

Webinar slide scripts

DWP Health & Work Service Webinar 23/10/2013

[To be read in conjunction with the slide pack].

Slide 1 – Title

[Lisa Holden]

Slide 2 – Welcome and purpose of the webinar [Lisa Holden]

Good Morning and thank you for taking the time today to join DWP's Health & Work Service webinar. I am Lisa Holden and work in Commercial Directorate within Department for Work and Pensions (DWP).

This webinar is being recorded and it will be available on demand from the same logon site shortly after the event. Questions can be posed at any point during this webinar, via the questions tab. If we are unable to answer any of your questions at this time we will answer them fully after the event and they will be published on Supplying DWP website.

Slide 3 – Agenda for today

[Lisa Holden]

The webinar is an opportunity for you to learn more about the proposed Health & Work Service Contract that DWP is preparing to procure.

So today we

- Are presenting to suppliers to help development of the Health and Work Service design and contract requirement before it is presented to Ministers for their final decision. It will therefore refine our approach in Invitation to Tender; so the final specification may change.
- Your input will greatly assist us in this aim
- We want to encourage your feedback and suggestions so there will be a short closing survey to capture immediate feedback and a more detailed post webinar survey to capture further thoughts.

Slide 4 – Agenda - Today's presenters

[Lisa Holden]

We have three speakers from different areas who will talk you through our current thinking. Adam Bailey, Head of DWP Sickness Absence Policy will cover the Policy intent, Barbara Brown, DWP Health & Work Service Project will cover the procurement approach and contract package areas and Lorraine Lewis, DWP Commercial Finance will cover the payment model.

Lisa - I will now hand you over to Adam Bailey

Slide 5 – Title Slide introducing Adam Bailey

Slide 6 – Sickness absence – context

[Adam Bailey]

So to provide some context for today Great Britain currently loses around 130 million days due to sickness absence per year, with a significant cost to employers, individuals and the State.

From the Department for Work and Pensions perspective, this has an implication for the number of claims made to Employment and Support Allowance, which is the Department's health-related benefit offering financial support if an individual is unable to work and personalised support if found able to work.

The most recent activity in the sickness absence policy area has been the Independent report authored by Dame Carol Black – who has a history of activity on the Health and Work agenda – and David Frost CBE, who was head of the BCC. Their report was published in 2011, and made a number of recommendations. Central to this was that the Government should fund an “Independent Assessment Service” to “provide an indepth assessment of an individual’s physical and/or mental function. It would also provide advice about how an individual on sickness absence could be supported to return to work”. The reviewers suggested this could be funded by the abolition of the Percentage Threshold Scheme, which compensated employers for high Statutory Sick Pay costs.

The Government response which was published in January 2013 accepted these recommendations and the Chancellor announced at Budget 2013 that the Government would also introduce a tax exemption on health interventions recommended by the Service.

Given the funding comes from the Percentage Threshold Scheme which compensates employers for high SSP costs, the funding envelope is fixed at around £38.6m per annum. We would be interested in getting your views about the achievability of our objectives given this size of resource available.

Slide 7 – Purpose and success factors

[Adam Bailey]

So to turn to the purpose and success factors, our purpose in introducing the health and work service is to make independent expert health and work advice more widely available to employees, employers and GPs. This drives our success factors for the Service. I won't run through each individually, but to pick out a couple that are particularly important from a policy perspective:

- 1. Provided by qualified specialists.** We expect the HWS to use a range of healthcare professionals. These include occupational health nurses, nurses with occupational health experience, occupational therapists, occupational physicians, physiotherapists and mental health specialists. We would expect the clinical quality of the occupational health advice to be assured by a named occupational health physician. We will be specifying the competencies required for each function of the service and expect the supplier to demonstrate the mix of appropriate professionals and the assurance arrangements they would use.
- 2. Holistic:** Our evidence base suggests that in a number of cases the health condition is not always the obstacle that prevents a return to work. There are often workplace issues (for example an employee not getting on with their line manager) or non-health and non-work issues (such as debt) which impacts on whether an individual is able to return to work. We therefore envisage the Service using a biopsychosocial approach.

3. **Prompt and rapid:** Of critical importance is that the service provides timely advice to facilitate an earlier return to work – we don't want a service which prolongs the length of time an individual is on a period of sickness absence because they are waiting to be seen by the Service
4. **Tailored to individuals on a case by case basis:** core to the Service is the fact that it undertakes an assessment of individuals and provides bespoke advice to an individual. I'll discuss more on this in the next slide.

Slide 8 – Health and Work Service – Design overview [Adam Bailey]

So to move to slide 8, we envisage the Health and Work Service to be comprised of 2 elements.

The first we term 'advice' and is the provision of generic health and work advice. We see this as being primarily through a website, but also a telephone line which is available to all employers, employees or GPs – anyone looking for good quality information about health and work. So there would be no pre-requisite for anyone to access this part of the Service. This would include general advice on health and work, provided by a professional with occupational health experience. Both the website and advice line would include signposting to further sources of advice as necessary.

The second element is what we term 'assessment', and this is the main part of the Service. It is designed to provide an occupational health assessment for employees who have been, or likely to be, on a period of sickness absence lasting 4 weeks.

So to go into some more detail about our intentions for this aspect:

- The scope, as I've mentioned, is all employees on a period of sickness absence likely to last 4 weeks
- In terms of the referral process, our thinking at this time is that the route is primarily through General Practitioners given their role in signing fitnotes and clinical care of their patients. However, we also envisage a route for employers to refer employees if the GP has not referred after 4 weeks. Given the need to make this Service work for GPs, it will be critical that the referral process is as quick and simple as possible.
- Given the funding available, we think that the primary means of conducting the OH assessment will be over the telephone, with face to face only required in a very small number of cases.
- One of the points made to us as we've been working with experts in this area is the importance of a case managed approach. In other words, the importance of the same individual working in the Service having contact with an employee as they go through their customer journey through the Service. That said, of course, we also recognise that the need to refer onto a specialist in cases will also be important.
- The focus of the 'assessment' side of the Service is the production of the 'Return to Work Plan'. This plan should reflect best OH practice and include details such as:
 1. information about the individual's fitness for work and how this impacts on ability to work,
 2. the expected timetable for a return to work and for any interventions to be progressed,
 3. any temporary adjustments the employer could make and how long these would be expected to last,

4. the type of interventions the employer could fund in order to facilitate a return to work, where these interventions could be found and the benefit of funding these interventions to the employer,
 5. any relevant interventions or steps the employee could arrange (including Access to Work).
- Obviously in identifying the obstacles preventing a return to work the Service will need to contact the employer in many cases.
 - Funding for interventions will not be provided by the Service and so it will be really important for the Service to have a comprehensive signposting function. In terms of the advice side of the Service this could include signposting to other organisations who might be able to provide additional support to an individual who calls the advice line. For the assessment side of the Service, this would be an awareness of the health-related, work related/workplace adjustments and non-health/non-work related interventions locally available to the employee and employer. But we do not anticipate the Service making partnerships with suppliers of interventions.
 - Finally, just a word on expertise. Musculoskeletal and mental health are two of the most prevalent conditions for this group, and so we would expect the Service to have an expertise in these areas.

Slide 9 – Health and Work Service model

[Adam Bailey]

So having outlined some of the key features of the Service, slide 9 shows the draft model. What I propose to do here is step through the elements of the Service from an employees perspective to give a sense of how we see the various stages working. At the top of the slide you can see two elongated arrows – Telephone/online Service and Self help etc. this represents the 'Advice' side of the Service and, as I've already said, is available for all.

So we start with an employee on, or expected to reach, four weeks sickness absence. As I mentioned, the GP is the main referral route and we expect referral to be the default option. We intend for there to be a referral route for employers if the GP has not referred. Once referred a case manager will be assigned to the employee.

Following referral everyone receives stage 1 – an initial assessment:

- The case manager will contact the employee for an initial assessment where they will ask the employee about their health condition, their absence, any treatment they have received and details about their job and work pattern
- Where more information about the employer situation is required, the case manager will contact the employer
- In cases where more information about the medical condition is required, the GP can be contacted
- During this biopsychosocial assessment the case manager will identify all the obstacles preventing a Return To Work (RTW)
- The case manager will guide the employee to appropriate sources of self-help, techniques or exercises that would help facilitate a RTW

At that stage, once the case manager and employee have agreed a RTW plan, which includes a date for the return to work, the case manager will keep in touch on a weekly basis through a short call of between 5-10 mins – this is the progress update you can see

in the slide. "We anticipate for the majority of individuals stage 1 will deliver the necessary input to enable a return to work"

Stage 2a represents a further level of engagement with the Service. We anticipate an employee being referred into stage 2a in 2 ways. First, if the case manager cannot immediately identify all the issues preventing a return to work at stage 1. Second, if the case manager identifies during the short progress update call that the individual has not returned to work and the service may be able to help them further the employee enters Stage 2a and then, if that does not produce a return to work, stage 2b of the service. Stage 2b, which provides the same functionality as Stage 2a, is a final step if the progress update call reveals that stage 2a has also not led to a return to work.

The main additional elements in stage 2a and stage 2b are:

1. More specialist advice with a more experienced OH professional who can give OH advice in complex cases or a relevant (MH or MSK) expert who can give specific MH or MSK advice
2. More detailed discussion with the employer
3. A face to face assessment. But we consider that the numbers requiring a face to face assessment will be small – experts we have consulted have suggested a figure of between 5-10%.

As I'm sure people are aware, this is what's termed a 'stepped' approach. In this instance the Return to Work Plan would be refined.

So looking at the slide, that covers the main chunk of the middle section. There are three other elements here:

1. Interventions or adjustments to enable a return to work: as discussed above, the Service does not fund interventions, but recommends and signposts.
2. Outcomes: are self explanatory.
3. Follow-up: Our intention is that everybody gets followed up for evaluation purposes. Obviously the evaluation – both in the early days of live running and over the longer term – will be really important in terms of refining the Service.

Along the bottom you can see the intention is that the Return to Work plan fulfils the same function as the fitnote. The intention here is that the GP writes a fitnote at the time he or she refers into the Service for two weeks. At that point the Service then follows up with the Return to Work plan including a return to work date.

Lisa - Thanks Adam, I will now hand over to Barbara Brown

Slide 10 – Title Slide introducing Barbara Brown

Slide 11 – Service Scope

[Barbara Brown]

As mentioned previously, employees who are either on, or in the GP's opinion expected to reach, a four week period of sickness absence would be suitable for referral, although employees who are expected to return to work imminently without further assistance would not be suitable for referral. The GP can refer earlier than four weeks if they expect that their patient will be off for longer than four weeks and anticipate either a full or partial return to work.

Clinical suitability will be based on the individual's circumstances and their likelihood to benefit from an OH assessment and there will be guidance to further define the referral criteria. The self-employed, self-referral by employees, re-referrals and unemployed are initially out-with scope for assessments. However some of these groups could be included at a later date. There will be no role for the Service in challenging the clinical judgement of GPs if they refer an individual to the Service.

Slide 12 – Procurement Timeline

[Barbara Brown]

We are looking to complete our Specification in late November 2013 and will be ready to go out to market in early January 2014. The Invitation to Tender will be published on Contracts Finder and we will be utilising E-Procurement via Bravo Solutions for the competition.

The bidding period will end in the middle of February and following evaluation of the bids, we expect to award contracts by the end of April 2014. The Invitation to Tender will outline this timeline more fully and also set out clearly the criteria against which the bids will be evaluated. Draft Terms and Conditions will also be set out within the Invitation to Tender.

Having awarded contracts in April 2014, the successful bidder or bidders will have a period of time to prepare and mobilise and we will work with the successful supplier throughout this period. Our intention is that this Service is introduced in October 2014, in a limited number of areas.

Our thinking is that implementation will be staged from October 2014 by geographical region. In England this will be by Government Office Region, which are North East, North West, East Midland, West Midland, Yorkshire & Humberside, East Anglia, London, South East and South West. We are also looking to contract in Scotland, Wales and Northern Ireland. The first implementation areas will run from October 2014 to January 2015 and will incorporate two Government Office Regions in England along with Scotland, Wales and Northern Ireland to ensure service coverage in all UK areas. This implementation approach will allow DWP to manage risk and also to help understand whether process and enablers are working and whether any adjustments need to be made to these before the service is rolled out across the remaining GORs.

All elements of the service will need to be available from the first implementation phase, this includes the Web based and advice line service.

We do though expect the Service to be available nationally from April 2015 and an implementation approach will be sought as part of the tender and will be agreed with the supplier who is awarded the contract to achieve this.

Contracts are being awarded for 5 years with consideration of a further 2 years.

Slide 13 - Contract package areas

[Barbara Brown]

We are still to finalise what contracts we will offer and therefore welcome any views that you have on what makes most sense both from a delivery/customer perspective and from the commercial angle. The slide sets out one possible option, which is that there are 4

contracts awarded (England, Scotland, Wales and Northern Ireland) and that each contract has full responsibility for the delivery of all aspects of the Service. In other words each contract will deliver the Advice line, online/website support as well as the Assessment element.

Slide 14 - Service volumes/implementation road map [Barbara Brown]

The primarily beneficiaries of the assessment side of the Service are, as outlined earlier, employed people who have been sick and off work for 4 weeks. Data from the Labour Force Survey and other sources leads us to believe that the number of people that fall into this category is in the region of 878,000 per year thus providing our maximum volumes

However the considerations that we have factored in are that:

- The Service is voluntary – and therefore even if recommended the employee may not think that it will help them and can choose to say “no”;
- The employee will need to give their consent to a referral being made and for the assessment to take place and a report to be produced which can be shared with the GP and the employer;
- The GP, as the main source of referral, may use their clinical judgement to decide not to refer;
- The employee may also return to work without needing the additional support that the Service can offer.

We therefore believe the numbers referred are more likely to be in the region of 350,000 (40%) and 700,000 (80%) rather than being the full population of employed people that have a period of 4 weeks absence due to sickness.

As we have this degree of uncertainty about the likely volumes, we believe our implementation approach will help us learn something about the behaviours of those either being referred or referring to the Service.

Lisa – Thanks Barbara, I will now hand over to Lorraine Lewis

Slide 15 – Title Slide introducing Lorraine Lewis

Slide 16 - Payment model

[Lorraine Lewis]

The main purpose of this session is to share with you our current thinking on proposed payment models for this contract and seek your views on them. A number of questions will be asked at the end of the webinar that we would appreciate answers to. These will give us an indication of the estimated total costs to inform our budget management for this contract. Any cost estimates that are supplied will be treated in confidence and on a “without prejudice” basis and will not form part of the bid evaluation process. Suppliers will not be held to any costs supplied and they are to be used merely to inform our thinking on

the structure of a payment model that is acceptable and fair to DWP and any potential suppliers.

The service is split into 2 main areas – firstly the website maintenance and advice line and then the assessment service and I want to discuss the proposed payment models for each area separately.

Consideration is being given to funding the costs of setting up the whole service in the implementation period through milestone payments rather than over the life of the contract. We would welcome your initial views, based on what you have heard today, on what the capital cost of setting up this service would be and how long it will take to stand this service up. This question will be included in the question & answer survey to be shown at the end of the webinar.

Given that the default will be web, the volumes for the advice line are expected to be relatively low – less than 4,000 calls per annum based on findings from the Occupational Health Advice Line (OHAL) pilot with an average handling time of around 20 minutes for each call. The advice line will be a contact centre model but the line will be manned by Health Care professionals. As the volume of calls is expected to be low the current thinking is that this would be funded through a standard monthly service fee rather than cost per customer minute. Do you see any issues with this proposal or any alternative payment models that we should consider? The website maintenance would also be included in this service fee.

The running costs of the assessment service are expected to be funded through a combination of a service fee and output payments to ensure a guaranteed level of income to suppliers particularly in the early stages of the contract. The relative split of these is to be decided and we would welcome your input on what an acceptable % split of the total contract price between service fee and output payment would be – eg 40% / 60%. This split may change over time as the volume of outputs increases. It would also be useful if we could understand the main cost drivers in your business model to supply this service and what the fixed cost elements of this are – a brief description & monthly value will be required.

The output payments may be linked to the production of a timely return to work plan that meets the quality requirements. We would welcome an insight into how sensitive any output price you provide would be to differing volume levels. There may need to be volume bandings for the output payments with unit prices expected to reduce as volumes build.

It is expected that a service credit regime will operate for both the advice line and assessment service for non adherence to performance targets.

Lisa – Thanks Lorraine

Slide 17 - Questions

[Lisa Holden]

We are now moving onto the question and answer session and our first question is:

We have had some questions posed during this session that we would like to consider in more detail. These along with the questions already answered at this session will be published on supplying DWP website.

Slide 18 - Next Steps

[Lisa Holden]

So, to reiterate the aim of this webinar was to present to suppliers to help development of the Health and Work Service design and contract requirement before it is presented to Ministers for their final decision. It will therefore refine our approach in Invitation to Tender; so the final specification may change.

We want to encourage your feedback and suggestions so there will be a short closing survey to capture immediate feedback and a more detailed post webinar survey to capture further thoughts which can be accessed via the two Excel spreadsheets located on the Question tab on the webinar site, these should be downloaded and completed prior to returning them to SAR.RESPONSE@DWP.GSI.GOV.UK. We would appreciate an immediate response on the feedback spreadsheet and responses to the questionnaire spreadsheet prior to close of business on Wednesday 30th October.

All questions and answers from this webinar will be published on Supplying DWP website. A recording of this webinar will also be available on demand from the webinar logon site.

Thank you for attending and we would be really grateful if you would take the time to complete both questionnaires.