

April 2015

Healthy, working economies:

Improving the health and wellbeing of the working age population locally

The third white paper of the Health at Work Policy Unit

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About the Health at Work Policy Unit

The Health at Work Policy Unit (HWPU) provides evidence-based policy recommendations and commentary on contemporary issues around health, wellbeing and work. Based at The Work Foundation, it draws on The Work Foundation's substantial expertise in workforce health, its reputation in the health and wellbeing arena and its relationships with policy influencers. The HWPU aims to provide an independent, authoritative, evidence-based voice capable of articulating the views of all stakeholders.

The Work Foundation transforms people's experience of work and the labour market through high quality applied research that empowers individuals and influences public policies and organisational practices. For further details, please visit www.theworkfoundation.com.

Acronyms

ASCOF	Adult Social Care Outcomes Framework
BIS	Department for Business Innovation and Skills
CCG	Clinical Commissioning Group
CCG-OIS	Clinical Commissioning Group Outcomes Indicator Set
CQUIN	Commissioning for Quality and Innovation
DCLG	Department for Communities and Local Government
DH	Department of Health
DpH	Director of Public Health
DWP	Department for Work and Pensions
ESA	Employment Support Allowance
ESIF	European Structural Investment Funds
ESF	European Social Fund
GM	Greater Manchester
HWB	Health and Wellbeing Board
JSNA	Joint Strategic Needs Assessment
JHWS	Joint Health and Wellbeing Strategy
JSA	Jobseekers Allowance
LEP	Local Enterprise Partnership
LGA	Local Government Association
PHE	Public Health England
SFA	Skills Funding Agency
SME	Small and Medium-sized Enterprise
VCSE	Voluntary, Community or Social Enterprise

Executive summary

Introduction

The coalition government has overseen a number of measures to move responsibility for aspects of health and social care and for economic growth away from Whitehall, to localities across England. These measures have included the introduction of Health and Wellbeing Boards (HWBs), and Clinical Commissioning Groups (CCGs), moving public health functions into local authorities, and the creation of local enterprise partnerships (LEPs). These changes present considerable potential to influence improvements in the health of the working age population through greater joined up activity at a local level.

This paper seeks to identify to what extent these policy changes are influencing the health of the working age population – both the employed and the unemployed. We ask: are national policymakers encouraging and supporting local action strongly enough on this issue, and are local actors recognising the importance of these issues and driving action? It highlights some good practice examples where policy levers have been used effectively by local actors to achieve improved workforce health, and it also identifies what the main barriers are to this issue being more highly prioritised and dealt with in a joined up way locally. It makes a number of recommendations addressed to both national and local policymakers to suggest how policy could more effectively encourage joined-up action on workforce health locally.

This paper has been informed by a number of site visits to different areas across England, discussions with a range of representatives from those areas (including representatives of CCGs, HWBs, local authorities, LEPs and the wider business community) and a number of expert interviews.

The case for going local

At the national level it is well established that there is an economic and social imperative to improve the health of the working age population. Poor health and wellbeing in the working age population costs the UK over £100 billion each year.

The costs of ill health in the working age population are often discussed in the context of the costs to government, employers, and individuals, yet less prominent in this narrative is the significant burden which this places on local economies. Local economies experience costs through lost productivity, long-term sickness absence, unemployment and the increased costs of health and social care. In addition to these immediate costs, local economies face a longer-term structural challenge to build sustainable, healthy communities, through creating better quality jobs which are good for health and wellbeing, as well as building a healthy and skilled workforce to meet demand.

Alongside this, local areas are well placed to manage and support health and wellbeing in

the working age population. Local actors have a number of advantages:

- Knowledge of the local labour market.
- Knowledge of local health needs.
- The ability to work collaboratively at a local level.
- Links with local employers.

The policy landscape

Changes in policy over the last 5 years have led to the creation of local bodies (e.g. HWBs, CCGs, the movement of Public Health into the local authority and the creation of LEPs) which possess the potential to work towards improving the health and wellbeing of the working age population. The work of new local structures is influenced through national policy mechanisms, including national outcomes frameworks and Public Health England's (PHE) national priorities. Although some of these include a mention of health and employment outcomes, it is not a central feature. Issues such as welfare remain highly more centralised, although opinion around increasing local influence over more specialised services seems to be changing.

This chapter reviews recent policy changes and the potential policy levers they offer which could be used to encourage greater consideration of the health and wellbeing of the working age population at a local level and to encourage better local collaboration to achieve this.

Health and Social Care Integration

The Health and Social Care Act of 2012 introduced a number of general measures to improve the integration of health and social care at a local level and to devolve more control to local actors. This included the establishment of Health and Wellbeing Boards (HWBs), Clinical Commissioning Groups (CCGs) and the movement of Public Health functions into the local authority. Health and Social Care integration has been encouraged through a number of devolved local funds, including the Better Care Fund and Community Budgets, and through the introduction of personal budgets (known as Integrated Personal Commissioning) (see boxes 2.1, 2.3 and 2.4). More specifically, national outcomes frameworks for these local bodies include some employment measures to incentivise them to consider the health of the working age population in their work (see box 2.2).

Back to work and in-work support for individuals with health conditions

There have been fewer policy changes to encourage local areas to take responsibility for improving employment outcomes for individuals with health conditions with national programmes dominant. The Work Programme is the flagship back to work support program for the Department of Work and Pensions (DWP), and consequently is the main service used by unemployed people with health conditions. Work Choice is a national voluntary back to work program for people with recognised disabilities. Access to Work provides support to help people with disabilities and health conditions stay in work. The DWP has also been

involved in a number of local pilots (primarily the Fit for Work pilots), which provide more specialised support locally to help individuals with more complex needs to stay in work.

Economic Growth

A large part of this government's localism agenda has been about providing local areas with greater responsibilities for promoting economic growth – this has been particularly true for large cities outside of London. Central to this, the Department for Business Innovation and Skills (BIS) and the Department for Communities and Local Government (DCLG) have set up Local Enterprise Partnerships (LEPs) and the Cabinet Office has presided over a number of Growth and City Deals. Although there is no direct reference to health and wellbeing within their remit, their work on employment and skills might offer the potential to consider the health and wellbeing of the working age population in their work.

What is and isn't working?

Our conversations with local and national actors have highlighted a number of locally run best practice case studies which show the type of positive activity which is happening, driven by local areas to improve the health and wellbeing of the working age population, to support individuals with health conditions to find and stay in work and to create healthier workplaces and build good jobs. However these conversations also highlighted a significant number of barriers.

Improving the health of the working age population through health and social care integration

Health and social care integration has afforded new opportunities which embraced by some areas, to start to improve the health and wellbeing of their working age populations. However a significant number of barriers, most notably the lack of a clear remit given by central government for localities to consider this area and a failure to incentivise action through greater prominence of employment in national outcomes frameworks, are holding back local actors from taking the more comprehensive action which is needed.

Examples of good practice we found include:

- Prioritising employment through the health and wellbeing board – including consideration in the Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategies (JHWS), with relevant Key Performance Indicators (KPIs) to drive joint commissioning and accurately record progress.
- Integrating work on health and employment across different local authority structures (e.g. adding a health and wellbeing element to existing work on employment and skills).
- Gaining senior council and clinical leadership buy-in.
- Co-commissioning of health and employment services between the local authority and CCGs.

- Prioritisation of employment by local public health teams as they integrate their work across local authorities.
- Leading by example though improving employee health and wellbeing in the in the public sector.

Barriers include:

- No clear remit given by central government for local areas to consider health and employment.
- Employment not featuring strongly enough in outcome measures, measures are not joined up and data is of insufficient quality.
- Failure to collect appropriate data locally with which to make the business case for local action.
- Lack of resources.

Supporting individuals with health conditions to find and stay in work

Due to failings of the Work Programme, some local areas have been driven to develop local schemes to fill in the gaps, and provide support for individuals with more complex needs to stay in and return to work. These programmes are effective because they offer more bespoke, specialised support and access to a range of services for individuals with complex needs. More work in this area at a local level is held back by centralised commissioning of the Work Programme but also by the complexity of the commissioning process within different local organisations, preventing more joined up local commissioning to provide these services.

Examples of good practice we found include:

- Mapping out of current local provision of employment and health support services. Bringing services together and creating additional services to fill in any gaps in a way that is complimentary to existing service provision rather than duplicating it.
- Forging of strong links with local providers, including the voluntary, community and social enterprise sector.
- Joining up services around the individual - identifying early on which barriers are holding individuals back from entering employment and ensuring individuals get access to specialist support relevant to their specific needs.

Barriers include:

- Specialised back to work support is too centralised.

- Payment structure of the Work Programme favours large providers.
- Lack of direct financial incentives for the local authority to invest in health and employment.
- Differences in commissioning processes between different local actors.
- Complexity of funding streams does not encourage collaboration between local actors.

Creating healthier workplaces and developing more 'good' jobs

Some local areas are working to improve health and wellbeing within the workplace through the work of public health teams and through specific workplace health programmes which support employers to implement health and wellbeing strategies. However the work local authorities' can do in this area is significantly held back by a lack of funding by central government. LEPs are a natural vehicle through which to grow better quality, and therefore healthier jobs in the local economy and to promote more inclusive economic growth. At the moment, creating good quality jobs, is not defined within their core remit from central government and this prevents the creation of 'good work' from being a strategic priority.

Examples of good practice we found include:

- The local authority providing bespoke support to improve workplace health in SMEs.
- Encouraging large private sector employers to improve health and wellbeing within their workforce and supply chains.
- The LEP working in partnership with others to promote more inclusive economic growth.
- Use of the European Social Fund to promote employment amongst hard to reach groups.

Barriers include:

- Creating 'good jobs' not within the core remit given to LEPs by central government.
- Lack of resources.
- Failure of health and employment advocates to make an effective business case to LEPs locally.
- LEPs lack transparency and accountability.

Recommendations

Despite pockets of good practice where areas are prioritising improving the health and wellbeing of the working age population, due to the lack of a clear remit given by central government, there is a systematic failure to address this issue comprehensively at a local level.

In this final chapter we suggest how recent changes in policy and the policy levers which they afford could be used to significantly improve workforce health and wellbeing at a local level. We make a number of recommendations for policy changes, for both local and national policymakers, which would help to overcome barriers and encourage a more joined up local approach, to improve employment outcomes for the working age population.

Incentivising and enabling local action to improve the health and wellbeing of the working age population

- 1) National bodies should introduce a more standardised guideline of measurements and metrics to be included into the JSNA, including measures of health and employment outcomes locally.
- 2) Public Health England should make good work for all one of its big ambitions as set out in its business plan in order to send a clear message to regional and local public health teams.
- 3) Central government should pool existing funds into a budget for local areas to access, to tackle the wider social determinants of health (the Marmot principles).
- 4) Employment data should be collected through the health system and be used to more accurately benchmark local authorities' progress around the health and wellbeing of the working age population.
- 5) Public Sector procurement processes should be used to encourage local employers to take action on employee health and wellbeing.

Giving local areas the tools to improve the health and wellbeing of the working age population

- 6) DWP should devolve greater responsibility to local areas for the re-commissioning of the Work Programme.
- 7) Directors of public health should use health and employment data gathered through both the health system and DWP locally to build the business case for local action and to benchmark progress.
- 8) The LGA should gather and share best practice case studies where local authorities' have been effective in addressing the wider determinants of health, leading to the development of a best practice network.
- 9) Individuals with long term health conditions should be enabled to work towards

employment outcomes through personalised care planning and personal budgets with improved signposting and guidance locally to inform decisions and join up services around individuals.

Encouraging more collaborative working at a local level

- 10) National outcomes frameworks should be better aligned around health and employment.
- 11) Joint commissioning guidance should be developed around health, wellbeing and work to improve the ability for local bodies to commission services together, to work towards achieving shared outcomes.
- 12) A representative of the business community should sit on the Health and Wellbeing Board in order to bring an employer perspective to their work and to better link the worlds of health and of economic growth.
- 13) LEPs and HWBs should collaborate in order to advise how European Social Inclusion money is spent.
- 14) Local areas should consider using opportunities presented through the Public Sector Transformation Network to better join up work around health and employment.

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Chapter 1 Introduction

Throughout this government there has been a growing consensus that many issues, including local economic growth and health and social care, can be dealt more effectively through a greater influence at a local level. There is a natural limit to the influence of national institutions and initiatives over the lives of people in local communities and without local bodies to tailor services to local needs and to direct resources to where they are most needed, national policy is nothing more than a blunt instrument. The coalition agreement was testimony to this in its promise to “*oversee a radical redistribution of power away from Westminster and Whitehall to councils, communities and homes across the nation*” with the health service as its prime target, “*together, our ideas will bring an emphatic end to the bureaucracy, top-down control and centralisation that has so diminished our NHS*” (Cabinet Office, 2010: 7).

This has been put into practice through measures ranging from: the Health and Social Care Act of 2012; the restructuring of Public Health and the creation of Local Enterprise Partnerships (LEPs). It has perhaps been most dramatically demonstrated through the Greater Manchester devolution deal and the announcement this February to devolve the entire health and social care budget worth £6 billion to the local authorities (GMCA, 2015). The vision of these policies was that the devolved bodies created (such as Health and Wellbeing Boards (HWBs), Clinical Commissioning Groups (CCGs) and LEPs), would be able to deal more effectively with the many issues affecting their local area. It also means that through them, national policies to improve the health of the working age population also have the potential to have a much greater local focus.

In this third paper of the Health at Work Policy Unit, we look at how well the ‘localism’ agenda has promoted joined-up and locally tailored interventions to improve the health of the working age population. Based on a series of site visits and interviews with both local and national policymakers, practitioners and experts, it highlights a number of best practice cases and considers what more needs to be done to deliver sustainable improvements to the health of the working age population locally.

In the next chapter we set out the case for why addressing the health of the working age population is so important for local economies and what the benefits of taking a more localised approach are. In Chapter 3 we outline recent changes in policy and the policy levers these have created which could be used to encourage local areas to give higher priority to improving the health of the working age population, and to better coordinate work in this area. This leads us to Chapter 4 where we consider how well these policy levers are currently being used to improve the health of the working age population, to get more people back to work and to create more jobs which are good for our health. A number of best practice examples are included to illustrate how this is working locally, as well as a

discussion of the barriers preventing further action. Finally, in Chapter 5 a number of recommendations are made regarding how local and national policymakers might overcome these barriers, and encourage more joined-up local action to improve the health and wellbeing of the working age population.

Chapter 2 The case for going local

In this chapter we consider why the health and wellbeing of the working age population is an important issue for local economies in England¹ and the benefits for a number of stakeholders in taking a local approach to improving it.

Linking health and economic growth

The last decade has seen a growing agreement in clinical, academic, business and policy arenas of the economic and social imperative to improve the health and wellbeing of the working age population. Considerable progress has been made in deepening our understanding that work is an important social determinant of health (Marmot, 2012), that ‘good work’ is good for our health (Parker & Bevan, 2011), and that sickness absence, presenteeism and unemployment can have negative consequences for the employee, the employer and for wider society (Black & Frost, 2011). As Black & Frost write, *“for most people of working age, work – the right work – is good for their health and well-being and, for most people worklessness is harmful”* (Black& Frost, 2011:5).

Poor health and wellbeing in the working age population costs the UK over £100 billion each year. Sickness absence alone is estimated to cost over £10 billion – with an estimated 140 million working days lost every year to sickness absence (Black & Frost, 2011). Lost production (related to sickness absence), reduced performance when attending work while ill (presenteeism) and falling out the labour market, are the largest costs to the UK economy, with the estimated cost at £63 billion every year.

Stress and mental health problems are one of the most (if not the most) common reason for long term sickness absence, as well as short term absence (ONS, 2014). Musculoskeletal conditions, and back pain in particular, are also a considerable burden (Pfizer, 2010).

The ageing population may increase these costs further. In the UK by 2024 nearly 50 per cent of the adult population will be 50 and over (Taylor, 2007). As our workforce ages, retires later and are at risk of more frequent development of chronic and work-limiting health conditions, the pressure to invest more energy and resources in measures to prevent and manage the health, wellbeing, work ability and productivity of the working age population will become more intense.

Costs to the local economy

The costs of ill health in the working age population are often discussed in the context of the costs to government, employers, and individuals. Less prominent in this narrative however

¹ For the purposes of this study we have chosen to focus on England alone as many of the policies discussed (e.g. health and social care integration) have not been applied in the same way in Scotland, Wales or Northern Ireland.

is the significant burden which this places on local economies through the increased costs of health and social care, lost productivity and the increases in long-term sickness absence.

In England the costs of individuals with a health condition falling out of work and remaining unemployed for long periods of time are significant. Individuals with health conditions are also at risk of falling into a mutually re-enforcing cycle of poor health and wellbeing and poverty – poor physical and mental health limits their capacity to work productively and to access higher paid jobs, and this makes them more likely to experience in-work poverty and less able to access services which might improve their health and wellbeing (Core Cities, 2012).

The implications of poor health and wellbeing among the local working age population will be felt differently in different parts of the country. In Greater Manchester (GM) for example, this has led to persistent levels of long-term unemployment over the past 30 years. More than 230,000 people (13.5% of working age population) are currently out of work across GM; with 59% of these claiming some kind of health or disability related benefit, such as Employment and Support Allowance (ESA) (New Economy, 2014). National back to work support, such as that provided through the Work Programme, is not working effectively enough to help those with more complex needs back to work (see Chapter 3 for more detail). A recent report by Inclusion found that the average job outcome performance for someone on Job Seekers Allowance (JSA) going through the Work Programme is 26%, yet for someone claiming ESA it is only 7% (CESI, 2015). The implications for the local economy are considerable - for every ESA claimant moving back into work, the local economy could gain a boost of £13,100, whilst national government would gain £6,900 (CESI, 2015).

Ill-health among those in work also presents a major cost to local economies through lost productivity, presenteeism and sickness absence. Employees in good health can be up to three times more productive than those in poor health, can experience fewer motivational problems, are more resilient to change and are more likely to be engaged with the business's priorities (Vaughan-Jones & Barham, 2010). Sickness absence rates across England vary from 4.6% in Bexley, to just 0.8% in Derby (PHE, 2015). Costs of sickness absence are well documented in the public sector. For example, in 2011, Bristol City Council estimated the cost of staff sickness absence at £8 million a year, with a survey finding that one in three staff had underlying health conditions and one in three described their stress levels as poor or very poor (Core Cities, 2012). High levels of stress within public sector workplace are unlikely to change with a continued squeeze on their budgets. Similarly in the NHS, sickness absence rates are high with an average of 4.06 % in 2013-14 (falling from 4.40 % in 2009-10) (HSCIC, 2014). This ranges from 4.87% in the North West region, to 3.43% in the North Central and East London region (HSIC, 2014).

Employee health and wellbeing is increasingly being recognised by employers, in particular by large employers in the private sector, as something they need to address. Whilst many of these larger employers are implementing health and wellbeing programmes, small and micro businesses, which are often fundamental to driving local growth, are less likely to do so. For example whilst Occupational Health Services are offered by almost two thirds of employers

with 250 or more employees, this compares to only one in five small employers (1-50 employees) (Wood, Silvester & Steadman, forthcoming). SME's make up 99.3 per cent of all private sector businesses in the UK, 47.8 per cent of private sector employment and 33.2 per cent of private sector turnover, therefore lost productivity and sickness absence amongst SMEs is particularly threatening to sustained local growth (FSB, 2014).

Creating good work

Good work is seen as contributing positively to good health and wellbeing (Waddell and Burton, 2009), while poor quality jobs may be worse for mental health than unemployment (Butterworth, 2011). Local economies also face a longer-term structural challenge to build sustainable, healthy communities, through creating better quality jobs which are good for health and wellbeing, as well as building a healthy and skilled workforce to meet demand.

Creating jobs that are good for our health and wellbeing increases organisational engagement and productivity, whilst reducing the likelihood of sickness absence and the risk of individuals falling out of the labour market (Parker & Bevan, 2011). Box 2.1 shows a number of factors which generally feature in definitions of work that is good for health and wellbeing.

It has been argued that sectors and professions at the top of the social gradient are more likely to feature these 'good work' elements (IHE, forthcoming). In general, those in higher-skilled positions are likely to have better health outcomes than those in lower-skilled positions (although the single most important determinant of wellbeing remains the employees position within the company). We now increasingly know what constitutes 'good' and 'poor' quality work. A challenge for local actors is to develop local job creation strategies (e.g. by local authorities and local enterprise partnerships) which create jobs where workers are valued, receive a living wage, have opportunities for promotion, and are protected from unstable or anti-social work conditions where possible (IHE, forthcoming).

However it is not only about job creation, it is also about having the right skills locally to be able to fill jobs. On the supply side, skills shortages in England present a real threat to the continuing productivity and growth of local businesses. Trends over the last decade have seen a substantial growth in high-skilled jobs, with a move towards a knowledge and service based industry, and a reduction in mid-skilled jobs (UKCES, 2014). It is suggested that currently in England, people are not suitably qualified at a population level – NIESR estimates that the skills gap for England is the equivalent of increasing everyone from an average of five GCSEs to an average of three 'A' levels (or their equivalents) by 2022 (CESI,

Box 2.1: What is good work?

- Secure employment
- Varied and interesting work
- Autonomy, control, ownership and task discretion
- A fair workplace
- Effort-reward balance
- Learning, development and skill use
- Employee voice
- Strong working relationships

Source: see Parker & Bevan (2011)

2015). The challenges therefore are not only around encouraging the creation of jobs that are better for people's health and wellbeing, but also about upskilling employees, particularly those with long term health conditions, to ensure that they have the capacity to participate in the current labour market.

The benefits of a local approach

Taking a more local approach to tackling ill health in the working age population would allow for the development of more bespoke and efficient systems. At present the government is spending over £13 billion a year on 28 different national employment and skills schemes, creating a fragmented system designed within a national bureaucracy. Local government is often left to fill the gaps where these national schemes fail (Rolfe et al., 2015).

We suggest that greater involvement of local actors will bring a number of benefits to the management of the health and wellbeing of the working age population, including a greater awareness of the local labour market and local health needs, greater potential for collaborative working between local government bodies and other local agencies and improved links with local employers.

Awareness of the local labour market

Local authorities, providers, and the local business community are best placed to understand the local labour market. Many local labour markets across England have changed significantly in recent years, with differing affects on different areas. While the reduction in manufacturing has disadvantaged industrial areas, a growth of the business and finance sectors has favoured London and the South East. This is reflected in local unemployment rates, with 7.7% of the population unemployed in the North East compared to 4.5% in the South West and South East (ONS, 2015b). Skills gaps also differ, in Essex on average 75% of the population will need to 'catch up' by one qualification by 2022 to meet employer needs, whilst in Surrey only 37% of the population will need to gain one more qualification (CESI, 2015). Such local intelligence can be used to develop back to work programmes which better reflect the local context. Local initiatives such as 'Get Bradford Working' develop bespoke support for some of the hardest to reach residents, including individuals with disabilities and mental ill-health. This initiative has achieved a sustainable job outcome rate of 62% (Rolfe et al., 2015).

Local programmes might also be developed to reflect differences in sectoral make-up, which might affect the types of in-work health risks likely. For example in Cornwall the majority of employment is in the public sector, a high-risk sector for stress (Cornwall Council, 2013). There is also a high rate of employment in the hospitality sector where individuals are more likely to be on part-time and temporary contracts affecting job security. Approaches such as that seen in Cornwall through the 'Healthy Working Cornwall Award' are beginning to use local knowledge in order to prioritise and to target employers (The Cornwall & Isles of Scilly Healthy Workplace Award, 2015).

Awareness of local health needs

The use of local health data and improved understanding of local health needs offers the potential to tailor local in and out of work health support to deliver improved results. The Marmot Review in 2010 identified a large variance in health inequalities across the UK caused by differences in the wider social determinants of health (Marmot et al., 2010). The

Box 2.2: The Marmot Review – 6 objectives for reducing health inequalities:

- 1) Give every child the best start in life
- 2) Enable all children, young people and adults to maximise their capabilities and have control over their lives
- 3) Create fair employment and good work for all
- 4) Ensure healthy standard of living for all
- 5) Create and develop healthy and sustainable places and communities
- 6) Strengthen the role and impact of ill-health prevention

Source: see Marmot et al., 2010

review highlighted six policy objectives, essential for reducing health inequalities (see Box 2.2). These were seen as drivers for local action.

The Marmot Review set the scene for a shift in the use of health data, so that the work of local authorities is now better aligned to local health needs. Data from Public Health England allows local authorities to identify health priorities and this informs their Joint Health and Wellbeing Strategies (JHWS). For example, the gap in the employment rate for individuals with a long-term health condition ranges from 24.2% in Knowsley, to -2.5% in Kingston upon Thames (PHE, 2015). The awareness of difference in local outcomes has led to increased attention to the variations in the social determinants of health.

Local areas are the best placed to identify local problems, and to develop local solutions, which fit their context.

Potential for better partnership working

Improving the health and wellbeing of the working age population does not fit neatly under the responsibility of any one government department. The benefits of improving workforce health accrue across a number of stakeholders including central and local government, the NHS, the welfare system, as well as employers and GDP – therefore no one party has an overriding incentive to invest (Bajorek et al., 2014). Yet all parties bear a cost – individuals with complex needs are likely to access a wide range of different services throughout their lives. A lack of coordination across bodies that might benefit from improved workforce health means that health and employment risks are being addressed by all and none at the same time.

A local approach offers the potential to better coordinate the planning and delivery of different services across stakeholders, removing duplication in the system and improving outcomes for all. Local authorities already have a strong record of partnership working with the voluntary, community and social enterprise sector (VCSE), while new structures created under the Health and Social Care Act allow greater collaboration between local authorities and the health system locally. The benefits of strong local integration are exemplified by the

Greater Manchester Working Well project (see case study 4, p. 21). Co-commissioned by the local authority and DWP, this project takes a holistic approach to employment support, with partners working together so that individuals can access a wide range of local services, getting access to the right support at the right time. This shows the potential for local action to improve the health and wellbeing of the working age population to be far more integrated.

Links with local employers

The fate of the local labour market and of the working age population does not just rest with local and national government providers, and with employees, but also with local employers. Local business leaders need to be engaged in this agenda in order to start changing the organisational cultures of local businesses and to improve the health and wellbeing of the workforce. In order to better match the supply and demand of skills and reduce long term unemployment, employers also have a critical role to play in job creation and training. Local authorities and local agencies such as Local Enterprise Partnerships (LEPs) and business representative organisations (e.g. Chambers of Commerce or other regional groups) will have a strong network of contacts with local businesses. There are opportunities to improve the use of these local links to engage and support employers in this agenda.

In Liverpool local business networks have been used to engage employers with the 'Workplace Wellbeing Charter' and this is beginning to alter their organisational cultures. The chair of the Chambers of Commerce has promoted the benefits of workplace health and wellbeing in the workforce. This approach helped to sign up 182 local businesses, ranging from large (250+ employees) to micro (less than 10 employees) in the first two years. A survey of employers in Liverpool found high levels of awareness of the intervention (Liverpool Primary Care Trust & Health@Work, 2013).

Summary

In this chapter we have made the case for local economies to have more influence over initiatives to improve the health and wellbeing of the working population in their areas and we have identified a number of benefits of taking a more localised approach. It is argued that localities are well placed to manage and support health and wellbeing in the working age population, given their knowledge of the local labour market and health challenges, the ability of local agencies to work better together and their links with local employers.

In the next chapter we identify a number of policy levers which could be used to encourage local areas to give higher priority to improving the health of the working age population, and to better coordinate work in this area.

Chapter 3 The policy landscape

This chapter reviews recent policy changes and the potential policy levers they offer which could be used to encourage greater consideration of the health and wellbeing of the working age population at a local level and to encourage better collaboration to achieve this. We describe the policy landscape in three sections: the first looks at policy changes relating to health and social care integration which might be used to improve the health of the working age population, the second looks at policies which are currently helping individuals with health conditions to find and stay in work and the third considers how policy is encouraging the creation of healthier workplaces and developing more jobs that are good for us.

Health and Social Care Integration

The Health and Social Care Act of 2012 introduced a number of general measures to improve the integration of health and social care at a local level and to devolve more control to local actors. This included the establishment of Health and Wellbeing Boards (HWBs), Clinical Commissioning Groups (CCGs) and the movement of Public Health functions into the local authority. Health and Social Care integration has been encouraged through a number of devolved local funds, including the Better Care Fund and Community Budgets, and through the introduction of personal budgets (known as Integrated Personal Commissioning) (see Boxes 3.1, 3.3 and 3.4). More specifically, national outcomes frameworks for these local bodies include some employment measures to incentivise them to consider the health of the working age population in their work (see Box 3.2).

Box 3.1: The Better Care Fund

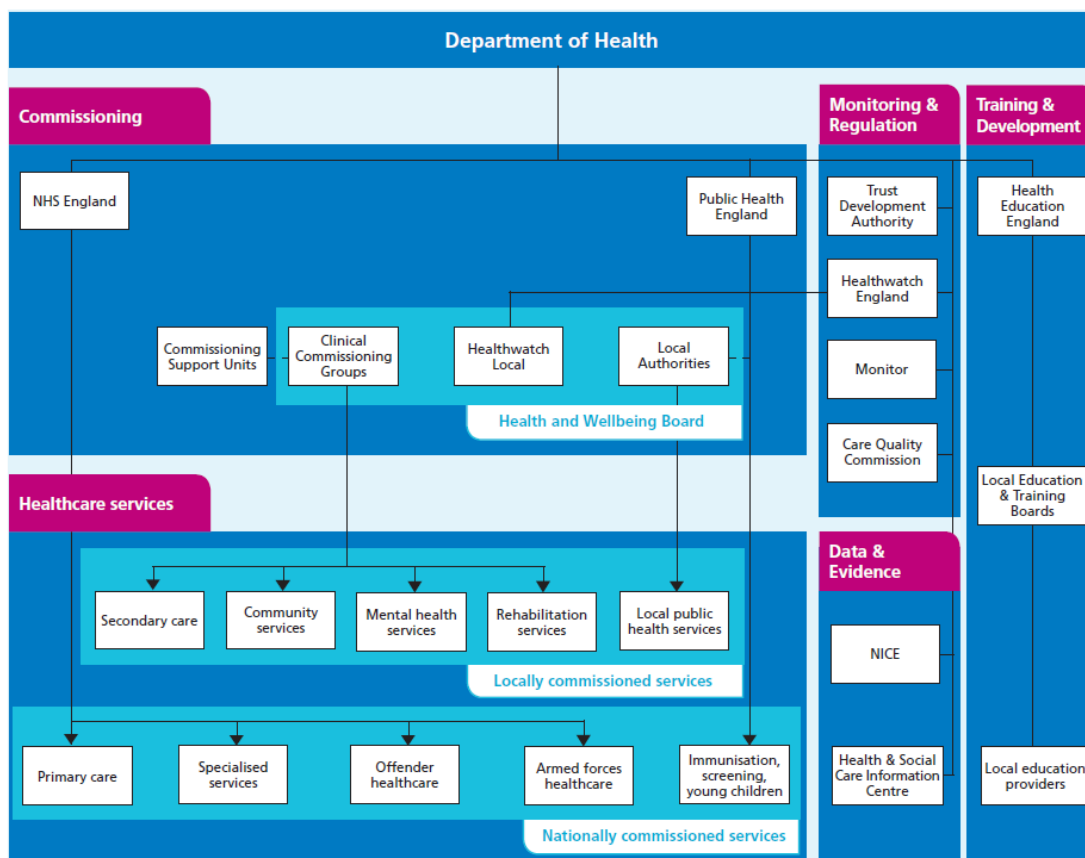
In June 2013 the government announced the creation of a new £3.8 billion 'Integration Transformation Fund', now known as the Better Care Fund, to support transformation and integration of health and social care services to improve the care received by local people.

The fund does not contain any new money, but pools £1.9 billion from CCGs, along with funds which had already been transferred from the NHS to social care. The Fund must be spent on supporting adult care services that have a health benefit. The intention was to shift activity away from the hospital and into the community, and will involve most CCGs having to redeploy funds from existing NHS services.

HWBs have set strategic spending plans for this, working in collaboration with CCGs, the local authority and local providers. Measures of success include 'admissions to residential care homes', 'effectiveness of re-ablement', and 'avoidable emergency admissions'. It will be the first budget over which the HWB has collective responsibility.

Source: see The King's Fund (2014)

Figure 1: The NHS structure explained



Source: <http://www.nhs.uk/NHSEngland/thenhs/about/Pages/nhsstructure.aspx>

Health and Wellbeing Boards

Health and Wellbeing Boards (HWB) were created to act as a forum for key local leaders from health and social care to work together to improve the health and wellbeing of their populations and reduce health inequalities. Every top-tier and unitary authority were required to develop a HWB. They were intended to improve democratic legitimacy, strengthen working relationships between health and social care and encourage the development of more integrated commissioning of services (DH, 2012a).

HWBs have a number of duties, including:

- Developing a shared understanding of the health and wellbeing needs of the community and undertaking a Joint Strategic Needs Assessment (JSNA);
- Using this information to develop a Joint Health and Wellbeing Strategy (JHWS) for how needs can best be met;
- Driving local commissioning of health care, social care and public health to create a more effective and responsive local health and care system.

Statutory Membership of the HWB includes:

- One local elected representative.
- A representative of the local Healthwatch organisation.
- A representative of each local CCG.
- The local authority director of adult social services.
- The local authority director of children's services.
- The director of public health for the local authority.

It is interesting to note when considering the health of the working age population, that there is no statutory requirement for business representation on this list – an issue discussed in the next chapter.

HWBs are expected to identify a small number of key strategic priorities that will make the most impact in their locality rather than taking action on a broader range of nationally defined issues (DH, 2012a). There is no minimum data set which HWBs must collect in their JSNAs or a minimum set of issues which must be considered in their JHWS (DH, 2012b). Rather, their work is supported by Department of Health Statutory Guidance about JSNAs and JHWS and by the Local Government Association's Health and Wellbeing System Improvement Programme (this includes leadership development, bespoke support and a peer challenge programme). Given that there are very little statutory requirements for the work of HWBs, if issues are identified to be of national significance, at present there is little central government can do to influence them through these local vehicles. We will discuss what this might mean for workforce health in the next chapter.

HWBs are held to account through the membership of the local Healthwatch organisation and through the health scrutiny role of the local authority (Centre for Public Scrutiny & Local Government Association, 2012). Members of the HWB also report against a number of national outcomes frameworks to demonstrate the success of their work; these are the NHS, Adult Social Care, Public Health Outcomes Frameworks and the CCG Outcomes Indicator Set. These frameworks currently contain some measures around employment and access to secondary mental health services (see Box 3.2), however they do not cover more comprehensive measures of how health and wellbeing is having an impact on employment, such as individuals with long term conditions who are in employment (see p. 33 for a discussion of the implications of this). The HWB develop their own dashboard of indicators, based on the outcome frameworks to measure success against their strategic priorities.

Box 3.2: Summary of current employment related measures in national health and social frameworks

NHS Outcomes Framework 2013/14

- Improving functional ability in people with long-term conditions: 2.2 Employment of people with long-term conditions (ASCOF 1E PHOF 1.8).
- Enhancing quality of life for people with mental illness: 2.5 Employment of people with mental illness (ASCOF 1F & PHOF 1.8).

Adult Social Care Outcomes Framework (1E)

People are able to find employment when they want, maintain a family and social life, and contribute to community life, and avoid loneliness or isolation.

- 1E Proportion of adults with a learning disability in paid employment (PHOF 1.8, NHSOF 2.2).
- 1F Proportion of adults in contact with secondary mental health services in paid employment (PHOF 1.8, NHSOF 2.5).

Public Health Outcomes Framework (1.8)

- 1.08i - Gap in the employment rate between those with a long-term health condition and the overall employment rate.
- 1.08ii - Gap in the employment rate between those with a learning disability and the overall employment rate.
- 1.08iii - Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate.
- 1.09i - Sickness absence – The percentage of employees who had at least one day off in the previous week.
- 1.09ii - Sickness absence – The percent of working days lost due to sickness absence.

Clinical Commissioning Group Outcomes Indicator Set

- Proportion of adults in contact with secondary mental health services in paid employment.

Box 3.3: Personal care plans and Personal Budgets

Personalised care plans are not a new thing, but have received renewed interest due the role they will play in the move towards greater patient involvement in decisions about care, greater empowerment and independence. They sit alongside the introduction of personal health and social care budgets (or Integrated Personal Commissioning).

Personal care planning currently exists for individuals with long term conditions. With the help of a professional, normally a community matron or specialist nurse, they agree a personal plan which the individual has control over and can share with other professionals they may be referred to, to share information and ensure care is coordinated around the same goals. Care planning discussions normally include:

- The individual's goals.
- Information about their condition and it's management.
- Supporting individuals to self-care.
- Agreeing on any treatments, services or medications.
- Agreeing any actions and a review date.

Alongside this process, *personal budgets* have been introduced under plans set out by Simon Stevens (CEO of the NHS) in 2014. Under these the NHS is offering local authorities across England the option for individuals to control their own combined health and social care support. Integrated Personal Commissioning (IPC) as it is called, will blend comprehensive health and social care funding for individuals, and allow them to direct how it is used.

Four groups of high-need individuals will be included in the first wave from April 2015:

- people with long term conditions, including frail elderly people at risk of care home admission;
- children with complex needs;
- people with learning disabilities; and,
- people with severe and enduring mental health problems.

Voluntary/Third Sector organisations will be commissioned locally to support personal care planning, advocacy and service 'brokerage' for individuals enrolled in the IPC programme.

Source: Department of Health (2011)

Box 3.4: Community Budgets and the Public Sector Transformation Network (PSTN)

Community budgets operate on two different levels:

Whole Place Community Budgets test how to bring together all funding for local public services in an area to design better services and achieve better outcomes, rather than funding a specific set of programmes or projects. They are intended for local areas to:

- understand spending patterns and identify fragmented, high cost, reactive and acute services.
- focus on outcomes and select interventions that best deliver those outcomes, rather than being limited by existing organisational responsibilities.
- develop services that are user-focused.
- shift the balance of resources in favour of prevention, early intervention and early remedial treatments.
- identify investment from partners in new delivery models including considering whether pooling or aligning resources could help maximise provision and minimise duplication.

Whole place community budgets were piloted in 2011-12 in four areas, Essex, Greater Manchester, the West London Tri-borough (Hammersmith & Fulham, Kensington and Chelsea and Westminster) and West Cheshire.

They designed new delivery models that eliminated duplication; used public assets, back office and staff resources more efficiently; aligned outcomes, targets and systems and shared information about customers; fixed the problem whereby one partner has no incentive to invest in something that could save another partner money (through investment agreements and sharing savings) are based on robust financial evidence and business cases.

In March 2013 the government announced the establishment of the **Public Services Transformation Network (PSTN)** to support new areas in taking a community budget approach.

Our Place Neighbourhood Community Budgets give communities the opportunity to take control of managing local issues in their area. They compliment the work of whole place community budgets. They give people more power over their local services and budgets in a neighbourhood and align these with all the other resources that the local community can bring. Resources can be brought together from a range of service providers at the whole place level and then, where appropriate, be devolved to neighbourhoods to decide how best to deploy them to meet the specific needs of their communities.

In 2013 DCLG announced £4.3m of new financial support over 18 months to enable at least 100 communities to design and deliver local services that focus on local priorities, and reduce costs. It is hoped at least 20 of the 100 new areas will come up with very ambitious proposals focusing on large or complex services, such as adult social care or exploring complex delivery models, such as payment by results or the use of social finance.

Source: HM Government & Local Government Association (2013); Local Government Association (2015a)

Clinical Commissioning Groups

The Health and Social Care Act included the abolition of Primary Care Trusts and the establishment of **Clinical Commissioning Groups (CCGs)** to commission community and hospital services locally, deciding what is needed and monitoring the performance of these services. The intention was to give local clinicians greater influence over what services are commissioned for their patients. **NHS England** (or the NHS Commissioning Board) was established to oversee this and to avoid conflicts of interest through retaining the commissioning of primary care services.

CCG boards include GPs, one nurse, one secondary care physician and two lay members, one of which must act as the chair or deputy chair. There are currently 212 CCGs – all GP practices in England are required to belong to a CCG. CCGs are free to design their own structure, membership and priorities, and are run by their own governing body (The King's Fund & Nuffield Trust, 2013).

Every year CCGs are expected to consult with patients, carers, local communities and interest groups to develop a commissioning plan. CCGs are also expected to consult with the HWB, JSNA and JHWS in this process. HWBs can exert influence on CCG decisions through referring plans back to the CCG or to NHS England where they do not align with the JHWS, although it cannot veto them.

The performance of CCGs is monitored by NHS England through the CCG Outcome Indicator Set, intended to help the CCG identify priorities and benchmark performance (see Box 3.2). At the moment, the only measure this includes which relates to employment is the number of individuals in contact with secondary mental health services who are in employment, and does not provide any comprehensive incentive for CCGs to consider the health of the working age population in their work setting (see p. 36 for more detail).

Public Health

Since 2012 Public Health functions have been taken out of the NHS and local authorities have taken on new public health responsibilities. **Directors of Public Health (DpHs) have been established in every local authority** who lead specialist public health teams – these teams were allocated ring-fenced grants in 2012. The intention was for local authorities to embed public health functions across all their activities, taking a joined up approach to reducing health inequalities (DH, 2012c). A new non-departmental government body, **Public Health England (PHE)**, was established to advise and support local authority roles. DpHs

Box 3.5: Commissioning responsibilities

Which services do CCGs commission?

- most planned hospital care
- rehabilitative care
- urgent and emergency care (including out-of-hours)
- most community health services
- mental health and learning disability services

Which services does NHS England commission?

- GP services
- dental services
- specialised hospital services

are to some extent encouraged to consider the health of the working age population in their work through the inclusion of some employment related outcomes in the Public Health Outcomes Framework (see Box 3.2). However currently improving health and wellbeing is not one of PHE's 6 core ambitions at a national level and this limits the incentive for local public health teams to prioritise this area (for a more detailed discussion see p. 37).

Public Health within local authorities has a statutory duty to deliver:

- steps to protect the health of the local population.
- ensuring NHS commissioners receive the public health advice they need (including helping to develop the JSNA and JHWS).
- appropriate access to sexual health services.
- the National Child Measurement Programme.
- NHS Health Check assessment.

The public health team will produce a report annually setting out their priorities. Through their membership of the HWB the DpH provides a key link with their work.

PHE and its 15 regional centres support local authorities with knowledge and expertise to help them deliver on their health improvement responsibilities. They work nationally to protect and improve the public's health and wellbeing and to reduce inequalities. Their work is shaped by six 'Big Ambitions' which are - tobacco, obesity, alcohol, tuberculosis, dementia and every child having the best start in life (PHE, 2014). Improving the health of the working age population is addressed through rolling out the national standard for the Workplace Wellbeing Charter (see Box 3.5 below) and working to engage employers of all sizes in all sectors to recognise the return on investment for supporting the health and wellbeing of staff.

Links to health and employment agenda

Though the integration of health and social care does not explicitly focus on the health and wellbeing of the working age population, there are doubtless considerable implications for it. As mentioned, this is most clearly articulated in the inclusion of several measures relating to health and employment in the health and social care outcomes frameworks (see Box 3.2). In chapter 4 we discuss in more detail how health and social care integration is and is not supporting improvements to the health and wellbeing of the working age population.

Box 3.6: The Workplace Wellbeing Charter

Championed by PHE as a national standard for workplace health, the Workplace Wellbeing Charter is a benchmarking process which businesses can work through in order to gain accreditation for their investment in workforce health.

It includes a self-assessment tool to discover what they are already doing to meet the charter and where there are gaps. It provides a clear set of wellbeing standards to be met, which takes a holistic approach incorporating both physical and mental health, health promotion and ways for businesses to evaluate the information and services available. There are three levels businesses can work towards – commitment, achievement and excellence.

Organisations are assigned an assessor who will also help guide them through the process – they must gather a portfolio of evidence to show what they have done/are doing towards the charter. Once awarded the charter is valid for 2 years before reassessment is necessary.

The Charter was originally developed by Health@Work in Liverpool and PHE is now helping to develop contracts across local authorities in England.

See: <http://www.wellbeingcharter.org.uk/index.php>

Back to work and in-work support for individuals with health conditions

There have been fewer policy changes to encourage local areas to take responsibility for improving employment outcomes for individuals with health conditions. The Work Programme is the flagship back to work support program for the Department of Work and Pensions (DWP), and consequently is the main service used by unemployed people with health conditions. Other national programs which support those with health conditions into work include Work Choice (a voluntary back to work program for people with recognised disabilities). Access to Work provides in-work support to people with disabilities and health conditions. The DWP has also been involved in various pilots (primarily the Fit for Work pilots, to provide more specialised support locally to help individuals with more complex needs to stay in work.

Work Choice and the Work Programme

The Work Programme is a national, mandatory welfare to work scheme which provides support, work experience and training for up to two years to help individuals to find and stay in work. Individuals may be eligible if they have claimed Jobseeker's Allowance (JSA) for over 3 months or have been claiming Employment and Support Allowance (ESA) and are in the Work-Related Activity Group (as opposed to the support group). Individuals are assigned a job coach who assesses their needs and help them search and apply for work (GOV.UK, 2015a).

The Work Programme is delivered by a range of public sector, private sector and third sector

organisations across England. It has been contracted out using a payment by results mechanism. Service providers must fund delivery upfront and will only be paid upon reaching sustainable job outcomes for participants. The longer a customer stays in work, the more delivery partners will be paid. Payments are also higher for helping participants who are further from the labour market into sustained work (DWP, 2012). Work programme providers (known as Primes) operate under 'black-box' provision, meaning that we do not know what methods they use to support users into work (i.e. whether they consider local factors and tailor support to this). Outcomes under the Work Programme are highly varied; for example the highest performing area (Essex) is 16% (or 3.6 percentage points) above the average whilst the lowest performing area (Southampton and Portsmouth) is 11% (or 2.5 percentage points) below the average (CESI, 2015).

The next round of the Work Programme is due to be re-commissioned in 2016. There has been growing consensus amongst local and some national policy makers that this may require greater local input than previously. This has led to a deal with Greater Manchester that they will be the first area to fully co-commission the work programme alongside DWP nationally. It remains to be seen whether this paves the way for more local co-commissioning in the future.

Work Choice is a much smaller national voluntary employment support scheme run by the Department for Work and Pensions to help individuals to stay in or return to employment. It includes six months support to find work, up to two years of in-work support and longer term help. It is also contracted out to a range of providers. There has been some criticism that this specialist service operates on a very small scale, is not widely known about and that Job Centre Plus too rarely makes referrals to such specialist services (DWP, 2014a).

Access to work

The national DWP Access to Work scheme is the primary source of government support for making adjustments to enable people with chronic health conditions and disabilities to remain in work. Access to Work provides grants to individuals already in, or about to commence work, to support workplace adjustments to be made, where they are seen as above and beyond those "reasonable" adjustments required by legislation. It also provides vocational rehabilitation support and guidance on what adjustments and support might be appropriate. This may include things like new specialist equipment or adaptation to equipment; flexible working arrangements; fares to travel to work if public transport can't be used; job coaches; or disability awareness training for colleagues. In 2011 the scheme was complemented by the development of a specific mental health Access to Work programme, 'the Workplace Mental Health Support Service'. This goes a step further and provides hands on vocational rehabilitation to support employees with mental health conditions.

Outcomes for Access to Work in terms of provision of support and job retention are positive, though there are many concerns about the programme, particularly in terms of access to the support for people experiencing a diverse range of health conditions (GOV.UK, 2015b).

The Fit for Work Pilots

Following Dame Carol Black's 2008 review of the health of Britain's working age population (Black, 2008), the Department of Health (DH) and the Department for Work and Pensions (DWP) commissioned 11 Fit for Work Service (FFWS) pilots throughout Great Britain. Designed and run locally, they were intended to test different approaches to supporting employees of small- and medium-sized enterprises who were in the early stages of sickness absence to get back to work as quickly as possible. They took a case-managed and multi-disciplinary approach to addressing both social and clinical needs (Hillage et al., 2012).

The pilots were launched between April to June 2010, and from April 2011 seven of the pilots were funded for another two years (Scotland, Greater Manchester, Kensington and Chelsea, Leicester and Leicestershire, North Staffordshire, Nottinghamshire and Rhyll). Funding finished in 2013 and five services managed to secure funding locally to continue the service.

These pilots offered effective local support to employers and employees to help improve the health and wellbeing of the workforce, offering access to a range of diagnostic tools for businesses and treatments for individuals (for example see case study 7, p. 48). However the intensity of the services offered meant this was not the most financially attractive option for this government. Instead this has been taken forward through a national advisory service, Fit for Work, providing an advice line which individuals can be referred into to develop return to work plans, as well as an advice line for employers (Fit for Work, 2015).

Local Economic Growth

A large part of this government's localism agenda has been about providing local areas with greater responsibilities for promoting economic growth locally – this has been particularly true for large cities outside of London. Central to this, the Department for Business Innovation and Skills (BIS) and the Department for Communities and Local Government (DCLG) have set up Local Enterprise Partnerships (LEPs) and the Cabinet Office has presided over a number of Growth and City Deals. Although there is no direct reference to health and wellbeing within their remit, their work on employment of skills might offer the potential to consider the health and wellbeing of the working age population in their work – this is discussed in more detail in Chapter 4.

Local Economic Partnerships

A local growth white paper in 2010 committed the government to the establishment of **Local Economic Partnerships (LEPs)** under the remit to provide a 'clear vision and strategic leadership to drive sustainable private sector-led growth' (HM Government, 2010:13). They replaced considerable regional government structures (i.e. Regional Development Agencies) with slimmed down, business led boards.

As non-statutory bodies, every LEP is free to design its own structure and membership. Generally, membership is split 50:50 between the public sector (including elected representatives from each local authorities within the LEP's geography and representatives from the further education sector) and local private sector employers. The average size is

around 15 members and a private sector employer must be chair. At the time of writing there are 39 LEPs across England (Centre for Local Economic Strategies and Federation of Small Businesses, 2014).

The core of the LEPs work involves bidding into national funds and allocating funding according to local needs. They set strategic priorities in the areas of employment, transport, housing and infrastructure. There is no guidance or outcome framework to encourage LEPs to work towards any particular areas, but their activities are based on their perceptions of local needs and interests around local enterprise and the business economy. As is the case with HWBs, the lack of any statutory guidance for LEPs means that national government can have little influence over local spending where there may be issues of national importance (see p. 47 for further information).

Funding for LEPs has included the Regional Growth Fund (£2.7 billion between 2011 and 2016), the Local Growth Fund (£1.1 billion between 2015 and 16) and the European Union Structural and Investment Funds (ESIF) (over £5 billion between 2014 and 2020). The ESIF funding included a strand for social inclusion (the European Social Fund) and the first round of this ran from 2007-2013 going to areas with significant levels of deprivation, such as Cornwall (see p.47 for more detail).The next round of ESF funding will run from 2014-2020 and is targeted at skills, employment, and social inclusion activities. It has been influenced by investment strategies developed by LEPs and local partners, and will be allocated predominantly through the DWP and the Skills Funding Agency (SFA) (DWP, 2014b).

Growth and City Deals

There has been a recent policy trend towards devolving power for local economic growth on a deal by deal basis – agreeing specific plans and devolving specific pots of money to certain areas, as opposed to a nation-wide blanket approach, devolving long-term spending powers.

Early examples of this were ***City Deals*** – where some local areas were successful in gaining devolved funding to promote economic growth locally. This occurred through an amendment to the 2011 Localism Act. City Deals are agreements between national government and a given city, providing defined powers to that city, i.e.:

- to take charge and responsibility of decisions that affect their area;
- to do what they think is best to help businesses grow;
- to create economic growth;
- to decide how public money should be spent.

The first wave of City Deals was announced in 2011 with the 8 largest cities outside of London, known as the Core Cities (Birmingham, Bristol, Leeds, Liverpool, Manchester, Newcastle, Nottingham and Sheffield). The second round was launched in 2012 and

involved 20 cities - the next 14 largest cities outside of London and their wider areas, and the 6 cities with the highest population growth during 2001 to 2010 (GOV.UK, 2015c).

Following on from this approach, in 2014 the government agreed to a series of **Growth Deals** with businesses and local authorities across England. Worth over £12 billion (including £2 billion allocated from the Local Growth Fund for 2015 to 2016), they devolved funds to provide support for local businesses to train young people to create new jobs, to build homes and infrastructure projects; including transport improvements and superfast broadband networks (GOV.UK, 2015c).

More recently, in 2015 the government agreed to expand Growth Deals with all 39 LEPs. The focus on employment and skills in much of this work offers the potential to integrate improving the health of the working age population within this work.

Summary

Changes in policy over the last 5 years have devolved greater control to local areas for issues such as health and social care and local economic growth. Measures include the creation of HWBs, CCGs, the movement of Public Health into the local authority and the creation of LEPs – and these local bodies possess the potential to work towards improving workplace health and wellbeing. The work of new local structures is influenced through national policy mechanisms, including national outcomes frameworks and PHE's national priorities. Although some of these national mechanisms include a mention of workplace health and wellbeing, it is not a central feature. Issues such as welfare still remain more centralised, although opinion around increasing local influence over more specialised services also seems to be changing.

In the next chapter we critically discuss how far these new policy mechanisms are really going towards improving the health and wellbeing of the working age population and consider in more detail what good practice around this looks like and what the barriers might be to local areas doing more in this area.

Chapter 4 What is and isn't working?

We have argued that there is an economic and social imperative for local areas to improve the health and wellbeing of the working age population and we have looked at current policy levers through which this could occur. In this chapter we consider to what extent local areas have embraced these arguments and are using policy levers to their full extent to give this issue the priority it requires and to join up efforts. We consider what is currently happening, including some 'good practice' examples, as well as raising some of the barriers to this happening more widely.

This is discussed in terms of three areas, identified as priorities in terms of the health and wellbeing of the working age population locally:

- Improving the health of the working age population through health and social care integration.
- Supporting individuals with health conditions to find and stay in work.
- Creating healthier workplaces and developing more jobs that are good for us.

This section has been informed by a number of site visits to different local areas across England, discussions with a range of representatives from those areas (including representatives of CCGs, HWBs, local authorities, LEPs and the wider business community) and a number of expert interviews.

Improving the health of the working age population through health and social care integration

What is currently happening?

Policy changes to better connect health, social care and public health at a local level have enabled some localities to take action to improve health and wellbeing outcomes in the working age population. Where they exist, interventions focus on increasing and improving support to keep individuals with health conditions in work, promoting better psychosocial conditions at work and using the workplace as a place to promote public health.

However, the nationally prescribed remits of these organisations and the outcomes frameworks which they work to contain no clear focus on improving the health and wellbeing of the working age population which means that across England local areas are systematically failing to give this issue the priority it deserves. Many areas have been further restricted by not having local data which is of a good enough quality to carry out an effective assessment of need and to build a business case locally. They are also restricted by a significant lack of resources to fund work in this area.

Health and Wellbeing Boards are a natural vehicle through which the health of the working age population and the Marmot policy objectives (see p. 18) could be promoted (these include the objective “Create fair employment and good work for all”). The statutory guidance for Joint Strategic Needs Assessments (JSNA) and Joint Health and Wellbeing Strategies (JHWS) suggest that there is a consideration of the wider social determinants of health and wellbeing in their assessments of local needs. This includes a reference to employment as a wider issue affecting health (DH, 2012b). However as this is only a suggestion and not a requirement, we argue that there is not a clear enough signal being given by central government that HWBs should assess employment in their JSNAs or consider setting it as a strategic priority.

A number of HWBs have been influenced by the Marmot policy objectives and do consider the wider determinants of health in both their JSNAs and following on from this, their JHWS. According to the King’s Fund, 49 out of the 65 councils they surveyed in 2013 included the six Marmot principles in their JHWS (Humphries & Galea, 2013). However a 2014 review of prominent themes in JHWS found that fewer than a third of them (39 of over 130 councils they reviewed) featured the wider determinants of health as a strategic priority (LGA, 2014a). Consequently, these JHWS contain no key performance indicators (KPIs) focussing on the health of the working age population in their communities. This in turn means no prioritisation in commissioning decisions by the CCGs, NHS England and the local authority and no resources.

Similarly, HWBs are held back from prioritising the health and wellbeing of the working age population at a local level due to a lack of incentive through the various national outcomes frameworks which their members report on (see p. 23 for details). These frameworks are not aligned around, and do not contain specific enough measures of, the health and wellbeing of the working age population. Again this shows the lack of a central agenda around workforce health and wellbeing to drive local action.

Despite this, there are some good examples where the HWBs and the JHWS have been used to prioritise employment as a health issue across the local authority. This involves setting a number of relevant KPIs in the JHWS and driving commissioning decisions in this area across different actors (CCGs, NHS England, and the Local Authority). Often this involves aligning work which is already happening in different parts of the council, rather than creating new structures, for example in Manchester this priority is managed through the pre-existing work and skills board (see case study 1 below). It has been suggested that in bringing senior council and clinical leaders together, the HWB can provide a vehicle to gain buy-in from a range of local government and local clinical stakeholders, and facilitate their working towards a shared objective to improve the health and wellbeing of the working age population (see case study 1).

As **CCGs** mature and gain their footing some are beginning to turn their attention to the wider social determinants of health. This may happen in those areas where the wider determinants of health have been identified as local priorities in the JHWS. A King’s Fund Survey in 2013 found that 89% of HWBs felt their JHWSs had had an impact on

commissioning decisions (Humphries & Galea, 2013). Similarly, the requirement that representatives of local CCGs sit on the HWB means that clinical leaders can gain an insight into wider health and social care issues and feed these back into health services. Relationships between CCGs and HWBs have been reported as generally positive – in 2013 93% of HWBs rated their relationship with the CCG as between 4-6 out of 6 (Humphries & Galea, 2013).

Case Study 1: Prioritising the health of the working age population through the Health and Wellbeing Board in Manchester

Manchester 's Health and Wellbeing Board has driven work to improve the health of the working age population and employment outcomes for the hardest to reach, through **setting employment as a strategic priority** in their JHWS. Their JHWS includes the priority 'Bringing people into employment and leading productive lives' (Manchester Joint Health & Wellbeing Strategy, 2013). They also **set appropriate Key Performance Indicators** for this in their JHWS*.

The decision to include this priority was influenced during the period when the HWB was in shadow form, where local data was reviewed and **buy in from senior NHS, Council and Voluntary Sector leadership** about the need to address Marmot principles locally was gained. Local demographics showed consistent levels of long term unemployment over the past 30 years. Over the last two years a health and employment programme has been driven forward focusing on projects to support people with health conditions to obtain and stay in work; changes within commissioning and primary care to integrate work as a health outcome; and workplace health.

Key to the success of this work has been that the chair of a local CCG from the HWB leads on this objective providing **clinical leadership and buy-in. Responsibility for this priority is shared with** the Work and Skills Board **integrating it within existing structures** and also making an important **link with work on local economic growth**. Clinical leadership has also included the establishment of a working group for GPs interested in this area, encouraging more of them to refer into employment programmes.

As a result of this prioritisation, the local authority and the CCG decided to **co-commission** a Fit for Work referral service. This has helped nearly 600 individuals off work sick or in-work with a health condition, with 96% agreeing the support had helped them return to work sooner (Manchester City Council, 2015).

Manchester has also been **incentivised at a local level** through the devolution of funds from DWP to Greater Manchester local authorities to commission a pilot back to work service to reach some of those furthest from the Labour market (Working Well Greater Manchester). If successful in getting 5,000 individuals back to work, GM will see a direct return on investment and the potential to scale up the pilot.

** 'Proportion of adults in contact with secondary mental health services in paid employment' and 'Proportion of adults moving back into, training, volunteering or work as a consequence of accessing the Fit for Work referral service.'*

However measures collected in the CCG Outcomes Indicator Set still do not go far enough in encouraging CCGs to work towards employment as a clinical outcome. Although the recent inclusion of an outcome measuring the number of individuals in contact with secondary mental health services in employment was recently introduced, this represents a very small proportion of the working age population. There is still no measure relating to the employment of individuals with a long-term condition.

Where CCGs are working on this agenda, they have included 'improving employment outcomes' in their commissioning plans – in some cases leading on to co-commissioning arrangements being made between the CCG and the local authority. They have also commissioned clinical pathways, such as the mental health pathway in Nottingham, which brings together a range of clinical and social services such as employment for individuals with a mental health condition (see case study 5). Often they work best where there is buy-in from clinical leadership which has improved GP awareness locally of the importance of employment, and encouraged more GPs to refer their patients into employment support programmes (see case study 1).

Through its move into local authorities, **Public Health** has begun to make some progress towards improving the health of the working age population. Public health has been enabled to gain knowledge about and have influence over the local authorities' 800+ services – with many reports of significant progress being made towards integrating public health priorities across the local authorities work (for example see case study 2). A survey of DpHs and senior members of their teams found that almost three quarters (73%) agreed that bringing public health within the remit of the local council has delivered better public health outcomes for the local population, whilst 96% agreed that it would offer improved outcomes in the future (LGA, 2015b). Over 8 out of 10 (83%) agreed that their position on the HWB had allowed them to directly influence decisions on public health. However this opportunity is not being used to its full advantage to improve the health and wellbeing of the working age population. The same survey found that only 17% had set 'Helping people find good jobs and stay in work' as a public health priority, meaning 83% were giving this little or no consideration.

Local areas that are working well to improve the health and wellbeing of the working age population are those that have modelled their public health priorities on the wider determinants of health and have integrated their work across different parts of the council, placing public health at the centre of a system wide transformation. They have taken a holistic approach using care packages to achieve better outcomes for individuals and communities rather than a narrow focus on single issues (e.g. smoking). They also tend to focus on preventative models, using local data to identify at risk populations and delivering services such as the NHS health check in community settings (see case study 2 for further information).

Case Study 2: Integrating public health priorities to address the wider determinants of health in Wigan

In Wigan relationships between the local authority and public health were strong prior to integration with the local authority. When setting new public health priorities a clear consensus was reached to **model these on the Marmot principles**.

Staff were fully integrated into different teams across the council rather than operating as a standalone team. They decided to take a life course approach through the priority areas – Start well, Live Well, Age Well. Each area was led by a service manager placed within the Adult Social Care or Children and Families Directorates. The Live Well programme is aimed at integrating care for adults of working age so that they lead healthy, productive working lives and are empowered to be fully engaged citizens.

Taking a **holistic approach**, the public health team have offered care packages which build on the assets of individuals and communities to achieve better outcomes for all. They have re-commissioned integrated health and wellbeing services which are based around the wider needs of individuals rather than single issues, such as smoking. For example the 'Making Every Contact Count (MECC)' initiative which encourages conversations based on behaviour change methodologies to empower healthier lifestyle choices, has been embedded across the community healthcare trust, children's centres, emergency services, and council department's adult social care, economic regeneration and environmental services.

In Wigan the gap in male life expectancy has dropped from 11.1 years in 2013, to 9.4 years in 2014.

Source: LGA, 2015

Public Health England (PHE) drives the national Public Health agenda, including within it the terms of pushing for greater local activity on the health and wellbeing of the working age population. Although they do have a team working to promote healthy workplaces, the admission of 'creating good work for all' from their 6 ambitions fails to send a clear signal to local public health teams about the need to prioritise this issue (see p. 27 for more detail on PHE ambitions). Therefore although in places such as Wigan, where public health is now well integrated within the council and has used this to begin to improve the health and wellbeing of the working age population, there is not widespread prioritisation of workforce health and wellbeing across local public health teams in England.

The work of PHE tends to focus on promoting the Workplace Wellbeing Charter which has been taken up by a number of local authorities (see p. 28 for details). Alternatively, some local public health teams also run local programmes to promote healthy workplaces. The Workplace Charter seems to work well in areas where a lot of resource is put behind it, such as in Liverpool. However its take up is being held back by the fact there is no national funding for this programme, meaning that local authorities must buy into the business case and put their own resources behind it. Often this has meant that local authorities only

contract the programme on a limited scale. Where there is not pre-existing capacity in the local authority to deliver the programme, recruitment and training must take place, using up limited local resources.

Another approach seen is local areas developing their own local award schemes (see case study 3). Through our site visits, we found that in these cases there is a sense of pride for local areas in having their own schemes. They are more easily tailored to the needs of local employers, and in general such schemes are seen as particularly successful in getting large public sector employers to improve workforce health and wellbeing, leading by example for those in their supply chain and beyond (for example see case study 3).

Case Study 3: Leading by example in the Public Sector in Hartlepool

The North East Better Health at Work Award (BHWA) is a regional workplace health programme which has been running since 2009 across 12 local authorities in the North East of England. It is a partnership between the Local Authorities, the Northern TUC and the NHS.

Similarly to the Workplace Wellbeing Charter, it recognises the achievements of organisations that are already promoting workplace health and helps them to move forward in a structured and supported way. It allows organisations to benchmark progress against a regionally recognised standard of health and wellbeing in the workplace and to work towards accreditation. Every organisation who signs-up to participate in the Award scheme is supported by a dedicated Health Improvement Specialist, who helps amongst other things, to raise awareness of health in general, conducts a workforce health needs assessment and helps to run workplace health campaigns/events based on this results.

There are 4 levels to the Award –Bronze, Silver, Gold and Continuing Excellence. Organisations have up to a year to complete each level before they are assessed and progress to the next one, with the ultimate aim of workplace health and wellbeing becoming as embedded as health and safety.

The evaluation showed that 232 businesses and organisations with 209,319 employees have actively participated in the BHWA between 2009 and 2012 and covered 21.4% of the working-age population in the North East. Mean reductions in sickness absence were between 0.26 and 2.0 days per employee depending on the length and level of participation in the BHWA and sector of employment. Public service organisations seemed to benefit most and the estimated cost of the BHWA to Public Health/NHS was £3 per sickness-absence day saved.

Source: <http://www.betterhealthatworkne.org/>

Though awards and accreditation schemes are often viewed positively locally, it is important to collect evidence on the extent to which such schemes are reaching employers who are less active in this space. The risk with all awards and accreditation schemes is that they

reward and accredit only those who are already active in this space, rather than encouraging those who are doing nothing and have not yet realised the importance of improving employee health and wellbeing (Bajorek et al., 2014).

What are the barriers?

A number of constraints have been identified as preventing more local authorities, HWBs, CCGs and public health teams from prioritising the health and wellbeing of the working age population in their local area and from working collaboratively to improve it. These are summarised below.

- **No clear remit given by central government for local areas to consider health and employment.** At the national level there is a lack of specific information for local authorities and partners on the benefits of investing in the health and wellbeing of the working age population and on how best to do this. Statutory guidance for JSNAs and JHWSs does not include a strong recommendation to consider the wider determinants of health nor specific guidance on how to do this. In addition, PHE have not included 'good work for all' in their core ambitions meaning local public health teams are less likely to prioritise this area. There is not enough being said nationally to local authorities about this issue and so it is not likely to feature highly on their agenda.
- **Employment doesn't feature strongly enough in outcome measures, measures are not joined up and data is of insufficient quality.** Though several national outcomes frameworks feature employment, a lack of alignment across the measures, as well as a focus on restrictions to employment among very specific groups (i.e. those in secondary mental health care services), make prioritisation within local authorities less likely. It is further noted that the mechanism to collect data even for current measures (i.e. high-level measures collected through the Labour Force Survey) may not be of high enough quality to provide data which can be used effectively to measure employment levels or to show change, support benchmarking and needs assessments.
- **Failure to collect the correct data locally and to make the business case.** Similarly to above, the fact that data may be of poor quality means that local areas are less able to make an accurate assessment of local need and to build a successful business case locally. Given the economic climate, council and clinical leaders are increasingly requiring strong evidence of a return on investment to invest in services. As the benefits of improving the health and wellbeing of the working age population are spread across a number of different stakeholders, making the business case for investment to any one of these stakeholders becomes challenging. Where other priorities can more clearly demonstrate a direct return to the local authority, they are more likely to be prioritised.
- **Lack of resource.** The work of local authorities has been severely affected by budget cuts. This has led many to focus more predominantly on their statutory

requirements and to greater scrutinise the other services which they deliver. There is also a considerable disparity between local authority, CCG and LEP funding across England, allowing some areas far greater financial freedoms than others.

- **Lack of leadership buy-in.** Strong local leadership is required to move this agenda forward. Personalities and local politics play a large role in what priorities are taken forward. Knowledge and interest of leaders is crucial. Where they have had previous experience of the benefits of improved workforce health (for example if a member of the HWB is also a trained Occupational Medicine physician) they might be more likely to pursue this agenda. Similarly, for elected representatives, drivers will include the extent to which this is an important issue for voters.
- **Differences in organisational culture.** The health sector and local government in particular, may face cultural differences as the NHS and associated organisations are affected by their own institutional cultures. This is often true when it comes to language used, with the health sector more used to acting on significant levels of evidence, whereas local authorities may be more willing to make decisions more opportunely for political gain. These might present barriers to effective joint working.
- **Political Instability.** National politics often leads to chop-and-change in local structures, as exemplified by the changes resulting from the implementation of the Health and Social Care Act under the current government. Job losses and movements have meant that many pre-existing collegial relationships were lost, as well as time and resource in establishing new structures.

Health and social care integration is affording a number of new opportunities which some areas are embracing to start to improve the health and wellbeing of their working age populations. However a significant number of barriers, most notably the lack of a clear remit given by central government for localities to consider this area and a failure to incentivise action through greater prominence of employment in national outcomes frameworks, are holding back the more comprehensive action which is needed. A number of suggestions for how central government could address these barriers are discussed in the next chapter.

Supporting individuals with health conditions to find and stay in work

What is currently happening?

Improving employment outcomes for those with a health condition or disability, both through preventative action to keep individuals in work and programmes to get individuals into work, have an obvious benefit to both the local and national purse. In contrast to health and social care this area remains more centralised, with little opportunity for local variation. Where centralised services are failing, local areas are running various specialist programmes to help some of those with the most complex needs. The co-commissioning of employment programmes between national and local agencies is increasingly being developed as a way to deliver more appropriate and effective services locally. Local partners (e.g. DWP/JCP,

CCGs and the LA) are also increasingly co-commissioning specialised in-work and back to work services between themselves at a local level. However more activity in this area is held back by differences in commissioning models between partners and by a lack of direct local incentive to get individuals back to work.

The Work Programme and **Work Choice** have had very varied success rates across England (see p. 29). Although the Work Programme is working well to get some JSA claimants back to work, the same is not true of those claiming ESA - less than 8 per cent of people being supported by ESA have moved into employment through the Work Programme (Mind, 2014). The payment by results mechanism has led some providers to be accused of “creaming and parking” – focussing on those closest to the labour market rather than individuals with more complex needs. As these results become apparent, there has been some attempt by government to devolve some of the more specialist support to local partners. For example in beginning to consider co-commissioning of the work programme, as will be the case in Greater Manchester (see p. 29 for more detail) and in the GM Working Well pilot outlined in case study 4.

Case Study 4: Helping individuals with complex needs back into work in Greater Manchester

The ‘GM Working Well’ project in Greater Manchester aims to get 5,000 of the hardest to reach back to work over 5 years.

Co-commissioned by DWP nationally and GM local authorities, it provides bespoke support for unemployed individuals with complex needs making sure that they receive access to the right services at the right time. It aims to fill the gaps where the Work Programme isn’t working – service users are ESA claimants who have been through the Work Programme without a successful outcome. Each individual has a **keyworker** who has access to an **integrated network of local services** in the form of local integration boards. These boards contain representatives from public health, CCGs, skills, housing and the police. They offer brokerage and support to keyworkers to help them **join up services around the individual** and achieve the best outcomes possible.

The **payment mechanism for providers is front loaded**; they are paid 50% in an attachment fee, 20% on job entry and 30% for sustained employment. This prevents providers from only targeting ‘quick wins’.

It is still too early on in the project to analyse the specific impacts, however by January 2015 the programme had enrolled 1,924, with 1,445 clients attached (a conversion rate of 75%) and achieved 26 job starts. GM have successfully made a case for the programme to central government and as a part of the Greater Manchester Devolution deal it is set to be expanded to a potential 50,000 more individuals.

Local schemes have been introduced in some areas, to offer specialist employment support to residents with health conditions where the Work Programme is failing. A report by NIESR

in 2014 emphasised 'localised knowledge' as one of three factors which make these schemes successful – (Rolfe et al., 2015).

Several local authorities have taken a lead on improving local back to work support to unemployed residents with long-term conditions. Through our site visits and interviews we found a common approach was the mapping out of current local provision of employment and health support services, and the forging of strong links with local providers. The approach was to develop partnerships, and bring services together, creating additional services to fill in any gaps, in a way that is complimentary to the current provision rather than duplicating it. The end result is a wide range of referral routes and provision. Local schemes often involve a wide range of local partners including the voluntary sector, Job Centre Plus and employers. By harnessing local expertise in employment and skills they seek to identify early on which barriers are holding individuals back and ensure individuals get access to specialist support relevant to their specific needs (for example see case study 4). Another important model of locally developed services are the Fit for Work pilots (see p. 30) – which were jointly commissioned by DWP and local partners and delivered locally.

In order to develop specialised local services, some areas are also building stronger relationships between local partners to facilitate more co-commissioning locally and to be able to commission services across a wider area and on a more long-term basis. This normally involves the CCGs commissioning in partnership with their local authority and sometimes also involves DWP locally. Local co-commissioning works well where the interests of each partner and the outcomes they work towards are made explicit and are aligned as far as possible. Local co-commissioning processes should also involve building strong local partnerships with the VCSE sector and other providers so that commissioners make effective local decisions (see case study 5).

Though there has been some progress in commissioning between local authorities and health related bodies, this is less common between the local authority and employment related commissioners – in particular in forming local partnerships with DWP and LEPs. In particular in this research we found it particularly challenging to identify good examples of how LEPs and local authority/health partners are working together to improve employment outcomes for those with health conditions (for one example found see case study 7). This was seen as a significant gap.

Case Study 5: Building commissioning partnerships around mental health and employment in Nottingham

Nottingham has just undertaken a 'Building Health Partnerships' project, funded by NHS England and jointly delivered by Social Enterprise UK (SEUK) and the Institute for Voluntary Action Research (IVAR). It aims to improve partnership working between commissioners and the VCSE sector around health and employment.

The programme involves up to four half-day cross-sector partnership development and implementation sessions – including contributions from experts and input from the local steering group – with a wider group of 25-40 participants including a range of local providers and commissioners.

This offers the opportunity to develop partnership working further, providing a catalyst over 6 months to review and plan health and employment support at a local level, building on the respective expertise of all partners and providing the opportunity to reflect on and learn from national good practice.

In Nottingham the relationship between NHS Nottingham City CCG, Nottingham City Council, other HWB members including public health and the voluntary and community sector (VCSE) is well established, with cross sector partnerships and relationships at strategic commissioning and delivery levels. This has previously led to the City CCG commissioning a range of mental health services (the mental health pathway), the re-commissioning of which is now on hold after a large consultation. The CCG have recently commissioned a provider to focus on mental health in black and minority ethnic communities.

There is however a need to build commissioning relationships with and align work more closely with the Department of Work and Pensions (DWP) and they will participate in the BHP core group; likewise broadening Local Enterprise Partnership (LEP) work around the social inclusion strategy in relation to European funding.

The aims of the programme are:

- to review existing health and employment support against identified need.
- to develop a common vision and proposals for action some of which could be achieved through joint commissioning.
- to work as a cross-sector partnership to develop good practice models to be shared with other areas.

The project is only in its early stages, but the specific focus on health and employment and its focus on testing and improving ways of working, rather than a specific set of programmes or projects offers good potential for learning.

What are the barriers?

- **Specialised back to work support is too centralised.** National commissioning of the Work Programme does not seem to be working for individuals with more

complex needs. It favours large, non-specialised providers rather than smaller local providers who are more likely to have strong local networks and specialised knowledge. This prevents the development of more bespoke programmes which reflect the needs of the local population (particularly for those with complex needs) and reduces the capacity for local authorities to tap into the support already available in the local community.

- **Payment structure of the Work Programme favours large providers.** A barrier for smaller local providers becoming Work Programme providers is the current payment by results mechanism. This only works for providers who can fund programmes up front and take a risk on reaching outcomes. This means smaller local providers have often been priced out of the programme. A more upfront payment structure may allow the VCSE sector to be more involved. Additionally in order to compete for Work Programme contracts, providers must be able to deliver on a relatively large scale across a range of generalised services, which may also prevent many smaller more specialised providers from winning contracts.
- **Lack of direct financial incentives for the local authority.** Budgets to improve employment outcomes are still not widely devolved and this means that much of the return on investment goes back to central government. For example, for every claimant that moves into a job, of each £1 saved, only 7p goes to the local authority, 80p to central government and 13p to the police, NHS, housing providers and others (CESI, 2015). This means local leaders are not incentivised to prioritise this issue. Additional incentives may be needed to make it worthwhile for local authorities' to more highly prioritise back to work support.
- **Differences in commissioning processes.** The local authority, CCGs, DWP and the LEP all have different commissioning processes and planning requirements (as well as different outcomes to work towards). DWP local partnership teams must abide by DWP national procurement processes which may take some time, whilst CCGs have more autonomy to make quicker decisions. LEPs have to put in clear spending plans to BIS/DCLG in order to bid for funds. This means that although there is funding available in the system, bringing it together and aligning outcomes and timeframes is very challenging.
- **Complexity of funding streams.** Another way to improve partnerships working locally and deliver more local programmes is to form joint bids for centralised funding. The complexity of different centrally run programmes make this quite challenging. Where networks between the different bodies are not strong there is often a lack of co-ordination in applying for it, as well as difficulty in finding resources to both apply and coordinate.

Due to failings of the Work Programme, some local areas have been driven to develop local schemes to fill in the gaps, and provide support for individuals with more complex needs to stay in and return to work. These programmes are effective because they offer more

bespoke, specialised support and access to a range of services for individuals with complex needs. More work in this area at a local level is held back by centralised commissioning of the work programme but also by the complexity of the commissioning process within different local organisations, preventing more joined up local commissioning to provide these services.

Creating healthier workplaces and growing more jobs that are good for us

What is currently happening?

As discussed in chapter 2, there is a clear link between economic growth and the health of the workforce. There is a need to work with and support employers to improve psychosocial conditions within the workplace, increase employee engagement and productivity and to promote more inclusive economic growth – growing more jobs which are good for our health and wellbeing.

Much of what is happening locally to improve health and wellbeing within the workplace is happening through the work of public health teams in the form of the Workplace Wellbeing Charter and through local workplace wellbeing awards (for example see case study 3). In addition to this, many large private sector employers have their own health and wellbeing strategies. For example in Cornwall, Ginsters have worked to improve health and wellbeing not only within their workforce but also across their supply chain (Robertson Cooper, 2010). Another approach taken in a number of places has been to continue the funding of Fit for Work Service pilots (for details of these see see p. 30). Although as mentioned in the previous chapter many of these provide specialist in-work and back-to work support for individuals with health conditions, many also provide tailored diagnostics services for employers and help them to develop strategies to improve health and wellbeing across their workforce. An example of this is the Healthy Workplace Programme in Leicester (see case study 6 below) where local small and medium sized enterprises are offered health needs assessments, are provided with appropriate recommendations to promote health and wellbeing (e.g. training for managers, workplace champions) and help to link people into interventions based on needs. However, bespoke programmes funded through the council like this are rare. They are costly to run, although as the case study shows, they are effective. Without increases in funding from the centre for this type of work there is a considerable limit to how far local areas can implement these types of programmes.

Alongside work to improve health and wellbeing within the workplace, some local areas are also working to grow more jobs which are good for our health and wellbeing locally. In areas where thinking is particularly joined up, the economic regeneration and the employment and skills work of the council has looked to consider health and employment in their work. What is particularly rare however is the engagement of the LEP in this work.

Case Study 6: Providing bespoke support to improve workplace health in SMEs in Leicester

The Healthy Workplace Programme, run by the Fit for Work Team, started in 2010 as a part of the Fit for Work Pilots. It is now funded through Leicestershire County Council and run as a social enterprise.

As a part of the programme any Leicestershire business (employing less than 250 staff) who wants to increase their organisational and economic productivity by looking after the health and wellbeing of their staff can access the service. Recruitment to the scheme can occur through partner referral (via a local authority) or through network and scheme outreach.

Label Apeel are a Leicestershire based manufacturing firm who produce bespoke self-adhesive labels. They currently have 47 employees and a turnover of £4million. In April 2012 the organisation were forced to ask all staff to go to 4 day weeks as a result of poor sales in Q1 of 2012. At the same time, it was reported that staff turnover was at 23%, average uncertified sickness levels were at 2.8 days per employee and 3 employees were signed off on long term sick leave which had resulted from work related stress.

The Fit for Work Team undertook a health needs assessment of the Label Apeel staff finding that 27% of staff found their job very stressful, 24% of the employees were dissatisfied with their job. The average number of respondents reporting their current job either made them ill or caused their existing illness, injury or disability to become worse was over 8 times above the national average. In terms of physical health 70% did not have a healthy diet, 66% had little or no physical activity and 40% of staff were current smokers.

A number of interventions were implemented to help both physical and mental health and wellbeing including: stress management awareness and training for line managers on site; a 9 point health check delivered to all staff on site; employee engagement surveys; free fruit provided throughout the office; setting up walking groups; provision of on-site yoga taster sessions and off-site crown green bowls taster sessions; smoking cessation support and nicotine replacement therapy (paid for by the Managing Director).

These interventions have resulted in positive business and health related outcomes including:

- All staff working 5 days a week, with operating profits up 23% and a 63% increase in staff retention.
- 23% reduction in uncertified sickness with £40,000 of savings and a 1:1- return on investment.
- A nomination for the CIPD People Management Health and Wellbeing Award.
- 66% reduction in people reporting their job was very or extremely stressful, 50% reporting their job was not stressful at all, 21% reduction in levels of anxiety and 42% decrease in those reporting dissatisfaction with their job.

As non-statutory bodies, LEPs currently have no legal requirement to consider the health and wellbeing of the working age population in their work, or to collaborate with the health and social care community. The greater part of their spending to date has been on areas such as employment, transport, housing and infrastructure – all of which also present considerable opportunity for tackling the wider social determinants of health.

A small number of LEPs have been identified as seeking to create jobs to build a more sustainable economy, and pursue active labour market policies - seeking to create employment opportunities for groups most at risk (i.e. those with physical or mental illnesses) – either through existing jobs or through creating new jobs. LEPs which are more successful in terms of funding and performance tend to be those where there is a precedent of collaboration and political alignment rather than those who do not represent a functional geography (Localis, 2015).

Another, less direct approach, identified during this project, involved building partnerships between the LEP, local authority, employers and the VCSE sector in order to plan and implement a strategy for inclusive economic growth (for example see case study 7).

The new European Social Fund (ESF), targeted at skills, employment, and social inclusion activities, offers the potential for LEPs to start addressing some of the more complex barriers to growth. This approach has already been used successfully in Cornwall – with a project (funded by the previous ESF) looking at sustainable economic growth and improving social inclusion by extending employment opportunities and by developing a skilled and adaptable workforce (see p. 31 for more details about the ESF). The project engaged local employers, further education providers, and local trades unions to improve the skills basis and competitiveness of the Cornish region. Of those who benefitted, 56% of employees reported increased job satisfaction, 58% reported increased interest in their job and 57% of employers reported an increase in productivity (IHE, forthcoming). The allocation of 2016-20 ESF funds to LEPs has the potential for local actors to have a greater influence over how money is spent and to better link this with local health priorities.

Case Study 7: Creating healthy Jobs through the LEP in Leeds

The 'More Jobs, Better Jobs' programme was launched in February 2014 by the Joseph Rowntree Foundation (JRF) in partnership with Leeds City Council and the Leeds City Region (LCR) Local Enterprise Partnership (LEP). As the Leeds City Region is beginning to prosper following the recent recession, it has been seen as important that all people and places benefit equally from the prosperity growth and job and skill development that a return to economic growth can bring. The partnership hopes to commission and manage practical research that can shape policy and services in the Leeds area, and share what they learn with other cities. 'More Jobs, Better Jobs' therefore recognises that the quality of jobs is just as important as the number of jobs developed.

The aims of the partnership included:

- To better understand the relationship between poverty and the economy at a city region level;
- To identify what can be done, by who, at local level to create more and better jobs that help lift people and places out of poverty;
- To make a compelling, practical case for change on why and how cities should link growth and poverty;
- To address poverty as a more integral part of local growth strategies.

The initiative proposed to bring together local employers, local authorities and local and regional politicians and other leaders to design and deliver new policy initiatives and approaches so that growth is felt by everyone in the region. The Chief Economic Officer at Leeds City Council chairs a steering group that includes representatives from local authorities, the LEP, charities and the voluntary sector to develop areas where local ownership of economic growth and job development can occur.

The role of the partnership is to influence the national agenda on skills and create more 'better jobs' in the future. This can include the health and wellbeing of staff in these roles, and this was recognised at the launch of the partnership when the Chair of the LEP, Roger Marsh said, *"The LEP's objective is not simply focused on economic output, but also encompasses good growth that creates jobs and quality of life for everyone... This partnership is important as it will deliver vital information that will enable the LEP to address the key challenges in the skills and labour market in the future."*

Source: Joseph Rowntree Foundation, 2014

What are the barriers?

- **Health not within the core remit given to LEPs by central government.** LEPs were initially set up to stimulate a growth in private sector jobs – their core work focuses around transport, infrastructure and employment and skills. There has been no clear guidance from central government that there should be a consideration of

health and wellbeing within their work. As many LEPs are concerned about increasing 'mission creep' – being given more duties beyond their remit – a change in the remit given by central government and funding to go with it (mentioned below) may prevent them from prioritising workforce health and wellbeing in their work.

- **Lack of resource.** As with local authorities and CCGs, LEPs work is restricted by funding. Lord Heseltine's 2012 report on economic growth recommended that LEPs need an extra £10bn of central government funding a year (Heseltine, 2012). Limited funds mean there is little administrative support and restricted time for developing partnerships with the health sector. It also means prioritising spending is very competitive and so if this is not within their core remit and there is not an effective business case, tackling health and wellbeing issues is unlikely to feature.
- **Making the case locally to LEPs.** The majority of LEPs have not bought into the idea that health is an important aspect of sustained economic growth. Those in the local authority and in particular public health are not making the business case in an effective way to LEPs about the costs of sickness absence and the underutilisation of skills. Without a clear business case made in economic terms, LEPs may continue to fail to engage. Similarly, it is suggested that in many areas, local authorities and health agencies may not even recognise the potential of engaging with LEPs.
- **Lack of transparency and accountability.** A LEPs current make up does not reflect their local business communities (women, BME communities and small business and further/higher education sectors are all underrepresented) (Localis, 2015). The chair is not democratically elected by its members, there is no requirement for business representative organisations to join (e.g. FSB, CC, and CBI) and they are not subject to the Freedom of Information Act. This creates a lack of awareness of their work locally making future partners less likely to approach them and threatening wider partnership working.
- **Lack of collaborative working between BIS and DH/DWP at a national level.** At a national level it is suggested that BIS is not working closely enough with other departments to plan for the wider role which LEPs could play, particularly in terms of the health and work agenda. In order to take a strategic approach to economic growth locally, BIS must seek further engagement in the health and work agenda, and consider ways of enhancing the relationship with LEPs to create a narrative about the links between health, work and economic growth and to influence local action.

Some local areas are working to improve health and wellbeing within the workplace through the work of public health teams and through specific workplace health programmes which support employers to implement health and wellbeing strategies. However the work local authorities' can do in this area is significantly held back by a lack of funding by central government. LEPs are a natural vehicle through which to grow more healthy jobs in the local economy and to promote more inclusive economic growth. At the moment this is not defined

within their core remit from central government and this prevents the creation of good work from being a strategic priority.

Summary

Our conversations with local and national actors have highlighted a number of best practice case studies which show the type of positive activity which is happening to improve the health and wellbeing of the working age population generally, to support individuals with health conditions to find and stay in work and to create healthier workplaces and grow good jobs. However these conversations have also highlighted a significant number of barriers, in particular stemming from the level of national priority this issue is being given, and the remit which is being scoped out for local actors on this issue. In the next chapter we consider how these barriers might begin to be addressed through changes in local and national policy.

Chapter 5 Recommendations

In the previous chapter we discussed where we see the potential for local partners in driving the health and work agenda, as well as identifying some of the barriers to this happening more widely. Despite pockets of good practice where areas are prioritising improving the health and wellbeing of the working age population, due to the lack of a clear remit given by central government, there is a systematic failure to address this issue comprehensively at a local level.

In this final chapter we suggest how recent changes in policy and the policy levers which they afford could be used to their full extent to significantly improve workforce health and wellbeing at a local level. We make a number of recommendations for policy changes, for both local and national policymakers, which would help to overcome barriers and encourage a more joined up local approach, to improve employment outcomes for the working age population.

Incentivising and enabling local action to improve the health and wellbeing of the working age population

Recommendation 1: National bodies should introduce a more standardised guideline of measurements and metrics to be included into the JSNA, including measures of health and employment outcomes locally

The health and wellbeing of the working age population is prevented from being given priority locally as it is not emphasised strongly enough within the core remit given to local areas by central government. Currently, there is no standardised template or minimum data set which must be collected for HWBs when carrying out JSNAs. We suggest that the current statutory guidance on JSNAs and JHWS does not go far enough in its mention of health and employment.

Therefore central government should renew the statutory guidance for JSNAs and JHWS to include a more standardised guideline of employment measures to be included in the JSNA. These measures should include employment outcomes for individuals with a mental health or long-term condition and sickness absence data. Guidance should also suggest that other more in depth data, such as that which could be collected through the health system (see recommendation 5) could be included in the JSNA.

This would ensure systematic consideration of health and employment in needs assessments and therefore encourage more areas to consider and introduce employment as a priority where they see fit. This would influence their commissioning processes and wider activity to include a focus on improving the health and wellbeing of the working age population.

Recommendation 2: Public Health England should make good work for all one of its big ambitions as set out in its business plan in order to send a clear message to regional and local public health teams

Alongside the above recommendation, central government should encourage local areas to prioritise improving the health and wellbeing of the working age population through Public Health England showing clearer recognition of this issue at a national level. Messages from PHE about the importance of health and work as a population health issue should be more clearly translated through them by including ‘creating good work for all’ as an ambition in their Health and Wellbeing Framework.

One of PHEs core functions is “to improve the public’s health and wellbeing and to reduce health inequalities”. The PHE business plan 2014-15 says it will do this by “supporting local authorities in their duty to improve the public’s health, and through the CCGs, by providing evidence and knowledge of local health needs, alongside practical and professional advice on what to do to improve health and reduce inequalities”.² We argue that activity in this area also needs improved focus on health and work.

Currently, PHE work in this area is focussed primarily through rolling out the national standard for the Workplace Wellbeing Charter (in early 2015) and working to engage employers of all sizes in all sectors to recognise the return on investment for supporting the health and wellbeing of staff. At present this work encourages PHE to focus predominantly on the workplace as a place to promote public health. Health and wellbeing in the workplace is seen as a cross-cutting theme through which to improve other ambitions, such as smoking cessation and reducing obesity.

Although this work is important, it downplays the direct detrimental effect with which poor quality work itself and worklessness in particular have on the health and wellbeing of the working age population. As Marmot has argued ‘creating good work for all’ itself is a crucial factor for reducing health inequalities. We suggest that a fundamental part of improving health and wellbeing and reducing inequalities is addressing unemployment and worklessness.

We suggest therefore that the work of PHE should go beyond what it’s currently doing and work more closely with the DWP to consider its role in also helping those who are out of work with health conditions get back into work. A standalone ambition would drive this change and encourage regional and local public health teams to consider more seriously the impact that work can have on health and wellbeing.

²https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/319696/Business_plan_11_June_pdf.pdf

Recommendation 3: Central government should pool existing funds into a budget for local areas to access, to tackle the wider social determinants of health (the Marmot principles)

BIS, DWP and DH should consider pooling existing resources to create a national ring-fenced, fund, to support locally designed and managed projects which address any of the six Marmot policy objectives (the wider determinants of health). Pooling resources to the end of meeting shared objectives around improving the health and wellbeing of the working age population would encourage greater collaboration between different government departments, and provide collective responsibility, where the benefits of a project are spread across a number of different stakeholders.

At a local level, HWBs should be responsible for the oversight of the fund administration. The implementation of the proposed fund should be based on lessons learnt from the Better Care Fund, which will also be administered through HWBs. The HWBs would work with local partners (for example DWP, LEPs and the VCSE) and take a lead on managing partnership working, e.g. leading the formulation of strategic spending plans and bidding for funds. At a local level, having a specific budget to drive local activity which reflects the Marmot principles, would enable local authorities (whose funding often limits their capacity to work in this area) to expand their work - and particularly the work of HWBs - beyond the narrower remit of typical public health issues (i.e. healthy lifestyle choices).

Specific guidance around health and employment should be developed to support HWBs and local partners in developing bids for this fund.

Recommendation 4: Employment data should be collected through the health system and be used to more accurately benchmark local authorities progress around the health and wellbeing of the working age population

Greater recognition of the importance of health and employment as a pertinent local issue requires that appropriate data is available to improve local understanding of the issue, to make the business case, as well as to evidence effective interventions and benchmark progress. Though employment features in some form in several health and social care outcomes frameworks (see p. 23), the data is often not of suitable quality to measure employment in sufficient detail, providing only part of the picture. Current instruments (e.g. the labour Force Survey) do not have the capacity to collect data to the level and quality required.

To this end, reflecting on the recent Chief Medical Officer's report, we would recommend, that employment status should be recorded routinely on patients records, with GPs and other primary care providers incentivised (e.g. through the CQUIN) to collect this information. This would require considerable simplification of the coding used in GP surgeries to record employment and welfare status – Manchester are currently doing work in this area, simplifying the codes to 7 options.

Recommendation 5: Using Public Sector procurement processes to encourage local employers to take action on employee health and wellbeing

Local authorities should take a lead on promoting the importance of health and wellbeing of those in work, by rewarding those employers and organisations who have taken active steps to improve their employee's health. Local government (and other local public sector bodies), should qualify the 'most economically advantageous tender' principle when undertaking public procurement, ensuring they only procure the services of organisations that have reputable policies with regards to organisational health, safety and wellbeing. This reflects existing examples wherein public sector procurement requires suppliers to have various forms of accreditation e.g. Investors in People accreditation (for example, Procurement for Housing³), or ISO:9000 quality management⁴ accreditation. The accreditation might include factors such as health and safety records, levels of sickness absence, health and wellbeing policies (e.g. around return to work and reasonable adjustments) and the provision of the living wage.

The development of any such accreditation system will need to be well-considered, and developed in consultation with local employers and other local experts/stakeholders. This is vital to ensure that the selected measures appropriately reflect positive employer activity in this regard, but also to ensure that the introduction of such a policy does not disadvantage smaller employers, who will not have the same capacity as larger organisations.

Policy makers may be resistant to this approach on economic grounds – especially if this reduces competitive intensity and results in rising costs to the public sector. However, it can be argued that if labour standards improve for organisations that are encouraged to implement health and wellbeing schemes, then costs elsewhere (e.g. health costs and health risks) are likely to reduce.

Giving local areas the tools to improve the health and wellbeing of the working age population

Recommendation 6: DWP should devolve greater responsibility to local areas for the re-commissioning of the Work Programme

Given the failures of the Work Programme in improving employment rates for individuals with more complex needs, we suggest that there should be greater consultation with local areas (through the local authority, the HWB and the LEP) to inform the commissioning of the next round of the Work Programme. Depending on the capacity within local areas, the level of input could range from an advisory role, to a full co-commissioning model, as in the case of Manchester. This range of options would allow different localities to have more or less control over programmes as they deemed appropriate, with the potential to move towards greater control as they build capacity.

³<http://www.procurementforhousing.co.uk/who-we-are/sustainable-procurement-policy/> [accessed 16 October 2014]

⁴http://www.iso.org/iso/iso_9000 [accessed 16 October 2014]

This would allow programmes to be tailored to local needs. It would open up the possibility to reform incentive structures within the Work Programme so that there is more payment upfront, to allow smaller providers the ability to deliver aspects of the programme. Local networks may also support more specialist local providers to become involved, as currently smaller, specialist, third sector organisations face many barriers to accessing Work Programme funding.

In addition, more specialist support may also be developed through a pooled central government fund (see recommendation 3) which would allow local authorities to develop more bespoke programmes for individuals with more complex needs both to support them to stay in work and to return to work.

Recommendation 7: Directors of public health should use health and employment data gathered through both the health system and DWP locally to build the business case for local action and to benchmark progress

As suggested above, improving the quality of data regarding the extent to which health and employment (and particularly health related unemployment and worklessness) are issues in the local population, could be used to develop a more in depth understanding of local needs. Alongside this, this data should be used to build a business case locally and to benchmark progress in improving health and employment outcomes. As suggested in recommendation 5, GP's should be supported and incentivised to collect employment status data on patients. Detail around benefits claimants is already available through DWP locally and widely used by local authorities. Between these two datasets we suggest local areas will be able to develop a more detailed and useful local analysis.

We suggest that Directors of Public Health (DPHs) within local authorities are well placed to lead this analysis. DPHs engage in related data analysis through their work supporting the JSNA process. We suggest that part of their role includes the development of a 'health and employment local business case', outlining what is known locally about health related sickness absence, unemployment, and worklessness, and providing an assessment of the associated costs to the local area.

The business case should be shared with the HWB, the CCG, DWP and the LEP, to ensure they understand the local need for intervention in this space, and potentially drive prioritisation and investment in the area. A useful example of this type of work already occurring is the 'Review of Employment Support for People with Mental Illness, Physical Disabilities and Learning Disabilities' carried out in the tri-borough of Hammersmith and Fulham, the Royal Borough of Kensington and Chelsea, and the City of Westminster.⁵

⁵<http://www.jsna.info/sites/default/files/Employment%20Support%20JSNA.pdf>

Recommendation 8: The LGA should gather and share best practice case studies where local authorities' have been effective in addressing the wider determinants of health, leading to the development of a best practice network

As highlighted in this report, there are many cases where local areas are doing good work to address the wider social determinants of health and are to improve the health of the working age population.

We suggest that local authorities' could learn a lot about what might work in their area through this existing practice. Therefore we suggest that work be undertaken to highlight how different local authorities have tackled the wider determinants of health and the benefits they saw. This should include a case studies portal, providing good practice examples of where HWBs have effectively tackled the wider determinants of health. Over time depending on uptake this could develop into a best practice network for HWBs interested in tackling the wider determinants of health.

The LGA are well placed to take on this role, alongside similar work they are currently doing through the Health and Wellbeing System Improvement Programme which supports HWB leadership, strengthens regional partnerships and provides some capacity for bespoke support.

Recommendation 9: Individuals with long term health conditions should be enabled to work towards employment outcomes through personalised care planning and personal budgets with improved signposting and guidance locally to inform decisions and join up services around individuals

Personalised care planning and personal budgets provide an opportunity for individuals to set their own goals and to direct the support they receive towards their individual health and social care needs, and recovery goals. For some people, employment will be important, but too often it is not seriously considered in this process. In addition where health and employment services exist locally, there is no guarantee that individuals and professionals who are planning care are well placed to refer someone to them or will even know about them.

A barrier to accessing local health and work related services is poor awareness that they exist – among both service users and professionals. The development of a 'health and work care pathway', highlighting the services and support available in a given local area, and the pathways into them, would enable more professionals to make confident referrals to services.

In order to disseminate information about this 'care pathway' widely, in particular to those involved in developing individual care plans (often a community matron, specialist nurse or social worker) there should be a tool to encourage discussion of employment as an outcome when agreeing care plans. This should also include increased signposting to more information on available services helping to inform these discussions and allow better decisions to be made.

Driving care through individual needs in this way has the potential to provide a more

bespoke service; a more coordinated care pathway locally would increase the likelihood of professionals referring patients to it and ensure individuals receive more joined up care.

Encouraging more collaborative working at a local level

Recommendation 10: National outcomes frameworks should be better aligned around health and employment

Health and employment is slowly making in-roads into health related outcome frameworks (see p. 23). This is positive, but we feel that the effect would be greater if these could be aligned – improving the capacity for different bodies to see where working together could be particularly valuable.

Some overlaps already exist between the key health outcome frameworks - the Adult Social Care Outcomes Framework (ASCOF), Public Health Outcomes Framework (PHOF), and NHS Outcomes Framework (NHSOF), and most recently the Clinical Commissioning Group Outcomes Indicator Set (CCGOIS), are all aligned on an outcome relating to users of secondary mental health services in paid employment (NHS has a broader focus - Employment of people with mental illness). Though progress in this area is important and should be recognised as such, the value of this measure in terms of benchmarking local progress is limited by the relatively small numbers in this population group, compared, for example, to numbers of ESA claimants, or numbers of people with long term health conditions accessing primary health services – the latter is currently only considered in the PHOF and NHSOF, with the ASCOF focussed on people with learning disabilities, and nothing further on this in the CCGOIS. It is noted also that LEPs do not have an outcomes framework to work to, and therefore their activities are not prioritised in this way.

We suggest that ‘improving employment outcomes for people with health conditions’, given its cross-over with so many areas and bodies locally, can be a key area for alignment across outcomes frameworks, and across local bodies. Such alignment may also increase the likelihood of the inclusion of health and work related measures on the Health and Wellbeing Board dashboard.⁶

In order for this to work, we must be able to collect data of a sufficiently high quality on health and employment with which to measure this - as discussed in recommendation 4. This information will also be highly valuable for improving assessment of local need, building the business case locally and benchmarking – as discussed in recommendation 7.

Recommendation 11: Joint commissioning guidance should be developed around health, wellbeing and work to improve the ability for local bodies to commission services together, to work towards achieving shared outcomes

We need to make it easier for local organisations, including local authorities, Public Health England, CCGS, LEPs, DWP providers and the voluntary sector, to work together, to

⁶ For example see: <http://hwb.warwickshire.gov.uk/files/2014/04/WHWBB-Performance-Framework.pdf>; http://www.leics.gov.uk/health_quarter_3_dashboard-2.pdf

achieve shared outcomes. After aligning outcomes frameworks (see recommendation 10) we should then take action to improve their capacity to work together and to achieve these outcomes. It is suggested that this could be better achieved through the development of guidance for the joint commissioning of health and employment related services. A helpful model is the joint commissioning guidance, led by the Royal College of Psychiatrists, and the Royal College of General Practitioners⁷.

Recommendation 12: A representative of the business community should sit on the Health and Wellbeing Board in order to bring an employer perspective to their work and to better link the worlds of health and of economic growth

Given the substantial evidence around the relationship between health and employment (including the implications of poor health and wellbeing of the working age population for productivity and economic growth, that health and wellbeing can be detrimentally effected by poor quality work, and that the workplace presents a major vehicle through which to influence and improve the health and wellbeing of the working age population) it is short-sighted that the business community is so poorly represented on HWBs. There is no statutory requirement for a member of the business community to sit on the HWB and this does not appear to be a practice taking place.

We suggest therefore that government makes it a statutory requirement for a member of the business community to sit on the HWB. The individual should be a high-profile local business leader and could be either a local private sector employer or a leader from a business representative organisation (e.g. the chair of the Chambers of Commerce). This would show recognition of the connection between health and economic growth at a leadership level locally and would bring a much needed employer perspective to the HWBs work. It would also give the HWB more authority and profile in the eyes of the business community (currently awareness is low) and through this, begin to encourage employers to consider the health and wellbeing of their own workforce, as well as encouraging working with LEPs.

Recommendation 13: LEPs and HWBs should collaborate in order to advise how European Social Inclusion money is spent

LEPs should be better informed about local health and employment needs when advising how European Social Fund (ESF) money is spent. Representatives of the health and social care system, through the HWB, should be involved in some capacity in the LEPs advisory role. Local areas should determine how this would work best for them; however examples such as in Sheffield include a representative of the Health and Wellbeing Board sitting on a LEPs Social Inclusion Board.

Data collected from the health and social care systems (as suggested in recommendation 7) should be used to begin to make the business case to LEPs about the economic benefits of improving the health and wellbeing of the working age population. It should also be used to

⁷<http://www.icpmh.info/>

inform LEPs about exactly what the local needs within the working age population are.

Starting to increase partnership working between the HWB and the LEP in this way would begin to integrate a consideration about health within work that the LEP is already doing, without tacking on additional duties when LEPs are already stretched. This could also lead to more informed decisions and a consideration of health when LEPs are delivering current employment and skills projects and make them more likely to include HWBs when planning the spending of future funding.

Recommendation 14: Local areas should consider using opportunities presented through the Public Sector Transformation Network to better join up work around health and employment

The opportunity afforded by the Public Sector Transformation Network, for example through whole place community budgets and neighbourhood budgets should be grasped by local authorities in order to improve the health and wellbeing of the working age population.

These programmes provide the potential for local authorities to better align outcomes, targets and systems, to share information and resources and to develop investment agreements to ensure fair incentives for all partners. This work should involve a wide range of partners including the HWB, CCG, DWP/JCP, LEP and local providers. All areas should consider developing and implementing plans where possible and evaluations should be carried out nationally to share learning in this area in particular.

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Acknowledgements

The authors would like to thank the local representatives and expert advisors who kindly offered their time to take part in interviews and focussed discussions – in particular Jane Abraham, Simon Calvert, Heather Downey and Jenny Osborne for helping to arrange site visits and interviews. The authors would also like to thank colleagues at The Work Foundation for their support with this paper.

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This paper has been supported financially by grants from Napp Pharmaceuticals Limited and Bupa who have had no editorial input.

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