Fairer Health For All

Greater Manchester Integrated Care Partnership

Fairer Health for All Fellowship Cohort 1: Optional Template – Interim and Final report

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Project details

Project Name	Tackling Economic Inactivity to Improve Work and Health Outcomes and Reduce Inequality
Fellowship Dates	February 2024 - January 2025

Summary/Abstract – FINAL REPORT

The summary / abstract provides the reader with an overview of all covered in the project report. Even though a summary is placed at the beginning of a project report, you can only write it once your entire report is complete.

Introduction	The AMAR report (2023) stated that employment and deprivation were the most important factors influencing musculoskeletal (MSK) health. Manchester has high economic inactivity, which has significantly worsened since the pandemic. This significantly impacts a person's ability to live a quality and fulfilling life. People who do not work have a higher failure to recover rate, use NHS services more and have worse health outcomes. Unfortunately, not everybody has the same opportunities to access and stay in good work and there are large health inequality disparities throughout Greater Manchester (GM). Tregenna medical Practice is based in Wythenshawe, which has high levels of economic inactivity and social deprivation. In my role as a first contact musculoskeletal (MSK) Physiotherapist, based in primary care, patients present with multiple health issues driven by long-term conditions, making them clinically complex which contributes to their poor health outcomes. Good employment is a driver of higher reported quality of life and employment support is often overlooked in busy GP clinics. MSK conditions are one of the leading causes of unemployment and can often lead to prolonged periods of absence from work, reduced productivity, and in many cases, unemployment. MSK conditions also account for 30% of a GP case load. Targeting

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	patients with work-health input, early in the patient pathway can prevent future unemployment or assist non-workers into employment and help to bring low-income families out of poverty. There has been a recent government push to encourage people into good work to reduce the social and economic burden on society and reduce escalating unemployment rates.
Central aim of your project	My project aimed to tackle health inequality by improving access to work support for people in and out of work. By sign posting to evidence-based work well input, support will be provided to find good work, which is proven to be good for health. The primary aim is to establish a referral pathway from primary care into work well programmes to support patients access to good, suitable work.
Methodology, results, conclusion	The model for service improvement methodology approach was adopted to deliver this Quality Improvement Project (QIP). It consisted of a route cause analysis which established project need and justification. I implemented x4 PDSA cycles and tracked data on practice referrals into the Growth Company (GC) from June to November 2024. Addressing employment as a health outcome in MSK clinics, reduces health inequality in a deprived area of Greater Manchester. A pathway was established from primary care to direct access to a work coach for people who need it the most or may be living in poverty due to unemployment.In total 36 patients were referred into the Growth Company and given the opportunity to improve their employment status and ultimately their quality of life. Referrals from GP's remained low throughout the project and further GP engagement was highlighted as an onward learning point.

Introduction: Purpose and Overview of the Project Brief – INTERIM REPORT

Provide background, context, and an outline for your chosen project

Background; Provide the evidence and theory behind your project	Economic inactivity is a driver of poor health. People who do not work have higher social isolation, use NHS services more and have a poorer quality of life. Ultimately, work is an important social determinant of health for individuals, their families, and communities (Gov, 2024).

	Greater Manchester (GM) has 23.4% economically inactive residents, compared to the national average of 21.2%. Within the 10 localities of GM, Manchester has the highest proportion of economically inactive residents. There are an estimated 102,600 people, aged 16-64 in GM, who have work-limiting mental health or MSK needs, with 10,000 inactive residents due to temporary absence (GMCA, 2024). There has been a recent national and local Government push to improve health outcomes by embedding work well programmes to improve health and work outcomes (Gov, 2024). A government evaluation in an NHS service found benefits to mental health, improved employment outcomes and freed up NHS staff time (Gov, 2019). International research showed reduction in absence days, reducing the risk of long-term unemployment (Gov UK, 2024). A key priority for GM ICP strategy is to help people get into and stay in good work. Those who spend more time out of work, are less likely to find future employment. If a person is out of work for longer than 6 months, the likelihood of them returning to the workplace significantly reduces. Those who have not worked for over one year, are likely to never return to the workplace throughout their life (Census, 2021).
Problem the idea is seeking to solve or address (if any) and population group	To improve health and employment outcomes by embedding work well services, for Wythenshawe patients, who are registered at Tregenna medical practice. Wythenshawe is one of the most deprived areas in Greater Manchester, with higher-than-average unemployment rates and a reduced life expectancy, when compared to more affluent areas of GM. The population focus is those patients who are working but struggling to manage their health condition in work and are at risk of falling out of work. Patients who off sick and requiring support to move into sustainable employment in some capacity, and patients who are not working due to a health condition but feel they may be ready to work.
Project Rationale	Root Cause Analysis (RCA) is widely used in healthcare for service re-design (Bowie, 2013). It uses data collection to identify the root cause of a problem and identify recommendations to eliminate risk or reoccurrence. Initial stages of the project involved a pre-study patient questionnaire, to scope patient opinion and justification for this project. A 10 question, Microsoft Forms questionnaire was text to all patient who received a med-3 (fit-note) in April and May 2024 (Appendix 1). 47 patients responded, and results are summarised below.

	86% of respondents were currently employed. 50% did not or were unsure whether they received any support to manage their health condition when issued their fit note. Interestingly, 53% felt worried about managing their current health condition in work. This demonstrates a disparity between the input given and the demand for support. There was a larger proportion of patients stating that a physical health condition was limiting their ability to work. Research supports a high proportion of mental health barriers to employment. The limitations with Likert closed questionnaires, is that broader information can be overlooked. On reflection, an option to choose both physical and mental health conditions combined, may have produced different results. 33% of patients had been off work between 2-6 months. Targeting this important cohort of patients will be essential to preventing these people falling out of work completely, and central to this project. Encouragingly, 46% of respondents stated that they would be agreeable to receiving employment support at some point in the future or with more information. In summary this questionnaire demonstrates need and stakeholder interest for this project.
Key assumptions and interdependencies	Patients who engage with a work well programme, will receive a package of care to improve their employment status. In the longer-term, this will improve their future health outcomes. The project is dependent on clinicians having meaningful work-well conversations with patients. It is dependent on GP's identifying and offering this service at first point of contact when triaging appointment request, especially those seeking recurrent fit-notes. It is also dependent on patients engaging with services, and clinical staff educating patients on intended beneficial outcomes, in a meaningful and positive way. The Growth Company (GC) are a Non-profit social enterprise who specialise in supporting people with health conditions and disability into employment to improve lives. They form part of GM new action plan Making Manchester Fairer (MMF), to tackle preventable gaps in health inequalities. Via the fellowship I developed links with GC and developed a direct patient referral pathway. The success of this project is dependent on GC providing sound work and heath input and facilitating patient engagement into a work and health programme.
What is the overall purpose of this project? Aims?	My project will embed a patient pathway to access Work Well input which will;

	• Encourage patient engagement in managing their own health and employment status. • Facilitate GP's engagement to tackle economic inactivity. • Improve strategies to identify patients at risk of falling out of work. • Implement interventions to enable patients to feel supported in returning to their current employment. • Create an easy referral link into services that can direct patients to good employment, training, and education. Unemployment is a key driver of poor MSK health and inequality, which disproportionately affects deprived communities. By supporting people into good employment, they will have better opportunities to improve their own health outcomes.
Why it needs to be done? / Why it should be done now?	Unemployment has risen since the pandemic and demand for health services has increased. Since COVID there are 534,249 GM residents waiting for an elective service. 38,941 have been waiting over 52 weeks (GMCA, 24) The annual economic cost of absenteeism, together with worklessness, is estimated at £100 billion. Both these issues put a significant financial burden on society and strain on the NHS (Gov, 24). Health care needs a rapid redesign from reactive to preventative health, which will reduce development of long-term health conditions and improve quality of lived years for residents. The GM ICP missions' states that GM resident will have access to and remain in good employment. The national long-term plan also sets out strategies for targeting unemployment. (The Kings Fund, 2019)
Opportunities and Challenges?	Opportunities: Since the pandemic sickness claims have risen and the government has recognised that they must act now to tackle widespread economic activity. We need to re-think how we deliver healthcare services that are appropriate for demand and communities. The 2023 AMAR report into MSK inequality placed employment as a key determinate of reducing inequality and has challenged services to do something different and act now (AMAR, 2023). Collaboration between community and NHS services is an excellent opportunity to work together, reduce repetition and work more efficiently. Highlighting the benefits of integrated employment and health services can change how future programmes are designed and delivered in GM. Challenges: Services need to re-think their approach, but change is often challenging. Despite training and raising awareness with GP's, they failed to refer into the work and

	health pathway. Time constraints are regularly cited as a barrier to engagement and meaningful change. Patient engagement can also be challenging. We need to listen to the patient voice and learn from communities to improve access and engagement. Services need to be embedded in community, reducing the need to travel into hospital sites.
Project design; Brief description of methodology used.	The Plan Do Study Act (PDSA) is a cycle of service improvement, which allows new learning to be built into the experimental process. It is succinct and flexible in the context of healthcare (Reed and Card, 2016) and chosen as this project design methodology. **Plan-** see RCA above **Do** A direct patient referral was developed to be used in primary care. https://www.gcemployment.uk/wwipspc/nhs-referrals/ Inclusion criteria; • GM resident or registered with a GM GP • Over 18 • Patient consent • A right to work in the UK PDSA Cyle 1; Development of a simple referral pathway to GC which went live in June 2024. Appropriate patients were highlighted, and meaningful work-well conversations took place to establish appropriate referrals to GC. Patient consent was sort prior to referral to GC. PDSA 2; Training to GP and clinic staff at Tregenna Medical Practice highlighting the benefits of work well input and the risks of re-issuing repeat 'fit notes' on long-term health and unemployment. PDSA 3; Developed a simple text response to be sent by GP's at any fit-note request. PDSA 4; A text questionnaire was sent to all patients registered at the practice to offer work well input and a referral to GC, without the need for a clinical appointment.
Desired results of the project?	Process Goals • Changes in GP behaviours regarding engagement with work well referrals and reducing reissued fit-notes.

	• Patients valuing work well input and gaining knowledge and self-efficacy regarding the importance of good work. • Developed relationships with wider community services including GC. • Established a referral pathway widely used by clinicians. • Increased referral rates into the Growth Company. Outcome Goals • Established referral pathway widely used by clinicians. • Increased referral rates into the Growth Company. • Increased number of patients who engage with their package of care. • Increased number of patients who move into new employment. • Patients returning to work. • Patients valuing work well input and gaining knowledge and self-efficacy regarding the importance of good work. Patients will move into good, fulfilling employment which will improve their health and employment outcomes. They will contribute to society and improve their own prospects

Logic Model – INTERIM REPORT

A Logic Model is a way of mapping and visualising the future goals you want for your project which is fundamental to its design. It helps to set out; A clear link between the activities you want to do to achieve your goals; What needs to be in place to ensure your activities link to your goals; how you will know whether you have achieved your goals. It helps to test how plausible and feasible are your goals and provides a framework from which you gather data, learning and insight on your journey to prove how you are achieving your goals.

Please see the Appendix below for a blank template of a logic model. Guidance for how to complete this can be found below:

Body of the report – INTERIM REPORT & FINAL REPORT

This section provides the detail of your work analysis, data, and graphics.

<table>
<tr><td>Provide the evidence and theory behind your project</td><td>See Background section</td></tr>
<tr><td>Explain your key findings, results,</td><td>Referral numbers per month

<table><tr><td>June</td><td>2</td></tr><tr><td>July</td><td>6</td></tr><tr><td>August</td><td>1</td></tr><tr><td>September</td><td>4</td></tr><tr><td>October</td><td>12</td></tr><tr><td>November</td><td>11</td></tr></table>
Key findings;
After implementation of PDSA cycle 1 and 2 a referral pathway had been established. There were particularly low referral rates in August. A potential consideration would be clinician annual leave over the summer period which may have negatively impacted referral rates.
PDSA cycle 4 was implemented at the beginning of October. A text questionnaire was sent to all patients with a 10% return rate. This questionnaire generated a further 22 referrals to GC between October and November. It proved that patients were receptive to work and health input and many were concerned regarding managing their own health condition in work</td></tr>
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Describe achievements, changes and difference made, impact	Implementation of a patient pathway to a Work-Well provider has been successful. Most referrals were made by the FCP and one GP. Potential reasons for this are that I am invested in the project and have a broader knowledge base. Through the fellowship learning, I am aware of the key drivers of health inequalities and the wider determinants of health. Stand out learning points have been establishing clear links between deprivation and health, and how this disproportionately impacts vulnerable communities. I have reflected on the importance of population health strategies to ease the burden on the NHS, strive for community wellbeing and our role in primary care to facilitate that. Universal proportionalism ensures that services are responsive and proportionate to the needs of that community. I felt strongly regarding including patient opinion and my pre-project and mid project questionnaires provided an invaluable insight to this. More GP engagement is needed. Time constraints on GP appointments can impact the ability to have wider work well conversations. GP's may not be confident in having appropriate work-well conversations; therefore, a training need may have been highlighted. Change is challenging and people are not always receptive to do things differently.
Provide any recommendations	This pilot project has been used to support a wider GM national Work Well partnership Vanguard with Manchester Foundation Trusts Musculoskeletal (MSK) Physiotherapy department to deliver low-intensity work and health support services. This project commenced in December 2024 and will run until March 2026. The next steps are to deliver work and health training to the wider MSK clinicians to improve confidence in having work and health conversations with patients who come into MSK outpatient clinics. The referral link continues to remain active for onward use from MSK physiotherapists who want to refer patients into GC for work and health input. The pilot project demonstrates the importance of collaborative working between the NHS, Primary care and GM. This ongoing project has the opportunity to do these differently. We need to coproduce services with communities that reflect their lived experience of inequality. Unemployment is higher in more deprived communities. We need to ensure services are flexible and appropriate for all communities to ensure equality. Through

	adapted leadership which redistributes the power to communities we can reduce barriers to access and embed services in the community. By collaborating between the NHS and local government we hope to join up NHS and community services to provide efficient pathways which are streamlined. We hope to design accessible community activation days which will join up clinical care, social prescribing, employment and housing advice in one local place reducing the need for multiple trips to hospital sites. Improving access will reduce health inequality, and removing barriers will encourage communities to engage in the own health outcomes. Data collection is essential to evaluate the success of the project and make recommendations. We plan to collect demographic data to evaluate which referrals are converting into employment support. Proportionate universalism strives to prioritize care and treatment based on need, to ensure equality. Data will also be analysed to identify patient demographics who do not engage, so we can ask important questions as to why and redesign our approach. We have the capacity to design different access for the same services to target inequality, which disproportionately affects deprived areas. Along with designated metrics such as referral numbers, stipulated from the project terms of contract, we will look at qualitative data from resources such as patient experience, focus groups and clinician opinion. We hope to use a validated quality of life outcome measure to robustly determine the success of this joint venture strengthening the pathway into work and health services directly from NHS MSK Physiotherapy input.

Conclusion – FINAL REPORT

This section brings the entire project report together, summarising your argument and why it is significant.

Restate original ambition	My project aimed to tackle health inequality by improving access to work, help people who are at risk of falling out of work or who have recently stopped working due to ill health, find suitable employment.
Summarise the key themes	Collaborative working with community work and health providers. Establish a direct referral pathway into the Growth Company. Raise awareness regarding the importance of good work to improve health outcomes.
Summarise your thoughts	This has been a successful project which has led to successful implementation of a referral pathway and supported a wider work and health project collaboration.

	I have learned the importance of the patient voice. Both questionnaires I sent to patients highlighted that some patients are open and receptive to work and health advice and many have worries regarding managing their health conditions in work. I now value work as an important health outcome and my fellowship learning has taught me to recognise health equity as a driver of poor health. I am aware of how health care can increase the health inequality gap, not improve it. I feel motivated to strive to do things differently. To challenge the norm and look at innovative ways we can improve patient waiting lists, increase health access and drive patient self-management through engagement.
Describe any future actions or work needed	I will continue to build on the success of this project through the GM/NHS work and health partnership which I am leading on. This will improve patient access to work well input from outpatient MSK physiotherapy clinics and waiting lists. We aim to improve access to work and health input by giving patients many opportunities to discuss their work-related needs. We will provide training to wider clinical staff to have the confidence to have meaningful work-well conversations and know where to appropriately sign-post. The GC referral pathway remains active, and I will continue to address work as a priority in clinic. I will remind GP colleagues regarding the pathway and urge them to use it going forward.

Logic Model

Project Title:	**Completed by**:	**Date**: 10/9/2024
Tackling Economic Inactivity to Improve Health Outcomes and Reduce Inequality	Philippa Norris	**Version**: 1

Context:

Economic inactivity is a driver of poor health. People who do not work, have worse health outcomes and use NHS services more. There are currently 421,500 residents in GM who are economically inactive. Temporary sickness equates to, 2.3%, which equates to almost 10,000 residents.

Whythenshawe is located in the borough of Manchester and considered one of the most deprived areas of the city. There is a high proportion of economically inactive residents, resulting in health inequalities. Life expectancy is 8 years lower when comparing the most and least deprived areas of GM, for an adult male.

Rationale for change:

See written report

Inputs:	**Activities**:	**Outputs**:	**Outcomes**:	**Impacts**:
Stake holder engagement • GP partners	Referral pathway development with the growth company	Increased support for any patients worried	Increased referrals to a work well initiative	Improved quality of life for employed residents

• Patient questionnaire Time Collaboration with the Growth Company	Promotional material Training to GP/clinical staff	about managing their health condition in work Support for patients who are not currently working, to find appropriate employment Simple and effective embedded referral pathway for clinic staff Increased GP identification of patients struggling in work and strategies to sign post	Increased patient employment Reduced work-related absence/sick days	Reduced poverty Reduced social isolation Improved self-worth and self esteem Reduced residents claiming benefits Impact on wider community and families Low-income households rising out of poverty and dept. Reduce crime and anti-social behaviors in communities
Assumptions: See above				