

# **A Review of Employment Support for People with Mental Illness, Physical Disabilities and Learning Disabilities**

Tri-Borough Joint Strategic Needs  
Assessment (JSNA) Report

August 2013

## This Report

### Purpose of the report

This report focuses on employment support services for residents with mental illness, physical disabilities or learning disabilities within the councils of the London Borough of Hammersmith and Fulham, the Royal Borough of Kensington and Chelsea, and the City of Westminster, which make up the Tri-borough area.

This Joint Strategic Needs Assessment (JSNA) report aims to:

- **Set out the case** for locally commissioned specialist employment support for clients with mental illness, physical disabilities and learning disabilities
- **Map existing local services**, including national provisions
- **Review the evidence** of best practice
- **Outline the vision** for a new service

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# CONTENTS

<b>ABBREVIATIONS .....</b>	<b>4</b>
<b>1 EXECUTIVE SUMMARY .....</b>	<b>5</b>
<b>2 BACKGROUND.....</b>	<b>11</b>
2.1 Definition of employment support.....	11
2.2 Background to policy and local commissioning.....	12
2.3 Rationale for change.....	13
<b>3 MAKING THE CASE FOR EMPLOYMENT SUPPORT SERVICES .....</b>	<b>14</b>
3.1 Local prevalence of mental ill-health .....	14
3.2 Unemployment, sickness absence and presenteeism related to mental illness.....	16
3.3 Local prevalence of physical ill-health .....	18
3.4 Unemployment, sickness absence and presenteeism related to physical disabilities .....	19
3.5 Local prevalence of learning disabilities .....	20
3.6 Unemployment related to learning disabilities .....	21
3.7 Expected need for employment support services .....	22
3.8 Evidence around unemployment and health .....	23
3.9 Benefits of supporting mental health clients into work .....	25
3.10 Benefits of supporting clients with disabilities into work.....	27
3.11 Likely impact of economic climate and benefits reforms.....	29
<b>4 MAPPING PROVISION OF EMPLOYMENT SUPPORT SERVICES.....</b>	<b>31</b>
4.1 Mapping process .....	31
4.2 Main findings .....	31
4.3 Current spend locally .....	35
4.4 Range of support provided locally .....	37
4.5 Access to local services.....	38
4.6 Outcomes from local services.....	40
4.7 Value for money from local services .....	42
4.8 National services.....	42
4.9 Local support for other client groups.....	45
4.10 Limitations of the mapping exercise and analysis .....	45
<b>5 TOWARDS AN EVIDENCE-BASED FUTURE SERVICE .....</b>	<b>46</b>
5.1 Service aims .....	46
5.2 Key components of a good employment service.....	47
5.3 Evidence based models of employment support.....	48
5.4 Working alongside national programmes .....	48
5.5 Measures of success .....	53
5.6 Learning from other London boroughs .....	54
5.7 Commissioning implications .....	55
<b>APPENDIX A – Summary of Tri-borough prevalence of mental illness, learning disabilities and physical disabilities .....</b>	<b>57</b>
<b>APPENDIX B – Health-related employment benefits.....</b>	<b>58</b>
<b>APPENDIX C- Evidence for employment support models and approaches.....</b>	<b>59</b>
<b>REFERENCES .....</b>	<b>59</b>

## ABBREVIATIONS

ASC	Adult Social Care
ATW	Access to Work
CMH	Common mental health issues
CPA	Care Programme Approach
DH	Department of Health
DWP	Department for Work and Pensions
ESA	Employment Support Allowance
ESA-WRAG	ESA-Work Related Activity Group
ESA-SG	ESA-Support Group
H&F	Hammersmith and Fulham
IAPT	Improving Access to Psychological Therapies
IB	Incapacity benefit
JSA	Job Seekers Allowance
JSNA	Joint Strategic Needs Assessment
K&C	Kensington and Chelsea
LD	Learning disabilities
NAO	National Audit Office
MH	Mental Health
PD	Physical disabilities
SMI	Severe and enduring mental illness
WC	Work Choice
WP	The Work Programme

# 1 EXECUTIVE SUMMARY

## Purpose of this document

This document reports the needs assessment and service mapping of local and national specialist employment support for Tri-borough residents with mental illness, physical and learning disabilities. Also reported is an overview of evidence of best practice and an outline of vision for a new evidence-based service.

## Level of illness and economic inactivity

Across the Tri-borough area, there are high levels of economic inactivity, particularly in relation to mental illness and physical disabilities.

Nationally, mental health conditions are the most common reason for people to be dependent on health-related benefits (2). Tri-borough rates of severe mental illness (SMI) are among the highest in London and England. Local levels of Incapacity Benefit (IB) and Employment Support Allowance (ESA) claims due to mental ill-health are also high compared to London, particularly in Hammersmith and Fulham (8<sup>th</sup> highest in London). Paid employment rates for clients with severe mental illness in Kensington and Chelsea (K&C) and Westminster are below the London and England averages. This is despite the fact that nationally up to 90% of all mental health service users want to work (4) and at least a third of those currently unemployed due to SMI would like to find work (10).

Rates of physical disabilities are also high in parts of the Tri-borough area compared to London, with large numbers of IB and ESA claims for physical ill-health in these areas. Hammersmith and Fulham (H&F) has particularly high levels (12<sup>th</sup> highest in London).

The numbers of people with learning disabilities are low in the Tri-borough area and employment rates are on a par with London levels. However, clients with learning disabilities have worse employment prospects than other disability groups. The current employment rate for disabled people nationally has risen to 48% overall but remains only 10% for those with learning disabilities (11). It is reported that 65% of people with learning disabilities nationally would like a paid job (11).

Sickness absence and presenteeism (reduced productivity at work related to ill health) are also likely to have major impacts in the Tri-borough area, based on what we know nationally (12). Extrapolating from national data, sickness absence is estimated to cost the Tri-borough economy £84 million per annum in employer costs, health and social care costs and welfare (13). Mental illness is the number one cause of long-term sickness absence, closely followed by musculoskeletal problems (7).



**Not all people with severe mental health conditions want to be employed, but almost all want to 'work', that is to be engaged in some kind of valued activity that meets the expectations of others.**

DWP and Department of Health joint commissioning guidance 2006 (5)



## Costs of economic inactivity

The impacts of economic inactivity are felt by individuals, communities, employers, local authorities and the NHS.

Unemployed individuals have a higher risk of poor physical and mental health compared with those in employment. The health and social impacts of a long period of unemployment can last for years (6).

Health inequalities are closely linked to worklessness and its links to physical and mental health and wellbeing (6, 14). Both unemployment and mental illness impact on other wider determinants of health such as income and secure housing, and also affect the wellbeing of families and communities

Unemployed people have higher levels of GP consultations and longer in-patient stays (2). Extrapolating from national figures, the cost of mental illness locally is approximately £300 million in H&F, £250 million in K&C and £350 million in Westminster. Over a third of this is due to loss of economic output (over £80million per borough) and a fifth due to health and social care costs (over £5million per borough) (2). These figures are probably underestimates due to high local prevalence of severe mental illness and a larger working age population than the national average.

## Evidence-based employment interventions

Evidence-based employment interventions can deliver jobs, improve health and wellbeing and generate substantial cost savings to local commissioners.

There is substantial evidence that specialist employment support, tailored to the needs of clients with mental illness or disabilities, can deliver jobs. The most cost effective models of support include *Individual Placement and Support* (IPS) for mental health clients and *Supported Employment* (SE) in the disabilities field.

There is also evidence to support a role for 'Very Supported' employment opportunities (such as social enterprises) for clients with very complex needs.

In addition, Government policy advocates early intervention *in-work support* to help individuals to retain employment, to prevent the 'revolving door' of sickness absence and to avoid the negative health impacts of unemployment (2, 7).

Evidence shows that these approaches to employment support can deliver:

- Improved individual health and wellbeing
- Increased personal income
- Reduced use of health and social care services

Action on unemployment for these client groups is aligned with national policy on Welfare to Work and helps deliver expectations in the NHS and Adult Social Care Outcomes Frameworks (15, 16). Issues related to employment are part of Health and Wellbeing Board priorities in all three boroughs.

## Costs Savings

Evidence-based employment support is, at least, cost neutral. At best it can generate significant cost savings to local commissioners.

### Summary of evidence for cost saving

- A number of IPS trials found up to 50% reductions in health and social care costs (4).
- IPS reduces the need for and length of hospital stays (2, 4). A multi-site European randomized trial found that IPS delivered saving of around £6,000 per client in inpatient psychiatric care costs, compared to usual care (4).
- Social Return on Investment analysis has shown returns of between £5 and £13 for each £1 invested Supported Employment for clients with disabilities (9).

## Mapping services

The JSNA team has undertaken an extensive mapping of existing local employment support for people with mental illness and disabilities.

Local specialist employment support was mapped using data from: contract monitoring, email and telephone interviews with national and local providers, co-production meetings with local service users and providers and other service user feedback.

There are four national schemes available, 14 locally commissioned providers funded specifically for tailored employment support to the client groups, and over 30 other voluntary sector providers working with these clients.

**Pathways** within the service are complex. There is no single point of referral and silo working between providers means that there are major issues around communication. It is likely that overlaps in provision may also occur.

**Current good practice** – The mapping identified some areas of excellent practice, particularly where evidence-based approaches were being pursued. Feedback from co-production meetings was positive about the increasing numbers of professionals with understanding of mental health issues.



**Interviewing people at the day service, or other friendly and accessible facility works well**

Service user at coproduction meeting



**Spend** – The majority of spending is on mental health, which reflects the greater numbers of mental health clients in the Tri-borough, compared to the number of people with disabilities. However, spend by borough is not always allocated according to need. Westminster currently spends much less than other boroughs on support for clients with mental illness, despite having a significantly higher proportion of people with these conditions; Kensington and Chelsea spends the most.

**Gaps in provision of services for specific client groups** were identified and are already being addressed. For example, Hammersmith and Fulham is currently working to fill its gap in provision of specialist support for clients with physical disabilities.

**Stages of support** – There are gaps in provision of some stages of employment support. In particular, there is significant need for in-work support both for clients getting jobs through specialist local support *and* for employed people struggling in work with common mental illnesses and musculoskeletal problems.

**Outcomes** – The mapping identified that some providers seem to be achieving a far smaller number of outcomes for the money received compared to others. This will need to be investigated further to understand underlying reasons, as there may be legitimate reasons for this.

**Limitations of the mapping and subsequent data analysis** come from gaps in the data and inconsistent terminology. Providers use different definitions of interventions (e.g. what constitutes in-work support) and outcomes (e.g. what constitutes a job outcome). Many providers do not routinely collect details of jobs obtained or impacts on health and wellbeing. Comparisons of provider performance are further complicated by their clients having different levels of need.

## National provision

There have been developments in national provision, with increased focus on supporting clients challenged in the open job market. However, national evidence has identified major issues for all four national programmes around their ability to fully meet the needs of clients with mental illness and disabilities.

**JobCentre Plus** (JCP) is the first point of contact for any client claiming benefits and offers generic employment support with some specialist provision for clients with health problems. However, a national review identified that JCP staff may have ‘poor awareness of mental health issues’ (10). Co-production feedback identified that service users felt that JCP advisers were not always trained to support people with disabilities, particularly in communicating with clients with learning disabilities.

**The Work Programme** is the Government’s flagship Welfare to Work programme and is being delivered in West London by three Prime contractors. This started in 2011; it aims to support clients with additional barriers to work, including claimants of Employment Support Allowance (health-related) and Job Seekers Allowance (not health-related). There are concerns that current early performance is not yet up to the levels expected. The Public Accounts Committee described one-year performance as ‘disappointing’. Overall outcomes were worse than previous programmes and considerably lower than DWP expectations (17). Clients with a disability were half as likely to have a job outcome as people without a disability. London performed worse for disabilities clients than the rest of the UK (18). However, there is considerable national and local commitment to improve on this early performance.

“

**Work Programme Primes don't offer enough support for people with complex needs.**

Co-production group feedback

”

The two schemes designed specifically for clients with registered disabilities (**Work Choice** and **Access to Work** grants) are not available to clients already on the Work Programme. Furthermore, **Work Choice** requires clients to be able to work for 16 hours per week (19) which excludes many people with disabilities. A major national review



found that *Access to Work* is underused, particularly by clients with mental illness and learning disabilities (20).

## Economic climate

Under the current economic climate and with reforms to welfare, investment in employment support is an even greater priority.

During an economic downturn, the job market is challenging, particularly to clients with disabilities and mental illness (where the prevalence increases during periods of recession (6)). With reforms to benefits, there is likely to be an influx of clients into the job market who have previously been considered 'too ill to work'. Employment support providers are likely to face additional challenges in successfully supporting clients into jobs at this time. However, if provision of employment support were reduced, the resultant impacts on individuals will ultimately be passed onto NHS and local authorities with increased use of services (2).

## A future service

Local employment support provision is to be recommissioned by Adult Social Care and NHS Mental Health commissioners.

The JSNA has identified some key aims for a new service, based on local and national findings. Commissioners may want to consider the following:

### 1. To maximise the effectiveness of existing national provision

There is scope for better partnership work (including delivery of mental health and disabilities awareness training) and improved referral pathways between local and national providers.

### 2. To commission evidence-based specialist employment support for clients not eligible for national schemes and for those whose needs are not currently being fully met by national provision

### 3. To integrate in-work support as a key element of the specialist employment support service

### 4. To commission an early intervention in-work support service across the Tri-borough councils

## Building on good practice

The JSNA has identified some key elements of good practice based on feedback from service users, benchmarking against other boroughs and reviews of national evidence.

Commissioners may want to consider incorporating the following elements:

- **Evidence-based approaches** to employment support. For example IPS in the mental health field and SE in the disabilities field
- **Regular review of progress** to ensure that clients progress towards paid employment and do not get stuck at earlier stages along the pathway to work
- **High quality information** on services needs to be available so that providers can refer and signpost appropriately
- **Benefits advice easily available to clients and support workers.** The computer software to make “better off calculations” should be accessible to those supporting clients into employment
- **A single point of referral** into the system and **clear pathways** within it
- **Partnership work and effective communication** between employment support providers, care managers, health care and benefits advisors
- **Co-location** of employment support within social and health services (e.g. IAPT). This can improve the effectiveness of support for clients and may be cost saving
- **Employer engagement** so that more high quality job opportunities are available to clients. Fewer people will fall out of employment when employers know what to expect when they employ individuals with mental illness or disabilities.
- **High quality work opportunities**
- **Provision of early intervention support for job retention supporting employees and employers**
- **Strong links with national programmes, especially where these are compulsory.**
- **The local Councils and CCGs leading by example** as employers.

## Success measures

Commissioners may have expectations that employment rates reach at least the London average.

Currently available data will allow employment rates to be measured for clients with SMI and learning disabilities. Improvements in recording of employment status for clients with physical disabilities will allow commissioners to measure the impact of support on employment rates for this group also. The numbers of jobs retained will also be a key measure of success.

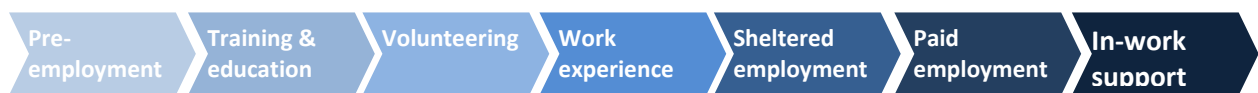
In addition, it is important to recognise that employment in the open job market may not be realistic or an ideal outcome for some clients with more complex needs. There is good evidence that engagement in other meaningful activity can confer benefit to these individuals. Participation in training, volunteering and social enterprises will be key measures of success for these clients.

## 2 BACKGROUND

### 2.1 Definition of employment support

#### The pathway to employment

Employment support encompasses a wide array of activities that aim to prepare individuals for paid employment and help them into jobs. The route to competitive employment in the open job market can be seen as a pathway with stages including pre-employment support (motivation and CV preparation), training and education, volunteering and work experience. All stages can contribute to an individual's readiness for paid employment. Clients may require support at any combination of stages.



#### Outcomes on the pathway

The end goal depends on the needs of the client and approach of the provider. While some clients rightly aim for full time competitive employment, the best outcome for other clients with complex needs may be just a few hours of paid work, volunteering or some form of sheltered employment (10).

Once in work, in-work support is advocated to develop skills and address sickness absence and 'presenteeism' (clients at work but struggling due to health problems with its knock on effects on wellbeing and productivity) (7).

## 2.2 Background to policy and local commissioning

### National drivers

Increasing the employment rates for people with mental illness and disabilities aligns with several national priority policy areas:

- Promoting employment supports delivery of government objectives outlined in *No Health without Mental Health*, the national *Health, Work and Wellbeing Programme*, and the Government's public health strategy set out in *Healthy Lives, Healthy People* (2).
- *Valuing Employment Now* (11) set out a cross-government strategy to increase the number of people with learning disabilities in employment.
- The 2013 *Government Response to the Sickness Absence Review* advocates early intervention in-work support to prevent long-term sickness absence and related unemployment (21).
- QIPP and NHS Operating Framework Expectations, as well as NHS, Public Health and Social Care outcomes (2).

### Local commissioning

The need for specialist employment support for disadvantaged groups has been recognised by the Tri-borough councils and local NHS for some time. For a number of years, local Mental Health and Adult Social Care (ASC) commissioners have funded an array of specialist employment support services for Tri-borough residents with mental illness, learning and physical disabilities.

While most employment support providers are funded independently by either ASC or NHS mental health commissioning teams, about a quarter of services have been jointly funded by these commissioners. Jointly funded services specifically target clients with mental illness who are also eligible for ASC services.

This sits alongside a range of other commissioned employment support services in the Tri-borough, for example for substance misuse clients and ex-offenders. In addition, services for young people or lone parents are commissioned in some instances as part of local authority strategies to reduce local worklessness.

## 2.3 Rationale for change

### Service complexity

Current service commissioning and provision is recognised to be complex. Feedback from service users, providers and commissioners has highlighted frequent silo working and unclear referral and signposting pathways. Reasons for this complexity include:

- Local restructuring of commissioning including the switch from single borough to Tri-borough commissioning
- A wide range of client needs
- A number of different types of support on offer and range of providers
- The existence of parallel provisions from national programmes and a number of non-commissioned voluntary providers

This mirrors the national picture, with researchers finding *‘little logic in the range of [employment support] programmes that have been developed over the years in terms of what or who they were for’* (20).



**Employment support works better when it is integrated into services.**

Member of Tri-borough Community Learning Disabilities team



### Lack of evidence base

A recent report from the National Development Team for Inclusion found that, nationally, just over half of all Adult Social Care commissioners were able to break down their spend on employment support according to *‘approaches that are underpinned by an evidence base and those that are not’* (22).

### Local redesign

A redesign of locally commissioned employment support services has been proposed by Adult Social Care (ASC). This aims to review the current landscape in terms of national and local provisions, target investment to need and strengthen joint working in order to improve cost effectiveness

An ASC-led executive group has been overseeing this process. A coproduction group, comprising service users and providers, has been meeting for a year to input their views on the shape of future service provision.

The future of joint commissioning of mental health and ASC funded employment support was still to be decided at time of reporting. Issues pertaining to joint commissioning are discussed briefly within this document.

## 3 MAKING THE CASE FOR EMPLOYMENT SUPPORT SERVICES

### 3.1 Local Prevalence of Mental Ill-health

#### Summary

The prevalence of severe and enduring mental illness (SMI) is very high in the Tri-borough compared to London and England. It is highest in areas of deprivation, consistent with the strong associations between mental illness and health inequalities. Tri-borough levels of common mental health disorders (CMH) are more similar to London and England levels. However, there are far more individuals affected by CMH than SMI.

#### Data sources

Prevalence rates of mental illness are calculated from records of numbers of people known to the NHS and local Councils. GPs keep a register of patients known to have severe and enduring mental illness (SMI). Councils record the number of mental health clients in contact with Adult Social Care (predominantly SMI).

Employment rates among mental health clients are routinely recorded only for clients on the Care Programme Approach (CPA). All these clients are in contact with secondary mental health services and are therefore likely to have SMI.

#### Definitions

##### Severe and enduring mental illness (SMI)

These mental health disorders include a range of diagnoses characterised by a longer duration, significant health service usage and a major negative impact on social functioning and disability. Examples include schizophrenia, bipolar affective disorder and personality disorders (3).

##### Common mental health (CMH) disorders

There is considerable variation in common mental health disorders. CMH disorders can occur once in a lifetime or recur episodically over a person's lifetime. Prevalence ranges from 1 to 15 % of the general adult population at any one time. Examples include depression, generalised anxiety disorder, panic disorder, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD) and social anxiety disorder. CMH conditions tend to be treated in primary care but all can be associated with significant long-term disability (8).

## Numbers known to GPs

### Severe and enduring mental illness (SMI)

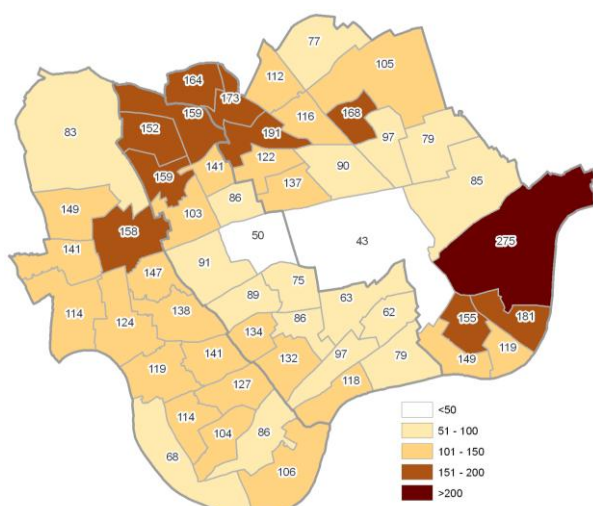
There are estimated to be 1,919 patients of working age with severe and enduring mental illness in Hammersmith and Fulham, 1,875 in Kensington and Chelsea, and 2,641 in Westminster (which has a larger overall population than the other two boroughs, hence higher numbers with SMI). Tri-borough prevalence of severe and enduring mental illness is very high compared to London and England. In 2011/12, rates known to GPs were the 2<sup>nd</sup> highest in London in K&C, the 4<sup>th</sup> highest in Westminster, and 7<sup>th</sup> highest in H&F. Numbers are highest in areas of deprivation for all three boroughs, although the Victoria area (Westminster) also has high numbers due to high prevalence among homeless populations.

### Common mental health disorders (CMH)

Exact numbers with common mental illness are not known, but national estimates suggest there are between 25,000 and 35,000 people suffering from common mental illness in each borough across all ages, far higher than the numbers with severe and enduring mental illness. However, common mental illness is not generally considered to be a long-term condition and many of these people will only have the disorder for a short period of time. GP practice registers for depression identify prevalence rates similar to London and England and spread more uniformly throughout the boroughs, with less focus on deprivation.

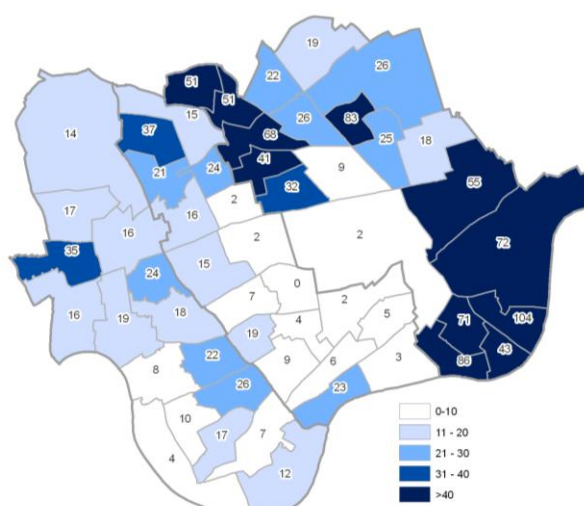
Estimated working-age population with SMI (GPs)

Source: Quality and Outcomes Framework (QOF) 2012



Working age mental health clients known to councils

Source: Adult Social Care RAP P25 data, 2012



## Numbers known to councils

Data on numbers known to councils identifies K&C as having the highest prevalence of mental health service users in London per size of population (975 clients), with Westminster prevalence also high (3<sup>rd</sup> highest in London – 1,025 clients). The lower ranking for Hammersmith and Fulham (275 clients) probably reflects a narrower range of services included in the categorisation.

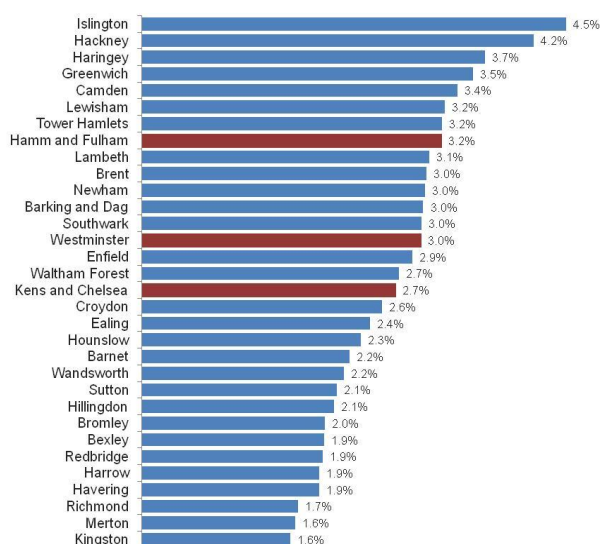
### 3.2 Unemployment, sickness absence and 'presenteeism' related to mental illness

#### Summary

Mental health conditions are the most common reason for people to be dependent on health-related benefits (2). Tri-borough rates of incapacity benefits claims for mental ill-health are above average for London, particularly in Hammersmith and Fulham. Employment rates for clients with SMI in the Tri-borough area (as measured by CPA reporting) are relatively low compared to other London boroughs.

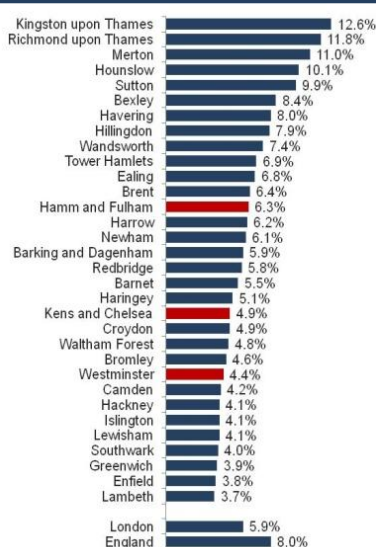
London ranking for incapacity benefit for mental ill-health

Source: DWP, August 2012



Proportion of adults in contact with secondary mental health services in any paid employment (includes <16 hours/wk) in 2011/12.

Source: CPA returns 2012



#### Incapacity benefit and ESA claimants for mental ill-health

Just under half of the wards in the Tri-borough area fall into the highest 20% in London, predominantly in deprived areas.

#### Numbers of mental health clients in paid employment

In 2011/12, both K&C (4.9%) and Westminster (4.4%) had a smaller proportion of those known to secondary mental health services in paid employment, compared to London (5.9%). Neighbouring boroughs also had lower than average rates. To meet the London level, Westminster would need 20 more people known to secondary services to be in employment, and Kensington and Chelsea would need 9 more.

Employment rates across all mental health service users in UK are around 20% according to surveys by the Care Quality Commission (4).



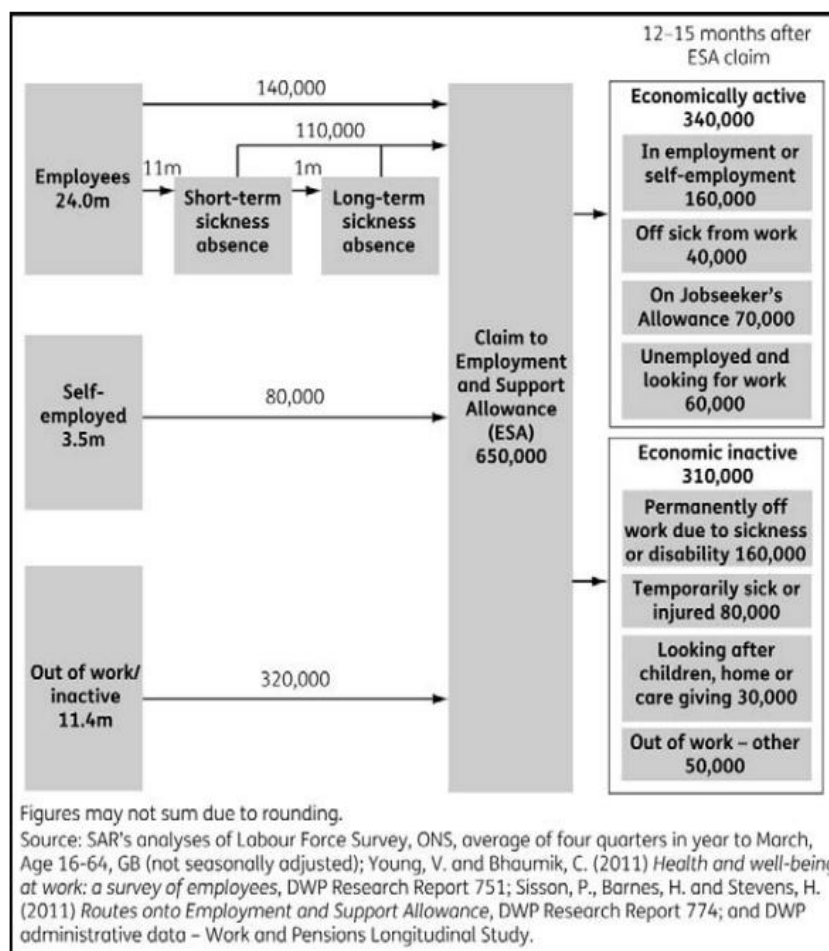
### Sickness absence and presenteeism due to mental illness

Mental health issues are the number one cause of long-term sickness absence. Data on absences is difficult to source, partly due to lack of robust sickness management systems. Black and Frost's Sickness Absence Review included Chart 1 below indicating that a million people each year in England and Wales are on long-term sickness absences (7). Sickness absence in inner London is higher than outer London (23).

Around 75% of people who are on sick leave because of mental health conditions do return to work. However, the majority of those absent for more than 20 weeks will ultimately fall onto benefits (7). London has the greatest proportion of individuals falling out of work within 6 months following return (23).

**Chart 1**

**Flows between work, sickness absence and benefits – annual numbers for England and Wales (from the Sickness Absence Review (7))**



The most common cause of long-term sickness absence is common mental health problems, closely followed by musculoskeletal conditions (7). National policy advocates early intervention in-work support to help individuals to retain employment, to prevent the 'revolving door' of sickness absence, flow onto benefits and to avoid the negative health impacts of unemployment (2, 7).

### 3.3 Local Prevalence of Physical Ill-health

#### Summary

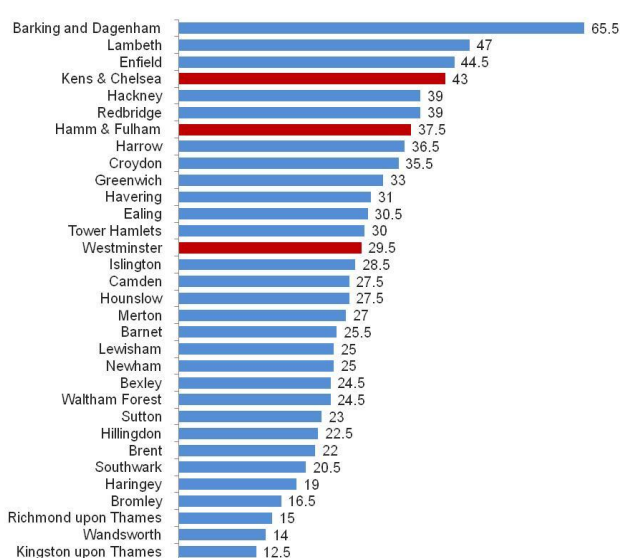
There is limited data to identify the prevalence of physical disability among the working age population across the Tri-borough. The different ranking between boroughs for numbers known to councils and numbers claiming benefits may be influenced by the social care eligibility thresholds and reporting. According to IB and ESA claimant data, rates of physical disabilities are high in parts of the Tri-borough area compared to London, predominantly in areas of deprivation. Generally, rates are higher than average in H&F but lower in K&C and Westminster. Although the numbers of IB claims for physical ill health are not insignificant, there are still more incapacity benefit claims for mental health reasons.

#### Numbers known to councils with a physical disability or frailty of working age

Analysis of numbers known to councils with a physical disability or frailty (aged 18-64) shows K&C as having a higher rate of clients per population than the other two boroughs, and the 4<sup>th</sup> highest rate in London (505 clients). This is substantially higher than expected, given low levels of incapacity benefit, and may relate to eligibility thresholds for ASC and reporting. Hammersmith and Fulham have the 7<sup>th</sup> highest rate in London (505 clients with physical disabilities known to councils). Westminster has the 14<sup>th</sup> highest rate in London (470 clients).

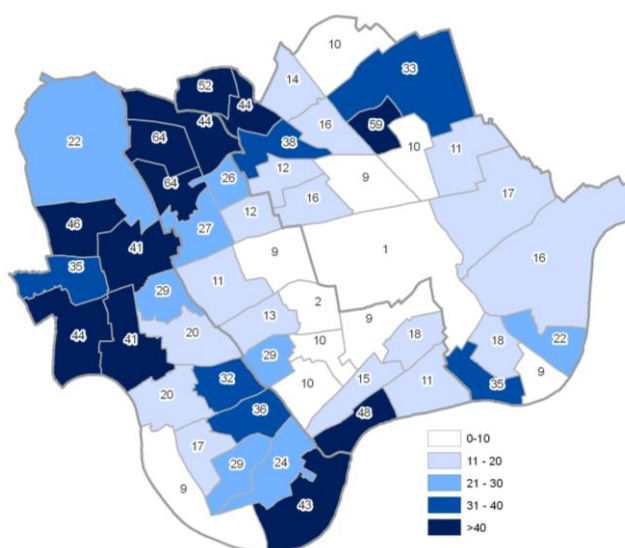
London ranking for physical disability clients known to councils 18-64 per 10,000 pop

Source: NASCIS/ IC 2011/12



Working age clients known to councils with physical disability/frailty

Source: NASCIS/ IC 2011/12



### 3.4 Unemployment, sickness absence and 'presenteeism' related to physical disabilities

#### Numbers of clients with physical disabilities in paid employment

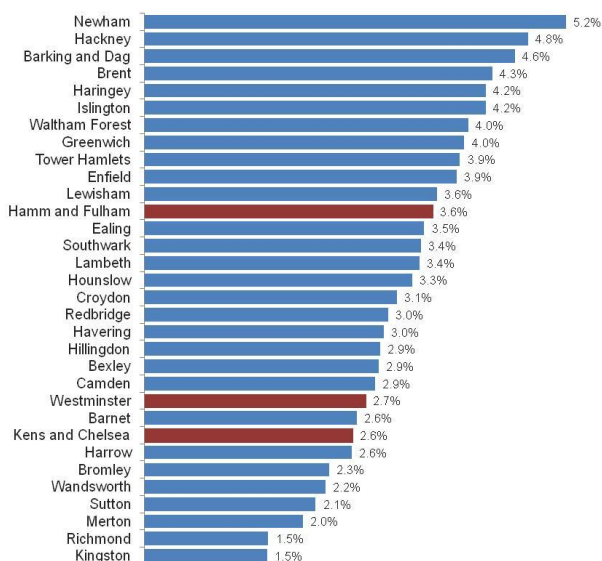
Employment rates for clients with physical disabilities are not routinely recorded by GPs or Social Services, therefore the data is less accurate than for mental illness or learning disabilities. According to the ONS Population Survey (September 2012) rates are 40% in H&F, 47% in K&C and 32% in Westminster. London average is 46%. This shows employment rates for clients with physical disabilities in Westminster to be considerably lower than the other boroughs and London.

#### Incapacity benefit and ESA claimants for physical ill-health

Incapacity benefit claimant rates for physical ill-health in the Tri-borough area are the 12<sup>th</sup> highest in London in H&F, 23<sup>rd</sup> highest in Westminster, and 25<sup>th</sup> highest in K&C. Higher levels of claims are made in areas of deprivation.

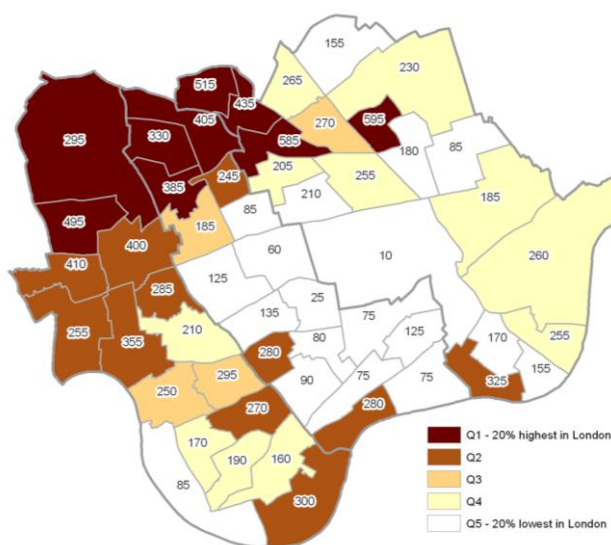
#### London ranking for incapacity benefit for physical ill-health

Source: DWP, August 2012



#### Working-age population claiming incapacity benefit for physical ill-health by ward

Source: DWP, August 2012



#### Presenteeism and sickness absence

Musculoskeletal conditions are the second most common reason for sickness absence and presenteeism (7).

### 3.5 Local prevalence of learning disabilities

#### Summary

The number of people with learning disabilities is very low in the Tri-borough area. The low levels are probably influenced by the high cost of living in the area, amongst other factors. Individuals with learning disabilities live predominantly in the north, usually where supported residence is located.

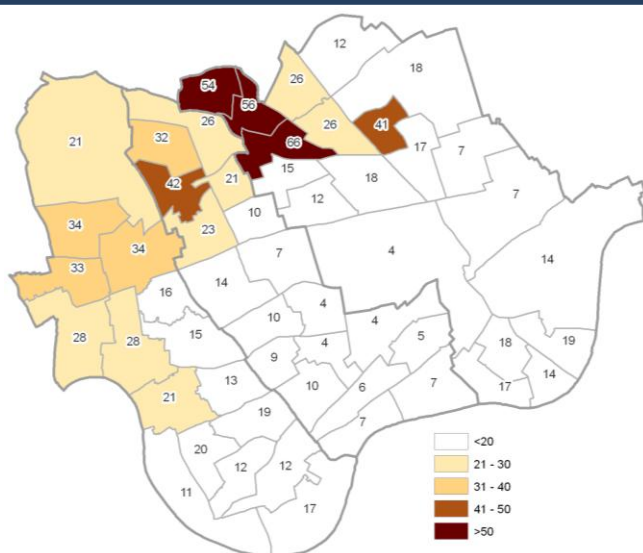
#### Numbers known to GPs

In 2011/12, the number of people on GP learning disability registers was very low in the tri-borough area: the lowest in the country in K&C (243 clients), the 2<sup>nd</sup> lowest in H&F (335), and the 7<sup>th</sup> lowest in Westminster (460).

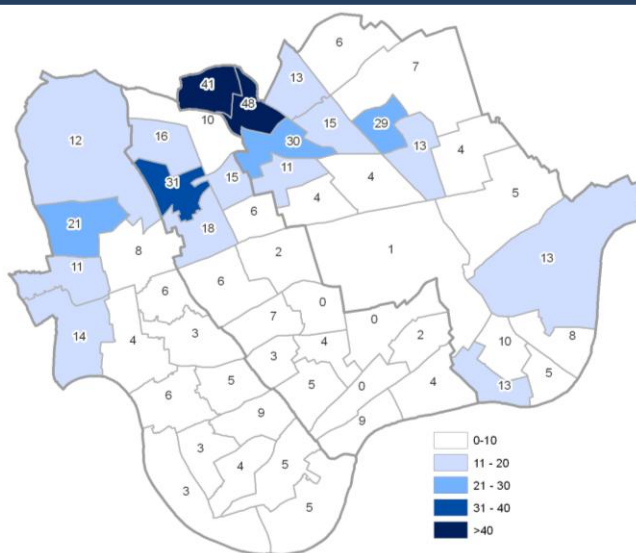
#### Numbers known to councils

The number with learning disabilities per population aged 18-64 that are known to social services is reflective of GP registers, with very low rates in K&C in particular, but with all three below the London average.

Estimated working-age population with learning disabilities (GPs)



Working age learning disabilities clients known to councils



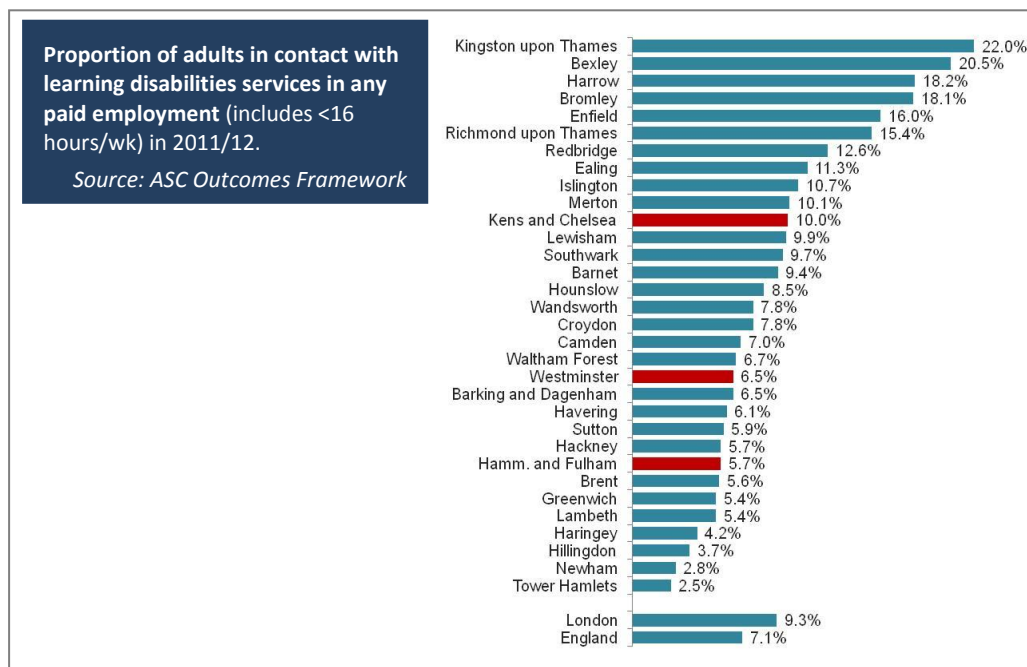
### 3.6 Unemployment related to learning disabilities

#### Numbers of clients with learning disabilities in paid employment

In 2011/12, H&F and Westminster both had a lower proportion of those known to have learning disabilities in paid employment, compared to London. Neighbouring boroughs also had lower than average rates.

However, the prevalence of learning disabilities is very low across the Tri-borough. To meet the London level, Westminster would need only 12 more people with learning disabilities to be in employment. Hammersmith and Fulham would need only 16 more.

Although K&C has a higher rate than the other two boroughs (just above the London average), this is a result of lower frequency work (*less than weekly*). Rates are similar between the three boroughs for *at least weekly* employment.



#### Note on low numbers in employment generally

Despite the apparent good performance in parts of the Tri-borough area compared to elsewhere, there is still considerable scope for improvement. We know that employment rates for clients with learning disabilities remain worse nationally than for other disability groups. The current employment rate for disabled people nationally has risen to 48% overall but remains only 10% for those learning disabilities (11). Yet national research finds that around 65% of people with learning disabilities nationally would like a paid job (11).

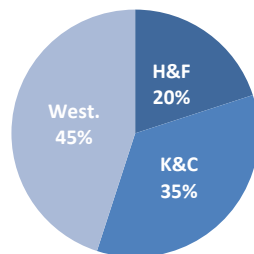
### 3.7 Expected need for employment support services

The expected share of resources that would be split between the three boroughs if spend matched the reported numbers of disability has been estimated for each client group. The allocation was based on a summary estimate of numbers of SMI, PD and LD (calculated using the available data from GP and Council reporting as well as IB claims).

Please note that this calculation assumes that reported mental illness or disability is equivalent in each borough. This may not in fact be the case, especially as ASC eligibility thresholds differ between boroughs.

#### Severe mental illness

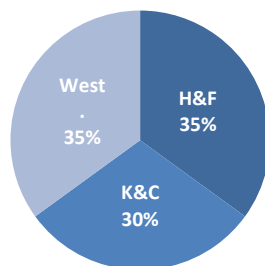
It could be expected that just under half of a Tri-borough budget for SMI would be spent on Westminster, around a third in K&C, and a fifth in H&F.



Expected share of resource for SMI clients if the available Tri-borough monies were divided according to the reported numbers of SMI in each borough

#### Physical Disabilities

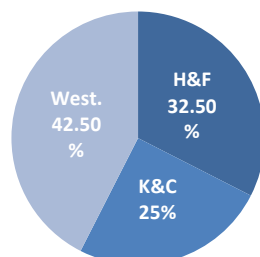
It could be expected that about a third of the budget for PD would be spent in each borough, with slightly less being spent in K&C. This is based on an average of those known to social services and IB claimant data.



Expected share of resource for PD clients if the available Tri-borough monies were divided according to the reported numbers of PD in each borough

#### Learning disabilities

It could be expected that just under a half of the total budget for LD would be spent in Westminster, a third in H&F, and a quarter in K&C.



Expected share of resource for PD clients if the available Tri-borough monies were divided according to the reported numbers of LD in each borough



### 3.8 Evidence around unemployment and health

#### Unemployment and health

Unemployed individuals have a higher risk of poor physical and mental health compared with those in employment. Unemployment is related to premature death, higher rates of smoking, increased alcohol consumption and lower physical activity (6).

The health and social impacts of a long period of unemployment can last for years (6). Health inequalities are closely linked to worklessness and its links to physical and mental health and wellbeing (6, 14)

#### Mental illness and unemployment

Mental illness is the number one cause of health-related unemployment (2) and the largest cause of disability in the UK (2). Mental illness is a major cause of short and long-term sickness absence. Based on population size, it is estimated that sickness absence costs the Tri-borough economy £84 million per annum (13). 'Presenteeism' (underproduction in the workplace due to health issues) may be costing double what sickness absence is thought to cost (9, 13).

Common mental health issues contribute to around two thirds of all health-related unemployment, sickness absence, long-term incapacity and early retirement (14). Moderate to severe mental illness (with musculoskeletal problems) make up a substantial proportion of the remainder.

Extrapolating from national data, the cost of mental illness locally is estimated to be £300 million in H&F, £250 million in K&C and £350 million in Westminster (2). Over a third of this is due to loss of economic output (over £80million per borough) and a fifth due to health and social care costs (over £5million per borough) (2). These figures are probably underestimates due to high local prevalence of severe mental illness and a larger working age population compared to the general population. This increased use of services is reflected in the fact that twice the proportion of unemployed people need psychological treatment compared to those who are in work (6).

#### Disabilities and unemployment

Having a disability can be a major disadvantage in the competitive workplace. Across the life course, evidence shows that disabled people consistently earn less than non-disabled people (24).

Physical disabilities are a major cause of unemployment (7). Musculoskeletal problems are the second largest cause of sickness absence and presenteeism (7).

Individuals with learning disabilities have worse employment prospects than other disability groups. According to the Department of Health, unemployment rates for people with learning disabilities are lower, and have risen slower, than for other disability groups (11). Nationally, the current employment rate for disabled people has risen to 48% overall but remains only 10% for those learning disabilities (11). Clients with moderate and severe learning disabilities tend to benefit least from employment support compared to other disability groups (11, 25).

## The cost to individuals, society and local economies

Unemployment and ill health are mutually reinforcing. The negative effects of unemployment are borne first by individuals but also put considerable strain on families, local resources, the economy and communities.

**Table 1** Summary of the costs of unemployment within the mental health and Adult Social care populations

<b>Cost to individuals</b>	<ul style="list-style-type: none"> <li>• Unemployment has major negative impacts on general health, mental health and wellbeing (2, 6)</li> <li>• Mental illness and disabilities significantly disadvantage people in their attempts to get into and retain employment (2, 6)</li> <li>• Both unemployment and mental illness both impact on other wider determinants of health such as income and secure housing, and also impacts on the wellbeing of families and communities (2)</li> </ul>
<b>Cost to local services</b>	<ul style="list-style-type: none"> <li>• Unemployment and mental illness increase the use of primary health care, social care, medication and hospital care (2)</li> <li>• Health and social care use in unemployed mental health clients is up to 50% greater compared to employed mental health clients. This can be reduced by getting clients into jobs (2).</li> </ul>
<b>Costs to local economy</b>	<ul style="list-style-type: none"> <li>• An average London firm of 250 employees loses around £4,800 per week (£250,000 a year) due to <b>sickness absence</b> (23)</li> <li>• Mental ill health is the reason for over half of all sickness absence. Physical disabilities including musculoskeletal (MSK) problems contribute significantly to the remainder (7)</li> <li>• Mental illness and MSK problems also <b>reduce productivity at work</b>. 'Presenteeism' is estimated to cost the UK economy double the cost of sickness absence</li> </ul>



### 3.9 Benefits of supporting mental health clients into work

#### Benefits to individuals

There is overwhelming evidence that good quality paid employment improves health and wellbeing and can promote recovery from mental illness (2, 14). This is associated with improvements in social status, social networks and support, social and financial inclusion, a means of structuring and occupying time, a sense of personal achievement and reduction in poverty (5, 6, 14).

There is strong evidence that the benefits are dependent on availability of good quality employment opportunities (6, 14).

#### Most mental health clients want paid work

Evidence suggests that many unemployed mental health clients are capable of moving into paid work quickly without extensive training (10). Nationally, up to 90% of all mental health service users want to work but only about 20% are employed (4). At least a third of those currently unemployed due to SMI would like to find work (10).

#### Full-time competitive employment is not always the optimal outcome

Mental health clients need a range of employment options, as individual needs vary (10). 16 hours paid work per week is the DWP threshold for full-time work. It is used both as a target for employment support and a threshold determining eligibility for certain benefits. However, 16 hours per week is not a realistic or desirable target for some mental health clients with more complex needs (10).



**Not all people with severe mental health conditions want to be employed, but almost all want to ‘work’, that is to be engaged in some kind of valued activity that meets the expectations of others.**

DWP and Department of Health joint commissioning guidance 2006 (5)



Engagement in any meaningful activity for clients with complex needs can confer benefits to health and wellbeing comparable to those from paid work (10).

Unfortunately, our evidence review identified no studies indicating the number of hours of meaningful activity, or the type of work, that is needed to have a beneficial effect. This is consistent with findings from large national reviews (9, 14).

#### Economic and social benefits

Evidence demonstrates that investment in specialist employment support can bring substantial social benefits and significant returns on investment for local authorities and clinical commissioning groups. These are summarised in Table 2.

**Table 2** Summary of the benefits to Local Government and CCGs from investment in employment support for clients with mental illness

Benefits for Local Government	Benefits for CCGs
<p><b>The most effective employment support schemes for mental health clients (e.g. IPS) are, at least, cost neutral.</b></p> <p><b>At best, a number of studies found reductions of up to 50% in health and social care costs (4).</b></p>	
<p><b>Employment support for mental health clients:</b></p> <ul style="list-style-type: none"> <li>Promotes more effective use of and reduces the cost of health and social care for mental health clients (2, 4).</li> <li>Contributes to local strategies to address local worklessness.</li> <li>Promotes individual and community health and wellbeing.</li> <li>Delivers Public Health and Social Care outcomes and support national policy on welfare to work.</li> <li>Reduces the economic costs of long-term mental health illness and unemployment for employers (2).</li> </ul>	<p><b>Employment support for mental health clients:</b></p> <ul style="list-style-type: none"> <li>Supports recovery of patients with mental illness (2).</li> <li>Reduces the number of GP consultations, which are higher for people with mental illness and for unemployed people than the general population (2). One UK study found that for clients helped into employment through IPS, weekly service use was reduced by over 60% (4).</li> <li>Reduces the need for and length of hospital stays (2, 4). A multi-site European randomized trial found that IPS delivered saving of around £6,000 per client in inpatient psychiatric care costs over the 18-month period, compared to usual care. This was twice the total direct cost of IPS (4).</li> <li>Delivers QIPP and NHS Operating Framework Expectations, as well as NHS, Public Health and Social Care outcomes.</li> </ul>
<p><b>In-work support for Tri-borough clients specifically can deliver:</b></p> <ul style="list-style-type: none"> <li>£850,000 per year in estimated savings for the economy by avoiding Tri-borough clients falling on benefits (26)</li> <li>£228,000 per year in estimated savings to employers from the prevention of sickness absence and turnover costs among Tri-borough employees (26). Evidence also demonstrates increase in staff productivity (2)</li> </ul> <p>Savings are local estimates from national data (26)</p>	<p><b>In-work support for Tri-borough clients specifically can deliver:</b></p> <ul style="list-style-type: none"> <li>£126,000 per year in estimated Tri-borough savings to the NHS of in reduced use of NHS services</li> <li>Savings are local estimates from national data (26)</li> </ul>

### 3.10 Benefits of supporting clients with disabilities into work

#### Benefits to individuals

There is overwhelming evidence that employment benefits individuals with disabilities (9, 25). Benefits include:

- Improved health, mental health and wellbeing measures
- Reduced use of health and social care services
- Increased household income
- Improved self reported measure of social integration, self-esteem, meaningful activity, self-determination and quality of life

#### Many people with disabilities want paid work

According to the Office for Disability, a slightly higher proportion of disabled compared with non-disabled people report that they want to work *more* hours than they do at present (24). According to the Department of Health, 65% of people with learning disabilities would like a paid job. However, employment rates for these clients are only 10% (11).

#### High quality work is achievable and important

A number of studies have shown that, with adequate support, people with moderate and severe learning disabilities can learn complex real work tasks, and that ‘these tasks could (and should) be taught on the job’. As for mental health clients, low quality, part-time jobs are less likely to deliver health and wellbeing benefits (11).

#### Full-time competitive is not always the optimal outcome

Clients with very complex needs can benefit from very supported employment, for example social firms (25). For these clients, engagement in this type of meaningful activity can confer benefits including improved health and reduced use of health services, as well as improved self-reported social functioning, life experience, self-esteem and life satisfaction (25).

Feedback from specialist local providers and service users indicated that payment should not be linked only to employment outcomes of over 16 hours per week of paid work.



**The threshold of 16 hours per week of work is not realistic for many with disabilities**

Local employment support provider at coproduction meeting



## Economic and social benefits

There is good evidence that investment in employment support for clients with disabilities can deliver substantial return on investment to local councils. Benefits are summarised in Table 3.

**Table 3**      **Summary of the benefits to Local Government from investment in employment support for clients with learning disabilities and physical disabilities**

Benefits for Local Government
<p><b>Social Return on Investment analysis has shown returns of between £5 and £13 for each £1 invested in the most effective model of support for clients with disabilities (Supported Employment) (9)</b></p>
<p><b>Economic benefits</b></p> <ul style="list-style-type: none"> <li>• There is substantial evidence that Supported Employment reduces use of health and social care services (9, 25).</li> <li>• This support is considerably cheaper than alternatives such as day centres and sheltered workshops (25).</li> <li>• Cost effectiveness analysis in North Lanarkshire and Kent showed overall cost per job gained of just of £7000 to £9000, compared to £15,000 for day services (9).</li> <li>• Social Return on Investment analysis has identified returns of between £5 and £13 for each £1 invested in Supported Employment (9). Returns come from: reduction in welfare benefit payments, tax and national insurance receipts, decreased costs of sustaining disabled people if the employment support had not been given (25).</li> <li>• Increasing employment rates for disabled people promotes individual and community health and wellbeing</li> </ul> <p><b>Investment is aligned with national policy priorities</b></p> <ul style="list-style-type: none"> <li>• Investment in employment support delivers Public Health and Social Care outcomes and supports national policy on welfare to work</li> <li>• The Government is committed to achieving employment equality for all disabled people by 2025. The aim is to radically increase the number of people with moderate and severe learning disabilities in employment by 2025 (11).</li> </ul>

### 3.11 Likely impact of economic climate and benefits reforms

#### Impact of the economic climate

The prevalence of mental illness increases during periods of recession. Inequalities in health, particularly mental health, are widened as socioeconomically disadvantaged groups are less resilient to economic challenge (6). During an economic downturn, the job market is challenging, particularly to clients with mental illness and disabilities (6).

Additional challenges are likely to be faced by employment support providers in successfully supporting clients into jobs in an increasingly competitive job market. However, if provision of employment support were reduced, the impacts on individuals will ultimately be passed onto NHS and local authorities with increased use of services and greater dependence on welfare support (2). Investment in employment support is an even greater priority at this time.

#### Impact of benefits reforms

The government has introduced £18billion of welfare savings and there may be a further £10billion by 2016 (6). A summary of the key changes and their impact follows.



**With current reforms to benefits, we expect the number of clients with severe and complex mental health problems in primary care to increase. And we expect the need for job retention support to further increase.**

Provider speaking at the co-production meetings



#### Likely impact of reforms

- **An influx of clients into the job market who, until now, have been considered ‘too ill to work’.** These clients are likely to require additional support to get into employment and retain jobs.
- **Increasing anxiety about benefits.** It will be particularly important that local employment support services offer high quality benefits advice and on site ‘better off calculations’.
- **Increased prevalence of mental illness.** This is associated with risk factors including: decreased household income, increased debt, increased homelessness and housing insecurity (6)

### Key changes affecting clients with mental illness and disabilities

- **Introduction of a Work Capability Assessment** for all claimants of health-related unemployment benefit. Many clients previously deemed unfit to work may now be expected to find work.
- **Introduction of a national Work Programme** to support people with additional needs into jobs.
- **Reduction of total household income for some clients.** This may be due to: caps to housing benefit, the single room rate, changes to council tax benefits, replacement of disability living allowance with personal independence payment, and the total benefit cap. Londoners will be disproportionately affected because of high housing costs (6).
- **Realignment of the incentives to promote work over benefit dependence.** This policy depends upon effective incentives, a sufficient number of jobs being available and effective support programmes (6). However, evidence shows that there are currently not enough jobs in London for the numbers searching and the Work Programme is not yet meeting performance expectations, especially for clients with mental illness and disabilities (6).

## 4 MAPPING PROVISION OF EMPLOYMENT SUPPORT SERVICES

### 4.1 Mapping process

An extensive mapping exercise was undertaken to identify specialist employment support currently available to local people with mental illness and disabilities.

#### Information was collected using a range of methods

- Email and telephone interviews with local and national providers
- Contracts and monitoring data for locally commissioned providers
- Coproduction meetings with providers and service users arranged by ASC
- Service user feedback from Adult Social Care and Mental Health clients

For the purpose of this analysis, services have been divided into three groups:

- Nationally commissioned
- Commissioned by local authorities or local NHS
- Other providers

### 4.2 Main findings

#### Multiple providers

There are many providers of employment support in the Tri-borough area (see overleaf): four nationally commissioned schemes, 14 locally commissioned providers and over 30 other local providers offering some sort of specialist employment support.

#### Locally commissioned

The 14 locally commissioned providers include local mental health trusts as well as third sector providers commissioned by Tri-borough Adult Social Care, local authority and NHS mental health commissioners.

#### National providers

Four national employment support programmes are available to clients with mental illness and disabilities. Eligibility for *JobCentre Plus* (JCP) and *The Work Programme* support does not depend on having health barriers to work. *Access to Work* and *Work Choice* are only eligible to clients with registered disabilities.

Evidence from DWP evaluations, Public Accounts Committee and national reviews suggests that support offered by JCP and the Work Programme may not currently be fully supporting the needs of clients with mental illness and disabilities (1, 10, 17). In addition, issues around eligibility and low numbers of referrals mean that many clients with disabilities are not using Access to Work or Work Choice (11).

## Complexity of pathways

Pathways for all clients groups within the service are complex. Many clients may be in contact with at least two different providers who may be unaware that the client is receiving other support. Given this complexity, it is likely that duplication may occur.

There is no single point of referral. Referrals come from several sources, with Care Managers being a major source of referrals to local services. National programmes have other referral processes



**Providers are not all aware of other agencies' existence or role.**

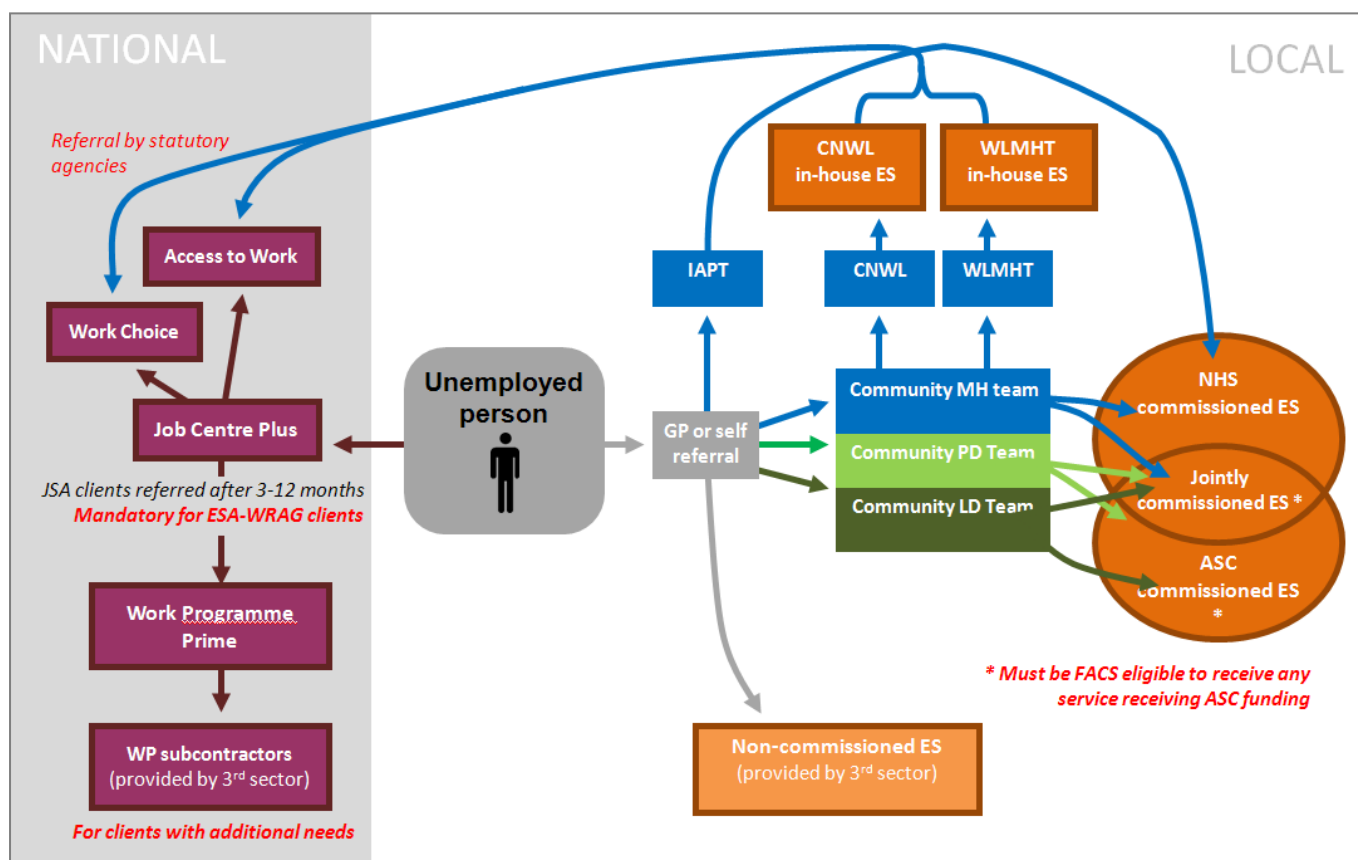
Co-production group feedback



**Chart 2**

### Map of pathways within local specialist employment support

Only includes services for clients with mental illness, physical and learning disabilities



ASC Adult Social Care  
CNWL Central and North West London Mental Health Trust  
ES Employment support  
ESA-WRAG Employment Support Allowance-work-related activity group

FACS Family and Children's Services  
IAPT Increasing Access to Psychological Therapies  
JSA Job Seekers Allowance  
LD Learning disabilities

MH Mental health  
PD Physical disabilities  
WLMHT West London Mental Health Trust  
WP The Work Programme



### Gaps in provision

Despite availability of different provisions, gaps remain in each borough in provision at specific employment support stages and for certain client groups. For example, there are major gaps in support for clients with physical disabilities in Hammersmith and Fulham. There are also gaps in provision of in-work support across the Tri-borough.



**Job retention is difficult and many people claim to be doing it - but not very well. Better job retention support must be included in the new service.**

Co-production group feedback



### Communication issues

There are also issues around communication and provision of information. There is limited communication between different providers and with other local services.

It is often difficult for clients to access benefits advice when receiving employment support. As a result, many clients are concerned that work may not make them better off financially.



**Better Off calculations should be delivered by staff that have a relationship with the client. It needs a motivated “sell” coupled with knowledge of the client’s situation to persuade clients that a small increase in weekly income will still make a positive difference.**

Co-production group feedback



### Data collection issues

Data collection is problematic. Providers use different definitions for their interventions (e.g. what constitutes in-work support) and outcomes (e.g. what is considered a work outcome). Improvements in data collected within contract monitoring could improve the allocation of resources according to need.

**Table 4** List of local providers of employment support

Nationally commissioned	Locally commissioned	Other providers
<ul style="list-style-type: none"> <li>• JobCentre Plus</li> <li>• The Work Programme</li> <li>• Work Choice</li> <li>• Access to Work</li> </ul>	<p><b>NHS MH Commissioner funded</b></p> <ul style="list-style-type: none"> <li>• Jobs in Mind</li> <li>• Mental Health Matters</li> <li>• Mind H&amp;F</li> <li>• Richmond Fellowship</li> <li>• WLMHT</li> <li>• Volunteer Centre Kensington and Chelsea-Stepping Stones</li> </ul> <p><b>Council funded</b></p> <ul style="list-style-type: none"> <li>• HAFAD</li> <li>• Pure Innovations</li> <li>• Westminster Employment</li> <li>• SMART</li> <li>• Volunteer Centre Westminster</li> <li>• Volunteer Centre Kensington and Chelsea-Stepping Stones</li> </ul> <p><b>Joint funded</b></p> <ul style="list-style-type: none"> <li>• CNWL</li> <li>• Mind K&amp;C</li> </ul> <p><b>Other</b></p> <p>Fit for Work Service **</p>	<ul style="list-style-type: none"> <li>• Turning Point</li> <li>• Action Disability Kensington &amp; Chelsea</li> <li>• Action for Blind People</li> <li>• Arabic Centre for Career Development</li> <li>• Benefits of Working</li> <li>• Blenheim CDP *</li> <li>• Bespoke International Foundation</li> <li>• Bishop Creighton House*</li> <li>• Broadway London - ETE*</li> <li>• Connexions - H+F</li> <li>• Connexions - RBKC</li> <li>• Connexions – Westminster</li> <li>• Dalgarno Trust</li> <li>• DIAL UK</li> <li>• LBHF Supported Housing pilot ETE funds</li> <li>• London Apprenticeship Company</li> <li>• Mencap</li> <li>• Prospects</li> <li>• Pursuing Independent Paths</li> <li>• Salvation Army - Edward Alsop Court</li> <li>• Share Community Ltd</li> <li>• St Christopher's Fellowship</li> <li>• TASHA</li> <li>• The citizen's Trust</li> <li>• Vital Regeneration *</li> <li>• Volunteer Centre Hammersmith &amp; Fulham*</li> <li>• Westminster Adult Education Service*</li> <li>• Westminster Personality Disorder Service*</li> </ul>

\* **The list of 'Other Providers'** does include some providers that offer employment support to clients with mental illness and disabilities using funding from the council or NHS. These have been excluded from the 'Locally Commissioned' list for two reasons. Either:

- Employment support is not targeted at clients with mental illness, physical or learning disabilities
- Funding is not tied to employment support. For example, Bishop Creighton House provides a mentoring service funded by a Council. They recruit and train mentors who support clients with learning disabilities in the community. A major aim is to encourage clients into job preparation activity and paid work.

\*\* The Fit for Work Service was a pilot early intervention in-work support service funded by DWP between 2010 and 2013. The service was contract managed by NHS INWL Public Health team. It was initially offered only in K&C but funding was extended by DWP and enabled delivery to the rest of the Tri-borough area in 2011. The pilot end date was 31<sup>st</sup> March 2013, however, successful presentation of business cases has secured funding from Westminster City Council and Kensington and Chelsea Performance Reward Grant to enable a similar service provision to be delivered 2013-2014 in these two boroughs

### 4.3 Current spend locally

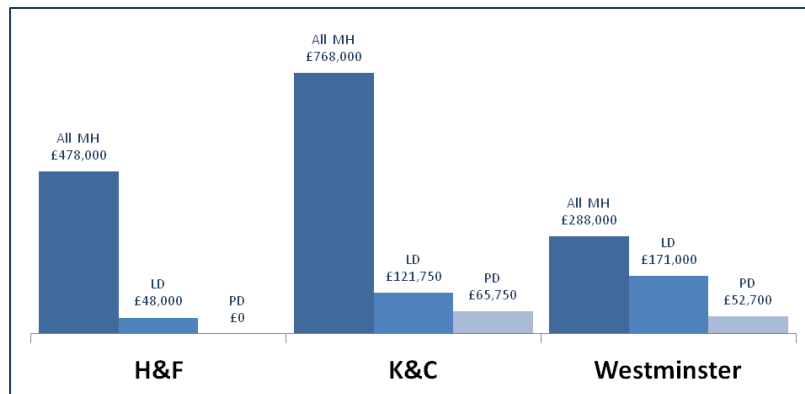
#### Overall spend per client group

The data suggests:-

More is spent on employment support for mental health than for the other disability groups. However, this reflects the larger number of mental health clients in the Tri-borough area compared to the other groups.

Chart 3

#### Current contracts for specialist employment support

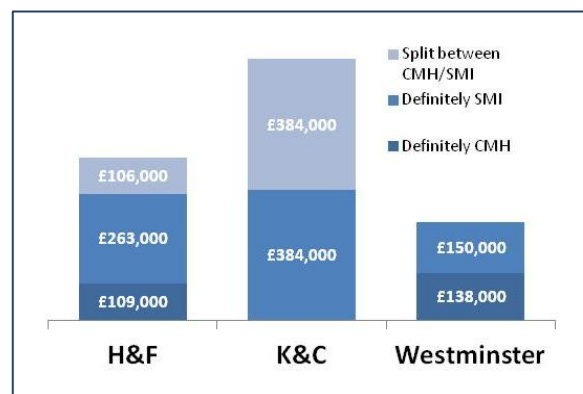


H&F has zero spend on support for clients with physical disabilities, despite having the highest rates of IB and ESA benefit claims for physical ill health in the Tri-borough area.

Westminster spends less than half as much on support for mental health clients as Kensington and Chelsea, despite having almost twice the number of incapacity benefit claimants for mental illness.

Chart 4

#### Breakdown of mental health spend on specialist employment support by severity of illness



**NOTE:**

- CMH/SMI refers to providers offering services to both CMH and SMI clients.

The breakdown of spend by severity of mental illness shows more is spent on support for SMI clients in all boroughs. However, in Westminster this difference is only marginal with Westminster spending proportionately more on CMH compared to the other boroughs.

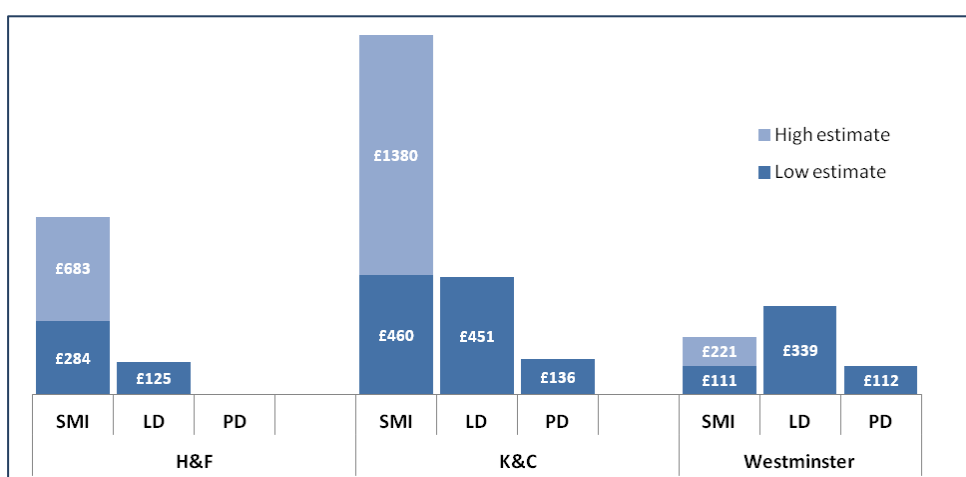
## Spend per head of population

Chart 5 details estimates of spend per head of population, calculated by dividing total contract values in each borough by the average working age population of each client group.

These data indicate that H&F and K&C spend more per capita on SMI than on the other clients groups. Westminster, on the other hand, spends less on SMI and more on each client with learning disabilities.

When viewed in conjunction with the data on outcomes (Chart 9) it is interesting to note that Westminster achieves a surprisingly high number of paid job outcomes for mental health clients, given its lower spend. Possible explanations for this are discussed later in section 4.6.

**Chart 5** Spend per head of population for each client group in each borough

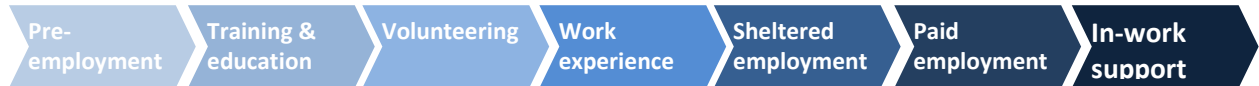


### NOTE:

- Estimates of spend per head of population were calculated by dividing total contract values in each borough by the average working age population of each client group.
- CMH is not included as the CMH population data is of insufficient quality.
- To evaluate SMI spend per head, high and low estimates had to be calculated for the SMI population as some providers offered services provision is to both CMH and SMI clients and their contracts could not be unpicked. The high estimates assumed that, for CMH/SMI joint contracts, all the money went to SMI. Conversely low estimates assumed that all joint-contract money was spent on CMH, with none on SMI. The denominator in both cases was the GP-registered working age SMI population. High and low estimates give a maximum and minimum value that commissioners are spending on employment support per working-age resident with SMI.
- The true value for spend per head on SMI clients is likely to be somewhere between the low and high estimates.

#### 4.4 Range of support provided locally

Most stages along the pathway to work are supported across the Tri-borough councils. However, it is important to note that where a stage of support is offered, it may not actually be the core business of the provider. For example, although many organisations reported that in-work support was offered, the data suggests that few demonstrated retention of jobs in outcomes.



The data suggests that there are clear gaps for certain disability groups:

<b>H&amp;F</b>	No locally commissioned provision for physical disabilities at any stage
<b>K&amp;C</b>	Without continuation of some fit for work service type provision (post March 2013) there would be no support for CMH clients at any stage other than volunteering. No support into training/education for clients with learning or physical disabilities
<b>Westminster</b>	No support into training/education for clients with learning or physical disabilities

## 4.5 Access to local services

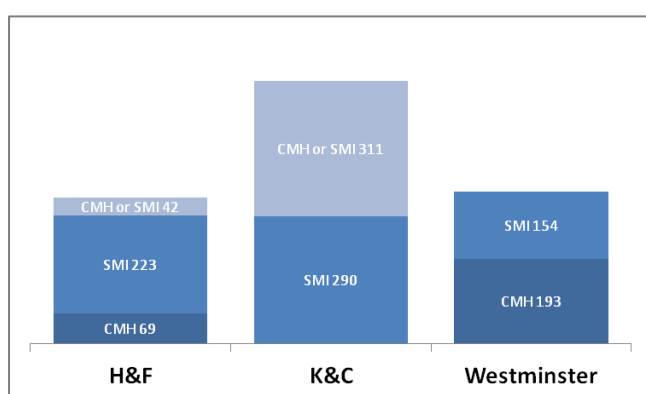
The data suggests that:-

### Mental health

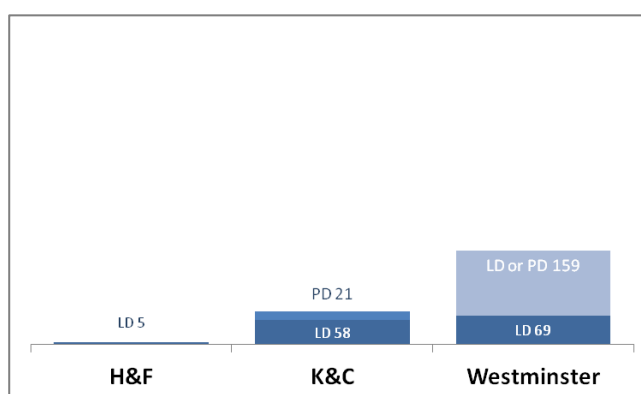
1,382 mental health clients accessed locally commissioned employment support services across the Tri-borough councils during 2011/12. Overall, more clients were seen in K&C (total 701) than in H&F (334) or Westminster (347). This distribution broadly reflects the amounts spent in each borough.

In K&C and H&F, the majority of clients accessing services had SMI. Conversely, in Westminster, the reverse is true. In all boroughs, numbers of CMH and SMI clients accessing support reflects the relative amounts spent on services targeting either group.

**Chart 6** Number of mental health clients accessing locally commissioned employment support in 2011/12



**Chart 7** Number of clients with disabilities accessing locally commissioned employment support in 2011/12



- 'CMH or SMI' refers to contracts with providers offering services to both CMH and SMI clients
- 'LD or PD' refers to data from providers that support both LD and PD clients. Our data does not break down their data by disability group

### Physical and Learning Disabilities

312 clients with physical or learning disabilities accessed locally commissioned employment support services across the Tri-borough councils during 2011/12.

The majority (over 70%) of all Tri-borough clients with learning and physical disabilities accessing specialist employment support in 2011/12 did so in Westminster.

Only five clients with learning disabilities and none with physical disabilities, accessed employment support in H&F.

## Other issues around access

### Complexity of need

User feedback from coproduction meetings identified gaps in support for clients with dual diagnosis. Services may be too tailored to the needs of a single disability group.



**People rarely have just one or two obstacles to returning to work. It is also rare for one service to provide all interventions a client may require.**

Co-production group feedback



National evidence shows that severity of disability is inversely correlated with likelihood of being referred to programmes, success in achieving employment outcomes, and likelihood of sharing the benefits (e.g. wage levels and work integration) (20, 25).

### Ethnicity, gender and socioeconomic status

The data does not allow analysis of local employment support provision, uptake or outcomes by socioeconomic status, ethnicity, gender, or at ward level.

Some national evidence suggests that women with disabilities access proportionately less employment support than men (20). Evidence around the impact of ethnicity on access to support is inconclusive (20).

## 4.6 Outcomes from local services

The data suggests that:-

### Mental Health

Most outcomes are achieved in SMI clients, reflecting borough spending allocations by severity of illness.

#### Training

Training placements account for the majority of all outcomes. More than half the training outcomes occur in H&F. Westminster has far fewer training outcomes than other boroughs.

#### Volunteering

There are surprisingly few volunteering outcomes across the Tri-borough, given the large number of providers offering support here.

#### Work experience

There are few work experience outcomes in any borough, which probably reflects the small number of providers offering this support. Several providers reported that they supported work experience; the data however would suggest that few work experience outcomes were achieved.

#### Paid jobs

Westminster delivers a surprisingly larger number of paid job outcomes for mental health clients, given that it invests less than half the amount spent in K&C, Westminster achieves twice as many job outcomes. This may be explained by Westminster's concentration on the evidence-based IPS model for SMI clients and relative focus on CMH clients (who are closer to the job market than SMI clients).

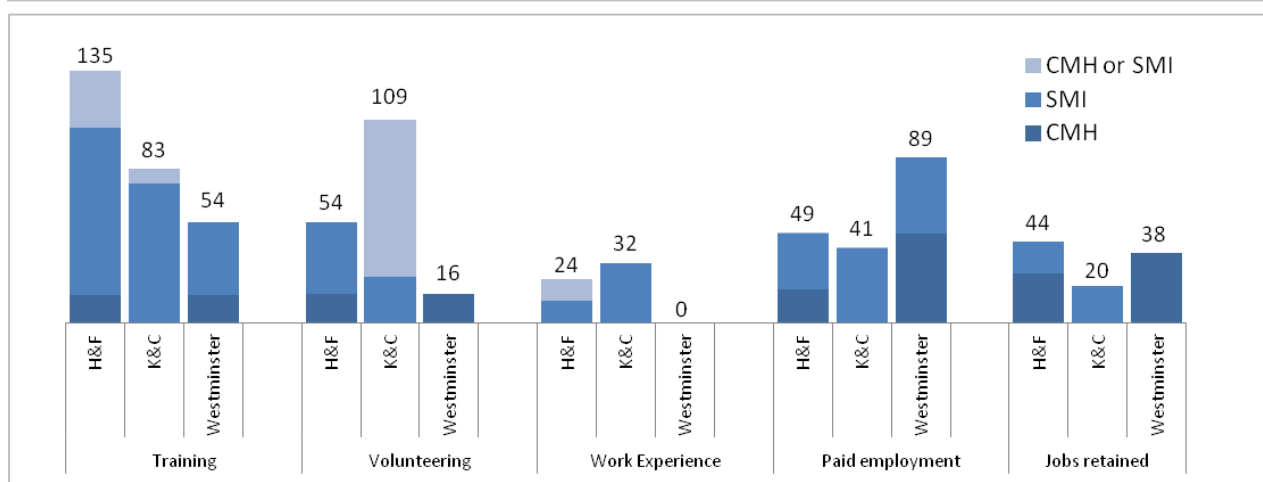
#### Jobs retained

Half of all jobs retained across the Tri-borough area for mental health clients (100) were achieved by the Fit for Work Service (FFWS). These are not included in the bar chart as FFWS data was not broken down by borough at the time of reporting. Almost all providers reported that they offer in-work support, but the data would suggest that half did not demonstrate job retention outcomes.

#### Chart 8

**Outcomes from locally commissioned employment support for mental health clients in 2011/12, broken down by stage of support and by borough**

\* The 2010-2013 Fit for Work Pilot Service is not included here as its data was not broken down by borough at the time of reporting. However, it contributed 100 job retention outcomes for CMH clients across the Tri-borough, which accounts for half of all jobs retained.





## Physical and Learning Disabilities

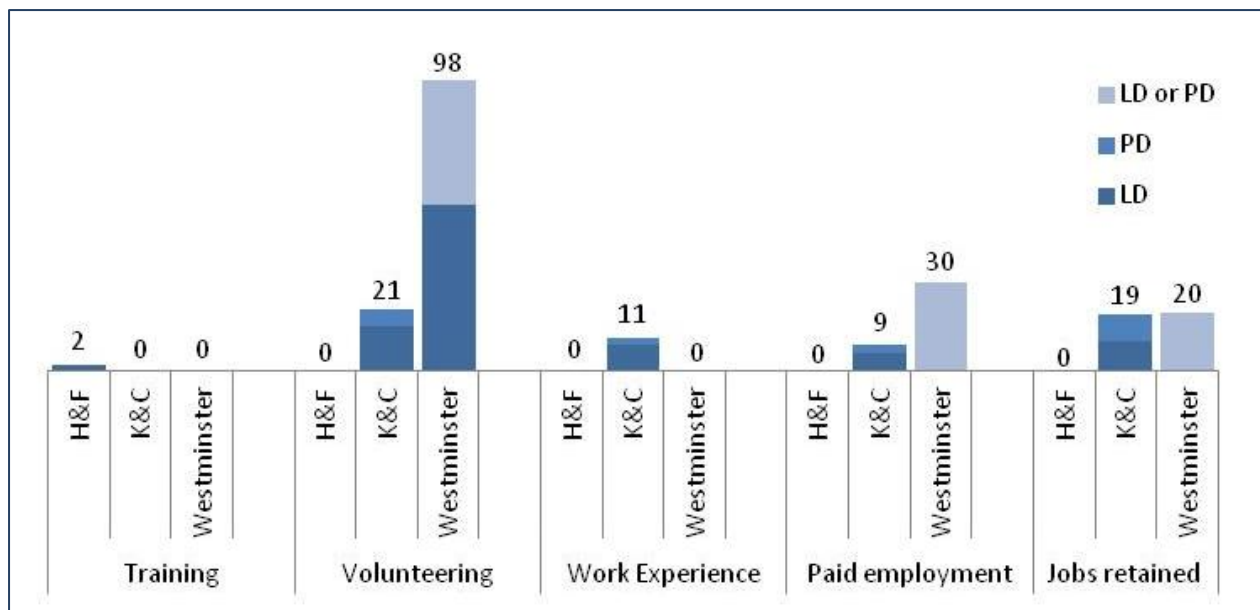
By far the most common outcome for clients with disabilities is volunteering, accounting two thirds of all outcomes.

Westminster delivered about three quarters of all outcomes for clients with disabilities. .

Hammersmith and Fulham delivered two outcomes for clients with learning disabilities (both were training placements) and no outcomes for clients with physical disabilities.

NOTE: Volunteer Centre Hammersmith and Fulham does receive funding from the council but it is not allocated specifically to support clients with disabilities. As a result, this support is not considered here.

**Chart 9** Outcomes from locally commissioned employment support for clients with learning and physical disabilities in 2011/12, broken down by stage on the pathway to work and by borough



## 4.7 Value for money from local services

It is not possible to calculate return on investment with any accuracy, as the types or duration of jobs or other placements are not known for some services. Individual level information on health and wellbeing outcomes is also unknown for some services.

However, crude analysis of total service cost as a proportion of number of outcomes – a crude unit cost – suggests that some providers may be achieving a smaller number of outcomes for the money received compared to others. In some cases this may be legitimate; this will need to be investigated further to understand underlying reasons.

Providers offering IPS appear to deliver better value for money within the mental health field. This is consistent with the evidence that IPS is the most cost effective model in mental health.

Within providers working with LD and PD clients, providers using evidence-based supported employment model appeared to deliver services at considerably better value for money

## 4.8 National Services

There are four national employment support programmes available for clients with mental illness and disabilities. Data on access by Tri-borough clients with mental illness or disabilities is not released. However, for all four programmes, national evidence identifies issues around the ability of schemes to meet the employment needs of clients with mental illness or disabilities. These issues are discussed below.

### JobCentre Plus (JCP)

*This is the first point of call for anyone claiming employment-related benefits. JCP provides services to help people move from welfare into work, primarily through pre-employment support and job brokerage.*

A national review identified that JCP staff may have 'poor awareness of mental health issues' (10). Many clients have undisclosed mental health conditions. There is scope to improve the early identification and management of these issues to prevent worsening of health condition and subsequent impacts on return to employment.

User feedback identified that, in their view, JCP advisers were not always trained to support people with disabilities, particularly in communicating with clients with learning disabilities. The lack of personalisation has been identified as an issue for all clients with complex employment needs.

“

**Some JCP staff are rude. They are not trained in talking to people with a learning disability.**

JCP client with learning disabilities at coproduction

”

“

**They don't listen to you properly. They don't put you first. They don't think about how you communicate. They can speak too quickly and you get half of the sentence.**

JCP client with learning disabilities at coproduction

”

### Work Choice

*Work Choice is available to job seekers who are registered disabled and able to do more than 16 hours work per week. The programme aims to help individuals to find work or stay in their current job. It is delivered across London by Remploy.*

Clients on the Work Programme are unable to access this support. Eligibility based on ability to work more than 16 hours per week (19) excludes many clients with mental illness and disabilities.

### Access to Work (ATW)

*This scheme provides grants to help clients with registered disabilities find work or stay in a job. There is also a specific mental health component supporting clients with mental health issues already in work.*

A 2011 DWP review of disability employment support found that ATW was underused (20). There is particularly poor uptake by mental health and learning disabilities clients who accounted for only 5% of total ATW uptake in 2009/10 (20). Only four referrals were made to the ATW mental health support across the Tri-borough area in 2012/13.

Clients on the Work Programme are ineligible for ATW; therefore many disabled people are automatically excluded from this financial help.

## The Work Programme (WP)

*Set up in 2011, the WP is the government's flagship 'welfare to work' scheme aiming to support clients who are most challenged within the job market*

### One year performance

The Public Accounts Committee described performance as “disappointing”. Outcomes were worse than previous programmes and considerably lower than DWP expectations (17). There is considerable variation between providers nationally, with London performance worse than England. However, the three West London Primes all performed better than East London (18).

### Performance for clients with disabilities

Outcomes were significantly worse than for all other groups: clients with a disability were half as likely to have a job outcome as people without a disability. London performed worse for disabilities clients than the rest of the UK (18).

“

**Work Programme Primes don't offer enough support for people with complex needs .**

Co-production group feedback

”

**A qualitative evaluation of the WP** commissioned by DWP identified (1):

- *‘Overall, it appears that providers are more able to support participants with few and less severe barriers to employment than they are those with severe and multiple barriers who potentially require specialist support’.*
- *‘Some providers at least, took the view (perhaps surprisingly, given the design and remit of the Work Programme) that it was inappropriate for the hardest to help to be referred to their services at all’. (1)*

## 4.9 Local support for other client groups

This JSNA focuses on the specialist employment support available to local residents with mental illness and disabilities. There is, however, a considerable amount of Tri-borough work on employment-related issues looking at wider populations. This includes commissioning by the Substance Misuse Service team as well as borough-specific work by local Economic Development Teams targeting a range of clients including substance users, ex-offenders, young people and lone parents.

## 4.10 Limitations of the mapping exercise and analysis

### Data gaps

Availability and quality of data is a major limitation.

The questions that this JSNA is unable to answer include:

- Are there any inequalities in access to locally commissioned services based on ethnicity, gender, age or geographical location?
- How many people should we have been getting into work?
- Are we helping people into sustained employment?
- What quality and type of jobs are clients getting through locally commissioned support?
- How many people have been lifted out welfare dependence as a result of local employment support?
- What happens for the people who do not achieve employment through these programmes?

### Data analysis

Providers use different definitions for their interventions (e.g. what constitutes in-work support) and outcomes (e.g. what is considered a work outcome). This complicates any like-for-like comparisons between providers. This is particularly true when attempting to compare cost effectiveness.

### Data for contract monitoring

Improvements to contract monitoring would allow us to answer many of these questions. Reporting should include anonymised data linking access and outcomes to:

- Gender
- Age
- Ethnicity
- Diagnosis and complexity of impairment
- Postcode
- Details of benefits claimed and any changes that result from employment support
- Participation in any national employment support programme
- Details of jobs attained through support, how long clients remain in work and reasons for any job terminations.

## 5 TOWARDS AN EVIDENCE-BASED FUTURE SERVICE

### 5.1 Service aims

A future locally commissioned service might take many forms. Commissioners may want to consider the following:

#### 1. To maximise the effectiveness of existing national provision

There is scope for better partnership work (including delivery of mental health and disabilities awareness training) and improved referral pathways between local and national providers. This is already being developed in the Tri-borough by the Substance Misuse Service and Offender Health Team, and aligns with current national policy (2).

#### 2. To commission evidence-based specialist employment support for:

##### *Clients not eligible for national schemes*

These clients are likely to have complex needs (those not able to work for 16 hours per week are ineligible for *Access to Work* and *Work Choice* and are not expected to join the *Work Programme*). Outcomes may not involve full-time or competitive employment and may include 'Very Sheltered' employment.

##### *Clients whose needs are not currently being fully met by national provision*

This is advocated where positive outcomes can be dependent on collaboration with an individual's health and social care team. There is potential for a stronger focus on early intervention and more preventative approaches.

#### 3. To integrate in-work support as a key element of the specialist employment support service

Any mental health or ASC client supported into a job should be considered for ongoing support.

#### 4. To retain an early intervention in-work support service across the Tri-borough councils

This might be separate to the specialist employment support service as it would predominantly support clients with common mental illness and those with musculoskeletal problems (the two principle causes of sickness absence from work and presenteeism) (7). Commissioners should also take into account any forthcoming national provision of in-work support.

## 5.2 Key components of a good employment services

There is good evidence that an effective employment support service benefits from the following components:

- **Evidence-based approaches** to employment support. For example IPS in the mental health field and SE in the disabilities field
- **Regular review of progress** to ensure that clients progress towards paid employment and do not get stuck at earlier stages along the pathway to work
- **High quality information** on services needs to be available so that providers can refer and signpost appropriately
- **Benefits advice easily available to clients and support workers.** The computer software to make “better off calculations” should be accessible to those supporting clients into employment
- **A single point of referral** into the system and **clear pathways** within it
- **Partnership work and effective communication** between employment support provider, care managers, health care and benefits advisors
- **Co-location** of employment support within social and health services (e.g. IAPT). This can improve the effectiveness of support for clients and may be cost saving
- **Employer engagement** so that more high quality job opportunities are available to clients. Fewer people will fall out of employment when employers know what to expect when they employ individuals with mental illness or disabilities.
- **Good quality work opportunities**
- **Provision of early intervention support for job retention supporting employees and employers**
- **Strong links with national programmes, especially where these are compulsory.**
- **The Local council and CCGs leading by example** as employers.



Engagement with employers needs to be a key part of the new service. Otherwise people will bounce in and out of work as employers don't know what to expect from new employees with disabilities.

Co-production group feedback



Career Development for people with disabilities is not emphasised in current system. You need to offer more than the minimum wage to incentivise people to risk losing benefits and go into work.

Co-production group feedback



### 5.3 Evidence-based models of employment support



The majority of those we spoke to during the course of this review appear to be satisfied with the evidence that supported employment (within the learning disability field) and IPS (within mental health) are the accepted, most effective solutions to supporting people into paid jobs..

National Institute for Health research Economic evidence around employment support: scoping review (8)



There are broadly two approaches to employment support:

- **‘Train then place’ models** prepare clients to be ‘job-ready’ before job placement. This may include volunteer placements and sheltered work before competitive employment.
- **‘Place then train’ models** support clients into competitive work as quickly as possible, training and supporting them on the job. There is considerably more evidence for this approach. Many regard the aim of work to be more a form of treatment than a means of achieving economic self-sufficiency. Examples include Supported Employment (SE) and Individual Placement and Support (IPS), which are both discussed below.

#### Best evidence

It is widely accepted that SE (for learning disabilities clients) and IPS (within mental health) are the most effective and cost effective models of support (9).

There is limited evidence around the most effective support for clients with physical disabilities. It is likely that place-then-train approaches are most effective due to their success both for clients with mental illness and learning disabilities.

Although there is some evidence that support at other stages on the pathway to work is effective, it will be extremely important to ensure that clients deemed most suited to support at these earlier stages are regularly assessed to ensure progression towards employment. Please see the Appendix C for more details on the evidence for individual models and figures for return on investment.

#### Poor fidelity

A major theme in the literature is the degree to which providers combine different models. Some organisations appear to be successfully using a mixed approach. These providers claim that it helps them tailor support to the client (9). However, one randomised controlled trial found that a substantially cheaper implementation of IPS (at around £442 per client) was far less effective (9).

Within the Tri-borough area, not all provision offering IPS adheres completely to the model. Some providers offer volunteering and work experience alongside ‘place then train’ IPS support. It would appear that this can still deliver fairly good paid work outcomes.



## 5.4 Working alongside national programmes



**The Work Programme is mandatory so we need to set up a service that works alongside it, rather than duplicate it.**

Co-production group feedback



There is no point commissioning local services that duplicate existing national provision. However, DWP, National Audit Office and national review evidence suggests that national programmes are not currently fully supporting the needs of clients with mental illness and disabilities (1, 10, 27, 28).

Feedback from the coproduction group advocated stronger partnership work with national schemes, particularly highlighting the need for better referrals pathways into Work Choice and Access to Work.

Collaborative commissioning between mental health commissioners and national employment support providers is an approach advocated by the London Mental Health and Employment Partnership (2). They specifically recommend joint working between Increasing Access to Psychological Therapies (IAPT) and Work Programme Primes, and have established a pilot in Newham (see page 51).

### Partnership aims might include:

1. **To deliver training** to the employment advisors in national programmes to maximise the effectiveness of their support.
2. **To share information** on the employment support a client is accessing locally and nationally
3. **To develop shared procedures** around mental health disclosure, information governance and safeguarding
4. **To develop referral pathways** into mental health services from national providers

### Training

It is likely that training delivered by local specialist teams to national providers in how to support clients with mental illness and disabilities needs would be a simple and effective way of maximising the effectiveness of national programmes. This type of collaboration and training is already being developed in the Tri-borough area by the Substance Misuse Services Team and by IAPT services in Newham (LMHEP pilot).



**We need to help educate employers and partnership organisations in how to deal with mental health and disabilities in the workplace, reducing the stigma.**

*Member of Tri-borough Community Learning Disabilities team*





**We want better training for Job Centre Plus staff.**

Advocacy Project feedback from JCP clients with learning disabilities



Mental health and disabilities awareness training could be delivered by any of the following local specialists:

- Relevant provider of a locally commissioned service
- Existing local IAPT (*Increasing Access to Psychological Therapies*) or other mental health services
- Local Care Management Teams
- Any of the above in partnership with the Tri-borough Substance Misuse Service team (already developing partnerships with local JCP and Work Programme Primes)

### Potential challenges

Work Programme Primes are extremely busy and under pressure to deliver job outcomes across a wide client population. The experience of the Tri-borough Substance Misuse Services team has been that it has been harder to establish relationships with representatives from local Primes than JCP.

National Programmes, particularly the more recently contracted Work Programme Primes, may not have developed policies and protocols around disclosure, information governance and safeguarding for the purposes of joint working. These would need to be agreed before referrals can take place.

### **Case study**     Newham Increasing Access to Psychological Therapies (IAPT) services working with local Work Programme Primes

#### **Background**

- The London Health Programmes (LHP) set up a pilot to develop partnership working between Newham's IAPT services and local Work Programme Primes.
- The pilot aims to deliver mental health awareness training to employment advisors at local Primes and to develop referral pathways into IAPT treatment services.

#### **Training**

- Newham IAPT has delivered initial half-day training sessions to staff from three local Primes
- Topics covered included: awareness of mental illness, available treatment services, and risk assessment.
- Feedback from trainees was very positive but identified that there was too much to cover in a half-day. Whole-day sessions are now operating.
- There is a plan to generate a package of training materials that can be used by other areas to deliver training to their local Primes. However, this will not be available until at least 2014 as the pilot needs to be evaluated.

#### **Referrals for IAPT treatment**

- Referrals from Work Programme Primes are planned but not operational at present.
- Before referral pathways can be developed, basic issues around information governance, disclosure and safeguarding need to be addressed.

#### **Challenges**

- Work Programme Primes are already under pressure to deliver their contracts and advisor time is at a premium.
- The partnership has identified a difference in information governance protocols at Work Programme Primes. These will need to be aligned before referrals into IAPT services can be made.

## **Case study**     Tri-borough Substance Misuse Service and Offender Health Team Work with JCP and the Work Programme

### **Background**

- An action plan was formulated in August 2012 by the Tri-borough Substance Misuse Service & Offender Health (SMOH) team, the JCP Partnership Managers and the three Work Programme Primes across the Tri-borough area to address the low numbers of referrals from JCP into treatment and to improve joint working with shared clients.

### **Planning**

- Single Points of Contact (SPOC) have been named from each organisation (treatment hubs, JCP offices and Work Programme providers) in each borough.
- In each borough, the SPOCs meet regularly.

### **Training**

- Training has been delivered to JCP and Work Programme staff in substance misuse awareness, referral pathways and strategies for eliciting disclosure.
- A rolling programme of further training is planned.

### **Co-location of services and referrals for Substance Misuse treatment**

- Substance Misuse Treatment providers are rolling out a pilot satellite service (on half-days either every one or two weeks) across a number of JCP sites in the Tri-borough area to increase referrals and to improve joint working with shared clients.
- The aim is to offer specialist substance misuse support to JCP staff in their regular contact with client; as well as to generate referrals to SMOH treatment services.
- From November 2012- 31<sup>st</sup> March 2013, there have been 45 referrals from JCP staff to the relevant treatment service across the Triborough, with 15 subsequent starts in treatment. Most of these referrals came from North Westminster and unfortunately post April 2013 these referrals have dropped away.
- Treatment providers are now attending JCP team meetings and floor walking in offices to encourage referrals from advisors.

### **Challenges**

- JCP engagement has been more fruitful than that from the Work Programme. The three local Primes have not attended all meetings, perhaps due to competing priorities.
- JCP and SMOH are now in discussions about developing improved partnership working around those clients that are currently shared, focusing on those that want to move into paid employment.

## 5.5 Measures of success

### To reach London average level

Commissioners may have expectations that employment rates reach at least the London average. Available data will allow this to be measured for SMI and learning disabilities.

### To match best performing London boroughs

An ambitious target would be to reach the best in London levels. The best performing London boroughs tend to be in outer London. Demographic differences are likely to account for much of the difference in performance.

See chart 10 below for the numbers of jobs that need to be found to reach both London average and best in London employment levels for clients with mental health and learning disabilities.

**Chart 10** Additional numbers needed to get into employment per year per borough to reach employment rates equivalent to the London average level and the best performing London boroughs.

	Severe & Enduring Mental Illness		Learning Disabilities	
	London average	Best performing in London (Kingston)	London average	Best performing in London (Kingston)
H&F	-	57	16	65
K&C	9	65	-	34
Westminster	20	111	12	76

## 5.6 Learning from other London Boroughs

Employment rates for clients with mental illness and disabilities in the best performing London boroughs are over twice as high as in the Tri-borough. The highest employment rates tend to be achieved in outer London. Underlying demographic and job market factors are likely to explain much of the difference in performance.

Adult Social Care commissioners were contacted in Kingston and Bromley, two of the best performing boroughs, to compare commissioned services.

### Providers

Both boroughs use a range of third sector providers to deliver elements of their service. Bromley has engaged in partnership work with both JCP and Work Programme Primes.

### Key components of their approaches

- Support given at all stages on the pathway to work
- 'Job Carving' approach (where jobs are fitted to the client)
- Use of social enterprises
- Comprehensive data collected within contract monitoring including:
  - Details of jobs obtained (job title, number of hours per week)
  - Self-reported measures of self esteem and wellbeing (before/after support given)
  - Details of any national scheme used (e.g. Work Choice/ Access to Work)
  - Detailed explanations for termination of any jobs
- Investment in job retention with high numbers of jobs retained
- Encourage clients to self-fund with personal budgets
- Specific funding for a post responsible for employer engagement
- Specific project to increase uptake of Work Choice (national support)
- User-lead approach

## 5.7 Commissioning implications

### Spend per client

#### Individual Placement and Support (IPS) in the mental health field

Parsonage suggests an annual direct cost of £2000 per person, making it an affordable solution (4). According to calculations cited in Parsonage's report, the direct cost of provision of IPS services at the recommended level is estimated to be just under £440,000 per year per average borough (based on the unit cost of £46,667 a year for an employment specialist).

Where IPS replaces existing vocational provision, the budgetary impact is more likely to be favourable than when setting up IPS from scratch (4).

#### Supported Employment (SE) in the learning disabilities field

Cost-effectiveness analyses from UK-based studies have shown an overall cost per job gained of around £7000 to £9000. This compares to £15,000 for day services (9).

### Use of Personal Budgets

Personal budgets are an underused source of funding for employment support. Their use in this way is a national policy, as advocated by the report *Real Jobs for Real People* (11).

However, a recent national survey of ASC commissioners found that over a third of respondents didn't know whether clients were using personal budgets to fund employment support (22). Of the 28% of respondents that said clients were using personal budgets in this way, only a small number knew *how* the budgets were being used (22).

### Payment by results (PBR)

PBR is an outcome-based commissioning approach. It aims to encourage a focus on outcomes, not processes, and is seen as a way of driving improvement in public services (28). However, there are acknowledged risks to PBR, particularly for services supporting clients with complex needs.

#### Poorer outcomes for clients with complex needs

Studies have shown that PBR which rewards numbers of job outcomes tends to steer clients with complex needs towards short-term, part-time jobs in sectors that attract low pay and require low level skills, regardless of the circumstances of the individual. These are sectors in which clients are already most frequently employed. This 'reinforces existing unequal socio-economic relationships' and does not promote career development for the individual (29). This finding was a major theme in feedback from coproduction meetings.



**The target culture is bad and promotes cherry picking... Funding by results is bad news.**

Co-production group feedback



### **Contractual emphasis on complex need and sustained outcomes**

PBR contracts can be designed to encourage providers to support clients with more complex needs or to ensure sustained job outcomes. Both are a feature of the Work Programme (described as possibly the largest single payment by results employment programme in the world) (28). The up-front 'attachment payment' (when the participant enters the programme) is greater for clients with health problems or disabilities. However, the bulk of funding to providers is triggered only for sustained job outcomes.



**Payment by Results can skew voluntary groups away from their core mission. Unless payments are made in advance, voluntary sector groups can't manage the 'cash flow' requirements, results aren't achieved (or are unachievable) and the voluntary sector is in danger of losing significant money.**

Member of the West London Training and Education Network of voluntary sector organisations





## APPENDIX A – Summary of Tri-borough prevalence of mental illness, physical disabilities and learning disabilities

Client group	Data source	H&F	K&C	Westminster
<b>Mental health</b>				
SMI - registered with GP	Working age estimated from QOF 2011/12	1,919	1,875	2,641
SMI - denominator for ASC Outcomes Framework	ASC Outcomes Framework 11/12	925	835	1,355
MH - Working age known to councils	NASCIS/ IC 2011/12	275	975	1,025
Incapacity benefit/ESA for mental ill-health	DWP Aug 2012	2,030	1,655	3,160
Prevalence of common mental illness (estimated for ages 16-64)	NE PHO (estimate)	23,000	22,400	30,300
<b>Learning disability</b>				
LD - registered with GP	Working age estimated from QOF 2011/12	335	243	460
LD - denominator for ASC Outcomes Framework	ASC Outcomes Framework 11/12	385	270	505
LD - working age known to councils	NASCIS/ IC 2011/12	250	165	305
<b>Physical disability</b>				
PD - working age known to councils	NASCIS/ IC 2011/12	505	485	470
Incapacity/ESA benefit claimants for physical ill-health	DWP Aug 2012	2,255	1,550	2,705

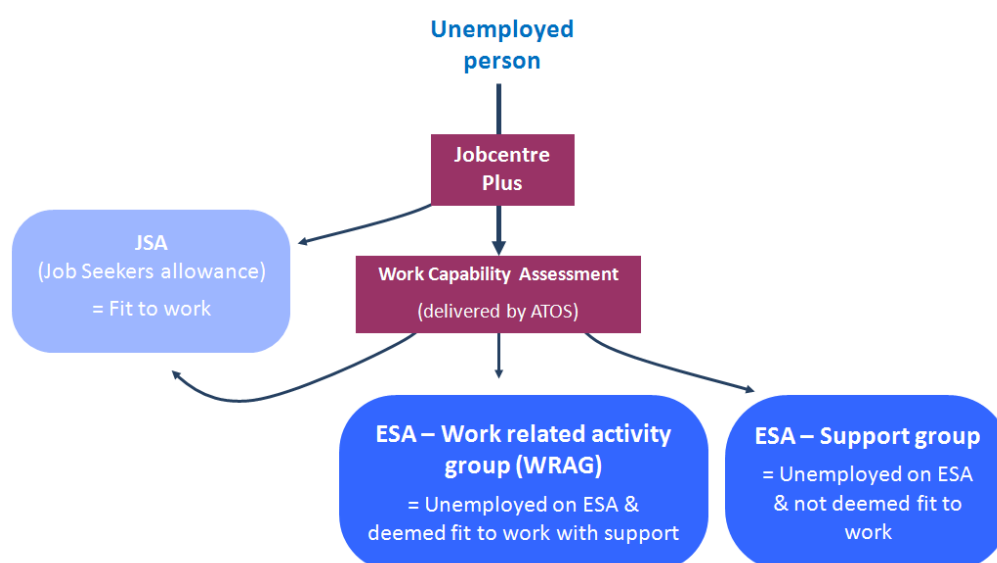
## APPENDIX B– Health-related employment benefits

Prior to the reforms, anyone with a health condition affecting their ability to work could apply for Incapacity Benefit (IB). Eligibility was determined by JCP. People on IB were not expected to look for work.

Since the reforms, IB has been replaced by Employment Support Allowance (ESA). Under the new system, any client making a claim for ESA undergoes a Work Capability Assessment delivered by private companies. This allocates clients into one of three groups depending on the degree to which ill health impacts their functional ability to work:

- **Clients deemed fully fit to work** are advised to make a claim for *Job Seekers Allowance*. They are expected to actively seek work with the help of JobCentre Plus (JCP). Some may be eligible for nationally provided specialist employment support programmes for people with disabilities (such as Access to Work and Work Choice). If JSA claimants are not employed after six months to a year (depending on age) they will be mandated to join the Work Programme (see Section 4.8).
- **Clients deemed fit to work with support** are put on *Employment Support Allowance - Work Related Activity Group* (ESA-WRAG). Of these clients, individuals who are deemed able to return to work within 12 months are mandated to join the Work Programme to support them into work.
- **Client deemed not fit to work** are put on *Employment Support Allowance – Support Group*. They are not expected to look for work. Some are unlikely to be eligible for nationally provided specialist employment support programmes for people with disabilities as eligibility depends on a client's ability to work for more than 16 hours per week.

### Diagram of current health-related employment benefits



## APPENDIX C– Evidence for employment support models and approaches

### Supported Employment (SE)

#### Strong evidence base

It is widely acknowledged that SE is the most effective solution within the learning disability field, with more economic evidence in support of SE than for other approaches (9).

#### Key elements of SE (9)

- Placement in a job has been found to be a necessary first step in successful training for people with a learning disability. Tasks and social demands can vary between workplaces and are consequently difficult to replicate in day or training centres (26).
- Vocational profiling of clients to match job to interests
- Training and on-going support in the job

#### Evidence of benefits

- Higher wage levels (25)
- Improved social integration, self-esteem and job satisfaction, increase in meaningful activity, and self-determination (25)
- Some evidence suggesting an improvement in quality of life although this is not conclusive (25)

#### Good evidence for cost effectiveness

Cost effectiveness analysis in North Lanarkshire and Kent showed overall cost per job gained of £7000 to £9000, compared to £15,000 for day services (9). These studies identified net savings of £3500 to just under £7000 per person per year. Social Return on Investment analysis has shown returns of between £5 and £13 for each £1 invested (9).

The cost-benefit of SE improves over time in comparison to sheltered workshops where the cost benefit tends to be static. Cost benefit ratios for SE in the first two years tend to be less than 1.0 but do appear to improve over time (about 4-5 years) (9).

Converting less effective programmes to SE or IPS could be cost-saving, or at least cost-neutral for local services and the government (10).

Employer engagement is advocated to ensure that an adequate number of high quality jobs are available (31).

#### Limitations

- Services need to mature to deliver their full potential (9,25)

## Individual Placement and Support (IPS)

### Strong evidence base

Research and guidance points to the Individual Placement and Support (IPS) model as having the strongest evidence base in terms of improved employment rates (2,4, 9,33,34,35).

Of all clients receiving IPS, broadly about a third become consistent workers, a third become occasional workers and a third remain unemployed (4). Other models deliver between 20-30% in any paid job outcome.

### Key elements of IPS

IPS follows the 'place then train' approach, where clients are placed as quickly as possible in competitive employment then trained and supported on the job. The aim is for jobs that follow the clients preferences and interests.

Support is integrated with primary and secondary mental health services, so that clinical treatment and employment support are mutually reinforcing

### Evidence of benefits

- Higher rates of employment achieved through IPS compared to other models (4)
- Substantial evidence for reduction in use of health services. Studies have found £6,000 savings in use of inpatient psychiatric care over 18 month follow up, and up to 50% savings in health and social care over 10 years (4)
- Lower drop-out rates, people sustain their jobs for longer, work more hours and earn more (32).

### Limitations

- Tends to result in part time jobs (4)
- Savings to tax payer reside in the clients that achieve more than 16 hours work per week (4,26) (roughly a third of all those receiving IPS).

### Good evidence for cost effectiveness

Parsonage (4) suggests an annual direct cost of £2000 per person for IPS, making it an affordable solution. Converting less effective programmes to SE or IPS could be cost-saving, or at least cost-neutral for local services and government (10).

IPS may be easier to commission than other models as it can be 'supported by a more detailed, explicit and outcome focused service specification and can be monitored against readily measurable outcome data' (4).

## IPS continued

**Summary of the evidence for cost savings from IPS**

## Short-term savings

- A multi-site European randomized trial found that IPS delivered saving of around £6,000 per client in inpatient psychiatric care costs over the 18-month period, compared to usual care. This was twice the total direct cost of IPS services over the same period in this trial, which was less than £3,000 per client (4)
- A non-randomized study in England found that for those who were helped into employment through IPS, weekly service use was reduced by over 60% during the follow-up period compared to before the intervention. In the group who remained unemployed, service use was the same as the employed group at baseline but was not significantly changed by IPS (4).

## Long-term savings

- Two US studies based on 10-year follow-ups have produced evidence that about a third of IPS clients get into full-time work, a third into part-time and a third remain unemployed (4).
- It appears that most healthcare savings reside in reduced service use by the third in full-time jobs. The savings are suggested to be up to 50% over a 10-year period compared to groups that work occasionally or not at all (4).
- The public sector cost of providing health and social care for someone with a diagnosis of schizophrenia is around £10,000 a year (based on 2008 figures). Reducing these costs by 50% over 10 years could potentially save £50,000. This saving far outweighs the costs of providing IPS (no more than £20,000 over the same period) (4).
- Clients achieving only occasional work or who remain unemployed are likely still to benefit from IPS individually, even if the costs of their health and social care are not reduced.

### Social enterprises, social firms and 'very supported' employment

There is evidence that clients with very complex needs may benefit from 'very supported' work environments. The best evidence support social enterprises (also known as social firms) (25).

#### Key elements of the social enterprises

Businesses should achieve a substantial portion of income through sales and must have a paid workforce comprising people with disabilities or who would otherwise be disadvantaged in the open labour market (25).

#### Benefits

NOTE: Evidence on outcomes is limited

- Improvement in mental health and reduced use of medical services
- Improved measures of social functioning, life experience, self-esteem
- Improved knowledge of employment rights

#### Limitations

- Limited impact on social inclusion, social network size or density
- Low rates of transition into competitive employment, possibly due to the supportive atmosphere

#### Key elements of successful social enterprises

- Involvement of carers and local support agencies in development
- Worker participation in the firm's development and operation
- Subsidy is a major factor in their success as businesses (25)
- Payment at the minimum wage rates or higher
- A workforce comprising disabled and non-disabled workers

## Volunteering as a route to employment

### Role of volunteering

Volunteering is regarded both as an employment outcome in itself as well as a step on the pathway to competitive employment (9). It may help people to develop their CV and skills, and to explore various types of activity. It appears that the best outcomes from volunteering occur when people explicitly volunteer to improve their CV, rather than just for social reasons.

### Benefits

Improvements in mental health, self rated health, life satisfaction, social interaction, health behaviours/ lifestyles, self-efficacy and coping strategies have been reported as some outcomes related to volunteering.

### Limitations

- 'Unclear' evidence that it increases chances of gaining competitive employment (25)
- Lack of economic evidence to demonstrate cost effectiveness (9).

## Early intervention in-work support

### Strong evidence base

There is considerable evidence that early intervention can prevent long-term sickness absence and can deliver high rates of job retention (7). This is a government priority as detailed in the Government Response to the Sickness Absence Review (21). Early intervention can deliver significant savings to employers as well as reduce the burden on services (7, 21).

Most long terms absences are caused by common mental health or musculoskeletal problems which can be 'treated'. Early intervention can help prevent worsening of health conditions and identify and address potential barriers to work. This has been shown to prevent long-term absences and risk of loss of employment. The longer someone is absent from work, the lower their chances of going back to work. After being off work for six months, the chances of a return to employment drop by 50% (23).

### Good evidence from local pilot: the Fit For Work Service (FFWS)

The Fit for Work programme was piloted within Kensington and Chelsea and subsequently in the Tri-borough between 2010 and 2013. This was an evidence-based early intervention service for sickness absentees to support them to return to work.

An evaluation of the FFWS pilot in Kensington and Chelsea found that 75% of clients were in work at case closure. The service was well-liked by clients with 80% rating their experience as 'excellent' (35).

### Benefits

- Delivers benefits to health and wellbeing
- Prevents the escalation of low level health problems, reduces presenteeism issues, short- and long-term sickness absence, and prevents job losses related to illness (7, 21).
- Prevents the 'revolving door' of unemployment. The sickness absence review identified that, when unemployed people find work but are not supported on the job, they often rapidly fall out of work again (7, 21).
- Reduces use of primary and secondary healthcare and social care (7, 21).

### Estimated Tri-borough cost savings

- Tri-borough estimates of annual costs avoided to the NHS by having a FFWS in place are at least £126,150. Cost savings to employers approximate £228,000. Cost savings in work-related benefits in approximate £850,000 (26) .

### Limitations

- It is difficult to engage employers; despite time and resources in marketing to employers to raise awareness of the service the main source of referrals remained to be General Practitioners



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