

Working Well Early Help Annual Report 2022



Working Well Early Help: Final Annual Report 2022

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Acronyms

BPSA	Biopsychosocial assessment
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CMON	Combined Measure of Need
EPN	Expert Practitioner Network
GPEO	GP Engagement Officer
JCP	Jobcentre Plus
MSK	Musculoskeletal
PEC	Partnership Engagement Consultant
RTWP	Return to Work Plan
SME	Small and Medium Enterprises
VRC	Vocational Rehabilitation Caseworker
WWEH	Working Well Early Help

Executive Summary

Working Well Early Help: a final view

Working Well Early Help (WWEH) is a three-year long **early intervention programme** available to residents in all ten local authority areas in Greater Manchester. It seeks to support a return to sustained employment for individuals with a health condition or disability who have either become newly unemployed within the last six months or taken medical leave from an existing job. It launched in March 2019 and the final participant was discharged in March 2022.

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. It was designed on launch to predominantly support employees on medical leave who worked for small or medium-sized enterprises (SMEs). However, the outbreak of the COVID-19 pandemic led to **a strategic decision to accept a significantly higher proportion of newly unemployed participants** than originally planned to support efforts to minimise negative labour market impacts.

This is the **third and final annual report of the WWEH evaluation**. Drawing on programme monitoring data and interviews with participants and stakeholders across the three year duration of WWEH, it highlights **a range of positive outcomes, particularly in relation to health and wellbeing**. Feedback from participants interviewed was overwhelmingly positive, with the vast majority highlighting the benefits of empathetic, personalised and expert support from the Provider team. It vindicates the biopsychosocial model underpinning WWEH in demonstrating the value of addressing health and wellbeing issues as the precursor to a return to work.

In terms of core outcomes, **the programme either achieved or nearly reached most health and wellbeing targets**. One reason it may have just fallen short of some targets is the decision to accept more newly unemployed participants. This group tend to have higher levels of need and require more support to return to work than those on medical leave. This presents a challenge for a programme whose core model was designed before the pandemic and intended to focus mainly on supporting those on medical leave to go back into work.

Job outcome targets were missed by a small margin in terms of supporting those on medical leave to return to work, although job starts for the newly unemployed fell far shorter of targets. However, this has to be set against the significant challenge of supporting participants to return to work during the COVID-19 pandemic. Where positive job outcomes were achieved, an assessment of impact – the difference WWEH made over and above what would have happened anyway – suggests the programme has a higher level of additionality than many other employment programmes.

WWEH faced a **number of performance challenges**¹ in terms of shortfalls against targets for referrals and starts, particularly in relation to the SME pathway. This limits the ability of the programme to provide insights into the potential for integrated health and employment support to change the landscape of support for SME employees with health conditions and disabilities.

At the same time, **WWEH developed effective relationships and referral pathways with some GP practices and Jobcentre Plus (JCP) offices** which illustrates the benefits of wider partnership around the work as a health outcome agenda. Shortfalls in referrals and starts must also be set against the challenging backdrop of the

pandemic which severely disrupted the operation of all three sources of referrals: GP practices, JCP offices and SMEs.

Despite these challenges, there remains **a strong appetite among stakeholders in Greater Manchester to commission further provision** to test and develop integrated health and employment models. Most felt that WWEH coming to an end would **leave a gap in upstream support** for employees on medical leave that needed to be filled.

Key findings

Referrals and starts

- Meeting targets for referrals and starts proved challenging throughout the programme with WWEH achieving just over three fifths (63 percent) of the target for referrals and one third (34 per cent) of the target for starts. This must be set in the difficult context of delivery during the COVID-19 pandemic for two of the three years for which the programme was in operation. GP practices, for example, had to prioritise the immediate response to the pandemic and later rollout of the vaccination programme.
- Despite underperformance, referral and start volumes during the pandemic exceeded pre-pandemic levels. This is likely to reflect some combination of: referral pathways becoming more established and provider engagement activities proving more effective; increasing demand due to increases in unemployment or health issues during the pandemic; and the impact of lifting the cap on JCP referrals.
- JCP became the dominant referral pathway following the strategic decision to refocus activities towards supporting the newly unemployed, generating half (49 per cent) of all referrals. One consequence is that the programme saw a broadly even split between in-work (53 per cent) and out-of-work (47 per cent) starts. This clearly indicates how WWEH moved away from its initial intention to focus on supporting those in work but on medical leave.
- The majority of JCP referrals failed to 'convert' to starts. This may be due to lower quality referrals by newly recruited JCP staff during the pandemic, the lack of a formal referral pathway, and a tendency of JCP referrals to disengage from WWEH when they realise participation is not mandatory.
- Employer (SME) starts remained consistently below target throughout the programme, accounting for only 15 per cent of starts against a target of 40 per cent. Moreover, around half of those SME starts (46.4 per cent) were sourced through Jobcentre Plus rather than directly through engagement with SMEs and their employees².

Profile and needs

- Health issues featured prominently in terms of presenting needs and barriers to work reported by participants. By contrast fewer participants reported employability issues as a need although a lack of relevant workplace experience was sometimes noted in interviews. This may reflect the fact that those on medical leave were already in employment while the newly unemployed by definition had recent work experience.
- Mental health issues are particularly prevalent: 59 per cent of all participants report at least one mental health condition compared with 37 per cent who experience a physical health condition. 'Health management' was also by far the most common barrier to work reported.

- Compared with all participants, younger participants were *more* likely to experience issues with mental ill health or lower wellbeing while older participants were *less* likely.
- In many cases, presenting health issues were the primary factor contributing to withdrawal from work or perceived difficulties in returning to employment. However, experiences of work were often a further contributing factor to poor health in terms of: overwork, bullying or harassment, difficult or dangerous working conditions, job insecurity, lack of support from managers, and perceived employer discrimination on the basis of ill health.
- Other barriers to work included age-related factors (poor health, lack of IT skills), discrimination based on ethnicity, bereavement, caring responsibilities, and relationship issues. COVID-related issues were notably less prevalent than reported in previous annual reports.

WWEH support

- Participant interviews indicate that the priority for many when joining WWEH is to access support for a physical or, more commonly, mental health condition. Employment is not always seen as an immediate priority, particularly for older participants and those whose health conditions are considered to be extremely limiting in terms of work.
- Customer satisfaction data shows that the majority (69 per cent) of those receiving the Support Service are satisfied with support compared with less than half (46 per cent) of those receiving the Advice Service. Past findings suggest lower levels of satisfaction among Advice Service recipients may be accounted for by disappointment once referred that they are only eligible for the lighter touch Advice Service.
- The majority of participants interviewed were very positive about their experiences of the WWEH programme and valued a range of elements of the offer including: emotional and practical support provided by frontline staff; the non-discriminatory approach; help in understanding health issues; holistic support to address the full range of presenting needs; the ease and speed of access to a range of specialist support; and impartial, external advice on returning to work. A far smaller number of participants were more equivocal or, in some cases, negative about the service. In most instances, this was more about the lack of relevance or appropriateness of support given their circumstances than service quality.
- The two main suggestions for improving WWEH's delivery model were opportunities for face-to-face contact and extending the duration of support. The latter is testament to the value of support provided insofar as it shows participants did not want engagement to end after six months.

Outcomes and impact: health

- Presenting needs data and health assessments show consistent improvement in health and wellbeing outcomes for participants between joining and leaving the programme. 'Health' and 'Coping and confidence' are the needs where the most positive change is seen by the point of discharge.
- In-work participants referred via the GP pathway consistently experience better health and wellbeing outcomes than JCP or SME referrals. One clear implication is that the refocus of WWEH towards out-of-work JCP referrals as a strategic response to the pandemic has had the effect of depressing overall performance. JCP clients have higher levels of need and are further from the labour market which may limit the extent of positive outcomes.

- Health and wellbeing outcomes tend to be better for participants who have moderate levels of anxiety or depression. This indicates there may be a 'sweet spot' in terms of positive change relative to severity of mental health conditions.
- The assessed level of additionality for participants who achieved a health or wellbeing outcome is between 43 and 51 per cent. This means for every 100 participants whose health or wellbeing, or management of a condition, improved, between 43 and 51 would not have done so if it were not because of WWEH.
- By far the majority of interviewees reported positive health and wellbeing improvements. Elements of support contributing to change included: fast-track access to physiotherapy and CBT; the empathetic, non-judgemental and listening approach of frontline staff; practical tools and techniques to self-manage health conditions; and signposting or referral into other valued support.
- For a smaller number of interviewees, WWEH support seemed to have limited impact on health and wellbeing. In some cases this was ascribed this to the ineffectiveness or inappropriateness of support, particularly where health conditions were more severe.

Outcomes and impact: employment

- Just over a third (38 per cent) of all participants experienced a positive employment outcome by the point of discharge. Evidence suggests WWEH is more effective in supporting health and wellbeing than employment outcomes.
- Impact analysis assessed the level of additionality for participants who achieved a job outcome as between 33 and 38 per cent. This means for every 100 participants who found, or returned to, work, between 33 and 38 would not have done so without WWEH support. This is above the level of impact that studies have attributed to a range of other employment programmes.
- Interviewees who were not looking for work tended to be older which is likely to reflect health conditions and the challenge of transitioning into new jobs in the latter stages of working life.
- A number of interviewees who were looking for work reported benefits from WWEH support including: increased confidence and motivation in job search; greater awareness of employment options; better understanding of entitlements to request adjustments; and recognition of the need to take gradual steps to return to work.
- Those had returned to existing jobs or taken up new employment often suggested WWEH had contributed to this through some combination of: offering advice on a gradual return; encouraging use of workplace occupational health services; enabling better self-management of health conditions; designing a structured Return to work Plan; providing the knowledge and assertiveness to articulate needs to employers; and strengthening resolve to leave harmful jobs.
- Those who returned to work often reported positive health and wellbeing impacts. These benefits were sometimes realised through a change of employer, occupation or sector where previous jobs had been a source of negative mental health or wellbeing. This highlights the importance of support to switch, or find new, jobs as part of integrated health and employment provision.

Examples of positive health and employment outcomes for participants are shown in the case studies of Zoe and Michael below:

Positive health and employment outcomes – Zoe and Michael’s experience

Zoe’s story

Zoe described how the support of WWEH helped “*massively*” with her health and wellbeing and also to break the cycle of a succession of short-term, unsatisfying jobs since leaving school.

After a course of Cognitive Behavioural Therapy (CBT), Zoe got a job as a support worker for a charity which she was still undertaking at the time of interview. She attributes this to WWEH support in helping her recognise that she had a mental health condition and the type of work that would be most appropriate for her.

Gaining a better understanding of her needs and building her confidence not only helped Zoe find and sustain work but also to secure better quality employment. This ended the cycle of unsatisfying temporary jobs that had previously marked her employment history:

“This is the longest job I’ve had since I was 19...I would never have gone into this role without their support...It just like put me on the path of how I could actually move forward, it was kind of like a life coach...I will be forever grateful, they were so great”.

Michael’s story

Michael was referred to WWEH by his GP. He was unemployed at the time and had severe mental health issues having left his previous job in the ICT sector following a lack of support from his employer for a serious health condition. He now wanted to change his career and study towards a professional qualification.

Michael was effusive about the CBT he had received through the project, describing it as “*brilliant*”. By the time WWEH support came to an end, he felt much more relaxed and confident about returning to work. At the point of the evaluation interview, he had recently started work at a financial institution and was full of praise for their supportive attitude to someone with a disability.

Partnership and integration

- JCP was a key partner for referrals with support often dependent on good working relationships between JCP staff and Partnership Engagement Consultants (PECs). Partnership also worked well where PECs were co-located within local authority business support teams.
- Local Leads played an important role in supporting integration by promoting WWEH; brokering access to organisations; enabling triage and referrals between services; and co-ordinating meetings. However, there were concerns about the capacity of Local Leads to support integration activities, as well as misalignment between WWEH and local authority employment and business support structures and processes.
- Wider partnerships were also important in sourcing referrals and identifying signposting opportunities. Nonetheless, it was not always clear that the Programme has been able to maximise opportunities to integrate within wider structures in the GM ecosystem. One key issue was that the remote, telephone-

based delivery model of WWEH did not fit well with holistic and place-based hubs being developed in Localities.

- Local Integration Boards (LIBs) were seen to play a useful role in fostering networks; increasing mutual understanding of organisational practices; facilitating referrals; and identifying signposting opportunities. However, their potential has been significantly constrained by the lack of meetings held during the pandemic.
- Engagement with health partners helped to generate referrals and WWEH filled a gap in the health ecosystem for provision that supported the 'work as a health outcome' agenda. However, there were significant challenges in integrating WWEH within the health system, particularly in terms of:
 - a lack of buy-in from health commissioners and practitioners from Clinical Commissioning Groups (CCGs) and Public Health teams.
 - a preference for GPs to refer into longer-term, more holistic, single gateway social prescribing provision which WWEH was not integrated into.
 - the negative impact of the COVID-19 pandemic on integrated working.
- There was some tentative evidence of systems change in terms of some GPs embracing the work as a health outcome agenda, and Fit Note clinics illustrating how this could be embedded in practice systems. At the same time, systems change was constrained by demands on GP time; the short-term goals of the programme in terms of generating referrals; and the time-limited nature of WWEH.

Recommendations

Good practice and learning from the evaluation of WWEH supports a number of recommendations for any future commissioned work and health provision:

Referrals

- **Subject proposed targets at the design or commissioning phase to greater critical scrutiny** and, possibly, external challenge to assess feasibility.
- Consider 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.
- Balance the **ambitiousness of targets against the need for space to experiment, innovate and even fail** as part of a test and learn ethos.

JCP referrals

- **Establish a formal referral process rather than signposting** to raise the quality, volume and ease of referrals while providing a mechanism to feed client experiences back to JCP staff.
- **Develop a single point of access from JCP into all GM employment provision** to streamline identification of appropriate support given the time constraints of JCP client appointments.

GP referrals

- **Replicate GP clinics and GPEO-style workers** in future provision to increase the volume and quality of referrals.
- **Review geographical coverage** to ensure alignment with primary care structures and boundaries.

- **Increase the ease with which non-affiliated GP practices can be incorporated** to avoid potentially committed practices being excluded.
- Ensure from the outset that **sufficient time, resource and expertise is invested in developing governance structures and relationships with key health partners** of appropriate seniority who can advocate for the programme and forge durable connections with GPs.
- **Extend the programme duration to allow sufficient time to build relationships** and establish the profile of programmes with GPs.
- **Locate any future offer with other programmes behind a single gateway** (e.g. social prescribing) which can triage referrals into appropriate provision to reduce complexity for GPs.

SME referrals

- **Develop an evidence base on SME diversity, needs and demand** for external occupation health provision through prior consultation before designing and commissioning any future provision.
- **Review expectations** that SMEs can be engaged in high volumes and set any targets at a level that allows scope for piloting or innovation provision.
- Ensure through recruitment and training that **engagement workers have the expertise and skillset** to engage employers.
- **Embed SME engagement teams more closely in local authority business support teams** to facilitate joint working and promote employment provision within a single integrated business offer.
- **Consider involving representative bodies** such as the Chamber of Commerce and Federation of Small Business as potential delivery partners to increase reach into, and engagement from, the business community.
- **Extend eligibility to ‘wobbling’ employees** who have health issues that affect work to prevent issues escalating and address presenteeism.
- **Use commissioning processes to ensure that providers or supply chain organisations have a strong footprint and relationship with SMEs in GM.**

The WWEH model

- **Maintain aspects of the model that have proven efficacy** including: fast-track access to physiotherapy or CBT; resources to self-manage health conditions; the health-focussed approach of the VRC team; carefully sequenced support that prioritises health as a precursor to employment; and structured advice and guidance on returning to work (formalised in the RtWP).
- **Provide a single tier of support or – if adopting a tiered model – a more client-led approach** where criteria can be flexed to ensure that participants can benefit from more intensive support where needed, regardless of size of employer.
- **Enable support to be extended beyond six months on a discretionary basis** where further positive outcomes may result.
- **Provide opportunities for in-person support** as originally intended before WWEH switched to a wholly remote model during the pandemic.
- Design support to respond **to emerging or increasing levels of need related to the COVID-19 pandemic** including: managing or reducing stress and anxiety; bereavement counselling due to COVID-related deaths; living with the physical

and psychological impacts of long COVID; and supporting individuals while waiting for delayed elective care.

Supporting participants

- Provide **more focused employability support alongside health provision** including job brokerage and employment coaching (accessed internally or externally).
- **Embed more intensive clinical provision** internally or set up clear referral pathways into appropriate external provision to support those with the highest levels of need.
- **Recognise that addressing health issues may need to take priority** and that employment outcomes may be unlikely - or uneven unwanted – within the timeframe of support.
- **Design initial assessment processes to identify severe need at the earliest possible stage** to enable quicker triage into more appropriate support such as external clinical services.
- Review whether service-based referral pathways exclude harder-to-reach groups such as NEETs and **consider extending referral activities to community organisations or developing outreach mechanisms**.

Partnership and integration

- **Embed programme provision and workers directly within health service structures** such as GP practices to encourage deeper integration.
- **Review the resourcing and remit of any future local authority-based integration role** that replaces Local Leads to ensure they have the capacity, expertise and connections to engage more fully with partners in the health system.
- **Better sensitise and design provision around** the needs and ecosystem of support and delivery within individual Localities.

Employer practices

- 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.
- **Provide on-going, in-work support** where beneficial to ensure that participants can be supported to address any challenges that emerge or resurface in workplaces on returning to work.
- 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 or new job and deal with employers reluctant to make adjustments.
- **Complement WWEH-style integrated health and employment provision with a wider upstream ‘healthy workforce’ provision** to encourage employers to promote healthy lifestyles among staff as well as raise awareness of environments, cultures and practices beneficial to staff wellbeing.
- **Ensure that work and health provision is promoted is part of the wider business offer.**
- **Pursue GM-wide policies and strategies which support a ‘good work’ agenda.**

1. Introduction

1.1. Overview of WWEH and Working Well family

Working Well Early Help (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 offer is described in Section 4.1.

Working Well Early Help (WWEH) is part of the wider family of Working Well programmes⁴ 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.

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 COVID-19 pandemic led to a strategic 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. It also reflected 'spare' capacity to accept more newly unemployed referrals from JCP due to lower than anticipated in-work referrals from the GP and SME pathways.

WWEH was established as a devolved response to the UK government's Improving Lives⁵ 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 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.

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 began supporting clients in March 2019 and discharged the last client at the end of March 2022 after supporting a total of 3,433 participants. As the last of three annual reports this report provides an overview of the achievements of WWEH across the lifetime of the programme.

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.

1.2. Policy and strategy on work and health

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 and local priorities**:

- The 2017 *Improving Lives: the future of work, health and disability* white paper⁶ has been 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 Work⁷ review on **mental health and employers** is a central strategic framework for identifying how employees with mental health issues can be supported.
- The **positive relationship between good quality employment and good physical or mental health** - and the barriers to work presented by poor health - has been recognised in a series of recent national strategies⁸ and Greater Manchester-level reports including The Health Equity in England⁹ report and the *Build Back Fairer review*¹⁰ produced for Greater Manchester by the Institute of Health Equity.
- The *Joining up care for people, places and populations*¹¹ white paper published in February 2022 emphasises **the importance of integrating services, defining successful integration** as:

“The planning, commissioning and delivery of co-ordinated, joined up and seamless services to support people to live healthy, independent and dignified lives and which improves outcomes for the population as a whole”.
- The principles and model underpinning WWEH also align with the *Health is Everyone’s Business*¹² strategy which seeks to **encourage all employers to take positive action to support employees who are managing health conditions** in work, and to manage sickness absence more effectively.
- The recently published *Greater Manchester Strategy 2021–2031: good lives for all*¹³ outlines **priorities for creating better jobs and good employment**, reducing health inequalities, and ensuring businesses are able to access the skills and talent they need.

1.3. Labour market and employment trends

National

WWEH was launched in relatively benign labour market conditions in March 2019 but subsequently saw the outbreak of the COVID-19 pandemic in early 2020. This initially led to rising unemployment but the duration and size of the downturn was not as significant as anticipated. The rollout of the COVID-19 vaccine and, until very recently, rising consumer and business confidence have seen improvements in employment conditions. The latest UK labour market data published by the Office for National Statistics (ONS)¹⁴ indicates that:

- **Employees:** The number of payrolled employees for May 2022 increased to a record 29.6 million - well above pre-pandemic levels.
- **Unemployment:** The unemployment rate for February to April 2022 decreased by 0.2 percentage points on the quarter to 3.8 per cent which is, again, lower than the pre-pandemic levels.
- **Vacancies:** The number of job vacancies in March to May 2022 rose to a new record of 1,300,000. However, the rate of growth in vacancies continued to slow down.

However, there are also **some areas of concern** in terms of:

- **Pay:** In real terms (adjusted for inflation) regular pay fell on the year by 2.2 per cent. This fall is likely to continue if wages fail to keep up with inflation forecast to peak at over 10 per cent in the final quarter of 2022¹⁵. This further increase in the cost of living will, in turn, see rates of unemployment rise as consumer and business demand falls.
- **Economic inactivity:** The UK economic inactivity rate is currently 21.3 per cent, 1.1 percentage points higher than before the coronavirus pandemic. This was initially driven largely by young people moving into education during the first year of the pandemic, but older workers (aged 50 – 64) account for nearly all the recent increase. There is some evidence this is accounted for, in large part, by those in higher skilled occupations (professional and associate professional) taking retirement, which may reflect their higher level of savings. Separate analysis further suggests rising inactivity may be explained more as a lifestyle choice to retire in light of changed preferences or priorities rather than by poor health or low labour demand leading to people being unable to find work and becoming discouraged¹⁶.

However, it is clear that poor health is a factor for at least a sizeable minority of older workers, especially at the lower end of the age band. ONS analysis finds that while retirement was the most common reason given for leaving work by both those in their 50s (28 per cent) and those aged 60 years and over (56 per cent), those in their 50s were significantly more likely to give stress or mental health reasons (19 per cent) than those aged 60 years and over (5 per cent)¹⁷.

Greater Manchester

Recent analysis by GMCA¹⁸ shows some positive labour market trends:

- **Employment rates** improved in the three months to April 2022 in the North West (73.9 per cent compared with 73.1 per cent in the three months to March). This saw the gap between employment rates in the North West and the UK narrow to 1.7 percentage points (down from its widest level in two years of 2.6 percentage points in the three months to March 2022).

- **Economic inactivity** fell for the first time in many months to 22.7 per cent in the three months to April 2022 from 23.5 per cent in the three months to March 2022. This narrows the gap with the UK figure from 2.1 percentage points to 1.4 points.
- **Unemployment** remained stable at 4.3 per cent (0.5 percentage points above the UK rate).

At the same time the North West has the **largest COVID jobs deficits of any UK region**. There were 86,500 fewer jobs in the latest quarter for which data is available (February to April 2022) than before the pandemic (January to March 2020) although other regions have seen bigger percentage falls in jobs. At the same time, the number of job vacancies has remained consistently above levels seen in both 2020 and 2021, with an average of 11,477 jobs postings per week in GM in the latest four weeks for which data is available. This is consistent with participant accounts which indicate the relative ease of finding work (see Section 6.1).

1.4. Methodology

This annual report focuses on the entirety of programme delivery. The findings presented in this report draw on four primary sources of data:

- **Client monitoring** data on 3,433 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.
- **81 in-depth participant interviews** undertaken by telephone between September 2021 and April 2022 with programme participants who had received at least three month's support from WVEH. All direct quotes in this report are taken from this group of 81 interviewees although findings from past interviews undertaken for the 2021 Annual Evaluation report are summarised where relevant.

Characteristics of the sample were identified by linking interviewees to programme monitoring data. Issues with the completeness of the dataset 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 (35 male and 45 female) and age range (50 were aged 45 and under while 31 were aged over 45). The majority were White British (39) followed by Asian/Asian British (17), Black/African/Caribbean/Black British (16), Mixed/Multiple (7), White - Other (1) and Other Ethnic Group (1).

There was an even split on entry between those in work but on medical leave (40) and those who were unemployed (41). Mental health (anxiety or depression/low mood) was the predominant health condition experienced by more than half (40) of all 71 participants for whom data on health conditions was available.

- **Four stakeholder workshops** undertaken by video conference call between November 2021 and June 2022. Attendees included the Commissioner team (GMCA and GMHSCP); managers and frontline delivery staff in the Provider organisations (MAXIMUS and Pathways); Local Authority Leads; Jobcentre Plus staff; and representatives from the Work and Health Unit. A further **55 in-depth stakeholder interviews** were undertaken between June 2021 and May 2022 to further explore experiences and perceptions of the programme.

- **Impact assessment** based on analysis of 60 in-depth participant interviews and quasi-experimental analysis comparing WVEH outcomes to those for a matched counterfactual from the Labour Force Survey Five Quarters Longitudinal Panel. This estimates the extent to which outcomes would have been achieved without WVEH and how important WVEH interventions were to outcomes over and above the influence of other factors, interventions, or changes. The findings are summarised in Sections 5.2 and 6.1 and the method detailed in Appendices 6 and 7.

1.5. Report structure

The remainder of the report is structured as follows:

- Section 2 examines volumes of **referrals and starts** against programme targets.
- Section 3 **profiles participants** joining the WVEH programme in terms of personal characteristics, health conditions and presenting needs, and barriers to work.
- Section 4 reviews the **support offered** by WVEH and the number and type of interventions delivered to date. It considers expectations of, and satisfaction with, support from the perspective of participants.
- Sections 5 and 6 consider, in turn, **health and employment outcomes** experienced by participants between entry onto and discharge from WVEH. Impact analysis estimates the extent to which WVEH interventions contribute to outcomes while interviews with participants provide further insights into the factors contributing to change.
- Section 7 considers the extent and benefits of **partnership and integration** with stakeholders across Greater Manchester. It also explores the degree of **systems change** achieved in terms of engagement with the work as a health outcome agenda among health organisations.
- Section 8 reviews the key points of **learning** to emerge from the evaluation and makes **recommendations** for how the programme might inform any future commissioned health and employment provision.

2. Performance

Summary

- Meeting targets for referrals and starts proved challenging throughout the programme with WWEH achieving just over three fifths (63 percent) of the target for referrals and one third (34 per cent) of the target for starts. This must be set in the difficult context of delivery during the COVID-19 pandemic for two of the three years for which the programme was in operation. GP practices, for example, had to prioritise the immediate response to the pandemic and later rollout of the vaccination programme.
- Despite underperformance, referral and start volumes during the pandemic exceeded pre-pandemic levels. This is likely to reflect rising some combination of: referral pathways becoming more established and provider engagement activities proving more effective; increasing demand due to increases in unemployment or health issues during the pandemic; and the impact of lifting the cap on JCP referrals.
- JCP became the dominant referral pathway following the strategic decision to refocus activities towards supporting the newly unemployed, generating half (49 per cent) of all referrals. One consequence is that the programme saw a broadly even split between in-work (53 per cent) and out-of-work (47 per cent) starts. This clearly indicates how WWEH moved away from its initial intention to focus on supporting those in work but on medical leave.
- The majority of JCP referrals failed to 'convert' to starts. This may be due to lower quality referrals by newly recruited JCP staff during the pandemic, the lack of a formal referral pathway, and a tendency of JCP referrals to disengage from WWEH when they realise participation is not mandatory.
- Employer (SME) starts remained consistently below target throughout the programme, accounting for only 15 per cent of starts against a target of 40 per cent. Moreover, around half of those SME starts (46.4 per cent) were sourced through Jobcentre Plus rather than directly through engagement with SMEs and their employees¹⁹.

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 Note²⁰. 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 Plus (JCP)²¹:** 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 WVEH. JCP staff do not make direct referrals but provide information ('signpost') on WVEH 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 for the entire duration of the programme. Explanations for underperformance against targets for referrals and starts are explored in Section 7 and have also been extensively reviewed in the 2020 and 2021 Annual Evaluation reports²².

2.2. Referrals

A total of 7,078 referrals had been made into WVEH by the end of September 2021 as the cut-off date for new referrals (Figure 2.1). This is **just over three fifths (63 percent) of the lifetime target**. The chart clearly shows that referrals have remained consistently below the cumulative target since March 2020.

Figure 2.1: Cumulative referrals

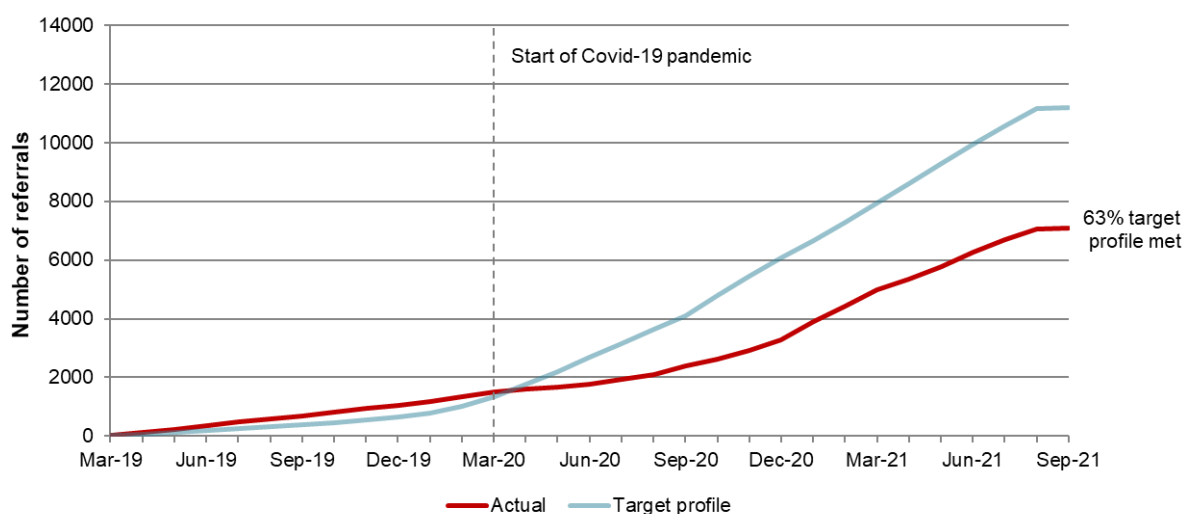


Table 2.1 compares referrals before the pandemic (up until 31 March 2020) and during the pandemic (after 01 April 2020). It shows **average monthly referral volumes almost trebled in the period after the pandemic started** (from 115 to 310 per month). This is likely to reflect rising some combination of: referral pathways becoming more established and Provider engagement activities proving more effective; increasing demand due to increases in unemployment or health issues during the pandemic; and the impact of lifting the cap on JCP referrals.

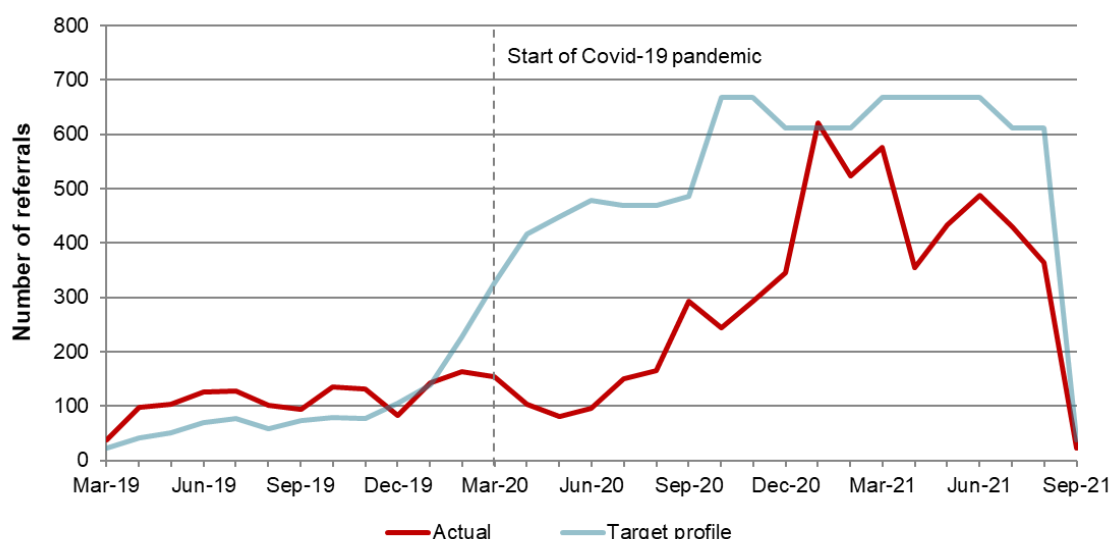
Figure 2.2 clearly illustrates how monthly referrals increased significantly after an initial dip following the first UK-wide lockdown that began in March 2020 to reach a programme high of 621 in January 2021. It also shows, however, that monthly referrals were consistently below target for most of the duration of the programme. Moreover, the marked increase at the end of 2020 also partly reflects a change to the way that

the Provider reported referrals which had the effect of increasing referral volumes compared with the previous method.

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

	Actual referrals	Average monthly referrals
Performance (lifetime)		
Mar 19 – Sep 21	7078	228
Performance before pandemic		
Mar 19 – Mar 20	1497	115
Performance during pandemic		
Apr 20 – Sep 21	5581	310

Figure 2.2: In month referrals



Referrals by pathway

Targets were initially set for the proportion of referrals by pathway and work status to ensure WWEH focussed on in-work participants. The GP and Employer pathways were each 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 account for the largest proportion (49 per cent) of all referrals** compared with GP referrals (40 per cent) and Employer referrals (12 per cent). This shows both the challenges in generating Employer referrals, as well as how WWEH accepted significantly higher volumes of newly unemployed participants than originally expected.

Figure 2.3: Performance of referral pathways against original expectations

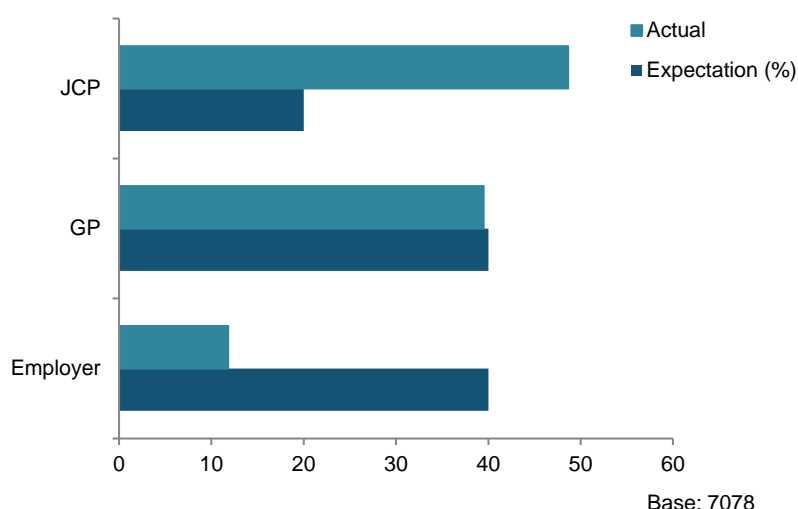


Table 2.2 shows the overall performance of each pathway against cumulative referral targets. JCP referrals have met 154 per cent of the target. This is partly due to a change in reporting method²³ but also reflects a pre-existing trend where JCP referrals consistently exceeded monthly targets. By contrast, GP referrals achieved 62 per cent of the target and employer referrals only 19 per cent of the target by the end of the programme.

Table 2.2: Overall referral pathway performance

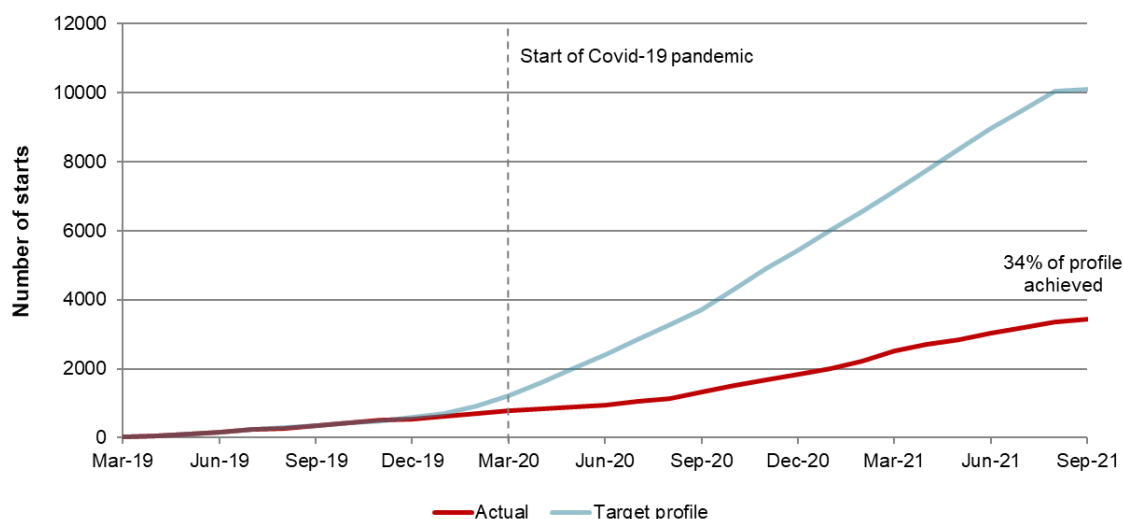
Referral pathways	Total number of referrals	Cumulative referral target	% of cumulative target profile achieved
GP	2796	4482	62%
Employer	838	4482	19%
JCP	3444	2241	154%
Total	7078	11206	63%

2.3. Starts

A programme start is recorded when a participant completes a welcome call and at least one initial biopsychosocial health assessment (BPSA). WWEH achieved 3,433 starts by the end of the programme which is **34 per cent of the lifetime programme target of 10,085 starts**. Figure 2.4 shows the gap between actual and target starts increased over time.

There is a broadly even split between in-work (53 per cent) and out-of-work (47 per cent) starts. Again, 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 2.4: Cumulative starts

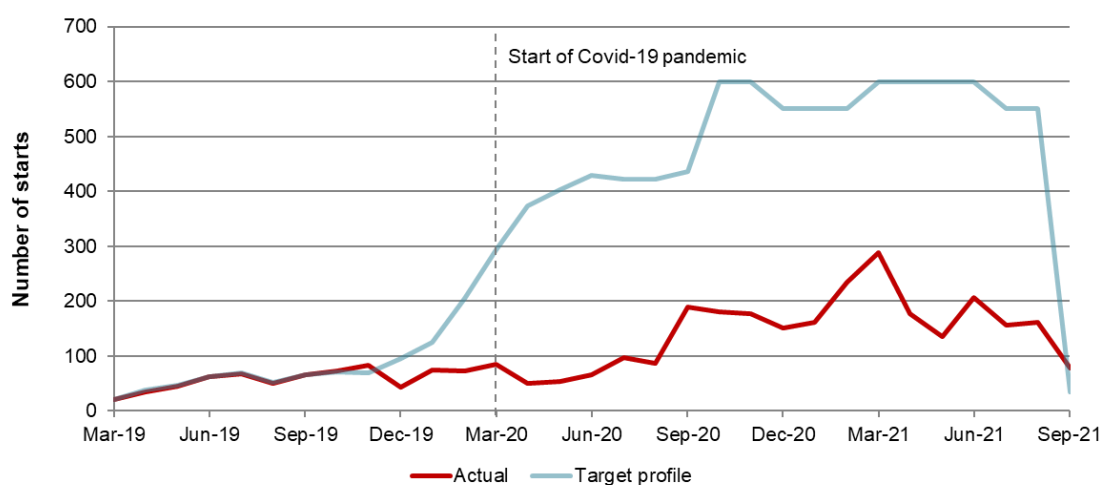


Volumes of starts more than doubled during the pandemic compared with performance before the first UK-wide lockdown (Table 2.3). An average of 60 starts per month were made prior to the pandemic which increased to 147 per month during the pandemic. Figure 2.5 shows the broad trend of increasing volumes of monthly starts during this period until a peak of 289 in March 2021, albeit at levels consistently below target.

Table 2.3: Starts before and during the COVID-19 pandemic

	Actual starts	Average monthly starts
Performance (lifetime)		
Mar 19 – Sep 21	3433	111
Performance before the pandemic		
Mar 19 – Mar 20	780	60
Performance during the pandemic		
Apr 20 – Sep 21	2653	147

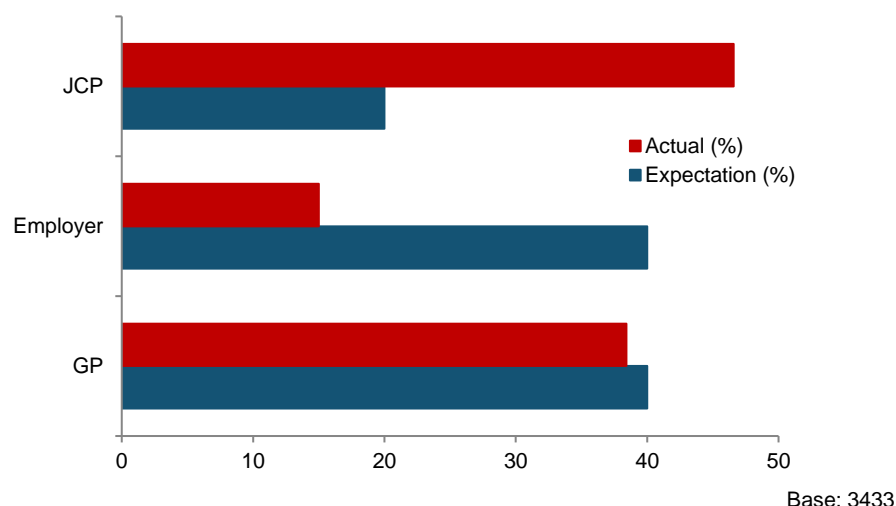
Figure 2.5: In month starts



Starts by pathway

As with referrals, Figure 2.6 shows that the overall proportion of starts on the Employer pathway is far lower than original expectations (15 per cent compared to 40 per cent). The proportion of starts on the GP pathway (38 per cent) broadly 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 2.6: 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 because of low conversion rates. Table 2.4 shows a conversion rate of 57 per cent up until December 2020 and, following a change to a more accurate reporting method, 42 per cent from December 2020 onwards. In other words, **for every 10 participants referred since December 2020, six participants did not eventually join the programme**. This is less than half the target conversion rate of 90 per cent.

The JCP referral pathway has the lowest conversion rate with just over one in three referrals (36 per cent) starting on the programme. Stakeholders suggested this may be explained by lower quality referrals from newly recruited JCP staff during the pandemic as well as a tendency of some JCP clients referred to disengage from WVEH when they realise participation is not mandatory.

Table 2.4: Overall pathway performance (starts)

Referral route	Total referrals	Total starts	Conversion rate (pre-Dec 2020)	Conversion rate (from Dec 2020)	Cumulative target starts	% target achieved
GP	2796	1319	47%	48%	4034	33%
Employer	838	515	70%	57%	4034	13%
JCP	3444	1599	73%	36%	2017	79%
Total	7078	3433	57%	42%	10085	34%

2.4. Referrals and starts by locality

There are some notable differences in referrals and starts by Locality (Table 2.5). Stockport has generated the highest volume of GP referrals (71 per cent of all Stockport referrals). This is likely to reflect, in part, the effective combination of a committed GP Lead and good working relationship with the GP Engagement Officer (see Section 7.3). Manchester has been the leading source of JCP referrals (76 per cent of Manchester referrals). It should be noted that Manchester makes few GP referrals to avoid duplication with other local provision.

Table 2.5: Referrals and starts by locality

Locality	Total referrals	GP referral	Employer referral	JCP referral	Starts
Manchester	1159	4	276	879	514
Stockport	1109	786	47	276	586
Bolton	937	486	79	372	427
Tameside	893	514	48	331	406
Oldham	605	180	72	353	317
Rochdale	574	131	126	317	265
Wigan	509	146	41	322	240
Bury	453	247	51	155	222
Salford	420	157	49	214	261
Trafford	403	144	45	214	195

Base: 7,072

3. Profile and needs

Summary

- Health issues featured prominently in terms of presenting needs and barriers to work reported by participants. By contrast fewer participants reported employability issues as a need although a lack of relevant workplace experience was sometimes noted in interviews. This may reflect the fact that those on medical leave were already in employment while the newly unemployed by definition had recent work experience.
- Mental health issues are particularly prevalent: 59 per cent of all participants report at least one mental health condition compared with 37 per cent who experience a physical health condition. 'Health management' was also by far the most common barrier to work reported.
- Compared with all participants, younger participants were *more* likely to experience issues with mental ill health or lower wellbeing while older participants were *less* likely.
- In many cases, presenting health issues were the primary factor contributing to withdrawal from work or perceived difficulties in returning to employment. However, experiences of work were often a further contributing factor to poor health in terms of: overwork, bullying or harassment, difficult or dangerous working conditions, job insecurity, lack of support from managers, and perceived employer discrimination on the basis of ill health.
- Other barriers to work included age-related factors (poor health, lack of IT skills), discrimination based on ethnicity, bereavement, caring responsibilities, and relationship issues. COVID-related issues were notably less prevalent than reported in previous annual reports.

3.1. Introduction

This section profiles the characteristics of participants joining the WWEH 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 the factors shaping decisions to take medical leave or leave jobs altogether and how these function as barriers to work.

3.2. Characteristics of WWEH participants

Tables 3.1 and 3.2 shows the characteristics of all individuals who participated in 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 (59 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 (30 per cent). The split is more even for other age categories.
- Four fifths of participants (81 per cent) are White British/Irish and a further six per cent identify as White - Other. This means the non-White proportion of WWEH participants (12 per cent) on the programme is significantly lower than the non-White proportion of the unemployed population of Greater Manchester (31 per cent)²⁴.
- Over half of participants are educated to post-secondary or graduate/postgraduate level. Only one fifth (20 per cent) have no qualifications beyond secondary education (GCSEs) compared with 31 per cent of the working-age population of Greater Manchester²⁵. This indicates educational attainment levels of WWEH participants are, on average, higher than the population as whole.

Table 3.1: Characteristics of participants

Socio-demographics	In work (%)	Out of work (%)	All (%)
Gender			
<i>Male</i>	40	52	46
<i>Female</i>	59	48	54
<i>Other</i>	0	0	0
Age			
<i>18-24</i>	6	11	8
<i>25-34</i>	24	28	26
<i>35-44</i>	23	21	22
<i>45-54</i>	26	22	24
<i>55-64</i>	21	17	19
<i>65+</i>	1	1	1
Ethnicity			
<i>White - British/Irish</i>	84	78	81
<i>Asian/Asian British</i>	4	5	4
<i>Black/African/Caribbean/Black British</i>	2	3	2
<i>White - Other</i>	6	7	6
<i>Mixed/Multiple</i>	3	7	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>	26	27	27
<i>Post-secondary (college, BTEC courses)</i>	22	34	28
<i>Undergraduate/Postgraduate</i>	27	22	24
<i>Not applicable</i>	1	0	1

Base: 3,433

Customer Service occupations are the most common occupation amongst in-work participants (15 per cent) followed by Administrative occupations (9 per cent). In combination the three health and caring occupations comprise nearly a fifth (19 per cent) of the total.

Table 3.2: Most common occupations

Top occupations	%
Customer service occupations	15
Administrative occupations	9
Health and social welfare associate professional	7
Caring personal service occupations	6
Health professional	6
Other	18

Base: 1,814

3.3. Health and wellbeing

Health conditions

The predominance of mental health conditions is highlighted in that, overall, **59 per cent of all participants report at least one mental health condition** compared with 37 per cent who experience a physical health condition. This compares with survey data indicating that just under a third of the UK population reported a clinically significant level of psychological distress at the height of the pandemic (29.5 per cent in April 2020)²⁶. While the figures are not directly comparable they suggest that WWEH may have supported a significantly higher proportion of individuals with mental health conditions than in the UK population as whole. It is also far higher than the proportion of participants with mental health conditions in the other major Working Well programme (Work and Health Programme²⁷) in Greater Manchester (31 per cent compared with 59 per cent in WWEH).

Data on specific health conditions (Table 3.3) shows that **mental health is by far the most common health problem** across the programme. Twenty six per cent of all participants report anxiety disorders as their primary health problem. This was closely followed by depression or low mood (24 per cent). Problems with back was the third most common health problem (9 percent). These figures mirror reported levels of health conditions among both the in-work and out-of-work cohorts.

Table 3.3: Most common primary health conditions

<i>In work</i>	%	<i>Out of work</i>	%	<i>All</i>	%
Anxiety Disorders	25	Anxiety Disorders	27	Anxiety Disorders	26
Depression or low mood	23	Depression or low mood	25	Depression or low mood	24
Problems with Back	10	Problems with Back	9	Problems with Back	9
Fibromyalgia	5	Arthritis - Osteo	3	Fibromyalgia	3
Asthma	3	Diabetes	2	Arthritis - Osteo	3

Base: 2,189

There were some notable variations by subgroup with **younger participants being more likely to experience mental ill health while older participants were less likely** compared with all participants (Table 3.4):

- 70 per cent of **younger participants** (aged 18 to 24) reported anxiety or depression/low mood, with 54 per cent reporting these as their primary health

condition. This compares with 57 per cent and 43 per cent of all participants. The finding aligns with wider evidence²⁸ of increasing mental health issues among young people as result of the pandemic. Furthermore, one stakeholder reported “a huge increase in social isolation, increase in mental health, anxiety” among young people across GM based on involvement in other employability provision.

- By contrast forty-four per cent of **older participants** (aged 50 and over) reported anxiety or depression/low mood, with 28 per cent reporting these as their primary health condition. This is lower than the equivalent figures for all participants.

Table 3.4: Participants reporting a mental health issue (either anxiety or depression/low mood) on entry

	All		18-24		50+		Ethnic minorities	
	Count	%	Count	%	Count	%	Count	%
Overall	1475	57	145	70	373	44	208	55
As primary health condition	1093	43	111	54	236	28	145	38

Base: All (2564-2567); 18-24 (206); 50+ (838-839); Ethnic minorities (381)

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.

Table 3.5 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’ (68 per cent), ‘Coping and confidence’ (62 per cent) and ‘Personal finances’ (38 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 (see Section 3.6).

Table 3.5: Presenting needs on entry

Presenting needs	Severe (%)	Moderate (%)	Severe or Moderate (%)
Health	27	41	68
Coping and Confidence	25	37	62
Personal finances	17	21	38
Access to Work	8	18	26
Skills and Qualifications	4	18	22
Housing	8	10	18
Caring and Family responsibilities	2	8	10
Alcohol and Drug Use	3	5	8

Note: Columns may not sum to 100% due to rounding.
Base 3,433

Again, there were some variations across subgroup:

- a **higher proportion of young people experienced needs relating to mental health and wellbeing than WWEH participants as a whole**: 35 per cent indicated severe need around coping and confidence compared to 25 per cent of all participants.
- **Ethnic minority participants had slightly higher levels of need** on all presenting needs measures excluding 'Coping and confidence' and 'Alcohol and drug use' compared with all participants.

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 (CMON)** 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.

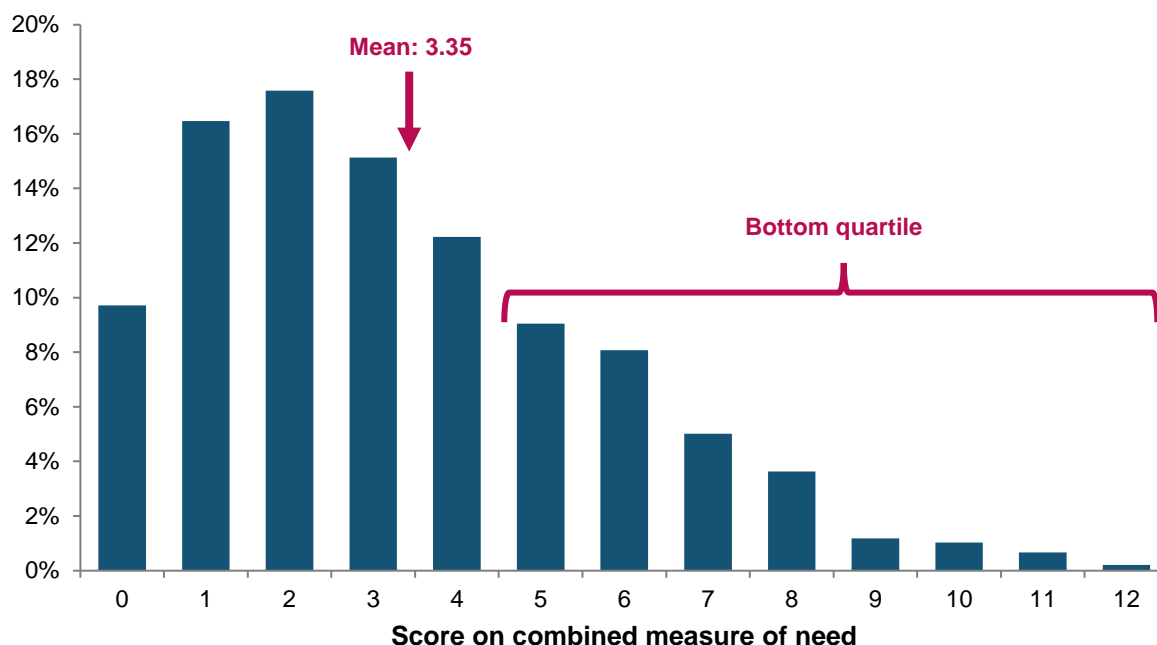
The combined measure of need is based on 15 separate indicators comprising all eight presenting needs measures, four health assessments and three other indicators: disability status, if currently in paid work and lack of basic skills. A full list is provided in Appendix 2.

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 3.35 (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:1,956

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 (37 per cent compared to 24 per cent and 25 per cent respectively).
- **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 (33 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 (26 per cent); the youngest cohort aged 18-24 have the highest level of need (38 per cent).
- **Ethnicity:** A greater proportion of participants from ethnic minorities were also placed in the category of most need compared to participants overall (35 per cent compared to 29 per cent).

Variations by referral route and employment status are perhaps unsurprising. Those who are referred by JCP are out of work and therefore more likely to be further from the labour market than the in-work cohort. Nevertheless, it has important implications given the decision to lift the cap on JCP referrals. It means that, overall, **the programme is likely to have supported a greater proportion of out-of-work participants with higher levels of need than if it had retained its original focus on in-work referrals.**

The higher proportion of those with most need receiving the Support Service compared with the Advice Service (33 per cent compared to 22 per cent) confirm that those with highest level of need are more likely to receive the most intensive support. At the same time, it indicates that just over one fifth of those receiving the Advice Service still have high levels of need. This raises questions over the appropriateness of lighter-touch

service where participants are not accessing occupational health provision through their workplace (see Section 7.2).

3.5. Barriers to work

Data collected on self-reported barriers to work highlights that health management was by far the most common issue (Table 3.6). Financial concerns, family issues, and confidence and motivation were the next most frequently cited barriers, although to a much lesser extent. The prevalence of health management as a barrier to work undoubtedly reflects that fact that eligibility is limited to those who have at least one health condition

Table 3.6: 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	8	Confidence	9	Family	5
Confidence	3	Motivation	7	Confidence	7
Motivation	3	Family	4	Motivation	6

Base: 3,391

Interview data provides further insights about precisely how health conditions and other factors contribute to decisions to leave work or prevent a return to employment. The remainder of this subsection looks in turn at barriers relating to health and employment, the COVID-19 pandemic, age and ethnicity, and wider personal factors such as caring responsibilities or relationship issues.

Health and employment-related factors

Interviewees reported a wide range of health-related issues that had contributed to leaving work including:

- **Mental health conditions** such as anxiety, low mood or depression, panic attacks and post-traumatic stress disorder (PTSD).
- **Physical health conditions** such as chronic fatigue, arthritis, musculoskeletal problems including injuries, fibromyalgia and respiratory disease.

In many cases, **presenting health issues were the primary factor contributing to withdrawal from work or perceived difficulties in returning to employment**. One out-of-work participant described, for example, how their mental health condition prevented them from sustaining work:

I have so many opportunities when it comes to jobs and sometimes when I actually go and get one, my depression, you know, gets in the way, like it's a massive, lifelong, shield that's blocking me. (Young participant 9)

The evaluation has consistently found, however, that it is not the health condition alone but **the interaction of workplace experiences and health that often shapes decisions to take medical leave or leave work altogether**. The previous Annual Report 2021 noted a range of workplace factors that caused or aggravated ill health including: overwork, bullying or harassment, difficult or dangerous working conditions, job insecurity, lack of support from management, and pressures related to working during the COVID-19 pandemic. An additional factor related to employment highlighted in more recent interviews is the perception that **employers discriminated against individuals with health issues** in recruitment and staffing decisions:

I applied for so many [jobs]...when I went to interviews...as soon as I mention mental health it tends to you know, be a shut off...they go like a bit more quiet and you know don't ask many questions and then it tends to end within like five, ten minutes from that. (BAME Participant 2)

[Speaking of the involuntary termination of a temporary contract after a period of leave due to a physical health condition] *It is more important [to the employer] that the job gets done, not my wellbeing...I wrote [the employment agency] an email to say how disgusting and inhuman they really are, how they treat their workers and they did not call to apologise. (Participant 3).*

These findings underscore Health and Safety Executive (HSE) research showing rising levels of work-related stress, depression and anxiety since 2010²⁹ and the high volume of workers who report suffering from an illness they believe was caused or made worse by work³⁰.

It was far **less common that participants reported employability-related issues as the main barrier to work**, although a small number did note issues with a lack of experience. In one case, prolonged periods out of work due to mental ill health led to significant gaps on their CV:

My mental health problems were really bad a few years ago, I just didn't really look at any employment and just been on benefits...I feel a bit better now... there are maybe some jobs that I could do but I just send in an empty CV without experience of it and I just don't feel hireable. (Participant 4)

Stakeholders also suggested **a lack of experience may be a particular issue for young people** due to the curtailment of work experience opportunities during the pandemic which employers do not always take into account:

Employers still put some unrealistic expectations in terms of their job adverts and their requirements, they need x amount of experience. We've got a lot of young people who just can't put that on their CV at the minute. (GMCA)

These qualitative findings reflect the wider data on the relative balance between health and employability as barriers to work: nearly all participants (97 per cent) report health management as a barrier to work compared with just over a fifth (22 per cent) of participants reporting moderate or severe needs around skills and qualifications (see above).

Pandemic-related factors

The 2021 Annual Report reported a number of pandemic-related factors as contributing to mainly mental health issues that prompted interviewees to leave work. This included excessive workloads; bullying or harassment over COVID-related concerns; changes in roles or team structures; and a failure to make workplaces COVID-secure. Perhaps unsurprisingly, the pressures of working during the pandemic were particularly acute for those in the health and social care sector.

The more recent round of interviews highlighted some similar concerns, albeit **with far fewer interviewees raising COVID-related issues as barriers to work**. This might be explained by timing as the interviews took place after all major restrictions had been lifted.

Ethnicity and age

A small number of ethnic minority participants reported **discrimination as a barrier to work**. One participant observed, for example, that a request to work from home to

accommodate health conditions when returning from medical leave had been denied while other employees had been granted similar flexibilities:

The only difference between me and the other two females is that I'm not Caucasian, that is the only difference. That's the only thing I can think of. Do I think it's racism? I don't know...I was sitting there for two and a half months at home mulling over why I'd been treated [like] this. (Participant 5)

While reported experiences of discrimination were not widespread among ethnic minority interviewees, wider evidence indicates such experiences are not uncommon. Recent survey data suggests ethnic minority workers are more likely to have experienced microaggressions (bullying or harassment), racist harassment (directly or indirectly) or at work, less likely to feel valued at work, or felt they have been treated fairly by recruitment agencies³¹. The 2017 McGregor-Smith review of race in the workplace also observed that ethnic minority workers experience “discrimination and bias at every stage of an individual’s career, and even before it begins”³².

A minority of older participants noted **age-related barriers to work**:

- Older people sometimes reported that a combination of **physical, age-related and deteriorating health conditions** made it difficult to envisage a return to work. Some also expressed **doubts about the willingness of employers to take on older workers** with long-term health conditions. A few participants closer to state pension age **planned to retire early** on the grounds of ill health: *“I am okay with the decision because...I couldn't return to work at this point in time”* (Participant 6).
- A smaller number described feeling **discriminated against on the basis of age**. One noted, for example, their lack of success in applying for retail roles when younger candidates were preferred.
- Two participants suggested **a lack of IT literacy** may have been an issue: *“I've never done that before. I wouldn't even pretend I could do it”* (Participant 7).

Notably, few older participants appeared to be contemplating a withdrawal from working life as a ‘lifestyle choice’ as suggested in wider analysis (see Section 1). Among older participants interviewed there was more a sense that being out of work was largely involuntary.

Personal barriers

A small number of participants identified **a range of wider barriers to work**, some of which had contributed to a deterioration of mental health and wellbeing:

- **Bereavement** was a factor contributing to medical absence or decisions to leave work in a small number of cases. Three ethnic minority respondents reported losing close family and friends from COVID-19 which may reflect a higher mortality rate in some ethnic minority communities³³.
- **Caring responsibilities** for children combined with the prohibitive costs of childcare or a perception that employers would be unwilling to flex to accommodate the need for ad-hoc leave to look after children with health conditions:

I was due to start a [vocational] course...but I've put it off now because my daughter's too little... my partner is still, he's an engineer apprentice, so because he's doing his apprentice stage I can't really afford the childcare”. (Participant 9)

At the moment if I went to work now then they would have to be hugely flexible or I'd just end up losing the job because [my child's] demands are not within non-working hours. (Participant 8)

- **Relationship problems or separation** as a cause of health issues: *"I've been through a lot of stress too, like, with my ex, you know, because that does set off my depression". (Participant 10)*

4. WWEH support

Summary

- Participant interviews indicate that the priority for many when joining WWEH is to access support for a physical or, more commonly, mental health condition. Employment is not always seen as an immediate priority, particularly for older participants and those whose health conditions are considered to be extremely limiting in terms of work.
- Customer satisfaction data shows that the majority (69 per cent) of those receiving the Support Service are satisfied with support compared with less than half (46 per cent) of those receiving the Advice Service. Past findings suggest lower levels of satisfaction among Advice Service recipients may be accounted for by disappointment once referred that they are only eligible for the lighter touch Advice Service.
- The majority of participants interviewed were very positive about their experiences of the WWEH programme and valued a range of elements of the offer including: emotional and practical support provided by frontline staff; the non-discriminatory approach; help in understanding health issues; holistic support to address the full range of presenting needs; the ease and speed of access to a range of specialist support; and impartial, external advice on returning to work.
- A far smaller number of participants were more equivocal or, in some cases, negative about the service. In some cases, this was more about the lack of relevance or appropriateness of support given circumstances. A small number were critical of service quality including: a failure to provide support appropriate to the nature or severity of mental health conditions; staff turnover and a subsequent need to retell personal histories; and the perceived paucity of support.
- The two main suggestions for improving WWEH were opportunities for face-to-face contact and extending the duration of support. The latter is testament to the value of support provided insofar as shows participants did not want engagement to end after six months.

4.1. Support offer

The WWEH model centres on personalised, health-focussed and holistic support provided through a team of key workers known as Vocational Rehabilitation Worker (VRCs). Some aspects of support were 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 4 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 was 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 either 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 the seven domains as outlined in Appendix 4.

This section draws on programme monitoring data and interviews with participants to look at support provided, expectations and satisfaction with the service.

4.2. Support provided

At programme launch it was expected that the majority (80 per cent) of in-work participants would access the full Support Service and the remaining 20 per cent would receive the lighter-touch Advice Service (20 per cent). This balance was intended to focus delivery on SME employees and the self-employed as a group less likely to have access to occupational health support.

In practice, however, only 45 per cent participants accessed the Support Service and 55 per cent the Advice Service. This is explained by the higher than expected proportion of in-work participants working for larger companies (over 250 employees) referred through the GP pathway as well as the challenges in generating Employer referrals through SMEs (see Section 8.2). It may also reflect a higher than anticipated preference for external impartial support even where employees of large companies have access to workplace occupational health services, as highlighted in the Annual report 2021.

Information on interventions either provided or advised (Figure 4.1) shows:

- The most common intervention is Vocational Rehabilitation, which has been provided to 85 per cent of those who have received an intervention. Coping Strategies (69 per cent), Cognitive Behavioural Therapy (46 per cent), and Mindfulness (40 per cent) are also commonly provided or advised interventions.
- **Four of the top five most common interventions relate to mental health and wellbeing**, reflecting the prevalence of mental health conditions among the cohort.

Figure 4.1: Most common interventions across the programme



4.3. Expectations of support

Participants were asked in interviews to reflect on how they had hoped to benefit from WVEH support when they first accessed the programme. Consistent with data on presenting needs and health conditions, the **majority identified improving physical or, more commonly, mental health conditions as their main priority**, either as a sole motivation or as a means of eventually returning to and sustaining employment. One participant described, for example, how they hoped *“it was going to be like practical support, you know to help find a job and for counselling and some physiotherapy as well”* (Participant 11).

Less frequently, participants saw support primarily as a way to secure employment, as in one case where the key expectation was that WVEH could assist with discussions with potential employers about required adjustments: *“I was hoping that, that they’d help me find a job...talking to my employers and stuff”* (Participant 12).

For a significant minority, however, employment support was not seen as immediate priority, particularly where the severity of health conditions meant participants did not feel a return to work was likely in the short term. Notably, **older participants were most likely to identify health rather than work as the primary reason for engaging with WVEH**: *“If it was going to improve anything in my life either my wellbeing or the symptoms, it was worth giving a go”* (Participant 6). Where work was still considered a priority, finding employment that was suited to age and, particularly, physical health conditions took precedence.

4.4. Satisfaction with support

Participants reported receiving a range of support including:

- **Employment-related support** such as job search preparation (CV writing, interview techniques) and information on training or job opportunities such as job fairs.
- **Health-related and wellbeing support** such as CBT and physiotherapy; dietary advice; online resources on mindfulness and coping strategies to support self-management of mental health issues such as stress and anxiety; and links to external health services (e.g. acupuncture and chiropractors).
- **Signposting to external provision** including grief counselling; financial, debt, housing or benefits advice; external employability support (e.g. to provide a laptop for job search); assertiveness training; and self-employment advice.

Not all support offered was taken up, especially where participants already had access to support from other organisations such as JCP (employability support), debt advice charities, and other providers of CBT.

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.
- Interviews with programme participants.

The data available from the customer satisfaction survey (Table 4.1) shows that **the majority of those receiving the Support Service report higher levels of satisfaction**. In total 69 per cent of those receiving the Support Service were either satisfied or extremely satisfied with the service provided. This compares to 46 per cent for those receiving the Advice Service. Past evaluation findings suggest lower levels of satisfaction among Advice Service recipients may be accounted for by disappointment among those who only realise once referred that they are only eligible for the lighter touch Advice Service. Moreover, some Advice Service recipients find the limited contact with VRCs and expectation of working through self-directed online materials does not meet their needs (see Annual Report 2021).

Table 4.1: Satisfaction with service by support provided

Level of satisfaction	Advice Service	Support Service
Extremely satisfied	16 (20%)	30 (26%)
Satisfied	22 (27%)	50 (43%)
Neither satisfied nor dissatisfied	20 (24%)	14 (12%)
Dissatisfied	14 (17%)	12 (10%)
Extremely Dissatisfied	9 (11%)	6 (5%)
Prefer not to say	1 (1%)	4 (3%)
Total	82 (100%)	116 (100%)

Base: 198

A significant majority of participants interviewed expressed satisfaction with the service including references to the WWEH being “*fantastic*”, “*brilliant*”, “*really good*”, “*an absolute excellent service*”, “*a great experience*” and “*wonderful*”. Throughout the evaluation a number of different elements of the WWEH approach and support have been singled out for praise including:

- **emotional and practical support** provided by VRCs and EPN practitioners which was valued for being personalised, empathetic, non-judgemental and relatable:

He fully understands... he could relate. (Participant 13).

I always felt that she never judged me and she would always be there for me no matter what, so yes, I think she's wonderful. (Participant 14)

- **a non-discriminatory approach** was valued by a small number of ethnic minority participants that had experienced discrimination in other contexts:

[The advisor made me feel] visible... in a world where you've been invisible... They were very nice, they were very helpful, very understanding. I did not feel like a black woman trying to find a job. I was an individual in need of support and that support was there (Participant 15, see full story in Box 1 below)

[The VRC] was the one who opened my eyes for me to know that the Working Well was there to support me rather than discriminate me. (Participant 16)

Box 1: Tanya's story

Tanya has spent the last four years studying at university, gaining an undergraduate and Masters degree, despite dealing with racism throughout her study. After leaving university, Tanya worked as a carer but was not retained after her probationary period. She felt this was due to racism among colleagues who expressed views that they didn't want to work with her:

My colleagues have a problem working with me and one of them then [sent a note] she said, if [she's] still working here, I'm not going to work here because I am not comfortable working with her and she couldn't give a reason why she didn't want to work with me.

Although she subsequently found temporary employment, she suffers from depression caused, in the most part, from the racism she has experienced in the past.

She was referred to WWEH by JCP as she wanted help to find employment. Tanya found the WWEH coach highly approachable and felt like they treated her as “*visible*” – with respect and without discrimination - and as someone with skills and experience to offer an employer:

I think it's important to feel supported and seen because sometimes we can be invisible. The support that I received made me feel like, okay, I see you, I understand, I'm here to support you.

She received support with CV writing and employment options. After several positive interviews she secured a job as a data analyst, working from home.

Although a confident and capable person, she felt she wouldn't have secured the job without the support of WWEH:

I think being in my position, when you have a middle person support your things, move a bit faster. I'm a very confident person in spite of everything that tries to knock me ... I felt seen and valued and I think that is very important for someone's confidence, I haven't felt that in a very long time.

- expertise in **identifying health conditions and presenting needs** including 'root causes' of issues that were not always self-evident to participants.
- **holistic support to address the full range of needs:** One participant who initially felt "*a bit overwhelmed and not knowing what direction to go in*" (Participant 17) described the value of being given a comprehensive plan with information, links and advice on food banks, welfare benefits and managing physical and mental health issues.
- **ease and speed of access to a range of specialist support** such as CBT and counselling services compared with NHS provision.
- **an impartial and external source of information and advice** on returning to work. This was sometimes compared favourably with work-based occupational health provision seen as too oriented towards an immediate return to work rather than health or wellbeing.

WWEH was sometimes **contrasted positively with other sources of support for being more tailored and responsive to needs, aspirations and life circumstances**. Some older participants nearing retirement who considered a return to work unlikely welcomed the focus on health and wellbeing without pressure to find work. This was compared with JCP's 'work-first' approach: "*They don't really care whether you're well...you just have to go back to work*" (Participant 18).

WWEH was also **contrasted positively on occasion with support provided by GPs** because it was easier and quicker to access, and more concerned with understanding and addressing underlying issues than the medicalised approach of GPs: "*I'm always getting kind of encouraged to take medication and that's just it*" (Participant 19). This participant also praised the **trauma-informed skillset of the WWEH advisor** as more appropriate for dealing with her emotional needs than other NHS and privately-funded provision she had engaged with:

Her expertise is trauma-focused so, the time spent with her was quite productive...it was [a] struggle finding that same or that similar level of support elsewhere at a reduced cost or through charities. (Participant 19)

A far **smaller number of participants were more equivocal or, in some cases, negative about the service**. In some cases, this was more about the **lack of relevance or appropriateness of support given circumstances** than the quality of service per se. This had a number of different dimensions including:

- **a change of circumstances** such as finding a job that made support unnecessary.
- **difficulty in engaging with support due to challenging life circumstances** such as caring commitments or, in the following case, bereavement:

It was too early. Back to the work and I wasn't ready for that yet. I'd barely got used to being at home...or dealing with my bereavement. (Participant 20)

- an **inability to self-manage health conditions due to the severity of mental health conditions** that rendered support – particular self-help resources - of limited value:

It wasn't really beneficial...the key is to be able to want to help yourself and I wasn't in that sort of frame of mind to do that. (Participant 21)

These final two points showing inability to engage with support may provide one explanation for why health and wellbeing outcomes tend to be worse for those with the most severe health conditions (see Section 5.2). Some participants are simply not ready or able to benefit from support, especially given WVEH's emphasis on taking active steps to self-manage conditions.

In other cases, however, a very small number of participants were **more directly critical of service quality**. Issues highlighted included:

- a **failure of the programme to offer support appropriate to the nature or severity of mental health conditions**. One participant noted, for instance, that the CBT provider did not sustain support when their mental health issues led to missed appointments:

I was just pushed away...you're not keeping up with these sessions and you're not answering our phone calls much, 'well that's it then, we're done now'...when somebody is suffering with mental health issues you'd think there'd be a bit more understanding, especially from people who are involved in that field. (Participant 21)

- **staff turnover and a subsequent need to retell personal histories**: “*It was like restarting and explaining everything again*” (Participant 22).
- **the perceived paucity of support** which one participant saw as amounting to little more than “*a few emails...there wasn't much to be honest*” despite receiving the full Support Service (Participant 23).

All interviewees were asked about how support could be improved. Many suggested they had all the support required: “*I never came away thinking I wish I'd have spoke about this or that, they covered everything, everything was fine*” (Participant 24). Where ideas for improvements were volunteered, the most common suggestion was to **increase the frequency and, particularly, duration of support**, especially where participants had not found work or continued to face mental health issues: “*She just told me at the last session that it's just so unfortunate I only have four sessions...although I was getting better...I needed more help*” (Participant 3).

Suggestions made included the option to pause and later resume support to allow for periods when participants felt unable to engage. Lighter-touch, less regular ‘check-ins’ were also proposed as a way of a tapering engagement once the core period of intensive programme support ended. This desire for extending support is testament to the value of support provided insofar as it clearly indicates participants did not want it to end after six months.

The other main suggestion for improvement was the option of **face-to-face support** or, as the next best alternative, videocalls, although it was acknowledged that the pandemic had precluded the former. At the same time, some participants liked the flexibility of timing and location of telephone contact. Stakeholders have also reported that participants became accustomed to, and comfortable with, remote support once all services shifted to this mode of delivery during the pandemic.

5. Outcomes and impact: health

Summary

- Presenting needs data and health assessments show consistent improvement in health and wellbeing outcomes for participants between joining and leaving the programme. 'Health' and 'Coping and confidence' are the needs where the most positive change is seen by the point of discharge.
- In-work participants referred via the GP pathway consistently experience better health and wellbeing outcomes than JCP or SME referrals. One clear implication is that the refocus of WWEH towards out-of-work JCP referrals as a strategic response to the pandemic has had the effect of depressing overall performance. JCP clients have higher levels of need and are further from the labour market which may limit the extent of positive outcomes.
- Health and wellbeing outcomes tend to be better for participants who have moderate levels of anxiety or depression. This indicates there may be a 'sweet spot' in terms of positive change relative to severity of mental health conditions.
- The assessed level of additionality for participants who achieved a health or wellbeing outcome is between 43 and 51 per cent. This means for every 100 participants whose health or wellbeing, or management of a condition, improved, between 43 and 51 would not have done so if it were not because of WWEH.
- By far the majority of interviewees reported positive health and wellbeing improvements. Elements of support contributing to change included: fast-track access to physiotherapy and CBT; the empathetic, non-judgemental and listening approach of frontline staff; practical tools and techniques to self-manage health conditions; and signposting or referral into other valued support.
- For a smaller number of interviewees, WWEH support seemed to have limited impact on health and wellbeing. In some cases this was ascribed this to the ineffectiveness or inappropriateness of support, particularly where health conditions were more severe.

5.1. 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. 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 considers health outcomes while Section 6 explores employment outcomes. 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 modelling 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.

5.2. Health outcomes

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

Presenting needs

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

Table 5.1 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 bar ‘Caring and Family responsibilities’ have seen falls in the proportion of participants reporting moderate or severe needs (in aggregate).**
- ‘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 27 percentage points for ‘Health’ and 24 percentage points for ‘Coping and Confidence’. This may reflect the effectiveness of WWEH support but is also important to note that higher levels of need within this category on entry provide more ‘headroom’ for positive change. At the same time, the programme had very little impact on needs relating to ‘Personal Finances’ despite relatively high levels on entry. It is possible this reflects the more limited support for financial issues provided through WWEH compared with health issues, as well as wider challenges the programme cannot influence such as recent increases in the cost of living

Table 5.1: Presenting needs (severe and moderate) on entry and discharge

Presenting needs	Severe on entry (%)	Moderate on entry (%)	Severe on discharge (%)	Moderate on discharge (%)	Change (Severe)	Change (Moderate)	Total change
Health	25	42	14	26	-11	-16	-27
Coping and Confidence	21	35	10	22	-11	-13	-24
Alcohol and Drug Use	2	6	1	2	-1	-3	-4
Personal finances	16	20	11	22	-5	2	-3
Housing	6	11	6	9	-1	-1	-2
Caring and Family responsibilities	2	8	3	8	0	0	0

Base: 1042

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)**³⁴ gives a score between 7 (lowest mental wellbeing) and 35 (highest mental wellbeing). A score between 7-19 is considered low³⁵:
- 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 5.2 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 5.3 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 21.36 reported on discharge.

- WVEH has **closed the gap with national averages** on the two indicators where benchmarks are available (SWEMWBS³⁶ and ONS Life Satisfaction³⁷).
- It is also important to consider the proportion of participants experiencing positive change. **Two thirds or more saw improvements in scores** against GAD7 (anxiety, 72 per cent), PHQ9 (depression, 71 per cent), PAM (Health management, 70 per cent), SWEMWBS (wellbeing, 68 per cent) and EQ Visual Analogue score (health, 67 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, 57 per cent) and MSK-HQ (Musculoskeletal health, 59 per cent). This may partially reflect backlogs, delays and on-going use of remote appointments for physical health services such as physiotherapy as the UK emerges from the pandemic. 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 16 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 5.2: Change in health assessment scores

Health assessments	Measure	Entry (mean)	Discharge (mean)	National average (mean)	% participants showing improvement in scores
EQ-5D-5L score	Physical and mental health	0.43	0.59	-	57
EQ Visual Analogue score	Health	54.33	64.93	-	67
SWEMWBS total score ³⁸	Wellbeing	18.92	21.36	25.2	68
ONS Life Satisfaction score ³⁹	Life Satisfaction	4.93	6.22	7.0	65
PAM total score	Health management	54.04	61.42	-	70
GAD7	Anxiety	13.27	8.79	-	72
PHQ9	Depression	14.63	9.50	-	71
MSK-HQ	Musculoskeletal health	24.48	29.74	-	59

Base: 195-1070

Table 5.3: Change in PAM Activation Levels

PAM Levels	Entry (%)	Discharge (%)	Change (%)
Level 1	31	15	-16
Level 2	26	20	-6
Level 3	36	45	9
Level 4	7	20	13

Base: 1070

It is also instructive to look at outcomes by pathway (Table 5.4). This shows better outcomes in terms of health and wellbeing against all five indicators for GP referrals compared with JCP and SME referrals. Two possible explanations stand out. First, participants referred by GPs are, by definition, already receiving support for health issues which, alongside WVEH interventions, may contribute to better outcomes. Second, data presented above clearly indicates that JCP referrals are more likely than GP referrals to have multiple needs (as measured by the CMON) which may limit engagement with WVEH support and the extent of positive outcomes.

Another important finding is that is that outcomes for GP referrals meet three of the five targets (depression, physical health and health condition management) and fall only slightly short of one other (anxiety, -2 percentage points). One clear implication is that the refocus of WWEH away from prioritising in-work participants may have had the effect of depressing performance given the lower likelihood of positive change for out-of-work referrals via the JCP pathway.

Table 5.4: Change in health assessment scores by pathway

	GP	JCP	SME	Overall	Target	Base
1a Mental health (anxiety)	78	71	70	72	80	561
1b Mental Health (depression)	80	72	65	72	80	512
2 Physical health	87	52	59	60	80	185
3 Wellbeing	77	66	62	68	85	1036
4 Health condition management	75	69	70	70	70	1036

Highest figure for each indicator is shown in **bold**.

Health outcomes by subgroup

Health and wellbeing outcomes were analysed to see if, and how, the proportion of participants experiencing a positive outcome varied for different groups using a range of variables including: social and demographic characteristics (e.g. age, ethnicity, education and employment status); whether participants had a mental condition and how severe it was; the nature of support they received (Service or Support Service); and the local authority in which they lived. The full analysis is presented in tables A1 to A5 in Appendix 5.

Data suggests outcomes tend to be *better* for participants who:

- experience **‘Moderate’ anxiety (GAD 7 score) or ‘Moderate’ or ‘Moderately severe’ depression (PHQ 9 score)**. This may be partly explained by qualitative data below showing participants with the most severe health conditions sometimes struggle to engage with WWEH support which limits positive outcomes. At the other end of the scale, it could be more difficult to achieve positive outcomes for those with mild conditions as there is less headroom for positive change. This indicates there **could be a ‘sweet spot’ where participants with mental health conditions whose severity falls between mild and severe are more likely to experience positive change**
- **are in work at the start of their engagement** compared to those who were out of work. This could reflect the programme’s focus on vocational rehabilitation to support participants to return to existing jobs. WWEH was never designed principally as a programme for the newly unemployed who tend to have more severe health conditions as indicated by the CMON analysis and may have additional employability support needs to find work.
- **are resident in the Stockport locality** which is consistently one of the highest performing Localities, both in relation to all programme participants and other Localities. Reasons why Stockport outperforms is explored further in in the modelling analysis in Section 7.3.
- **have educational attainment levels above upper secondary** (A-level or equivalent)
- receive **a greater number of interventions** (either 4-6 or 7+). Caution should be exercised in assuming this indicates a *causal and automatic* relationship between number of interventions and positive outcomes. Nonetheless, qualitative evidence

suggests that those with multiple needs receiving a range of interventions may benefit from feeling well-supported rather than “overwhelmed” (see example on page 28).

Data also suggests health and wellbeing outcomes tend to be *worse* for those:

- **aged 50 and over** compared to participants overall. Proportions reporting positive change were lower for those aged 50 and over on all measures excluding the EQ-5D-5L Score. The difference was most pronounced on the ONS Life Satisfaction Score. One explanation may be that a lower propensity to return to work means older workers are less likely to benefit from the positive health and wellbeing changes described by some who go back into employment (see Section 6.1).
- **with ethnic minority backgrounds compared to participants overall.** Proportions reporting positive change were lower for those with ethnic minorities on all measures except SWEMWBS and the ONS Score. The difference was most pronounced on the GAD7 (anxiety) measure.

Impact analysis

A key question is the extent to which health outcomes are additional to what would have happened without WWEH support. Appendix 6 details the contribution analysis method that was determined from an Impact Development Study to assess the additionality of WWEH to beneficiary outcomes. Qualitative assessment supported by exploratory quasi-experimental analysis determined the following range for the likely level of additionality:

- **The assessed level of additionality for participants who achieved a health or wellbeing outcome is between 43 and 51 per cent.** This means for every 100 participants whose health or wellbeing, or management of a condition, improved, between 43 and 51 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:

- Between 312 and 370 participants (29 to 35 per cent) were supported by WWEH to achieve a positive improvement in their **wellbeing**, measured on **SWEMWBS**.
- Between 323 and 384 participants (30 to 36 per cent) were supported by WWEH to achieve a positive improvement in their **ability to manage a health condition or disability**, measured on **PAM**.
- Between 297 and 352 participants (28 to 33 per cent) were supported by WWEH to achieve a positive improvement in their **life satisfaction**, measured on the **ONS Life Satisfaction** measure.

- Between 263 and 312 participants (25 to 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.
- Between 306 and 363 participants (29 to 34 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

Interview data provides further detail on how changes in health and wellbeing are experienced and the factors contributing to improvements. By far the majority of interviewees reported **positive health improvements**, most commonly in terms of **better mental health or wellbeing**. Benefits reported included reductions in stress or anxiety and improvements in coping, confidence, self-worth, motivation and, in a small number of cases, a reduction in suicidal thoughts.

In the **majority of cases these improvements were attributed directly, at least in part, to WWEH support** as the following examples indicate:

I just felt stressed constantly [from my previous job]...The point that I started speaking to [WWEH] I was in a really bad place...I spoke to them and three sessions later I felt like myself again. (Participant 25)

I'm much better than a year ago...I can see more sunshine in my life...[without WWEH] psychologically, I will be very depressed, maybe on the medication or something. (Participant 26)

[If] Working Well wasn't there to help me psychologically [during lockdown]...I don't know...Let's just say there's no need to continue. You understand. (BAME Participant 3)

Improvements in mental health secured through WWEH could also have **knock on benefits**, with one participant describing how it may have prevented him losing both his home and his relationship: *"If I hadn't have helped myself to get help...I don't know whether I'd still be with my partner?...I might have obviously eventually lost my home"* (Participant 28).

Drawing on data from both the 2021 and 2022 annual reports, **elements of support identified as contributing most to positive change** were:

- **fast-track access to physiotherapy and CBT support** for which they were long waiting lists on the NHS. In some cases this prevented conditions from worsening, underscoring the importance of early intervention. One participant, for example, noted the value of rapid access to CBT after suffering a bereavement given prior experience of mental health deteriorating when she did not access support:

I used those experiences what I went through to know like that I needed it ASAP rather than waiting...[that is] the reason why I got so ill and had the breakdown back then...if I wouldn't have had that CBT from WWEH...I'd still be waiting [for treatment on the NHS]. (Participant 29)

- the **empathetic, non-judgemental and listening approach** of VRCs and EPN practitioners which helped participants understand issues as well as the steps needed to secure beneficial change. Interviewees noted the importance of the *"support and kindness...the friendly voice"* (Participant 30), *"someone to talk to"* (Participant 32) and *"emotional support"* (Participant 27). Notably, some older men in particular, stressed the value of being supported to *"open up"* (Participant

32) **in ways they would previously not have felt comfortable doing**, perhaps reflecting gendered assumptions about acknowledging these challenges. For some, this support was critical in making progress:

It got to a little bit of a stage where I was waiting for her call...she understood what I was going through...I could talk to her and she wasn't being judgemental...You open the curtains and you go, "oh it's sunlight outside" and I felt, once I could put my finger on it, I could deal with it. (Participant 31)

- advice and resources that provided **practical tools and techniques to self-manage health conditions** such as stress, anxiety and depression. Younger participants seemed notably positive about, and willing to use, self-help resources to manage health conditions compared with sometimes more ambiguous or negative responses from other participants: *"It was fantastic because [the VRC] wrote...an eight or nine page document that had links, it had all the information...It helped with my anxiety because I have terrible, terrible anxiety"* (Participant 17). One implication may be that younger people are more comfortable with, and likely to use, online and self-directed materials than older cohorts, highlighting the need for a differentiated approach⁴⁰.
- **signposting or referral into other support** that could provide additional help such as housing or benefits advice.
- **support to address to some of the wider determinants of health beyond employment**. One interviewee described feeling less isolated due to social connections fostered through referral to a social prescribing service:

The links sent me, to meet up with like other African communities...they asked me to come over, it's just like a house, you know, so you don't feel like you're alone...I made new friends and these people that would be concerned about you... I felt less alone. (Participant 33)

In some cases, it was the **combination of the empathetic approach of the VRC combined with resources to manage health conditions that generated positive change**:

The good part is you get techniques... she sent me some email techniques...to help with my anxiety... and I felt like she was listening. She's really lovely like. (Participant 34)

The account of Sonia (Box 2 below) also illustrates how **WWEH could offer a range of support** which might not all be useful or accessible but – underpinned by the foundation of the emotional support of the VRC - could lead to both positive health and employment outcomes.

Box 2: Sonia's story

Sonia was referred to WWEH by her GP. She was experiencing anxiety, depression and suicidal thoughts after the loss of a close relative. She had attempted to take up employment in a care home, but work aggravated her mental health issues and she was forced to give up.

She had received CBT and weight management advice from WWEH but did not find either particularly productive as she already knew some CBT techniques and couldn't travel to weight management classes due to lack of funds and closures during a period of COVID-19 lockdowns. Her VRC also referred her to grief

counselling that she had yet to access at the time of interview due to a long waiting list, although she remained keen to take the opportunity up.

Despite the limited value of some of the support offered, Sonia was broadly positive about WWEH and full of praise for the caring and supportive attitude of her VRC who had remained in contact with her beyond the allocated six months support: *“She’s a lovely person and she’s one of those people who...won’t judge you...you have really got that caring side from her”*.

She still joined in Zoom quizzes organised for a group of WWEH clients and stressed the fact that the VRC had gone ‘above and beyond’ in terms of supporting her practically and emotionally.

Her VRC also put her in touch with a training organisation through which she had accessed and enjoyed a range of work-based training. At the point of interview Sonia was about to embark on a telephone-based role at a contact centre, which she indicated was preferable to a job that involved face-to-face interactions.

Health and wellbeing support was also sometimes contrasted favourably with WWEH employment support that was seen as insufficiently tailored to circumstances:

The CBT was really, really helpful, I actually felt much more confidence after I talked with that psychologist and I wish I had more of it. But the rest of it actually was really, really generalised, it wasn’t really specific or designed to help certain people to get back into the work. (Participant 34)

One note of caution is that while impacts on health and wellbeing can be very positive, they are not always sustained when programme support ends or circumstances change (Box 3). Megan’s experience also shows how different components of support have variable impacts depending on the perceived calibre of staff.

Box 3: Molly and Megan’s story

Molly

Molly had a track record of working in a range of low paid, service-related occupations. She left her last job in retail because of a combination of mental and physical health issues. Molly was put in touch with WWEH through Jobcentre Plus (JCP) and valued the support around coping strategies and counselling she received. This focussed primarily at first on improving her health and wellbeing through counselling which, in agreement with VRC, she felt she needed to address before she could consider going back into work: *“When I started explaining what was going on in my life, it become obvious that work was not a priority. I needed the help to sort my own personal [health] problems out before working”*.

WWEH made a significant positive difference to her wellbeing and put her in a position where she felt she *“loved myself a bit more again”*. Molly even credited the programme with helping her to overcome suicidal thoughts: *“I don’t think I would be here [without WWEH]. You know it kept me going while I was in a situation where I had no-one”*.

However, a combination of personal issues relating to family and relationships has since seen her health and wellbeing deteriorate: *‘I have been spiralling down’*. Despite the challenges she faces, Molly would still like to find work eventually in the educational sector as a support worker and has relevant qualifications. However, she feels her lack of experience will hold her back, especially as volunteering to gain experience is not an option

with her financial situation: *“It was like you know, I can’t really afford to go and do voluntary work, I have got to pay my bills at the same time”.*

Megan

Megan owns and runs a hospitality venue and found out about WWEH during the second lockdown through a JCP Work Coach when making a Universal Credit claim because she was temporarily unable to work. Megan needed support with pain management for a physical health condition and was advised to try WWEH due to long waiting lists for physiotherapy through the NHS. Initially, she was very disappointed with the service she received as the telephone appointments were too short, provided no scope to visually demonstrate exercises, and consisted largely of advice to check out online materials she could have found herself anyway:

The physio was terrible. I think the longest phone call we had was six minutes, and it was always just a case of: ‘Have you found a YouTube video? I’m going to send you a link for one, okay bye’...if you’re sat down watching a YouTube video, your form could be way off, you could be injuring yourself more, and you would have no idea.

However, she also received CBT through WWEH to try and limit the impact of stress as part of pain management techniques. Megan found CBT useful and wished it would have lasted longer than four weeks as it helped to have someone to talk to about issues in her personal life:

The therapist for the CBT was lovely...It was nice just to have someone to actually talk to about everything that was going on rather than just kind of like bottling it up and getting even more stressed.

For a smaller number of interviewees, however, WWEH support **seemed to have limited impact on health and wellbeing although participants often still valued the support received**. In some cases this was ascribed to the ineffectiveness or inappropriateness of support, particularly where health conditions were more severe as the second quote illustrates:

I don’t really find therapy useful to be honest, I’ve had it several times over the years...I’ve got plenty of people I can talk to, it wasn’t really that useful... It made a little bit of difference. (Participant 35)

It didn’t really do anything...usually I’m the first person to complain if I think they’ve just not helped through their own incompetence but I just don’t think there was anything that they could offer me (Participant 36)

The final point once again confirms the challenges faced by those with more severe conditions in engaging with the programme. One member of the Provider team also suggested that the unexpectedly high proportion of participants with severe needs meant that CBT did not always function as intended as a short-term foundation for those with mild to moderate needs until they could access external clinical support: *“[It was intended to be] more of a stop gap than a be all and end all for the lighter touch cohort but we know the bulk of the cohort had a severe need2.*

Other interviewees had **experienced positive change but attributed this to alternative sources of support** such as CBT or physiotherapy or, as in the second example, their own capacity to self-manage health conditions:

[Support from an external employability organisation] was very, very useful in terms of my assertiveness skills. (Participant 37)

I'm grateful for the support I got..[but] I like to think that I've quite a strong will power so I think I would have come through this by myself. (Participant 29)

6. Outcomes and impact: employment

Summary

- Just over a third (38 per cent) of all participants experienced a positive employment outcome by the point of discharge. Evidence suggests WWEH is more effective in supporting health and wellbeing than employment outcomes.
- Impact analysis assessed the level of additionality for participants who achieved a job outcome as between 33 and 38 per cent. This means for every 100 participants who found, or returned to, work, between 33 and 38 would not have done so without WWEH support. This is above the level of impact that studies have attributed to a range of other employment programmes.
- Interviewees who were not looking for work tended to be older which is likely to reflect health conditions and the challenge of transitioning into new jobs in the latter stages of working life.
- A number of interviewees who were looking for work reported benefits from WWEH support including: increased confidence and motivation in job search; greater awareness of employment options; better understanding of entitlements to request adjustments; and recognition of the need to take gradual steps to return to work.
- Those who had returned to existing jobs or taken up new employment often suggested WWEH had contributed to this through some combination of: offering advice on a gradual return; encouraging use of workplace occupational health services; enabling better self-management of health conditions; designing a structured Return to Work Plan; providing the knowledge and assertiveness to articulate needs to employers; and strengthening resolve to leave harmful jobs.
- Those who returned to work often reported positive health and wellbeing impacts. These benefits were often realised through a change of employer, occupation or sector where previous jobs had been a source of negative mental health or wellbeing. This highlights the importance of support to switch, or find new, jobs as part of integrated health and employment provision.

6.1 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

Two of the presenting needs measures relate to reliability: 'Access to work' and 'Skills and qualifications'. Table 6.1 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 small falls as measured by total change. These decreases are not

as large as those reported above for some of the health-related outcomes (Section 5.2). This may reflect the more limited focus of WWEH on employability support.

Table 6.1: Proportion of participants reporting improvements in outcomes

Presenting needs	Severe on entry (%)	Moderate on entry (%)	Severe on discharge (%)	Moderate on discharge (%)	Change (Severe)	Change (Moderate)	Total change
Access to Work	8	20	10	15	2	-5	-3
Skills and Qualifications	4	19	4	13	0	-6	-6

Base: 1042

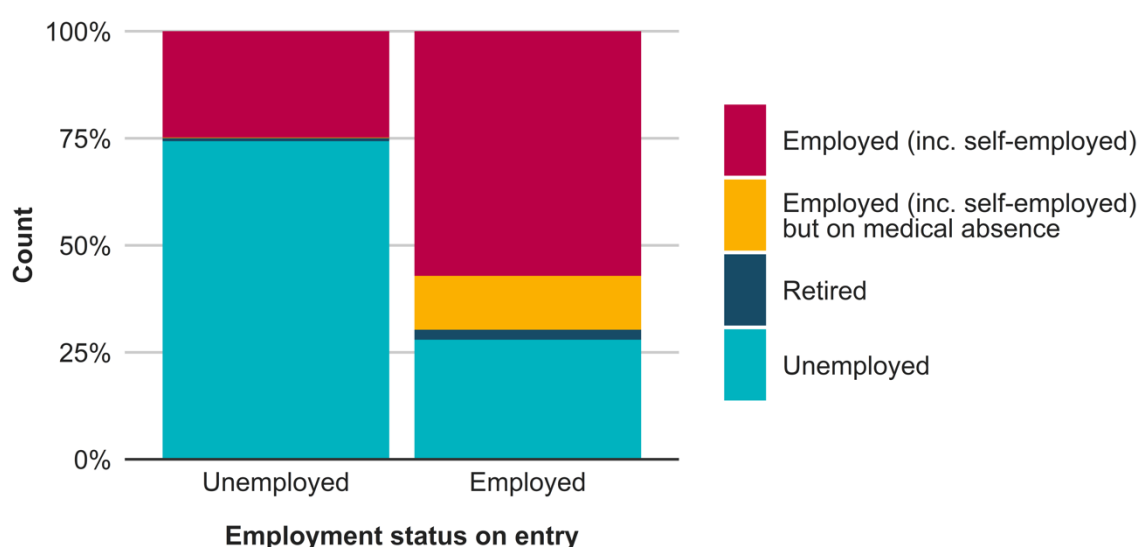
Return to work

A key measure of programme success is the extent to which WWEH supports a return to work. Among those formally discharged from the programme, 38 per cent were in employment on exit and 55 per cent were unemployed. In other words, **just over a third of all participants experienced a positive employment outcome by the point of discharge.**

Figure 6.1 details participant employment status on discharge by status on entry. It shows that:

- Of those **unemployed on entry** to the programme, a quarter (25 per cent) had moved into work on exit from the programme against a target of 60 per cent. The majority of the remaining 74 per cent remained unemployed, although a very small number had either retired or moved into self-employment.
- Of those **employed (but presumed to be on medical absence)** on joining the programme, nearly three fifths had returned to work on exit (58 per cent) against a target of 80 per cent; 28 per cent were recorded as unemployed on exiting the programme and a small number had retired (2 per cent). The remaining participants (13 per cent) were still employed but remained on medical absence.

Figure 6.1: Employment status on exit by status at entry



Base: 1158

Note: 'Employed on entry' includes those self-employed.

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, health conditions and barriers to work they experience (see Section 3.3.).

The programme did not meet either target for the proportion of participants who return to work. The biggest shortfall related to the newly unemployed finding work (job starts, -35 percentage points). This is not unexpected given challenging labour market conditions during the COVID-19 pandemic. However, performance on job starts actually improved after the pandemic started (Table 6.2 below). One explanation given by JCP stakeholders is that those made unexpectedly redundant or furloughed during the pandemic often had little experience of unemployment and were relatively close to the labour market. This 'pandemic cohort' were therefore better positioned and motivated than typical 'repeat customers' to secure new jobs with relatively light touch support, not least because their health condition had not prevented them working in the past. Other explanations may include improving labour market conditions as the UK emerges from the pandemic (see Section 1) and increased use of remote working which has lowered some of the barriers to work faced by those with health conditions or disabilities, as indicated by some interviewees (see below).

Table 6.2: Proportion reporting improvements in employment outcomes (%)

	Pre-pandemic cohort (Apr 2019-Mar 2020)	Pandemic cohort (Apr 2020-Apr 2021)	Pandemic recovery cohort (May 2021-Mar 2022)	Target
5. Returned to and sustained in work (medical absence cohort)	64*	57	57	80
6. Job starts (newly unemployed cohort)	19	27	26	60

Base: 98-411

* 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.

Employment outcomes by subgroup

Analysis of employment outcomes by subgroup shows some variations. Tables A1 to A5 in Appendix 5 examine changes in the proportion of participants achieving a positive employment outcome between discharge than entry. Data suggests employment outcomes tend to be *better* for those:

- with **one health condition** compared to those with two or more, especially in terms of returning to work from medical leave. This indicates that, perhaps unsurprisingly, co-morbidity may present an additional barrier to returning to work.
- with **mild or moderate anxiety (41 per cent and 42 per cent) or moderately severe depression (45 per cent)** who were more likely to experience a positive employment outcome than all participants (38 per cent) or those with severe anxiety (37 per cent) or severe depression (34 per cent). Once again, this suggests that participants with mental health conditions of a severity that falls between mild and severe tend to achieve better outcomes.
- **in paid work at the start of their engagement** compared to those who were out of work. This is likely to reflect the lower levels of need among the in-work cohort (see Section 3).
- **receiving the advice service** compared to those receiving the support service. A total of 70 per cent of those receiving the Advice Service experienced a positive employment outcome compared with 36 per cent of Support Service recipients. This difference is likely to be related to proximity to work with participants more

likely to return to an existing job or take up a new job while on medical leave than secure a new job if unemployed. It also indicates that, while there are some concerns with the lighter-touch Advice Service not providing adequate support, over two thirds of recipients do still return to employment. It may also reflect the value of WWEH provision that Advice Support recipients received including the Return to Work Plan and self-directed online materials (see examples of positive impacts on pages 37 and 50)

- with the highest **educational attainment level of** tertiary or equivalent (undergraduate or graduate level).
- **resident in the Stockport locality** (see modelling below for further explanation).
- **who were younger** with 41 percent of those aged 18-24 securing a positive employment outcome compared with 38 per cent overall and just 33 per cent of older participants.

Data also suggests that the **quality of work secured varied by subgroup**:

- **Younger participants were more likely to experience precarious labour market positions** than WWEH participants overall as indicated by a greater likelihood of frequent job switching, low pay and part-time work:
 - Of those not in work on entry to WWEH, a greater proportion of 18–24-year-olds had held *more than* one job in the last three years than participants overall (73 per cent compared to 53 per cent).
 - Over three quarters (77 per cent) of 18–24-year-olds in employment on discharge from WWEH were in the lowest hourly pay band (less than £10/hour) compared to 48 per cent of respondents overall.
 - A greater proportion of in-work 18–24-year-olds were in part-time work compared to participants overall. A lower proportion were also self-employed.
- **A smaller proportion of in-work ethnic minority participants from ethnic minorities were in full-time work** compared to participants in work overall (58 compared with 72 per cent), while **a higher proportion were self-employed** (34 compared with 20 per cent). This may have implications for income and security given the growth in more precarious forms of self-employment and the large proportion of the self-employed on low earnings⁴¹. One BAME participant, described for example, struggling to make a living from a craft-based business: “*I still do markets occasionally or like workshops and things but not enough to live off*” (BAME participant 49).

Impact analysis

Impact analysis **assessed the level of additionality for participants who achieved a job outcome as between 33 and 38 per cent**. This means for every 100 participants who found, or returned to, work, between 33 and 38 would not have done so without WWEH support. This is slightly lower than the range of additionality for health outcomes (between 43 and 51 per cent). It is perhaps to be expected given that support through VRCs or the EPN can directly and identifiably improve health and wellbeing. The contribution of WWEH towards a return to employment may be harder to pinpoint or, as suggested below, be seen as facilitated by wider support from employers or health practitioners outside the programme. However both the lower (33 per cent) and upper (38 per cent) estimate suggest that WWEH has achieved a high level of additionality compared to other employment interventions – albeit for general populations. For example an international meta-analysis of 505 programmes found the mean effect size to be 22.4 percentage points over the longer term⁴².

As part of the qualitative impact assessment there was a suggestion that additionality for job outcomes 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 these additionality ratios to the 440 participants who either found a new job or returned to an existing job suggests that between **145 and 167 participants (13 to 15 per cent of all with discharge assessments) were supported by WWEH to an employment outcome**. These outcomes are unlikely to have been achieved in the absence of WWEH support. One final caveat is that returning to work may not always be a positive outcome as it depends on the quality and experience of employment, as highlighted by less positive examples at the end of this section.

Factors contributing to positive employment outcomes change (modelling)

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 outcome⁴³. The method and model used is explained fully in Appendix 3. Holding other things equal, three factors are statistically significantly associated with gaining an employment outcome:

- **Participants resident in the Stockport locality** were on average 2.51 times more likely to have gained an employment outcome, compared to the programme average across the 10 local authorities. One explanation may be that the programme proved particularly effective in Stockport due to the good relationship between GPs and GPEOs and embedded GP clinics which may have maximised the flow of appropriate referrals (see Section 7.3). That said, there may be other factors which account for this which are not included in the model such as more employment opportunities accessible to residents compared with other Localities.
- Those whose **score had improved on the PAM (health management) measure were on average 2.06 times more likely to have gained an employment outcome**. This aligns with findings from interviews showing the value of tools and techniques to self-manage health conditions in enabling a return to work.
- Those whose score had **improved on the SWEMWBS (wellbeing) measure** from entry to discharge were on average 1.97 times more likely to have gained an employment outcome.

The final two factors appear to **further confirm the positive relationship between employment and good physical or mental health**, and to validate the dual focus of WWEH 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 employment, or if improvement on these measures had helped them to secure or return to work.

Qualitative data does provide such insights and suggests that both causal pathways are possible. Many participants saw or experienced improvements in health and wellbeing as a prerequisite for returning to work. Equally, going back into work was also clearly associated by some with positive impacts on health and wellbeing (see below).

In contrast, there were two groups who were **statistically less likely to have gained an employment outcome**:

- those who **were placed in the category of most need on the combined measure of need**
- those out of work on entry to the programme and accessing the Support Service.

Again, this appears to confirm that the number or severity of needs experienced (as captured by the CMON) and distance from the labour market in terms of being unemployed function as additional barriers to work.

Participant insights

Interviews with participants provide more in-depth insights into employment outcomes. Findings in this section are presented by employment status at the point of interview among four different cohorts depending on whether they were: out of work and *not* looking for work; out of work and looking for work; returning to existing jobs; or, taking up new employment. For each group reflections are provided on the extent to which WWEH support contributed to any change.

Not looking for work

A small number of interviewees were out of work (on medical leave or unemployed) but not actively looking for work at the time of interview. This cohort was **predominantly made up of older participants with mental or physical health issues**. Health conditions were sometimes complemented or aggravated by wider circumstances such as social anxiety brought on by the COVID-19 pandemic, caring responsibilities, relationship difficulties (first example below), and challenges in securing sickness benefits (second example below):

I'd love to go back to work...I'm going through court with my marriage...I'm pre-occupied in sorting that out as well as the impact it's had on my health. (Participant 38)

A lot of people have said, with you having heart problems, you should be on [sickness benefits]...I've been rejected again for the second time ...it just seems they want to try and push me back into work, but am I fit for work [when] I thought about taking my own life? (Participant 15).

The dominance of older workers in this group may also reflect the challenges in transitioning from relatively stable employment into new jobs in the latter stages of working life. Certainly, programme monitoring data showed that, among those out of work on entry to WWEH, **a greater proportion of those aged 50 and over had held just one job in the last three years** (63 per cent) compared to participants overall (47 per cent). One stakeholder also suggested that:

It's going to be a big adjustment for them because they've been used to doing [a job] and maybe if it's a practical job and they're going to have to upskill, there might be some reticence there. (Provider).

These findings suggest life stage is a key factor shaping the extent to which WWEH can support a return to work. It also reiterates the point that some participants are significantly detached from the labour market despite recently being in work. This **perhaps challenges the logic and assumptions of programme design that early intervention can always prevent this kind of disengagement**.

At the same time, many older participants experience health and wellbeing benefits from WWEH support *regardless* of employment outcomes (see Section 5.2). This raises questions about whether the health and wellbeing benefits alone validate programme support for those not looking for work, or whether provision needs to be more focussed on overcoming some of the entrenched barriers that preclude a return to employment.

Looking for work

Many interviewees looking for work at the time of interview were largely positive about WWEH support which was reported to have **impacted positively on prospects of finding work** in a number of ways:

- **increasing confidence and motivation in looking for work:**

[WWEH] got me into a spot, where I was able to look for work and find jobs that I wanted...tailored to me...get confident enough to look for jobs. (Participant 39)

- **widening awareness of career choices and job options:**

It's helped me to find other areas of work that I might not have looked at before...things like the voluntary sector. (Participant 40)

- providing **greater knowledge of entitlements to request adjustments:**

[My VRC] helped me understand what adjustments I might need. I thought [employers] could just do what they want [but now I know] they can make special adaptations...I can actually try and apply for some remote work or at home working. (Participant 41)

- **recognising the need to take gradual steps** to return to work to avoid a decline in health:

[I said] I just can't go back to work and he was saying, 'well don't jump in the deep end, and have another breakdown...build up slowly'... so that's what I'm trying to do. I think that will work". (Older participant 42)

These examples provide insights into how **WWEH support can move participants closer to work that** that is not captured in programme monitoring data focussed on job outcomes.

Finally, while past annual reports found that a very small minority of participants criticised the lack of direct employability support to find jobs, this was far less prevalent from more recent interviews.

Returning to existing jobs

In many cases WWEH support was **directly credited with supporting a return to existing jobs** through:

- **advice on a gradual return** such as undertaking pre-return visits that helped to reduce anxieties about going back into work.
- **encouraging use of occupational health services** that participants may not otherwise have accessed.
- **enabling better self-management of health** as precursor to returning to, and staying in, work:

When I was able to do the CBT and go through and kind of calm everything it did help me go back to work a lot. I don't know whether I would have gone back as quickly. (Young Person 11)

- **providing the confidence, knowledge and assertiveness to articulate needs** and request adjustments in the workplace:

I thought it was just me just being awkward but after speaking to the counsellor and having it all like this report, I actually felt...they've got to help... it just gave me that confidence to go in and say...you need to sort it out... [without WWEH] I'd probably still be going in work and then letting it all build up and then being off for a week or two with stress and anxiety, and then it just being a continuous cycle. (Participant 43)

In some cases **the responsiveness and supportiveness of employers was also a critical factor in enabling a return to work**. Interviewees emphasised the value of a phased return to work, reduced workload, less physical duties and willingness to accommodate the need for time off due to health issues:

Work were very supportive [about an injury]...they said they'd find me something that wasn't strenuous. (Older participant 44)

My manager does know [about my physical and mental health conditions]...she's really supportive. If I ever need...a day off because of something, then yes, she's very accommodating". (Participant 45)

There were **fewer examples of employers failing to respond adequately to participants' needs** in order to support a return to work compared with the numerous instances documented in the 2021 Annual report. This may reflect - as some stakeholders have suggested - a greater willingness of employers to support employees with health conditions given current tighter labour market conditions.

That said, there were still **examples of employers showing limited flexibility to accommodate needs**:

WWEH had sent the plan to the employer... I read through it, I thought right that's fantastic, it'll help massively, and they just dismissed it, I don't even think they looked at it if I'm honest. (Participant 25)

Some participants suggested they might have found work anyway but WWEH support gave them the techniques or external support to manage conditions in a way that enabled a **quicker return to work** (see Leanne's story in Box 4):

Box 4: Leanne's story

Leanne was working at a supermarket part-time when the pandemic broke out and she became anxious and suffered from panic attacks due to concerns about working in a busy environment.

She was referred to WWEH by her GP to receive support to help her cope with her anxiety. She spoke positively about the online materials she received from WWEH, particularly the Mindfulness and Coping Strategies modules that she used regularly:

I printed out a lot of the resources. I can look back on them and just go through them again just to jog my memory... the more I read it the more it'll probably help me in the future.

After consultation with her GP she also self-referred to a mental health support service and received group CBT for 12 weeks, which she found very helpful. She feels she is now better able to cope with her anxieties and has techniques in place should she need them.

Her employer was sympathetic to her concerns and after three weeks' medical leave she returned to work on other duties that enabled social distancing from the public.

Leanne thought she would not have returned to work as early as she did without the WWEH modules and the CBT support: *"I think I would have probably struggled to go back to work as soon. I probably would have gone back but not as soon as I did"*.

Finally, a smaller number indicated that **they would have been able to return to work without WWEH, but often still appreciated the support they received**. The lifting of lockdown restrictions enabled one participant, for example, who had been highly positive about CBT received to return to a career in the live entertainment industry without direct WWEH support: *"For me I definitely would have done that ... I was as determined as anyone to get back and do concerts"* (Participant 46).

Finding a new job

A number of interviewees reported securing new jobs that included positions as a cleaner, a bank job, bar work, personal caring assistant and bookkeeper. In some cases it was clear that **WWEH had directly contributed towards participants securing work or enabled them to find a job more quickly than they otherwise would have done**:

[Without WWEH], I'd probably still be like unemployed, and I think I'd definitely still be very anxious. (Participant 12)

When you have a middle person support you things... move a bit faster... I don't think I would have been here without the support that I got. (Participant 47)

A minority of interviewees also noted that find WWEH support helped them find **better quality work or secure training to improve opportunities for progression**. One interviewee, for example, credited his VRC with encouraging him to secure a more interesting job, moving away from an IT post he found *"boring"* to a hotel maintenance worker that was *"not boring at all"* (Young Person 15). The VRC also motivated him to undertake further work-based training to increase opportunities for progression: *"As soon as I got the job, she still carried on telling me how I could progress...she said that it's worth it, so I should apply for [training] and just go for it"*.

Interviewees **attributed positive employment outcomes to a number of different elements of WWEH support** including:

- **support to manage mental health issues generating the confidence and motivation to look for work:**

It was a really, really hard time I was just very anxious. I didn't want to socialise with anyone, I just sat in my room...I just feel as though if I didn't get that help...I wouldn't have been trying to find another job because I wouldn't have been in the right frame of mind. (Young Person 3)

- **trauma-informed support** to realise the possibilities of returning to work after life-changing events such as bereavement:

[WWEH provided] an inner confidence to get back out and do work again... helping to get that that point where I was able to acknowledge that, you know, there is life after this virus” (Participant 56)

- **appropriately sequenced support with presenting health needs addressed before employment:** *“I was really impressed by the fact that the focus of it was on my health and my wellbeing as the first step towards them being able to get back into work” (Participant 40).*
- **developing the resolve to leave jobs that had been harmful to mental health wellbeing:**

It was just healthcare assistant. And I just didn't enjoy it, I used to hate going up. And then I went on the sick and just thinking I can't go back there...my anxiety was getting worse and worse...I think when I were speaking on the phone to [WWEH they encouraged me to] try different things...to think about leaving...I knew I had them to help me to find something and to support me...I made a decision, handed my notice in, got this new job, started new jobs and do you know what, I haven't looked back at all. (Participant 32)

- **a structured and holistic Return to Work Plan (RTWP) to address the range of barriers faced.** One participant spoke of how it enabled them to address a number of challenges – *“physical, intellectual, emotional and social”* - to support a return to work: *“It was useful because I feel as though if I didn't use it I wouldn't have gone back to work. It was a very stressful time” (Participant 48).*
- **opening up new and better opportunities such as more stimulating or secure career choices.** One participant observed that their VRC had helped them to break the cycle of a succession of short-term, unsatisfying roles which had characterised their labour market trajectory since leaving school (Box 5 below).
- **the tools and techniques to manage health conditions in work enabled some to sustain a return to employment:** *“[On the drive to work] I just pulled over, had five minutes, got myself sorted and then went to work, there is no way, without these techniques I would've gone to work that day”. (Participant 49)*

Box 5: Zoe's story

Zoe explained that the support of WWEH had helped *“massively”* with her health and wellbeing. The initial health assessment by the VRC persuaded her to access CBT despite initial reticence, and she remained engaged with therapeutic support which:

really helped me, because I didn't think I needed therapy. I didn't really think there was anything wrong with me... [but] I was finding out all of this stuff about like how trauma is caused and that sort of thing.

She had since decided to commit to taking her medication regularly she which described as the *“best decision ever taking it, I still don't take it every day, but I take it as and when and that definitely helps.”*

Eventually, Zoe got a job as support worker for a charity which she was still undertaking at the time of interview. She attributes this to WWEH support in helping her recognise that she had a mental health condition and the type of work that would

be most appropriate for her: *“How you work best and sort of found out that, flexi working, part time, would be good...just like working out what would be best for me.”*

Gaining a better understanding of needs and building her confidence not only helped her find and sustain work, but also to secure better quality employment that ended the cycle of unsatisfying temporary jobs that had previously marked her employment history:

This is the longest job I've had, since I was 19...I would never have gone into this role without their support... you could go to a job, be miserable, stick it out for six months...then quit that job, spend your savings, get another job, like it's not a very healthy cycle. So, I think [the VRC] was more coming from a point of, I want to get you in a job as quickly as possible, but I also want you to want to be in that job, so you stick that job out...I could have gone into warehouse work...but now I... have that confidence to know that I don't need to... because that's not going to be beneficial to my mental health... [WWEH] definitely put me on the right path to recovery, because I think without it, I would still be very much stuck, I'd probably still be smoking a lot of weed, taking a lot of illegal drugs and that sort of thing. It just like put me on the path of how I could actually move forward, it was kind of like a life coach...I will be forever grateful, they were so great.

Looking back, she is effusive about the empathy and compassion shown by her VRC:

They completely understood everything I was saying... completely non-judgemental, just kind of really caring and like general wellness and just kind of went through everything it was really, really good.

The example of Michael (Box 6 below) illustrates how it is **sometimes the health and wellbeing benefits of WWEH support that appear to support progress into work** rather than direct employability support:

Box 6: Michael's story

Michael was referred to WWEH by his GP. He was unemployed when he first engaged with the project and experiencing severe mental health issues including suicidal thoughts. Michael had left his previous job in the ICT sector following a lack of support from his employer for a serious health condition. He now wanted to change his career focus and study towards a professional qualification.

He was very positive about his WWEH advisor, recalling how the latter cheered him up when he was feeling down. In terms of practical support, he had been offered assistance around work preparation. Although he felt this had not been particularly useful, he was effusive about the CBT he had received through the project, describing it as *“brilliant”*. The project had also referred him to an external service which offered advice on getting professional qualifications and had encouraged him to make changes with regard to his diet, leading him to eat much more healthily and lose a considerable amount of weight.

By the time he had finished his engagement with Working Well, he felt much more relaxed and confident about returning to work. He said he did not think he would still be alive without WWEH support. At the time of the evaluation interview, he had just

recently started work at a financial institution and was full of praise for their supportive attitude to someone with a disability.

In contrast, **some participants felt they would secured a new job anyway** but often spoke about the value of WVEH support regardless, particular in terms of positive impacts on health and wellbeing: *“On the long run, I would have been able to [get that job]. But, having someone there to speak to...make sure that you’re doing the right things, for me that was fantastic”*. (Participant 50)

Aside from WVEH support, one other factor that made securing new jobs possible for a small number of participants was **the ability to work remotely and flexibly**, which made it easier to manage health conditions:

It’s all remote anyway so yes, that’s fine, I’ve needed to take more frequent breaks. But I can do that and as long as I do the hours it doesn’t really matter and as long as the work gets done it doesn’t matter. (Participant 36)

One implication is that **the shift towards remote forms of working precipitated by the pandemic may open up new opportunities for those with health conditions and disabilities** to secure and sustain jobs they would otherwise find difficult to undertake in the workplace. Conversely, this may offer little for those whose usual occupation does not lend itself to remote working, or who lack the technology or workspace to work from home.

Local labour market conditions

Interviews also explored the ease of finding work to gauge perceptions and experiences of local labour market conditions as the UK emerges from pandemic. Previous rounds of fieldwork had noted issues with redundancies, furloughing and reduced hours or wages after the pandemic broke out. However, there is some indication in recent interviews that **the pressures of finding work have eased** in the period since pandemic-related restrictions have been lifted. Nearly all of those who had found work or were looking for work expressed a view that it was comparatively easy to get a job, as the following examples illustrate:

[It was] quite straightforward to [find work] be honest...Security jobs are definitely out there. (Participant 39)

I know the boss and he’s offered me a job a few times and I just messaged him to see if he had any work and he literally had me in the next day. (Participant 35)

Indeed, one interviewee noted that labour shortages in the haulage sector had led to wage increases and improved shift patterns for HGV drivers after years of flatlining wages:

A lot of companies, sort of, came in and sort of [said] how can we improve driving standards, you know, the work life, the balance because a lot of drivers complained...so a lot of companies have tried to tweak it. (Participant 31)

A further indication of the buoyancy of the local labour market was a striking degree of unanimity among those who had returned work that they **enjoyed job security**, as characterised by comments such as feeling *“very secure”* (Participant 51), *“pretty secure”* (Participant 52 and Participant 53) and *“very confident”* (Participant 54). One skilled tradesman noted how high demand gave him confidence that his current employer would be supportive if his health fluctuated: *“[They] are basically begging me to stay...they don’t really want to lose me...I feel quite comfortable”* (Young person 7).

This indicates that **high demand for employees in some sectors may provide more scope for flexibilities or advantageous terms and conditions that help manage or mitigate health conditions.**

One important caveat is that **plentiful employment does not necessarily mean attractive job opportunities.** One participant who had moved away from work in the health care sector to take up two jobs as bar manager and personal assistant noted the prevalence but insecurity of employment in her former line of work: *“I could get a job and go back into care if I wanted but I don’t want to do that .. it was all zero contract”* (Participant 32).

On balance, however, findings suggest that labour market conditions across a range of sectors and occupational levels are relatively buoyant. This indicates that – contra to expectations at the outset of the pandemic – that WVEH had been operating in its latter stages in a relatively favourable economic climate. The apparent ease of finding or changing jobs also appears to have benefited participants given the evidence of the health and wellbeing benefits of securing new work highlighted in the section which follows.

Work as social determinant of health

A key theme of the evaluation is the relationship between employment and health. It has found consistently that experiences of work can cause or aggravate physical or mental issues and, for many, was one of the primary reasons for leaving jobs. Equally, this relationship works both ways and **those who returned to existing jobs or found new employment often reported positive health and wellbeing impacts in terms of:**

- **improvements in confidence and motivation:** *“It got my confidence [up] a bit more”* (Participant 39).
- **a return to a routine and structured activity:** *“It’s been more positive on my mental health starting this job...it’s just that routine that I need”* (Participant 21).
- **feeling valued and respected by new employers:** *“Mentally it is good, really, really good... me and my manager are quite close...It is appreciated of my effort and my contribution to the role here”* (Participant 27).
- **the benefits of remote forms of working** such as reduced need to commute: *“I used to travel to the office a long way every day. And since lockdown being sat at home is also very beneficial. The general stress levels are a lot less”* (Participant 53).
- **A more stable financial situation:** *“My finances a little bit more stable now I’m working and I’m back with my parents as well, so they’re getting on the right track”* (Participant 21)

One notable finding was that these **benefits were often realised through a change of employer, occupation or sector** where previous jobs had been a source of negative mental health or wellbeing:

I was fine going into the college job, because I knew it wasn’t cold calling people, it was people who were actually customers and who wanted to be in there...I enjoy it. (Participant 55)

It was striking that improvements in the experience of work **could sometimes be secured through taking on jobs that were – at least objectively – relatively precarious** in terms of being relatively low-paid and low-skilled.

It's fantastic, it's really good, it's really flexible, really works around my children. I enjoy it and it makes me feel positive. (Participant 11, working as delivery driver)

I'd say good 8 to 9 out of 10. (Participant 39, working in night-time security)

I'd say, like, very satisfied. (Participant 52, working in hospitality)

It was notable that young people were just as likely to reflect positively on jobs secured, despite, on average, being in more precarious labour market positions than WWEH participants overall (see above).

In a few cases, new jobs were contrasted favourably with previous employment that had been a source of stress and anxiety, even if this entailed downward mobility as Edward's story below indicates:

Box 7: Edward's story

Edward had worked in sales most of his working life, reaching managerial level but latterly began to find it too pressured and stressful. He began taking the odd sick day, which gradually accelerated, until he had what he described as a breakdown. His employer was ill-equipped to deal with his situation and had nothing in place in terms of occupational health or wellbeing support.

After taking six months of sick leave he left the company and decided he wanted a fresh start away from the sales environment. His GP was very supportive and referred him to WWEH as Edward was keen to work due to financial pressures. During this time Edward's health and homelife were under immense pressure and Edward found himself relying on alcohol as a coping mechanism.

Edward spoke positively about the WWEH coach and found the online support helpful. He received weekly tasks to encourage his motivation and lift him out of his 'rut'.

The focus was on obviously getting me to do things, it could be house cleaning, going for a walk, just doing anything...to build it up...It did help, because I wouldn't have had... the knowhow really of what do I do?

He is now employed in a role he enjoys as a cleaning operative at a large entertainment venue with flexible hours. Edward described the benefits of this new job despite his boss being surprised by his downward occupational mobility:

I am currently working at the moment...my boss.. she went, 'oh, what are you in a job like this for?', I said 'because pardon my words but instead of talking crap I pick up crap'... at least I find it more fulfilling [than my previous stressful job as a sales executive].

Ultimately, Edward credits WWEH with helping him to stabilise his work and home life:

It definitely helped, because it helped me pushing any work associated worries aside, it helped me in my own home life, and so because that improved, obviously my outlook then improved.

Clearly, this is not to argue for the benefits of more precarious forms of work. One significant caveat is that interviews were perhaps undertaken too soon after new jobs were secured to reflect whether perceived benefits were sustained. However, it does

suggest there is value in **programmes such as WVEH enabling people to move away from jobs which are injurious to health even if new roles might not be considered ‘good work’** on objective measures of job quality. As wider research on the experience of young people shows, job quality is not just a function of pay or job security but also of a wider range of factors including the extent to which they feel stimulated, valued, and supported⁴⁴.

All this said, it remained the case that **a small minority found returning to work a less positive experience** where it led, for example, to long hours, lengthy commutes, lower pay or insecure working patterns:

It's just a temporary job [in childcare]...the other day I was at work, after finishing a fifteen hour shift. (Participant 57)

It's less money than I was earning before... And most of my wage goes on rent, basically. But it's also less hours. (Participant 29)

They tend to treat agency staff like, they are nobody... I'm not supposed to be cleaning toilets... I want to leave the job. (Participant 33)

These examples caution that a ‘positive’ employment outcome as measured by movement into work may not always be experienced as such.

7. Partnership and integration

Summary

- JCP was a key partner for referrals with support often dependent on good working relationships between JCP staff and Partnership Engagement Consultants (PECs). Partnership also worked well where PECs were co-located within local authority business support teams.
- Local Leads played an important role in supporting integration by promoting WWEH; brokering access to organisations; enabling triage and referrals between services; and co-ordinating meetings. However, there were concerns about the capacity of Local Leads to support integration activities, as well as misalignment between WWEH and local authority employment and business support structures and processes.
- Wider partnerships were also important in sourcing referrals and identifying signposting opportunities. Nonetheless, it was not always clear that the Programme has been able to maximise opportunities to integrate within wider structures in the GM ecosystem. One key issue was that the remote, telephone-based delivery model of WWEH did not fit well with holistic and place-based hubs being developed in Localities.
- Local Integration Boards (LIBs) were seen to play a useful role in fostering networks; increasing mutual understanding of organisational practices; facilitating referrals; and identifying signposting opportunities. However, their potential has been significantly constrained by the lack of meetings held during the pandemic.
- Engagement with health partners helped to generate referrals and WWEH filled a gap in the health ecosystem for provision that supported the 'work as a health outcome' agenda. However, there were significant challenges in integrating WWEH within the health system, particularly in terms of:
 - a lack of buy-in from health commissioners and practitioners from Clinical Commissioning Groups (CCGs) and Public Health teams.
 - a preference for GPs to refer into longer-term, more holistic, single gateway social prescribing provision which WWEH was not integrated into.
 - the negative impact of the COVID-19 pandemic on integrated working.
- There was some tentative evidence of systems change in terms of some GPs embracing the work as a health outcome agenda, and Fit Note clinics illustrating how this could be embedded in practice systems. At the same time, systems change was constrained by demands on GP time; the short-term goals of the programme in terms of generating referrals; and the time-limited nature of WWEH.

7.1 Introduction

The principle of integration sits at the core of WWEH and is intended to ensure that clients with different types and levels of need have access to the services they require both within the programme and through access to external provision in the wider Greater Manchester ecosystem.

As a programme rooted in the Improving Lives⁴⁵ agenda, WWEH aims to align health and employment systems to provide an integrated service to support residents with health conditions or disabilities to return to work. It seeks to promote systems change in terms of durable changes in organisational cultures, practices and processes that break down siloed working across the employment and health sectors and, in doing so, develop a shared agenda around supporting work as a health outcome.

Partnership is a key element of integration with WWEH intended to work with:

- Jobcentre Plus (JCP), General Practitioners (GPs) and local employers (especially SMEs) and wider stakeholders such as clinical services and housing providers to source referrals.
- Local Authorities to facilitate integrated delivery at the local level.
- other employment support providers to ensure that residents are triaged into appropriate provision.
- wider clinical and non-clinical services to provide external support to address presenting needs and barriers to work among participants.

A number of **mechanisms** in terms of roles and processes have been put in place to facilitate integration:

- **Partnership Engagement Consultants (PEC)** within the Provider team are tasked with engaging with SMEs and JCP while dedicated GPEOs provide focussed resource to: generate GP referrals; work with designated Local Leads in local authorities to develop local partnerships; and build links within the wider ecosystem as both a source of referrals into WWEH and into which the Provider can refer or signpost clients for external support.
- **Local Leads** based in local authorities in each of the ten boroughs support the Provider to engage with local health and employment services and ensure that delivery is integrated and effective at a local level.
- **GP Leads** in each Locality provide clinical co-ordination and oversight for GP practices within participating areas.
- Each Locality was expected to set up a **Local Integration Board (LIB)** or use existing partnership meetings to oversee the delivery of WWEH and support integration objectives by bringing key partners together.
- **Ask and Offer documents** were drawn up in the pre-implementation phase in each Locality to articulate offers of support and involvement from the Commissioner, Provider and partners including local authority leads in Employment and Public Health teams, JCP, GPs and GP Practices, Clinical Commissioning Groups (CCGs), NHS services (especially Musculoskeletal (MSK) and Mental Health teams), and voluntary and community sectors organisations.

This section considers the extent to which WWEH developed partnerships with local services and governance arrangements to facilitate effective integration; the benefits and challenges of achieving integration across health and employment systems; and the extent of systems change within local ecosystems brought about through the programme.

7.2 Partnerships

This subsection considers partnerships with three core groups of stakeholders: Jobcentre Plus (JCP), Local Leads and wider partners in the Greater Manchester

ecosystem. Relationships with GPs and other health partners are explored in section 7.4.

Jobcentre Plus (JCP)

Past evaluation outputs noted that the partnership between the Provider and Jobcentre Plus (JCP) is widely regarded as positive and effective, with JCP a 'natural' partner given the alignment of interest in supporting clients back into work. JCP proved a reliable source of referrals once the cap was lifted, accounting for the highest proportion of total referrals (49 per cent) of all three pathways.

While there had been confusion at times over eligibility criteria given the growing number of employment programmes in Greater Manchester, particularly among newer JCP staff, there was a view that, on the whole, **JCP offices understood and valued WWEH:**

We've pretty much had a steady supply of referrals coming in since the Jobcentre Plus offices have really understood the role that we play and the support we can provide to their staff. (Provider, Manchester)

A number of factors were critical to good relationships with JCP including:

- **close working relationships between PECs and JCP staff** including a regular WWEH presence in JCP offices. This ensured that the needs of JCP clients and the appropriateness of WWEH provision could be assessed:

I would have an initial conversation with the engagement officer before we do a referral to see if it is the right support for the customer...So, that rapport with the engagement officer has been really, really valuable to me. (JCP)

- The **ability of PECs to lead in-person or virtual information sessions** to support JCP staff in understanding the eligibility criteria and signposting process for WWEH. By extension, variable willingness of JCP staff to facilitate sessions explained some of the differences in JCP referrals across Localities:

[In one Locality] it's very, very difficult to just to arrange an information session. We say we tried it [elsewhere] in Rochdale, it works perfectly, referrals have doubled. So I just think that if they were...more open to listening to what we think works then the programme might have been extended. (Provider)

Local Leads

Interviewees were highly positive of Local Leads described respectively as "*fantastic*" (Bolton stakeholder) and "*incredibly well-informed...very, very good*" (Stockport stakeholder). There was a clear sense that Local Leads were able to **play an important role in supporting integration** in a number of ways:

- **Promoting WWEH** as part of a wider integrated package of employment and skills provision, as in the case of the Get Rochdale Working offer.
- **Facilitating access to JCP sites and GP practices** in the implementation phase to establish referral pathways.
- **Brokering Provider access to a range of organisations** including colleges, the community and voluntary sector, and housing associations as both a potential source of referrals into the programme and opportunities to signpost WWEH clients into external support.

- **Sourcing vacancies and enabling triage and referrals between services** to ensure that residents received appropriate support. In Rochdale the PEC had weekly meetings with the Local Lead and this was seen as a valuable mechanism for exchanging information on employer vacancies and redirecting ineligible WWEH referrals into alternative health and employment provision.
- **Providing access to individual employers** and business forums as a potential source of SME referrals. In Bolton, for example, the Local Lead, enabled the PEC to attend two separate forums for businesses in the care and hospitality sectors.

The relationship between the Local Lead and Provider was considered particularly effective where the **PEC had been recruited through, and co-located with, the local authority's business support team**: *"That was brilliant, that worked and then they had a desk, so they were seen as part of the team and it was good for that person as well, because they felt supported"* (Local Authority, Rochdale). The PEC also supported the local authority's 'single access point' approach where employer engagement was co-ordinated across a range of different provision (the 'Rochdale Offer') to avoid multiple contacts with businesses.

Bury stakeholders also noted the value of having a PEC who had **prior local contacts** from a previous role and was co-located with the business support team one day a week. This gave them the *"confidence"* (Local Authority) to allow the PEC to promote the entire offer including WWEH as a way of connecting with local businesses. They also praised the social value activities of the Provider:

There wasn't enough acknowledgement of some of the good work that [the Provider] did, from a social value point of view... we have an offer to schools where businesses will go in, so they supported us with that. They offered us mental health first aid training, which I took advantage of. They invited us to lots of different sort of training webinars. (Local authority, Bury)

However, these examples were the exception rather than the rule with a number of challenges identified which **constrained the ability of Local Leads to support integration** including:

- **Limited capacity and resource to support WWEH** due to austerity-related increases in responsibilities; competing priorities in terms of other employment or business support programmes, particularly following the outbreak of the pandemic; and the challenges of working across multiple directorates (i.e. both employment/skills and business support) to support integration.
- **Missed opportunities to harness other activities for the benefit of WWEH.** In one area it was noted that the significant amount of communication with local businesses during the pandemic had not been used to promote the programme (Local Lead).
- **A lack of WWEH integration with Locality structures or processes.** Stakeholders in three different Localities suggested the Provider had 'cold-called' employers in a way that did not align with existing Local Authority employment and business engagement structures and activities. This had the potential to impact negatively on business engagement activities if employers felt overwhelmed or irritated by multiple contacts.
- A perception that Local Authorities had **not always been willing or able to share intelligence** on local employers or push a 'healthy workforce' agenda that might have provided opportunities for the Provider engage with SMEs and promote WWEH.

- A loss of trust due to early programme implementation issues, particularly delays in putting physiotherapy and CBT in place, made it more difficult for Local Leads to secure and sustain buy-in from potential referral partners.

These points highlight **a clear gap** in terms of Provider expectations and the nature of support Local Leads could offer, as well as challenges in the **ability of the Provider to align activities with pre-existing structures and processes within Local Authority models of working**.

Relationships with wider partners

Interviewees also reflected on the extent and nature of engagement with wider partners in the Greater Manchester ecosystem. The three main **reasons for, and benefits of, wider engagement** identified were:

- **Referring or signposting participants** into external provision to meet the full range of presenting needs such as support around housing, debt, domestic violence, mental or physical health, and employability including other employment programmes seen as more appropriate to needs.
- **Identifying potential new sources of referrals** beyond the three main pathways, particularly in terms of engaging SME employees through organisations other than their employer. PECs highlighted engagement with a range of alternative referral sources including foodbanks and homeless shelters in Rochdale, voluntary and community sector (VCS) organisations and housing associations in Bolton, and a major housing association in Stockport.
- **Signposting unsuitable referrals into more appropriate provision.** One member of the Provider delivery team in Bolton noted, for instance, that they were able to signpost individuals with severe mental health conditions that could not be addressed by WVEH into NHS services. This was valued by the NHS mental health team due to their own difficulties in engaging with GP practices at the time: *“We got evidence back from the chap that runs that, saying you have been invaluable in picking these, picking these people up”* (Provider, Bolton).

However, it was clear that **the Programme has not always been able to maximise opportunities to integrate within wider structures** in the Greater Manchester ecosystem, particularly in terms of a lack of alignment with existing place-based models of integration (final bullet). This had a number of dimensions:

- **A reluctance to explore avenues for wider engagement with local organisations.** One stakeholder suggested the programme had not fully taken advantage of an offer by the local authority to facilitate access to a range of local organisations as potential alternative source of referrals including VCS organisations, social prescribing pharmacies and housing associations.
- **Local Lead capacity pressures and bottlenecks in accessing ecosystems.** In one Locality it had taken time for the WVEH team to get access to organisations they could signpost participants into because of the capacity pressures on the Local Lead.
- **Concerns that WVEH provision duplicated existing health provision in Localities:** *“We’ve got a really good MSK service in Rochdale, you can get quick access...so why are you purchasing that when we’ve already got, we might need support in other areas?”*. (Local Authority)
- **Lack of alignment with existing place-based models of integration.** Stakeholders in Rochdale and Wigan observed that WVEH’s remote telephone-based model of delivery had prevented it from taking up the opportunity, unlike

other employment programmes, to co-locate physically within community hubs. This limited opportunities for developing relationships and cross-referrals with local service providers:

[WWEH could have been in the hub] an afternoon a week...[it] would have worked really well just to do that and almost those warm handovers, so people were like chatting to one person...and they might just mention, 'I'm a bit stressed because my husband's poorly and he might lose his job'...'Oh, can I have word with you over there and go and talk to that person'...And I just think that...Early Help [didn't] really bite on any of those [opportunities]". (Local authority, Wigan).

7.3 Governance

Local Integration Boards and other meetings

Each Locality was expected to set up a Local Integration Board (LIB) or use existing partnership meetings to oversee the delivery of WWEH and support integration objectives by bringing key partners together. The precise structure, format and composition varied by locality but meetings typically comprised some mix of the Provider team; local authority officers (Work and Skills, and Public Health); other employment Programme Providers; JCP; the CCG and GP Leads; clinical health teams (e.g. mental health or MSK); and key anchor institutions such as housing associations and further or higher education providers.

While the precise format and attendance at partnership meetings varied across Localities there was **a clear sense that they supported integration objectives** by:

- **fostering networks** of employment providers to raise awareness of the aims and eligibility criteria of their respective programmes.
- **identifying referral and identifying signposting opportunities.** One stakeholder noted that the LIB helped build connections between WWEH and wider clinical services in terms of referrals from, and into, MSK and mental health teams.
- **discussing WWEH programme performance and identifying ways of increasing referrals.**

At the same time, it was recognised that the **potential for partnership meetings to facilitate integration had been constrained by a number of factors**. Principle among these was the pandemic disrupting scheduled meetings but other constraints were also identified:

- The **pandemic** was noted as having a particularly significant impact in three localities (Rochdale, Bolton and Stockport) as regular, face-to-face meetings stopped and partners were diverted to COVID-related priorities. In Bolton, the sudden lack of GP and CCG representation made it harder to address issues with GP engagement.
- **Limited referrals being secured** despite partnership meetings providing an opportunity to engage with other local service providers.
- **Staff turnover** among the Commissioner and Provider management teams as well as the absence of a key member of the LIB in one Locality saw a number of sometimes disruptive personnel changes, although management roles remained filled at all times.
- **Inconsistent commitment from the Provider team in some Localities** e.g. only attending a section of partnership meetings.

Ask and Offer documents

Interviewees were asked about the Ask and Offer documents drawn up at the pre-implementation phase to articulate offers of support from all partners directly involved in the programme as well as wider service providers in the Locality. There was **limited evidence that these had been actively used as a mechanism to facilitate partnership and integration** in Localities.

Stakeholders in Wigan and Stockport did observe that Ask and Offer documents had been useful in the initial phases. In Stockport for example it had helped to “*set the scene*” (Local authority), facilitating links between services and shaping the health support offer.

However the majority of stakeholders had either not actively used Ask and Offer documents – and in one case had never heard of them - or questioned their value as documents intended to secure buy-in and foster integration. Issues raised included:

- **diminishing relevance** as Provider staff focussed on generating referrals, moving away from the initial focus on integration with local health services: “*I feel that might have slipped off a little bit if I am honest*”. (Provider)
- a perception on the part of the Provider that Ask and Offer documents were **not always accurate** or up-to-date in terms of contacts or organisational information.
- Ask and Offer documents **focusing too heavily on employability and skills support** which limited their use to develop links into the health system.
- a concern in one Locality that Ask and Offer documents provided **no “leverage”** (Local authority, Rochdale) for Local Leads to shape WVEH provision or engagement strategies. This meant the local authority had little scope to address their concerns around WVEH duplicating existing health services (e.g. mental health) and not co-ordinating activities with local authority business support.

Ask and Offer documents were primarily intended to support integration at the implementation phase so issues with take up, usage and relevance may have locked in a lack of WVEH integration in structures and processes throughout the duration of the programme.

7.4 Integration within the health ecosystem

One of the key aims of WVEH is to facilitate integration across the health and employment systems in Greater Manchester to support those with health conditions and disabilities to return to work. This section considers the extent to WVEH achieved that goal by exploring the extent and perceived value of integration; the challenges in working with wider health partners; and the extent of systems change facilitated by WVEH.

Benefits and challenges of integration

One core aspect of integration built into the design of WVEH was the GP referral pathway. Stakeholders identified **two main benefits of integration** activities involving GPs:

- An **additional service to support patients on medical leave back into work** that addressed a gap in GPs’ ability to provide employment-related advice and guidance:

Normally we say, okay, you need amended duties, off you go and we're not in a position to negotiate work with their employers to do that, whereas the service did...so that was beneficial and a new track. (GP, Rochdale).

In some boroughs having a presence on multi-agency forums increased the visibility of WWEH and helped to remind GPs and other healthcare professionals about the suitability of the programme and eligibility criteria for patients.

- **Integration activities in some GP practices also served to enhance referral volumes.** This was seen as particularly effective in Stockport due to:
 - a GP lead committed to the 'work as a health outcome' agenda and willing to promote WWEH to colleagues and other practices, combined with an enthusiastic GP Engagement Officer (GPEO):
Putting together that GP who has been able to really sell it to other GPs within the cluster...with a very proactive [GPEO], I think has had really, really positive results. (Local authority, Stockport)
 - embedding GPEOs in Fit Note Clinics on site enhanced the integration of, and flow of appropriate referrals into, WWEH.
 - relationships built up before the pandemic which gave the GP practices confidence to provide patient data to the Provider once on-site clinics were no longer possible.

Despite these positive experiences, **stakeholders more commonly noted the challenges rather the benefits of integration with health services.** The sheer volume of issues relating specifically to GP engagement highlighted in past and current reports shows the scale of these difficulties:

- initial selective rollout of WWEH to GP practices 'locking in' less committed practices while excluding others that were keen to engage.
- challenges in setting up referral systems and information governance agreements for GP referral pathways.
- a lack of feedback mechanisms on support and outcomes for GP patients deterring subsequent referrals.
- restructuring in the primary care system and lack of alignment between new Primary Care Networks and WWEH GP practice clusters made the programme harder to promote: *"You can't just go along to one primary care network and push a program that's only associated with [only some] GP practices". (Local Lead)*
- delays in implementing EPN provision diminished trust among GPs.
- poor marketing materials did little to promote the service to clinical services.
- a preference for GPs to use social prescribing services seen as having simpler eligibility criteria and being more holistic in the range of needs they can address:

We use our social prescribing link worker [for] anybody who might have financial worries, housing worries, other things contributing to mental health issues...Working Well is about getting people back into work with access to services, rather than the more holistic view. (GP, Rochdale).

The failure to integrate WWEH within existing 'single point of access' social prescribing platforms was also described *"at odds"* (Rochdale stakeholder) with the ambition to simplify the referral process for GPs into different provision.

- **a failure to implement the Fit Note pilot⁴⁶** to enable Provider staff to reissue Fit Notes reduced its appeal to GPs in terms of reducing administrative workloads.

- the **division of integration responsibilities** for different referral pathways between PECs and GPEOs as well as across the two Provider organisations was seen in one Locality to militate against integrated forms of working.
- **challenges in securing and sustaining buy-in from key health partners** (CCGs and Public Health Leads) needed to engage GP practices due to:
 - turnover in the Commissioner and Provider management teams limiting early efforts to secure buy-in from health partners.
 - attempts to engage health partners too early in the implementation phase without a clear and attractive offer in place led to disengagement.
 - a perception that the programme sat more naturally with the work and skills agenda: *“I don’t think the CCG really saw the value in it”* (Local Lead).
 - The limited knowledge of, and leverage within, health systems of Local Leads who nearly all had work and skills remits:

It was like a whole new world working with GPs and the health world so there’s a lot of work involved which really, as Local Leads, we don’t have the time to because we’re quite stretched with all programmes. (Local Lead).

One implication is that the ability of the programme to embed itself within the local health system was highly variable across Localities and often dependent on the particular combination of commitment, capacity and expertise among senior health practitioners, GP Leads, GPEOs and Local Leads

Finally, and perhaps unsurprisingly, **the pandemic impacted on activities to support integration across all case study Localities** in ways such as:

- **Fit Note clinics** being suspended (Bolton) or not implemented (Rochdale).
- the **closure of GP practices** meant GPEOs lost face-to-face contact and subsequently found it very hard to access staff or patients.
- **disengagement of health services** including GPs, CCGs and Public Health teams to prioritise COVID-19 emergency responses including the vaccination programme and clearing waiting lists. This had impacts on referrals: *“Working Well has probably taken a lot of priority backseat...I think it probably did die a death with Working Well in terms of the referrals”* (EPN Provider, Bolton).
- **loss of institutional knowledge and recognition of WVEH** once health services began to open up: *“There were so many practices that didn’t know who I was, what they should be doing, what Working Well was and couldn’t remember a thing about it...A lot of the GPs that I did speak to were very frank and open and went, ‘you are not on the radar now’”* (Provider, Bolton).

Systems change

A key question concerns the extent to which WVEH catalysed change in the culture, practices and processes or service providers, and the extent to which any change is durable beyond programme end. This ‘systems change’ has been described by New Philanthropy Capital (NPC)⁴⁷ as:

[achieving] lasting change by altering underlying structures and supporting mechanisms which make the system operate in a particular way. These can include policies, routines, relationships, resources, power structures and values.

The evidence presented in this chapter above highlights numerous examples of systems change in terms of developing new governance structures, embedding Provider staff in local authority teams, and developing new close working relationships

with JCP staff. A small number of interviewees identified further developments that could be construed as forms of systems change including cultural and organisational shifts in GPs' engagement with the 'work as a health outcome' agenda:

- **Encouraging GPs to recognise, and act upon, the importance of employment as a social determinant of health:** *"With my patients it gives me a reason to have the conversation about work"* (GP, Stockport).
- **Generating referrals through Fit Note clinics in GP practices** run by GPEOs reduced the reliance on individual GPs to promote the work as a health agenda and embedded it instead in practice processes:

Essentially, we've developed a system whereby it doesn't require even a GP referral now, we've kind of got the GPEO worker working on behalf of the practice... it doesn't even require us to think this service exists. (GP, Stockport)

While there is an argument that this inadvertently reduces one element of systems change in terms of changing cultures of practice among *individual* GPs, it arguably suggests a more durable process-led form of systems change that cuts across the entire practice.

- One GP noted the decision by their practice to **recruit new specialist workers** to continue the valued support WWEH provided once the programme ended:
Since we've lost [WWEH] we've commissioned a physiotherapist to be at our practice...every day. What we're also looking at is to have a mental health worker...there's obviously a need and these two big areas are the ones. (GP)
- **JCP taking a more health-focussed approach** to understanding client needs, including the use of Disability Employment Advisers (DEAs) to triage clients onto WWEH. In Wigan JCP was also working in partnership with the local authority and health partners to organise marketplaces for claimants with health issues. The events provided an opportunity for their Work Coaches to find out and better understand what these organisations offered so that they could refer claimants more effectively.

However, the weight of evidence suggests that **systems change was seen as difficult to achieve** for a wide range of reasons:

- It was **overambitious** to expect to change the large and complex local health system through a single programme:
I think it tried to do everything all at once and we probably needed to take smaller steps because it is a very big system change and I think for all the right reasons we were very ambitious but I think changing everything all at once through one programme probably was a little bit too much. (GMCA)
- **Workload pressures** constraining the ability of GPs to embrace the early intervention agenda:
It's trying to sort of persuade people that you can...reduce your workload, you can reduce the disease, you can improve your patients' health by looking a bit upstream...but I think when you're faced with the amount of workload that we're all buried in at the moment, it's really difficult to see that prevention. (GP, Stockport).
- **The limited benefits in terms of time savings from reduced GP appointments**, as often GPs only issue two Fit Notes at the beginning and end of periods of medical leave. This remained unchanged even if WWEH reduces the total duration of this period.

- **The failure to implement the Fit Note pilot was seen as a missed opportunity** to shift responsibility for issuing Fit Notes onto a Provider that is much better placed to understand, and support patients to address, needs around occupational health:

Occupational health isn't a great skill in general practice...whereas you've got organisations that are negotiating working with employers to get the individuals back in. I think they'd have been much better. (GP, Rochdale)

- **The time-limited nature of WWEH** meant that progress with integration would be lost when the programme ended:

I think it will fizzle back to what it's always been like. It's always a concern with these [programmes], they take a long time to get going, integration doesn't happen quickly and when the driver behind it disappears, you quite often just revert to type. (GP, Rochdale)

8. Learning and recommendations

8.1 Overall reflections on the WWEH approach

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. The evaluation highlights **a number of performance challenges in terms of shortfalls against targets for referrals and starts, particularly in relation to the SME pathway**. This constrains the ability of the programme to provide insights into the potential for integrated health and employment support to change the landscape of support for SME employees with health conditions and disabilities. At the same time, WWEH developed effective relationships and referral pathways with some GP practices and JCP offices which illustrate the benefits of partnership around the work as a health outcome agenda.

Furthermore, **these performance challenges should not distract from the range of positive outcomes experienced by participants**. This is most evident in relation to health and wellbeing outcomes, with the programme probably only falling short of targets due to the rebalance towards accepting a higher number of newly unemployed referrals, who tend to have greater needs than originally anticipated. Job outcome targets were missed by a wider margin but this has to be set against the challenge of supporting participants to return to work during the COVID-19 pandemic.

Feedback from participants interviewed was overwhelmingly positive, with **the vast majority highlighting the benefits of empathetic, personalised and expert support from the Provider team**. This vindicates the biopsychosocial model underpinning WWEH in terms of demonstrating the need to address health and wellbeing and its wider determinants as the precursor for a return to work.

Stakeholders interviewed recognise performance challenges the programme faced in hitting targets but overwhelmingly suggested this **did not invalidate the core principles and design**. This meant that there was strong appetite to commission further provision to test and develop a similar model. Most stakeholders felt that **WWEH coming to an end would leave a "gap" (GMHSCP) in upstream support** for employees on medical leave that needed to be filled.

There was also a shared view that **integrated health and employment provision remained a strategic priority**, aligning both with agendas within primary care to address the social determinants of health as well as the national *Health is Everyone's Business* ⁴⁸ strategy to reduce ill health-related job loss. Forthcoming NHS requirements for Primary Care Networks (PCNs) to make tackling health inequalities a key strategic priority may also provide further scope for partnership with the health sector around mutual priorities.

This remainder of this section summarises good practice and learning across the lifetime of WWEH that could shape future commissioning and strategies around integrated health and employment provision. It considers seven core themes: referrals

and starts, the WWEH model, balancing health and employment support, supporting participants, partnership and integration, employer practices, and scalability and replicability.

8.2 Referrals and starts

Setting targets

WWEH achieved nearly two thirds (63 per cent) of the target for referrals and one third (34 per cent) of the target for starts during the lifetime of the programme. Previous evaluation reports have explored the factors contributing to programme underperformance in detail, highlighting in particular the significance of high staff turnover in both the Programme and Provider management teams in the earlier phases of the programme as well as the impact of the COVID-19 pandemic. Pathway specific performance issues are explored in more detail below.

Stakeholder interviews revealed a widespread consensus that **targets had been too ambitious, particularly in relation to SME referrals**: *“We perhaps bit off a lot more than we could chew with the program. It was laudable but not achievable”* (Local authority). Performance pressures were also seen to compromise the test and learn ethos of WWEH and drive behaviours that were not always beneficial such as ‘cold calling’ employers rather than more organic forms of engagement.

Recommendations for future provision

- **Subject proposed targets at the design or commissioning phase to greater critical scrutiny** and, possibly, external challenge to assess feasibility.
- Consider 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.
- Balance the **ambitiousness of targets against the need for space to experiment, innovate and even fail** as part of a test and learn ethos. Targets need to be set at a level that balances ‘public purse’ interests with the ability of providers to test new models through a *“fall hard, learn fast”* (Provider) approach. The meaning of, and scope for, a test and learn approach within the context of contractual expectations around targets and delivery could also be more clearly defined.

JCP pathway

JCP referrals comfortably exceeded programme targets and volumes of starts hit four fifths (79 per cent) of the lifetime target. The pathway was seen as a ‘natural’ partnership where JCP organisational goals aligned with those of WWEH. JCP staff were largely very positive about a programme seen to provide valuable early intervention support: *“It really supports the customer and it does what it aims to do which is move them towards the job”* (JCP).

However, there have been issues with the low conversion rates of referrals to starts (36 per cent) caused by:

- the unfamiliarity of new JCP staff recruited during earlier phases of the pandemic with WWEH programme eligibility criteria, especially in an increasingly **“crowded space”** (Provider) of employment provision in Greater Manchester.

- a tendency of some JCP clients to disengage once referred but then realise participation is not mandatory.

These issues with low conversion rates have been magnified by the scaling up of JCP engagement during the pandemic to become the dominant referral pathway. Other issues highlighted by stakeholders included:

- **a loss of programme distinctiveness** as an early intervention programme for those on medical leave once WVEH removed the cap on JCP referrals.
- **a lack of feedback to JCP staff** about the experience of clients signposted to WVEH that discouraged referrals.

While the JCP pathway was seen as a less innovative element of the programme, there was **still an appetite to sustain it in some form in future** provision due to the renewed gap in early intervention support for the newly unemployed once WVEH ends: *“I definitely had a lot of comments from staff to say they were really sad that it was coming to an end, nothing really been put in place to cover that group of customers now”* (JCP). In a recent workshop JCP staff also emphasised the value of fast-track provision that offers longer-term support than can be secured through JCP’s own dynamic purchasing framework.

Recommendations for future provision

- **Establish a formal referral process rather than signposting** to raise the quality, volume and ease of referrals while providing a mechanism to feed client experiences back to JCP staff.
- **Develop a single point of access from JCP into all GM employment provision** to streamline identification of appropriate support given the time constraints of JCP client appointments: *“You’ve only got that small period of time to decide what’s best for that person and not necessarily the time to look”* (JCP).

GP referrals

GP starts only met one third (33 percent) of lifetime targets, with a multitude of reasons for lower than anticipated referrals and starts as explored in Section 7.4. This highlights the complexity of establishing referral routes through GP practices as well as, critically, the need for greater buy-in from health partners to navigate the local health system.

At the same, there was **broad support among both GPs and wider stakeholders for maintaining the GP pathway, Fit Note clinics and embedded GPEO-type workers** given good engagement with some practices and the perception that this is *“still absolutely the logical pathway”* (GMHSCP) to access residents for whom health issues were a barrier to remaining in work. The high number of referrals and better outcomes among participants from Stockport also indicates the potential scale of benefits when this pathway operates effectively. There are also tentative indications of systems change in terms of the *“breakthrough”* (Local Lead) of increasing recognition among some GPs of work as a social determinant of health

Indeed, some stakeholders suggested it **may be appropriate for future work and health provision to focus solely on the GP pathway** given its essential role in generating in-work referrals. One option presented was to separate out the two components, developing a health-led successor programme focussing on the GP pathway and commissioning separate SME provision at a later point once the demand for, and feasibility of, SME-focussed provision was better understood.

Recommendations for future provision

- **Replicate GP clinics and GPEO-style workers** in future provision to increase the volume and quality of referrals.
- **Review geographical coverage** to ensure alignment with primary care structures and boundaries.
- **Increase the ease with which non-affiliated GP practices can be incorporated** to avoid potentially committed practices being excluded.
- Ensure from the outset that **sufficient time, resource and expertise is invested in developing governance structures and relationships with key health partners** of appropriate seniority who can advocate for the programme and forge durable connections with GPs.
- **Extend the programme duration to allow sufficient time to build relationships** and establish the profile of programmes with GPs. The on-going Be Well programme in Manchester established in 2018 (as a successor to the former Manchester Fit for Work programme set up in 2013) was highlighted, by contrast, as an example of the benefits of much longer-term provision in terms of building trust, generating referrals and educating GPs around the value of the programme.
- **Locate any future offer with other programmes behind a single gateway** (e.g. social prescribing) which can triage referrals into appropriate provision to reduce complexity for GPs.

SME engagement

SME referrals and starts have been very low since the beginning of the programme. Stakeholders unanimously suggested that the target of generating 40 per cent of all programme referrals through SMEs had been unrealistic given the lack of an evidence base to support the feasibility of this volume.

A number of challenges were identified in generating referrals:

- **businesses closures** during the pandemic.
- confusing and poorly targeted Provider **communications materials** that did not always communicate the potential 'bottom line' benefits for employers of reduced staff absence and improved productivity
- **a failure of WWEH to understand, segment and target support appropriately** to the diverse range of employers by size and type within the SME sector.
- **a lack of eligible employees** on medical leave within SMEs at any one time.
- an **inability to intervene early** to support employees with health issues who were still in work but "*wobbling*" (Local authority stakeholder).
- **initial high turnover among the PEC team** as well as, in some cases, a lack of the experience, skillset and local knowledge needed to effectively engage employers.
- **a lack of willingness among SME employers to promote a service** that could support employees to challenge management and working practices.
- **a failure in some Localities to maximise opportunities to work through existing local authority-based business engagement teams** (see Section 7.2).

Recommendations for future provision

- **Develop an evidence base of SME diversity, needs and demand** for external occupation health provision through prior consultation before designing and commissioning any future provision.
- **Review expectations** that SMEs can be engaged in high volumes and set any targets at a level that allows scope for piloting or innovation provision.
- Ensure through recruitment and training that **engagement workers have the expertise and skillset** to engage employers.
- **Embed engagement teams more closely in local authority business support teams to facilitate** joint working and promote employment provision within a single integrated business offer.
- **Consider involving representative bodies** such as the Chamber of Commerce and Federation of Small Business as potential delivery partners to increase reach into, and engagement from, the business community.
- **Extend eligibility to ‘wobbling’ employees** who have health issues that affect work to prevent issues escalating and address presenteeism.
- **Use commissioning processes to ensure that providers or supply chain organisations have a strong footprint and relationship with SMEs in GM.**

8.3 The WWEH model

Programme evaluation provides an opportunity to explore and reflect on key elements of the WWEH model. There was **a strong consensus that WWEH illustrated the value of embedding health coaching at the heart of an employment programme**, underpinned by the BPSA assessment framework to identify key needs. The value placed by the majority of participants on the support received also vindicates this approach.

Moreover, stakeholders suggested **the COVID-19 pandemic had only amplified the need for this kind of support** given the way it had deepened health inequalities; underscored the critical relationship between health, employee wellbeing and workplace productivity; heightened the need for more vulnerable workers to be supported to switch away from higher risk occupations or sectors; and, alongside Brexit, created acute shortages in some sectors that would potentially increase demand among employers for support to recruit or retain employees with health conditions.

More specifically, evidence in this report and previous outputs shows **clear value in a number of specific WWEH components** including: fast-track access to physiotherapy or CBT; resources to self-manage health conditions; the health-focussed approach of the VRC team; carefully sequenced support that prioritises health as a precursor to employment; and structured advice and guidance on returning to work (formalised in the RtWP).

At the same time, **the programme worked less well where the lighter touch Advice Service seemed inappropriate or inadequate** for those with higher levels of need or more complex aspirations (e.g. changing employers). Findings also challenged the assumption that those working for larger employers automatically have less need for external, independent and intensive occupational health-style support.

There was also **some criticism by both participants and stakeholders of the six-month time limit** which elapsed regardless of whether participants had on-going need.

Finally, a small number of participants expressed a preference for face-to-face provision although the majority were comfortable with telephone-based support.

Recommendations for future provision

- **Maintain aspects of the model that have proven efficacy.**
- **Provide a single tier of support or – if adopting a tiered model – a more client-led approach** where criteria can be flexed to ensure that participants can benefit from more intensive support where needed, regardless of size of employer.
- **Enable support to be extended beyond six months on a discretionary basis** where further positive outcomes may result. Options for extending support include:
 - enabling participants to pause engagement when needed less.
 - tapering support after a fixed time period to avoid a ‘cliff edge’ when support is suddenly withdrawn, including in-work support where appropriate.
- **Provide opportunities for in-person support** as originally intended before WVEH switched to a wholly remote model during the pandemic.
- Design support to respond **to emerging or increasing levels of need related to the COVID-19 pandemic** including: managing or reducing stress and anxiety; bereavement counselling due to COVID-related deaths; living with the physical and psychological impacts of long COVID; and supporting individuals while waiting for delayed elective care.

8.4 Balancing health and employment support

The evaluation has consistently found that participants prioritise health and wellbeing support, both in its own right and, for some, as a precursor for contemplating a return to work. At the same time, the severity of health conditions and wider challenges faced by a small minority - particularly but not exclusively older participants - meant work was seen as a distant or unrealistic prospect.

A small number of participants and stakeholders suggested that WVEH did not include sufficient employability provision or dedicated staff with employment coaching skills, despite employability support being a key part of programme design. There was a view that **the clinical expertise of the VRC team was “brilliant” (GMCA) but their health focus may have reduced the emphasis on supporting individuals to return to work**, as reflected in better outcomes around health and wellbeing compared with employment. The failure to launch a planned online Employment Hub was also seen as a crucial gap in the offer. According to one stakeholder, it also limited referrals from some partners because of the perception that WVEH offered relatively little employment support.

Evaluation evidence shows that finding a new job can generate improvements in health and wellbeing, even if the objective quality of employment is not always high. This further suggests **the potential value of a stronger employability and job brokerage offer to facilitate transitions to employment more conducive to positive health and wellbeing**. In some cases this might increase opportunities for progression into employment that is higher skilled, better paid or provides better terms, conditions or working environments.

Recommendations for future provision

- Provide **more focused employability support alongside health provision** including job brokerage and employment coaching (accessed internally or

externally). This will enable employees to change jobs where employers or workplaces are clearly a contributing factor to poor health conditions.

8.5 Supporting participants

There was strong evidence that the majority of programme participants were satisfied with the support received and valued the personalised, empathetic and client-focussed approach of WWEH. While many participants with high levels of need benefited from WWEH, it was also clear that **a minority of participants with the most severe presenting issues found it harder to engage with, and achieve positive change through, WWEH support that was more orientated to those with mild to moderate conditions**. This is an issue given that stakeholders also reported higher levels of safeguarding issues and greater clinical need among participants than anticipated.

These findings **challenge the assumption that those recently taking medical leave or the newly unemployed are relatively close to the labour market** and only require a short, if potentially intensive, period of intervention to enable a return to work. Some participants have far more complex, cumulative and severe needs than employment status and time since last in work suggests. Certainly WWEH seems less effective when individuals have acute or chronic health conditions or other severe presenting needs that require sustained, intensive support.

In terms of different groups of participants, findings suggest **younger people feel well supported by WWEH**. This is encouraging given their higher propensity to experience mental health issues and more precarious forms of work. Stakeholders suggested, however, that mainstream employment programmes with service-focussed referral pathways miss harder-to-reach groups young people who are Not in Education Employment or Training (NEET) and may not be accessing referring services.

At the same time many older participants did not feel ready or able to return to work due to a mix of health issues and the need to find appropriate work, caring responsibilities and perceived age discrimination. These findings vindicate wider calls to ensure that older workers are supported to return to work through encouraging employee flexibility around hours, location of work, caring responsibilities and workplace adjustments while also reducing discrimination on the basis of age⁴⁹. These changes to employer practices are vital but potentially challenging to achieve in the short-term and may require national legislation. This makes programmes such as WWEH all the more important in supporting older workers to experience health and wellbeing benefits even if positive employment outcomes are a more distant prospect.

Recommendations for future provision

- **Embed more intensive clinical provision** internally or set up clear referral pathways into appropriate external provision to support those with the highest levels of need. Internal support may be preferable if there are long waiting times for external services.
- **Recognise that addressing health issues may need to take priority** and that employment outcomes may be unlikely - or uneven unwanted – within the timeframe of support. This may particularly be the case for older participants.
- **Design initial assessment processes to identify severe need at the earliest possible stage** to enable quicker triage into more appropriate support such as external clinical services. 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.

- Review whether service-based referral pathways exclude harder-to-reach groups such as NEETs and **consider extending referral activities to community organisations or developing outreach mechanisms.**

8.6 Partnership and integration

A number of effective partnerships have been established through WWEH and there has been some progress towards integration of the programme within the wider health ecosystem. **Local Leads have played a particularly important role in supporting integration.** However, there have been concerns about the capacity of Local Leads to support integration activities given other priorities, as well as about the misalignment between WWEH and local structures and processes such as business support teams, social prescribing platforms and place-based, multi-service hubs.

Engagement with health partners helped to generate GP referrals and WWEH **filled a gap in the health ecosystem for provision** that supported the ‘work as a health outcome’ agenda. Nevertheless, there were significant **challenges in integrating WWEH within the health system**, particularly in terms of a lack of buy-in from CCGs and Public Health teams; a preference for clinicians to refer into longer-term, more holistic social prescribing provision; and the negative impact of the COVID-19 pandemic on progress towards integrated working.

Recommendations for future provision

- **Embed provision and workers directly within health service structures.** One suggestion was to employ frontline workers directly through health partners or routinely place them in GP practices to encourage deeper integration.
- **Review the resourcing and remit of any future local authority-based integration role** that replaces Local Leads to ensure they have the capacity, expertise and connections to engage more fully with partners in the health system. **Seconding provider engagement workers into local authority teams** could also help with resourcing issues and support deeper integration.
- **Better sensitise and design provision around** the needs and ecosystem of support and delivery within individual Localities *“because you know at a Locality level where your gaps are and how you can be most effective”* (Local Lead). Some stakeholders suggested that designing and commissioning a range of provision around needs at Locality level may facilitate better integration than implementing a single GM-wide programme, as well as encourage a greater sense of local ownership and buy-in. Recent NHS funding for local authorities to design their own pathways for tackling obesity was highlighted as a model of how this might be done.

8.7 Employer practices

Employers have a key role to play in helping employees manage health conditions in the workplace. Wider research suggests employers are often committed, in *principle*, to recognising the importance of, and supporting, the wellbeing of staff. Survey data presented in the Improving Lives White Paper⁵⁰ 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. One of the original aims of WWEH 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 evaluation provides extensive and consistent evidence that **work is a social determinant in health in both a positive and, all too often, a negative sense**. A number of employers do take steps to support employees on medical leave back to work through making flexibilities and adjustments. In many cases, however, 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 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**. This reflects findings from a range of studies showing that both job insecurity and a range of psychosocial aspects of work (including high job demands, low job control, low co-worker support, low supervisor support and a high effort-reward imbalance) can have significant negative impacts on mental health⁵¹.

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. Existing studies provide a clear indication of the factors that are important for workplace health that should guide any engagement activities with employers should support. These include collaboration and teamwork; growth and development of the individual; recognition; employee involvement; positive, accessible and fair leadership; autonomy and empowerment; appropriate staffing; skilled communication; and safe physical work⁵².

As some stakeholders noted, this may be an **opportune time to engage with employers** due to recruitment challenges in some sectors as well as greater willingness to accommodate health issues following the pandemic. Experiences of remote working and flexibilities during the pandemic have also increased the receptiveness of some employers to make adjustments such as working from home or flexible hours.

Recommendations for future provision

- 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.
- **Provide on-going, in-work support** where beneficial to ensure that participants can be supported to address any challenges that emerge or resurface in workplaces on returning to work.
- 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 or new job and deal with employers reluctant to make adjustments.
- **Complement WWEH-style integrated health and employment provision with wider upstream ‘healthy workforce’ provision** to encourage employers to promote healthy lifestyles among staff as well as raise awareness of environments, cultures and practices beneficial to staff wellbeing.
- **Ensure that work and health provision is promoted is part of the wider business offer**. This needs to stress the *“bottom line”* (GMCA) benefits of workforce wellbeing to be attractive to employers, and could be wrapped into a wider business offer around leadership, management, skills and training to maximise traction. Public health expertise can be used to engage and support

businesses around employee health, as is already happening in some GM Localities.

- **Pursue GM-wide 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 paper⁵³ to create healthy workplaces where people thrive and progress. The recent ‘Build Back Fairer’⁵⁴ 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. Existing strategic frameworks (e.g. the *Thriving at Work* review⁵⁵) can also guide such activity.

8.8 Scalability and replicability

Assessment of value for money (VfM) is outside the scope of the evaluation so it is not possible to provide this analysis. However, stakeholders did suggest that underperformance in terms of starts will inevitably have compromised VfM and the commercial viability of WWEH. This makes it **harder to make a business case for scaling up provision** in any future GM-wide programme in terms of rolling out a similar model to all GP practices as the most obvious option for scaling. Variable performance across pathways means VfM will also differ accordingly, so the case for scaling GP referrals may be stronger once the better outcomes achieved compared with the JCP and SME pathways are taken into account.

The practical difficulties in engaging some GP practices highlighted above led some stakeholders to caution against scaling up any future programme to all GP practices across Greater Manchester. However, it was also noted the existing Be Well programme demonstrated the viability of full coverage and that engaging all GPs may encourage greater commitment from key health partners by creating a stronger sense of ownership.

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: Logistic regression analysis

Logistic regression modelling⁵⁶ has been used to test and analyse the influence of a range of factors on the likelihood that a participant has gained an employment outcome⁵⁷.

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

Appendix 4: The WWEH 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 5: Outcomes by sub-group

Table A1: Proportion reporting improvements between entry and discharge to outcome scores by mental health condition (anxiety or depression/low mood) and condition severity

	All	Mental health condition indicated	Normal anxiety (GAD7)	Mild anxiety (GAD7)	Moderate anxiety (GAD7)	Severe anxiety (GAD7)	GAD7 Caseness - Yes	GAD7 Caseness - No	Normal depression (PHQ9)	Mild depression (PHQ9)	Moderate depression (PHQ9)	Moderately severe depression (PHQ9)	Severe depression (PHQ9)	PHQ9 Caseness - Yes	PHQ9 Caseness - No
GAD7	72	75	!	63	76	79	76	40*	!	61*	82	80	67	77	58*
PHQ9	71	70	!	64	78	72	73	51*	!	61*	73	80	73	75	43*
MSK-HQ	59	57*	!	56*	75*	51*	60	!	!	!	50*	70*	!	61	!
SWEMWBS total score	68	70	59*	68	65	70	68	63*	62*	63	65	73	69	68	63
PAM total score	70	73	68*	70	75	70	72	63*	74*	65	77	67	72	71	69
Returned to work	59	58	!	60*	57*	57	58	55*	!	56*	49	66*	51	56	62*
Started work	25	28	!	30*	32	26	29	19*	!	26*	28	35	24	30	21*
Employment outcome overall	38	38	30*	41	42	37	40	32*	41*	39	36	45	34	39	39
ONS Life Satisfaction score	65	66	59*	61	68	65	66	58*	59*	57	66	66	69	67	57
EQ-5D-5L score	57	58	41*	55	56	59	58	46*	51	52	64	55	52	58	47
EQ-5D-5L Visual Analogue score	67	65	73*	61	71	65	66	67*	67*	57	70	69	63	67	59

Base: All (195-1143); Mental health condition (77-556); GAD7 Normal (37-47); GAD7 Mild (34-156); GAD7 Moderate (44-224); GAD7 Severe (57-310); GAD7 'Caseness' Yes (123-643); GAD7 'Caseness' No (33-90); PHQ9 Normal (39-41); PHQ9 Mild (52-120); PHQ9 Moderate (38-192); PHQ9 Moderately severe (37-199); PHQ9 Severe (57-148); PHQ9 'Caseness' Yes (111-577); PHQ9 'Caseness' No (53-123)

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

! Indicates where the base figure for the outcome is less than 30 so the data has been excluded.

Table A2: Proportion reporting improvements between entry and discharge to outcomes scores by sub-group

	One health condition	Two or more health	In paid work on entry	Not in paid work on entry	Received advice service	Received support service	White British/Irish ethnicity	White Other ethnicity	Mixed/Multiple ethnicity	Asian/Asian British ethnicity	Black/African/Caribbean/Black British ethnicity	Lower secondary education	Upper secondary education	Post-secondary education	Tertiary education level
GAD7	68	72	74	70	!	72	74	!	!	41*	!	70	69	74	73
PHQ9	72	68	71	70	!	71	71	!	!	61*	!	72*	64	76	71
MSK-HQ	69*	54	68*	53	-	59	61	!	!	!	!	63*	57*	52*	68*
SWEMWBS total score	60	68	70	66	76*	67	67	75*	!	61*	74*	68	65	68	71
PAM total score	71	70	73	68	76*	70	70	67*	!	70*	68*	70	67	73	73
Returned to work	67	48	59	-	70*	56	59	!	!	44*	!	54*	58	51	69
Started work	21	26	-	25	-	25	24	22*	!	29*	28*	22	20	29	29
Employment outcome overall	39	33	59	25	70*	36	39	38*	35*	35*	39*	38	34	36	47
ONS Life Satisfaction score	63	63	66	64	69*	64	64	63*	!	63*	66*	66	59	65	70
EQ-5D-5L score	56	56	64	52	65*	57	58	54*	!	46*	60*	54	54	60	60
EQ-5D-5L Visual Analogue score	67	64	71	64	73*	66	67	75*	!	55*	60*	70	67	64	69

Base: One health condition (54-300); Two+ health conditions (123-653); In paid work (87-458); Not in paid work (108-685); Advice Service (86-93); Support Service (195-1057); White British/Irish (150-905); White Other (37-55); Mixed/Multiple (34); Asian/Asian British (31-80); Black/African/Caribbean/Black British (39-54); Lower secondary (41-198); Upper secondary (64-347); Post-secondary (non-tertiary) (64-347); Tertiary (44-278)

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

! Indicates where the base figure for the outcome is less than 30 so the data has been excluded.

Table A3: Outcomes by locality where more positive result recorded at discharge than on entry (%)

	All	Bolton	Bury	Manchester	Oldham	Rochdale	Salford	Stockport	Tameside	Trafford	Wigan
GAD7	72	70*	81*	64	74*	74*	72*	82*	73*	74*	70*
PHQ9	71	71*	79*	63	80*	71*	73*	76*	66*	73*	69*
MSK-HQ	59	!	!	53*	!	!	67*	!	!	!	!
SWEMWBS total score	68	66	75*	66	62	59*	63	81	73	70*	63*
PAM total score	70	68	71*	65	71	77*	72	74	64	74*	76*
Returned to work	59	53*	58*	50*	!	59*	64*	78*	49*	!	!
Started work	25	29*	26*	28	22*	26*	25*	28*	21*	20*	22*
Employment outcome overall	38	40	41*	35	27	41*	39	60	33	35*	32*
ONS Life Satisfaction score	65	68	68*	61	70	66*	59	69	60	59*	70*
EQ-5D-5L score	57	68	59*	45	62	59*	50	68	57	50*	60*
EQ-5D-5L Visual Analogue score	67	71	65*	63	70	58*	58	75	69	68*	73*

Base: Bolton (59-140); Bury (31-69); Manchester (59-219); Oldham (44-110); Rochdale (41-88); Salford (30-122); Stockport (46-131); Tameside (47-113); Trafford (33-69); Wigan (39-82)

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

! Indicates where the base figure for the outcome is less than 30 so the data has been excluded.

Table A4: Proportion reporting improvements between entry and discharge to outcomes scores by number of interventions received

	All	1 to 3 interventions	4 to 6 interventions	7 or more interventions
GAD7	72	72	69	74
PHQ9	71	65	71	74
MSK-HQ	59	55*	55*	67*
SWEMWBS total score	68	62	70	69
PAM total score	70	62	72	75
Returned to work	59	56	63	57
Started work	25	23	29	23
Employment outcome overall	38	38	42	36
ONS Life Satisfaction score	65	56	64	70
EQ-5D-5L score	57	55	53	62
EQ-5D-5L Visual Analogue score	67	58	64	74

Base: 1-3 (56-288); 4-6 (67-410); 7+ (72-445)

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

Table A5: Outcomes: Participants recording a more positive result at discharge than on entry or reporting an employment outcome by sub-group

	All		18-24		50+		Ethnic minorities	
	Count	%	Count	%	Count	%	Count	%
GAD7 Score	421	72	33*	70	132	69	42*	57
PHQ9 Score	379	71	26*	60	123	70	49*	70
PAM Score	752	70	57*	70	256	67	106	70
SWEMWBS Total Score	725	68	55*	68	246	65	105	69
EQ Visual Analogue Score	712	67	51*	63	248	65	90	59
ONS Life Satisfaction Score	691	65	57*	70	222	58	101	66
MSK-HQ Score	116	59	!	!	57*	58	16*	53
EQ-5D-5L	611	57	51*	63	221	58	82	54
Employment outcome	440	38	35*	41	131	33	61	36

Appendix 6: Assessment of additionality

1) Introduction

The evaluation of WWEH aimed for a rigorous and robust assessment of the 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 was undertaken during the first year of the evaluation to consider different approach to assess the additionality of the WWEH programme. This study sought to balance the needs of the key stakeholders while being sympathetic of practical, logistic and resource constraints. As an outcome of the study a contribution analysis approach was agreed which triangulates evidence between the following sources:

- a qualitative assessment of additionality was identified as the primary approach. This involved the evaluation team making an assessment of additionality based on reviewing in-depth qualitative interview data
- a trial quasi-experimental analysis comparing WWEH participants against a small number of respondents to the Labour Force Survey Five Quarters Panel.

These approaches are considered in turn before being summarised as an overall assessment of impact.

2) Qualitative assessment of additionality

This subsection briefly summarises the qualitative assessment approach that was used by the evaluation team. It then provides an assessment of additionality based on 60 in-depth interviews undertaken between January 2020 and April 2022.

A summary of the approach

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** (Appendix 7) is completed during analysis of interview transcripts which collate 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 Guide⁵⁸ 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.

The final assessment of additionality was based on 60 in-depth participant interviews undertaken during the evaluation of WWEH. These interviews took place between January 2020 and April 2022. Of the 60 interviewees, 28 were unemployed on entry to WWEH, so are likely to have required support with their job search, as well as intervention to promote their health and wellbeing. Focusing on outcomes achieved:

- 38 participants managed to secure a job outcome: defined as gaining a new job or returning to work
- separately, 28 participants indicated a health and wellbeing outcome: defined as improved health and wellbeing or better management of a health condition.

Sixty interviews is an adequate number on which to base a qualitative assessment of additionality. However, the assessment below is based on only 38 participants who managed to secure a job outcome and separately 28 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.

Assessment of additionality

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
- reductions in the restrictions and / or the effects of the COVID-19 pandemic
- the participant's physical or mental health situation improving enabling a return to work.

Overall, the **level of additionality was assessed at 38 per cent for those gaining a job outcome**. This means for every 100 participants who find, or returned to, work, 38 would not have done so if it were not because of WWEH. 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 (36 per cent). The

qualitative evidence suggests this is because their outcomes are more likely to be supported by non-WWEH factors:

- 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 being provided by a GP or mental health services.
- health conditions improving naturally over time.

The assessed level of additionality was higher for participants who achieved a health or wellbeing outcome: 51 per cent. This means for every 100 participants whose health or wellbeing, or management of a condition, improved, 51 would not have done so if it were not because of WWEH.

Again, there are limits to the reliability of a comparison based on 28 interviews. However there appears to be 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.

The next section focuses on the quasi-experimental analysis of impact.

3) Quasi-experimental assessment of additionality

The impact development study explored the potential for a quasi-experimental approach, using the Labour Force Survey (LFS), which would achieve a higher level of scientific rigour - Level 4⁵⁹ on the Maryland Scale. However this was ruled out as a primary approach due to low numbers of respondents in the LFS Five Quarter Longitudinal Panels who have recently fallen out of work for a health reason or are in work and at risk of falling out of work due to a health issue. Furthermore there is uncertainty regards how effective the questions used to identify relevant LFS subsamples are at identifying people in similar situations to WWEH clients. Especially with respect to those at risk of falling out of work due to a health issue, where it appeared likely that the LFS sample may have relatively lower health concerns - thus increasing their likelihood of remaining in work.

Recognising these (significant) concerns but also the scientific rigour offered, the evaluation has sought to conduct an exploratory trial study comparing outcomes for WWEH participants against a matched sample from the LFS Five Quarter Longitudinal Panel. The resulting analysis is be used to complement the qualitative approach set out above. The next subsection summarises the approach.

A summary of the approach

The analysis compares the proportion of WWEH participants who are in paid work 26 weeks after engaging with the programme to equivalent job outcomes for a counterfactual group of LFS respondents. A two-stage procedure was adopted to increase the similarity between the comparator group and the WWEH participants. First, responses to the LFS Five Quarter Longitudinal Panel between Quarter 1 2019⁶⁰ and Quarter 1 2022⁶¹ were used to identify respondents who at a baseline survey point (either their first, second or third quarter as part of the sample) had either recently fallen out of work for a health reason or were in work and at risk of falling out of work due to a health issue. The former group had left their last paid job in

the past six months and had stated that this was due to a health issue. While the latter group were on sick leave in the survey week and had a limiting health condition that was expected to affect them for more than a year. As noted above there is some concern that the latter group were at less risk of falling out of the labour market compared to the respective population of WWEH participants.

Second, propensity score matching (PSM) was used to improve the similarity between WWEH participants and LFS respondents who had either recently fallen out of work for a health reason or were in work and at risk of falling out of work due to a health issue. This found 'nearest neighbours'⁶² for WWEH participants in the LFS sub-sample. The variables used in the PSM were age, gender, ethnicity, highest education and year and quarter of first data.

In the absence of a Random Control Trial (RCT) the approach provides a high level of scientific rigour. The resulting analysis is robust, especially when compared to other evaluations of employment initiatives in the UK. Because of this it is likely to have also provided a harsher assessment of impact, for example with no scope for optimism bias. Despite these strengths, however, there were complexities and weaknesses in the data which affect the resulting estimates. These include:

- The matching process could only cover a limited number of socio-demographic characteristics as well as aspects of health and employability; this means there are likely to be important unobservable differences between the characteristics of WWEH participants and the matched Labour Force Survey sample which may bias the comparison.
- There were only 186 respondents in the Labour Force Survey sample who could be considered in the matching. Of whom just 93 were matched to one of the 983 WWEH participants. This limits the confidence that can be placed on the precision of the estimated level of additionality. It also reduces the likelihood that statistically significant results will be identified, especially if the level of additionality is in the range of that identified through the qualitative assessment.

The analysis undertaken compared the proportion of WWEH participants in work after 26 weeks to the matched counterfactual sample from the LFS Longitudinal Five Quarters sample over the same time duration. Importantly, this was done separately for the two WWEH client groups. This reflected concerns about how representative the LFS sample who were at risk of falling out of the labour market are compared to the respective population of WWEH participants.

Assessment of additionality

The results show 25 per cent of WWEH participants who had recently fallen out of work for a health condition were in paid work after 26 weeks. This compared to just 17 per cent of the matched Labour Force Survey respondents. This difference (9 percentage points – note rounding) is not statistically significant at a 0.05 level. However, as identified above, it's important to note that the sample size for this analysis meant that it was unlikely that the study would find statistically significant results, especially given the likely level of impact. Bearing this in mind, the result implies that 32 per cent of this subgroup of participants who gained an employment outcome would not have done so had it not been for their participation in WWEH. The remaining 68 per cent who secured a job would have done so without participating in the programme, for example due to improvements in personal circumstances, participation in other initiatives and increased availability of jobs in their area.

This implied level of additionality – 32 per cent – is slightly below that from the qualitative assessment (38 per cent). However they are broadly equivalent if a 15 per cent level of optimism bias is acknowledged within the qualitative assessment.

The results are very different when considering those at risk of falling out of paid work due to a health issue. In this case 59 per cent of WWEH participants were in paid work 26 weeks later which compared to 85 per cent of the matched counterfactual sample from the LFS Longitudinal Five Quarters sample. A difference of 26 percentage points which is statistically significant at a 0.05 level. This perverse result supports concerns that there are unobservable differences which mask the fact that the matched sample from the LFS have, on average, lower health issues which mean that they are far more likely to remain in paid work. Consequently, this comparison does not adequately support an assessment of additionality.

4) Summary

This chapter has provided an assessment of the level of additionality: the level of outcomes that can be attributed to the WWEH programme over and above what would have occurred anyway. An earlier impact development study identified a contribution analysis approach to assess the level of impact. Primarily this involved an evaluation team assessment of additionality based on reviewing in-depth qualitative participant data. This was further supplemented by a quasi-experimental analysis comparing WWEH participants against a small number of respondents to the Labour Force Survey Five Quarters Panel.

Where comparison can be made, the two methods for assessing the level of additionality produced fairly similar results, especially if a 15 per cent level of optimism bias is included within the qualitative assessment. Therefore when assessing the level of additionality the evaluation applies a range. The upper estimate being the qualitative assessment and the lower estimate allowing a further 15 per cent level of optimism bias, with the level of optimism bias being applied to the assessments of both employment and health outcomes.

The following table summarises the levels of additionality which are applied in our assessment of impact in Chapters 5 and 6:

	Upper estimate	Lower estimate
Employment outcomes	38%	33%
Health outcomes	51%	43%

Appendix 7: 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, local authority area.

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 WWEH 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	

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- ¹ A full account of performance challenges in the implementation and early delivery phases of the programme are detailed in the two previous WVEH Evaluation Annual Reports from 2020 and 2021 available at: <https://www.greatermanchester-ca.gov.uk/what-we-do/work-and-skills/working-well/>
- ² These were starts generated through Jobcentre Plus referrals but recategorised as an Employer start because the participant was employed by an SME or self-employed. The figure of 46.4 per cent is likely to *underestimate* the total proportion of Employer starts that came through this route due to changes in the ways referrals and starts were recorded which meant not all starts through this route were initially captured. See also endnote 21 on Employer referrals via JCP.
- ³ The 10 local authority areas in Greater Manchester comprise Bolton, Bury, Manchester, Oldham, Rochdale, Salford, Stockport, Tameside, Trafford, Wigan.
- ⁴ For a description and evaluations of the other Working Well programmes see <https://www.greatermanchester-ca.gov.uk/what-we-do/work-and-skills/working-well/>
- ⁵ Department for Work and Pensions (DWP) and Department of Health and Social Care (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>
- ⁶ DWP and DHSC (2017a) *op cit*.
- ⁷ Department for Work and Pensions (DWP) and Department of Health and Social Care (DHSC) (2017b) *Thriving at work: The Stevenson / Farmer review of mental health and employers*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/658145/thriving-at-work-stevenson-farmer-review.pdf
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- ¹⁰ Institute of Health Equity (2021), *op cit*.
- ¹¹ Department of Health and Social Care (DHSC) (2022) *Joining up care for people, places and populations: government's proposals for health and care integration* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1055688/joining-up-care-for-people-places-and-populations-print-version.pdf
- ¹² Department for Work and Pensions (DWP) and Department of Health and Social Care (DHSC) (2019) *Health is everyone's business: proposals to reduce ill health-related job loss* <https://www.gov.uk/government/consultations/health-is-everyones-business-proposals-to-reduce-ill-health-related-job-loss>
- ¹³ Greater Manchester Combined Authority (2022) *Greater Manchester Strategy 2021–2031 good lives for all* https://aboutgreatermanchester.com/media/jlsqby/gmca_gm-strategy_our-plan_04-03-2022-not-accessible.pdf
- ¹⁴ Office for National Statistics (ONS) (2022a) *Labour market overview, UK: June 2022* <https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/bulletins/uklabourmarket/june2022>; Office for National Statistics (ONS) (2022b) *Employment in the UK: September 2022* <https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/bulletins/employmentintheuk/latest>
- ¹⁵ Bank of England (2022) *Monetary Policy Report – May 22* [https://www.bankofengland.co.uk/monetary-policy-report/2022/may-2022#:~:text=Reflecting%20similar%20factors%2C%20CPI%20inflation,2022%20Q4%20\(Chart%201.6\)](https://www.bankofengland.co.uk/monetary-policy-report/2022/may-2022#:~:text=Reflecting%20similar%20factors%2C%20CPI%20inflation,2022%20Q4%20(Chart%201.6))
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Conversation, 18 May. <https://theconversation.com/shortage-of-workers-threatens-uk-recovery-heres-why-and-what-to-do-about-it-183260>

¹⁷ Office for National Statistics (2022c) Reasons for workers aged over 50 years leaving employment since the start of the coronavirus pandemic <https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/articles/reasonsforworkersagedover50yearsleavingemploymentsincethestartofthecoronaviruspandemic/2022-03-14>

¹⁸ Analysis undertaken by GMCA using ONS data.

¹⁹ See footnote 2

²⁰ Fit Notes are issued by GPs to provide evidence of the advice they have given about their fitness for work.

²¹ 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.

²² See the two previous WWEH Evaluation Annual Reports from 2020 and 2021 available at: <https://www.greatermanchester-ca.gov.uk/what-we-do/work-and-skills/working-well/>

²³ It should be noted that a change in the way that referrals were captured and recorded since December 2020 resulted in a substantial increase in the number of referrals, mainly via the JCP pathway. 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.

²⁴ Source of figures for Greater Manchester: ONS Annual Population Survey Jan 2021-Dec 2021 (via Nomis)

²⁵ See endnote 22.

²⁶ Office for Health Improvement and Disparities (OHID) (2022) *COVID-19: mental health and wellbeing surveillance report* <https://www.gov.uk/government/publications/covid-19-mental-health-and-wellbeing-surveillance-report/2-important-findings-so-far>

²⁷ SQW (2021) *Working Well: Work and Health Programme & Job Entry: Targeted Support (JETS) Evaluation 2021 Annual Report* <https://www.greatermanchester-ca.gov.uk/what-we-do/work-and-skills/working-well/>

²⁸ Almost two-thirds of young people say the pandemic has worsened their mental health in a survey reported in CIPD (2021) *Youth Employment In The UK 2021*. <https://www.cipd.co.uk/knowledge/work/skills/youth-employment-2021#gref>

²⁹ 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>

³⁰ Health and Safety Executive (2012) reported in Buck, D. and Gregory, S. (2013), op. cit.

³¹ Business in the Community (BITC) (2021) *The Scorecard Report: Race at Work 2021*, McGregor-Smith Review Four Years On [bitc-race-report-raceatwork2021scorecardreport-oct2021.pdf](https://www.bitc-race-report-raceatwork2021scorecardreport-oct2021.pdf) ; Ipsos (2022) *2 years on: Understanding the work experiences of UK employees since the murder of George Floyd* <https://www.ipsos.com/en-uk/2-years-on-understanding-work-experiences-of-uk-employees-after-murder-of-george-floyd>

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³⁴ Short Warwick Edinburgh Mental Well-Being Scale (SWEMWBS) © NHS Health Scotland, University of Warwick and University of Edinburgh, 2008, all rights reserved.

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- ³⁶ Benchmark is UK adults aged over 16 in 2015 to 2016. Data taken from ONS Measuring National Well-being - Office for National Statistics (ons.gov.uk)
- ³⁷ National benchmark is adults in Great Britain, March 2020 to May 2022 Source: Office for National Statistics (2022e) *Opinions and Lifestyle Survey*
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- ³⁸ See Endnote 34
- ³⁹ See Endnote 35
- ⁴⁰ There was insufficient programme data to explore whether younger Advice Service recipients reported higher levels of satisfaction compared with all Advice Service recipients.
- ⁴¹ The Institute for Fiscal Studies (IFS) (2020) *Moving into solo self-employment reduces income but improves well-being on average* [Moving into solo self-employment reduces income but improves well-being on average](https://www.ifs.org.uk/moving-into-solo-self-employment-reduces-income-but-improves-well-being-on-average) | Institute for Fiscal Studies (ifs.org.uk); TUC (2019) *Almost half the self-employed are on poverty pay*
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- ⁴⁴ Health Foundation and IES (2021) *op. cit.*
- ⁴⁵ 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>
- ⁴⁶ It was initially agreed with the Work and Health Unit that WHEH would test an alternative approach to the issuing of Fit Notes for those on the Programme, therefore becoming the first city region to pioneer different solutions for one of the issues that General Practitioners identify as a key challenge within primary care. However this ambition was not realised, primarily due to data sharing issues.
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- ⁵⁴ Institution of Health Equity (2021), *op cit.*
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- ⁵⁶ 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).

⁵⁷ Either returning to work (sickness absence cohort) or starting work (newly unemployed cohort).

⁵⁸ Homes and Communities Agency (2014) Additionality Guide.

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

⁵⁹ Level 4: Measures of an outcome before and after the programme in multiple experimental and control units, controlling for other variables that influence that outcome (e.g. number of WVEH participants by age, gender, same level of labour market experience etc., in work (and not on medical leave) rises after engagement with the programme and the same rise is not seen in the same groups elsewhere).

⁶⁰ The January-March 2019 to January-March 2020 data

⁶¹ The January-March 2021 to January-March 2022 data

⁶² Within a given level.



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