Approved Consultant 2010 ncvo

CLES Centre for Local Economic Strategies

March 2010

GREATER MANCHESTER HEALTH AND WORKLESSNESS

Final report prepared by

CLES Consulting

Presented to

Commission for the New Economy and the Manchester Commission for Health

CLES Consulting is the trading arm of CLES European Research Network. A not-for-profit company registered as a limited company no. 2467769. VAT no 519493812. The Centre for Local Economic Strategies is a company limited by guarantee no 4242937 with charitable status no 1089503

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'Improve the economic prospects of adults in our most deprived communities by reducing the number of people with limiting illnesses and out of work due to ill health.' [1]

The Greater Manchester Strategy highlighted the economic impact of health related worklessness as a key factor behind the productivity gap between the Greater Manchester City Region and more prosperous parts of the UK. The Commission for the New Economy and the Greater Manchester Health Commission have come together to identify ways in which tackling health related worklessness can be progressed. The following report is the response to the Health and Worklessness Call for Evidence issued jointly by the two Commissions. CLES Consulting, in partnership with Mental Health Strategies, has assembled the evidence base. The study has mapped provision across Greater Manchester and identified gaps and key issues that will shape future intervention and investment decisions.

The response to the Call for Evidence was conducted between September 2009 and January 2010. The methodology provided a study that fully reflected the policy context and an understanding of how health related worklessness is being addressed across Greater Manchester. The methodology had five elements:

1) statistical analysis;
2) policy review;
3) review of current strategies and activities across Greater Manchester;
4) consultation with local authorities, Primary Care Trusts and Mental Health Trusts;
5) best practice review.

The relation between health and work has been subject to significant research, review and policy development in recent years. The body of work which now exists in this field can be seen to coalesce around three key themes:

1) health and employment are inter-related;

2) funding the treatment of ill health but failing to address the causes is unsustainable in relation to both the NHS and welfare budgets;

3) health policy and employment policy should be more fully integrated.

Health related worklessness in Greater Manchester

Between August 1999 and May 2009 the number of Incapacity Benefit (IB) claimants fell slightly to stand at 157,520 claimants, equating to 9.7% of the working age population. On average, over 20,300 new claims for IB are made annually; 37% of new claimants move directly from employment onto IB. The number and rate of IB claimants varies across Greater Manchester. The areas of greatest concern are those that have shown dramatic increases in claimant numbers and also have an IB rate above the Greater Manchester average. These include:

- parts of central Bolton such as Tonge, Central and Halliwell Wards;
- Farnworth ward on the boundary of Bolton and Salford;
- Kingsway and Milstone and Deeplish wards in Rochdale;
- parts of Ashton and Hyde in Tameside, in particular Ashton St Peter's Ward;
- Brinnington in Stockport.

The cost to the Exchequer of health related worklessness in Greater Manchester is estimated to be in excess of £1,417,680,000 per annum; this is a conservative estimate as is it based on the cost of IB and lost tax revenues. It does not take account of lost economic output or the cost associated with the wider social impact of worklessness.

The largest proportion of claims for IB across Greater Manchester is due to mental and behavioural disorders, accounting for 45.5% of claims. Over the past nine years there has been a noticeable percentage point increase in claims for mental and behavioural disorders in all Greater Manchester Districts. Over 60% of claimants with a mental health condition have depression, anxiety or a stress related disorder.

[1] Prosperity for All: The Greater Manchester Strategy, 2009

This equates to approximately 45,000 people across Greater Manchester. The categories that have shown the large percentage point fall in claims are primarily for more physical conditions such as diseases of the musculoskeletal and circulatory system.

In the future, the classification of people claiming out of work benefits due to ill health will change markedly. There are two key factors that will drive this change:

1) the transition from IB to Employment Support Allowance (ESA) will create a fundamental shift in terms of the number of people that have an underlying health condition who are seeking employment. The impact of the shift towards ESA is that there will be a huge increase in the number of people who will require some kind of employment related support. There are potentially over 100,000 who will be placed in the 'work related activity' group and will therefore require formal support. There will also be over 20,000 people who will be declared 'fit for work' and will require support in making the transition into employment. There was a lack of awareness and strategic planning to support the transition to ESA;

2) the recession will have an inevitable impact on the labour market that will be partly manifested in the numbers of people out of work due to ill health.

Current strategies and activities in Greater Manchester

The study provides an insight into current provision which is addressing health related worklessness. It examined provision funded and delivered through the NHS, local government and Jobcentre Plus. Where data is available, the study has demonstrated the level of investment and the impact the service is having in terms of outputs and outcomes. A description of the services considered in the study is included in a comprehensive service directory appended to the full report.

NHS investment

There is a growing investment in psychological therapies, including Cognitive Behavioural Therapy, which are being delivered via primary and secondary care services. The nationally funded Increasing Access to Psychological Therapies (IAPT) Programme is increasing the level of investment in this type of service. The impact of this programme will continue to grow in the short term for two reasons:

1) during 2010/11, it will be fully rolled out across Greater Manchester and specific employment advice will be available to everyone who is referred to an IAPT service. One of the important aspects of investment in primary care provision is that it can prevent mental health conditions resulting in someone actually losing their job and/or having a deterioration in their health;

2) investment in services directly targeted at people with more severe mental health conditions is limited to two or three small scale, advisor based projects in each district. These projects have capacity for between 50 and 200 people at any one time. Using an average of 200 beneficiaries per area, the investment per beneficiary ranges from between £250 to £5,100. These services tend to be accessed by people who are receiving secondary care for a mental health condition.

The role of mental health day services has been reviewed in many areas in recent years in line with the recovery model. A key question for commissioners going forward is whether mental health employment support should be provided by mental health staff in mental health settings, or whether this is better provided by employment specialists in non-mental health settings. A combination of both would appear the most appropriate, but at present the balance appears heavily tilted in the provision of employment support within existing mental health services and settings.

Geographical coverage

Services across both the health and employment sectors are generally in place in areas that have rates of IB above the Greater Manchester average; however the location of the service does not necessarily imply that service users are drawn from the locality.

Many of the projects were targeted at claimants of out of work benefits generally. There is also a range of activity that is targeted specifically at IB/ESA claimants; however there were few activities that explicitly targeted people with specific conditions. This suggests that although provision does take account of the health needs of clients, it does not fully recognise the different requirements that people with different health conditions may have.

Long term impact

There was a lack of evidence about the long term impact of services on individual clients. It is acknowledged that it is often too difficult to properly assess the impact of programmes that are supporting people with health issues to return to work. People will often require long term support, and project, programme and activity evaluation often does not acknowledge the distance travelled by clients.

There was a lack of real understanding and insight into the impact of specific activities. Activities tended to be delivered in an isolated manner rather than as part of a wider coordinated portfolio of interventions aimed at an individual client. In the coming months and years, adverse conditions within the labour market may mean that it proves more difficult to reduce the numbers of people who are out of work due to ill health.

Coordinating client support

A number of programmes are being implemented that are seeking to improve client engagement and the coordination of support. These include Working Neighbourhoods Teams, IAPT, Pathways, Health Trainers and the Fit for Work pilot.

Preventing ill health and promoting health and well-being

There has been more emphasis in recent years on the preventative health agenda, which has begun to influence the delivery of primary care (e.g. GPs now offer advice around healthy eating, exercise, smoking cessation and sensible drinking). Although there is less evidence of the employment agenda being incorporated into this type of approach, there are some examples of employment services delivered in GP surgeries. It is not clear why there is a lack of such service at the moment. National policy documents such as Boorman and Black may represent a move towards giving employment a prominent place within the health field.

A range of interventions are being developed nationally for implementation at the regional, sub-regional and local level. These include:

- an occupational health helpline for SMEs;
- a regional challenge fund that will support SMEs to improve workplace health and well-being;
- a business well-being tool.

A health and well-being coordinator is being recruited in the Northwest who will be tasked with leading the implementation of these initiatives in the region. The importance of workplace health within the NHS is increasing and further emphasis will result from the implementation of the Boorman Review.

Greater Manchester strategic leadership

Good progress has been made at the strategic level to develop an understanding of the links between health, work and worklessness. AGMA, through the work of the Greater Manchester Commission for Health and the Commission for the New Economy, has been raising the profile of these issues. However, at the district level, health and employment tend to be treated as distinct issues and there are insufficient links through LSPs. There were some examples of partners at the district level working together to develop formal strategies related to this agenda, which included wide ranging health and well-being strategies that incorporated employment issues or specific health and employment strategies.

There are a wide range of services that fall under the broad theme of health and worklessness – there is no single agency or partnership structure that is responsible for this issue. Many of the districts identified issues related to health and worklessness within key strategic documents such as Local Area Agreements (LAA). However, very few of the partnerships within the districts have established strong processes or structures that provide strong links between the commissioning, delivery and performance management of services aimed at addressing health and worklessness.

Recommendations

The Commission for the New Economy and the Greater Manchester Health Commission are using the results of the Call for Evidence to develop a programme of work which will be taken forward by the Health and Work Group and relevant support staff. The evidence gathered in this study has been used to develop 40 individual recommendations which are grouped around five themes:

1) investment – the evidence has demonstrated the cost to the public purse and the wider economy of health related worklessness; therefore investment in addressing health related worklessness has both an economic and a social payback. The recommendations centre on ensuring that potential savings are considered when making investment decisions. This includes ensuring that the impact on employment outcomes is fully understood so that the true value of investment decisions can be articulated. It is also recommended that investment is targeted on activities which are likely to have the most significant impact on employment, in particular continuing the focus on providing access to services through primary care and also providing opportunities for supported employment and work experience;

2) strategy – the Call for Evidence represents a first step in developing a comprehensive strategic approach to addressing health related worklessness across Greater Manchester. The results of the Call for Evidence can now form the basis of ongoing strategy and should be built upon in a number of ways. It provides the basis of an evidence based approach to policy development which can be enhanced with access to more detailed Department for Work and Pensions (DWP) data, improved coordination of the collection of client based data, and wider use of the available data at a district and locality level. There is a need for a greater recognition of the importance of health related worklessness amongst both employment and health focused agencies (e.g. this could be undertaken through raising the priority of worklessness within the portfolios of Directors of Public Health);

3) research – the evidence presented in this report is based on existing data; however there are a number of issues identified which merit further analysis. This includes reviewing the experience and case histories of people with different mental health conditions, the extent to which former public sector employees are on health related benefits, and the impact of workplace health programmes;

4) provision – the study has provided a number of examples of aspects of current provision which could be improved or developed in the short term. The study itself represents a resource which should be promoted and used widely across agencies, in particular the mapping of services can be utilised by frontline staff to enhance current signposting. Activities should be developed which enable the ongoing recording of employment activities at both organisational and individual client level. Emphasis is also placed on expanding Continuous Professional Development (CPD) activities which enable cross organisational and cross sectoral learning, given the range of organisations which an individual client may be receiving support from;

5) piloting – the two Commissions could play an important role in encouraging innovation and supporting the piloting of new approaches to addressing health related worklessness. Initially, this should be focused on providing support to people in work, either at the general level through workplace health programmes or more specifically through programmes such as the Fit for Work pilot.

Conclusion

The link between health and worklessness has been recognised by national, regional, sub-regional and local agencies. This recognition has recently gained a momentum which is starting to have an impact in the way that services are delivered and configured. This report provides an overview of current provision and the strategic approach to tackling health related worklessness. There are three key issues which should underpin the overall strategy to tackling health and worklessness:

1) current and planned provision will not meet demand or address the problem. There is currently too little investment in services which provide sustained, bespoke support to people with health issues that are acting as a barrier to employment;

2) service providers will have to adapt both the scale and nature of provision as the profile of clients changes. Generally, there will be more emphasis on people with mental health conditions. In addition to this, the transition from IB to ESA will significantly increase the number of people who will be expected to engage in meaningful job related activities;

3) in response to the previous two issues, policy is developing across Greater Manchester and there is an opportunity to take a more strategic approach to tackling health related worklessness. This will require a change in mindset amongst health and employment professionals, employers and clients themselves. It will also require a step change in the level of investment in services in this area.

1 INTRODUCTION

> 'Improve the economic prospects of adults in our most deprived communities by reducing the number of people with limiting illnesses and out of work due to ill health.' [2]

The Greater Manchester Strategy highlighted the economic impact of health related worklessness as a key factor behind the productivity gap between the Greater Manchester City Region and more prosperous parts of the UK. The link between health and worklessness is a key issue within the labour market. The Greater Manchester Strategy recognises that the future prosperity of the sub-region is in part based upon helping people participate in the economy through employment. Therefore, the high numbers of people who are currently not working due to poor health is preventing the full potential of the Greater Manchester economy being realised. The Greater Manchester Strategy is drawing upon a growing body of academic knowledge which is showing a clear linkage between worklessness and health.

> 'There is a strong association between unemployment and measures of psychological and psychiatric morbidity… Upon re-employment, there appears to be a reversal of these effects. While the direction of causality is difficult to determine, unemployment is considered to be a significant cause of psychological distress in itself.' [3]

Health is a major cause of worklessness; however worklessness can lead to poor health. Claimants of IB and ESA should not be classified as one homogenous group; the underlying causes of ill health related worklessness are wide ranging and work is not an option for individuals until the health barriers are overcome.

The following report represents the response to the Health and Worklessness Call for Evidence issued jointly by the New Economy and Greater Manchester Health Commissions. CLES Consulting, in partnership with Mental Health Strategies, has assembled the evidence base. The research is intended to map provision of mental health focused worklessness programmes and other interventions delivered by sub-regional bodies, local authorities, Jobcentre Plus and NHS organisations. The study has used the mapping exercise to identify gaps and key issues that will shape future intervention and investment. The report has addressed the key elements outlined in the Call for Evidence:

- current national government policy context – the policy review explores how general government policy relates to health and worklessness and how the Government has made deliberate moves to understand health and worklessness, developing policies that address health related worklessness, improve health within the workplace and ensure that the public sector acts as an exemplar employer. The policy review demonstrates that there is a greater awareness of the links between health and worklessness and provides the basis for reviewing how agencies in Greater Manchester have responded to this agenda. The policy review highlights specific initiatives related to worklessness and health programmes, exploring the overlap between the two policy areas and how health and worklessness relates to mainstream development across government;

- summary of the current position in terms of health related worklessness in Greater Manchester – this includes a geographical profile of IB/ESA at a Greater Manchester and district level. The characteristics of IB claimants are described in relation to age, length of claim and condition;

- summary of the approaches which have been taken at both a strategic and operational level across Greater Manchester – the summary within the body of the report provides an overview of the approaches taken across the sub-region, highlighting the key activities that are making a difference at the strategic and operational level. The mapping exercise has been used to make general conclusions about provision across Greater Manchester.

[2] Prosperity for All: The Greater Manchester Strategy, 2009
[3] Mclean (2005) Worklessness and health – what do we know about the causal relationship?

The findings are intended to provide a focus for strategic discussions about policy related to health and worklessness; therefore they are intended to stimulate debate. The findings relate to key issues concerning the extent and impact of current provision, where there are key gaps in provision, how employers are linked into provision, and the impact of the wider economic climate.

The report is intended to be a practical body of work that can be used at both the Greater Manchester and individual district level to inform strategic development and improve services. In many respects, the Call for Evidence represents the start of a process that will see greater efforts in reducing the impact of poor health on people's working lives. The report therefore provides analysis, findings and recommendations, and practical resources that can inform the policy debate around this issue.

The recommendations have been developed as a response to current policy context, Greater Manchester provision and key findings, and are focused on strategic rather than operational issues relating to actions that can be taken at a Greater Manchester level. They seek to provide the two Commissions with a basis for developing a better understanding of the impact of services, a policy structure that can address the issues raised in this report, and more effective engagement between the health and employment sectors.

1.1 Methodology

The response to the Call for Evidence was conducted between September and December 2009. The aim of the methodology was to provide a study that fully reflected the policy context and provided an understanding of how health related worklessness was being addressed across Greater Manchester. The statistical evidence was analysed to explore the scale of health related worklessness in Greater Manchester, drawing on publically available data such as Nomis Official Labour Market Statistics.

Following the statistical review, a review of the current strategies and activities across Greater Manchester was conducted:

- review of key documents and strategies from each of the ten local authority districts. This review was used to provide a basic analysis of current and planned activities, which was then complimented by an analysis of the National Mental Health Finance and Service Mapping Exercises that Mental Health Strategies undertake annually on behalf of the Department of Health (DH);
- this initial analysis was then used as the basis of consultation with key leads from each of the ten local authorities, Greater Manchester Directors of Public Health, and a representative from each of the three Greater Manchester Mental Health Trusts;
- the aim of this consultation was to ensure that the mapping exercise reflected the full extent of activities being delivered across Greater Manchester to review the impact of different approaches and explore any gaps in provision that currently exist;
- the results of the review were validated during interviews with Primary Care Trusts, Mental Health Trusts, local authority leads and other key stakeholders (e.g. Jobcentre Plus). In order to compliment this, CLES Consulting has reviewed best practice from across the country, drawing on its own extensive database and identifying best practice from elsewhere.

2 POLICY REVIEW

The Government has recognised that a high proportion of the working age population are on IB and that there is a link between non-engagement in the labour market and physical and mental health issues. The Government has faced the challenge of deriving policy which matches these two agendas of health and employment, bringing together different agencies to tackle health related worklessness. The Government is also trying to realise savings in some of the costs associated with health related worklessness, particularly around benefits, and has responded to these challenges with a raft of policy interventions designed to tackle health related worklessness. These interventions are underpinned by a number of key principles:

- the prevention of health related worklessness;
- a notion of rights and responsibilities on the part of the claimant;
- individualised and personalised programme and project responses for claimants;
- a focus upon health and economic development stakeholders working in partnership;
- an enablement of cost savings through more efficient and effective policy;
- a reflection of the impact of ill health upon productivity and the UK economy.

The following section provides an overview of the core government policies that have emerged over the last five years in relation to health related worklessness, looking particularly at three areas:

1) the National Health Service agenda around prevention;
2) the local authority and economic development sector strategic agenda around employment;
3) the joining up of health and worklessness interventions.

2.1 Shifting the balance towards preventing ill health and promoting well-being

Traditionally, healthcare budgets have been focused on treating ill health as opposed to preventing ill health and promoting good health. One area in which health and employment policy overlaps relates to the prevention of ill health and the promotion of well-being. The cost of treating ill health in terms of both direct healthcare costs (e.g. NHS budget) and indirect costs (e.g. out of work benefits) can be reduced if the focus of policy is placed on preventing ill health. Promoting health includes ensuring people are fit for work; therefore there is a strong argument for ensuring that health and employment policy are integrated. This philosophy has been recognised both explicitly and implicitly in several different policy documents.

2.1.1 The Wanless Report

The Wanless Report[4] commissioned in 2002 sought to assess the long term resource requirements of the NHS. This report argued that in the long term health costs would rise to unsustainable proportions unless more investment was made in tackling prevention of ill health and the wider determinants of health. It recommended that more investment was made by the NHS in activities which provided:

- coherent information about what the health service will and will not provide for them;
- coherent information about how people can shape their own health and care;
- coherent information about how their local health services are performing.

2.1.2 Claiming the health dividend: Unlocking the benefits of NHS spending

The Claiming the health dividend: Unlocking the benefits of NHS spending[5] report was published in May 2002 by The King's Fund. The report aimed to demonstrate the wider role of the NHS, in that it is more than a provider of health services with an impact on health, the environment, and the social and economic fabric of individuals' lives. In terms of employment, The King's Fund suggests the NHS should be doing three things:

[4] DWP (2004) 'Securing good health for the whole population: Final report', accessed at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4074426
[5] The King's Fund (2002) 'Claiming the Health Dividend: Unlocking the benefits of NHS spending', accessed at: http://www.kingsfund.org.uk/research/publications/claiming_the_1.html

1) recruiting staff from areas of high unemployment;

2) take a long term view of workforce needs, and how training routes may be opened up for local people;

3) working in partnership across different NHS agencies.

These different aspects of policy can be realised in several ways, including:

- ❑ developing pre-employment training programmes for local communities;
- ❑ developing more lower skilled and entry level jobs;
- ❑ taking measures to understand their locality and the employment needs of the population;
- ❑ working with other sectors to foster employment opportunities.

2.1.3 World class commissioning

World class commissioning[6] was one of the initiatives which developed after the Wanless Report and changed the organisational ethos of the NHS in terms of how health and social care services are commissioned. One of the aspects of world class commissioning is to ensure that the NHS is cognitive of other agendas, such as employment. There are a number of remits for world class commissioners, including actively steering the local health agenda. They will also take into account the wider determinants of health and well-being of their local community by working closely and developing a shared ambition with key partners. As such, commissioners should be undertaking the following:

- ❑ actively promoting the role and activities of their Trust;
- ❑ considering community benefit in commissioning services;
- ❑ working in partnership with the wider public sector to improve health outcomes.

2.1.4 High quality care for all

The High quality care for all[7] report (the Darzi Review*)* was commissioned by the Government to develop a vision for the future of the NHS. It is hoped the findings will allow NHS services everywhere to reflect the needs of their local communities. There are a number of visions and recommendations in this report in relation to health and worklessness. The report recommends that every Primary Care Trust will commission well-being and prevention services in partnership with local authorities, together with a number of actions targeted at healthy workplaces, including a Coalition for Better Health. Furthermore, greater preventative support is recommended for people to stay healthy at work, including Fit for Work services, to help people who want to return to work but are struggling with ill health. The report also recommends the implementation of a wide ranging programme to support the development of vibrant, successful community health services. The recommendations of the Darzi Review are in the early days of implementation, but include the Fit for Work services which are being piloted in a number of localities, including Greater Manchester.

The DWP and Department for Health have confirmed that Greater Manchester will be awarded up to £450,000 to develop the first city regional Fit for Work pilot in the UK. The pilot will reduce on flows to health related employment benefits by providing active case management and support and advice to individuals whose health condition is putting their job at risk. The pilot will support 1,500 Greater Manchester residents in 2010/11.

The pilot will build on an existing NHS North West contract delivered by Pathways Community Interest Company and will provide active case management for individuals who are either off sick from work, or at high risk of going off sick. The service will be accessible to people affected by any medical condition that threatens their employment.

A team of employment advisors will work with individuals, their employer and their clinicians to develop return to work plans, referring to a wide range of relevant support services such as debt advice, childcare, housing and transport. If the individual's current job is no longer suitable, they will be supported to find alternative employment.

[6] See http://www.dh.gov.uk/en/managingyourorganisation/commissioning/worldclasscommissioning/index.htm
[7] DoH (2008) 'High Quality Care For All: NHS Next Stage Review Final Report', accessed at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_085828.pdf

Referrals will be accepted from multiple sources, including employers, clinicians and self-referrals. Around 70% of referrals will be sourced via GPs. A lead GP will be identified for each district to champion the project, support referral volumes and, working with the Primary Care Trust, identify which neighbourhoods and practices should be targeted to generate referral volumes.

2.2 The local authority and economic development sector strategic agenda around employment

Tackling worklessness has not only become a strategic priority for economic development departments but a corporate priority for local government. A number of studies[8] have emphasised that the most effective interventions are those that are locally focused and small scale. The Government has introduced a number of policies to be implemented at the local level focused upon the following themes:

- supporting areas with significant proportions of worklessness and deprivation;
- recognising the links between worklessness, local skills and enterprise formulation;
- embedding partnership in delivery between local authorities, other parts of the public sector, and voluntary and community sector organisations.

These themes flow through a number of policy documents and interventions; the City Strategy Programme was delivered through fifteen pathfinder areas, one of which was Greater Manchester.

The aim of the pathfinders was to explore ways in which local partners can identify shared priorities and combine resources to meet these priorities. In particular, the pathfinder was designed to test different approaches to integrating the work of government agencies, local government, the private sector, and voluntary and community sector in order to provide appropriate support for jobless people.

2.2.1 City Strategy for Greater Manchester

The City Strategy for Greater Manchester brought together ten local authorities, Learning and Skills Council, Primary Care Trust, Jobcentre Plus, Regional Development Agency, employers and the third sector. The Greater Manchester City Strategy focused upon the 58 wards in the City Region with the worst labour market conditions, which were effectively the blueprint of worklessness strategy and intervention for the Greater Manchester City Region. Given the drive towards pooling resources and aligning targets, local authorities and partners should be working towards shared worklessness priorities through the City Strategy.

2.2.2 Working Neighbourhoods Fund

The Working Neighbourhoods Fund (WNF) is an area-based and deprivation allocated funding source dedicated to tackling worklessness, low skills and enterprise formulation, which replaced the more holistic Neighbourhood Renewal Fund (NRF). Seven authorities in Greater Manchester were allocated approximately £140 million annually through the WNF. Table 1 provides a detailed breakdown of the allocations. The mapping of services did not identify direct links between tackling health related worklessness and the WNF. The current WNF Programme ends in 2010/11. There is a strong likelihood that the programme will either not continue or continue in significantly reduced form.

[8] CLES, Alan Harding

Table 1: Working Neighbourhoods Fund, Greater Manchester allocations

Local authority	Revised WNF allocation 2009/10	Revised WNF allocation 2010/11
Bolton	6,757,326	7,056,333
Manchester	29,667,819	30,711,793
Oldham	6,101,043	6,359,588
Rochdale	6,278,074	6,542,437
Salford	10,177,514	10,585,931
Tameside	4,296,584	4,534,105
Wigan	7,354,605	7,753,832
Total	70,632,966	73,544,019

Recommendation 1

Any future WNF Programme or similar type of investment should be closely targeted at activities focused on addressing health related worklessness.

2.2.3 The Houghton Review

The Houghton Review[9], published in March 2009, examines how local authorities in England can do more to tackle worklessness. It suggests that the present framework of tackling worklessness is too disparate and a clearer framework for integrating skills, employment and wider support for workless people is needed to guide more flexible local funding. The Review suggested a number of strategic recommendations, in which local areas should:

- undertake a worklessness assessment of the locality, which should be undertaken as part of the Local Economic Assessment that local authorities will be undertaking from April 2010 onwards;
- develop work and skills plans for those authorities and partnerships that want to align budgets and co-commission services;
- look to integrate work and skills budgets.

The Review recommended that health bodies are involved in the development of worklessness assessments and work and skills plans. The Review also called on local authorities and their partners to do more to expand employment, work experience and training opportunities for long term benefit claimants. A number of the recommendations of the Houghton Review are being brought into policy (e.g. the Economic Assessment Duty, legislated for in autumn 2009, will require authorities to produce a worklessness assessment as part of the process of economic assessment). Additionally, areas in receipt of Future Jobs Fund and WNF will be expected to produce a work and skills plan. As such, economic development practitioners need to be undertaking the following activities:

- gathering data which enables them to understand the scale and culture of worklessness;
- understanding the strategic and delivery activities currently taking place in their locality;
- working with partners to identify gaps in provision;
- deliver recession and worklessness specific interventions such as Future Jobs Fund.

[9] CLG (2009) 'Tackling worklessness: A review of the role and contribution of English local authorities and partnerships', accessed at: http://www.communities.gov.uk/documents/communities/pdf/1161160.pdf

2.3 The joining up of health and worklessness interventions

Worklessness is one policy area where economic and health outcomes are intertwined (e.g. the Government has recognised the scale of claims of IB, the impact of this upon the economy, and the inherent linkages between health and worklessness). The policy response has been wide ranging and has sought to more effectively link the two agendas through a framework of:

- reviewing the benefits system, particularly IB;
- enabling a benefit system framed around the notion of rights and responsibilities;
- providing individualised and personalised responses;
- preventing worklessness in the first place through workplace interventions;
- ensuring health related worklessness interventions are framed within partnership working.

As such, these themes flow through a number of policy documents.

2.3.1 Health, work and well-being: Caring for our future

The Health, work and well-being: Caring for our future[10] report was published in October 2005 and was largely focused upon preventing ill health through workplace intervention. These objectives are matched with a number of suggested interventions:

- the strategy argues for greater engagement with stakeholders by developing a charter for health and supporting the creation of local stakeholder councils;
- the strategy makes suggestions for improving working lives and creating healthy workplaces;
- the strategy includes piloting links between GPs and employment support to assist patients to stay in or return to work following health problems;
- the strategy sets out a number of interventions around common mental health problems.

Health Charters and local stakeholder councils should be in place in every locality. Practitioners should therefore be engaged strategically in the local stakeholder councils and adhere to the focus of the Charter. The healthy workplaces element of this review was formulated in Health, work and well-being launched in 2005, with trusts and partners expected to develop initiatives. Issues around common mental health problems and improved access to work focused activities have been incorporated in the rollout of Pathways to Work.

2.3.2 The Black Review

The Black Review of the health of the working age population: Working for a healthier tomorrow[11] was commissioned in March 2007 to undertake a wide ranging review of the health of Britain's working age population and its impact upon the economy and society. The Review sets out a number of actions deemed necessary in order to take this agenda forward. It suggests that employers bear the primary responsibility for minimising the likelihood of people being made ill by their job and also promote health and well-being in a more holistic sense. It also recognises that healthcare professionals could provide crucial advice on fitness for work, if they are given the right support.

The Review was a wide ranging evaluation of the health of Britain's working age population and its impact upon the economy and society. The Review represents a landmark in the way that it brought together the health and work agendas, both in terms of emphasising the importance of work to health and health to work, but also in making in a number of key recommendations.

> 'At the heart of this Review is a recognition of, and a concern to remedy, the human, social and economic costs of impaired health and well-being in relation to working life in Britain.' [12]

[10] DoH (2005) 'Health, work and well-being: Caring for our future', accessed at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4121757.pdf
[11] OPSI (2008) 'Dame Carol Black's Review of the health of the working age population: Working for a healthier tomorrow', accessed at: http://www.workingforhealth.gov.uk/documents/working-for-a-healthier-tomorrow-tagged.pdf
[12] Ibid

The review focuses on three key themes:

1) prevention of illness and promotion of health and well-being;
2) early intervention for those who develop a health condition;
3) an improvement in the health of those out of work – so that everyone with the potential to work has the support they need to do so.

The review recognises that whilst there have been improvements in health and safety at work, there has been less emphasis on health and well-being within the workplace. One of the key reasons for this was that employers did not recognise the economic benefits of promoting health within the workplace. The review challenges perceptions that once someone becomes too ill to work they cannot return to work until they are 100% fit, and that work can only be a barrier to people becoming well again. It recognises that people on IB are not provided with enough support and motivation to view returning to employment as a realistic option. There is a lack of understanding amongst employers, employees and the health professions about the links between health, well-being and work, and a lack of synergy between employment policy and health policy.

The Review sets out a number of actions deemed necessary in order to take this agenda forward. It suggests that employers bear the primary responsibility for minimising the likelihood of people being made ill by their job and also promoting health and well-being in a more holistic sense. It also recognises that healthcare professionals could provide crucial advice on fitness for work, if they are given the right support. A number of programmes and initiatives have been developed as a result of the Black Review and are potentially available at the local level, including:

- Fit for Work service;
- business health check;
- reforming the medical statement;
- public sector as an exemplar programme;
- health, work and well-being coordinators;
- employment advisors in the IAPT Programme;
- national educational programme for GPs;
- pathways advisory service;
- occupational health advice line for small businesses;
- health, work and well-being Challenge Fund.

2.3.3 Ready for work: Full employment in our generation

Ready for work: Full employment in our generation[13] is one of a range of reports released in recent years with the remit of reviewing the welfare system and tackling worklessness. This report particularly sets out how the Government intends to move towards full employment in the UK and outlines a number of health related worklessness proposals, including the replacement of IB with ESA. It also outlined that, from April 2008, everyone on IB in Britain would have access to the Pathways to Work Programme and set out plans to replace the Personal Capability Assessment with the Work Capability Assessment. The core proposals of this review have been taken forward in subsequent Green and White Papers and Acts of Parliament, including No one written off: Reforming welfare to reward responsibility[14].

Perhaps the key action to emerge from this Green Paper is legislation for the ESA, which was introduced for all new applicants of incapacity related benefit in October 2008. It will be rolled out to all those under-25 from April 2010 and all existing IB claimants from April 2011. In this, there is a key role for the health sector in that between 2009 and 2013 all IB claimants will be reassessed using a medical assessment called the Work Capability Assessment. The Green Paper also led to a roll out of the Employment Retention and Advancement project for lone parents and greater influence for local partnerships in drawing up back to work contracts and services. Finally, it led to the development of a new 'right to bid' for public, voluntary and private providers that believe they could deliver services more effectively than current providers.

[13] DWP (2007) 'Ready for work: Full employment in our generation', accessed at: http://www.dwp.gov.uk/docs/readyforwork.pdf
[14] DWP (2008) 'No one written off: Reforming welfare to reward responsibility', accessed at: http://www.dwp.gov.uk/docs/noonewrittenoff-complete.pdf

2.3.4 Realising potential: A vision for personalised conditionality and support

Realising potential: A vision for personalised conditionality and support[15] was published in 2008 and is an independent report on conditionality and support. The report sets out a vision for a single personalised conditionality and support regime, where virtually everyone claiming benefits and not in work should be looking for or engaging in activity to help them move towards employment. It sets out a number of key recommendations in relation to three key groups:

1) work ready group – people that are ready to enter employment supported through a personalised regime based on rules and requirements, similar to the Jobseekers Allowance (JSA) regime;

2) progression to work group – people who are capable of a return to work with time, encouragement and support;

3) no conditionality group – people with no conditional requirements, such as those currently in receipt of ESA, lone parents and certain carers.

2.3.5 The Boorman Review

The Boorman Review[16] was commissioned in November 2008 as an independent review of the health and well-being of NHS staff. The Review recommends that all NHS organisations provide staff with health and well-being services that are centred on prevention of both work and lifestyle related ill health. The report also cites ensuring managers have the skills and tools to support staff with mental health issues as a key priority. Other recommendations include trusts undertaking proper assessment of key health priorities and risk factors, and consistent access to effective interventions for NHS staff with health problems. The report also recommends that all NHS organisations develop a staff health and well-being strategy with the full involvement of staff and staff representatives. The Review recommendations are new and, as yet, have not moved into solid interventions; however health and economic development practitioners can be proactive in seeking to implement some of the recommendations strategically, including:

- all NHS organisations provide staff with health and well-being services which are centred on prevention;
- all NHS Trusts implement strategies for actively improving the health and well-being of their workforce.

2.3.6 Jobs for the future

The Jobs for the future[17] report published by the Government in September 2009 outlines where, as a result of expected growth and emerging global trends, new jobs could be created by businesses in the UK economy. The paper highlights the role of the health sector in tackling worklessness (e.g. CareFirst are offering 50,000 traineeships for young people to provide them with the skills and experience they need for a permanent career in the sector).

2.3.7 New horizons: Towards a shared vision for mental health

In December 2009, the Government launched New horizons: Towards a shared vision for mental health[18], which sets out the Government's intention across a wide range of agencies to:

> 'Move towards a society where people understand that their mental well-being is as important as their physical lives if they are to live life to the full.'

[15] DWP (2008) 'Realising potential: A vision for personalised conditionality and support', accessed at: http://www.dwp.gov.uk/docs/realisingpotential.pdf
[16] DoH (2009) 'NHS Health and Well-Being Review', accessed at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_108907.pdf
[17] HM Government (2009) 'Jobs of the Future', accessed at: http://www.hmg.gov.uk/media/41730/jobs_of_the_future.pdf
[18] HM Government (2009) 'New Horizons: A shared vision for mental health', accessed at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_109708.pdf

The report sets out a number of ways in which the Government intends to meet these aims, including the prioritisation of mental health nationally and locally across government and all sectors through Public Service Agreements and LAAs. The report also argues that local government has a strong role to play in providing locally responsive and better value services for people with mental health issues. The majority of recommendations are not yet legislated for; there are a number of actions which will have implications for health and worklessness strategy and interventions at the local level:

- the IAPT Programme is expanding training on all therapies supported by recently revised NICE[19] guidance on depression;
- the DH is working with the Royal College of Psychiatrists and others to review the training needs of staff to better manage transitions across services;
- the DH will undertake a review of the workforce requirements to take the public mental health agenda forward;
- an e-learning resource for mental health practitioners is being developed.

2.3.8 Mental health and work

The Mental health and work[20] report supports the Black Review and aims to shed light on a number of different themes related to mental health and employment, including work and the stigma of mental ill health. The report sets out a number of policy recommendations:

- relevant government departments should coordinate or commission a programme of activity to raise awareness around the employment related challenges facing people with mental health issues;
- ensuring that those who have had prolonged absence from work, or are at risk of this, have rapid access to healthcare workers and support;
- people who are workless and have mental health problems should be provided with support to find and retain employment when they are ready to do so;
- the NHS, government departments and other public bodies ought to be exemplary employers with regard to the employment and support provided for people with mental health problems.

2.4 Summary

The relation between health and work has been the subject of a great deal of research, review and policy development in recent years. The body of work of work which now exists in this field can be seen to coalesce around three key themes:

1) a clear link has been established between health and work; there is a greater degree of understanding of the impact of work on health and well-being. This understanding has different perspectives. Being in work is generally good for people's health and, whilst health can be a barrier to employment, being out of work often has a negative impact on both mental and physical health and well-being. However, work can have a negative impact on health and well-being. For many conditions, particularly mental health conditions, employment can be a central part of a therapeutic process. These different strands are weaved together in both the Black Review and the Perkins Review but also form a key element of the Boorman Review;

2) the current model of using public funds to support the treatment of ill health whilst failing to address the cause is, in the long term, unsustainable. This is true in relation to both the NHS budget and welfare budgets. The Wanless report demonstrated that it is more cost effective for the NHS to focus its resources on promoting health and well-being rather than treating ill health, and this should become the basis for the future of publically funded health budgets.

[19] National Institute for Clinical Excellence
[20] RC Psych (2008) 'Mental Health and Work', accessed at: http://www.workingforhealth.gov.uk/documents/mental-health-and-work.pdf

A similar point was highlighted in the Freud Review in relation to the costs associated with supporting people who are not working due to ill health. The Black Review explored ways in which this shift towards a preventative agenda could be delivered through employment focused interventions. More emphasis has also been placed on promoting health and well-being through the workplace. The Boorman Review considered this issue from the perspective of the NHS's own workforce. Both the Black Review and the Perkins Review also recognised the responsibility that employers have for the health and well-being of the workforce;

3) a constant theme which runs through this agenda is that there must be greater overlap and synergy between health policy and employment policy. The Black Review is explicit about this but it is also a key feature of the reform of the benefits system and the development of a more strategic approach to reducing levels of worklessness at the local level. Several practical steps have already been taken, including most significantly reforming the benefits system so that being on out of work benefits due to poor health is no longer seen as a reason for not engaging in activities which could lead to paid employment. The replacement of IB with ESA is a clear expression of the Government's intent.

3 HEALTH RELATED WORKLESSNESS IN GREATER MANCHESTER

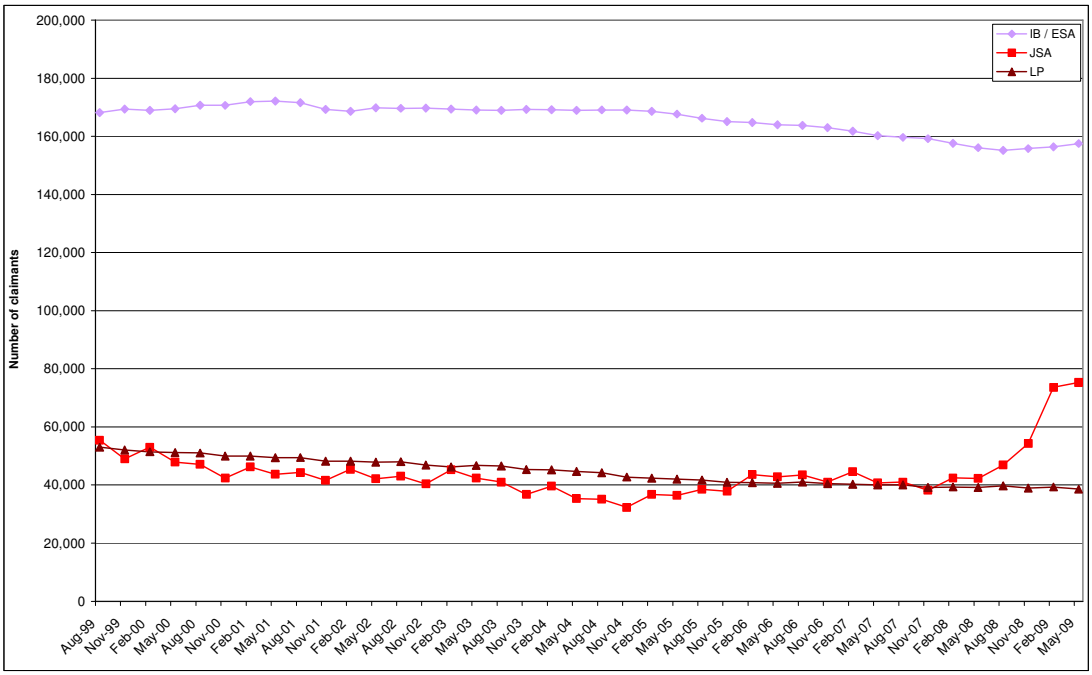
This section of the report outlines the scale of health related worklessness in Greater Manchester and the characteristics of worklessness at small area level. All of the data used is available from the DWP website[21] and Nomis[22]. The source data is provided in the data report which accompanies this report. The data clearly shows why health related worklessness is a priority issue in Greater Manchester and highlights that particular localities in the sub-region are experiencing significant pockets of worklessness.

A total of 322,680 Greater Manchester residents were workless (IB/ESA, JSA and Lone Parent Income Support) in May 2009. The number of IB claimants has fallen slightly since August 1999 (down 6.3%) to stand at 157,520 claimants. This figure includes claimants that have moved onto ESA. The fall in the number of IB/ESA claimants is due to a combination of the following factors:

- a range of activities that have been delivered which provide support for people who are on IB;
- there was a massive increase in the number of people who moved onto IB during the late 1980s and early 1990s, many of whom are now moving into retirement;
- the economic conditions of the last ten years have increased the number of jobs in Greater Manchester, which means there have been more opportunities for people to move off benefits and into employment.

A 35.8% rise in JSA claimants has been recorded between August 1999 and May 2009. More recently, unemployment rose by 77.8% between May 2008 and May 2009.

Figure 1: The scale of worklessness in Greater Manchester



3.1 The geography and profile of Incapacity Benefit/Employment Support Allowance claimants in Greater Manchester

A total of 9.7% (157,520) of the working age population were claiming IB and ESA in May 2009. The geography of IB claimants varies across the sub-region, with higher than average concentrations being found in Bolton, Manchester, Rochdale, Salford, Tameside and Wigan.

[21] http://www.dwp.gov.uk/asd/tabtool.asp
[22] https://www.nomisweb.co.uk/Default.asp

Table 2 shows the rate of IB/ESA claimants in each local authority district. It is clear that although the rate differs across the ten areas, the absolute numbers of claimants varies to such an extent that the scale of provision required in each of the areas will differ significantly.

Table 2: % of working age population claiming IB/ESA in Greater Manchester, May 2009

District	Number	Rate
Bolton	16,240	10.2
Bury	9,480	8.4
Manchester	34,070	10.6
Oldham	12,770	9.6
Rochdale	14,270	11.2
Salford	16,020	11.3
Stockport	11,710	6.9
Tameside	13,940	10.4
Trafford	8,970	6.9
Wigan	20,050	10.6
Greater Manchester	157,520	9.7

The number of IB and ESA claimants is not consistent over time or geography. The areas of greatest concern are those which have shown dramatic increases in claimant numbers and have a rate above the Greater Manchester average[23]. These include:

- parts of central Bolton, such as Tonge, Central and Halliwell Wards;
- Farnworth ward on the boundary of Bolton and Salford;
- Kingsway and Milstone and Deeplish wards in Rochdale;
- parts of Ashton and Hyde in Tameside, in particular Ashton St Peter's Ward;
- Brinnington in Stockport.

3.2 Age and duration of Incapacity Benefit/Employment Support Allowance claimants in Manchester

The significance of long term IB claims was highlighted in national policy documents such as In work, better off[24] suggesting that:

> 'Once someone has been on IB for more than two years they are more likely to die or retire than move off benefit to return to work.'

The reasons for this are complex contributory factors, including:

- a historical lack of conditionality of IB;
- deteriorating health once worklessness is experienced;
- claimants having outdated skills as labour markets change during a period of inactivity.

The majority of IB/ESA claimants in Greater Manchester (61.4%) have been in receipt of their benefits for more than five years, peaking in Manchester and Salford at just over 63%. Over 122,600 (77.9% of claims) IB claims in Greater Manchester have been in place for longer than two years. Short term claims (less than six months) account for approximately 9% of all IB/ESA claimants, peaking at one in ten claims in Bolton.

58.4% of IB/ESA claimants are aged over 45 while 11.1% are aged between 60-64 years of age. Only 6.3% of IB/ESA claimants are aged under-25 compared with almost a third of JSA. This pattern is mainly due to the increased prevalence of suffering from ill health in later life but also the significant length of time which most IB claimants have been in receipt of benefits.

[23] A more detailed mapping of Incapacity Benefit across Greater Manchester districts is contained in the data report.
[24] 'In work, better off: Next steps to full employment', DWP (July 2007)

It has been estimated that in terms of the cost to the Exchequer, which includes the cost of benefit payments and lost tax revenues, a person who is out of work due to ill health costs approximately £9,000 per annum[25]. Table 3 shows that if this figure was applied across Greater Manchester it would equate to in excess of £1.4 billion per annum. This figure is a conservative estimate of the economic cost of health related worklessness and does not include the impact in terms of additional economic output if people currently out of work were employed. It also excludes the costs associated with healthcare given the evidence highlighted earlier about the positive impact of employment on health.

Table 3: Cost to the Exchequer of health related worklessness

District	Number	Minimum cost to Exchequer
Bolton	16,240	£146,160,000
Bury	9,480	£85,320,000
Manchester	34,070	£306,630,000
Oldham	12,770	£114,930,000
Rochdale	14,270	£128,430,000
Salford	16,020	£144,180,000
Stockport	11,710	£105,390,000
Tameside	13,940	£125,460,000
Trafford	8,970	£80,730,000
Wigan	20,050	£180,450,000
Greater Manchester	157,520	£1,417,680,000

3.3 Health conditions and worklessness in Greater Manchester

The largest proportion of claims for IB across Greater Manchester is due to 'mental and behavioural disorders', accounting for 45.5% of claims. Only two other categories account for over 5% of claims each – 'diseases of the musculoskeletal system connective tissue' and 'symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified'. The figures at local authority level show that claims for 'mental and behavioural disorders' are highest in Manchester, Salford and Bury while claims for 'diseases of the musculoskeletal system connective tissue' are noticeably higher than the Greater Manchester average in Oldham, Wigan and Rochdale. Other noticeable trends across the districts include the higher than average level of claims for diseases of the nervous system in Stockport and claims due to 'symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified' in Wigan.

Over the past nine years, there has been a noticeable percentage point increase in claims for 'mental and behavioural disorders' in all Greater Manchester districts. The categories which have shown the largest percentage point fall in claims are primarily for more physical conditions such as diseases of the musculoskeletal and circulatory system. Manchester has seen the smallest percentage point rise in mental and behavioural disorders (+9.6), but had the largest proportion of claims for this condition overall. Wigan experienced the largest percentage point difference (+14.1) although the proportion of claims for this condition is still low (18.1%) compared to other authorities. Larger than average percentage point falls in physical conditions have been recorded in Bolton, Bury, Salford and Oldham. Causes for the changing pattern could include:

- the delivery of effective services in Greater Manchester. This seems unlikely to have accounted for the drop in IB/SDA claimants due to the limited nature of targeted interventions found by this study;
- reductions because on flows were high during and following the previous recession and have fallen steadily as this cohort ages and moves into retirement;
- reduction in manual employment meaning fewer people suffer from physical injuries.

[25] Reducing dependency, increasing opportunity: options for the future of welfare to work An independent report to the Department for Work and Pensions by David Freud, 2007

The factors could be tested locally to facilitate a deeper understanding of the cohort of IB claimants.

The 45.5% of claimants with a mental health condition equates to approximately 64,800 residents. This category includes the full range of mental health conditions. There is no data on the types of mental health conditions claimants have which is specific to Greater Manchester; however one can apply national prevalence rates to provide an indication. Using this methodology, one can estimate that over 46% of claimants have been diagnosed as having a depressive episode, equating to approximately 30,334 people. In total, depression, anxiety and other neurotic conditions are the cause of approximately 43,000 claims in Greater Manchester.

An alternative perspective of the nature of the conditions can be drawn from the Mental Health Minimum Dataset (MHMDS), published by the NHS Information Centre[26]. This provides details of the employment status of patients receiving secondary care services who are on the Care Programme Approach (CPA). Just 399 of the 10,988 (3.6%) patients reported to be on CPA across Greater Manchester were reported to be employed. Although there is a large amount of missing data, 2,951 (26.8%) were reported to be unemployed. In reality, this number is likely to be significantly higher. The 1998 Labour Force Survey published by the Department for Education and Employment estimated that 88% of those with longer term mental health problems are unemployed. The results of this study are supported by Perkins and Rinaldi[27] (2002) who in a study of patients with long term mental illness found that 92% of patients that had been in contact with psychiatric services for over two years were unemployed.

Research indicates that with appropriate ongoing support 58% of people with serious ongoing mental health problems can achieve employment[28]. Applying this to the 10,988 people on CPA in Greater Manchester indicates that 6,373 of those could gain employment. This is significantly higher than the 399 currently reported to be employed.

Recommendation 2

Further research is required which will explain why mental health results in a minority of people becoming too unwell to work, whilst the majority remain in employment.

When offering employment advice to people with underlying health conditions, it is important that employment advisors have some understanding of the impact of different conditions. Health conditions impact both in terms of the types of work that people can do and the way that people respond to support. It is estimated that one in three of the working age population may be experiencing some kind of distress or mental health condition[29] at any one time. Across Greater Manchester, this equates to approximately 540,000 people, 50% of whom have a condition that requires a need for formal clinical diagnosis and treatment[30]. However, this figure demonstrates that for the majority of people with a mental health condition in employment, having a mental illness does not necessarily prevent people from working.

Recommendation 3

Service providers should ensure that employment focused advisors have a full understanding of the impact of different types of mental health conditions.

[26] NHS Information Centre (2009) Mental Health Minimum Dataset http://www.ic.nhs.uk/statistics-and-data-collections/supporting-information/mental-health/nhs-specialist-mental-health-services/mental-health-bulletin/mhmds-2006-2009-annual-data-tables
[27] Perkins and Rinaldi (2002) Psychiatric Bulletin Unemployment Rates Among People with Long Term Mental Health Problems http://pb.rcpsych.org/cgi/reprint/26/8/295
[28] Ibid (Perkins and Rinaldi, 2002)
[29] 'Working our way to better mental health: a framework for action', data taken from The Adult Psychiatric Morbidity Surveys, conducted in 2000 and 2007 which use structure assessments and diagnostic screening instruments for a range of mental health conditions and distress
[30] Source: Data from the Psychiatric Morbidity Surveys applied to the 2008 Mid Year Population Survey, ONS

3.4 Future trends in relation to health related worklessness

The future picture in terms of health related worklessness is one which will see significant changes in the numbers of people claiming out of work benefits due to ill health. There are two key factors which will drive this change:

1) the transition from IB to ESA will create a fundamental shift in terms of the number of people that have an underlying health condition and are seeking employment;

2) the recession will have an inevitable impact on the labour market which will be partly manifested in the numbers of people out of work due to ill health.

Both of these factors are explored in more detail below.

3.4.1 The implication of Employment Support Allowance

Initial findings from the Work Capability Assessments provided to new claimants of ESA were released in October 2009. The results of Work Capability Assessments made between October 2008 and February 2009 are outlined in Table 4. It should be noted that 3% of assessments are made on a clerical basis, which accounts for those that are suffering a terminal illness or those that clearly have a work limiting disability and do not require a Work Capability Assessment.

Table 4: Summary of ESA on flow results of medical assessments[31]

Outcome	% of ESA medical assessments
Support group	5%
Work related activity group	11%
Fit for work	36%
Claim closed before assessment complete	38%
Assessment still in progress	10%

The introduction of ESA and Work Capability Assessment is having a clear impact on the distribution of benefit claimants as the support group effectively provides the same level of support as that provided under IB.

As stated previously, clerical assessments are not included in these figures. It is also important to note that one in ten assessments is still in progress. Table 5 reassigns the 10% of assessments that are still in progress as well as claims closed before the assessment was complete. This has been calculated based on the outcome of assessments that have been completed or terminated.

Table 5: Outcome of ESA on flow medical assessment process[32]

Outcome	% ESA medical assessments
Support group	5.7%
Work related activity group	12.3%
Fit for work	39.3%
Claim closed before assessment complete	42.6%

Table 5 shows that less than 10% of ESA medical assessments end in the claimant being placed in the support group; just over half are placed in the work related activity group or considered fit for work, meaning they will be required to access health and employment services designed to aid progression towards work. This has implications for worklessness service provision as it will be demanded by a larger number of people.

[31] Source: DWP, October 2009 (excludes the 3% of claims that are clerically assessed)

[32] Individuals that are classified as 'Fit to Work" have a right to ask for a reconsideration and then may appeal against the DWP decision. Initial data released by the DWP shows that 69% of appeals are upheld. No information is currently available regarding which group appeals that found in the appellants favour are allocated to

Table 6 provides an anecdotal indication of the potential numbers entering the ESA medical assessment outcome groups. This has been calculated by averaging the number of IB claims that lasted less than one year in the five years before October 2008 – the date when new claims would have been subject to the ESA framework. The table shows that on average over 20,300 claims for IB were made in the five years before the ESA was introduced.

Table 6: Outcome of ESA on flow medical assessment process applied to the average number of new IB claims (November 2005-08)[33]

District	Average new claims a year (04-08)	Support group	Work related activity group	Fit for work	Claim closed before assessment complete
Bolton	2,172	124	268	854	925
Bury	1,242	71	153	489	529
Manchester	4,338	248	536	1,706	1,848
Oldham	1,708	98	211	672	728
Rochdale	1,872	107	231	736	797
Salford	1,888	108	233	743	804
Stockport	1,548	89	191	609	659
Tameside	1,860	106	230	732	792
Trafford	1,198	68	148	471	510
Wigan	2,546	146	314	1,002	1,084
Greater Manchester	20,372	1,165	2,516	8,014	8,678

These figures provide an estimate of the numbers requiring services in relation to the work related activity and fit for work group. These estimates suggest that a significant number of Greater Manchester residents would be classified as fit to work, potentially placing additional demands on services provided by Jobcentre Plus and employment support provision.

An alternative perspective of the impact of ESA was provided by the Government which suggested that around 65% will be assessed to be in the work related activity group of ESA, 20% will be assessed to be in the support group, and 15% will be declared fit for work.[34] Table 7 demonstrates the impact of this estimate based on current levels of IB in Greater Manchester.

Table 7: Estimated impact of ESA

District	Number	Support group	Work related activity group	Fit for work
Bolton	16,240	3,248	10,556	2,436
Bury	9,480	1,896	6,162	1,422
Manchester	34,070	6,814	22,146	5,111
Oldham	12,770	2,554	8,301	1,916
Rochdale	14,270	2,854	9,276	2,141
Salford	16,020	3,204	10,413	2,403
Stockport	11,710	2,342	7,612	1,757
Tameside	13,940	2,788	9,061	2,091
Trafford	8,970	1,794	5,831	1,346
Wigan	20,050	4,010	13,033	3,008
Greater Manchester	157,520	31,504	102,388	23,628

[33] Source: DWP, October 2009. This information excludes the 3% of clerical claims and any 'Fit to Work' claims that are re-assigned after appeal. It should be noted that 69% of appeals are upheld

[34] Minister of State (Disabled People), Regional Affairs, parliamentary answer, 9 September 2009

Many clients with mental health conditions may not present symptoms during the Work Capability Assessment which will merit a request for the full medical report. This could mean that clients who should be placed in the work related activity group (where they would continue to receive support for their condition) would be moved onto JSA, a benefit which carries with it a large degree of conditionality. There is a risk that clients with mental health issues could fail to meet the conditions set related to their benefit claim and simply fail to receive any benefit even though they are not in paid employment. It should be noted that this is based on the best available data and the actual impact of the transition to ESA is under continuous review.

What is clearly demonstrated by the different estimates of the impact of the transition to ESA is that there will be a huge increase in the number of people that require employment related support. There are potentially over 100,000 people who will be placed in the work related activity group that will require some form of support. There will also be over 20,000 people who will be declared fit for work, but will require support in making the transition into employment. There was a lack of awareness and strategic planning to support the transition to ESA. The feedback from stakeholders showed an awareness of the potential impact of the transition to ESA; however there are currently no strategic plans in place beyond Jobcentre Plus which provide an overarching response to the imminent transition.

Even accounting for the lack of performance data from existing programmes, it is clear that current provision volumes are well below the future potential demand. New activities are coming on stream, in particular the Invest to Save Programme. In order for the Invest to Save Programme to meet this unmet demand, it will be necessary to align with existing provision to ensure the clients' needs are met.

Recommendation 4

The Commission for the New Economy should ensure that the DWP understands the potential demand for services delivered through the Invest to Save Programme. Provision will be required for approximately 102,000 people who will be in work related activity over three years.

Another issue that will impact on the scale and range of provision is the support requirements of the fit for work group. Although officially their status implies that there is no health related barrier to them securing employment, in reality it is possible that there will be health related issues that will need addressing (e.g. if people have been out of work for a considerable period of time, it is feasible that they will have mild to moderate mental health issues). It should also be recognised that the perception of poor health can be as much of a barrier as poor health itself. In addition to this, setting aside any health related barriers this group will require a range of employment related support to enable them to secure employment.

Recommendation 5

A strategy should be developed that outlines how the shift from IB to ESA will be managed across Greater Manchester.

Just over 7,500 Greater Manchester residents flowed from work and onto IB in 2007/08, providing an indication of the potential demand for services. Although this represents a very small proportion of the total number of employed residents (the figures do not exceed 1% in any of Greater Manchester's ten districts, ranging from 0.5% in Trafford to 0.8% in Bolton, Oldham and Salford), it is approximately 5% of the total stock of people on IB. The Fit for Work pilot offers an opportunity to support a proportion of this group. Measures that could be effective include those outlined in the Black Review such as:

- ensuring greater awareness amongst healthcare professionals of the aim of returning to work;
- stronger links between employers and healthcare professionals, including processes to support the development of back to work plans.

3.4.2 Impact of the current economic climate

The reduction in the number of people claiming IB seen across Greater Manchester, including areas with some of the highest rates of claimants, has taken place during the last ten years, a period of relatively favourable economic conditions. It would be reasonable to conclude that falling IB rates have been a result of the relatively strong economic context; research has shown that this is likely to be reversed as unemployment generally rises.[35] It is not possible to ignore the economic context in which the Call for Evidence is being prepared; the economic context is likely to have an impact on levels of health related worklessness in several ways.

There are increasing numbers of people who are out of work and fewer jobs. There will be more competition for work which is likely to make it more difficult for people with poorer work histories to secure employment. The perception that that there are fewer employment opportunities may mean that some people will be reluctant to enter into employment services as they feel they have a small chance of securing work. Fothergill's analysis on the impact of the labour market show that levels of IB are rising during the recession as people in employment move straight to inactive benefits and those on JSA move to IB/ESA. The impact of the recession will make it more difficult for people to secure and sustain employment. One example was provided of a situation where intensive support had been provided to get long term IB claimants into work at a local factory, but the factory is closing due to the recession.

'One factory closure has wiped out all the hard work we've done to get the long term unemployed into work.'

There may be a reduction in public sector investment in employment and health programmes and an indirect effect as public sector agencies reduce employment. Stakeholder feedback suggested that at both a national and local level there was political pressure to place more emphasis on staffing levels. This has had an impact both in terms of service levels and overall emphasis on the newly unemployed. The economic downturn may also lead to an increase in mental illness.

Recommendation 6

Strategies for tackling health related worklessness should retain a focus on demand side measures which will lead to suitable employment opportunities. Demand side measures should include:

- opportunities for supported employment. This could be delivered on the basis of Intermediate Labour Market Programmes and social enterprise agencies, approaches that have been proven to be effective in Greater Manchester and beyond;
- awareness raising amongst employers about the practical implications of employing people with health problems (e.g. addressing preconceptions about mental illness);
- the public sector acting as an exemplar in proactively employing people who have had, or have, health conditions that have prevented them from working.

Local authorities can build upon the baseline outlined in this report to improve knowledge and understanding of interventions at a district level, including data on condition prevalence rates. Services would be provided with more accurate information relating to changes in levels of health related worklessness. There is data available which could be used more effectively (e.g. data which relates to the prevalence of certain conditions). The differences between different districts may link to GP referral patterns; a joint approach across the NHS and local authorities will enable an approach which can go someway to addressing the gaps in the current DWP sourced dataset. Joint working on data analysis can often contribute to improved partnership working from a more general perspective. The analysis of health and worklessness should be integrated into the worklessness assessments that local authorities have been tasked with producing as part of the Local Economic Assessments.

[35] Fothergill

There is an extensive dataset that can be used to inform strategy development and service planning. Local areas should be encouraged to develop a detailed analysis of health and worklessness in their local areas and the Call for Evidence provides a good starting point for this analysis. This enables local areas to more accurately test the effectiveness and relevance of service provision. Local areas should consider how qualitative data can be used to provide an understanding of health and worklessness (e.g. by providing opportunities for frontline staff and service users to reflect on issues raised through analysis of quantitative data). Greater Manchester local authorities, Primary Care Trusts and NHS Trusts should review their own records to establish the proportion of ex-public sector employees currently in receipt of IB.

Recommendation 7

Local authorities and their partners, using elements of this report as a baseline, should develop a more refined approach to analysing the IB/ESA client group. This should be undertaken as part of the worklessness assessment element of the Local Economic Assessment.

This report has relied upon publically available datasets; these datasets could be enhanced at both district and Greater Manchester level through the provision of additionally sourced datasets from the DWP. There are a number of datasets which are collected by the DWP which would be useful, including:

- total number of people coming on and off IB per year (over the last five years);
- status of IB claimants prior to claim (e.g. JSA claimant, employed (industry/occupation), other benefit);
- status of IB claimants immediately after someone has stopped claiming (e.g. JSA claimant, employed (industry/occupation), other benefits);
- reason for someone stopping a claim (e.g. condition resolved, secured employment, ruled ineligible);
- breakdown of mental health conditions;
- number/proportion of people whose condition changes over the period of the claim (e.g. developmental of mental illness);
- breakdown of claims by doctor's surgery.

Recommendation 8

The Commission for the New Economy should lead on negotiations with the DWP to secure access to detailed data regarding IB/ESA on/off flows and mental health condition.

3.5 Summary

Approximately 10% of the working age population are in receipt of IB or ESA, equating to over 150,000 people. The Greater Manchester average masks significant differences between and within districts. Although the overall figure has been steadily declining over the last ten years, there are still parts of the conurbation where over one in four of the working age population are in receipt of these benefits and, in the worst areas, the proportion is still increasing. The majority of claimants are long term recipients of IB and are over 45 years old. In the coming years, there is likely to be a significant change in the scale, extent and nature of health related worklessness due to the challenging economic conditions that are likely to persist for the foreseeable future and the shift from IB to the new benefit regime structure around ESA. The remainder of the report explores what has been undertaken across Greater Manchester to address the problem of health related worklessness and what needs to be done in order to improve the overall strategic direction of policy at the Greater Manchester level.

4 CURRENT STRATEGIES AND ACTIVITIES IN GREATER MANCHESTER

The following section draws together the findings from the review of current provision and interviews with local and sub-regional stakeholders. The findings compare provision across Greater Manchester with the expectations laid out within government policy at the national and local level. The findings comment on the current strategic policy infrastructure that is managing issues related to health and worklessness at both the Greater Manchester and district level, in particular reviewing the extent to which the relationships between the health and employment sectors are effective and add value to service delivery. The findings comment on a number of issues relating to the operational understanding of the health and employment elements of support, the impact of different types of interventions and links with employers, providing lessons that can be learnt at both the individual district level and at a Greater Manchester policy level. Current provision is reviewed from six different perspectives:

1) investment in NHS Mental Health Services;
2) geographical targeting of services;
3) delivering integrated health and employment support;
4) supported employment;
5) support for employers;
6) strategic leadership of health and worklessness policy.

4.1 Investment in NHS Mental Health Services

There is an increasing focus on reducing the extent to which poor health is a barrier to employment. Therefore, the way that investment in health care services can deliver positive employment outcomes is an issue which is being considered both within the NHS and by other key policy makers at the national, regional and local level. In order to inform this debate within Greater Manchester, the study has considered the current level of investment by the NHS in activities which could potentially deliver employment outcomes. There are challenges associated with analysing NHS investment from the perspective of employment policy. Principally, because the NHS is not driven by employment objectives it does not accurately record how its investment links to employment outcomes. However, it is possible, using proxy data to provide a reasonable summary of how NHS investment relates is helping to tackle worklessness. For the purpose of this a study, two main data sources have been used:

- 2008-09 Programme budgeting benchmarking workbook 1.3
- NHS National Mental Health Mapping Exercise 2008-09

These two data sources can be analysed, firstly from the perspective of investment generally in mental health disorders and, secondly, from the more detailed perspective of service areas. This analysis gives an indication of how NHS investment is generally supporting people with mental health disorders. In particular, how investment is linked to the people who are more likely to be in contact with primary care services and therefore, have a greater possibility of securing and maintaining employment. This is followed by a review of specific service types, examining the proportion of NHS resources which support services that support people into employment in comparison with services that are unlikely to have an effect on employment outcomes.

4.1.1 NHS Financial Investment in Mental Health Disorders

The following section provides an overview of the general level of investment made by the NHS in treating people with mental health disorders. It provides an indication of the different levels of expenditure across Greater Manchester and an indication of the proportion of this funding which is directed at the conditions which are most prevalent amongst people who are claiming Incapacity Benefit. The analysis is based upon the Programme Budgeting exercise which is a retrospective review of the allocation of the total NHS budget in each PCT area across 23 different programme areas. The programme areas relate to different types of health condition. The function of the tool is to provide an overview of NHS expenditure which is more closely linked to outcomes rather than particular services. The Programme Budgeting analysis incorporates all aspects of NHS expenditure

including services delivery costs, central management and administration costs and prescribing costs. The Programme Budgeting Analysis is useful for providing a headline analysis of how resources are targeted at people with mental health disorders.

In 2008-09, across Greater Manchester, the total NHS investment in mental health disorders was £533m. Table 8 provides a summary of the breakdown of expenditure across the five sub categories used in the Programme Budgeting Exercise.

Table 8: Programme Budge Exercise Mental Health Sub Categories and Total Spend

Programme Budget Mental Health Disorder sub category	Total Spend Across Greater Manchester (000s)
Substance Misuse	£58,659
Organic Mental Disorders	£39,662
Psychotic Disorders	£87,268
Child and Adolescent Mental Health Disorders	£26,851
Other Mental Health Disorders	£320,188
Total	£532,628

£320m was invested in treating people in the 'other mental health Disorders' Category[36]. However, of this only £50m was invested in primary care services against an investment of over £270m in secondary care. Table 9 shows investment in 'other mental health Disorders'[37] across Greater Manchester and demonstrates that this emphasis on secondary care is consistently seen across Greater Manchester. The Table also shows that there is no strong relationship between the number of people who are claiming Incapacity Benefit due to a mental health disorder and the NHS investment in mental health programmes at either primary or secondary level. For example, although Manchester has the highest number of Incapacity Benefit claimants, its investment in primary care services for people with 'other mental health Disorders' is below that of both Rochdale and Stockport, when adjusted for population size.

[36] This category is important from the perspective of this study as it contains conditions such as depression, anxiety and social phobias which make up the bulk of conditions amongst Incapacity Benefit Claimants. Therefore, it is the category which has the clearest link to the types of conditions which are the cause of the majority of Incapacity Benefit claims.
[37] See Appendix xx for a full list of conditions within the "other mental health Disorders' category.

Table 9: Estimated spend on 'other mental health disorders' across Greater Manchester per 100, 000 of population

Local Authority District	Number of Incapacity Benefit Claimants with a mental health disorder[38]	Primary care (000s)/%	Secondary Care (000s)/%	Total
Trafford	3,520	£895/20%	£9,948/80%	£10,843
Bury	4,100	£914/17%	£4,920/83%	£5,834
Stockport	4,810	£2,541/31%	£5,322/69%	£7,863
Oldham	4,970	£633/11%	£7,087/89%	£7,720
Tameside	5,420	£1,450/15%	£5,633/85%	£7,083
Rochdale	6,140	£3,330/37%	£4,550/63%	£7,880
Wigan	6,540	£1,594/20%	£6,678/80%	£8,271
Bolton	6,580	£1,189/14%	£11,641/86%	£12,830
Salford	7,080	£1,032/13%	£17,028/87%	£18,060
Manchester	15,640	£2,359/15%	£13,180/85%	£15,539
Total	64,800	15,936/16%	85,988/84%	£101,924

Rochdale and Stockport are the only districts where less than 80% of NHS resources spent on mental health disorders are spent on Secondary Care. It is not clear from the available data why these two areas have spending profiles which are significantly different from the national and Greater Manchester norm. The bias towards secondary care is even more pronounced for the 'other mental health Disorders Category' as Table 10 shows. Again Rochdale and Stockport are the districts with the greater proportion of resources directed at Primary Care.

[38] This refers to claimants whose primary reason for claiming Incapacity Benefit is a mental health condition. Claimants whose primary reason for claiming is a physical condition may also have mental health problems which are not recorded by DWP.

Table 10: Split between primary and secondary care for 'Other mental health conditions'

PCT Area	% of Total Budget spent on Mental Health Conditions within Primary Care for people with 'Other Mental Health Conditions'.	% of Total Budget spent on Mental Health Conditions within Secondary Care for people with 'Other Mental Health Conditions'.
Bolton	9%	91%
Bury	16%	84%
Manchester	15%	85%
Oldham	8%	92%
Rochdale	42%	58%
Salford	6%	94%
Stockport	32%	68%
Tameside	20%	85%
Trafford	8%	92%
Wigan	19%	81%

The Programme Budgeting Data usefully demonstrates the extent to which NHS investment in mental health disorders is mainly concentrated in secondary care services. The implication of this is that the majority of investment does not impact on people with less severe mental health disorders who are likely to be closer to the labour market than those with more sever conditions.

Table 11 shows how Greater Manchester PCTs compare with other PCTs in terms of overall investment in 'other Mental Health conditions. The table also includes the local authority rank for the total number of Incapacity Benefit claimants. The table is illustrative of the lack of relationship between the comparative level of health related worklessness and the investment made by the NHS. This is particularly the case with the districts which have the highest number of Incapacity benefit Claimants. So for example, although Manchester has the 8th highest level of health related worklessness, it is only 27th in terms of the investment by the NHS in supporting people with 'Other Mental health Conditions'.

Table 11: Ranking of Great Manchester PCTs for Investment in 'Other Mental Health Conditions'

PCT/LA	National Rank for PCT Investment in 'Other Mental Health Conditions'	National rank for total number of Incapacity Benefit claimants
Salford	14	51
Manchester	27	8
Bolton	55	53
Trafford	70	118
Wigan	105	30
Rochdale	109	63
Stockport	110	90
Oldham	111	74
Tameside and Glossop	116	64
Bury	129	113

There are three caveats to the Programme Budgeting data set which have important implications for this study. Firstly, the Programme Budgeting data reviews investment across the whole population. It therefore includes investment in services targeted at children and young people and older people. Clearly for the purposes of this study, services accessed by those of working age are of primary importance. Age is an important factor in mental health services too because of the impact of dementia. In 2007, it was estimated that the service costs associated with dementia are far higher than all other conditions put together, making up 66 per cent of all mental health service costs[39].

Secondly, the fact that programme budgeting incorporates prescribing costs is an important consideration underpinning the analysis in this report for two reasons. Firstly, it is a significant proportion of the overall budget allocate to mental health disorders. Secondly, prescribing costs are often allocated to primary care budgets even where the individual patient may be being treated principally through secondary care services.

Thirdly, the Programme Budgeting data includes a proportion of central NHS costs such as management services. The Programme Budgeting analysis allocates a proportion of central costs to each programme area.

The service specific data outlined in the following section identifies £295m which is directly spent on service delivery. This would suggest that the three factors described above are 'worth' £240m. However, the available data does not enable costs to be allocated to each individual factor.

[39] Paying the price, The cost of mental health care in England to 2026, King's Fund

4.1.2 NHS Investment Specific Mental Health Services

The following section provides a detailed analysis of NHS investment in specific services. The data is used to illustrate the extent to which the NHS invests in services which are having an impact on worklessness. In order to provide an understanding of the extent and types of service which are potentially impacting on worklessness, addressing the limitations of the programme Budgeting exercise, data from the Mental Health Mapping Exercise has also been analysed. The NHS National Mental Health Mapping Exercise 2008-09 provides data on investment in both primary care and specialist mental health services and investment with the statutory sector (NHS) and the non-statutory sector (including the voluntary sector). The results of the benchmarking analysis are detailed below and overleaf. The analysis of investment is undertaken per head of working age adult population (age 18-64). The population figures were obtained from the Office for National Statistics population estimates and are weighted for mental health needs using the mental illness needs index. This is a recognised methodology for benchmarking investment in mental health services and is the methodology used in the National Finance Mapping Report submitted to the DH.

In total the NHS Finance and Service mapping exercise identifies approximately £295m of direct expenditure on mental health services. For the purposes of this study, the services have been divided into three broad categories relating to the contribution which services make to worklessness outcomes. As Table 12 shows, the bulk of expenditure relates to services which are unlikely to have any impact on employment outcomes[40]. One of the main reasons for this is that the NHS invests significant heavily inpatient facilities to treat people who have severe mental health conditions. In patient treatment by its nature is more expensive. However, over £90m is spent on services which may have some impact on employment outcomes. There may be opportunities to review the delivery of these services in order to place more impact on employment related outcomes.

Table 12: Expenditure on Mental Health Services and the relationship to employment outcomes

PCT	Services which make a strong contribution to employment outcomes	Services which make a minor contribution to employment outcomes	Services which do not contribute to employment outcomes
Bolton	£451	£8,895	£16,132
Bury	£1,055	£6,539	£17,631
Manchester	£4,447	£24,485	£52,533
Oldham	£1,728	£7,572	£10,967
Rochdale	£1,015	£7,529	£13,417
Salford	£2,490	£9,217	£19,316
Stockport	£1,246	£4,995	£12,741
Tameside	£1,729	£7,066	£14,271
Trafford	£325	£4,432	£13,930
Wigan	£1,186	£11,577	£15,867
Total	£15,673	£92,308	£186,806

[40] A full list of the services associated with each category can be found at appendix X

Services which make a strong contribution to employment outcomes

A benchmarking analysis was undertaken to compare investment in mental health employment schemes across the Greater Manchester region. This included primary and secondary care services and services that interface with employment, including:

- primary care services;
- secondary mental healthcare services;
- mental health day services.

The analysis was undertaken using data obtained from the National Mental Health Mapping Exercise. This is an annual exercise undertaken by Mental Health Strategies on behalf of the DH. The data presented in the report is for the financial year 2008/09 (the most recent published data available)[41].

Primary care services

There are a large number of people with mild to moderate conditions that will be primarily managed within primary care. Anxiety and depression is the most common form of mental illness in the UK affecting 9.2% of adults[42]. The bulk of this client group will not come into contact with secondary mental healthcare services. The mapping exercise has focused on the provision of psychological therapies, as this type of therapy is key to supporting people with mild to moderate mental health conditions. The mapping exercise has also provided an indication of the level of NHS investment in other primary care services. It is more difficult to provide a detailed analysis of these services as they are generally made up of individual therapists and support workers who operate within primary care settings such as GP surgeries, and do not necessarily have specific employment outcomes.

Psychological therapy services

Psychological therapy services cover a range of approaches which are used to support people with a wide range of mental health conditions. Therapeutic approaches which come under the banner of 'psychological therapy services' include:

- behavioural therapy;
- anxiety management;
- graded exposure;
- cognitive therapy;
- cognitive behavioural therapy (CBT);
- compliance therapy;
- counselling;
- family interventions for people with schizophrenia;
- interpersonal therapy;
- problem solving;
- psychodynamic therapy (analytical psychotherapies).

Table 13 compares the reported investment in psychological therapy services in 2008/09. This includes both NHS and non-NHS psychological therapy and counselling services for people with a mental health problem funded by the Primary Care Trust/local authority. The data does not include counselling services funded by individual GP practices (including through General Medical Services). The total investment in psychological therapies in Greater Manchester in 2008/09 was reported to be £13.5 million, equating to £6.65 per head of weighted working age adult population. This figure is likely to have increased in this financial year (2009/10) as more IAPT or equivalent psychological therapy services have been developed across Greater Manchester[43]. As can be seen, the highest investor in psychological therapies in Greater Manchester is Salford. Salford was the one of the first IAPT funded sites in Greater Manchester. Their investment of £2.6 million in 2008/09 equates to £12.6 per head of weighted working age adult population.

[41] Published data for the financial year 2009/10 will be available in April 2010
[42] Office for National Statistics (ONS) National psychiatric Morbidity Survey
[43] As previously we can provide the New Commission with this year's Finance Mapping data once it has been published and validated

Table 13: Investment in psychological therapy services

Area	Investment	Weighted working age adult population	Investment per head of weighted working age adult population	Approximate level of provision[44]	Total number of IB Claimants
Bolton	£341,834	188,883	£1.81	310	16,240
Bury	£923,574	117,397	£7.87	218	9,480
Manchester	£3,350,393	522,332	£6.41	1176	34,070
Oldham	£1,412,796	171,901	£8.22	220	12,770
Rochdale	£892,918	162,116	£5.51	360	14,270
Salford	£2,364,433	187,488	£12.61	1190	16,020
Stockport	£1,219,024	158,569	£7.69	1104	11,710
Tameside	£1,549,517	185,400	£8.36	1034	13,940
Trafford	£274,974	126,799	£2.17	2078	8,970
Wigan	£1,186,430	211,346	£5.61	94	20,050
Greater Manchester	£13,515,892	2,032,231	£6.65	7784	157,520

The IAPT Programme was launched in 2006 with the explicit aim to provide better access to a choice of evidence based psychological therapies for people suffering from anxiety and depression. A key element of IAPT is supporting people into recovery and back into employment. Across the Northwest, the target for the IAPT Programme is to support at least 3,700 people back into employment. This target equates to 2.7 people supported into employment for every IAPT therapist. In a review of psychological therapies, Lord Layard (2006)[45] estimated that the effect of a psychological treatment programme, compared with no treatment, is approximately 12 months free of depression and 1.5 extra months in work. This equates to an increased output of £2,000 per person receiving psychological therapy, and is more than double the £750 treatment cost. The IAPT Programme is currently being rolled out across Greater Manchester. Table 8 shows the progress made to date.

Table 14: IAPT sites in Greater Manchester

2008/09 sites
Salford
2009/10 sites

[44] Please note that these figures represent the minimum level of provision as data was not available for all services.
[45] Layard R (2006) The Case for Psychological Treatment Centres. British Medical Journal, 332, p. 1030-1032

Ashton, Leigh and Wigan
Bolton
Bury
Heywood, Middleton and Rochdale
Stockport
Tameside and Glossop
Trafford
2010/11 sites
Manchester
Oldham

Training for IAPT therapists is being provided by the Greater Manchester West Mental Health NHS Foundation Trust and the University of Manchester.

Additional funding for IAPT is being provided by the Government. Table 15 demonstrates the investment made to date across Greater Manchester. This funding is designed to provide additional psychological therapy services and therefore, this investment is over above that outlined in table 13. Total additional investment across Greater Manchester is £9,743,339.

Table 15: IAPT Funding in Greater Manchester

		2008-09	2009-10	2010-11	Total
Wave 1	Salford	£695,534	£1,040,498		£1,736,032
Wave 2	Bury		£373,476	£809,925	£1,183,401
	Trafford		£496,828	£1,090,870	£1,587,698
	Tameside		£423,137	£927,497	£1,350,633
	Bolton		£198,736	£436,322	£635,058
	Rochdale		£255,052	£556,001	£811,053
	Wigan		£346,118	£763,069	£1,109,187
	Stockport		£417,345	£912,932	£1,330,277

From 2010/11 the IAPT Programme in Greater Manchester will be supported by specific support, advice and signposting which will be delivered by an organisation called Pathways Community Investment Company (CIC). This support is based on a model that has proved successful in Cheshire. Pathways CIC will provide a single point of access to people with mental health conditions who are looking to return to work. Each client will be provided with an individual plan and will be tracked for up to 26 weeks, which includes the time when they return to work. This support will also be available for people who are already in work but require advice and support to enable them to remain in work despite their condition. One of the key elements of the service which Pathways CIC provides is that it will establish links with other service providers which the client is in contact with, including Jobcentre Plus and where appropriate the client's employer. Pathways CIC is

developing a directory of services to enable its advisors to be able to provide effective signposting. As part of its contract, Pathways CIC is also developing strategic links with Jobcentre Plus through the Mental Health Coordinators.

A similar service has been commissioned in areas which are not currently part of the IAPT Programme. The healthcare arm of AXA Insurance has been commissioned to provide a service which aims to support individuals who have concern about potential job loss, redundancy or changes in economic circumstances. The support available includes both psychological and practical support, including access to cognitive behavioural therapy. The service is intended to complement the Greater Manchester IAPT Programme and is delivered in Manchester and Oldham. It is funded by NHS North West and began operation in November 2009. Following the initial twelve months it will be replaced by the IAPT Programme. The Fit for Work service will complement the IAPT Programme by supporting clients with a range of health conditions.

In light of the current NHS financial stringencies, the future funding of psychological therapy services may, as with all other services, be at risk of spending cuts. However, based on the national evidence base for psychological therapies and local data on the success of psychological therapies in Greater Manchester, it is recommended that investment is not reduced. The demand for psychological therapy services is only likely to increase in light of current high unemployment; moreover an increasing number of people in work may require psychological therapies because of the increased stress at work and people at risk of redundancy/unemployment.

Other primary care mental health

Other investment in primary care mental health services is difficult to capture because of the difficulties of disaggregating data at this level. Table 16 details the investment in primary care mental health workers across Greater Manchester. Primary care mental health workers are staff trained in brief therapy techniques who are employed to help GPs manage and treat common mental health problems. The data does not include primary care mental health workers employed in specialist teams. As can be seen, Bolton is the highest investor in primary care mental health workers in Greater Manchester, but the lowest investor in psychological therapy services.

Table 16: Investment in primary care mental health workers

Area	Investment	Weighted working age Adult population	Investment per head of weighted working age adult population
Bolton	£1,595,199	188,883	£8.45
Bury	£193,600	117,397	£1.65
Manchester	£248,897	522,332	£0.48
Oldham	£109,454	171,901	£0.64
Rochdale	£1,351,600	162,116	£8.34
Salford	£4,092	187,488	£0.02
Stockport	£151,451	158,569	£0.96
Tameside and Glossop	£236,950	185,400	£1.28
Trafford	£150,753	126,799	£1.19
Wigan	£639,662	211,346	£3.03
Greater Manchester	£4,681,658	2,032,231	£2.30

Primary care services for people with mental health issues are likely to become increasingly important in unemployment policy, particularly as an aspect of the transition from IB to ESA takes place. Addressing mild to moderate mental health issues could be the key to enabling people with physical conditions to gain the confidence to return to work.

Secondary mental healthcare services

Secondary mental healthcare services are generally services accessed by people with more severe mental health conditions. There is a variation in levels of investment and service provision across the ten Greater Manchester districts. The highest investor in specialist mental health employment support services is Manchester, investing £1.1 million. The majority of other areas invest in the

region of £50,000 to £350,000. Table 17 shows the investment made in this type of service across Greater Manchester.

Table 17: Investment in Employment Support Projects

Area	Investment (£)	Weighted Working age Adult Population	Investment per Head of Weighted Working Age Adult Population
Bolton	£109,024	188,883	£0.58
Bury	£131,470	117,397	£1.12
Manchester	£1,096,830	522,332	£2.10
Oldham	£315,671	171,901	£1.84
Rochdale	£121,754	162,116	£0.75
Salford	£125,830	187,488	£0.67
Stockport	£27,000	158,569	£0.17
Tameside	£179,000	185,400	£0.97
Trafford	£50,463	126,799	£0.40
Wigan	n/a	211,346	n/a
Greater Manchester (Excluding Wigan)	£2,157,042	1,820,855	£1.16

The study mapping highlighted a number of innovative and successful employment schemes that are highly valued by service users. However, it is clear that where specialist mental employment schemes have been developed, this has been driven by specific individuals and groups; the schemes do not appear to have been developed with an overall strategic direction and policy. Generally speaking, the investment funds the provision of one or two small scale projects delivering services for between 50 and 200 people in each district. The available data enables a cost per beneficiary calculation; however using an average of 200 beneficiaries per area, the cost per beneficiary ranges from between £250 to £5,100.

In Bolton, the investment delivers:

- Bolton Employment Support Team which provides support to approximately 120 people per year. Referrals are made via care coordinators such as social workers or community psychiatric nurses;
- the Supported Training and Employment Project (STEPs) is a social enterprise which offers opportunities for people in catering, IT and horticulture. As well as the practical skills, development support is also available in employability skills and job search;
- the Workshop, based in Bolton Town Centre, provides access to a range of advice and support related to employment training and volunteering. It brings together services from a range of agencies and provides access to cognitive behavioural therapy sessions which are

targeted at specific groups such as young people. The service is aimed at people with both physical and mental health conditions who are in receipt of an out of work benefit.

In Bury, the investment delivers:

- the Bury Employment and Support Service provides a range of employment advice and support services to people from disadvantaged communities. Referrals to this service are made from care coordinators, although it is not exclusively aimed at people with health conditions.

In Manchester, investment outweighs that of other districts in terms of both overall investment and investment per head; however the scale of investment still falls significantly short when compared to overall potential demand. In Manchester, the investment delivers:

- Benchmark is a social enterprise which offers skills based training in furniture design and production. The aim of the service is to use the workplace environment as a therapeutic tool; a similar service is offered through the horticulture service. The two services have capacity for approximately 70 clients;

- Mainway Enterprises offers a range of work based activities which are aimed at addressing the social and skills needs of people with mental health conditions. The service has a caseload of 70 clients.

In Oldham, the investment delivers:

- Oldham Opus provides a service for 69 clients with mental conditions related to employment and skills development;

- Incapacity Benefit, a project delivered by Groundwork Oldham and Rochdale, provides support to people on out of work benefits to secure work placements with a range of local employers;

- Mental Health in the Workplace is delivered by Groundwork Oldham and Rochdale and is funded by the local authority and Primary Care Trust. The service provides workplace mental health advice which is focused on prevention and early intervention;

- The Prince's Trust is working with young people on a project aimed at improving the mental health of young people, raising awareness of the dangers of drug and alcohol misuse, and promoting physical activity.

In Rochdale, the investment delivers:

- Mind-Comple@t, delivered by Mind, is a user managed cyber café which provides practical work experience;

- the Rochdale Employment Development Service (REDS) supports people with mental health conditions to secure work placements;

- Hourglass, working with MIND and other mental health services, provides horticulture based training and work experience to mental health service users.

In Salford, the investment delivers:

- Making Space, a national organisation which delivers a range of services to people with mental health conditions. In Salford, the service works with people with severe mental illness and helps them re-engage with employment and employment support services. In Wigan, Making Space delivers the 'buddies' scheme with up to twenty clients; this service runs a social enterprise which offers supported employment opportunities complimented by a range of advice, support and training services;

- employment support for up to 130 clients delivered by the Greater Manchester West Mental Health Trust;

- Start in Salford offers people with mental health conditions training in arts based skills. The project offers a range of bespoke courses for people from different target groups, including young people and the over 50s.

In Stockport, the investment delivers:

- Worklink offers support to 40 clients within the permitted framework. In addition to work placements, the service offers employment advice and job search.

In Tameside, the investment delivers:

- Routes to Work provide services to people with physical and mental illnesses to help them into paid employment, and currently provides support for up to 70 clients.

In Wigan, the investment delivers:

- Workspace is a local authority run project which provides a supported employment scheme for people with mental health conditions. The scheme offers training in soft furnishing skills. The activities delivered are mainly targeted at people on out of work benefits with mental health conditions. The mapping of activities has highlighted several key points:
  - provision is based around small scale interventions which provide supported employment, advice and training;
  - the bulk of investment is related to staffing;
  - there is no strategic pattern to the types of services which are delivered;
  - provision generally reflects historical commissioning patterns.

It was not possible to undertake similar analysis for activities which were targeted more generally at people in receipt of IB (e.g. those with physical health problems). Based on these levels of investment, one can conservatively estimate that there is currently enough provision to deliver services to approximately 2,000 people with mental health conditions who are in receipt of IB. If one assumes that each year the support provided to this group results in 10% of the client group moving off benefits, this would result in a total saving of at least £1.8 million per annum, based on the estimates used in the Freud report. It is estimated that up to 6,373 people in contact with secondary mental healthcare services could secure employment. If the level of service provision was increased to meet the needs of this group, it would cost approximately £15,932,500 based on an average cost of £2,500 per client. This is an illustrative figure and is based on one off investment. If the total cohort of 6,373 was moved off benefits into employment the savings to the public purse would be at least £57,357,000 per annum. Again, this is illustrative and is based upon the calculations used in the Freud report.

Recommendation 9

Service commissioning should be related to both the cost of the service being delivered and the overall potential savings which could result from successful intervention.

4.1.3 Services which make a minor contribution to employment outcomes

The following section describes the level of investment which is made in services that are either potentially making a contribution to employment outcomes or are working with people who have mild to moderate conditions and are, in theory, closer to the labour market.

Mental health day services

As shown in Table 18 the total investment in mental health day services in Greater Manchester in the financial year 2008/09 was in excess of £5.0 million. The highest investors within the region were Wigan and Oldham. The £932,495 investment of Wigan equates to £4.40 per head of weighted working age adult population. The £794,066 investment of Oldham equates to £4.62 per head of weighted working age adult population.

Employment services provided within day services often do not to include explicit return to work targets, and are not performance managed against this. In light of this, the role of mental health

day services has been reviewed in many areas in recent years in line with the recovery model. A key question for commissioners going forward is whether mental health employment support should be provided by mental health staff in mental health day services, or whether this is better provided by employment specialists in non-mental health settings. A combination of both would appear the most appropriate, but at present the balance appears tilted in the provision of employment support within existing mental health services and settings.

Table 18: Investment in day centres/resource centres/drop in

Area	Investment	Investment per head of weighted working age adult population
Bolton	£681,153	£3.61
Bury	£376,528	£3.21
Manchester	£749,888	£1.44
Oldham	£794,066	£4.62
Rochdale	£418,088	£2.58
Salford	£320,125	£1.71
Stockport	£214,633	£1.35
Tameside	£281,346	£1.52
Trafford	£286,013	£2.26
Wigan	£932,495	£4.41
Greater Manchester	£5,054,334	£2.49

Recommendation 12

Mental health day services should be reviewed for their impact on employment outcomes.

In addition to day services it is also worth considering a number of other services which may provide some employment related support. These services are outlined in Table 19. The nature of these services means that it is not possible to outline the type of severity of the users of these services but it is interesting to consider investment in this wider group of services as it provides an illustration of the level of investment made across different service areas.

Table 19: Other Services with Possible Impacts on Employment Outcomes.

Service Type	Bolton	Bury	Manchester	Oldham	Rochdale	Salford	Stockport	Tameside	Trafford	Wigan	Total
Advocacy Services	£80	£90	£271	£53	£421	£60	£66	£158	£44	£52	£1,296
Assertive Outreach Team	£622	£333	£2,437	£579	£729	£767	£549	£674	£765	£941	£8,396
Carers' Support Service		£81	£3	£107	£34	£111		£84	£121		£541
CDW workers		£16	£321						£80	£132	£550
Community Mental Health Team	£2,547	£2,062	£12,359	£2,515	£2,673	£4,398	£2,776	£2,376	£2,034	£5,449	£39,189
Criminal Justice Liaison and Diversion Service	£65	£1	£92	£78	£0	£28	£97	£0	£0	£2	£363
Crisis Accommodation	£291		£605		£103		£110	£66			£1,175
Early Intervention in Psychosis Service	£969	£214	£2,451	£748	£218	£897	£247	£715	£695	£359	£7,513
Education and Leisure Opportunity		£40	£132		£9				£4		£184
Home/Community Support Service	£561	£242	£447	£344	£201	£1,952	£370	£749	£180	£1,300	£6,346
Homeless Mental Health Service		£31	£168							£88	£288
Hostel				£781							£781
Housing support		£963						£65			£1,028
Local Low Secure Service	£1,109	£1,872	£3,395	£1,465	£653	£529		£1,462		£1,287	£11,771
NHS Day Care Facility			£307								£307
Personality disorder service			£103				£22			£168	£293
Self-help and Mutual Aid Group			£25				£74	£2			£101
Service User Groups	£55		£275				£21	£1		£38	£391
Staff-facilitated Support Groups	£126		£80		£100		£59	£32			£397
Women-only community day services		£7									£7
Advice and Information Services					£546	£50	£84	£104	£68		£852
Grand Total	£6,426	£5,954	£23,472	£6,669	£5,687	£8,792	£4,474	£6,488	£3,991	£9,817	£81,769

4.1.4 Geographical targeting of services

The mapping of services demonstrates some linkages between the scale of overall IB claimants and the proportion of claimants with a mental health condition. Figures 2 and 3 provide an approximate location for key mental health services and local authority funded services which target IB claimants. Services are generally in place in areas which have rates of IB above the Greater Manchester average; however there are limitations to this analysis:

- many of the mental health focused services do not target particular geographical areas; therefore the location of the service does not necessarily imply that service users are drawn from the locality;
- as has been explored in the previous section, the current scale of service provision is far lower than the total number of claimants.

Figure 2: Health and employment services mapped against changes in IB/ESA rates

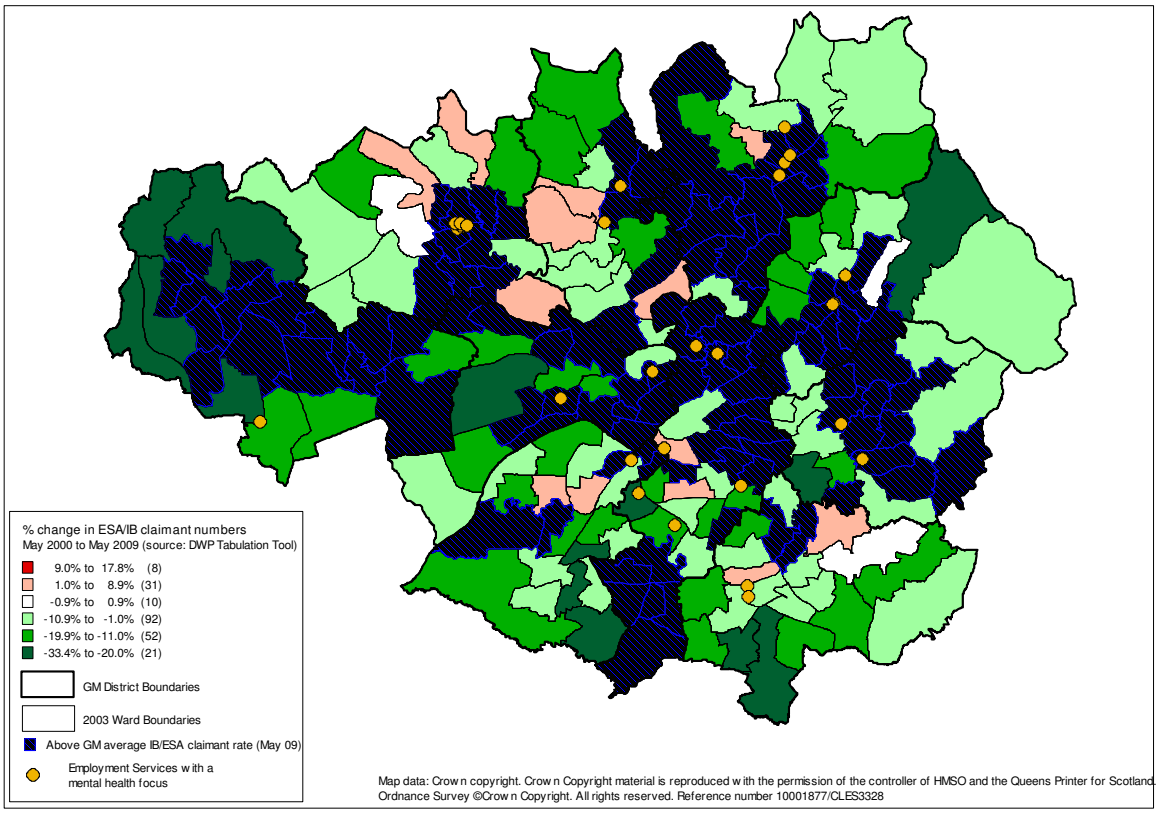
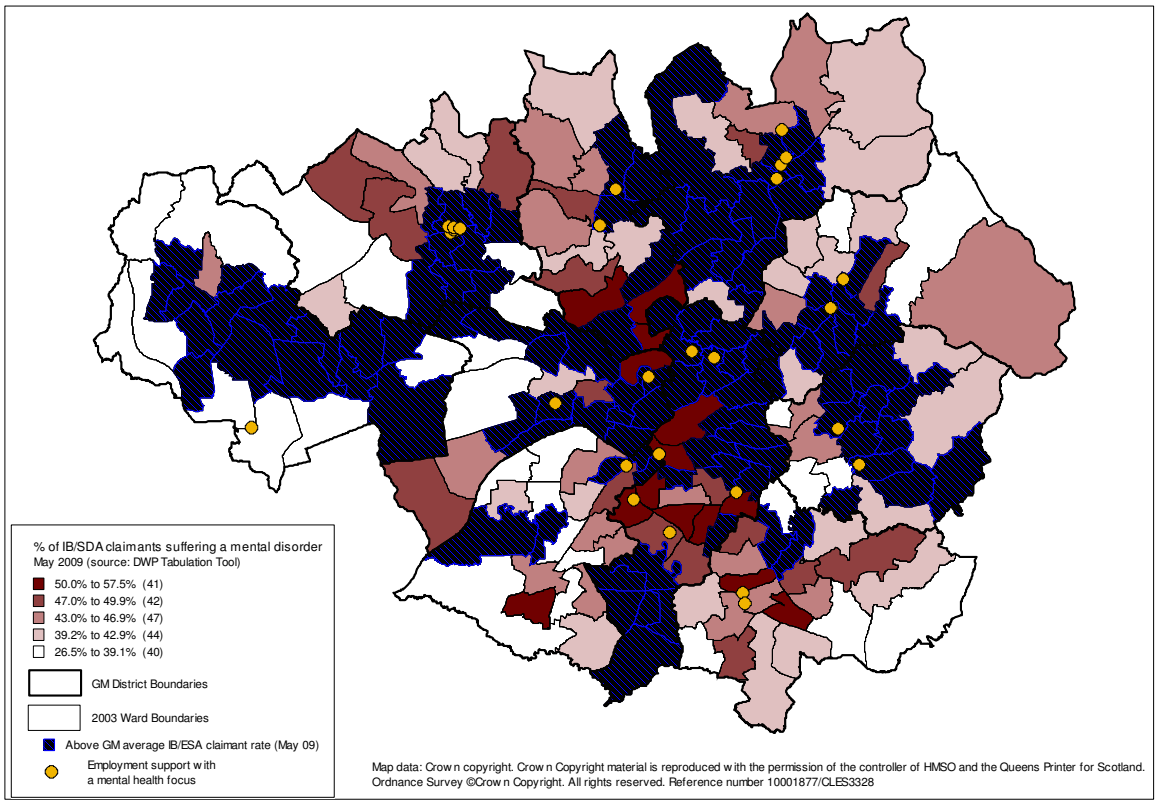


Figure 3: Services mapped against proportion of claimants with mental health conditions



4.1.5 Summary

The study has reflected the majority of activity which is being delivered across Greater Manchester. Investment in Greater Manchester in tackling the types of conditions which are the cause of the largest proportion of Incapacity Benefit claims is something in the order of £100m. This is approximately one fifth of total investment in tackling mental health disorders. The overwhelming majority of this investment relates to secondary care. Investment in services that are most likely to have an impact on employment outcomes, in particular physiological therapy services and primary care mental health workers, equates to approximately £20m. A small proportion of secondary care provision includes services which have a direct impact on employment outcomes. Approximately £2.2m is invested in this type of service. There are also some secondary care services which may be delivering employment outcomes but which do not formally recognise them. For example, mental health day services would fall into this category.

There is very little relationship between the way that the NHS invests in services and the overall level of Incapacity Benefit. This is likely to be a consequence of a organisational culture which has not in the past placed much value on the employment status of patients. The recommendations made in this section are related to actions which build upon the growing understanding of the impact that investment in health care can potentially have on employment status.

Comparing levels of investment in employment support services for mental health service users is difficult as employment support can be provided within a range of services. There are specialist employment support projects but elements of employment may be provided within other services such as mental health day services and psychological therapies. Additionally, employment support workers may be employed within specialist mental health teams, including community mental health teams. However, there remains some doubt about the totality of current service delivery because there is no central information resource either at Greater Manchester or individual district level. There are three main areas where it is likely that activities are being delivered which support people with health problems into employment:

1) employment schemes which do not have an explicit health focus but provide support to people with health problems. It is likely that activities are being delivered which do not fully address the health related barriers which individuals face;

2) health schemes which do not have an explicit employment focus but are providing employment related support;

3) small area schemes which are not known to stakeholders interviewed as part of this study.

There is a lack of evidence to show the actual scale and quality of employment related services; within the mental health sector, there is a lack of detailed understanding about the types of employment support which clients are accessing within mainstream commissioned services.

Recommendation 10

Primary Care Trusts should incorporate specific employment targets when commissioning day services.

This report has highlighted the need for an improved understanding of the activities which are being delivered that have an impact on health and worklessness. Many of the services which are relevant to this policy area are not currently recording the activities being delivering or the outputs/outcomes of those activities. Employment outcomes should be clearly defined and return to work targets should be included in service contracts with providers. This is not currently the case; the effectiveness of services in supporting people back to work is not known at a strategic level because it is not recorded at the operational level. Without this type of information, it is not possible to fully assess the value for money of different approaches. It is more difficult to effectively target services as stakeholders will not have a full understanding of what is being delivered in a particular area. It is likely that there are more services actually providing some kind of employment support than is recognised within this report due to the lack of reporting.

As a response to this issue, a common reporting template should be developed to be used by service providers commissioned by Primary Care Trusts in order to record employment support activities. The reporting template should record information related to the following aspects of project delivery:

- categorisation of activity against the different elements of the progression model;
- activity description;
- number of clients accessing the service over a given period of time;
- individual client information, including date of birth, postcode, benefit status, level of highest qualification, post-support referral/signposting.

Where possible, the reporting template should be incorporated into existing performance management and contractual systems. The national standard contract for mental health services will provide a structure for incorporating employment outcomes within contracts.

Recommendation 11

The Greater Manchester Primary Care Trusts/local authorities to make available to providers a template for recording the extent and impact of employment support activities.

4.2 Delivering integrated health and employment support

The key to providing coherent support which addresses the multiple needs of clients is to be able to access a range of support from initial engagement through to in work support. There is evidence that the most effective support for this client group is small scale community based projects. If a model which is intrinsically diverse is operating in this way, it is important there is an understanding at a strategic level of what is being delivered. This ensures that individual workers and agencies are made aware of the full range of support that is on offer, which means they are more likely to refer people onto appropriate support.

There were several examples of projects which integrated health and employment support. A number of projects were highlighted which are delivering health focused activities but are increasingly looking to develop links with employment agencies (e.g. both the Healthy Living Network and the Young Adult Advice and Support Project are currently looking to increase the degree of integration with employment support services).

4.2.1 Challenges of integrating health and employment support

Many of the stakeholders involved, including clients themselves, do not fully understand all of the barriers and issues which must be addressed (e.g. people who are in receipt of IB/ESA need to address a range of barriers if they are to secure employment). These include:

- being engaged with service providers;
- underlying health issues;
- having up to date skills and relevant experience;
- sufficient demand by employers.

Many of the projects identified were targeted at claimants of out of work benefits generally. There is also a range of activity which is targeted specifically at IB/ESA claimants; however there were few activities which explicitly targeted people with specific conditions. This suggests that although provision does take account of the health needs of clients, it does not fully recognise the different requirements that people with different health conditions may have. A number of stakeholders highlighted the lack of understanding of the health needs of clients amongst employment advisors as a key gap in the provision of effective services. This is an issue amongst both Jobcentre Plus advisors and other employment focused agencies.

Complexities of the benefits system

People in receipt of out of work benefits are often concerned about the impact any change in status will have on their eligibility for benefits. In order to be able to effectively support clients, it is important that advisors are able to fully understand the issues and barriers which the client is facing. The benefits system is complicated and is often a source of uncertainty for clients, which can act as a barrier to them actively considering returning to employment. Many employment focused services will have access to information about the impact of returning to work on benefits; this is often delivered through linkages to welfare rights services. Jobcentre Plus also offers a benefit calculation service which is used to guide people in terms of the impact of employment or training on their benefits status. The stakeholder feedback suggested that understanding the impact of employment on benefits was a particular issue within health related services. Uncertainty over benefits is likely to be highest amongst clients who have been out of work for longer periods of time as they will have developed the strongest degree of dependency on benefit.

There was no evidence of strong links to welfare rights services which can be a key point of access in terms of engaging clients. Welfare rights services also provide a useful contribution in terms of assessing the impact of employment on benefits and income.

Recommendation 13

Employment advisors should be provided with access to the Greater Manchester Service Directory.

Addressing wider social needs

Tackling basic needs (e.g. housing and finance) as well as employment issues, social exclusion, stigma and negative staff attitudes are key to addressing common mental illness. Supporting the development of emotional resilience, provision of appropriate access to support, and community participation in decisions are also essential in addressing population need.

Effective diagnosis of health conditions

There is a neglected majority (i.e. people who have long term needs but the wrong diagnosis, including people with chronic anxiety, agoraphobia, depression, phobias, drink and drug issues, debt issues, relationship problems, personality disorders) who are too complex for primary care but don't fit into secondary care services. As such, they struggle on, never leaving services but never having their needs properly met. There was some evidence that local approaches are being developed which provide tailored support for people with mental health issues, although there was less

evidence that tailored support is available for people with physical conditions. There are a lack of specific funds and initiatives aimed at providing tailored support for people with physical conditions.

There are no examples of services which specifically target people with newly diagnosed psychotic conditions. The initial diagnosis of conditions such as schizophrenia often takes place during the teens or early twenties. This is obviously an important phase in the lives of young people and a lack of support and guidance during this time can have a major impact on an individual's employment potential. There is very little evidence of a systematic approach to supporting people before sickness becomes long term. There is very little understanding of pre- and post-IB/ESA status.

Recommendation 14

Links should be developed between secondary mental health services and employment services to ensure that support is available immediately after diagnosis.

4.2.2 Client engagement

The first step in providing effective and integrated support for people out of work who have an underlying health condition is to be able to engage with them as a client group. There are a range of different approaches to engaging with clients which should be welcomed as it is likely to provide the best chance of reaching the range which exists.

In Salford, community based workers have been used to target particular areas through door-to-door contact, with the aim of proactively promoting the availability of services to a client group which is often hidden from service providers. The main drawback of this approach was that it required contact with large numbers of households in order to engage with the target group. The Health Trainers Programme in Salford is being delivered through a social enterprise and is commissioned jointly by Salford Council and the Primary Care Trust; it currently has 16 staff and has supported over 250 people. The scheme was delivered through clusters of GPs and targeted East Salford; staff were based in GP surgeries and targets were set for engaging with IB claimants.

In Tameside, a similar philosophy underpins the neighbourhood blitz approach which incorporated a number of different techniques concentrated within a small geographical area. The WNF has been used to deliver the project that targeted people who are not currently in any kind of provision. The project engaged with this group and was developed around a flexible delivery model which enabled project staff to develop action plans for each individual client. Staff were able to fund a wide range of provision through these actions plans with the maximum range of options in order to meet the individual needs of the client. The bulk of the beneficiaries were IB claimants, although some were in receipt of JSA or Lone Parents Income Support. This project has funding until 2011 and the Council has begun to link employment issues into other services (e.g. there are employment advisors working within the housing advice team).

4.2.3 Managing the client journey

The delivery of integrated health and employment support requires an understanding of the whole client journey which will involve intervention by a range of different agencies at different times. There was little understanding of the impact of specific interventions on individual beneficiaries due to a lack of knowledge concerning the range of services an individual client may be engaged with. There was a lack of evidence about the long term impact of services on individual clients; however it is acknowledged that it is often difficult to properly assess the impact of programmes that are supporting people with health issues. People often require long term support and programme activity evaluation does not acknowledge the distance travelled by beneficiaries. There was a lack of real understanding and insight into the impact of specific activities; activities tended to be delivered in an isolated manner rather than as a part of a wider coordinated portfolio of interventions aimed at an individual client. Another important dimension to this issue is that many services will not be able to directly demonstrate employment outcomes as they will be making a contribution to a long term programme of support for an individual; therefore it is important that commissioners are able to recognise this and demonstrate the impact they are having, even if this is not in terms of actual employment outcomes.

Connections are lacking between professional disciplines in understanding health issues. One of the key gaps flagged by a number of stakeholders relates to a lack of provision which is effectively addressing the full range of inter-related needs an individual may have. Many individuals will be accessing support from across a range of services, including housing, social care, Jobcentre Plus and the NHS.

Recommendation 15

Service users should be provided with a record of access that could be used to keep an up to date record of the different service providers they come into contact with.

Working Neighbourhoods Team

Salford is one of the pilot areas for the Working Neighbourhoods Team. Within the Salford model, a particular emphasis is being placed on ensuring effective client management across a number of different agencies (e.g. links are being developed with housing services in order to effectively target support at people on IB). Client management processes can be more fully integrated via partners; the partners are looking at ways in which agencies can share information about individual clients in order to improve the effectiveness of support. These models will test the efficacy of sharing information about clients with a view to building bespoke services that address multiple needs. The Working Neighbourhoods Team is relatively resource intensive and it may be necessary to explore a range of other models for sharing client information depending on the type of services involved. At a basic level, there is some logic in developing more effective ways of sharing client information between different providers at the district level.

The study has highlighted the importance of multi-faceted support for clients with health and employment related issues. The nature of this type of support means that clients will often be in contact with more than one agency at any one time. If one looks beyond the immediate issues relating to employment and health, it may be that an individual or their immediate family will be in contact with a wider range of public services, including health, employment, children's services, criminal justice services and housing services. The stakeholder consultation did not provide any substantial evidence that delivery agencies were sharing information. There are two principle benefits to improved client monitoring systems:

1) better tracking of clients across different provision;
2) better analysis of cost effectiveness.

Recommendation 16

Service mapping should be coordinated between Pathways Community Interest Companies, Jobcentre Plus and the Health and Worklessness Call for Evidence to produce a single service directory for Greater Manchester.

It is recognised that there are a number of technical issues related to establishing systems which can underpin the sharing of client data on a comprehensive basis. It has not fallen within the remit of this study to assess the feasibility of moving towards such a system; it is felt that advocating the move towards such a system falls outside the remit of this report.

Resolving the issues associated with large scale IT based information sharing processes is not a priority for action in the short term; however there is some merit in exploring processes which would enable client level data to be shared between individual projects and service delivers at the local level.

Recommendation 17

The Commission for the New Economy and the Health Commission should explore options for improving case management between agencies. The Fit for Work pilot will provide some opportunities for testing different approaches to client management.

Recommendation 18

The Commission for the New Economy should identify districts that would be willing to pilot different approaches to sharing client information. In the short term, this should be based upon relatively small scale exercises between two or more agencies in order to ensure that different interventions were accessed, coordinated and progress tracked.

The delivery of services that are aimed at addressing health related worklessness inevitably cut across existing professional boundaries; therefore it is important that professionals working in this field have access to up to date CPD opportunities, which can be both formal and informal in nature. There are a number of key areas where staff would benefit from enhanced CPD:

- understanding of the benefits system – the benefits system is complicated and is currently undergoing a major change through the shift from IB to ESA. Changes in benefit entitlement can be both a perceived and actual barrier to people on health related benefits returning to work;
- understanding of local service provision – the progression model requires both health and employment specialists to have a strong understanding of the types of activities which are being delivered in their locality. This involves understanding what is being delivered and the specific nature and benefits of what is being delivered. There is also a need to have an informal knowledge of the different projects, such as personal contact with project staff, to provide a working knowledge of the appropriateness of different interventions, enabling better contact with workers from different agencies. This has been recognised as beneficial by Jobcentre Plus in Manchester as it enables staff to manage the support offered to clients in a way which provides a supportive environment that is sensitive to the development needs of individual clients;
- understanding the impact of different health conditions – different conditions can have a significant impact on the type of employment which a client may be able to access and the type of support which will be of most benefit. Understanding the way in which different medical conditions manifest themselves is important from the point of view of designing, implementing and monitoring different types of support. Understanding different conditions can help the development of projects and policy at the strategic level and at the point of delivery to an individual client. The development of professional opportunities is one of the roles of the Mental Health Coordinators. Work has already begun in providing both generic and specific guidance to Jobcentre Plus advisors about mental health, depending on the nature of the role undertaken by an individual advisor. There are a number of different ways of delivering CPD which will grow the knowledge base across Greater Manchester; some of the most effective in terms of cost and outcomes are those which rely on the exchange of professional knowledge and expertise on a peer-to-peer basis;
- case conferencing – case conferencing is an approach which draws upon social and healthcare practice, where a number of different professional disciplines are involved in providing care to a particular individual. The Working Neighbourhoods Team model, which is being tested in Oldham and Salford, is exploring mechanisms which enable partners to share information on a client-by-client basis;
- work exchange programmes – work exchange programmes involve offering professionals from different organisations fulfilling broadly similar roles to spend some time working or being based in another organisation;
- topic guides – there is a great deal of knowledge already present across the many agencies which are operating within a single district and across Greater Manchester. This knowledge could be captured through the development of topic guides which would be produced by a range of services and agencies exploring different issues; the production of the topic guides should be centrally coordinated. The service directory which has been produced as a response to the Call for Evidence can be seen as an example of a topic guide; this directory should be widely circulated and maintained;

- district level professional development and networking conferences – supporting people with issues relating to health and employment requires access to a range of services. In order to ensure that employment advisors and health workers are able to signpost effectively, it is important that they are aware of the different services available within their locality. Effective cross referral between services relies on good interpersonal networks between staff; this enables people to have a good understanding of which services are most appropriate for particular clients. It also enables informal sharing of information about the particular needs of an individual client.

Recommendation 19

The Commission for the New Economy and the Health Commission should develop a CPD Programme which would provide opportunities for cross sectoral learning.

Recommendation 20

The membership of key groups, such as the Health and Worklessness Group, should be expanded to include Jobcentre Plus and a wide range of managers so that it can become a more active forum for sharing information regarding new initiatives and lessons learnt from existing delivery.

4.2.4 Integrated health and employment services

In several districts, services have been delivered which have successfully integrated health and employment services. The Chadderton Court Day Centre is an example of how an integrated approach to the provision of employment and mental health service can deliver successful outcomes.

A number of service users have returned to work following the support they received at the centre. The centre is also an example of a service which incorporates the monitoring of employment outcomes; this is not common across other services in Oldham, or indeed Greater Manchester in general. The potential for rolling out this model across Oldham is being reviewed.

The In2Work project provides support for clients and employers to help those with moderate mental health issues into sustained employment, including referrals onto condition management activities. The project has been delivered jointly by Jobcentre Plus, Rochdale Metropolitan Borough Council and the Primary Care Trust. In2work's services include an occupational therapist and the project also has very good links to employers, with beneficiaries receiving unlimited in work support. A similar service provided by REDS offers support to people with learning disabilities; it was funded through an LAA pump priming grant and is due to end in March 2010. In all, it has supported over 175 people, 25 of which have secured and sustained employment.

The partnership has been looking to develop more innovative approaches to helping people on IB move off benefits into secure employment (e.g. the Rochdale Partnership has put forward a proposal to develop a test trading scheme which would enable people on IB to move into self employment and have a period when they could trade without risking the loss of benefits). This builds on an option currently available through the New Deal Self Employment route. Rochdale is piloting the Working Neighbourhoods Team approach. In addition to these individual activities, there are also three common approaches which are seen to a greater or lesser degree across Greater Manchester:

1) many districts have implemented projects which place employment advisors within GP surgeries;

2) the two approaches to the Pathways to Work Programme;

3) the Health Trainers Programme which has been implemented across the conurbation.

GP surgery advisors

There have been a number of attempts to place employment advisors in GP surgeries. Manchester Central has implemented a pilot programme of placing Jobcentre Plus advisors in GP surgeries; two advisors are currently employed as part of the project, which enables delivery in 12 GP surgeries:

- Salford – six surgeries;
- Manchester – four surgeries;
- Trafford – two surgeries.

The advisors work with people who are on IB or ESA but who have mild to moderate conditions and may be able to secure employment with additional support. The advisors also work with people who are in employment but have a health problem which could mean they cannot work. This includes people who are in receipt of Statutory Sick Pay; therefore the advisors are able to help clients retain their existing employment. This can include help with managing their condition and working with the employer to look at ways in which the workplace can be adapted. The advisors have developed good networks within the districts amongst organisations which provide a range of services. The advisors do not play any formal role assessment of benefit eligibility; therefore they are able to develop good relationships with the clients on the basis of trust and honesty.

The Stepping Stones project, delivered in partnership with Manchester City Council and Manchester Primary Care Trust, was originally funded using NRF funding. The delivery of the project involved placing employment advisors within GP surgeries that were tasked with working with the GP to develop a 'prescription for work'. The Council has worked in partnership with the NHS Hospital Trusts based within the City to ensure that employment opportunities within the Trust are accessible to local people. In 2008, a survey was undertaken to research the attitudes of local people to working for the NHS; this survey was designed to inform the development of a toolkit which will inform the development of recruitment needs for the hospital trusts.

Two new GP surgeries are to shortly open in Bolton that will provide support in relation to employment and health but also traditional GP services too. In particular, the service provides a resource for other practices to refer to, where patients are identified as being at risk of loss of employment due to ill health, or where they are not currently working due to ill health.

The major client groups for the service are those who apply for ESA, get turned down and are placed on JSA, and residents who have been off sick for 8-13 weeks. This group still has health support needs and the service will provide access to physiotherapist, occupational health and adaptations services. The service needs to get a referral from 50% of GPs in Bolton but this is currently proving difficult. It may have been better if the service was held outside of a GP's surgery as they feel this is preventing referrals, with GPs possibly feeling they may lose a patient off their register if they refer.

The Oldham Partnership has supported the Incapacity Benefit to Work project which has helped over 160 claimants back into employment over the last three years. Support was provided to clients by specialist employment coordinators who worked out of GP surgeries. This project provided financial incentives to GPs who referred people onto the project. The project was jointly delivered and funded by the Council and Primary Care Trust, and came to an end in March 2009. The partners have recognised that there is a lack of provision related to health and employment. Oldham is one of the Working Neighbourhoods Team pilot areas.

The Fit for Work pilot, which is currently being developed jointly by the Commission for the New Economy and the Health Commission, will test different delivery models for providing advice and guidance through GP surgeries.

Recommendation 21

Jobcentre Plus should explore further opportunities for placing employment advisors in GP surgeries based on an evaluation of the different approaches currently being employed.

Recommendation 22

The service directory should be made available to GPs along with training about referring people onto employability programmes.

Pathways

Manchester Central, comprising the districts of Manchester, Salford and Trafford, is directly responsible for delivering the Pathways Programme. In Manchester Central, Pathways have been targeted at all new IB claimants who have come onto benefits since 2005/06. Feedback from stakeholders suggested that where Jobcentre Plus is involved in specific initiatives at a local level, it has proved to have a significant impact.

Links have been established between IAPT therapists and Jobcentre Plus Disability Employment Advisors. These links have provided a useful conduit for sharing client case histories between services. This can involve informal feedback on the progress the client is making which can then be reflected in the way that benefit conditionality is applied. In order to facilitate this, the client is asked to sign a disclosure consent form.

Manchester East and West, comprising the districts of Bolton, Bury, Oldham, Rochdale, Stockport, Tameside and Trafford, manages a provider led model of Pathways which has been in operation since 2008/09. Under the provider led model, Jobcentre Plus is responsible for the initial client contact and the first interview; the remaining five interviews are delivered by the provider. Pathways have been targeted at both new and existing IB claimants. The DWP, Jobcentre Plus and the NHS formed a partnership called the Condition Management Programme, which supports clients on IB to better understand and manage their health condition in preparation for a return to work. The partnership forms a major component of this national initiative managed by the NHS. The Condition Management Programme is managed by the Manchester Joint Health Unit.

In 2009, the DWP published an evaluation of the provider led Pathways Programme based on qualitative research carried out in 2008. The evaluation highlighted a number of points relevant to this report:

- collaboration between the providers and Jobcentre Plus was important; it enabled good practice to be shared and provided an opportunity to discuss client needs. However, relationships between different agencies were not always strong and this undermined the Pathways approach;
- most providers felt that it had proved more difficult than expected to get clients into employment. This created a tendency to work with those clients closest to the labour market in order to achieve job outcomes, potentially at the expense of supporting those who need more intensive intervention;
- it proved more difficult than expected to engage with clients which contributed to underperformance;
- the Pathways approach did nothing to address employer perceptions even though this was a key barrier to people securing employment;
- some clients were able to find employment despite their health condition. Pathways were helpful in a number of ways, including challenging people to think differently about their employment prospects and providing practical support, encouragement and financial resources;
- clients responded positively to being able to access support outside of the formal environment of the job centre.

Public sector support for people who are claiming out of work benefits is increasingly being commissioned on the basis of contractual arrangements which provide payment for services based upon providers achieving positive outcomes for clients. This approach encourages a wider range of agencies to become involved in delivering services, which could potentially lead to more innovation within the system and the development of bespoke service packages which meet the specific needs of different client groups; however there are a number of inherent risks which are built into a payment for results model.

Providers may not be sufficiently incentivised to work with client groups which require sustained long term support because of an underlying health condition. In particular, clients whose health condition has prevented them from working for a significant period of time may require long term support to move them closer to the labour market. In addition to requiring more in depth support over a longer period of time, clients who have been out of work for longer periods will present a greater degree of risk in terms of the likelihood of them securing employment.

It is widely recognised that people whose health prevents them from working often require bespoke support which can entail a number of different elements. One of the characteristics of supporting this group is that issues relating to both health and employment may have to be addressed. There is a risk that providers who are paid a fixed sum per client may be reluctant to offer support packages which vary in nature from client-to-client. Contracts which are based on a fixed payment per client will often only be commercially viable where clients are offered a standardised package of support, both in terms of the types of activity and the amount of support offered. The stakeholder consultation highlighted an instance where providers were said to be reluctant to refer clients onto Condition Management Programmes because of the cost implications.

The issue of contractual incentives needs to be further investigated in order to fully understand where disincentives may exist within the system and ways in which this can be resolved. Incentivisation needs to be understood in relation to individual providers and the balance between the level of resources needed to deliver effective provision with sufficient surplus and the savings that can accrue to the Exchequer. The second aspect is the relationship between the incentive and the saving (e.g. can NHS organisations be incentivised to engage with the employment agenda, if the savings accrue to non-NHS agencies such as the DWP?) At a Greater Manchester level, this should be led by the Commission for the New Economy. However, it is recommended that the potential of involving the DWP in the work is explored as there are national implications in terms of how contractual arrangements are developed. There needs to be a more nuanced conversation about how contractual infrastructure works to the disadvantage of individual clients.

This recommendation should be integrated with the 'invest to save' options activity that is being delivered across Greater Manchester. An element of incentivising service deliverers will be to establish economic models which enable the savings from a reduction in benefit costs to be reinvested in services, identifying different accounting models which can be used for benefit saving. This needs to move beyond the relatively limited approaches which have been taken to date, such as the LAA and Local Public Service Agreement reward grants.

Recommendation 23

The Commission for the New Economy should work with the DWP, Jobcentre Plus and service providers to address contractual disincentives to providing appropriate support.

Health Trainers

Health Trainer services are commissioned and managed by NHS Primary Care Trusts or local authorities and work in a broad range of settings. The aim of the programme is to provide individual support and advice to help people identify and achieve their own health goals and to make healthier lifestyle choices, most often in the areas of healthy eating, physical activity, smoking cessation and alcohol. The DH funds the national programme and local Primary Care Trusts fund provision in their own areas; there are also employer based schemes such as the Post Office and the Army. Referrals are made by primary healthcare services, local authorities or voluntary organisations; however some schemes offer self referral. In many cases, Health Trainers work alongside colleagues in primary care services, helping to address some of the underlying causes of lifestyle related ill health.

Health Trainers represent a new workforce within the NHS and are generally recruited from within the local communities they work; they are entry level positions which act as a gateway to wider NHS employment opportunities. On the job training is provided and the Health Trainers are given the opportunity to achieve a recognised health related qualification – NVQ Level II in volunteering and a City and Guilds bespoke qualification which is equivalent to NVQ Level III. Approximately 400 Health Trainers across Greater Manchester have gained the qualification.

Health Trainer schemes are generally targeted at specific communities, although some schemes have focused on specific groups such as the unemployed or older people. The approach taken by the Health Trainers within each individual scheme is common and was developed by the British Psychological Society. There is a national job description which provides the core used in each scheme. The Health Trainer scheme is designed to provide a programme which targets the hard to reach, promoting behavioural change which will have a positive impact on a person's health and well-being. The Health Trainers act as a gateway to a range of other services, which improves the appropriateness of services accessed by target communities.

Health Trainers are coordinated at both the North West and Greater Manchester level; the Greater Manchester hub is coordinated by the Joint Health Unit based at Manchester City Council. The link between the support the Health Trainers provide and the employment status of clients has been recognised. The regional coordinator is developing a monitoring framework which will collect data in order to demonstrate the employment status of clients before and after health trainer intervention. Employment goals are often included in the initial assessment and the mental health and well-being status of clients is assessed. Health Trainers are formally delivered in nine of the Greater Manchester districts; however there is no scheme in Trafford due to a pre-existing project delivering a similar service. The Greater Manchester programme is being evaluated and a report into its impact will be published in January 2010.

It is estimated that over 50% of clients achieve some degree of behavioural change which has a positive impact on their health (e.g. on average, smokers who receive support from a Health Trainer reduce the number of cigarettes they smoke per day from 16 to 2). There are some links between Health Trainer schemes at the local level and Jobcentre Plus; however there is currently no single system of referral across the Jobcentre Plus districts in Greater Manchester.

Table 20: Summary of the Health Trainer schemes across Greater Manchester

District	Target groups
Bolton	GP and hospital based referrals
Bury	Standard programme
Oldham	Standard programme
Manchester	Unemployed with long term conditions and older people (aged 50-70)
Rochdale	Employees and probationary clients
Salford	Standard programme
Stockport	Programme under development
Tameside	Mental health and NHS staff
Wigan	Employees, the unemployed and under 25's with mental health conditions

4.3 Supported employment

A key element of any approach which will address health related worklessness is activities which enable clients to access real employment. There is a link to individual placements which is recognised as an important element of the progression model and examples of different models for providing work placements.

In Salford, the Council's Community Health and Social Care Directorate runs a supported employment programme through a range of community based providers. The First Step Trust is a commercially operated motor garage which provides supported employment and training opportunities for people on long term IB. The project is now self-funding, using fee income secured through the delivery of car service and repair to invest in the support and training accessed by clients.

Pure Innovations is a social enterprise which provides skills and employment support for people with learning disabilities, physical disabilities and mental health conditions. Clients are referred onto the service by social workers, community mental health teams, and support, time and recovery workers. Clients are given a work capability assessment and then provided with one-to-one support to enable them to secure appropriate employment. Where clients do not secure full time employment, they will be supported into employment which comes within the permitted hours rule (less than 16 hours per week). Pure Innovations runs the Oasis Café on behalf of Pennine Care NHS Trust; this is used by patients and visitors at Stepping Hill Hospital. The café is run as a social enterprise and is staffed by mental health service users. The café is managed by Bubble Enterprises, a community interest group, which run and manage social enterprises across the North West. Pennine Care NHS Trust operated as an incubator for the café, providing capital and estate support to set up; the café now runs as a company and had a turnover of £130,000 in the last financial year.

Individual placement support pilot

This is a pilot programme targeted at people with mental health conditions who have accessed in-patient treatment or crisis and home treatment within the previous six months. The aim of the pilot is to test the approach with this client group before widening out provision over a period of twelve months. In total, there will be three employment officers working within the pilot. The pilot is being delivered in the Manchester City district across three patches – north, south and central. This enables the pilot to be integrated with local services such as mental health teams, Jobcentre Plus and the voluntary sector. Referrals to the pilot are made through community mental health teams. After being referred onto the pilot, the employment officers will work with each individual client in community venues such as libraries and cafés and a vocational plan will be delivered. Benefits advice will be provided by Manchester Advice. The employment officers will provide the link between the client and other employment services such as Jobcentre Plus Pathways Advisors, the Condition Management Programme and Intermediate Labour Market projects.

The employment officers will also provide proactive support through existing links with organisations, such as the Chamber of Commerce, and through developing links with specific employers which match the employment goals of the client. The employment officers will maintain an ongoing relationship with the employer to ensure that the client needs are met in terms of accommodation, skills development and other workplace based support.

The Manchester pilot is an example of the benefit of establishing good links with employers as it enables the employment officers to place the client in a job that is appropriate for their specific needs and employment goals.

Recommendation 24

Investment in services that support out of work people with health conditions should include supported employment and work experience opportunities.

4.4 Support for employers

In order to deliver a coherent model of support which addresses health related worklessness, it is important to engage with employers. Research at a national level suggests that employers may be reluctant to recruit people with a history of poor health or an existing chronic condition. In particular, there remains a stigma attached to mental health conditions which affects the attitudes of many employers. The employment of people with physical disabilities and mental health conditions is lower than for the population as a whole. It is not clear that there is a real understanding amongst economic policy makers of the impact of workforce health on productivity; there is no explicit work to measure the results of employer investment. There is little evidence of activities which are promoting the benefits of investing in employer health, which is further compounded by a lack of evidence of any involvement of employers in strategic policy making or operation delivery. Several examples of effective employer engagement were highlighted across Greater Manchester.

Nationally, performance against NI 173, which measures the number of people falling out of work and onto IB as a proportion of the number of working age residents that are in employment, appears to be the most positive in more affluent boroughs, while the largest proportion of people falling out of work and onto IB occurs within districts that are characterised by an economy that has experienced significant industrial decline. Such a pattern suggests an expected precedent whereby individuals in lower paid and manual occupations are more likely to move directly between employment and IB. Only a very small proportion of resident employees move directly from work and onto IB.

Research has shown that if someone is out of work for between 4-12 weeks, there is a 10-40% chance of being off work for at least one year; however if a worker is off work for between 6-12 months, there is a 90% chance of never returning to any form of work. A corollary of this is that evidence suggests that being in work is beneficial for your health and can help you recover from both physical and mental health problems, and unemployment damages people's health and well-being[46]; therefore one can conclude from this that the impact of being out of work for a sustained period of time acts as a catch 22 situation where someone is unlikely to become well until they secure employment but cannot secure employment because they are unwell. The figures do not exceed 1% in any of Greater Manchester's ten districts, ranging from 0.5% in Trafford to 0.8% in Bolton, Oldham and Salford. The analysis shows that just over 7,500 Greater Manchester residents flowed from work and onto IB in 2007/08, equating to approximately 37% of all new IB claims, providing an indication of the potential demand for services that could help to prevent employees moving onto IB. There are currently few services which work with people in the period between becoming unwell and losing their job.

Recommendation 25

More investment is required in services that support people to remain in or return to work immediately following a period of illness.

Recommendation 26

Greater Manchester local authorities, Primary Care Trusts and NHS Trusts should review their own records to establish the proportion of ex-public sector employees currently in receipt of IB.

46 Waddell G, Burton AK 'Is work good for your health and well-being?' London: TSO, 2006

4.4.1 Health and well-being in the workplace

There is a case being established which is demonstrating that the health of the workforce, both from a general economic perspective and from the perspective of an individual employer, has an impact on productivity; however it is likely that this remains an abstract concept amongst many employers. Attending to the health and well-being of employees is unlikely to be a high priority amongst the majority of employers, as it will be seen as a cost. Health and well-being is not generally seen as something that is the responsibility of the employer; however there is an increasing amount of evidence to show that ill health is caused by place conditions. Employment can also be a significant part of therapy and rehabilitation. Early intervention when a person becomes ill can prevent the loss of employment and subsequent shift into long term benefit dependency.

It is imperative that the workplace is a promoter of good health and well-being being rather than a cause of poor health and well-being; however it would be unreasonable to expect this to happen without facilitation and support from the public sector. It is important to ensure that links are developed between the strategic infrastructure currently in place to address health related worklessness and employers in both the public and private sector. This should go beyond mere representation on strategic boards and working groups, although this does have a place. The links should be based on a clearly articulated case that demonstrates the economic value of investing in the health of employees. Employer representative bodies, such as the Chamber of Commerce, should be encouraged to take a role in developing relationships between health bodies and employers.

There has been more emphasis in recent years on the preventative health agenda, which has begun to influence the delivery of primary care (e.g. GPs now offer advice around healthy eating, exercise, smoking cessation and sensible drinking). This advisory function has been reinforced through more substantive services such as prescribing access to physical activity. There is less evidence of the employment agenda being incorporated into this type of approach, but this is not to say that involving GPs in employment programmes would be something which was objected to on principle. The mapping has demonstrated examples of employment type services within GP surgeries. It would be reasonable to reflect on the fact that the link between health and employment has not been given the profile afforded to the link between food, alcohol or tobacco and health. National policy documents such as Boorman and Black may represent a move towards giving employment its proper place within the health field.

The Well-being at Work project is funded jointly through Tameside Primary Care Trust and the DH Communities for Health Programmes, and provides support and advice to SMEs on a range of health related issues, including assistance with the development of health policies, healthy eating, smoke free workplaces, physical activity, promoting good mental health, and safe and sensible drinking. The service provides onsite health checks, including Body Mass Index (BMI) and blood pressure. The project provides a link between employers and Tameside and Glossop Health Improvement Services, including Connect 4 Life, Stop Smoking Services and Weight Matters. The project has established a network of Health Champions in workplaces who are given the opportunity to complete the Royal Institute of Public Health Level 2 Understanding Health Improvement Award.

MINDFUL EMPLOYER® is the work of a voluntary, informal network of employers and support organisations and is open to any employer in the UK, whether small, medium or large, private, public or voluntary sector.

A range of interventions is being developed nationally for implementation at the regional, sub-regional and local level. These include an occupational health helpline for SMEs; a regional challenge fund which will support SMEs to improve workplace health and well-being; and a business well-being tool. A health and well-being coordinator is being recruited in the Northwest who will be tasked with leading the implementation of these initiatives in the region.

Recommendation 27

Health in the workplace schemes in Greater Manchester should be evaluated for their impact on health, productivity and sickness levels.

4.4.2 Addressing ill health in the workplace

There are several examples of activities which seek to promote health in the workplace. There has been a focus in Bolton on developing support for people already in employment who have a health problem (e.g. both the Healthy Workplace project and Clockon2health are providing support to individuals and organisations with the aim of promoting health and well-being). Although these projects are achieving some of their output targets, as specified within the Service Level Agreements, they are not achieving their targets in terms of clients either securing or retaining employment. The mapping identified a wide range of organisations involved in delivering services linked to health and worklessness, including the Shaw Trust, local libraries, the Chamber of Commerce and Bolton WISE.

Clockon2health is an umbrella branding which covers all the services which the NHS offers to local businesses. The Council is a partner in the programme and provides support around employer engagement. The programme has been well received by local businesses; 70-80 companies have been involved to date, primarily larger companies. The most positive example of impact is with Farnworth Post Office where impressive results have been achieved in terms of reducing absenteeism by improving health and staff morale. The service has been running for eighteen months and has been positively received by local businesses. Bolton Council's Economic Development Service is a partner in the initiative, in terms of helping with business engagement via Bolton's top 100 employer database. They also promote the scheme with local businesses when they are out meeting employers.

Mental Health in the Workplace is a project commissioned by Oldham Primary Care Trust, promoting and delivering coordinated workplace mental health services to local businesses and organisations focusing on prevention and early intervention. This service is provided at no cost to the businesses.

Routes to Work are currently piloting an exclusive service for Tameside Metropolitan Borough Council employees to support them to stay in or return to work after a period of absence due to a stress and/or mental health issue. The purpose of this is to support Human Recourses and Occupational Health in helping employees with stress and mental health issues back to work. If this is not a viable option for the employee after considering appropriate reasonable adjustments, the model is intended to provide short term support to help the employee consider alternative options. The purpose of this area of the model is to support, advise and guide managers who are currently supporting an employee off sick or returning to work after a period of absence due to a mental health issue.

Support for Primary Care Trust employees

Several Primary Care Trusts in Greater Manchester have implemented programmes which promote the health of their own workforce. In particular, Trafford Primary Care Trust has begun to work with employers on improving the health of employees. To date, this has focused on specific issues such as obesity and smoking.

The Primary Care Trust has an internal health and well-being programme which provides a nurse who offers a range of health checks such as blood pressure and BMI to Primary Care Trust staff; this service costs just over £20,000 per year. The Primary Care Trust also offers staff up to two hours per month to engage in leisure and health activities. Pathways provision in Trafford has incorporated health trainees, demonstrating a link between the NHS as an employer and the employment aims of the wider policy. The Primary Care Trust has developed a Workplace Champions project and offers training to local employers on health in the workplace. The Primary Care Trust has also been promoting social prescribing. The health and well-being time bank provides NHS Trafford staff with two hours a week to engage in health and well-being activities; this is supported by a specialist nurse who undertakes health checks with staff and provides health related advice and support.

Salford Primary Care Trust, Salford Council and Salford Royal NHS Foundation Trust are collaborating on a review of their own occupational health services. This review will consider both the effectiveness of occupational health services in terms of their own staff and the potential for using public sector occupational health services to support the local community. The review has drawn on examples of good practice from other areas, including Trafford. At the time of writing, the findings of this review had not been published.

The importance of workplace health within the NHS is increasing and further emphasis will result from the implementation of the Boorman Review.

Recommendation 28

The results of the review of occupational health in Salford should be shared across Greater Manchester.

Recommendation 29

Public sector employers should assess the impact of workplace health initiatives on sickness rates and the number of people leaving work due to ill health.

4.4.3 The public sector's role as an employer

The NHS itself is a major employer but does not always fully engage with the health and work agenda. One stakeholder posed the following question:

'Do Mental Health Trusts employ service users?'

There are some examples of NHS Trusts providing employment opportunities for target groups (e.g. Wigan Primary Care Trust provides a number of health trainee placements which are accessed via the Pathways Programme). The NHS has begun to work more closely with employers and there has been some progress made in terms of helping employers to address issues related to smoking cessation, obesity and physical exercise. There are some examples of the NHS Trusts and local authorities taking a role as an exemplar but these are not large scale. Employers have not been engaged in terms of general support for managing sickness and promoting health nor is there any evidence to show that this is having an impact on IB/sickness. One of the issues is a lack of evidence which show the numbers of people who leave work due to short term illness and then go onto IB.

Almost all NHS Acute Trusts are currently operating pre-employment training schemes. These schemes have been developed as part of the involvement of NHS Acute Trusts in Local Employment Partnerships. They involve providing two weeks pre-work training followed by at least two weeks in work experience. The aim of the scheme is to link NHS employment opportunities with local communities. Although the schemes are not specifically targeted at people who are on IB there is some evidence to suggest that it is benefiting this target group (e.g. in Salford, where benefit status is monitored, 17 IB claimants have been moved into employment as a result of involvement in the programme). It is difficult to say what impact the programme is having across Greater Manchester as there is a lack of data relating to the benefit status of clients.

The Stepping Hill Local Employment Partnership has been providing pre-employment support for job opportunities within the health sector in Stockport, supported through the City Strategy by Work Solutions. It complements the work that has been undertaken through the Health Enterprise Centre to develop a health and well-being campus in the town centre.

Recommendation 30

The Commission for the New Economy should take the lead in developing links between employers and the health sector which enable health promotion activities to be delivered in the workplace.

Recommendation 31

Best practice case studies should be developed based on real examples from across Greater Manchester and promoted across the conurbation. These case studies should be based upon demonstrating that employers are able to realise economic benefits by investing in the health of their employees. This work would build upon the mapping work carried out for this Call for Evidence by providing an overview of current employer led provision across Greater Manchester.

Partners at the Greater Manchester and district level should look to secure funding which would enable investment to be made in employer pilots. This investment may not need to be made in actual activities but could be concentrated in the research, evaluation and development of activities.

The employer pilots should cover a range of different types of businesses, including large employers and small and medium sized enterprises, encompassing a range of sectors, including service and manufacturing, and a range of different types of interventions, including:

- general health in the workplace;
- early intervention and prevention for physical and mental health conditions;
- support for people with long term conditions returning to the workplace.

Recommendation 32

Funding should be made available for employer pilots that test different models of workplace health promotion in relation to keeping people in work, productivity gains and employer cost reductions.

Recommendation 33

The Commission for the New Economy and the Health Commission should work jointly to provide training and support to local employers on health in the workplace and assist them in developing health strategies. This should be aimed at small to medium sized enterprises that do not have the internal resources and knowledge available to manage health problems.

Recommendation 34

In order to ensure that the lessons learned from employer pilots and case studies are given a high profile amongst employers, a series of employer champions should be recruited. These would be employers who would be prepared to promote and publicise the benefits of investment in the health and well-being of the workforce. This promotional role could take many forms, including speaking at networking events, acting as a mentor on a district or sector basis, and consenting to being included in health related publications, which would include activities that support people to remain in employment.

4.5 Strategic leadership of health and worklessness policy

Good progress has been made at a strategic level to develop an understanding of the links between health, work and worklessness. AGMA, through the work of the Greater Manchester Commission for Health and the Commission for the New Economy, has been raising the profile of these issues. However, at the district level, health and employment tend to be treated as distinct issues and there are insufficient links through Local Strategic Partnerships. There were some examples of partners working together at the district level to develop formal strategies related to this agenda, which included wide ranging health and well-being strategies that incorporated employment issues or specific health and employment strategies (e.g. the Manchester Mental Health and Social Care Trust is currently developing a Mental Health Employment Strategy).

The Manchester Mental Health Promotion Strategy makes specific reference to employment both from the perspective of mental health service users and in terms of workplace mental well-being. The strategy does not contain specific targets but does highlight related priorities to ensure people with mental health conditions are supported to access employment and that workplace environments promote positive health and well-being.

The introduction of the WNF and, to an extent, Neighbourhood Renewal Funding before that has improved the degree of partnership working between the health and employment sectors. Organisations within the NHS in Greater Manchester have responded to the challenge laid out by the Government to place more emphasis on preventing ill health and promoting health and well-being.

There are several examples of strategic approaches being taken at the district level, including:

- Salford has established an IAPT Board and the Council and Primary Care Trust have agreed to jointly fund a Health and Work Manager who will be responsible for developing a more coherent strategy relating to this agenda;
- the Manchester Mental Health Promotion Strategy makes specific reference to employment both from the perspective of mental health service users and in terms of workplace mental well-being. The strategy does not contain specific targets but does highlight related priorities to ensure people with mental health conditions are supported to access employment and that workplace environments promote positive health and well-being;
- stakeholders in Oldham have made tackling health related worklessness one of their key priorities;
- Stockport Primary Care Trust and the Council have been reviewing senior management structures to ensure a strong link between health and adult social care functions;
- Tameside Primary Care Trust is currently drafting a Health and Equality Strategy in response to the Boorman Review.

Recommendation 35

Employment and worklessness should be given a higher priority within the portfolios of public health leads. This may mean negotiating the relative priority of other target areas.

There are a wide range of services which fall under the broad theme of health and worklessness; however there is no single agency or partnership structure responsible for this issue. Many of the districts identified issues related to health and worklessness within key strategic documents such as LAAs; however very few of the partnerships within the districts have established strong processes or structures which provide links between the commissioning, delivery and performance management of services aimed at addressing issues related to health and worklessness. Even within organisations, the links are not being made across different service and policy areas (e.g. many of the Primary Care Trusts are simultaneously involved in commissioning mental health services which have an employment element and participating in local employment partnerships, but these two functions may not be coordinated within the Primary Care Trust).

There is no clear lead identified within districts for health and worklessness provision. A likely reason for this is that there is no clear definition of the types of activities which would fall into health and worklessness as a policy area. There is further scope for a lack of clarity when one incorporates issues relating to workplace health. As has been described elsewhere in this report, workplace health is a factor which has been highlighted by the Government as a key issue. The feedback from stakeholders reflected this lack of clarity locally about the types of service areas that would fall into a broader category of health and worklessness.

Recommendation 36

Each district should identify a senior manager within either the local authority or the Primary Care Trust who is responsible for policy relating to health and worklessness.

The lack of centralised commissioning and service delivery at the local level is not solely down to a lack of a coherent structure at the local level; in some respects, it is simply the context which local partners are working in. The policy related to health and worklessness is not being delivered in a coordinated manner; local districts do not have structures in place which enable the sharing of information that would inform the planning and commissioning processes. Policy is defined at different spatial levels and this has direct implications for service delivery (e.g. the development of the IAPT Programme is traced back to national policy drivers which have been operationalised through regional coordination).

Similarly, Jobcentre Plus activities are shaped centrally at the national level and then delivered through the district structure. Within Greater Manchester, this is within the Greater Manchester Central and Greater Manchester East and West area offices.

Recommendation 37

The Commission for the New Economy and the Health Commission should provide coordination of strategy across different spatial levels.

Another aspect which has made it difficult for services to be coordinated at the local level is the informal nature of some of the support which is offered. In particular, services which provide support to users in terms of either health or worklessness but do so in a manner which is part of the wider service offer.

Mental Health Coordinators

The two Greater Manchester Jobcentre Plus districts have recently established Mental Health Coordinators. The principal role of these coordinators is to:

- provide a focal point within Jobcentre Plus and, to an extent, across a range of agencies;
- provide access to expertise within Jobcentre Plus and a contact point for external agencies. It is a key role within the two Jobcentre Plus districts as it is not a function which is being picked up elsewhere;
- prioritise the development of mental health awareness training. Generic training will be provided for most advisors in order to help them recognise mental health issues that may not have been formally identified. More in depth training will be provided for advisors working with clients whose benefit status has changed due to the transition to ESA.

The establishment of the two coordinators should be welcomed but it represents a minimal investment given the scale of the challenge, particularly in terms of the shift from IB to ESA which will create huge pressures for Jobcentre Plus. The issues facing the coordinators include:

- establishing sufficient provision to meet the demand generated by the changing status of existing IB claimants and new ESA claimants;
- ensuring that Jobcentre Plus advisors have the skills and underpinning knowledge to support clients who have a health condition;
- to develop positive operational and strategic relationships with the wide range of providers in a local area to ensure that signposting is effective.

Recommendation 38

The Mental Health Coordinators should be provided with adequate support within Jobcentre Plus.

Recommendation 39

The Mental Health Coordinators should engage with the Greater Manchester Health and Work Group.

All Primary Care Trusts and NHS Trusts should develop health and well-being strategies and identify a clear lead for policy relating to health and worklessness. Leadership and champion roles both across Greater Manchester and within the individual districts should be established, which would include building upon the recommendations of the Boorman Review and developing the concept of the NHS as an exemplar employer. A major gap in the partnership delivery of worklessness services has been the involvement and role of the health sector (e.g. Primary Care Trust and NHS Trusts).

Stakeholders suggested that the health sector has been slow to engage with the worklessness agenda despite significant efforts in some areas; however feedback from the health sector suggests the level of engagement of economic development professionals in the health agenda is also limited. Difficulties have been experienced in engaging the health sector in terms of:

- involvement in strategic working groups related to worklessness – there was a general feeling that involvement relied on the commitment of an individual rather than the sector as a whole;
- understanding and navigating the structures of the health sector – in particular difficulty was experienced in relation to understanding who is responsible, and at what level engagement should take place to ensure health providers are engaged with the worklessness agenda;
- involving health providers in service delivery – in terms of being able to utilise the knowledge of clinical health workers to provide accurate assessment and referral of workless residents.

The health sector has a clear role in the drive to tackle worklessness due to the significant number of residents not working due to poor health. There are clear benefits for the NHS in assisting with tackling worklessness, as their services engage with residents in poor health and provide support to overcome these barriers. There are also clear mental and physical health benefits gained from working, meaning focusing on worklessness will also help to achieve the objectives of the health providers. Feedback suggests the struggle to engage the NHS is even more important as concerns were raised that health providers have commissioned their own provision rather than building upon existing delivery, leading to a lack of co-ordination and potential duplication.

There is a need for a greater understanding of the work that is being undertaken across the employment and health sectors. A lack of communication is apparent across the sectors and, where there are strategic structures in place, it is not clear how these translate into operational links. There needs to be strong articulation of new pressures in this area, in particular through the ESA and public sector cuts.

Recommendation 40

All local districts should develop a comprehensive health, well-being and employment strategy.

5 CONCLUSION

The link between health and worklessness has been recognised by national, regional, sub-regional and local agencies. This recognition has recently gained a momentum which is starting to have a real impact in terms of the way that services are delivered and configured. This report provides an overview of current provision and the strategic approach to tackling health related worklessness in Greater Manchester. There are three key issues which should underpin the overall strategy to tackling health and worklessness.

5.1 Current and planned provision will not meet demand or address the problem

The scale of provision which is currently being delivered and is planned to be delivered in the immediate future will not meet the demand for services or significantly reduce the numbers of people who are claiming out of work benefits due to poor health. Even though the overall number of IB claimants has fallen, there remains a significant proportion of the working age population who are out of work due to ill health. In order for the case for more provision to be made, it is important that within the public and private sectors, stakeholders understand the economic case for supporting initiatives which prevent or address health based worklessness.

Approaches which have proved to be effective are those which deliver intensive, long term support and incorporate direct routes into employment such as supported employment. This type of approach is expensive but can be demonstrated to be cost effective when compared to the cost of out of work benefits, lost tax revenues and health treatment.

5.2 Changes in the profile of clients

Provision for people who are out of work because of ill health will need to respond to a changing client group in the coming months and years. Targeting clients will become increasingly important as the transition from IB to ESA takes place, as many more people will require support. The shift from IB to ESA is not properly understood and it is not clear if there is adequate planning in place beyond Jobcentre Plus to meet this challenge.

The links between health and employment are constantly changing. There is an emphasis on 'working age' without recognising the particular needs or extremes of the younger and older adults. Younger people with no experience are very vulnerable and they need support to ensure that short term unemployment does not become the long term status. Conversely the working age is increasing with many of the population now expected to work to 67 years of age and beyond, which may bring its own issues for these individuals.

5.3 Policy infrastructure is developing across Greater Manchester

There is an emerging infrastructure based around Jobcentre Plus, Mental Health Coordinators, the IAPT Programme, the Fit for Work pilot and Health Trainers which can begin to grow into a coordinated and coherent service for people who are out of work and have an underlying health condition. However, there is a lack of knowledge across different sectors about what is actually being delivered. It is not always possible to fully assess the scale and extent of activities which are being delivered as activities that address employment issues often form an unrecorded aspect of the delivery of health services; however there are numerous examples of services which are explicitly trying to integrate health and employment support. Across Greater Manchester, it is clear that the link between health and worklessness is recognised and widely accepted, and positive relationships exist between the major public sector agencies which relate to this agenda. It is therefore important that the opportunities both within districts and at the Greater Manchester level for sharing the lessons learnt from innovation and experimentation are built upon.

6 RECOMMENDATIONS

The Commission for the New Economy and the Greater Manchester Health Commission are using the results of the Call for Evidence to develop a programme of work which will be taken forward by the Health and Work Group and relevant support staff. The evidence gathered in this study has been used to develop forty individual recommendations which are grouped around five themes.

6.1 Investment

The evidence has demonstrated the cost to the public purse and the wider economy of health related worklessness; therefore investment in addressing health related worklessness has both an economic and social payback. The recommendations centre on ensuring that potential savings are considered when making investment decisions. This includes ensuring that the impact on employment outcomes is fully understood so that the true value of investment decisions can be articulated. It is also recommended that investment is targeted on activities which are likely to have the most significant impact on employment, in particular continuing the focus on providing access to services through primary care and also providing opportunities for supported employment and work experience. These recommendations should be considered with regards to new investment and the alignment of existing resources.

Recommendation 1
Any future WNF Programme or similar type of investment should be closely targeted at activities that are focused on addressing health related worklessness.

Recommendation 4
The Commission for the New Economy should ensure that the DWP understands the potential demand for services delivered through the Invest to Save project. Provision will be required for approximately 102,000 people who will be in the work related activity group over three years.

Recommendation 9
Service commissioning should be related to both the cost of the service being delivered and the overall potential savings that could result from successful intervention.

Recommendation 10
Primary Care Trusts should incorporate specific employment targets when commissioning day services.

Recommendation 12
Mental health day care services should be reviewed for their impact on employment outcomes.

Recommendation 23
The Commission for the New Economy should work with the DWP, Jobcentre Plus and service providers to address contractual disincentives to providing appropriate support.

Recommendation 24
Investment in services that support out of work people with health conditions should include supported employment and work experience opportunities.

Recommendation 25
More investment is required in services that support people to remain in or return to work immediately following a period of illness.

6.2 Strategy

The Call for Evidence represents a first step in developing a comprehensive strategic approach to addressing health related worklessness across Greater Manchester. The results of the Call for Evidence can now form the basis of ongoing strategy and should be built upon in a number of ways. It provides the basis of an evidence based approach to policy development which can be enhanced with access to more detailed DWP data, improved coordination of the collection of client based data, and wider use of the available data at a district and locality level.

There is a need for a greater recognition of the importance of health related worklessness amongst both employment and health focused agencies (e.g. this could be done through raising the priority of worklessness within the portfolios of Directors of Public Health).

Recommendation 5
A strategy should be developed that outlines how the shift from IB to ESA will be managed across Greater Manchester.

Recommendation 7
Local authorities and their partners, using elements of this report as a baseline, should develop a more refined approach to analysing the IB/ESA client group. This should be undertaken as part of the worklessness assessment element of the Local Economic Assessment.

Recommendation 8
The Commission for the New Economy should lead on negotiations with the DWP to secure access to detailed data regarding IB/ESA on/off flows and mental health conditions.

Recommendation 20
The membership of key groups, such as the Health and Worklessness Group, should be expanded to include Jobcentre Plus and a wider range of managers so that it can become a more active forum for sharing information regarding new initiatives and lessons learnt from existing delivery.

Recommendation 28
The results of the review of occupational health in Salford should be shared across Greater Manchester.

Recommendation 35
Employment and worklessness should be given a higher priority within the portfolios of public health leads. This may mean negotiating the relative priority of other target areas.

Recommendation 36
Each district should identify a senior manager within either the local authority or the Primary Care Trust who is responsible for policy relating to health and worklessness.

Recommendation 37
The Commission for the New Economy and the Health Commission should provide coordination of strategy across different spatial levels.

Recommendation 38
The Mental Health Coordinators should be provided with adequate support within Jobcentre Plus.

Recommendation 39
The Mental Health Coordinators should engage with the Greater Manchester Health and Work Group.

Recommendation 40
All local districts should develop a comprehensive health, well-being and employment strategy.

6.3 Research

The evidence presented in this report is based on existing data; however there are a number of issues identified in the report which merit further analysis. This includes reviewing the experience and case histories of people with different mental health conditions, the extent to which former public sector employees are on health related benefits, and the impact of workplace health programmes.

Recommendation 2
Further research is required that will explain why mental health results in a minority of people becoming too unwell to work whilst the majority remain in employment.

Recommendation 3
Service providers should ensure that employment focused advisors have a full understanding of the impact of different types of mental health conditions.

Recommendation 26
Greater Manchester local authorities, Primary Care Trusts and NHS Trusts should review their own records to establish the proportion of ex-public sector employees currently in receipt of IB.

Recommendation 27
Health in the workplace schemes in Greater Manchester should be evaluated for their impact on health, productivity and sickness levels.

Recommendation 29
Public sector employers should assess the impact of workplace health initiatives on sickness rates and the number of people leaving work due to ill health.

Recommendation 31
Best practice case studies should be developed based on real examples from across Greater Manchester and promoted across the conurbation. These case studies should be based upon demonstrating that employers are able to realise economic benefits by investing in the health of their employees. This work would build upon the mapping work carried out for this Call for Evidence by providing an overview of current employer led provision across Greater Manchester.

6.4 Provision

The study has provided a number of examples of aspects of current provision which could be improved or developed in the short term. The study itself represents a resource which should be promoted and used widely across agencies, in particular the mapping of services can be utilised by frontline staff to enhance current signposting. This is practical in the short term as it will enhance the knowledge of individual advisors. It is also a useful resource for strategic discussions focused on aligning existing provision. Activities should be developed which enable the ongoing recording of employment activities at both organisational and individual client level. Emphasis is also placed on expanding CPD activities which enable cross organisational and cross sectoral learning, given the range of organisations which an individual client may be receiving support from.

Recommendation 6
Strategies for tackling health related worklessness should retain a focus on demand side measures that will lead to suitable employment opportunities. Demand side measures should include:

- opportunities for supported employment. This could be delivered on the basis of Intermediate Labour Market Programmes and social enterprise agencies, approaches that have been proven to be effective in Greater Manchester and beyond;
- awareness raising amongst employers about the practical implications of employing people with health problems (e.g. addressing preconceptions about mental illness);
- the public sector acting as an exemplar in proactively employing people who have had or have health conditions that have prevented them from working.

Recommendation 11
The Greater Manchester Primary Care Trusts/local authorities to make available to providers a template for recording the extent and impact of employment support activities.

Recommendation 13
Employment advisors should be provided with access to the Greater Manchester Service Directory.

Recommendation 14
Links should be developed between secondary mental health services and employment services to ensure that support is available immediately after diagnosis.

Recommendation 15
Service users should be provided with a record of access that could be used to keep an up to date record of the different service providers they come into contact with.

Recommendation 16
Service mapping should be coordinated between Pathways Community Interest Companies, Jobcentre Plus and the Health and Worklessness Call for Evidence to produce a single service directory for Greater Manchester.

Recommendation 19
The Commission for the New Economy and the Health Commission should develop a CPD Programme that would provide opportunities for cross sectoral learning.

Recommendation 22
The service directory should be made available to GPs along with training about referring people onto employability programmes.

Recommendation 30
The Commission for the New Economy should take the lead in developing links between employers and the health sector that enable health promotion activities to be delivered in the workplace.

Recommendation 33
The Commission for the New Economy and the Health Commission should work jointly to provide training and support to local employers on health in the workplace and assist them in developing health strategies. This should be aimed at small to medium sized enterprises that do not have the internal resources and knowledge available to manage health problems.

Recommendation 34
In order to ensure that the lessons learned from employer pilots and case studies are given a high profile amongst employers, a series of employer champions should be recruited. These would be employers who would be prepared to promote and publicise the benefits of investment in the health and well-being of the workforce. This promotional role could take many forms, including speaking at networking events, acting as a mentor on a district or sector basis, and consenting to being included in health related publications that would include activities which support people to remain in employment.

6.5 Piloting

The two Commissions could play an important role in encouraging innovation and supporting the piloting of new approaches to addressing health related worklessness. Initially, this should be focused on providing support to people in work either at the general level through workplace health programmes or more specifically through programmes such as the Fit for Work pilot.

Recommendation 17
The Commission for the New Economy and the Health Commission should explore options for improving case management between agencies. The Fit for Work pilot will provide some opportunities for testing different approaches to client management.

Recommendation 18
The Commission for the New Economy should identify districts that would be willing to pilot different approaches to sharing client information. In the short term, this should be based upon relatively small scale exercises between two or more agencies in order to ensure that different interventions were accessed, coordinated and progress tracked.

Recommendation 21
Jobcentre Plus should explore further opportunities for placing employment advisors in GP surgeries based on an evaluation of the different approaches currently being employed.

Recommendation 32
Funding should be made available for employer pilots that test different models of workplace health promotion in relation to keeping people in work, productivity gains and employer cost reductions.

APPENDIX 1

Consultees

CONSULTEES

Steering Group		
Name	**Organisation**	**Job Title**
Annie Smith	Commission for the New Economy	Head of Employment
Warren Heppolette	Association of Greater Manchester PCTs	Associate Director
Will Blandamer	Greater Manchester Public Health Network	Director
James Farr	Commission for the New Economy	Health and Worklessness Manager
Michael McCourt	Pennine Care MH Trust	Director of Operations
Claire Maguire	Bury PCT/Pennine Care MH Trust	Consultant Clinical Psychologist
Chris Linward	Acute Trusts CEOs Forum	Director of Policy Development
Libby Sedgley	NHS North West	Regional Healthy Workforce Coordinator
Stephen Watkins	Stockport PCT	Director of Public Health (Lead Director of Public Health –Worklessness)

Local authority employment leads		
Name	**Local authority**	**Job title**
Andy Walker	Bolton	Head of Service – Strategy
Tracey Webb	Bury	Strategy and Resources
Jon Bloor	Oldham	Economic Development Manager
Heather Clark	Manchester	Acting Head of Economic Development Unit
Naila Ilyas	Rochdale	
Mat Ainsworth	Salford	Manager, Employability Team
Nick Hill	Stockport	Economic Development Manager
Phil Spence	Tameside	Economic Development Manager
Kevin Walsh	Wigan	Senior Strategy Officer
Anthony Mohammed	Wigan	

Primary Care Trust leads		
Name	**Organisation**	**Job Title**
Ian Riding	Ashton, Wigan and Leigh PCT	Worklessnesss Lead
Jan Hutchinson	Bolton PCT	Director of Public Health
Peter Elton	Bury PCT	Director of Public Health
Wendy Meston	Heywood Middleton and Rochdale PCT	Deputy Director of Public Health
Sian Wimbury	Oldham PCT	Senior Project Manager (Mental Health)
Abdul Razzaq	Trafford PCT	Director of Public Health
Elaine Michel	Tameside and Glossop PCT	Deputy Director of Public Health

Mental Health Trusts		
Name	**Organisation**	**Job Title**
Michael McCourt	Pennine Care Mental Health Trust	
Stuart Hatton	Manchester Mental Health and Social Care Trust	Chief Operating Officer
Linda Colgan	Greater Manchester Mental Health Network	Network Director

Other stakeholders		
Name	**Organisation**	**Job Title**
Steve Cova	Jobcentre Plus Greater Manchester Central	Mental Health Coordinator
Sharon Kwei-Sutcliffe	Jobcentre Plus Greater Manchester East and West	Mental Health Coordinator
Wayne Eckersley	NHS Northwest	IAPT Programme Lead
Susan Ford	Commission for the New Economy	Working Neighbourhood Team Project Officer

APPENDIX 2

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APPENDIX 3

Conditions within 'other mental health disorder' category of the NHS Programme Budgetting Exercise

Conditions within 'other mental health disorder' category of the NHS Programme Budgetting Exercise	
Mental and behaviour disorder due to alcohol	Nightmares
Mental and behaviour disorder due to opiods	Nonorganic sleep disorder
Mental and behaviour disorder due to cannabis/cannaboids	Lack or loss of sexual desire
Mental and behaviour disorder due to seds/hypns	Sexual aversion and lack of sexual enjoyment
Mental and behaviour disorder due to alcohol	Failure of genital response
Mental and behaviour disorder due to other stimulants inc caffine	Orgasmic dysfunction
Mental and behaviour disorder due to hallucinogens	Premature ejaculation
Mental and behaviour disorder due to tobacco	Nonorganic vaginismus
Mental and behaviour disorder due to volatile solvents	Nonorganic dyspareunia
Mental and behaviour disorder due to multiple/psychoact	Excessive sexual drive
Mild depressive episode	Oth sex dysfunction not caused by organic disorder/disease
Moderate depressive episode	Unspec sex dysfunction not caused by organic disord or dis
Severe depressive episode without psychotic symptoms	Puerperal mental disorder
Recurrent depressive disorder	Psychological and behav factor assoc with disord or dis EC
Cyclothymia	Abuse of non-dependence-producing substances
Dysthymia	Unsp behav synd assoc with physiol disturb physical factor
Persistent mood [affective] disorder	Paranoid personality disorder
Unspecified mood [affective] disorder	Schizoid personality disorder
Agoraphobia	Dissocial personality disorder
Social phobias	Emotionally unstable personality disorder
Specific (isolated) phobias	Histrionic personality disorder
Phobic anxiety disorder	Anankastic personality disorder
Panic disorder [episodic paroxysmal anxiety]	Anxious [avoidant] personality disorder
Generalized anxiety disorder	Dependent personality disorder
Mixed anxiety and depressive disorder	Personality disorder
Anxiety disorder	Mixed and other personality disorders
Predominantly obsessional thoughts or ruminations	Enduring personality change after catastrophic experience
Predominantly compulsive acts [obsessional rituals]	Enduring personality change after psychiatric illness
Mixed obsessional thoughts and acts	Other enduring personality changes
Obsessive-compulsive disorder	Enduring personality change
Acute stress reaction	Pathological gambling
Post-traumatic stress disorder	Pathological fire-setting [pyromania]
Adjustment disorders	Pathological stealing [kleptomania]
Reaction to severe stress	Trichotillomania
Dissociative amnesia	Other habit and impulse disorders
Dissociative fugue	Habit and impulse disorder
Dissociative stupor	Transsexualism
Trance and possession disorders	Dual-role transvestism
Dissociative motor disorders	Gender identity disorder of childhood
Dissociative convulsions	Gender identity disorder
Dissociative anaesthesia and sensory loss	Fetishism
Dissociative [conversion] disorder	Fetishistic transvestism
Somatization disorder	Exhibitionism
Undifferentiated somatoform disorder	Voyeurism

Conditions within 'other mental health disorder' category of the NHS Programme Budgetting Exercise	
Hypochondriacal disorder	Paedophilia
Somatoform autonomic dysfunction	Sadomasochism
Persistent somatoform pain disorder	Disorder of sexual preference
Somatoform disorder	Sexual maturation disorder
Neurasthenia	Egodystonic sexual orientation
Depersonalization-derealization syndrome	Sexual relationship disorder
Other specified neurotic disorders	Other psychosexual development disorders
Neurotic disorder	Psychosexual development disorder
Anorexia nervosa	Elaboration of physical symptoms for psychological reasons
Atypical anorexia nervosa	Intent product/feign of symptom/disab eith physical/psychol
Problem related to education and literacy	Other specified disorders of adult personality and behaviour
Unemployment	Unspecified disorder of adult personality and behaviour
Change of job	Observation for suspected mental and behavioural disorders
Threat of job loss	General psychiatric examination
Stressful work schedule	Follow-up examination after psychotherapy
Discord with boss and workmates	Special screening exam for mental and behavioural disorders
Uncongenial work	Psychotherapy
Other physical and mental strain related to work	Convalescence following psychotherapy
Other and unspecified problems related to employment	Illiteracy and low-level literacy
Other specified counselling	Schooling unavailable and unattainable
Counselling	Failed examinations
Malingerer [conscious simulation]	Underachievement in school
Family history of other mental and behavioural disorders	Education maladjust and discord with teachers and classmates
Personal history of other mental and behavioural disorders	Other problems related to education and literacy
Personal history of psychological trauma NEC	Personal history of self-harm
Bulimia nervosa	
Atypical bulimia nervosa	
Overeating associated with other psychological disturbances	
Vomiting associated with other psychological disturbances	
Eating disorder	
Nonorganic insomnia	
Nonorganic hypersomnia	
Nonorganic disorder of the sleep-wake schedule	
Sleepwalking [somnambulism]	
Sleep terrors [night terrors]	

APPENDIX 4

NHS Mental Health Services: Link to Worklessness

Services which make a strong contribution to employment outcomes (£000s)

Service Type	Bolton	Bury	Manchester	Oldham	Rochdale	Salford	Stockport	Tameside	Trafford	Wigan	Total
Employment Scheme	£109	£131	£1,097	£316	£122	£126	£27	£179	£50	£0	£2,157
Psychology Therapies and Counselling Services	£306	£871	£2,765	£1,133	£825	£1,859	£931	£506	£203	£531	£9,929
Psychology Therapy Services not allocated to service categories			£6	£8				£209		£579	£802
Specialist Psychotherapy Service	£7	£53	£446	£272	£45	£505	£219	£409	£72	£76	£2,104
Voluntary/Private Counselling and/or Psychotherapy Service	£29		£134		£23		£69	£426			£681
Total	£451	£1,055	£4,447	£1,728	£1,015	£2,490	£1,246	£1,729	£325	£1,186	£15,673

Services which make a minor contribution to employment outcomes

Service Type	Bolton	Bury	Manchester	Oldham	Rochdale	Salford	Stockport	Tameside	Trafford	Wigan	Total
Advocacy Services	£80	£90	£271	£53	£421	£60	£66	£158	£44	£52	£1,296
Assertive Outreach Team	£622	£333	£2,437	£579	£729	£767	£549	£674	£765	£941	£8,396
Carers' Support Group		£6				£101		£1			£108
Carers' Support Service		£81	£3	£107	£34	£111		£84	£121		£541
Carers' Support Workers	£193						£123	£34			£350
CDW workers		£16	£321						£80	£132	£550
Community Mental Health Team	£2,547	£2,062	£12,359	£2,515	£2,673	£4,398	£2,776	£2,376	£2,034	£5,449	£39,189
Criminal Justice Liaison and Diversion Service	£65	£1	£92	£78	£0	£28	£97	£0	£0	£2	£363
Crisis Accommodation	£291		£605		£103		£110	£66			£1,175
Day Centres/Resource Centre/Drop-in	£681	£377	£750	£794	£418	£320	£215	£281	£286	£932	£5,054
Early Intervention in Psychosis Service	£969	£214	£2,451	£748	£218	£897	£247	£715	£695	£359	£7,513
Education and Leisure Opportunity	£0	£40	£132		£9	£0			£4		£184
Home/Community Support Service	£561	£242	£447	£344	£201	£1,952	£370	£749	£180	£1,300	£6,346
Homeless Mental Health Service		£31	£168							£88	£288
Hostel				£781							£781
Housing support		£963						£65			£1,028

Service Type	Bolton	Bury	Manchester	Oldham	Rochdale	Salford	Stockport	Tameside	Trafford	Wigan	Total
NHS Day Care Facility			£307								£307
Personality disorder service			£103				£22			£168	£293
Primary care mental health worker	£1,595	£194	£249	£109	£1,352	£4	£151	£237	£151	£640	£4,682
Self-help and Mutual Aid Group			£25				£74	£2			£101
Service User Groups	£55		£275				£21	£1		£38	£391
Short-term Breaks/Respite Care Service		£10	£14		£72		£31	£25	£5	£188	£345
Staff-facilitated Support Groups	£126		£80		£100		£59	£32			£397
Women-only community day services		£7									£7
Advice and Information Services					£546	£50	£84	£104	£68		£852
Sub Total	£8,895	£6,539	£24,485	£7,572	£7,529	£9,217	£4,995	£7,066	£4,432	£11,577	£92,308

Services which do not make a contribution to employment outcomes

Service Type	Bolton	Bury	Manchester	Oldham	Rochdale	Salford	Stockport	Tameside	Trafford	Wigan	Total
24 Hour Nurse Staffed Care	£897		£281		£1,847						£3,026
Non NHS Registered Nursing Home care		£933		£2,051	£251	£390				£933	£4,559
A&E Mental Health Liaison Service	£3	£235	£709	£169	£112	£13	£166	£223	£30	£0	£1,660
Access & Crisis	£9	£1	£1,700	£36	£4	£1	£36		£3		£1,790
Accommodation			£1,518					£8		£1,871	£3,398
Acute Inpatient Unit/Ward	£3,796	£2,881	£9,889	£2,163	£2,521	£3,746	£3,372	£2,175	£2,030	£2,533	£35,106
Adult/family Placement Scheme	£30			£95				£9			£134
Clinical Services not allocated to service categories	£148	£793	£2,668	£1,659	£2,043	£21	£1,762	£1,654	£10	£2,150	£12,908
Community Forensic Service		£26	£2								£28
Continuing Care		£1,996	£2,562		£3	£229		£2,820	£2,700	£820	£11,129
Crisis Resolution Home Treatment Team	£1,487	£468	£6,118	£1,129	£1,092	£938	£930	£609	£1,031	£1,090	£14,892
Direct Payments	£89	£44			£58	£195	£120	£103	£37	£127	£772
Emergency Clinics / Walk-in Clinic				£7	£48						£55
Emergency Duty Team				£92		£103	£51	£160		£62	£469
Gateway workers			£4	£5				£533			£542
LA and Registered Residential Care Home	£833	£1,519	£6,091	£1,011	£722	£2,742	£1,325	£857	£1,425	£1,566	£18,091
Local Medium Secure Service	£1,547	£6,364	£12,164		£1,074	£4,016		£2,487		£1,758	£29,410
Local Psychiatric Intensive Care Unit	£759	£237	£2,123	£1,058	£396	£638	£1,180	£297	£708	£880	£8,275
Mental health promotion				£151		£306		£1	£10	£168	£636
Mentally Disordered Offenders	£43	£5	£24	£1	£33	£173	£0	£36	£75	£132	£522
Community/hospital professional team/specialist	£134	£687	£202	£704	£99	£240	£1	£397	£845	£442	£3,749
Patient Advice and Liaison Service PALS	£0	£5	£59	£7	£7	£0	£7	£6			£92
Prison Psychiatric Inreach Service	£2	£7	£202		£221	£281		£1		£36	£748
Psychiatric Liaison Service			£34								£34
Psychiatric Outpatient Clinics	£714	£138	£2,057	£17	£511	£50	£113	£61	£348	£27	£4,035
Regional Medium Secure Service	£2,806					£917			£2,670		£6,393
Rehabilitation or Continuing Care Team	£294	£2	£139	£41	£0	£131	£11	£1,016	£384	£9	£2,026
Residential Rehabilitation Unit	£20	£1,201	£2,627	£5	£819	£1,441	£1,431	£5	£98	£357	£8,004
Secure and High Dependency	£1,227				£104	£1,654					£2,985
Specialist mental health services		£38	£47			£121	£1,318	£53	£885	£822	£3,284
Staffed Group Home	£684		£6	£8		£282		£224			£1,205
Support Services			£170		£252		£63		£172	£81	£738
Supported Housing	£451	£1	£1,136	£537	£877	£690	£611	£510	£464	£0	£5,278
STaR workers					£126		£163	£14			£303
Befriending and Volunteering Schemes					£197		£38	£1			£236
Unstaffed Group Home									£6		£6
ASW Service	£160	£53		£20			£45	£12			£289
Sub Total	£16,132	£17, 631	£52,533	£10,967	£13,417	£19,316	£12,741	£14,271	£13,930	£15,867	£186,806