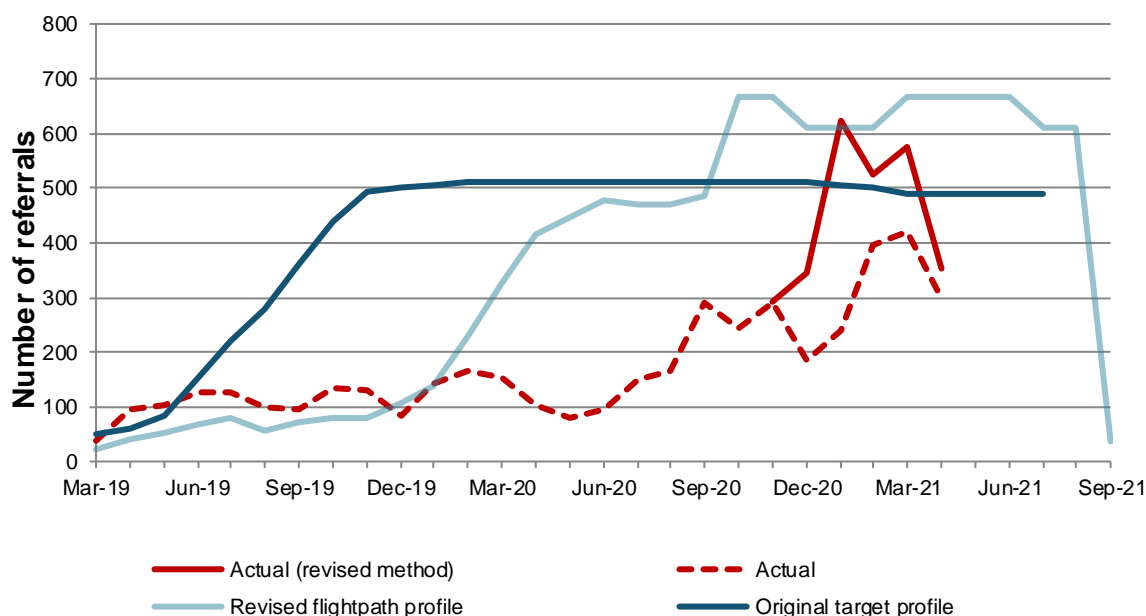


Table 2.2: Referrals, in month

Month	Original profile	Revised flightpath profile	Actual	% of original monthly profile achieved	% of revised flightpath monthly profile achieved
Nov-20	511	667	292	57%	44%
Dec-20	511	611	346	68%	57%
Jan-21	505	611	623	123%	102%
Feb-21	500	611	524	79%	86%
Mar-21	490	667	576	86%	86%
Apr-21	490	667	353	72%	53%

Referrals by pathway

Targets were initially set for the proportion of referrals by pathway and work status to ensure WVEH focussed on in-work participants. GPs and Employers were expected to generate 40 per cent each of all referrals (all in work) while JCP provided the remaining 20 per cent (all newly unemployed). These targets were removed during the COVID-19 crisis to enable a refocus towards supporting the newly unemployed. Nonetheless, it remains useful to monitor trends against these targets to appreciate this shift in programme design and purpose.

Figure 2.3 below shows that JCP referrals now account for the largest proportion (46 per cent) of all referrals compared with GPs (43 per cent) and Employers (10 per cent). This shows both the challenges in generating Employer referrals, as well as how

WWEH is now accepting significantly higher volumes of newly unemployed participants than originally expected.

Figure 2.3: Performance of referral pathways against original expectations.

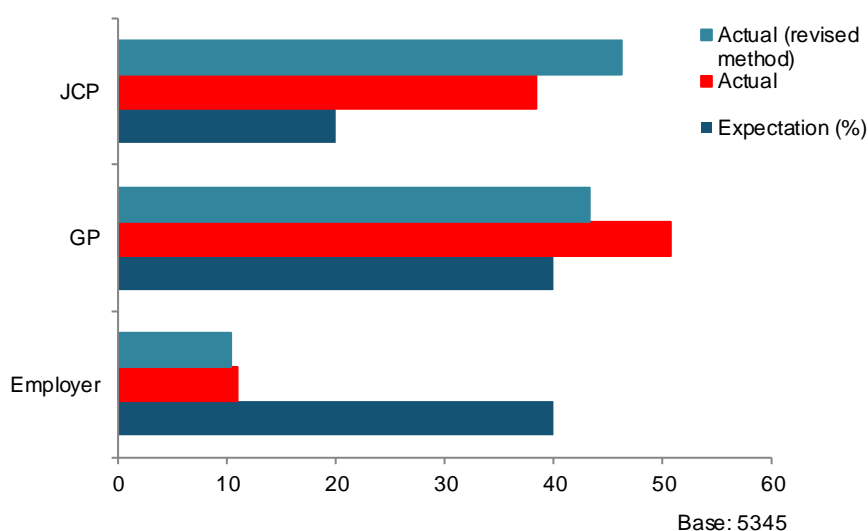


Table 2.3 shows the overall performance of each pathway against cumulative referral targets. JCP referrals have met 144 per cent of the target. This is partly due to the inclusion of additional referral data since December 2020 but also reflects a pre-existing trend where JCP referrals consistently exceeded monthly targets.

By contrast, the cumulative number of GP referrals achieved relative to target has declined in recent months and currently stands at 67 per cent. Employer referrals as a proportion of the cumulative target are only at 16 per cent.

Table 2.3: Overall referral pathway performance

Referral pathways	Total number of referrals	Cumulative original profile referral target	Cumulative revised flightpath profile referral target	% of cumulative original profile achieved	% of cumulative revised flightpath profile achieved
GP	2315	4301	3445	54%	67%
Employer	558	4301	3445	13%	16%
JCP	2472	2150	1723	115%	144%
Total	5345	10752	8613	50%	62%

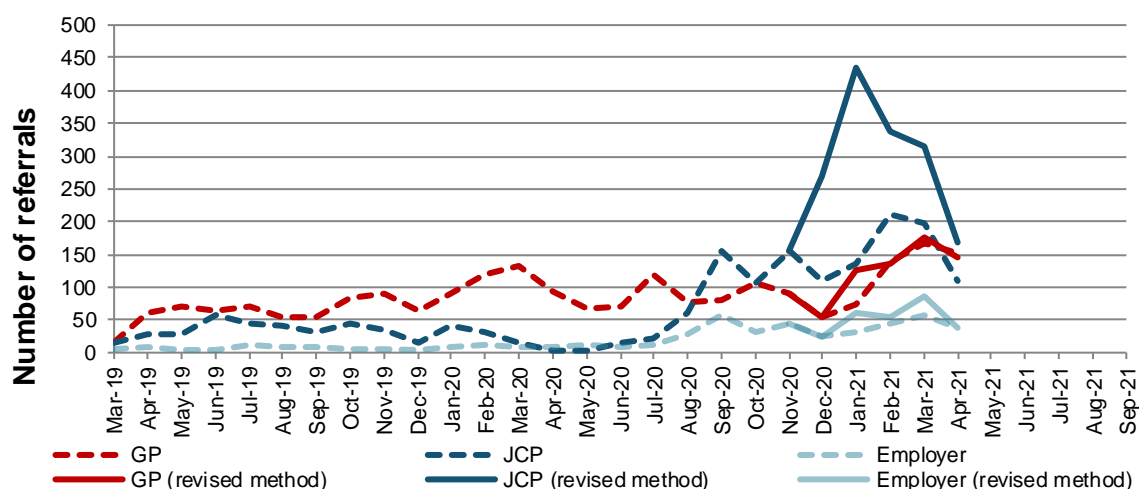
Monthly referral volumes by pathway (Figure 2.4) show a number of key trends including:

- **JCP:** This pathway saw a broadly consistent rise in referrals in the second half of 2020 as JCP offices began to resume activities after the first lockdown, with a significant spike in the three months up until January 2021. However, this was driven largely by a change in reporting method in terms of counting referrals that previously went unreported (the 'revised method'), as shown by the difference between the two JCP trendlines.
- **Employer:** Referrals through the Employer pathway remain consistently lower than the other two pathways. Moreover, **many Employer referrals are actually sourced through JCP** but then reallocated to this pathway (see

Endnote 19). In April 2021, for example, 36 of the 39 Employer referrals were sourced from JCP.

- **GP:** GP referrals have increased noticeably in 2021 despite the imposition of a third lockdown and the rollout of the vaccine programme, only dipping slightly in April 2021.

Figure 2.4: Number of referrals by pathway throughout the programme



2.3. Explaining referrals

The *WWEH annual report 2020*²¹ provided extensive analysis of the factors explaining trends in referrals during the early implementation and delivery phase of WWEH, particularly in terms of underperformance against targets. While some of these issues have been resolved, stakeholders see continued underperformance against cumulative targets as, to some extent, a **legacy of early challenges**. This includes high staff turnover in both Commissioner and Provider teams that made it harder to establish key referral pathways at speed and scale as well as significant delays of several months in implementing key parts of the WWEH offer including Cognitive Behavioural Therapy (CBT) and Physiotherapy.

The COVID-19 pandemic undoubtedly impacted referrals initially, with monthly volumes falling significantly during the first lockdown. However, more recent data shows referrals across all pathways reaching their highest ever levels during the third lockdown in early 2021. This indicates both **referral agencies and the programme delivery team have become more resilient to disruption from COVID-19 restrictions**.

Moreover, Table 2.1 above clearly shows that referral volumes increased substantially in the 13-month period during the pandemic compared with the 13-month period before the pandemic. These figures suggest **rising demand since the early phase of the pandemic**. This may be accounted for by increasing levels of unemployment and the growing prevalence of mental issues in the wider population. Despite these increases, cumulative underperformance means it is not possible WWEH can catch up to hit lifetime targets during the referral window remaining.

Stakeholders also suggested a number of further factors explaining performance against targets and over time by pathway:

JCP referrals

JCP referrals currently significantly exceed the cumulative target. Past findings suggest this reflects the 'natural' partnership with JCP where organisational goals align with those of WWEH, particularly with JCP looking to support additional volumes of claimants in the wake of the pandemic. However, there has been a decline in volumes since the peak of referrals in January 2021 attributed to a combination of factors:

- **Significant recruitment of new JCP staff and turnover** affecting awareness of WWEH.
- Remote working making it **harder for PECs to build relationships** with JCP staff.
- A **lack of feedback to JCP staff** about the experience of clients signposted to WWEH may discourage referrals: "*You have to push for information*" (JCP staff). A lack of an information sharing agreement between JCP and the Provider also reduced the amount of feedback that could be given.
- **Competition in an increasingly "crowded space" (Provider) of employment support programmes** including the Job Entry Targeted Scheme (JETS), the Kickstart Scheme, Restart and the Working Well Work and Health Programme²². Other programmes may sometimes be prioritised over WWEH for a number of reasons:
 - Direct referral processes onto other programmes are simpler than signposting to WWEH.
 - Uncertainty over eligibility criteria or the value of WWEH to clients over other provision.
 - A tendency for JCP staff to refer to DWP-contracted provision.
 - A preference to refer more digitally excluded clients to face-to-face provision where programmes offer this rather than the telephone and email-based WWEH service.
 - A more expansive employability offer on other programmes.

A series of actions are planned to address some of these challenges including Provider staff rebuilding a physical presence in JCP offices when possible; and on-going work to educate JCP staff about WWEH and its potential value relative to other programmes.

GP referrals

The recent increases in monthly GP referrals since December 2020 despite the third lockdown was attributed to a number of factors related to the COVID-19 pandemic:

- **Growing demand for Fit Notes for mental health issues** from in-work patients who either have experienced additional pressures working through the pandemic; or are on medical leave but increasingly concerned about pandemic-related changes to the nature and security of their jobs when they return. Wider evidence confirms the prevalence of rising levels of mental ill health among the general population²³.
- **Long COVID sufferers seeking advice** on how to change working conditions or occupations.
- The **attractiveness of fast-track access** to physiotherapy or Cognitive Behavioural Therapy (CBT) compared with NHS provision that has experienced growing backlogs and waiting times.

Some aspects of GP engagement work are seen to be highly effective, particularly in terms of the **success of Fit Note clinics** where GPEOs have been provided access to lists of patients receiving Fit Notes to inform them about WVEH and refer into the programme where appropriate. Fit Note clinics operate in 21 practices (only 32 per cent of all practices involved with WVEH) yet account for 74 per cent (429) of all referrals made in the first four months of 2021 compared with 26 per cent (152) of referrals made directly by GPs without triage by GPEOs.

Stakeholders noted that Fit Note clinics can be highly valuable in generating quality referrals as GPEOs can explain the service directly to patients and check eligibility. At the same time, increasing referral volumes by bypassing GPs could run counter to the aim of changing GP behaviours to recognise the importance of work as a social determinant of health.

Performance against cumulative targets remains around two thirds of expectation, however, and this was explained with reference to:

- **A failure to secure or maintain buy-in from Clinical Commissioning Groups (CCGs)** in some Localities at the outset made it harder to secure the trust and support of GP practices and GP Leads. This may have been exacerbated by significant change in the sector with the introduction of Primary Care Networks. Lack of engagement may also have been partly due to high staff turnover in the Commissioner and Provider teams which limited early opportunities to broker contacts and respond strategically to the challenges of engaging GPs during a period of significant reorganisation.
- **Lower throughput of patients** during the pandemic and recent **prioritisation of the COVID-19 vaccination programme**.
- **Difficulties in engaging GPs** while GPEOs have been working remotely.
- **Time pressures** on GPs during appointments to remember and discuss WVEH as one of many external services they can refer patients into.
- **Mistrust** among GPs in one Locality about the Provider's involvement in delivering Work Capability Assessments.
- An **inability to bring new GP practices onto the programme** despite expressions of interest from non-affiliated practices.
- Persistent **concerns among GPs around why patients working for larger organisations are ineligible for the full Support Service**, especially if occupational health support is not deemed appropriate.
- **Staff turnover or prolonged medical leave** among Lead GPs.

Steps taken in the last year taken to address referral issues include introducing Fit Note clinics and enhancing electronic referral forms to minimise inaccurate information that, in the past, had made it hard to contact patients. However, some potential solutions such as bringing new GP practices on board are too late to implement with the referral window closing by September 2021.

SME engagement

SME engagement has been very low since the beginning of the programme. Recent research with stakeholders highlights a number of on-going challenges:

- **Temporary closure of businesses** and reduced activity among business support networks during the pandemic has made it harder for PECs to engage SMEs.

- A **tendency of SME employees to remain in work** while sick (presenteeism) due to less generous sick pay entitlement.
- SMEs are less likely to retain someone who takes medical leave: *"They replace them, don't chase them"* (Provider).
- A perception among some that **training for PECs was not sufficiently rigorous** to equip them with the skillset to work with SMEs.
- Employer feedback that **supporting employees once on medical leave was too late** as the service was required while they were still in work but "wobbling" (Local authority stakeholder) due to health issues
- The early focus on referrals and performance after the programme went live did not allow sufficient time to develop relationships with SMEs.

The Provider has responded to referral challenges in a number of ways. Extensive work was undertaken to engage care sector businesses although this yielded few referrals. One stakeholder suggested that approaching managers rather than frontline staff in initial engagement activities by PECs may have limited take up as employers were not keen to promote a service that could support employees to challenge working practices.

More recently, the Provider has sought to recruit SME employees through community engagement activities. This includes PECs volunteering as delivery drivers for a food project (the Bread and Butter Thing) based in Salford, Trafford and Oldham. Volunteering provides an opportunity to meet social value commitments while also engaging with foodbank users who may benefit from WWEH support. To date this has only led to one referral but has highlighted possibilities for recruiting SME participants outside of workplaces.

At the same time, one implication of using community engagement to generate referrals is that it reduces direct contact with employers. Given the close relationship between health and workplace conditions outlined below in Section 4, this may mean the programme is *"missing a trick"* (Stakeholder) if opportunities to work with employers to improve practices and workplace conditions are diminished.

Finally, a series of webinars is being undertaken through business networks and Local leads to explain WWEH to SMEs.

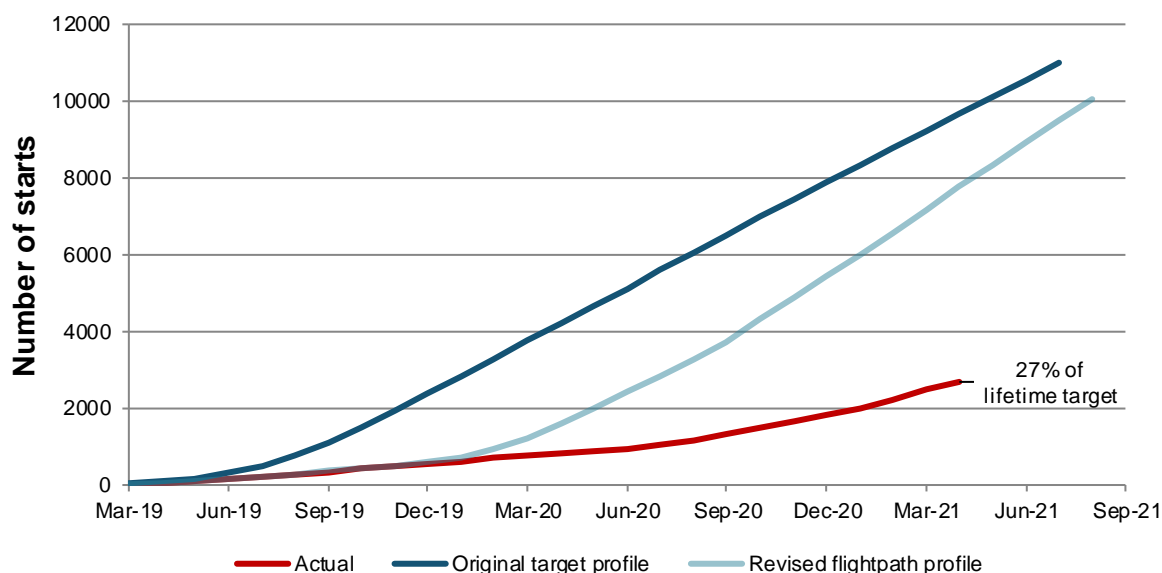
2.4. Starts

Cumulative starts

A programme start is recorded when a participant completes a welcome call and at least one initial biopsychosocial health assessment (BPSA). WWEH had achieved 2,686 starts by the end of April 2021 which is **35 per cent of the cumulative target by this point in the programme and 27 per cent of the lifetime target of 10,085 starts**. Figure 2.5 shows the gap between actual and target starts has increased over time. It is highly unlikely the programme will achieve its lifetime target for starts as all referrals cease on 01 September 2021.

There is a broadly even split between in-work (52 per cent) and out-of-work (48 per cent) starts. This reflects the rebalance of the programme away from predominantly targeting in-work participants to focus more on supporting the newly unemployed during the pandemic.

Figure 2.5: Cumulative starts



Volumes of starts more than doubled during the pandemic compared with performance before the first UK-wide lockdown, increasing nearly two and a half times from 781 to 1,906 between the two 13-month periods (Table 2.5 below). As with referrals, performance against the original profile target was better during the pandemic (32 per cent) than before (21 per cent), albeit still significantly below expectation.

Table 2.5: Starts before and during the COVID-19 pandemic

	Starts				
	Actual	Original profile	Revised flightpath profile	% of original profile achieved	% of revised flightpath profile achieved
Performance to date					
Mar 19 – Apr 21	2686	9677	7751	27.8	34.7
Performance before the pandemic					
Mar 19 – Mar 20	781	3751	1213	20.8	64.4
Performance during the pandemic					
Apr 20 – Apr 21	1906	5926	6538	32.2	29.1

Monthly starts

Starts increased slowly in the months following the first lockdown, peaking at 189 in September 2020 before gradually declining until December 2020 (Figure 2.6). This trend then reversed with starts increasing in every month until March 2021, suggesting programme resilience to increased COVID-19 restrictions during the third UK-wide lockdown implemented on the 06 January 2021. As noted above, this may reflect rising demand as well as growing programme resilience to COVID-19 restrictions.

Starts fell noticeably, however, in the latest month (April 2021) to 169 (28 per cent of target), with stakeholders attributing this to a drop in referrals due to seasonal factors

and IT disruption affecting JCP offices (see above). Volumes are consistently below target in all of the last six months (Table 2.6).

Figure 2.6: In month starts

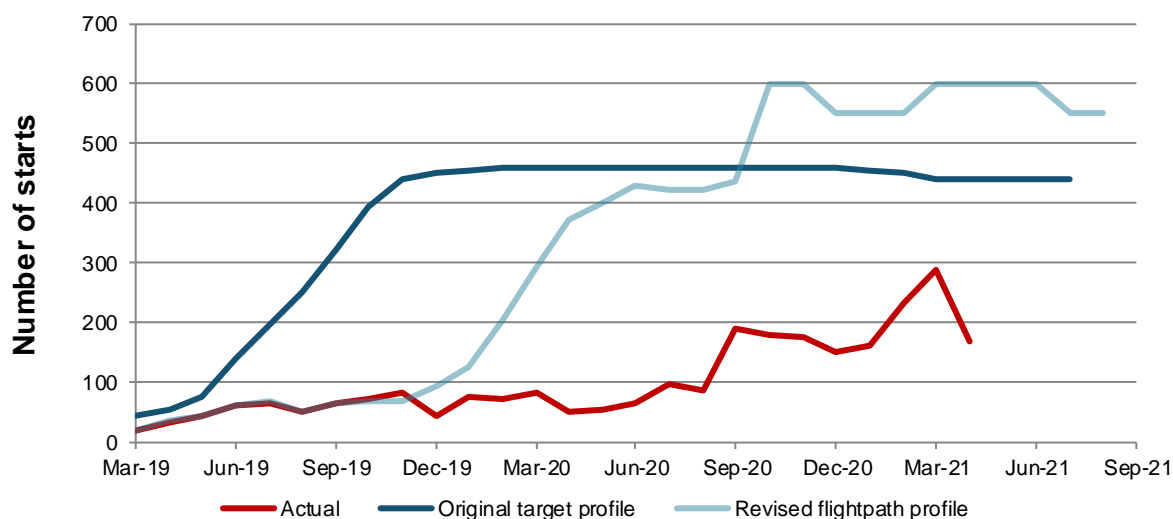


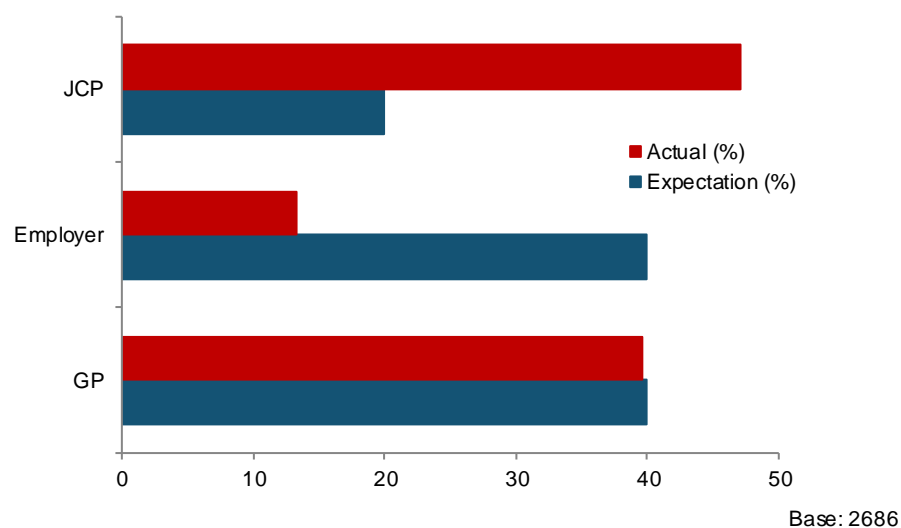
Table 2.6: Starts, in month

Month	Original profile	Revised flightpath profile	Actual	% of original monthly profile achieved	% of revised monthly flightpath profile achieved
Nov-20	460	600	178	39%	30%
Dec-20	460	550	151	33%	27%
Jan-21	455	550	162	36%	29%
Feb-21	450	550	234	52%	43%
Mar-21	441	600	289	66%	48%
Apr-21	441	600	169	38%	28%

Starts by pathway

As with referrals, Figure 2.7 shows the overall proportion of starts on the Employer pathway is noticeably lower than original expectations (13 per cent compared to 40 per cent). The proportion of starts on the GP pathway aligns with the expectation of 40 per cent, whilst the proportion of starts from JCP is much higher than expected (47 per cent compared to 20 per cent).

Figure 2.7: Actual and expected starts by referral pathway



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. Cumulative performance against targets for starts is much lower than for referrals as the **conversion rate is significantly lower than the 90 per cent target for the programme**. Table 2.7 shows a conversion rate of 57 per cent up until December 2020 and, following a change in reporting method, 41 per cent from December 2020. In other words, for every 10 referrals since December 2020, six do not eventually join the programme. This is less than half the target conversion rate of 90 per cent.

Table 2.7: Overall pathway performance (starts)

Referral route	Total referrals	Total starts	Conversion rate (pre-Dec 2020)	Conversion rate (from Dec 2020)	Cumulative original profile starts		Cumulative revised flightpath starts	
					Target	% achieved	Target	% achieved
GP	2315	1066	47%	53%	3871	28%	3100	34%
Employer	558	355	70%	56%	3871	9%	3100	11%
JCP	2472	1265	73%	38%	1935	65%	1550	82%
Total	5345	2686	57%	41%	9677	28%	7751	35%

Conversion rates for Employer referrals (56 per cent) and GP referrals (53 per cent) are currently higher than for JCP referrals (38 per cent). Stakeholder consultation provided further insights into why the JCP conversion rate is particularly low:

- Significant recent recruitment of **new JCP staff** has reduced familiarity with WVEH and increased ineligible referrals, with some confusion over different eligibility criteria for the various employment support programmes operating in Greater Manchester.
- The JCP **signposting process** does not allow the same level of pre-referral eligibility 'vetting' as referral processes for other programmes JCP refer into, or through the GP referral pathway, especially where GP referrals are generated through GPEOs.
- Disability Employment Advisers in JCP have a good understanding of, and ability to elicit, health issues among clients. This leads to better quality

referrals. By contrast, **Work Coaches do not always have this skillset** and therefore do not always ask the right questions, lowering the quality of referrals.

- **Remote working** makes it more challenging for JCP staff to assess the potential commitment of clients to WVEH without non-verbal clues.

In terms of other referral pathways, one stakeholder suggested that the **higher than expected rate of attrition for GP referrals could be due, in part, to the immediate focus of support on employment** through the return to work planning process. This could potentially deter individuals who want to prioritise health needs instead.

There is some support for this suggestion in programme monitoring data on reasons why participants do not join the programme (Table 2.8 below). This shows that half (49 per cent) of all GP referrals who do not join the programme decline support which is a higher than proportion than JCP referrals (35 per cent) and Employer referrals (32 per cent). Previous evaluation reports have also found that some in-work GP patients referred into WVEH who work for larger companies are not always initially aware that they are ineligible for the full Support Service. They subsequently decline to join when this becomes clear at a later stage in the referral process.

Table 2.8: Reason for not joining the programme by pathway

Reason for not joining the programme	JCP		Employer		GP		All	
Participant declined support	257	35%	37	32%	121	49%	415	38%
Unable to contact	254	34%	31	26%	64	26%	349	32%
Not in paid work in the last six months	82	11%	2	2%	22	9%	106	10%
Provision not suitable - signposted to other provision	34	5%	21	18%	11	4%	66	6%
Referral ineligible at welcome call	36	5%	0	0%	8	3%	44	4%

Base: 1,102

2.5. Locality

There are some notable differences in referrals and starts by Locality (Table 2.9). Since the programme started Stockport has been the leading source with 920 referrals made to date: equivalent to 17 per cent of all referrals. It has the highest level of GP referrals of any Locality which, as the *WVEH annual report 2020* showed, is explained by a high level of commitment to WVEH by one GP Lead. By contrast, four localities have made less than 400 referrals.

There are also key differences in referral source by district, with some areas primarily receiving referrals through GPs. For instance, 71 per cent of referrals in Stockport and 60 per cent in Bolton have come through this pathway while 93 per cent of Manchester referrals are sourced through JCP. It should be noted that Manchester makes few GP referrals to avoid duplication with other local provision.

Conversion rates range from 53 per cent in Salford to 35 per cent in Tameside. Planned evaluation case study work in Localities in early summer 2021 will explore reasons for these variations.

Table 2.9: Referrals and starts by locality

Locality	Total referrals	By referral source			Welcome call completed	Starts	Conversion rate %	
		GP	Employer	JCP			Before 1 st Dec 2020	After 1 st Dec 2020
Bolton	641	380	54	207	361	302	52	36
Bury	344	187	39	118	204	175	51	48
Manchester	696	4	129	563	396	341	72	37
Oldham	517	170	65	282	338	285	60	40
Rochdale	392	117	85	190	235	193	59	36
Salford	365	128	46	191	259	230	69	53
Stockport	920	651	42	227	524	477	56	44
Tameside	742	436	36	270	395	333	53	35
Trafford	313	119	31	163	183	150	57	35
Wigan	406	122	29	255	230	200	56	41

Base: 5,336

3. Profile of participants

Summary

- Health issues feature prominently in terms of data on presenting needs and self-reported barriers to work. Mental health issues are particularly prevalent, with 57 per cent of participants reporting a mental health problem as their primary health condition. 'Health management' was also by far the most common barrier to work reported.
- Few participants report employment issues as a presenting need. Interviews show a small number of newly unemployed participants experienced employment barriers relating to employability (interview technique and basic skills) or difficulties relating to the quality or quantity of jobs available, particularly during the pandemic.
- The COVID-19 pandemic was a factor highlighted by some participants as contributing to both health and employment-related barriers to work. Impacts included being made redundant; limited vacancies in the job market; additional workplace pressures prompting medical leave; and wider social impacts on health and wellbeing such as social isolation.
- One implication is that WVEH programme is operating in an increasingly challenging environment where the pandemic has contributed to worsening health and wellbeing at precisely the same time as job opportunities have diminished.

3.1. 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, health conditions and presenting needs. 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 then presents monitoring data and insights from participant interviews on barriers to work and how these interact to shape decisions to take medical leave or leave jobs altogether.

3.2. Characteristics of WVEH participants

Tables 3.1 and 3.2 shows the characteristics of individuals joining the programme by gender, age, ethnicity, education and occupation if in work. Key points include:

- Females make up 54 per cent of participants overall and a higher proportion of those in work (60 per cent). In contrast, just over half (52 per cent) of out-of-work participants are male.

- Younger participants (aged 18 to 34) make up a higher proportion of out-of-work participants (39 per cent) than in-work participants (29 per cent). The split is more even for other age categories.
- Four fifths of participants (82 per cent) are White British/Irish. A slightly higher number of in-work participants reported being White/British (86 per cent) than in the out-of-work group (79 per cent).
- Half of participants are educated to post-secondary or graduate/postgraduate level while only one fifth (20 per cent) have no qualifications beyond secondary education (GCSEs).

Table 3.1: Characteristics of participants

Socio-demographics	In work (%)	Out of work (%)	All (%)
Gender			
<i>Male</i>	40	52	46
<i>Female</i>	60	47	54
<i>Other</i>	0	0	0
Age			
<i>18-24</i>	6	12	9
<i>25-34</i>	23	27	25
<i>35-44</i>	23	21	22
<i>45-54</i>	25	22	24
<i>55-64</i>	21	18	20
<i>65+</i>	1	1	1
Ethnicity			
<i>White - British/Irish</i>	86	79	82
<i>Asian/Asian British</i>	4	5	4
<i>Black/African/Caribbean/Black British</i>	2	2	2
<i>White - Other</i>	5	6	5
<i>Mixed/Multiple</i>	3	6	5
<i>Other Ethnic Group</i>	1	1	1
Education (highest qualification)			
<i>Primary education or below</i>	1	2	1
<i>Secondary education (GCSE)</i>	23	15	19
<i>Upper secondary (A-levels)</i>	28	29	29
<i>Post-secondary (college, BTEC courses)</i>	22	34	27
<i>Undergraduate/Postgraduate</i>	25	20	23
<i>Not applicable</i>	1	0	1

Base: 2,686

- Customer Service occupations are the most common amongst in-work participants (16 per cent) followed by Administrative occupations (8 per cent). In combination health and caring occupations comprise nearly a fifth (19 per cent). As Section 4.2 shows, these are the sectors in which employees seem particularly impacted by the pressures of working during the pandemic.

Table 3.2: Most common occupations

Top occupations	%
Customer service occupations	16
Administrative occupations	8
Caring personal service occupations	7
Health professional	6
Health and social welfare associate professional	6
Other	18

Base: 1,401

3.3. Health and wellbeing

Health conditions

Data on health problems (Table 3.3) shows that **mental health is by far the most common health problem** across the programme. Twenty one per cent of participants in work reported depression or low mood as their primary health problem. This was closely followed by anxiety disorders (19 per cent). For those out of work, anxiety disorders were the primary health problem for 25 per cent of participants. Depression or low mood was a barrier for a further 24 per cent. Problems with back was the third most common health problem across both in work and out of work cohorts.

In total, 46 per cent of participants reporting a health condition stated that depression/low mood or anxiety disorders was their primary health condition. The prominence of mental health conditions is highlighted in that, overall, 57 per cent of those with a health condition reported this being related to mental health.

Table 3.3: Most common primary health conditions

Most common health problems					
<i>In work</i>	%	<i>Out of work</i>	%	<i>All</i>	
Depression or low mood	21	Anxiety Disorders	25	Depression or low mood	23
Anxiety Disorders	19	Depression or low mood	24	Anxiety Disorders	23
Problems with Back	11	Problems with Back	8	Problems with Back	9
Fibromyalgia	6	Diabetes	3	Fibromyalgia	3
Asthma	4	Problems with Legs	3	Diabetes	3

Base: 1,629

Analysis was undertaken of levels of mental health among the WVEH cohort joining before and during the pandemic (Table 3.4). This shows small increases in mean scores for anxiety and depression using standardised health assessments (explained in Section 6.2. below) among the pandemic cohort, but not by enough to suggest significantly worse mental health.

Table 3.4: Mental health mean (anxiety and depression)

Mental health indicator	Mean score	
	Pre-pandemic cohort (Apr 2019- Mar 2020)	Pandemic cohort (Apr 2020-Apr 2021)
GAD7 (anxiety)	13	14
PHQ9 (depression)	13	15

Note: Cohort is based on the month the participant entered the programme.
Base: GAD7 (1,258), PHQ9 (1,167)

Presenting needs

Participants are asked to identify their level of need on entry to and discharge from the programme against **eight presenting needs** (see Appendix 1 for full explanation). For each need, a series of factors are identified, and participants are asked to assess the extent to which these are an issue on a scale from 0 to 6 where 6 indicates the greatest level of need.

The table below shows the proportion of participants reporting either moderate or severe need. 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:

- ‘Health’ (65 per cent), ‘Coping and confidence’ (59 per cent) and ‘Personal finances’ (16 per cent) are the needs most commonly reported as severe or moderate on entry to the programme.
- Employment-related needs (‘Access to Work’ and ‘Skills and Qualifications’) are less prevalent, although participant accounts clearly show that health needs are often related to experiences of work (Section 4).

Table 3.5: Presenting needs on entry

Presenting needs	All (%)		
	Severe	Moderate	Severe or moderate
Health	25	40	65
Coping and Confidence	24	35	59
Personal finances	16	19	35
Access to Work	7	17	24
Skills and Qualifications	3	17	21
Housing	7	9	16
Caring and Family responsibilities	3	9	11
Alcohol and Drug Use	3	5	8

Note: Columns may not sum to 100% due to rounding.
Base: 2,686

3.4. Multiple barriers (combined measure of need)

A further way to explore levels of need is to consider the number of needs participants experience. 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.

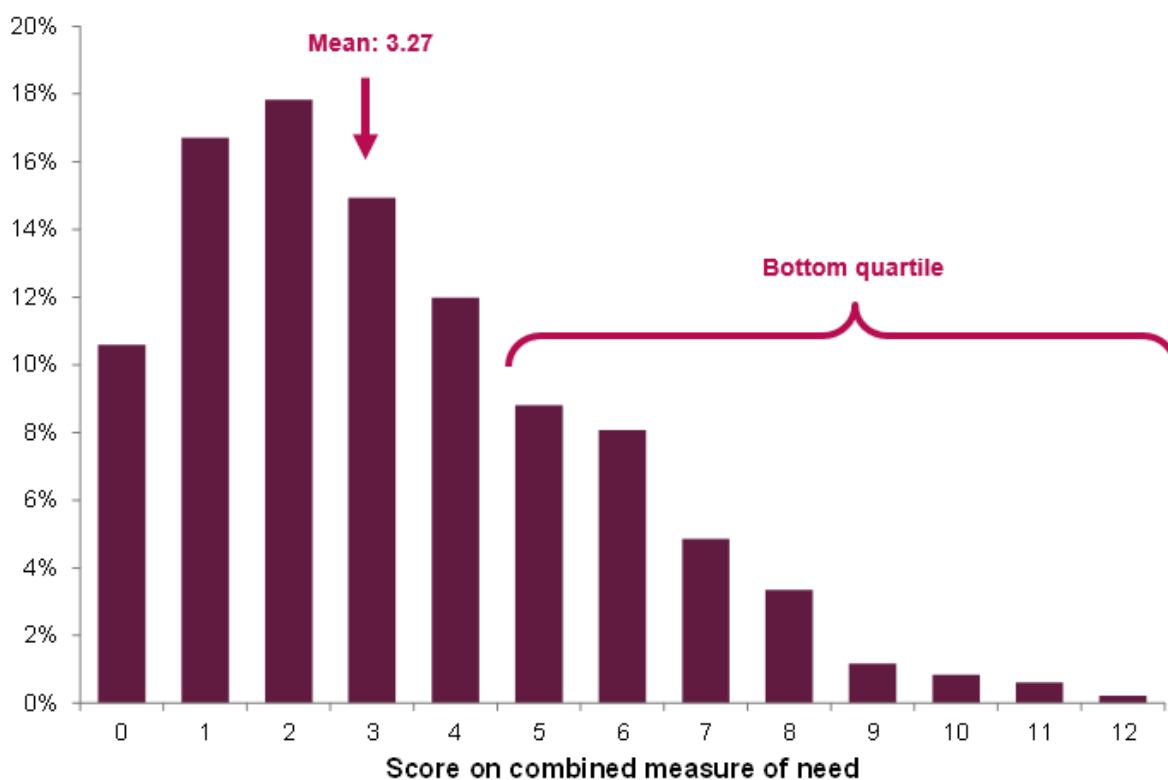
The combined measure of need is based on 15 separate indicators comprising all eight presenting needs measures, four health assessments and three other indicators: disability status, if currently in paid work and lack of basic skills. A full list is provided in Appendix 2.

Individual 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 2), a value of 1 is assigned. For example, any participant whose level of presenting need for 'Health' is categorised as severe would receive a score of 1 against that indicator. 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 3.27 (lowest score 0 and highest 12) (Figure 3.1). This highlights that, on average, participants face at least three 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 3.1 Distribution of combined measure of need scores (All participants)

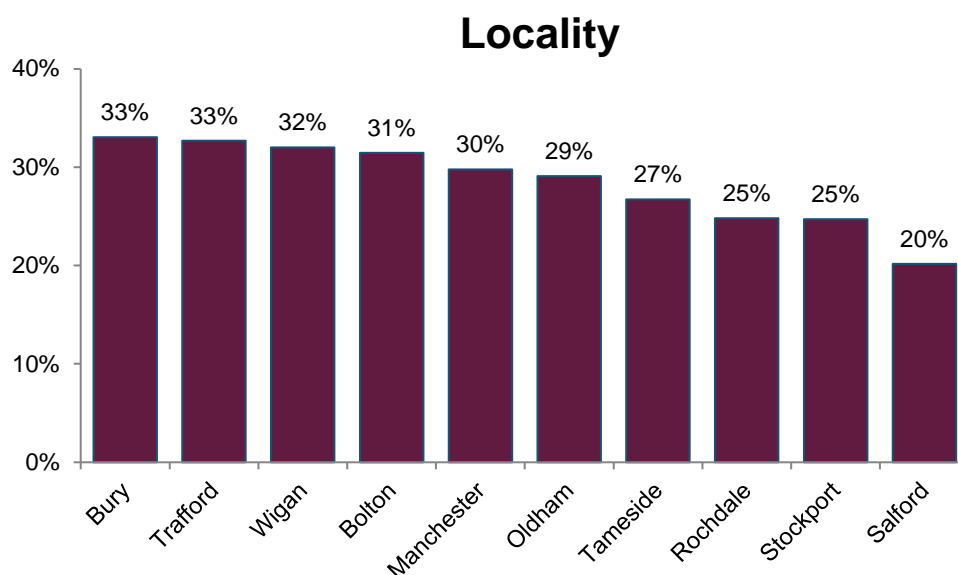


Base:1,795

This analysis shows 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 (35 per cent compared to 24 per cent and 23 per cent respectively).
- **Employment status:** Over one third (35 per cent) of those out of work have been assigned to the category of most need compared with 23 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 (31 per cent compared to 22 per cent).
- **Age:** Those aged 35-44 years old appear to have the lowest level of need among those starting on the programme so far (25 per cent); the youngest cohort aged 18-24 have the highest level of need (37 per cent).
- **Local authority area:** Figure 3.2 shows there are variations in the proportion of participants in the highest category of need by area, with Salford having the lowest proportion placed in this group (20 per cent, compared to a quarter or more in other localities).

Figure 3.2: Proportion of participants in the highest category of need by locality



Base:1,795

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 (31 per cent compared to 22 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 and interviews suggest this is not always met (see Section 5.4)

3.5. Barriers to work

Data collected on self-reported barriers to work highlights that health management was by far the most common issue facing participants across both in-work and out-of-work cohorts (Table 3.6). Family issues, financial concerns and confidence and motivation were also common barriers, although to a much lesser extent.

Table 3.6: Barriers to work

Most common barriers to work					
<i>In work</i>	%	<i>Out of work</i>	%	<i>All</i>	%
Health Management	98	Health Management	95	Health Management	97
Family	10	Financial	9	Financial	9
Financial	9	Confidence	9	Family	5
Confidence	4	Motivation	7	Confidence	7
Motivation	3	Family	3	Motivation	6

Base: 2,649

The prevalence of health management as a barrier to work is perhaps not surprising given that eligibility is limited to those who at least one health condition. However, interview data provides further insights about precisely how health and other barriers to work are experienced and interact. The remainder of this subsection looks in turn at barriers relating to health, employment and wider personal factors (e.g. caring responsibilities or relationship breakdowns) before considering how multiple factors often interact to shape decisions to leave work. It then moves on to consider how the COVID-19 pandemic has shaped barriers to work. Section 4 which follows looks in more detail at how health issues are related to the experiences and conditions of work.

Health barriers

Interviewees reported a wide range of health-related issues including:

- **Mental health conditions** including anxiety, low mood or depression, panic attacks and post-traumatic stress disorder (PTSD).
- **Physical health conditions** such as musculoskeletal problems including injuries and longer-term, conditions, multiple sclerosis, carpal tunnel syndrome, cancer and fibromyalgia.

Some of these conditions were chronic or fluctuating, which means reported health at the time of interview did not always capture subsequent health trajectories.

In many cases, the **presenting health issue – often a long-term condition - was the primary factor contributing to withdrawal from work** and perceived difficulties in returning to employment as the following examples illustrate:

Physical health

“The ankle is good for about two or three hours a day...I can’t walk far. So, physically, really, it was physical reasons I pulled out”. (Participant 37)

Mental health

“The reason why I stopped [work] was...every few months I’d have a massive bout of depression”. (Participant 70)

Mental and physical health

“I had a chest [problem]... it was like having flu ... that’s on top of my mental health problems, I suffer from anxiety, insomnia, panic attacks for about 18 years. And so it just got to the point where they just couldn’t keep me on”. (Participant 78)

In many cases, however, difficulties in managing health conditions were related to workplace conditions and experiences including the attitudes and practices of employers. This is explored in depth in Section 4.

Employment barriers

In line with programme data on presenting needs (see Table 3.5), **few participants identified employment issues as a barrier to work in itself that were not related to health**. Exceptions included a small number of newly unemployed participants who identified barriers relating to employability or the quality and quantity of work available. For example, one older worker expressed concerns about a range of **employability** challenges that included job interview technique, basic skills (maths) and the perceived need of employers for speed:

“I’d only hated and loathed the interview process...I never really got my head around decimals... one of the things I’ve always been is I’m slow...In a world that’s going increasingly quicker and faster I’ve struggled more and more”. (Participant 37, newly unemployed)

Another interviewee raised issues with **job quality** in terms of feeling pressured by Jobcentre Plus to accept low-paid work that would not enable them to meet financial commitments:

“If I get a [job] where it’s like a student’s pay of sixteen thousand, you know, how am I going to support my family?... I’ve got things to pay... like a lecky [electricity] bills and stuff”. (Participant 43, newly unemployed)

A small number of interviewees also observed that the pandemic had **seen job opportunities dry up**:

“There just wasn’t really jobs available, which is kind of the main obstacle in my way, and there’s nothing really that you can do about that except for waiting for the pandemic to be over”. (Participant 58, newly unemployed).

Personal barriers

Beyond employment and health issues, participants identified a range of wider presenting needs although prevalence was not high across the sample:

- **Caring responsibilities** for vulnerable family members:

“Mum was diagnosed with dementia around five or six years ago...she was getting into a terrible state and we’d find her in an awful state...we’d been right up there on the ceiling almost with the stress”. (Participant 49)

- **Financial issues:**

“I didn’t have any income and I had a massive outgoing...I went to the Jobcentre in the first place, because there just wasn’t enough money for me to be able to keep the roof over our heads”. (Participant 29)

- **Relationship problems or separation:**

“The primary issue is the relationship and I think it’s probably gone on for too long, but without realising it”. (Participant 71)

The first example also highlights how non-health related issues can worsen mental health and wellbeing, showing the interplay between different needs. In some cases, a **combination of several needs led individuals to leave work**. One participant described how a “*major bout of depression*” combined with a traffic accident and experiences of redundancy, illness and bereavement among family members made work insupportable: “*It all kind of stacked up*” (Participant 68).

Pandemic-related barriers

The **COVID-19 pandemic was a factor highlighted by some participants as contributing to both health and employment-related barriers to work**. Many examples related to the way it impacted on working conditions or expectations of employers with knock-on effects on health and wellbeing, as explored in Section 4, as well as labour market impacts in reducing job vacancies (see above).

Other COVID-related impacts included a small number of **redundancies**:

“Obviously COVID kicked in...they started laying off people ...because I was agency... last in first out kind of scenario”. (Participant 78)

Beyond the workplace, **the pandemic impacted negatively on mental health and wellbeing** through fears of being in public spaces, particular on public transport, as well as social isolation brought about by loss of contact with friends and family. This could, in turn, narrow employment options as the following example shows:

“I do want to find work but I struggle because there’s not a lot of places local to me and I won’t get on public transport, so to get taxis to and from work it’s quite expensive, so I need a well-paid job...my coping mechanism for my mental health before lockdown was... I’d call my friends all the time [but] because of Covid you can’t...so I’ve been at home with my thoughts... more depressed”. (Participant 56)

4. Workplace experiences and health

Summary

- This section combines programme monitoring and interview data to explore the relationship between workplace experiences and health. It shows that while 'Health management' is by far the most commonly reported barrier to work, health issues are intimately related to conditions of work.
- Negative workplace experiences including overwork, bullying or harassment, difficult or dangerous working conditions, job insecurity and poor management all shape decisions to take medical leave or leave work altogether. That said, the additional or intensified challenges identified in working through the COVID-19 pandemic suggest workplace demands and stressors may be unusually, and possibly temporarily, high.
- There is strong evidence that employer attitudes and practices can sometimes act as a barrier to returning to work. Moreover, occupational health services, where available, are not always seen as providing accessible, effective or appropriate support, undermining assumptions informing the programme's two-tier service design.
- These findings raise key questions about how interventions around health issues can be combined with improved job quality and employer support.

4.1. Introduction

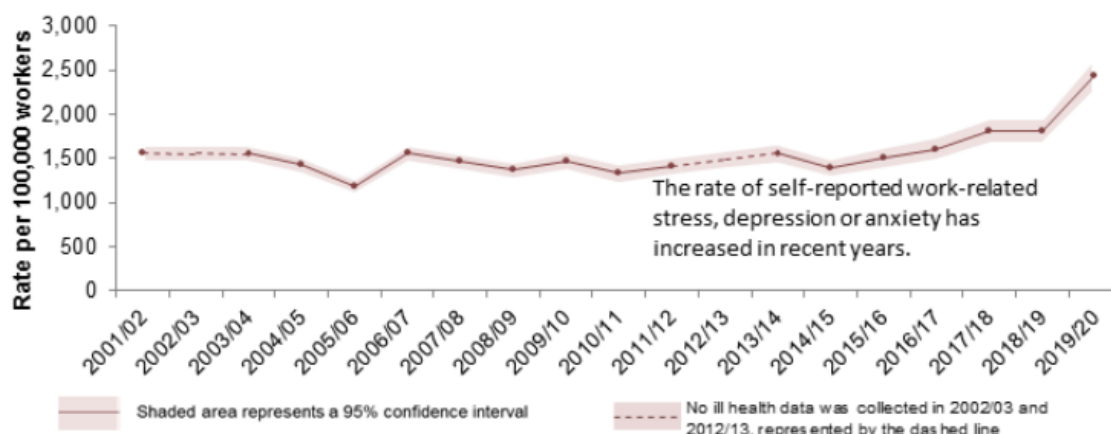
The **positive relationship between good quality employment and good physical or mental health** has been recognised in a series of recent national strategies and reports²⁴ and in the recent *Build Back Fairer*²⁵ review produced for Greater Manchester by the Institute of Health Equity. This acknowledges both the role that poor health can play as barrier to sustained employment, as well as the contribution that employment makes as a principal social determinant of good health.

Realising the benefits of employment, however, is not just about supporting those with health conditions or disabilities to access *any* job. The *Health Equity in England*²⁶ report published in 2020 emphasises the importance of good quality work²⁷ for positive health outcomes. It outlines concerns that some of the increase in employment rates since 2010 has been driven by the rise of poor quality work, putting health equity at risk.

Separate analysis by the Health and Safety Executive (HSE)²⁸ using Labour Force Survey (LFS) data that precedes the pandemic shows rising rates of self-reported work-related stress, depression and anxiety since 2010 (Figure 4.1 below). It indicates that the predominant cause of work-related stress, depression or anxiety is workload in terms of either tight deadlines, too much work, or too much pressure or responsibility. Other contributing factors identified included a lack of managerial support,

organisational changes at work, violence and role uncertainty (lack of clarity about what to do).

Figure 4.1: Estimated prevalence rates of self-reported stress, depression or anxiety caused or made worse by work in Great Britain, for people working in the last 12 months



Source: Labour Force Survey annual estimate, from 2001/02 to 2019/20 published in Health and Safety Executive (2020).

Other HSE research²⁹ shows around 1.8 million people report suffering from an illness they believe was caused or made worse by work; 80 per cent of new cases were musculoskeletal disorders or related to stress, depression or anxiety.

While work can cause or aggravate mental ill health, one study³⁰ indicates that being in work is still, overall, protective of health compared to other employment statuses. LFS data indicates that 27 per cent of employed workers experience poor mental health with rates higher among those who are furloughed (34 per cent) or unemployed (41 per cent).

This section draws on mainly qualitative data from interviews to explore the relationship between work and health before considering the level and nature of support provided by employers, including occupational health services where available.

4.2. Health and employment

The relationship between health and employment among WVEH participants can be explored using programme monitoring data and findings from in-depth participant interviews.

Using pay as a proxy for job quality, monitoring data shows that **higher pay is consistently associated with better outcomes:**

- Higher earners tend to experience lower levels of presenting needs (as measured by lower scores), particularly around 'Housing' and the two employability indicators ('Skills and Qualifications' and 'Access to work') (Table 4.1).
- Lower earners consistently report lower levels of health and wellbeing (as measured by lower scores) based on standardised health assessments (Table 4.2, see Section 6.2 for details of health assessments).

This further confirms the importance of good quality work for health and wellbeing and employability.

Table 4.1: Presenting needs scores by pay level

	Pay per hour (£)		
	Less than 15	£15+	Difference
Health	3.95	3.92	-0.03
Housing	1.78	1.61	-0.18
Personal finances	2.40	2.41	0.02
Caring and Family	1.81	1.87	0.05
Alcohol and Drug Use	1.43	1.49	0.07
Coping and Confidence	3.87	3.85	-0.02
Skills and Qualifications	1.88	1.59	-0.29
Access to Work	1.93	1.76	-0.17

Base: 1,236

Table 4.2: Health assessment scores by pay level

Health assessments	Pay per hour (£)		
	Less than 15	15+	Difference
EQ-5D-5L score (health)	0.41	0.44	0.03
EQ Visual Analogue score *health)	53.78	54.72	0.94
SWEMWBS total score (wellbeing)	18.33	18.52	0.19
ONS Life Satisfaction score (life satisfaction)	4.90	4.98	0.09
PAM total score (health management)	53.42	55.32	1.90
PAM levels of activation (health management)	2.10	2.25	0.15

Base: 1,238

Participant interview data provides additional insights into how job quality can impact on health and wellbeing. Data analysis in Section 3.5. already shows that health management is by far the most common barrier to work. However, interviews indicate that, in most cases, **it is not the health condition alone but the interaction of workplace experiences and health that shapes decisions to take medical leave or leave work altogether**. A range of issues were identified including:

- **Overwork:** Several interviewees reported issues where excessive hours impacted negatively on physical or, more commonly, mental health. One described working in automotive services for up to 120 hours a week:

“I was initially signed off sick. It was depression and anxiety... You would work ridiculous hours... I mean 7am till 2am... It was living to work not working to live... it drove me and many others into the ground... I had tight chest and difficulty breathing and it got to the point I was seeing double... it was affecting my family life as well”. (Participant 47, motor trade)

- **Bullying or harassment:** A number of interviewees reported bullying or harassment by managers or other staff:

“How my managers spoke to me, it was disgusting like... I said to them like, this is like bullying... I was like, pretty much a mental breakdown with it all, the stress. Not wanting to go to work and so on”. (Participant 20)

- **Working conditions:** A small number of participants highlighted the impact of uncomfortable, dirty or dangerous working conditions on health, particularly where forced to 'cut corners' on health and safety:

"You don't need to be a genius to work out that [my lung problems is caused by] working in a dusty atmosphere [using] rock wool [insulation]...it's too hot to wear glasses and mask, you kind of have to choose one or the other...yeah and you've got managers barking at you to do the jobs...you just have to cut a few corners basically, every now and then". (Participant 78, construction worker)

- **Job insecurity:** Losing work, temporary contracts or, in the following case, being 'fired and rehired' were all seen to contribute to stress or anxiety:

"They're now issuing you with a new contract where the pay is the same but holidays are less, sickness pay is less, overtime is less...in a couple of weeks' time, you were sacked [and rehired]...I probably did have a lot going on at work as well". (Participant 71, utilities worker)

- **Poor management:** Many of the issues above were compounded by employers failing to ensure adequate health and safety protections were in place:

"I got blown off the tail lift [of a lorry], this gust of wind came along and I lost my balance and I landed on my shoulder...all [my employer is] bothered about is getting the [product delivered]...it's at any cost basically whether that's monetary cost or somebody getting injured...I believe it's a culture that is rampant throughout the whole of the industry". (Participant 24, delivery driver)

Particularly striking in about a fifth of cases was the way in which **the COVID-19 pandemic had created or exacerbated a series of work-related pressures that worsened health and wellbeing**. This included: excessive workloads; bullying or harassment over Covid-related concerns; changes in roles or team structures; lack of support from management; and a failure to make workplaces Covid-secure, especially where individuals had concerns about passing Covid-19 on to medically vulnerable family members.

Perhaps unsurprisingly, this seemed to **impact most on those working in health and social care-related services**, echoing wider evidence of "exponentially" increasing burnout among healthcare staff during the pandemic³¹. There are also higher risks associated with these occupations which legitimate concerns outlined below. ONS analysis³² indicates statistically higher rates of death involving COVID-19 for men in both healthcare and social care occupations and for women in healthcare (but not social care) occupations, when compared with rates of death involving COVID-19 in the population among those of the same age and sex.

Key concerns included:

- **Excessive workloads:**

"The pressure was on to get people out of hospital to free up the beds for the COVID patients...they had us working every weekend and I just couldn't cope with it...I went off sick then". (Participant 60, NHS worker)

- **Changes in roles or team structures:**

“The COVID situation was the fly that broke the camel’s back...my teams were kind of broken up...and it changed like ten times a day on what I needed to manage [with] both of my teams... I thought, then my head was spinning from that and I don’t think I’m up to this challenge”. (Participant 49, NHS worker)

- **Lack of support from managers:**

“We had to start taking calls for NHS and coronavirus helpline, and that increased the workload a lot...So it was the stress of having to do with awful customers on top of the stress of management being on your arse all the time. And in the end, just it got too much and my insomnia and anxiety that I’ve had in the past started to come back, so I just left”. (Participant 45, call centre worker for a mental health support service)

- **Failure to make workplaces COVID secure and bullying over fears:**

“They have not got the right PPE [personal protective equipment]...they write out rules and put them on the doors but [staff] just ignore them and still carry on with their normal routine. And that got me panicking...I just don’t feel safe there at all...They are not taking the right precautions, plus I’m getting abuse from one of the colleagues [for staying at home with a child who was self-isolating]”. (Participant 51, Care home worker)

In some cases, work and health-related issues **interacted with other personal needs or barriers** such as caring responsibilities for sick or disabled family members or relationship breakdowns:

“Work was the final straw. I was getting under a lot of pressure at work and then Covid and my daughter has underlying health conditions and trying to protect her and it all just snowballed”. (Participant 1)

One finding from interviews and stakeholder workshops was that the uniquely challenging pressures of working through the pandemic had created **a new cohort of clients** experiencing “*circumstantial anxiety*” (Provider) **for whom taking medical leave for mental health issues was an entirely new experience**. This was reflected by one participant who observed the overwhelming stress of working in the NHS as well as fears of passing on COVID-19 to family:

“I was one of those people that stress just passes me by...[but] at work things were ramping up, I was worried about mum [who was elderly and needed care]... was worried about what I might be taking home to my family and I guess I just cracked... I started thinking these very, gosh, kind of extreme thoughts of you know, with the Covid situation”. (Participant 49)

One implication of the findings is that the dominance of COVID-related issues makes it hard to discern the extent to which these challenges are context-specific and may ease as the pandemic slows, or are longstanding issues endemic to workplaces.

At the same time, while the pandemic was largely identified as a barrier to work, **a very small number of interviewees noted the break from work afforded by being furloughed had seen health conditions improve:**

“I wasn’t feeling too good but with furlough...It actually did me good... my mum... was 86 and not in very good health so I was starting to reach a point where I was going to say I wasn’t going to work anymore”. (Participant 35)

Other participants also noted that their fears about COVID-19 in the workplace became less acute as the risks presented by the pandemic become more evident. One noted, for example they had become “*more relaxed*” (Participant 22) about working in the office.

In summary the findings above illustrate that **work is often a significant contributing factor to ill health**. Of course, it must be remembered that, by definition, the WWEH programme is by default likely to engage participants experiencing work-related ill health. Those in workplaces conducive to good health or who have a positive experience of successfully managing health conditions in the workplace clearly have no need to access WWEH support.

Nevertheless, issues are prevalent enough to raise important questions about what WWEH and future programmes can do to minimise the potentially harmful impacts of work. This has two main implications. First, it suggests the nature of work that WWEH helps participants to sustain or secure is important in shaping health and wellbeing outcomes. Second, and more broadly, it indicates a need at a strategic level to pursue policies and strategies which support a ‘good work’ agenda. The Greater Manchester Good Employment Charter is an example of this. This aligns with broader ambitions in the Improving Lives white paper³³ to create healthy workplaces where people thrive and progress as well as ambitions and recommendations for improving job quality outlined in the recent *Build Back Fairer* report³⁴.

4.3. Attitudes and practices of employers

Employers have a key role to play in helping employees manage health conditions in the workplace and supporting those who take medical leave to return to work. This can be done in a number of ways such as creating a culture conducive to disclosing conditions; making adjustments to workstations or working patterns; responding effectively to workplace issues that can cause stress or anxiety (e.g. workloads or relationships with colleagues); and providing access to good quality occupational support where appropriate.

Wider research suggests employers are often committed, in *principle*, to recognising the importance of, and supporting, the wellbeing of staff. Evidence presented in the Improving Lives White Paper from a survey of employers commissioned by DWP shows that nearly nine out of ten employers accept both that there is a link between work and employees’ health and wellbeing; and recognise that they have a role to play in encouraging health and wellbeing amongst their staff. This section considers the extent to which employers fulfil this commitment based on the perceptions and experiences of participants. It looks firstly at general support from employers before considering specific experiences of occupational health services where available.

General employer support

There were mixed reports on the extent to which employer support helped participants with health conditions remain in work or, once on medical leave, return to the workplace. **Some interviewees indicated employers had been supportive** by recognising health conditions and making appropriate adjustments such as reducing hours:

“They know that I suffer from anxiety and depression...been good with that... Sometimes if I’ve needed to kind of drop a shift because I’ve not been feeling too great, they’ve been OK with that”. (Participant 68)

"[My boss] was fantastic, she was under a lot of pressure but she made time for me, she listened to me and she tried to support me as best she could". (Participant 49)

A number of participants also described having regularly 'check ins' from supportive line managers while on leave, described for example as *"incredible supportive"* (Participant 19) and *"sympathetic"* (Participant 34).

Proactive steps taken to support a return to work included adjustments to shift patterns or working hours; enabling home working; reducing workload; supporting a phased return; exploring options for deployment to more appropriate roles (e.g. less physically demanding work); and buddying up with other colleagues. While not always effective such efforts were always valued and, in some cases, could make a significant difference to health and wellbeing:

"What really helped me was that I could go back not only on a phased return but I asked if I could go in at the weekend...the risk [from COVID-19] was very much reduced because there was nobody else around...So that was huge...psychologically [reducing] the pressure on me from my stress and anxiety". (Participant 49)

However it was **more common for interviewees to highlight a lack of support among employers** with a quarter of interviewees expressing concern. This lack of support had a number of different dimensions including failure to recognise health conditions, penalising sick leave, unwillingness to make adjustments, and failing to make workplaces COVID-secure:

- **Failure to recognise health conditions**, particularly relating to mental health in certain manual occupation centres. One interviewee spoke about the lack of support in the construction industry he experienced for anxiety and insomnia:

"A lot of people just don't understand anxiety...there are posters up saying report mental health problems to your manager, but everyone was sort of like, it doesn't work like that... I hardly ever got sick pay". (Participant 78)

- **Penalising staff for taking sick leave**, including one member of staff with suspected COVID-19 who also taken days off previously for anxiety and insomnia:

"I had a pretty bad cough...and I was still going into work. But I was paranoid about taking sick days because you could get put on a warning if you'd taken too many.... I think that was the turning point [in deciding to leave]". (Participant 58)

- **Unwillingness to make appropriate adjustments** such as adapting workstations, moving individuals to a different team to avoid bullying, or reducing the physical demands of roles. One participant with a neurodiverse condition suggested the failure to act on six separate ergonomic assessments was discrimination:

"There was some discrimination...they were just totally unwilling to put any adjustments in place...It was really starting to cause me more [mental] health problems than it was worth, so I cut all ties with them and left". (Participant 25)

- **Lack of contact once on medical leave:**

"I'd basically been off for 18 months before anybody would contact me from work". (Participant 31)

Some staff described managing the apparent indifference or lack of support from employers by working while ill, even if advised to take leave by clinicians, or dealing with periods of ill health by taking holiday leave:

“I’d fractured [two bones] and it’s healed offset... [NHS staff] wanted me to have three months off work...but obviously I can’t afford to have time off work so I just keeping going...I started [construction work] while it were broke”. (Participant 27)

“I’ve never spoke to work about it to be honest with you, I tended to use holidays...I tried managing it like that” (Participant 35, chronic physical condition)

Concerns were also raised in some cases about the lack of support to enable a sustained return to work. This included managers failing to explore or implement options for a phased return; applying pressure to work unsuitable hours; overriding preferences for particular shift patterns or home working; and reprising bullying behaviour. Two examples include:

“The manager failed to tell me that I could have a phased return so I did a week of full hours which absolutely killed me...And then I spoke to occupational health maybe the following week and they went mad”. (Participant 60)

“I could hear the boss upstairs, going, ‘I don’t need him’...that’s when I ended up going off again, because I was just so angry, I thought you bought me back in, I told you my issues and you just kicked me while I’m down”. (Participant 80)

Occupational health support

A key research question for the evaluation is the extent to which participants only eligible for the lighter-touch Advice Service are able to access any more intensive support required through workplace occupational health (OH) services, as assumed in WVEH programme design. Interviews suggest the **experience is mixed**.

On the one hand, **some Advice Service participants seemed satisfied with the OH support they received**, either as an alternative or in tandem with WVEH support:

“I think the culmination of both has definitely helped... I’ve got someone to offload to through occy [occupational] health and counselling and then I’ve also got the resources from Early Help”. (Participant 60)

In other cases, however, programme assumptions about access to external OH services underpinning the Advice Service were not always borne out. Three individuals suggested that **OH support was either inadequate or unsuitable for their needs**. In the first example below, concerns are expressed about the expectation of having to discuss issues with colleagues perceived to be the source of workplace problems. In the second, the OH service is seen as too focussed on a return to work rather than wellbeing, with attendant concerns that confidentiality could be breached by the Provider contracted to deliver OH provision. This latter concern directly led the Participant 71 to seek help from WVEH as *“someone outside the company”*:

“Basically they sit you down with the person causing the problem and you just feel under even more pressure so...it didn’t work for me anyway”. (Participant 22)

“The feelings we get from work, and it might be a cynical one, is that all they’re trying to do is just get you back in work...and they’re not actually sort of concerned about your wellbeing...I didn’t think it was anonymous”. (Participant 71)

These findings concerning the perceived inadequacy of OH services raise potential issues about the less intensive nature of the Advice Service. If used as an *alternative*

rather than an *adjunct* to work-based OH support, WVEH may be less likely to meet the full range of needs.

A small number of interviewees also noted that even where OH support was effective, poor managerial practices meant **advice or recommendations were not always implemented**. One participant described “fighting” management in tandem with their OH service to get a reduction in physical responsibilities following a work-related injury:

“I was in effect fighting the company and getting occupational health onboard and then she was fighting them as well... I was getting put on [delivery] runs and I just said I'm not going to be able to do that” (Participant 24).

This example and many of those in the previous subsection show that **attitudes and practices of employers can be a barrier to work**. This aligns with the findings of wider research (see Section 4.1) and raises important questions about how employers can be helped to better support employees with health conditions. This may be a particular concern given that the levels of direct engagement with employers is very low (see Section 2.3) which limits opportunities to work with them to improve practices.

5. WWEH support

Summary

- Participant interviews suggest that the primary concern for some is to access support with a physical or, more commonly, mental health condition. Employment is not always seen as an immediate priority, especially where health conditions are considered to be extremely limiting in terms of work. This may impact on the ability of the programme to support some individuals to return to employment.
- Most participants were positive about their experiences of the WWEH programme and valued a range of elements of the offer. A smaller number, however, suggested the support was not relevant to their particular circumstances, or in a few cases, questioned the quality of the offer.
- It was noticeable that recipients of the Advice Service tended to be more critical of the less intensive and more self-directed nature of the support they received. The assumptions underpinning the 'lightness' of this offer are perhaps not always borne out, as it might not align with levels of need, particularly where participants in larger organisations are reluctant to use occupational health services.

5.1. Introduction

The WWEH model centres on personalised, health-focussed and holistic support provided through a team of 16 key workers known as Vocational Rehabilitation Worker (VRCs). Some aspects of support are delivered directly by the VRCs who develop a package of support tailored to individual needs. VRCs can also refer into an Expert Practitioner Network (EPN) commissioned to provide Cognitive Behavioural Therapy (CBT) and physiotherapy services, as well as into wider work, health and skills services in the Greater Manchester 'ecosystem'. Appendix 3 lists the full offer.

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. Support during the pandemic has been provided remotely by phone, text, videocall or email although face-face meetings were possible before the coronavirus outbreak.

There are two levels of service designed to provide appropriate levels of support depending on whether participants have access to occupational health provision at work.

- **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 lighter-touch 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 employer 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 Appendix 3.

This section draws on programme monitoring data and interviews with participants to look at expectations of support; the nature of support delivered; and satisfaction with support.

5.2. Support provided

Assumptions were established at programme launch around the proportion of in-work participants expected to access the full Support Service (80 per cent) and the lighter-touch Advice Service (20 per cent). This is intended to focus delivery on SME employees and the self-employed as a group less likely to have access to occupational health support. However, only 42 per cent of participants to date have accessed the Support Service and 58 per cent the Advice Service. This is explained by the high proportion of in-work participants working for larger companies (over 250 employees) and the challenges in generating SME referrals (see Section 2.3). Information on interventions either provided or advised is available for 2,561 programme participants (Figure 5.1) and shows:

- The most common intervention is Vocational Rehabilitation, which has been provided to 83 per cent of those who have received an intervention. Coping Strategies (66 per cent), Cognitive Behavioural Therapy (44 per cent), and Mindfulness (38 per cent) are also commonly provided or advised interventions.
- Five of the top six most common interventions relate to mental health and wellbeing, reflecting the prevalence of mental health conditions among the cohort.

Figure 5.1: Most common interventions across the programme



Base: 2561

Support is **predominantly provided internally** with 83 per cent of all interventions delivered directly to participants by the Provider (Table 5.1). This reflects the frequent use of ‘in-house’ interventions such as Vocational Rehabilitation and Coping Strategies (amongst others). Counselling is the only one of the top ten most commonly delivered interventions that is provided externally.

Table 5.1: Balance of support provision

Type of provision	Count	%
Internal provision	11826	83.0
External provision	2414	17.0
Total	14240	

Base: 2,561

5.3. Expectations of support

Participants were asked in interviews to reflect on how they hoped to benefit from WVEH support when they first accessed the programme. Some were unsure about what the service offered or how they might benefit - “I’m not 100 per cent sure” (Participant 51) - but were still willing to “give it a go” (Participant 20) even if uncertain.

Other participants had clearer expectations, although motivations for accessing WWEH were mixed. **For some respondents the primary concern was to access support with a physical or, more commonly, mental health condition.** In terms of physical health, access to fast-track physiotherapy was a key incentive to sign up in small number of cases. More frequently, participants engaged with WWEH to access practical and emotional support with mental health problems:

“Just to chat to somebody, really, and because I was that low from losing my dad and then my mum being poorly”. (Participant 53)

In some cases, the perceived severity of health conditions meant that employment was not seen as an immediate priority:

“I do want to go back to work...But at the minute I don’t know how I’m going to do that because I don’t want to go through that front door...So it’s half my [chronic physical health condition] and half through Covid”. (Participant 5)

“I had every intention of returning but the anxiety and the stress it’s just, I just don’t know what to do about it now. It’s taken over”. (Participant 47)

While support with health issues was the sole motivating factor for some, others wanted help **with managing health conditions in the workplace** to enable a return to an existing job or, as the following example shows, take up new work:

“[I wanted] ways to deal with my anxiety, I guess, and hopefully find a job where it wouldn’t be exacerbated”. (Participant 58)

Others saw work itself as a way of improving wellbeing, highlighting the **importance of employment as social determinant of health**:

“Yes I was frightened to go back in [but] I needed for my own peace of mind and my own wellbeing to get back to work”. (Participant 49)

Specific help sought around returning to work or finding a new job included practical advice around CVs, job search and negotiating a return to work with employers. In a small number of cases, guidance was sought on career change to secure more meaningful work:

I recognised I needed help in getting not just another job, something more, not only suitable, something more satisfying now”. (Participant 37)

In combination these examples show that motivations for seeking support centred on aspirations around health and employment and, sometimes, a mix of the two. This aligns with the core premise of WWEH that work is a key social determinant of health.

At the same time, the **prioritisation of health and the severity of conditions highlighted by some underscores that many participants are not contemplating an immediate to return to work.** In such cases, early intervention may need to focus on health issues, with employment a secondary if still important concern. Moreover, despite recent experiences of work, issues may be of such severity that returning to work in the time frame of support (i.e. six months) may present a considerable challenge.

5.4. Satisfaction with support

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

- A Customer Satisfaction Survey administered by the Provider by email to participants who have been discharged from the programme. Survey results should be treated with caution as the sample is small (n=91) relative to the size of the overall cohort.
- Interviews with programme participants.

The Customer Satisfaction Survey shows that **only 54 per cent of the sample are ‘extremely satisfied’ or ‘satisfied’ with the service against a target of 90 per cent** (Table 5.1). All but six of the 22 participants reporting dissatisfaction receive the Advice Service which means they have been referred by GPs and work for large organisations with over 250 employees. This aligns with findings below that the two-tier level of service can lead to confusion or disappointment for those who realise they are only eligible for the lighter-touch Advice Service. One stakeholder noted that participants are sometimes frustrated by having to undertake a lengthy BPSA assessment only to find out that all they are entitled to is a Return to Work Plan and information or links on other service.

Table 5.1: Satisfaction with service by support provided

	Advice	Support
Extremely satisfied	7	12
Satisfied	16	14
Neither satisfied or dissatisfied	11	6
Dissatisfied	9	4
Extremely Dissatisfied	7	2
Prefer not to say	1	2
Total	51	40

Base: 91

Interviews provide further insights into the extent of satisfaction with the range of support received. Participants report 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), self-employment support and retraining or skills development.
- **Health-related and wellbeing 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, personal interests and hobbies, personal resilience, health coaching, and dietary advice.
- **Signposting to external provision including** alternative health therapies, legal advice around employment rights, training courses, housing support, building financial capability, and financial advice.

On balance **most participants were positive about WVEH**, including some who were highly effusive, with the range of emotional and practical benefits identified including:

- **Emotional support** from VRCs seen as empathetic and relatable, which was often contrasted favourably to other provision:

“I felt at that time I was banging my head against a brick wall with the GP...But the MAXIMUS people, they really did come across as looking for

an alternative to help me as much as they could. So yes they were brilliant to be honest with you”.

- Encouragement to consider **new ways of understanding and addressing needs and barriers:**

“And there’s just some suggestions that he made that I wouldn’t even have thought of. He was just such a good man to talk to, really...He just encouraged me to do things...step out of my box”. (Participant 52)

- An **ability to identify and address the causes of mental health issues:**

“We got to the kind of root of my anxiety being that I was scared of how I was going to communicate with my managers, so we spoke a lot about confidence and building up my repertoire of words to professionally explain a grievance”. (Participant 3)

- An **impartial source of information and advice** on returning to work:

“I remember thinking it would be good just to basically run through a situation...with someone who has [a]completely outside perspective, doesn’t know any of the people involved...I could get a plan together for when I go in”. (Participant 80)

- Resources and support to **develop strategies for managing health conditions and coping with the challenges of returning to work:**

“She sent me some amazing documents on conflict resolution kind of things and some work sheets on how to structure tasks...in a way that I could work through my anxiety”. (Participant 45)

- **Advice on how to negotiate a return to work providing confidence to deal with employers:**

“They gave me some advice before I went back to work. Get everything written down before you go back to work. Get assurances from your managers that it’s not going to continue...I’m not scared to speak to my managers now.” (Participant 52)

- **Ease and speed of access to a range of specialist support** such as CBT and counselling services compared with NHS provision:

“He’s helped me achieve [access to mental health support] that I’ve spent five years trying to achieve on my own...And he’s just kind of done it in two and a half, three months. Got a professional to speak to me.” (Participant, 70)

A smaller number of participants were **less positive about the WVEH service**. This included a mix of Support Service and Advice service participants, suggesting the issue was not simply related to receiving the lighter touch Advice Service (see above). For some, the key issue was the **appropriateness of support for their circumstances** rather than quality. Examples below included not requiring support because of imminent retirement; and the six-month time limit expiring at precisely the point when support was most needed:

“If I wasn’t retiring then I’m sure that [WVEH] would’ve got me, you know, helped me get back into work...but that wasn’t my situation”. (Participant 49)

“I wouldn’t say it’s because the programme, you know, wasn’t beneficial; it was more that the timing was wrong and I couldn’t engage in it...you got six months regardless of what you were doing”. (Participant 25)

Some also observed that **the pandemic limited the potential value of support**, either in terms of fewer labour market opportunities or difficulties accessing services:

“I think it would have been a lot better if we hadn’t been in the middle of a pandemic lockdown, you know we couldn’t really do very much and to be fair there wasn’t a lot of jobs out there to apply for that I could do”. (Participant 43)

“With COVID all they could do was really sort of signpost me to places and if they are not available, it’s just, you know...I suppose any other year.” (Participant 78)

Others, however, **questioned the quality of WVEH support** for a number of reasons:

- The **inappropriateness of self-help resources** either considered excessive or difficult to engage with given with health conditions:

“I don’t want to be sort of dismissive about them but a lot of the time, [the resources] end up being more detrimental than helpful...I really struggle to read because of the way my head is”. (Participant 78)

- A **lack of practical support with job search activities**:

“[The expectation was] maybe to help you find work if you want any help with maybe CVs or physically looking for roles. Yeah, I thought it was that kind of service”. (Participant, 25)

- The **lack of direct liaison between WVEH and the employer** on the participant’s behalf, although past findings suggest participants often do not want WVEH to engage directly with their employer³⁵:

“I would have liked someone to have walked into that meeting with at least the initial couple of meetings with me to sit at my side to witness what was being said because now I need it”. (Participant 22)

- The **period of support being too short or contact too infrequent** to fully benefit from the programme:

“It just felt like the deadline was just, you know, a waste of time in some cases because I felt it came to an end too soon”. (Participant 2 – see Box 1 below)

“I think it was effective for that point in time where it probably made me feel good for a certain period of time. But if it had been probably maybe a couple more calls, it might just keep your head above water a little bit more”. (Participant 10)

The final point highlights that it is not just the type of support offered that matters in relation to fit with needs, but also the duration and frequency as well. This may be all the more important given the ‘quasi-counselling’ function of WVEH where opportunities for interaction and emotional support are highly valued by participants. This view was echoed by stakeholders who also suggested that appointments were sometimes too infrequent for those with higher levels of need, both for Support Service participants entitled to one appointment each month and Advice Service recipients who were not eligible for any appointments in the six month period between entry and exit. The latter was seen as particularly insufficient for Advice Service participants who,

for example, needed guidance on options for changing employers, sectors or occupations to find a different type of work in which they could better manage health conditions or disabilities.

Box 1: Concerns with duration of support

Paul (Participant 2)

Paul was working for a large financial services employer but on long-term medical leave when first signposted to WWEH. At the time he was in dispute with an employer for failing to make reasonable adjustments for a neurodiverse condition. After taking out a grievance, Paul eventually accepted a settlement offer and left the firm.

Paul observed that WWEH Support Service was “*not something that really benefited*” him as he was not actively looking for a new job during the six-month period of support. He requested several times to postpone support because mental and physical health issues meant he was not in a position to look for work: “*I just don't feel that the time for me to engage was right.*” This request could not be met and support elapsed before Paul had recovered sufficiently to make effective use of it.

Offers of help with physiotherapy and mental health support were also declined as he was already accessing similar interventions elsewhere. Paul added that he felt there was a lack of understanding among WWEH advisers of his condition with face-to-face support offered that was not appropriate given his condition. Nevertheless, he noted that the advice on housing issues was useful.

It noticeable that **recipients of the Advice Service tended to be more critical** of the less intensive and more self-directed nature of the support they received:

“They gave me a website to go and fill in health things and questionnaires which I started doing initially, but I was getting no feedback from it...I went on today just to have a quick look and I hadn't been on it for five months. Yes, I didn't feel it was working really.” (Participant 22)

“[WWEH] basically said there wasn't a lot they could do for us, he had me confused because I was trying to get my head round exactly what the [ir] role was... I spoke to the doctors... They were confused as well, they said, ‘Well hang on a minute, what are they there for?’” (Participant 23)

Not all Advice Service recipients were dissatisfied with the level of support. One spoke of how there were “*quite happy*” with the materials provided and light touch support: “*I didn't feel like I needed any more*” (Participant 21). Another noted:

“I didn't really access anything major from them other than the phone call with the assessment and then the feedback from that...So it's difficult to say they could do this better or that better. I felt what I got was great.” (Participant 19)

The range of experiences of Advice Service participants is captured in the three examples in Box 12 below. They suggest that WWEH works best when individuals are motivated to take up suggestions for support (Mark) and able to combine WWEH support with their employer's OH service (Gill). Those requiring more intensive support and dissatisfied with in-house OH services benefit least (Mark).

The combined measure of need analysis (Section 3.4) also indicates that Advice Service recipients are less likely to be placed in the category of most need, which may suggest a more limited service is appropriate for some. However, that has to be balanced with evidence from interviews and the Customer Satisfaction Survey which indicates the Advice Service does not provide the intensity of support some participants would like, especially when considered alongside the perceived shortcomings of OH support highlighted in Section 4.3.

Box 2: Experiences of the WWEH Advice Service

Mark (Participant 23)

Mark was on medical absence due to mental ill health when referred into WWEH by his GP. He had worked for the same manufacturing company for over twenty years where he experienced increasing levels of stress and anxiety. This was attributed to rising workload, difficult relationships with managers, and personal factors which included bereavement, relationship difficulties, and the medical vulnerability of a child during the pandemic. Occupational health support available through his employer had only made things worse: “*The whole process was, it didn’t run smoothly let’s say from the company*”.

Mark received the WWEH Advice Service but did not feel he benefitted significantly from support. The Return to Work Plan had been useful as a basis for structured conversations with employers when we returned to work, but he felt under pressure to manage it himself. He also noted it would have been more beneficial if WWEH had been present during return to work discussions. Moreover, while crediting WWEH with initial support he did not receive a promised follow on in-work phone call.

Overall, Mark felt the limited number of contacts with a VRC and support comprising largely of information and materials left him feeling “*pretty much on my own*”. While he had returned to work full time by the point of interview, he suggested this would have happened anyway without WWEH support as he recognised the benefits of work for his wellbeing. Resuming employment had been challenging, however, particularly after a request to work from home was refused and Mark’s longer-term intention now was to secure redundancy.

Gill (Participant 60)

Gill was on medical leave due to workplace stress in her role as a health professional when referred into WWEH by her GP. An increase in workload, poor management and the pressures of working in the health sector during the COVID-19 pandemic had led to a deterioration in her mental health.

Gill was only eligible for the Advice Service as an employee of a large organisation. She questioned the value of signposting information on external sources of support when her condition meant she was not motivated to proactively seek out help. However, she did indicate that the VRC “*gave me that push*” to contact a financial advice service and to apply for Universal Credit, both of which helped to mitigate her financial difficulties.

Moreover, Gill also received resources on mindfulness and CBT which she found “*really good*”, as well as a Return to Work Plan. At the same time, her work-based OH service arranged counselling sessions which she found very beneficial. Gill was able to return to work having negotiated a change in shift patterns that better suited her needs. She remained concerned, however, that this adjustment could be reviewed and rescinded, and that her working environment remained stressful.

Nevertheless, she noted that she probably would have been a lot more stressed with WWEH support.

Darren (Participant 19)

Darren was working in an administrative role in the healthcare sector when referred into WWEH during a period of medical leave for depression. WWEH advised him support would be limited as he was working for a large employer. He had previously used the counselling service available through his employer's OH offer but stopped when it switched from in-person to over the phone support and was now looking for alternative provision.

Darren had three conversations with his VRC who signposted him to a CBT provider which he found highly effective, stating he would not have found the service without WWEH. He also found the Return to Work Plan and other online resources highly useful in helping him understand and improve his mental health. He has since returned to work and not taken any medical leave for the longest period ever since starting the job. Darren reported feeling supported by managers and confident in sustaining employment. Key to the effectiveness of the WWEH Advice Service in Darren's case was his motivation to take up external support advised by his VRC.

6. Outcomes and impact

- Evidence suggests WWEH is more effective in supporting health and wellbeing than employment outcomes.
- Presenting needs data and health assessments show consistent improvement in health and wellbeing outcomes for participants between joining and leaving the programme. However, not all participants experienced improvements in health or wellbeing, particularly where conditions were chronic or severe, or a return to work proved a negative experience.
- The picture with employment outcomes is more mixed. The proportion of those in work who return to employment remains relatively high but only around a quarter of the newly unemployed had moved into work on discharge from the programme. Moreover, returning to work is not always a positive experience.
- Qualitative impact assessment indicates that around a half of positive health and wellbeing outcomes (53 per cent) and nearly two fifths of positive employment outcomes (39 per cent) can be attributed to WWEH support.

6.1. Introduction

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

Analysing 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 terms 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, qualitative impact assessment and econometric analysis provide further insights into the nature of change, the factors associated with positive outcomes, and 'additionality' i.e. the extent to which WWEH interventions directly contribute to change.

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 – health and wellbeing

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').

Table 6.1 below shows the proportion of participants reporting either moderate or severe need at entry and exit from the programme. 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:

- **All presenting needs have seen falls in the proportion of participants reporting severe or moderate need**, except for severe needs around 'Caring and Family responsibilities' where there is no change.
- 'Health' and 'Coping and confidence' are the needs where the most positive change is seen on discharge. The total proportion of participants experiencing severe and moderate need fell by 24 percentage points for 'Health' and 28 percentage points for 'Coping and Confidence'.

Table 6.1 Presenting needs (severe and moderate) on entry and discharge

Presenting needs	%					
	Entry		Discharge		Change	
	Severe	Moderate	Severe	Moderate	Severe	Moderate
Health	24	36	13	23	-11	-13
Coping and Confidence	20	32	8	16	-12	-16
Personal finances	14	21	9	19	-6	-2
Housing	6	9	5	8	-1	-2
Caring and Family responsibilities	2	8	2	5	0	-4
Alcohol and Drug Use	3	6	1	2	-2	-4

Base: 451

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. Data is collected for eight core assessments:

- 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 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 **Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS)**³⁶ gives a score between 7 (lowest mental wellbeing) and 35 (highest mental wellbeing). A score between 7-19 is considered low³⁷:
- The **ONS Life Satisfaction** asks individuals to score their satisfaction with their life between 0 and 10 with 10 being completely satisfied.
- The **Patient Activation Measure (PAM®)** helps to measure the spectrum of skills, knowledge and confidence of patients, capturing the extent to which people feel engaged and confident in taking care of their condition. Participants receive a PAM score (between 0 and 100) with a higher score indicating greater ability to manage conditions. The resulting score places the participant at one of four levels of activation.

- **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.

Table 6.2 shows the means scores and proportion of participants experiencing positive change for all those who have been discharged from the programme to date against the eight core assessments. Table 6.3 indicates PAM activation levels achieved. Higher scores indicate improvement for all assessments *except* GAD7 and PHQ9.

Key findings include:

- Mean average **scores improved against every single indicator** between entry and discharge. This includes the mean SWEMWBS score moving above the range of a low score (7-19) with a mean score of 21.82 reported on discharge.
- WWEH has **closed the gap with national averages** on the two indicators where benchmarks are available (SWEMWBS and ONS Life Satisfaction).
- It is also important to consider the proportion of participants experiencing positive change. **Two thirds or more saw improvements in scores** against PHQ9 (depression, 72 per cent), GAD7 (anxiety, 70 per cent), SWEMWBS (wellbeing, 71 per cent), EQ Visual Analogue score (health, 68 per cent) and PAM (Health management, 66 per cent).
- Notably, the two measures with the smallest proportion of participants experiencing positive change both focus partially or wholly on physical health: EQ-5D-5L (Physical and mental health, 56 per cent) and MSK-HQ (Musculoskeletal health, 56 per cent). This may partially reflect greater difficulties in accessing physical health services such as Physiotherapy during the pandemic. Stakeholders reported that some of these services experienced delays, backlogs and are less amendable to remote delivery than mental health services. Physical health improvements can also be harder, or take longer, to achieve than mental health improvements.
- The proportion of participants placed in the lowest PAM Level 1 activation group fell by 13 percentage points. Individuals in this group tend to be passive and feel overwhelmed by managing their own health and may not understand their role in the care process.

Table 6.2: Change in health assessment scores

Health assessments	Measure	Mean scores			% Participants showing improvement in scores
		Entry	Discharge	National average	
EQ-5D-5L score	Physical and mental health	0.44	0.57	-	56
EQ Visual Analogue score	Health	53.73	65.75	-	68
SWEMWBS total score	Wellbeing	19.18	21.82	25.2	71
ONS Life Satisfaction score	Life Satisfaction	4.83	6.26	7.70	64
PAM total score	Health management	54.50	61.52	-	66
GAD7	Anxiety	13.80	8.65	-	70
PHQ9	Depression	15.25	8.76	-	72
MSK-HQ	Musculoskeletal health	25.42	29.82*	-	56

Base: 68-477

* The base for this score is below 100 so caution should be taken interpreting the scores.

Table 6.3: Change in PAM Activation Levels

PAM Levels	%		
	Entry	Discharge	Change
Level 1	30	17	-13
Level 2	24	18	-6
Level 3	38	42	4
Level 4	7	22	15

Base: 477

Another way to look at change is consider the proportion of participants who score highly enough on GAD7 (Anxiety) or PHQ9 (depression) assessments to meet 'caseness' requirements. This is a score above which clinical support is needed as defined by the Improving Access to Psychological Therapies (IAPT) service³⁸. Table 6.4 below shows significant decreases (around two fifths) in the proportion of participants who meet caseness requirements on both measures between entry and discharge points.

Table 6.4: Change in proportion of cases in need of clinical support

Health Assessment	%		
	Entry	Discharge	Change
GAD7	92	54	-39
PHQ9	86	43	-43

Base: PHQ9 (209), GAD7 (167)

A key question is if, and to what extent, the proportion of participants experiencing positive outcomes around health and wellbeing changed during the pandemic. Table 6.4 below shows the proportion of participants reporting improvements between entry and discharge depending on whether they joined the programme before or after the beginning of the pandemic (defined as 01 April 2020 as the first day of the first full month of lockdown in the UK).

The data shows that **the proportion of participants experiencing improvements in outcomes increased significantly for the cohort joining during the pandemic** in relation to three health assessments: anxiety (up 27 percentage points), depression (up 27 percentage points) and physical health (up 25 percentage points). Only wellbeing saw a small fall in the proportion experiencing positive change. Moreover, outcomes only narrowly missed targets for three of the five measures (anxiety, depression and health condition) during the pandemic.

One explanation for the improved outcomes during the pandemic may be that the personalised support and contact offered by WVEH made a difference for a greater proportion of participants during a period of heightened anxiety and social isolation. Certainly, there is good evidence that participants value the contact and support of VRCs (see Section 5.4 and below). One stakeholder also suggested participants may have particularly valued WVEH support at a time when it became very difficult to access and speak to health practitioners such as GPs.

Table 6.4 Proportion of participants reporting improvements in outcomes

Proportion reporting improvements in outcomes	Pre-pandemic cohort (Mar 2019- Mar 2020)	Pandemic cohort (Apr 2020-Apr 2021)	Target
1a. Mental health (Anxiety) (GAD 7)	52*	79	80
1b. Mental Health (Depression) (PHQ9)	51*	78	80
2. Physical health (MSK-HQ)	44*	69*	80
3. Wellbeing (SWEMWBS)	72	70	85
4. Health condition management (PAM)	64	69	70

Base: 36-260

* Indicates where the base figure for the outcome is less than 100 so caution should be taken with interpretation of change between cohorts.

Note: Cohort is based on the month the participant entered the programme.

Participant insights

Interview data provides further detail on how changes in health and wellbeing are experienced. A number of interviewees who had returned to work reported **positive health improvements**, particularly in relation to coping, confidence and mental wellbeing:

“I’ve not had a serious mental health issue for that length of time which I think is the longest time in about five or six years”. (Participant 19)

“In terms of my well-being I feel a lot happier”. (Participant 46)

Resuming work was, for some, a contributing factor to improved wellbeing, although sometimes combined with ongoing challenges. One participant (22) noted, for example, how returning after taking medical leave for stress had benefitted his mental health through social interaction with colleagues and the self-esteem attached to working identity. Despite this, work remained a source of anxiety due to a perceived lack of COVID-safe measures and the participant’s longer-term goal was to secure a redundancy package.

At the same time, **health improvements for others were attributed to leaving jobs that were a source of stress and anxiety**. One participant described, for instance, how his insomnia and anxiety had improved after he had stopped working at a high-pressure call centre with abusive management and lax approach to Covid security: *“Overall it is a lot better than it was...I don’t have those issues as much anymore”* (Participant 58).

Other participants were **less positive about changes in health conditions** with a number reporting little improvement or deterioration in chronic or fluctuating health conditions. One participant on medical leave due to harassment at work described their mental health situation as *“really bad”* (Participant 51) while another with serious, co-morbid physical and mental health issues observed that *“I’m a wreck as it is”* (Participant 47).

For some, **returning to work had worsened physical or mental conditions** where, for example, physical responsibilities aggravated existing injuries or pressures related to COVID-19 in the workplace (see Section 4.2) created or exacerbated stress or anxiety. For example, one participant (51) working in the care industry reported intentions to find a different job within the sector because of concerns over inadequate Covid security in their workplace.

Fears about COVID-19 outside the workplace also appeared to impede health improvements. One interviewee spoke of how shielding because of a long-term condition had left them fearful of going out with *“no light at the end of the tunnel”* (Participant 53), while others noted the negative impacts on mental health of social isolation experienced during the pandemic.

While programme monitoring data above indicates most participants experienced improvements in health and wellbeing between entry and discharge, particularly during the pandemic, these findings illustrate how such benefits were not experienced universally. Moreover, returning to work can serve both to enhance or worsen health wellbeing depending on the conditions and circumstances of employment.

WWEH Impact

Additionality

A key question is the extent to which health outcomes are additional to what would have happened without WWEH support. Qualitative impact analysis provides an assessment of this additionality (see Appendix 4 for details of methods). Analysis of 20 interviews where participants experienced improved health and wellbeing or better management of a health condition estimates that:

- **The assessed level of additionality for participants who achieved a health or wellbeing outcome is 53 per cent.** This means for every 100 participants whose health or wellbeing, or management of a condition, improved, 53 would not have done so if it were not because of WWEH. However, there were no cases where positive change could be *fully* attributed to WWEH as other sources of support also made some contribution to outcomes.
- **Additionality is higher for those who report improved mental health and wellbeing**, compared to those whose physical health, or management of a physical health condition, improved. More detailed analysis suggests this is due to:
 - The relative ability of WWEH to address physical health conditions compared to mental health or wellbeing conditions.
 - The greater dependence on other, often existing, forms of support required to affect physical health outcomes. These often include GPs and specialist health condition support services.

Applying the additionality ratio to health assessment outcomes suggests the following outcomes were achieved which can be attributed to WWEH:

- 176 participants (37 per cent) were supported by WWEH to achieve a positive improvement in their **wellbeing**, measured on **SWEMWBS**.
- 162 participants (34 per cent) were supported by WWEH to achieve a positive improvement in their **ability to manage a health condition or disability**, measured on **PAM**.
- 158 participants (33 per cent) were supported by WWEH to achieve a positive improvement in their **life satisfaction**, measured on the **ONS Life Satisfaction** measure.
- 138 participants (29 per cent) were supported by WWEH to achieve a positive improvement in their **physical and mental health**, measured on the **EQ-5D-5L** score.
- 167 participants (35 per cent) were supported by WWEH to achieve a positive improvement in their **health**, measured on the **EQ-5D-5L Visual Analogue** score.

Participant insights

Interviews with participants provide further insights into elements of programme support which contribute to change. Participants who experienced positive health and wellbeing outcomes attributed this to WWEH support in three key ways:

- The **empathetic and listening approach of VRCs** creating a safe and valued space to discuss issues:

“Just having someone to talk to. It’s almost like therapy in a way”. (Participant 58)

“[The VRC’s] gone above and beyond again... patiently listening”. (Participant 70)

- Advice and resources provided practical **tools and techniques to understand and manage health conditions** such as stress, anxiety and depression:

“[The Return to Work Plan] just clarified things in my head and made it easier for me to get a grip on what I was feeling and what I was going through”. (Participant 19)

“I still over think things but certainly not as badly as I use to... I put that down to... the modules and you know the bit of counselling I had (via WWEH)”. (Participant 28)

- **Signposting or referral into other support**, particularly for Advice Service recipients unable to access the full WWEH offer. One participant (19) noted, for example, how external CBT support he had been referred into had been vital in managing a recent mental health episode experienced since returning to work. Another noted how fast track access to physio helped them gain a diagnosis of an undetected fracture from a past injury.

In other cases, it was the **combination of different elements of support that contributed to health improvements**. One participant who had taken leave due to stress noted, for example, that emotional and practical support from their VRC in managing concerns about returning to work alongside resources for dealing anxiety helped generate improvements in wellbeing:

“[We talked about] about things help me get back to work...ways to try and make it less frightening....so I was able to use that and then the [resources]...just knowing that there was somebody there in terms of support and everything, was enough for me to sort of gradually get better.” (Participant 21)

Indeed the withdrawal of WWEH support after six months was sometimes felt keenly. One participant who had retired on health grounds at the point of interview due to a chronic physical condition rued the loss of the contact with their VRC. This social interaction had been valued for mitigating some of the social isolation experienced during the pandemic: *“It actually given me a purpose. It has actually helped. Helped me a lot” (Participant 31).*

One implication is that health improvements may, for some, be at least partly contingent on on-going contact with the programme. This example may also explain why health outcomes improved during the pandemic (see data above) with participants benefitting from contact with VRCs during a time of heightened anxiety or isolation. However, there is not sufficient interview data to conclude with confidence that this is one of the primary explanations for observed improvements in the proportion of participants experiencing positive change on some health assessments.

At the same time, a smaller number of participants suggested **WWEH had made little difference to positive change experienced in health and wellbeing**. One of these was only eligible for the Advice Service and expressed disappointment that they had only received one phone call and no follow up contact, attributing improvements in mental health instead to support sourced separately:

“But they [WWEH] certainly were not party to the way I’m feeling now. I would solely put that down to the online therapy session that I went through during those eight weeks”. (Participant 34)

Another criticised the time taken to arrange physiotherapy as the appointment arrived after the point of greatest need once her health was improving: *“[It] really would have helped... I mean, honestly [WWEH] didn't really make that much of a big difference to my recovery.” (Participant 46).*

It was also clear in some cases that **WWEH support could not always improve health or prevent it from declining**, although this not necessarily seen as a weakness of the programme. One participant highlighted deteriorating mental health but added *“that’s nothing to do with them [WWEH]” (Participant 29)*. Another praised the quality of WWEH support but noted it had limited effect given their level of health issues and the impact of the pandemic:

“Any other year [WWEH] would have been brilliant but, and no fault of the people that I’ve spoken to at all, it’s just the combination of COVID and my head and my lung. It’s just hard for them to try to point me in a good direction.at the moment”. (Participant 78)

Other pandemic-related factors limiting WWEH impact included the inability to take up some opportunities such as courses because facilities were closed down during the pandemic.

Several participants also noticed that their **mental health was too poor at the time of support to benefit fully from WWEH support**: *“I wasn’t really listening properly or couldn’t take in what was being explained at the time” (Participant 47)*. This meant self-help resources were of limited use for them: *“I still wasn’t in a position to be able to deal with all of that in my head having to read things yourself and it wasn’t what I*

needed at the time.” Again, this highlights issues with severity of condition limiting the ability of WWEH support to contribute to positive change.

This point was echoed by stakeholders who observed high levels of need or safeguarding issues among some participants for whom self-help materials and infrequent contact with VRCs was not always appropriate. Moreover, issues did not always become apparent at an early stage of the BPSA process which meant considerable time was sometimes spent working with participants before it became obvious that the programme could not meet their full range or intensity of needs. Finally small number of interviewees reported that **health improvements supported by WWEH are not always sustained**. One participant experienced initial positive change with WWEH support that enabled a return to work: “[They] *just helped me think of it in a different way, stop thinking of the worst*” (Participant 51). However, worsening mental health led to a further period of medical leave.

These examples underline the **potential fragility of recovery** for some. They also reflect challenges in supporting sustained improvement for chronic, acute or fluctuating conditions, especially in a period of heightened concern and uncertainty during the pandemic. In other words, **there may be limits to what WWEH can achieve for those who may need ongoing clinical support**.

6.3. Employment outcomes

Employment outcomes can be measured using two sets of indicators – presenting needs and return to work outcome data – and looking at change between entry and discharge onto the programme. In addition, the extent of impact and the interventions contributing towards positive change can be assessed using qualitative impact assessment and findings from participant interviews.

Presenting needs - Employability

Two of the presenting needs measures relate to employability: ‘Access to work’ and ‘Skills and qualifications’. Table 6.4 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**, except for a small increase in severe need around ‘Access to work’.

These decreases in the proportion of participants experiencing moderate or severe need are not as large as those reported above for some of the health-related outcomes. However, employability needs were not as significant on either measure at the point of entry so the ‘headroom’ for positive change is smaller.

Table 6.4: Proportion of participants reporting improvements in outcomes

Presenting needs	%					
	Entry		Discharge		Change	
	Severe	Moderate	Severe	Moderate	Severe	Moderate
Access to Work	7	18	8	13	2	-5
Skills and Qualifications	4	18	1	13	-3	-6

Base: Entry = Access (114), Skills (100). Discharge = Access (98), Skills (62)

Return to work

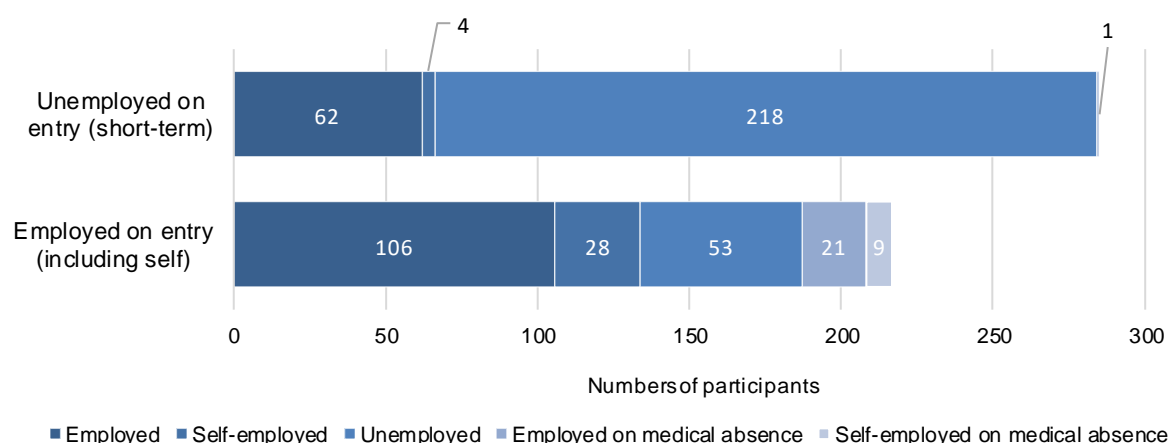
A key measure of programme success is the extent to which WWEH supports a return to work. Figure 6.2 details participant employment status on discharge split by their

status on entry (either unemployed or employed and on medical leave) for all participants who have completed discharge assessments to date. It shows that:

- 231 participants (46 per cent) who were either unemployed or employed but presumed to be on medical leave when joining WVEH were employed at the point of discharge (including 27 on medical absence).
- For those unemployed on entry to the programme, nearly a quarter (23 per cent) had moved into work on discharge from the programme (66 out of 285 participants).
- Two-thirds (62 per cent) of those employed (including self-employed) but on medical leave on entry had returned to work at the point of discharge from the programme (134 out of 217 participants).

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. Over one third (35 per cent) of those out of work have been assigned to the category of most need compared with 23 per cent of those who are currently in work (see Section 3.4).

Figure 6.2: Employment status on discharge by status at entry



Base: 502

Again, it is possible to look at how the proportion of participants experiencing positive change against the two core employment measures compares across the two cohorts who joined before and during the pandemic (Table 6.5). Data shows the proportion of participants who returned to work from medical leave was slightly lower (four percentage points) for those joining the programme during the pandemic which may reflect interviewees being furloughed or, as interviews clearly show (see Section 3.5), concerns about returning to workplaces not considered Covid-secure.

At the same time, there has been a **notable ten percentage point increase in the proportion of newly unemployed participants finding work**. Given the challenging labour market conditions experienced during the pandemic (see Section 1), this improvement in outcomes is all the more significant and warrants further exploration. One tentative suggestion by frontline staff in the Provider team was that the pandemic had seen more referrals of individuals who had been made redundant or furloughed unexpectedly and were “desperate” (Provider) to return to existing jobs or find work. In other words, a higher proportion of the pandemic cohort was closer to work than the pre-pandemic cohort. It was also suggested by some stakeholders that work may have

been easier to secure and sustain during the pandemic where working at home made employment more accessible for those with health conditions or disabilities.

- Achievement against both outcomes remains below target during both time periods, particularly in terms of job starts. While it was expected that employment targets would be challenging to meet during the pandemic, the data indicates that performance was even further below target in the period preceding the pandemic (Table 6.5). Reasons volunteered by stakeholders for lower than expected employment outcomes included:
 - a lack of employability support and specialist employment coaches on the programme relative to the higher level of provision and staff skills around health issues. It was noted that liaising with employers and job brokerage requires dedicated skills and significant staff capacity.
 - An on-going delay in launching the online Employment Hub intended to provide online employability support such as jobsearch tools and information on training opportunities to participants.
 - time taken dealing with complex health issues meant frontline staff did not always have the time to engage in time-consuming activities to address employment-related barriers to work.
 - difficulties in getting evidence of a return to work from participants once in employment.

Table 6.5: Proportion reporting improvements in employment outcomes (%)

	Pre-pandemic cohort (Apr 2019- Mar 2020)	Pandemic cohort (Apr 2020-Apr 2021)	Target
5. Returned to and sustained in work (medical absence cohort)	62*	58	80
6. Job starts (newly unemployed cohort)	18	28	60

Base: 98-148

* Indicates where the base figure for the outcome is less than 100 so caution should be taken with interpretation of change between cohorts.

Note: Cohort is based on the month the participant entered the programme.

A technique known as logistic regression modelling can be used to test and analyse the influence of a range of factors on the likelihood that a participant has gained an employment outcome³⁹. The method and model used is explained fully in Appendix 6. Two factors are statistically significantly associated with gaining an employment outcome:

- Those whose score had improved on the SWEMWBS (wellbeing) measure from entry to discharge were 2.76 times more likely to have gained an employment outcome.
- Those whose score had improved on the PAM (health management) measure were 2.95 times more likely to have gained an employment outcome.

In contrast, those who considered themselves to have a disability were statistically less likely to have gained an employment outcome, as were those out of work on entry to the programme and accessing the Support Service.

The findings appear to **confirm the positive relationship between employment and good physical or mental health**, and to validate the dual focus of WVEH on both elements. However, the data does not indicate the direction of causality. It is not clear whether participants' health or their ability to manage their health improved because

they had gained an employment outcome, or if the improvement on these measures had helped them to secure or return to work.

Participant insights

Interviews with the participants provide more in-depth insights into employment outcomes. Findings are presented by employment status at the point of interview among four different cohorts depending on whether they are: returning to existing jobs, unemployed and not looking for work, taking up new employment, or unemployed and looking for work. The focus is on the first two of these groups as they account for the experiences of the majority

The findings below illustrate two key points. First, returning to work was a positive step for some but others raised concerns that suggest employment is not always conducive to improved health and wellbeing. Second, a notable proportion of participants were not looking for work, with some identifying medical conditions combined with fears of working during the pandemic as contributing to long-term or permanent inactivity. These examples suggest that, in some cases, WVEH is faced with a group who have *already* become significantly detached from the labour market. This **perhaps challenges the logic and assumptions of programme design that early intervention can prevent this kind of disengagement.**

Returning to existing jobs

Nearly half (14) of the 32 participants had returned to their previous job at the time of interview. All had been on medical absence, with twelve on leave for mental health issues. **For some, returning to an existing job was a positive experience.** Participants reported, respectively, feeling valued and secure in their post; or supported by sympathetic managers who, in some cases, were willing to make adjustments such as a phased return.

This in turn could have positive impacts on health and wellbeing. Participant 81 observed that changes to his work situation (e.g. turning his phone off) made on returning from medical leave left him feeling less pressured and stressed. One rare beneficiary of the pandemic (Participant 46) also noted that it allowed them to work from home, where they could manage their physical health better than in an office setting. This aligns with the wider calls from some disability charities to recognise the accessibility benefits for the disabled of working from home during the pandemic, and the need to maintain these flexible options in the longer-term⁴⁰.

For others, returning to work was a less positive experience. Several stated they had little choice about returning to the same workplace, despite it being the source of stress had originally prompted medical leave. Concerns raised about returning to work and the sustainability of jobs included:

- **A perceived lack of support from managers:** Four participants indicated they might look for a new job because they felt unsupported by management.
- **Fears that presenting health conditions might make work unsustainable:** One participant (35) with a chronic physical health condition aggravated by a history of physical labour noted his health had deteriorated and that he was considering taking medical leave again.
- **Concerns that adjustments made could be reversed:** A participant (60) working in the health sector expressed concern that her employer had indicated that agreed adjustments to work shift patterns more conducive to health could be reviewed at a later point.

- **Poor perceptions of the quality of occupational health support** where available “*You’re just a number*” (Participant 45). This is explored in more detail in Section 4.3.
- **A lack of job security due to possible relocation of an employer.**

These examples once again clearly illustrate the importance of the experiences and conditions of work in shaping health and wellbeing. They caution that a ‘positive’ employment outcome as measured by movement into work may not be experienced as such if employees feel insecure, unsupported or exposed to working conditions inimical to good health.

Not looking for work

Over a third (13) of all interviewees were neither employed nor actively looking for work at the time of interview. For a small minority, this was **presented as a positive, temporary phase to retrain for more attractive careers**. For example, Participant 67 had taken redundancy from a physically demanding, low-skilled factory job to train for a career in professional services based on advice they had sourced independently of WVEH. The realisation of possibilities for career change was considered a highly positive outcome given the stress and harassment they had experienced in their previous role. It is worth noting that this kind of progress *towards* work is not captured in the core employment outcomes targets for WVEH, although may be reflected in health and wellbeing improvements.

For others, the **decision to not look for work was less of a positive choice**, shaped instead by poor health constraining ability to secure employment. In such cases, physical or mental health improvements were often seen as a pre-requisite to returning to work. Others also noted **limited job opportunities** during the pandemic as a deterrent to looking for work: “*To be fair there wasn’t a lot of jobs out there to apply for that I could do*” (Participant 44).

Health issues sometimes aligned with concerns over returning to work during the pandemic because of **pandemic-related fears** about whether workplaces were covid-secure:

“[I] don’t feel comfortable in going to work...warehouses, they’re treated like cattle...and then with retail it’s just all the confrontation with [customers]...especially with the Covid going on, it really wouldn’t help my anxiety”
(Participant 28)

Four participants had retired at the point of interview (three on medical grounds), with all indicating that a combination of medical vulnerability and the pandemic had accelerated this decision, as the following example illustrates:

“It seemed now almost like a god given opportunity to finish me off now... I kind of ran for cover and I think that’s what I’ve done”. (Participant 37)

In some cases, perceptions of limited job prospects had also been a contributing factor to withdraw from the labour market into long-term or permanent economic inactivity.

Looking for work

Three participants were on out-of-work benefits and looking for work. Two noted that finding work was particularly challenging due to competition from higher numbers of jobseekers during the pandemic as well as, in one case, the difficulty in finding work in which they could manage their disability.

Taking up new employment

Only two interviewees had secured new jobs at the point of interview. One of these participants described it as a highly positive change after an extended period of medical absence from her previous administrative role due to workplace bullying and hostility. She briefly returned to her old job before taking up a new role in a similar occupation that significantly improved her wellbeing:

“But to be honest yes, it has improved a lot, like I said, to be honest once I’d got in my new job I was right, I was happy”. (Participant 20)

WWEH Impact

Additionality

Qualitative impact analysis provides an assessment of the level of additionality associated with employment outcomes. Analysis of 24 interviews where participants managed to secure a job outcome defined as gaining a new job or returning to work shows that:

- The **level of additionality was assessed at 39 per cent for those gaining a job outcome**. This means for every 100 participants who find, or returned to, work, 39 would not have done so without WWEH support.
- Additionality is **slightly lower for those who are in the in-work client group**. Qualitative evidence suggests this is because their outcomes are more likely to be supported by:
 - Employers making changes to their working environment or conditions; often supported by employer occupational health teams.
 - Additional support being in place to improve, or manage, a health and wellbeing condition; for example being supported by a GP or mental health service.
 - Applying the additionality ratio to the 200 participants who either found a new job or returned to an existing job suggests that **78 participants (16 per cent) were supported by WWEH to an employment outcome**. These outcomes are unlikely to have been achieved in the absence of the WWEH.

A further way of measuring additionality is to consider whether WWEH facilitated a quicker return to work for those who were in employment. 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. Only **27 per cent of the 101 respondents surveyed agreed that they had returned to quicker with programme support**. This suggests the contribution of WWEH to speed of return is limited, especially given a target of 95 per cent, although the sample remains small and more data is needed to draw firm conclusions.

Participant insights

In-depth participant interviews provide further insights into the impact of WWEH support on employment outcomes. Several participants observed that **WWEH support directly helped them move closer to, or into, employment**. In terms of moving closer to employment, a small number observed that programme interventions helped them to recognise the possibility of, and options for, a career change. One participant noted, for example, that support from a VRC as well as a CBT therapist had given them a *“completely new mindset”* that led to return to studying:

“[The VRC] was like you need to think about your skills – not, like a physical job but think about your other skills that you’ve got...before then I didn’t think there was anything I could do...but they made me realise that there was”. (Participant 76)

Another participant (78) noted WVEH support had brought them closer to work in terms of a better understanding of employment options, although the pandemic still limited their labour market opportunities.

Several participants indicated that **WVEH advice and guidance made a direct, positive impact on their ability to return to, and sustain, work**. Specific elements of support credited with making a difference included:

- **Advice on a gradual return** such as undertaking pre-return visits that helped to reduce anxieties about going back into work:

“I think if I hadn’t had Working Well, I don’t think I would have...gone back to work. [My VRC was] really comforting to talk to...encouraged me to go back to work in small stages. He said don’t let it become a place of horror and try and...see some of your colleagues before you go back. So that’s what I did...it wasn’t like a frightening place. I wouldn’t have thought of doing that”. (Participant 52)

- **Encouraging use of occupational health services** they may not otherwise have sought out, which one participant attributed to a successful and sustained return to work: *“It was the Working Well actually behind all of that, because they were the ones that guided me into doing that”. (Participant 21)*
- **Guidance and materials on how to manage relationships with colleagues and negotiate flexibilities to manage health conditions (see Box 3 below)**
- Providing the **knowledge and confidence to request adjustments such as flexible working**: *“I think it’d probably be worse [without WVEH support] because I wouldn’t have considered at the start asking about the reduced hours”. (Participant 35)*

Box 3: Support to return to work

Evie (Participant 45)

Evie took medical leave from a job in a contact centre due to long-term health mental conditions combined with the perceived monotony of the job, difficult encounters with service users and, above all, a number of issues with management, who she felt were uncaring and largely unprofessional. Evie was eligible for the WVEH Advice Service and received a number of self-help materials on managing stress and workplace conflict. At the same time, she underwent counselling following a referral by her GP.

Evie was extremely positive about the support received through WVEH which she credited with helping to identify, and provide tools to manage, workplace issues. Alongside counselling support to help her address longstanding mental health issues, Evie credited WVEH support with helping her to return to and sustain work. She experienced a significant improvement in her relationships and ability to communicate with colleagues, which has been recognised by her managers:

"This whole situation was helped a lot by the materials...how I can communicate with [colleagues] and different words to use in order to take the emotion out of what I'm trying to say...I've recently had some amazing feedback in...my appraisal reviews, where they basically said that the way that I give feedback is really professionally done. And I think that's directly due to the work sheets and stuff that she provided me with".

Kieran (Participant 80)

Kieran was working in the professional services sector and took medical leave due to a combination of poor management and workload intensification. The stress of the situation also impacted his diet and he had lost weight. His hope was that support from WWEH would enable him to better manage his emotions and enable him to deal with workplace conflict:

"I'm more emotional than logical in them sort of situations. I'm very much a cut off my nose to spite my face kind of person. So I was hoping that speaking to them, if I could get a plan together for when I go in, it would help kind of curb that side of me a bit".

The main support received from WWEH was advice on how to manage interactions with colleagues and managers at work. He rated the quality of this support as *"ten out of ten"* and credits it with helping him to return to and sustain work by showing him how to manage emotions and respond more calmly when situations arose:

"It's like a sort of comfort blanket, or a safety blanket so where...even if I get really wound up or...I think I'm going to argue with them, I could just do what [my VRC] suggested...I probably would have ended up arguing with [colleagues] and losing my job if not for Working Well help".

Cutting across these examples is a clear sense that **WWEH provided the support, advice and tools to manage often challenging transitions back into work**. In some cases, WWEH was seen as crucial to sustaining jobs once back in post.

Other participants felt, however, felt that WWEH support had **made little or no impact on prospects of returning to work**. In some cases, this was directly related to the level, or perceived quality, of support offered. One Advice Service recipient valued their one phone call as *"like talking to a mate"* (Participant 71) but felt it was insufficient to support a return to work.

Others noted **personal circumstances** such as imminent retirement or, as in the following case, the severity of health conditions made it difficult to act upon advice and guidance: *"There wasn't much they could have done because I wasn't prepared to go forward with things because I was struggling with myself"* (Participant 43).

In other cases wider **external factors appeared to be the main constraints** on positive employment outcomes. Two participants suggested the support had not increased their short-term prospects of finding work, even though useful, because of difficulties in finding employment during the pandemic.

7. Learning and recommendations

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. This section summarises how WWEH might evolve in the time remaining to address on-going challenges. It also identifies good practice and learning that could shape future commissioning and strategies around integrated health and employment provision.

7.2. Target setting and performance

The programme has consistently underperformed against key targets, particular in terms of referrals and starts. Some of this is attributable to Provider performance and the impact of the COVID-19 pandemic. However, there are also questions about the feasibility of targets agreed as well as the robustness of contingency planning around eventualities such as high turnover of key staff. Future rounds of commissioning may be able to learn from this through **undertaking a review of:**

- how targets were initially agreed at the commissioning phase between the Commissioner and Provider, and how assumptions of feasibility were reached. This could include suggestions for **developing a more robust process for 'stress testing' targets** proposed by providers which critically assesses the strength and reliability of the evidence base underpinning targets.
- how 'probable' risks such as high turnover, prolonged absence and unfilled posts could be better mitigated through stronger contingency planning. Many of the performance issues WWEH experienced can be linked back to the loss of key personnel and associated knowledge in the early design and implementation phase. One option is to **set up a central team within GMCA responsible for oversight of all major programmes** to minimise the disruption if individual programme managers change. This would also better ensure that programmes are implemented to the timetable and specification agreed at the commissioning phase. Our understanding is that this action is already being progressed by the Commissioner.
- whether **greater flexibility can be built into targets** e.g. by introducing adjustable targets, review points or stretch targets to trigger additional payments above core targets. This has to be balanced against the need to achieve value for money and ensure minimum outcomes but if calibrated correctly could discourage overbidding, reward high performance and ensure sufficient margins for the Provider.

7.3 Referrals

Referral challenges across all three pathways are well documented in both the 2020 and 2021 annual evaluation reports. Key points of learning in relation to the three pathways include:

JCP Pathway

- JCP has been an increasingly important source of referrals but the signposting process is seen to reduce the quality of referrals and limit feedback on client experience which might, in turn, encourage further referrals. Future programmes **should establish a formal referral system between JCP and providers** to raise the quality, volume and ease of referrals while making it simpler to feed client experiences back to JCP staff making referrals. The precise form and expectations of this referral pathway needs to be clearly stipulated within contract specifications at the outset.

GP Pathway

- Introducing Fit Note clinics successfully embedded GPEOs in GP practices and increased the volume and quality of referrals. This could be usefully replicated in future provision. However, there are concerns that 'bypassing' GPs in this process may have reduced opportunities to change GP cultures and practices around recognising work as a social determinant of health. The **WWEH evaluation should explore this further by comparing practices where Fit Note clinics were in place with those who continued to rely on direct GP referrals.**
- There has been increasing recognition of, and demand for, WWEH, among participating GP practices in the latter phases of the pandemic to respond to growing need among patients. This has led to requests by non-affiliated practices to be incorporated into the programme. It is too late to implement such changes, raising questions about why this has not happened already despite awareness of interest from non-participating practices for some time. A review of the reasons for this would provide valuable understanding of why the programme seemed slow to respond and missed opportunities to 'swap out' existing practices or clusters providing few referrals for those expressing greater commitment.
- Time was clearly invested in developing early relationships with CCGs but it is not clear this was sustained and harnessed to broker enduring relationships between the Provider and GP practices. Engaging partners and developing pathways is resource intensive and the **programme should review whether sufficient capacity and expertise was allocated to building and sustaining relationships with partners in primary care throughout the design, implementation and delivery phases.**

SME referrals

SME referrals have consistently been well below target since programme launch. Key learning from this process includes:

- **Reviewing the target setting process** (see also above) that assumed generating 40 per cent of referrals via this pathway was feasible, especially given wider evidence from other programmes of the challenges of engaging SMEs.
- Recognising the potential difficulties in engaging SMEs in future rounds of commissioning by **building in scope for experimental approaches**, rather than assuming that SME referrals can be achieved at scale from the outset. The current community engagement strategy being pursued by MAXIMUS to generate SME referrals in settings outside the workplace provides a useful example of how

pilot approaches might be trialled. With hindsight, WWEH could have been commissioned as a hybrid approach with the JCP and GP components managed formally in terms of performance expectations while these were relaxed for SME component assessed more in terms of process and learning.

- **Exploring successful approaches and processes from elsewhere** could provide models for more successful employment engagement in future programmes. Rochdale's approach of providing a Single Point of Access for all business enquiries and communicating all employer support (the Rochdale Offer) through a single employer engagement team was seen as effective way to limit demands on employers from multiple programmes and secure buy-in. The Access to Work programme was also noted for its 'embedded approach' where Provider staff spent time in workplaces with the consent of employers. This reduced issues with employees being unwilling to use external services or provide consent for caseworkers to contact employers for fear of reprisals.

7.4 Two tier service offer

The design of the WWEH service is premised on the assumption that a two-tier service is needed to avoid duplication and resource inefficiencies where in-work participants working for larger employers already have access to OH services. The findings presented in this report partly challenge this assumption. The lighter-touch Advice Service works well in some cases. For others, however, the offer seemed inadequate given high levels of need and the perceived inappropriateness or ineffectiveness of any OH service they can access through their employers.

Stakeholders also expressed concern that contacts with Advice Service participants were too infrequent, particularly if complex or on-going support was needed e.g. guidance on changing sectors or occupations. There was also a perceived incongruity in the newly unemployed being automatically eligible for the full Support Service while GP referrals who, by definition, had immediate health needs were often only entitled to the more limited Advice Service. The scale of information requested through the BPSA process from Advice Service participants was also seen as excessive relative to the level of support offered.

With hindsight, there is a **clear case to be made in future provision for a more tailored, client-led approach where eligibility criteria can be flexed** to ensure that participants who would benefit from the full Support Service offer are eligible, regardless of size of employer. This would also recognise that one of the perceived benefits of WWEH is independent, impartial advice *outside* of the workplaces that may be the primary sources of stress and anxiety. Alternatively, it **may be easier and fairer to offer a full service to all participants** regardless of size of employer. While this might mean fewer participants are supported overall, it will reduce dissatisfaction with service. Moreover, it eliminates the risk that participants fail to achieve health or employment outcomes they might otherwise have experienced purely because they lacked access to the full range of support or greater frequency of contact. Value for money can still be ensured by not duplicating provision where participants are accessing effective interventions through workplace OH services.

7.5 Timing and duration of support

A small number of interviewees suggested that the duration of support was too short or that the six-month limit was inflexible as it elapsed at precisely the time when support was most needed. There are inevitably resource limits to the length and intensity of support that can be provided. However, it is also important to recognise that many participants particularly value the social interaction with VRCs and the emotional support this provided, especially when also experiencing feelings of isolation

during the pandemic. For some participants, health and wellbeing improvements may be contingent on regular and sustained contact with programme staff.

Actions to make the timing and length of support more sensitive to needs could include:

- **tapering support** after six months to avoid a 'cliff edge' when support is suddenly withdrawn to the detriment of the health and wellbeing of participants. Tapering needs to be carefully calibrated, however, to ensure it does not work against the potentially empowering effects in some cases of participants taking full responsibility for health and employment as support comes to an end. There should also be a clear process to refer clients into other provision such as the Work and Health Programme after six months where appropriate and eligible to provide continuity of support.
- **enabling participants to pause support** if not needed, but then later resume the service when required. This means that the six months' worth of support could actually be delivered over a longer timeframe to be more responsive to fluctuating needs.
- **increasing the number or frequency of contacts**, especially for Advice Service participants who sometimes were critical of the lack of interaction with VRCs.

7.6 Severity of need and outcomes

There was strong evidence from interviews that some participants had severe needs or chronic health conditions that meant that they are not necessarily ready in the short-term to consider work or take up WVEH support. This perhaps **challenges the assumption that the focus of WVEH on the newly unemployed or those on medical leave would mean the programme largely supports those who are relatively close to the labour market and require a short, if potentially intensive, period of intervention to enable a return to work**. This may not always work, particularly in the case of those for whom longer-term, clinical interventions may be more appropriate.

Findings presented above suggest that WVEH may be most effective where support acts as a 'tipping point' in encouraging individuals to address a discrete need or take a particular step such as negotiating a return to work with employers. It is less effective when individuals have acute or chronic health conditions or other severe presenting needs that require sustained, intensive support.

There may be little WVEH can do in the time remaining to redesign its offer to better support this group but it provides important learning in indicating that:

- needs may be more severe and entrenched for this cohort than employment status and time since last in work suggests.
- health needs may be an immediate and urgent priority for some participants, with employment a secondary concern.
- referral agencies may need better guidance on the appropriateness of the programme for those with more severe needs.
- the initial onboarding and assessment process could be better designed to identify severe need at an earlier stage through targeted questions to enable quicker triage into clinical support or other more appropriate programmes. At the same time it has to be recognised that some clients will not disclose particular issues until they have had time to build trust and rapport with staff.
- future commissioning may well want to take these findings into account in terms of, for example, increasing the intensity and length of the support offer including

clinical provision. Some clients, for example, may need more than six months of support to return to work or more frequent access to clinical support. In addition, early intervention may mean providing support while individuals are still working but ‘wobbling’ rather than after leaving work (on medical leave or altogether) when problems may be more entrenched or escalating.

7.7 Employer practices and workplace conditions

This report provides extensive and consistent evidence that work is a social determinant in health in both a positive and, all too often, a negative sense. In many cases, health issues and presenting needs were caused or aggravated by workplace experiences and conditions as well as, sometimes, the attitudes and practices of employers. Findings also cautioned that a ‘positive’ employment outcome as measured by movement into work may not be experienced as such if employees feel insecure, unsupported or exposed to working conditions inimical to good health.

Moreover, wider research suggests that as the economy opens up there are risks that rising unemployment leads to an increase in job insecurity and poor workplace conditions as employers pursue cost containment strategies and benefit from an expanding pool of pliant labour⁴¹.

One of the original aims of WVEH was to advise and support employers on employment and health issues, helping them retain staff and better manage health in the workplace. This opportunity has been lost, however, due to low levels of SME engagement. This underscores the **need to work more closely with employers to improve practices and cultures and make workplaces more conducive to health and wellbeing**, while also seeking to raise the quality of employment across Greater Manchester. Specific learning and recommendations that might inform the design and delivery of future commissioning and strategic frameworks include:

- Embed a **stronger advocacy element** within programmes including, potentially, in-house or commissioned legal advice to give participants the knowledge and confidence to negotiate a return to work and deal with employers reluctant to make adjustments.
- Provide **more focused support to enable employees to change jobs** where employers or workplaces are clearly a contributing factor to health conditions.
- Develop a clear programme of activity to **work with employers to improve support for employees with health conditions** and raise awareness of cultures and practices that are beneficial to staff wellbeing. Existing strategic frameworks (e.g. the *Thriving at Work* review⁴²) should guide such activity.
- Ensure that monitoring and evaluation systems are **capable of capturing experiences of employment after returning to work** so that employment outcomes are not automatically assumed to be positive. A measure of job satisfaction alongside customer satisfaction in post-support surveys would enable this.
- **On-going, in work support** may be essential to ensure that any participants can be supported to address any challenges that emerge or resurface in workplaces on returning to work.
- More broadly, it indicates a **need at a strategic level to pursue policies and strategies which support a ‘good work’ agenda**. The Greater Manchester Good Employment Charter is an example of this. This aligns with broader ambitions in the Improving Lives white paper⁴³ to create healthy workplaces where people thrive and progress. The recent ‘Build Back Fairer’⁴⁴ strategy also outlines a series of measures that could drive up job quality in Greater Manchester

such as a quality of work guarantee which extends commitments in the Good Employment Charter and is publicly available for each employer.

There may be limits to the extent that an employment and health programme can engage with, and change practices among, employers. This may be better addressed through alternative, dedicated business support provision. At the same, integrating different programmes including work and health support into a single, clearly communicated employer 'offer' delivered by one employment engagement team may increase buy-in from, and leverage with, employers. This in turn could serve to change cultures, practices and workplace support for employees with health conditions.

7.8 Employability support

There was widespread concern among stakeholders that the WWEH programme did not include sufficient employability provision or dedicated staff with employment coaching skills. This may explain lower than expected return to work outcomes, particularly in terms of newly unemployed participants finding work. The on-going delay in launching the online Employment Hub is also seen as a key gap in the current offer.

A key point of learning is to **ensure that any future work and health provision has clearly put in place appropriate provision and a specialist team to cover both health and employment needs**. Ideally, this could include a range of specialist staff alongside caseworkers able to respond to specific needs around health and wellbeing (e.g. mental and physical health practitioners), occupational health, employment law, and employment coaching. Programmes such as Be Well provide a model for how employment coaches can be incorporated into frontline teams.

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:

1. I have an excellent housing situation, this is a strength.
2. I have a good housing situation and I only rarely have problems.
3. I have a good housing situation but I still need regular support.
4. I have an ok housing situation but I still need support to improve.
5. I have an ok housing situation but I need a lot of support to improve.
6. I don't have a good housing situation and I want to improve but don't know how.
7. 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

Appendix 3: The WWEH Support 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>HealthWorks Online</i> which currently hosts 550 self-help articles, videos and podcasts covering 27 topics of health/wellbeing (e.g. anxiety, health 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, advice on requesting flexible working hours/patterns, coping strategies)

Appendix 4: Interim qualitative assessment of additionality

1) Introduction

The evaluation of WWEH aims for a rigorous and robust assessment of impact: the outcomes achieved by participants over and above what changes are likely to have occurred in its absence. This is known as the additionality of WWEH. An impact development study, undertaken during the first year of the evaluation, considered different approach to assess the additionality of the WWEH programme. This study sought to balance the needs of the key stakeholders while being sympathetic to practical, logistic and resource constraints. As an outcome of the study a contribution analysis approach was agreed which triangulates evidence between the following sources:

- Evaluation team assessment of additionality based on reviewing in-depth interview data.
- Bespoke 'additionality' questions within the monitoring data collected from WWEH beneficiaries.
- Experimental analysis comparing WWEH participants against a small number of respondents to the Labour Force Survey Five Quarters Panel.

This note focuses on the first of these methods. It briefly summarises the method used by the evaluation team and then provides an interim assessment of additionality based on 38 in-depth interviews undertaken between January 2020 and April 2021.

2) A summary of the method

The qualitative assessment of additionality based on in-depth interviews comprises three aspects:

- **Specific impact and additionality focused questions that are asked during the in-depth interviews with participants.** These questions cover the outcomes participants achieved, the types of support that they received through WWEH or were signposted to by the programme, alternative types of support being received, and the relative contribution of support that they received to outcomes.
- **A WWEH impact evaluation proforma** (see Appendix 5 below) is completed during analysis of interview transcripts which collates evidence to inform an assessment of additionality. This includes outcomes achieved, WWEH and non-WWEH support received and its relative contribution to outcomes. It also captures key information to understand variation in additionality across factors such as, age, area, route into WWEH, initial employment status, and health and employability aspects to address.
- Using the interview evidence, **a three-person review panel make an independent assessment** of the level of additionality provided by WWEH across the theme outcomes achieved by the beneficiary. The panel assess to what extent the outcomes would have been achieved without WWEH and how important WWEH interventions were to the given outcome over and above the influence of other factors, interventions, or changes.

The result is an additionality ratio that can be applied to convert gross to net additional outcomes attributable to WWEH.

It is important to reflect on the scale of additionality typically identified through qualitative methods. A review contained in the Government's 2014 Additionality Guide⁴⁵ suggests levels of additionality between 40 and 50 per cent for the following types of project: 'people trained obtaining jobs' and 'people trained obtaining jobs, who were formerly unemployed.' Given the nature of the WWEH client group it is realistic to expect a slightly lower level of additionality: between 35 per cent and 45 per cent.

3) Interim assessment of additionality

This section provides an interim assessment of additionality based on 38 in-depth participant interviews undertaken between January 2020 and April 2021. Of the 38 interviewees, 13 were unemployed on entry to WWEH, so are likely to have required support with job search, as well as intervention to promote their health and wellbeing. Focusing on outcomes achieved:

- 24 participants managed to secure a job outcome: defined as gaining a new job or returning to work.
- Separately, 20 participants indicated a health and wellbeing outcome: defined as improved health and wellbeing or better management of a health condition.

Thirty-eight is an adequate number of interviews on which to base a qualitative assessment of additionality. However the assessment below is based on only 24 participants who managed to secure a job outcome and, separately, 20 who indicated improved health and wellbeing, or management of a condition. This number limits the robustness of the estimated level of additionality and the reliability of comparisons between different factors. For example, differences in additionality between participants who were initially in, or out of, work.

The analysis identified **no instances where the work or health and wellbeing outcomes achieved by participants can be fully attributed to WWEH**. This should be expected. It means in all cases participants achieving outcomes were assisted by other factors as well as WWEH. These other factors include:

- Support and intervention for health and wellbeing conditions provided by GPs and other providers such as Healthy Minds.
- Job search and employability support provided by Jobcentre Plus and other specialist providers.
- Support, flexibility and adaptations provided by employers.
- Help, support and signposting provided by family and friends.
- The circumstances, experiences, and capabilities of the participant; for example, financial necessity was cited as a key determinant in one interview.
- The participant's physical or mental health situation improving enabling a return to work.

Overall, the **level of additionality was assessed at 39 per cent for those gaining a job outcome**. This means for every 100 participants who found, or returned to, work, 39 would not have done so without WWEH support. Putting this into context the appraised percentage is at the mid-level of additionality suggested for similar types of interventions in the previous section.

Bearing in mind limits in the reliability of comparisons by sub-groups, it appears that additionality is slightly lower for those who are in the in-work client group. The qualitative evidence suggests this is because their outcomes are more likely to be supported by:

- employers making changes to their working environment or conditions; often supported by employer occupational health teams.
- additional support being in place to improve, or manage, a health and wellbeing condition; for example support provided by a GP or mental health service.
- health conditions improving naturally over time.

The assessed level of additionality was higher for participants who achieved a health or wellbeing outcome: 53 per cent. This means for every 100 participants whose health or wellbeing, or management of a condition, improved, 53 would not have done so without WWEH support.

Again, there are limits to the reliability of a comparison based on 20 interviews. However there appears to be strong evidence that additionality is higher for those who report improved mental health and wellbeing, compared to those whose physical health, or management of a physical health condition, improved. More detailed analysis suggests this is due to:

- the relative ability of WWEH to address physical health conditions compared to mental health or wellbeing conditions.
- the greater dependence on other, often existing, forms of support required to affect physical health outcomes. These often include GPs and specialist health condition support services.

4) Summary

This note has provided an interim assessment of additionality based on 38 interviews conducted between January 2020 and April 2021.

Based on the interview evidence the analysis estimates:

- 39 per cent of job outcomes were additional: they would not have been achieved without WWEH.
- 53 per cent of participants who achieved a health or wellbeing outcome would not have done so without WWEH.

These levels of additionality for the WWEH programme lie at the mid-range of what might be expected based on qualitative assessments of similar types of intervention.

The number of interviews underpinning the analysis limits the reliability and rigor of comparisons between sub-groups. However exploratory analysis identified:

- Additionality is slightly lower for those who are in the in-work client group compared to those who were newly unemployed.
- There is strong evidence that additionality is higher for those who report improved mental health and wellbeing, compared to those whose physical health, or management of physical health condition, improved.

Appendix 5: WWEH impact evaluation proforma

During analysis of each interview transcript please provide a brief summary under each of the following headings to inform an assessment of impact:

- Question 1: Key socio-demographic characteristics: e.g. age, gender, ethnicity, SOC, LA
- Question 2: Entry route into WWEH
- Question 3: Key health and employability aspects to address
- Question 4: Employment and health outcomes achieved: e.g. job, sustained job, job readiness, improved health/perception of health, able to manage health condition.
- Question 5: What has been the contribution of WWEH support to these outcomes (what did they receive, what worked well and had the biggest impact?)
- Question 6: Contribution of non-WWEH support to these outcomes (What other support did they receive, what difference has this made, how important has this been relative to WWEH support?)
- Question 7: Overall assessment of impact.

To what extent have the outcomes occurred because of WWEH activities?

Level	Description	Reason
None	WWEH activities did not contribute at all to the outcomes	
Very low	WWEH activities were only a minor reason behind the outcomes	
Low	WWEH activities contribute one of a number of main reasons behind the outcomes	
Medium	WWEH activities contributed about half of the reason for the outcomes	
High	WWEH activities were a substantial reason for the outcomes	
Total	The outcomes occurred solely due to WWEH activities	

In the absence of WVEH activities how likely is it that the respondent would have achieved their outcomes by the point of interview?

Level	Description	Reason
None	Not at all	
Very low	A very small likelihood	
Low	A small likelihood	
Medium	About a 50/50 likelihood	
High	A good likelihood	
Total	Certain that they would have achieved the outcomes	

Appendix 6: Logistic regression analysis

Logistic regression modelling⁴⁶ has been used to test and analyse the influence of a range of factors on the likelihood that a participant has gained an employment outcome⁴⁷.

As the number of participants completing discharge assessments is still relatively low, the analysis in this section should be seen as exploratory at this stage. A more detailed assessment will be made in the final report.

The following factors were included in the modelling:

- Locality
- Type of support provided and employment status
- Number of interventions provided or advised
- Provided or advised CBT
- Age
- Gender
- Ethnicity
- In the category of most need on the combined measure of need
- Indicated mental health issue as primary condition (either anxiety or depression low mood)
- Participant considers themselves to be disabled
- Participant has caring responsibilities
- Positive change in wellbeing on SWEMWBS from entry to discharge
- Positive change in ability to manage health condition or disability on PAM from entry to discharge

Table A1 shows that there were two factors statistically associated with gaining an employment outcome. Those whose score had improved on the SWEMWBS measure from entry to discharge were statistically more likely to have gained an employment outcome as were those whose score had improved on the PAM measure. In contrast, those who considered themselves to have a disability were statistically less likely to have gained an employment outcome, as were those out of work on entry to the programme and accessing the Support Service.

Table A1: Factors which explain employment outcomes

Results of logistic regression					
Included	B (SE)	P	95% CI for Odds Ratio		
			Lower	Odds ratio	Higher
Constant	0.11 (0.94)			1.12	
Positive change in ability to manage health condition or disability on PAM from entry to discharge	1.08 (0.37)	0.00	1.44	2.95	6.07
Positive change in wellbeing on SWEMWBS from entry to discharge	1.01 (0.39)	0.01	1.28	2.76	5.96
Participant considers themselves to be disabled	-1.02 (0.37)	0.01	0.17	0.36	0.74
Out of work on entry and accessing the Support Service	-2.41 (0.64)	0.00	0.03	0.09	0.31

To a large extent the modelling produces findings which might be expected. The significant factors correspond to what we know about the positive relationship between employment and good physical or mental health. What is not clear though is whether participants' health and their ability to manage their health improved because they had gained an employment outcome, or if the improvement on these measures had helped them to secure or return to work.

Further logistic regression modelling was also undertaken to test the factors associated with recording an improvement on the SWEMWBS and PAM health measures. The same range of factors listed above were used, except the two health measures were excluded and if a participant had gained an employment outcome was included instead⁴⁸.

There was only one factor statistically associated with positive change in wellbeing on SWEMWBS from entry to discharge and this was securing an employment outcome (Table A2). Similarly, the only factor statistically associated with positive change in ability to manage health condition or disability on PAM from entry to discharge was gaining an employment outcome (Table A3). Again, these findings point to the positive relationship between employment and health, although it remains unclear from this analysis whether an improvement on the health measures came before an employment outcome was achieved or after.

Table A2: Factors which explain change in wellbeing on SWEMWBS

Results of logistic regression					
			95% CI for Odds Ratio		
Included	B (SE)	P	Lower	Odds ratio	Higher
Constant	-0.53 (0.85)			0.59	
Gained employment outcome	1.26 (0.36)	0.00	1.73	3.52	7.18

Table A3: Factors which explain change in ability to manage health condition or disability on PAM

Results of logistic regression					
			95% CI for Odds Ratio		
Included	B (SE)	P	Lower	Odds ratio	Higher
Constant	-0.97 (0.83)			0.38	
Gained employment outcome	1.30 (0.35)	0.00	1.84	3.66	7.27

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¹ For the first annual evaluation report see CRESR (2020) *Working Well Early Help: Annual report 2020*. <https://www4.shu.ac.uk/research/cresr/sites/shu.ac.uk/files/working-well-early-help-annual-report-2020.pdf>

² 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/>

³ The 10 local authority areas in Greater Manchester comprise Bolton, Bury, Manchester, Oldham, Rochdale, Salford, Stockport, Tameside, Trafford, Wigan.

⁴ 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>

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⁶ 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

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⁸ 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> 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>; Greater Manchester Independent Prosperity Review (2019) Reviewers' Report https://www.greatermanchester-ca.gov.uk/media/1826/gmis_reviewersreport_final_digital.pdf HM Government (2019) *Greater Manchester Local Industrial Strategy*, June 2019. <https://www.greatermanchester-ca.gov.uk/media/2132/gm-local-industrial-strategy-web.pdf> 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/gtr_mcr_model1_web.pdf

⁹ CRESR (2020) *op cit*.

¹⁰ Greater Manchester Combined Authority (2020) *Greater Manchester Living with Covid Resilience Plan*. <https://www.greatermanchester-ca.gov.uk/news/greater-manchester-living-with-covid-resilience-plan-published/>

¹¹ Taken from the following ONS bulletins:

<https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/bulletins/uklabourmarket/may2021#main-points>;

<https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/bulletins/jobsandvacanciesintheuk/latest>;

<https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/bulletins/employmentintheuk/latest#unemployment>;

<https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/bulletins/earningsandemploymentfrompayasyouearnrealtimeinformationuk/latest>

¹² OBR bulletin: <https://obr.uk/efo/economic-and-fiscal-outlook-march-2021/>

¹³ ONS bulletin:

<https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/bulletins/uklabourmarket/may2021#main-points>

¹⁴ Resolution Foundation (2021) *Low Pay Britain 2021*

<https://www.resolutionfoundation.org/app/uploads/2021/06/Low-Pay-Britain-2021.pdf>

¹⁵ <https://www.resolutionfoundation.org/press-releases/recent-education-leavers-and-young-black-workers-hardest-hit-by-covid-19-job-shock/>

¹⁶ <https://www.tuc.org.uk/research-analysis/reports/jobs-and-recovery-monitor-bme-workers>

¹⁷ GMCA (2021) *Labour Market Update – 18.5.2021* [unpublished]; *GMCA Economic Resilience Dashboard*. For definitions and data sources see:

https://www.gmtableau.nhs.uk/t/GMCA/views/GMEconomicResilienceDashboard/Definitions/jack.james@greatermanchester-ca.gov.uk/b7906092-2ef4-46a2-837e-6c00e7ef6284?%3Adisplay_count=n&%3Adisplay_count=no&%3AshowVizHome=n&%3AshowVizHome=no&%3Aorigin=viz_share_link&%3Aorigin=viz_share_link&%3AisGuestRedirectFromVizportal=y

[&%3Aembed=y%3FframeSizedToWindow&%3Aembed=y&%3AshowAppBanner=false](#); UK employment rates in last two quarters taken from ONS (2021) *Labour market in the regions in the UK: May 2021*.

<https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/bulletins/regionallabourmarket/latest>

¹⁸Institute of Health Equity (2021, p8) *Build back fairer in Greater Manchester: Health Equity and Dignified Lives*. <https://www.instituteoftheequity.org/resources-reports/build-back-fairer-in-greater-manchester-health-equity-and-dignified-lives/build-back-fairer-in-greater-manchester-main-report.pdf>

¹⁹ Fit Notes are issued by GPs to provide evidence of the advice they have given about their fitness for work.

²⁰ While most JCP referrals are newly unemployed a small number are in work. In-work JCP signposts tend to be reallocated by the Provider to the Employer pathway for monitoring purposes to reflect their employment status. Since 1st December 2020, 86 per cent (227 individuals) of all Employer referrals were originally sourced through JCP but subsequently reallocated to the Employer pathway. Direct engagement with Employers is therefore much more limited than the referral data suggests.

²¹ CRESR (2020) *op cit*.

²² JETS (Job Entry Targeted Support) is delivered through JCP offices and targets the recently unemployed (people who have been out of work and claiming either Universal Credit or New Style Jobseeker's Allowance for at least 13 weeks). <https://jobhelp.campaign.gov.uk/jets/>; the Kickstart Scheme provides funding to employers to create jobs for 16 to 24 year olds on Universal Credit. <https://www.gov.uk/government/collections/kickstart-scheme>; Restart will launch in April 2021 and target the longer-term unemployed (Universal Credit claimants who have been out of work for at least 12 months). <https://www.gov.uk/government/publications/restart-scheme/how-the-restart-scheme-will-work>; the Working Well Work and Health programme supports the long term unemployed and disabled people into sustainable employment across the city-region across Greater Manchester. <https://www.greatermanchester-ca.gov.uk/what-we-do/work-and-skills/working-well/>

²³ The impacts of COVID-19 on mental health are illustrated in wider analysis, with recent ONS data showing that impacts are worsening over the course of the pandemic. A round 1 in 5 (21 per cent) adults experienced some form of depression in early 2021 (27 January to 7 March); this is an increase since November 2020 (19 per cent) and more than double that observed before the coronavirus (COVID-19) pandemic (10 per cent).

²⁴ Department for Work and Pensions (DWP) and Department of Health and Social Care (DHSC) (2017b) *op cit*; The Mental Health Taskforce (2016) *The Five Year Forward View for Mental Health*. <https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf>; NHS (2019) *NHS Long Term Plan*. <https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf>; NHS England (2016) *General Practice Forward View*. <https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf>; Public Health England (2017) *Health profile for England: 2017*. <https://www.gov.uk/government/publications/health-profile-for-england>

²⁵ Institute of Health Equity (2021), *op cit*.

²⁶ 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%20and%20The%20Marmot%20Review%2010%20Years%20On_full%20report.pdf

²⁷ 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.

²⁸ Health and Safety Executive (2020) *Work-related stress, anxiety or depression statistics in Great Britain, 2020*. <https://www.hse.gov.uk/statistics/causdis/stress.pdf>

²⁹ Health and Safety Executive (2012) reported in Buck, D. and Gregory, S. (2013), *op. cit*.

³⁰ The Health Foundation (2021) *Mental Health and Unemployment: Why both require action for our COVID-19 recovery* <https://www.health.org.uk/publications/long-reads/unemployment-and-mental-health>. Figures are based on Health Foundation analysis of the Household Longitudinal Survey.

³¹ House of Commons Health and Social Care Committee (2021) *Workforce burnout and resilience in the NHS and social care*.

<https://committees.parliament.uk/publications/6158/documents/68766/default/>

³²

<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/>

coronaviruscovid19relateddeathsbyoccupationenglandandwales/deathsregisteredbetween9marchand28december2020

³³ DWP and DHSC (2017a), *op cit*.

³⁴ Institute of Health Equity (2021), *op cit*.

³⁵ CRESR (2020), *op cit*.

³⁶ Short Warwick Edinburgh Mental Well-Being Scale (SWEMWBS) © NHS Health Scotland, University of Warwick and University of Edinburgh, 2008, all rights reserved.

³⁷ <https://19//warwick.ac.uk/fac/sci/med/research/platform/wemwbs/using/howto/>

³⁸ Caseness is defined as a score of 7 and above for GAD7 and 9 and above for PHQ9. <https://www.oxfordhealth.nhs.uk/healthyminds/professionals/referral/diagnostic-criteria/>

³⁹ Either returning to work (sickness absence cohort) or starting work (newly unemployed cohort).

⁴⁰ See for example Leonard Cheshire (2020) *Policy briefing: Employment and Covid-19*. <https://www.leonardcheshire.org/sites/default/files/2020-04/Employment-Coronavirus-policy-briefing.pdf>

⁴¹ Resolution Foundation (2021), *op cit*.

⁴² Department for Work and Pensions (DWP) and Department of Health and Social Care (DHSC) (2017b), *op cit*.

⁴³ DWP and DHSC (2017a), *op cit*.

⁴⁴ Institution of Health Equity (2021), *op cit*.

⁴⁵ Homes and Communities Agency (2014) *Additionality Guide*.

<https://www.gov.uk/government/publications/additionality-guide>

⁴⁶ Enter method was utilised – this method adds explanatory variables to the model in a single step. Models were run both with and without the SWEMWBS and PAM measures. The results displayed in the table below are from the initial model run with the health measures (there were no further significant variables identified in the models run excluding these measures).

⁴⁷ Either returning to work (sickness absence cohort) or starting work (newly unemployed cohort).

⁴⁸ Enter method was utilised – this method adds explanatory variables to the model in a single step. Models were run both with and without the employment outcome measure. The results displayed in the tables below are from the initial models run with the employment measure (there were no further significant variables identified in the models run excluding this measure).