



Working for a
healthier tomorrow

Dame Carol Black's Review of the
health of Britain's working age population

Working for a healthier tomorrow

Presented to the Secretary of State for Health and the
Secretary of State for Work and Pensions

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Contents

Foreword	4
Executive summary	7
Key challenges and recommendations	16
1 Introduction.....	19
2 The health of the working age population.....	27
3 The role of the workplace in health and well-being	49
4 Changing perceptions of fitness for work	61
5 Developing a new model for early intervention.....	71
6 Helping workless people	83
7 Developing professional expertise for working age health.....	93
8 The next generation	101
9 Taking the agenda forward.....	107
Appendix – Glossary	115



Foreword

The subject of this Review is the health of people of working age, individuals whose health has consequences often far beyond themselves – touching their families and children, workplaces and wider communities. The economic costs of ill-health and its impact on work are measurable and set out for the first time in this Review; but the human costs are often hidden and privately borne.

For most people, their work is a key determinant of self-worth, family esteem, identity and standing within the community, besides, of course, material progress and a means of social participation and fulfilment.

A myriad of factors influence health and well-being, though many are familiar only to those who experience them. Individuals also bear their aspirations, burdens, skills and vulnerabilities to work. So, in turn, the working environment itself can be a major influence on their well-being.

At the heart of this Review is a recognition of, and a concern to remedy, the human, social and economic costs of impaired health and well-being in relation to working life in Britain. The aim of the Review is not to offer a utopian solution for improved health in working life. Rather it is to identify the factors that stand in the way of good health and to elicit interventions, including changes in attitudes, behaviours and practices – as well as services – that can help overcome them.

To date, occupational health has been largely restricted to helping those in employment. But supporting working age health today requires us to reach much further. It remains critically important to improve health at work and to enable workers with health problems to stay at work, but occupational health must also become concerned with helping people who have not yet found work, or have become workless, to enter or return to work.

My recommendations point to an expanded role for occupational health and its place within a broader collaborative and multidisciplinary service. Ultimately I believe such a service should be available to all, whether they are entering work, seeking to stay in work, or trying to return to work without delay in the wake of illness or injury.

Running through the Review is a firm belief that we must not reduce the issues around health and work to problems of medicine and medical practice, necessary though they are to the solution. As a clinician, I am continually reminded of the impact of social and environmental factors on health and that when good health can best be restored by the provision of healthcare, the delivery of that healthcare needs to be sensitive to the patient's circumstances in the home, at work and in society.

I am grateful for over 260 responses to my Call for Evidence and to all those who supported the discussion events held across Britain at the end of last year. The evidence they have provided is detailed in the accompanying *Summary of Evidence submitted*. Taken together it provides a clear and compelling case. In short, we cannot go on as we are.

I hope this Review will lay the foundations for urgent and comprehensive reform. But there are difficult and challenging messages for everyone here – whether politicians, healthcare professionals, employers, trades unions or even individuals themselves. All have a shared responsibility for the health of Britain's working age population. All must play their part in a shared response to the challenges set out in this Review.

We must act now to build on the emerging consensus around a new approach to health and work in Britain. We will not be able to secure the future health of our nation without it.



Dame Carol Black





Executive summary

Executive summary

Chapter 1 – Introduction

Life expectancy and numbers in employment are higher than ever before, yet around 175 million working days were lost to illness in 2006. This represents a significant cost, not only economically, but also in terms of social exclusion.

Recent evidence suggests that work can be good for health, reversing the harmful effects of long-term unemployment and prolonged sickness absence. Yet much of the current approach to the treatment of people of working age, including the sickness certification process, reflects an assumption that illness is incompatible with being in work.

Families without a working member are more likely to suffer persistent low income and poverty. There is also evidence of a correlation between lower parental income and poor health in children.

Improving the health of the working age population is critically important for everyone, in order to secure both higher economic growth and increased social justice.

This Review has sought to establish the foundations for a broad consensus around a new vision for health and work in Britain. At the heart of this vision are three principal objectives:

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

Successive chapters of this report will set out proposals for realising these objectives. First, however, it is essential to understand how the health of the working age population can be measured and to establish a baseline.

Chapter 2 – The health of the working age population

This Review sets out the first ever baseline for the health of Britain's working age population. It shows that we are living longer, but that this is not accompanied by a similar improvement in self-reported health status.

Employment rates in Britain are high relative to most other countries. The employment rate of those with a health condition is increasing, but around 7% are still on incapacity benefits and an additional 3% are off work sick at any one time. Ill-health can also impair economic productivity even if it does not lead to immediate absence.

Smoking rates have fallen over recent decades, but are still at 22%. Levels of obesity are increasing dramatically and, if current trends continue, around 90% of men and 80% of women will be overweight or obese by 2050.

Many common diseases are directly linked to lifestyle factors, but these are generally not the conditions that keep people out of work. Instead, common mental health problems and musculoskeletal disorders are the major causes of sickness absence and worklessness due to ill-health. This is compounded by a lack of appropriate and timely diagnosis and intervention.

The costs to the taxpayer – benefit costs, additional health costs and forgone taxes – are estimated to be over £60 billion.

The annual economic costs of sickness absence and worklessness associated with working age ill-health are estimated to be over £100 billion. This is greater than the current annual budget for the NHS and equivalent to the entire GDP of Portugal.

There is, therefore, a compelling case to act decisively in order to improve the health and well-being of the working age population – to help ensure a healthy, active retirement, to promote social inclusion and to deliver prosperity to individuals, employers and the nation as a whole.

Chapter 3 – The role of the workplace in health and well-being

A shift in attitudes is necessary to ensure that employers and employees recognise not only the importance of preventing ill-health, but also the key role the workplace can play in promoting health and well-being.

Great progress has been made in improving health and safety at work. A new approach to health and well-being at work is now needed. Responses to the Call for Evidence indicated that many employers were investing in workplace initiatives to promote health and well-being, but that there was still uncertainty about the business case for such investments. Research specially commissioned for this Review, however, found considerable evidence that health and well-being programmes produced economic benefits across all sectors and all sizes of business: in other words, that good health is good business.

A robust model for measuring and reporting on the benefits of employer investments in health and well-being would improve employers' understanding of the business case for investment. Safety and health practitioners could play a more expanded role in promoting these benefits, as could trades union safety representatives wherever present. A business-led health and well-being consultancy service would offer tailored advice and support as well as access to occupational health support, especially important for smaller organisations which tend not to be able to afford the costs of provision enjoyed by larger organisations.

Finally, health and well-being is not just a medical issue. The nature and characteristics of the jobs that employees do are vitally important in terms of satisfaction, reward, and control. The role of the line manager is also key. Good line management can lead to good health, well-being and improved performance. Line managers also have a role in identifying and supporting people with health conditions to help them to carry on with their responsibilities, or adjust responsibilities where necessary.

Chapter 4 – Changing perceptions of fitness for work

Any improvement in work-related support for those who develop health conditions will need to be underpinned by a fundamental change in the widespread perception around fitness for work; namely, that it is inappropriate to be at work unless 100% fit and that being at work normally impedes recovery.

Employers have significant scope to facilitate an employee's early return from sickness absence. Early, regular and sensitive contact with employees during sickness absences can be a key factor in enabling an early return. Yet as many as 40% of organisations have no sickness absence management policy at all.

Tackling stigma around ill-health and disability will be key to enabling more people with health conditions find work and stay in work. This is particularly true for those with mental ill-health, as many organisations often fail to recognise the full value of the contribution they can make.

Changing perceptions will also require greater public engagement on the benefits of work for health, raising expectations of what makes a good job and of the support people with health conditions should expect to enable them to remain in or return to work.

A lack of understanding about the relationship between work and a patient's health, and the omission of this evidence from professional training, has meant that despite the best intentions, the work-related advice that healthcare professionals give their patients can be naturally cautious and may not be in the best interests of the patient for the long term.

A ground-breaking Consensus Statement signed by leaders of the healthcare professions represents a profound commitment to promoting the link between good work and good health. This must be built upon with more support for healthcare professionals in providing fitness-for-work advice.

Replacing the paper-based sick note with an electronic fit note would support this, switching the focus to what people can do instead of what they cannot, and potentially improving communications between employers and GPs.

Chapter 5 – Developing a new model for early intervention

Emerging evidence suggests that for many people, early interventions help to prevent short-term sickness absence from progressing to long-term sickness absence and ultimately worklessness. A proposed new *Fit for Work* service, based on a case-managed, multidisciplinary approach, would provide treatment, advice and guidance for people in the early stages of sickness absence. With many people needing non-medical help, the case manager in the *Fit for Work* service would refer into a non-traditional, wide range of services, which could include advice and support for social concerns such as financial and housing issues as well as more traditional NHS services, such as physiotherapy and talking therapies.

With many employers to date having failed to provide access to adequate occupational health, and the associated costs to the taxpayer and the economy being so substantial, there is a strong case for the NHS being involved in the provision of these work-related health interventions.

The analysis of this report suggests that the financial benefits of an effective *Fit for Work* service could be very considerable, including higher tax receipts, better workplace productivity, reduced benefit payments and, over time, reduced costs to the NHS. These benefits are likely to significantly outweigh the costs of setting up and running these services.

Pilots of the *Fit for Work* service should test various models of service delivery, including variations in the timing of interventions and the mix of providers from public, private and voluntary sectors. Such pilots should, of course, be comprehensively evaluated.

If found to be effective, *Fit for Work* services should be rolled out across Britain so that access to work-related health support becomes available to all employees – no longer the preserve of the few.

Chapter 6 – Helping workless people

The sheer scale of the numbers of people on incapacity benefits represents an historical failure of healthcare and employment support to address the needs of the working age population in Britain.

The problem is not just with the existing caseload. Each year, 600,000 people move onto incapacity benefits. The system is failing those with common health condition, who, with the right support, could instead have maintained their job and progressed in the workplace.

While around 55% of those coming onto incapacity benefits came either from work or a period of sickness absence from work, a further 28% were claiming Jobseeker's Allowance or Income Support immediately prior to claiming incapacity benefits. This suggests that people are joining these benefits with undiagnosed or unsupported health conditions, or that they develop health problems while on these out-of-work benefits.

When appropriate models for the *Fit for Work* service are established for patients in the early stages of sickness absence, access to the service should be open to those on incapacity benefits and other out-of-work benefits.

Evaluation of Pathways to Work pilots has shown an increase of around eight percentage points in six-month off-flow rates from incapacity benefits compared with national averages. With the majority of claimants registered long-term, there is also a need to extend the policy to include them if we are to make significant inroads into the numbers of people currently workless due to ill-health or disability.

However, while successful overall, Pathways to Work has had limited effect for those whose main health condition is a mental illness. Furthermore, over 200,000 people with mental health conditions flow onto incapacity benefits each year, and this figure has not changed over the last decade.

Government must therefore fully integrate the option of specialist mental health provision into its employment support programmes – not just for those on incapacity benefits – but for all those who are workless, whether lone parent, jobseeker or Income Support recipient.

Finally, rehabilitation services and employer adjustments can be critical in enabling someone to return to and stay in work, not just addressing the specific health barriers to an individual's employment, but also providing a source of information for the patient on the types of work which may be most suitable.

Chapter 7 – Developing professional expertise for working age health

This Review sets out a new approach to supporting the health and well-being of all working age people in Britain. Delivering this change will depend upon having a workforce of health professionals who are equipped to meet current and future needs. For this they need the right skills, evidence base and organisational structures.

If we are to fundamentally change the way we support the health of working age people, then we have to address a number of the challenges which face occupational health as it is currently configured. These include the historical detachment from mainstream healthcare, the focus only on those in work, uneven provision, inconsistent quality, a diminishing workforce with a shrinking academic base and a lack of good-quality data.

Developing an integrated approach to working age health requires occupational health to be brought into the mainstream of healthcare provision. Its practitioners must address a wider remit and embrace closer working with public health, general practice and vocational rehabilitation in meeting the needs of all working age people. This should be underpinned by clear workforce plans, clear standards of practice and formal accreditation of all providers.

Such an approach must include clear professional leadership from the occupational health and vocational rehabilitation communities to expand their remits and work with new partners in supporting the health of all working age people.

It must be supported by a revitalised workforce which encompasses the development of a sound academic base to provide research and support in relation to the health of all working age people. This must be underpinned by the systematic gathering and analysis of data at national, regional and local level to inform the development of policy and commissioning of healthcare services.

Chapter 8 – The next generation

The health of the current working age population will affect the potential of the next generation too. When parents are prevented from working because of a health condition, the risk is not just that their children may end up in poverty, but that those children may experience worse health outcomes and face an increased likelihood that they themselves will be workless in the future.

Securing the future health of the working age population must start with those not yet of working age. We should encourage young people to understand the benefits of a life in work and what a healthy workplace offers so they can make an informed decision about the organisations for which they choose to work.

Chapter 9 – Taking the agenda forward

This Review has set out a vision of a new approach to health and work in Britain which can only be achieved with the active commitment of all those with an interest in the health of the working age population.

Individuals have a fundamental personal responsibility for maintaining their own health. In addition to their existing legal duties, employers must work with their employees to change the nature of the modern workplace in Britain and ensure the health and productivity of their workforce. Trades unions must seize the opportunity to champion health and well-being in the workplace.

Healthcare professionals must adapt the advice they give to patients to reflect the importance of remaining in or returning to work wherever possible. Government must lay the foundations for long-term change through the piloting of a new approach to early intervention and a renewed commitment to make the public sector an exemplar.

Monitoring the baseline set out in this Review will be critical, as will an extensive programme of research to inform future action with a comprehensive evidence base and increased cross-governmental effort to ensure progress.

Together we have the opportunity to deliver long-term change. We will not secure the future health of the working age population without it.

The following table presents the key challenges this Review has identified, together with the recommendations which, when implemented, are most critical in addressing them.

Key challenges and recommendations for reform

Key challenges

- 1** The economic costs of sickness absence and worklessness associated with working age ill-health are over £100 billion a year – greater than the current annual budget for the NHS and equivalent to the entire GDP of Portugal.
- 2** The evidence base to support the business case for investment in the health and well-being of their employees is inadequately understood by employers.
- 3** Lack of appropriate information and advice is the most common barrier to employers investing in the health and well-being of their employees. This is particularly true for smaller organisations which tend not to have access to an occupational health scheme.
- 4** The importance of the physical and mental health of working age people in relation to personal, family and social attainment is insufficiently recognised in our society.
- 5** GPs often feel ill-equipped to offer advice to their patients on remaining in or returning to work. Their training has to date not prepared them for this and, therefore, the work-related advice they do give, can be naturally cautious.
- 6** The current sickness certification process focuses on what people cannot do, thereby institutionalising the belief that it is inappropriate to be at work unless 100% fit and that being at work normally impedes recovery.
- 7** There is insufficient access to support for patients in the early stages of sickness, including those with mental health conditions. GPs have inadequate options for referral and occupational health provision is disproportionately concentrated among a few large employers, leaving the vast majority of small businesses unsupported.
- 8** The scale of the numbers on incapacity benefits represents an historical failure of healthcare and employment support for the workless in Britain.

Furthermore, the flow of recipients of other benefits onto incapacity benefits suggests a failure in other employment and skills programmes to identify developing health conditions at a sufficiently early stage.

Pathways to Work, while successful overall, has had limited effect for those whose main health condition is a mental illness. Furthermore, over 200,000 people with mental health conditions have flowed onto incapacity benefits each year over the last decade.
- 9** Detachment of occupational health from mainstream healthcare undermines holistic patient care. A weak and declining academic base combined with the absence of any formal accreditation procedures, a lack of good quality data and a focus solely on those in work, impedes the profession's capacity to analyse and address the full needs of the working age population.

Main recommendations

- 1** Government, healthcare professionals, employers, trades unions and all with an interest in the health of the working age population should adopt a new approach to health and work in Britain based on the foundations laid out in this Review.
- 2** Government should work with employers and representative bodies to develop a robust model for measuring and reporting on the benefits of employer investment in health and well-being. Employers should use this to report on health and well-being in the board room and company accounts.
Safety and Health practitioners and, where present, trades union safety representatives, should play an expanded role in acting to promote the benefits of such investment.
- 3** Government should initiate a business-led health and well-being consultancy service, offering tailored advice and support and access to occupational health support at a market rate. This should be geared towards smaller organisations. It should aim to be self-sustaining in the medium-term, and be fully evaluated and tested against free-to-use services.
- 4** Government should launch a major drive to promote understanding of the positive relationship between health and work among employers, healthcare professionals and the general public. This should include encouraging young people to understand the benefits of a life in work and its impact on their families and communities.
- 5** Building on the commitment from the leaders of the healthcare profession in the recent consensus statement, GPs and other healthcare professionals should be supported to adapt the advice they provide, where appropriate doing all they can to help people enter, stay in or return to work.
- 6** The paper-based sick note should be replaced with an electronic fit note, switching the focus to what people can do and improving communication between employers, employees and GPs.
- 7** Government should pilot a new *Fit for Work* service based on case-managed, multidisciplinary support for patients in the early stages of sickness absence, with the aim of making access to work-related health support available to all – no longer the preserve of the few.
- 8** When appropriate models for the *Fit for Work* service are established, access to the service should be open to those on incapacity benefits and other out-of-work benefits.
Government should fully integrate health support with employment and skills programmes, including mental health support where appropriate.
Government should expand provision of Pathways to Work to cover all on incapacity benefits as soon as resources allow, and explore how to tailor better provision for those with mental health conditions.
- 9** An integrated approach to working-age health should be underpinned by: the inclusion of occupational health and vocational rehabilitation within mainstream healthcare; clear professional leadership; clear standards of practice and formal accreditation for all providers; a revitalised workforce; a sound academic base; systematic gathering and analysis of data; and a universal awareness and understanding of the latest evidence and most effective interventions.
- 10** The existing cross-Government structure should be strengthened to incorporate the relevant functions of those departments whose policies influence the health of Britain's working age population.



1

Introduction

Chapter 1 – Introduction

The scale of the problem

Despite life expectancy and numbers in employment being higher in Britain than ever before, and against a background of one of the best workplace health and safety records in the world, around 175 million working days were lost to sickness in 2006. This is equivalent to seven days for each working person. In addition, around 7% of the working age population are workless and receiving incapacity benefits because of long-term health conditions or disabilities.

These figures should be a source of concern for us all. Not only do they represent a significant cost to the economy, but they also reflect patterns of poverty and social exclusion which blight entire communities and stunt the prospects of children and young people – the working age population of tomorrow. It is a waste of human potential which cannot be left to continue unchecked.

The positive links between health and work

Clearly, good health should improve an individual's chances of finding and staying in work and of enjoying the consequent financial and social advantages. There is also, however, compelling evidence that work has an inherently beneficial impact on an individual's state of health.

In particular, the recent review '*Is work good for your health and well-being?*' concluded that work was generally good for both physical and mental health and well-being¹. It showed that work should be 'good work' which is healthy, safe and offer the individual some influence over how work is done and a sense of self-worth. Overall, the beneficial effects of work were shown to outweigh the risks and to be much greater than the harmful effects of long-term worklessness or prolonged sickness absence.

The fallacy persists, nevertheless, that illness is incompatible with being at work and that an individual should be at work only if 100% fit. This thinking underpins much of the current approach to the treatment of people of working age with health conditions or disabilities. It is also reflected in the procedures for certification of sickness absence. This Review will make radical recommendations for reform in this area.

¹ Waddell, G. and Burton A.K. (2006), *Is work good for your health and well-being?*, London: TSO (The Stationery Office).

Impact of ill-health and worklessness on families and children

Families without a working member are much more likely to suffer persistent low income and poverty². For example, the child of a lone parent who does not work is three times more likely to be living in poverty than the child of a lone parent who works part time, and eight times more likely to be in poverty than the child of a lone parent working full time³.

Persistent low parental income is not only associated with children living in poverty, but also with poorer health outcomes. For example, the prevalence of psychiatric disorders among children aged 5-15 in families whose parents have never worked is almost double that of children with parents in low-skilled jobs, and around five times greater than children with parents in professional occupations⁴.

Similar evidence was found in a study undertaken in the five Scandinavian countries. Children in families where neither parent had worked for the previous six months had a higher prevalence of recurrent health conditions and lower well-being⁵.

Implications for wider economic and social goals

The links between health, employment, productivity and poverty underline the critical importance of improving the health of the working age population in achieving both greater social justice and higher economic growth⁶.

Promoting health and well-being for all will raise employment, reduce child poverty and poverty later in life, and raise the growth in productivity of the British economy. Similarly, increasing employment and opportunity of employment will directly promote better health and well-being for all.

Thus, the health of the working age population is important for everyone:

- for individuals and their families, because it impacts on the quality and length of life people lead, affecting their capacity to work and provide for their family;

² Burgess, S., Propper, C. and Rigg, J. (2004) *The impact of low income on Child Health: Evidence from a birth cohort study*, CMPO Working Paper Series, No. 04/098.

³ *Households Below Average Income (HBAI) A94/95-200/06* (Revised).

⁴ *The health of children and young people* (2001), Office for National Statistics.

⁵ Reinhardt Pedersen, C. and Madsen, M. (2002) *Parents' labour market participation as a predictor of children's health and well-being: a comparative study in five Nordic countries*, *Journal of Epidemiology and Community Health*, 56, pp.861-867.

⁶ Recent evidence establishes a statistical link between health and economic growth in the UK; Bell, Matthew, Y. Kossykh, M. Ridge and N. Woolley, *An empirical analysis of the effect of health and economic growth in the UK*, Health and Safety Executive (HSE) Research Report, (forthcoming).

- for employers, because a healthier workforce is a more productive workforce; having healthier workers also provides an incentive to invest in their training and development, as such investment will yield a higher return; and
- for society as a whole, because the consequences of ill-health lead to social exclusion, lower output and reduced tax revenues. Higher costs in terms of healthcare and social security benefits add to the burden on the taxpayer.

A new vision for the health of the working age population

This Review identifies the foundations for a wide-ranging consensus around a new vision for health and work in Britain, in which the relationship between health and work becomes universally recognised as integral to the prosperity and well-being of individuals, their families, workplaces and wider communities.

At the heart of this vision are three principal objectives:

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

Prevention of illness and promotion of health and well-being

Healthy workplaces, designed to protect and promote health and well-being, are key to preventing illness arising in the first place. It is important that employers provide and maintain them.

Allied with this is the importance of jobs being ‘good jobs’ in terms of individuals’ sense of control over how they work, relationships with colleagues and managers, and understanding of their role.

Employers and healthcare professionals should also recognise the opportunities offered by the workplace for the provision of facilities and dissemination of advice on how to improve and maintain health.

Chapter 3 will discuss in further detail how to bring about these changes.

Early intervention for those who develop a health condition

Employers, the public and healthcare professionals should come to understand better the links between work and health.

Early intervention for those who develop a health condition should be provided by healthcare professionals who increasingly see retention in or return to work as a key outcome in the treatment and care of working age people. This would be supported by improved education of those professionals themselves about the positive links between health and work, and the means by which people with health conditions can be assisted to remain in or return to work. Also, the sickness certification process should focus on identifying and promoting fitness for work.

Chapter 4 will set out proposals on the initial management of ill-health when it arises at work, including the support which employers should provide for their employees to enable them to continue working. It will also recommend far-reaching changes to the procedures for certifying sickness absence, with particular reference to the necessary shift in attitudes and expectations.

Chapter 5 will explore how to support those whose health conditions lead to sickness absence and enable them to return to work as quickly as possible.

Improvement in the health of those out of work

To improve the health of those out of work, *all* workless people with health conditions should be treated as effectively as possible without delay. Health should be reflected in all employment policies, fully exploiting the synergies between the health, employment and skills agendas. Thus, everyone with the potential to work would receive the support they need to do so.

Chapter 6 will recommend measures to improve the integration of health and employment support for workless people.

Sustaining the vision

To ensure that the changes made to realise these three principal elements of the vision endure, other reforms will be needed. Chapter 7 explores how the whole framework of occupational health provision can be adjusted so as to better support the health and well-being of all working age people. Chapter 8 focuses on children and young people, and proposes action to secure the health and well-being of tomorrow's working age population. All this will require important changes in the way employers, healthcare professionals, Government, trades unions and individuals approach health and work.

To enable evaluation of the effect of the changes that will be recommended in this report, it is essential to understand how the health of the working age population can be measured and to establish a baseline. This will be addressed in Chapter 2.





2

The health of the working age population

Chapter 2 – The health of the working age population

This chapter sets out a number of indicators which, when taken together, give a comprehensive picture of the current state of working age health in Britain.

There are many different ways of measuring health status, whether of an individual or of a population. These can vary from subjective measures of how well someone feels, to National Health Service (NHS) data, benefit records, and actuarial data on how long a person is expected to live. All of these are important, each giving a different perspective of health and its drivers. This Review draws on all of them to build up a composite baseline. The data used applies to Britain, unless stated otherwise.

What is the working age population?

For the purpose of data analysis, the working age population is taken to be females aged 16 to 59 and males aged 16 to 64. This is consistent with the current school-leaving age and State Pension age. With this definition the current working age population is 36.6 million people.

Actual working patterns do not always reflect this definition and are likely to evolve further. Over a million people are working beyond State Pension age, which, moreover, is set to rise to 68 for both men and women by 2046. This is likely to increase the average retirement age, which is currently around 62 years for women and 64 for men⁷.

Indicators of working age health

Life expectancy is the most commonly used comparative measure of national health. It is easily compared internationally as it is based on objective mortality data collected routinely in most countries. Calculated from birth, life expectancy currently stands at 81 years for females and 77 years for males, which is the highest it has ever been. However, when compared with other countries, the UK is ranked 22nd out of a reported 195, behind Australia, New Zealand, Canada and nine European Union countries⁸. Although most people in Britain die after retirement, 16% of men and 6% of women die during working age⁹.

⁷ *Pensions: Challenges and Choices* (2004), The First Report of the Pensions Commission, TSO (The Stationery Office), pp-53-55.

⁸ *United Nations, Department of Economic and Social Affairs, Population Division* (2007). *World Population Prospects: The 2006 Revision, Highlights*, Working Paper No. ESA/P/WP.202.

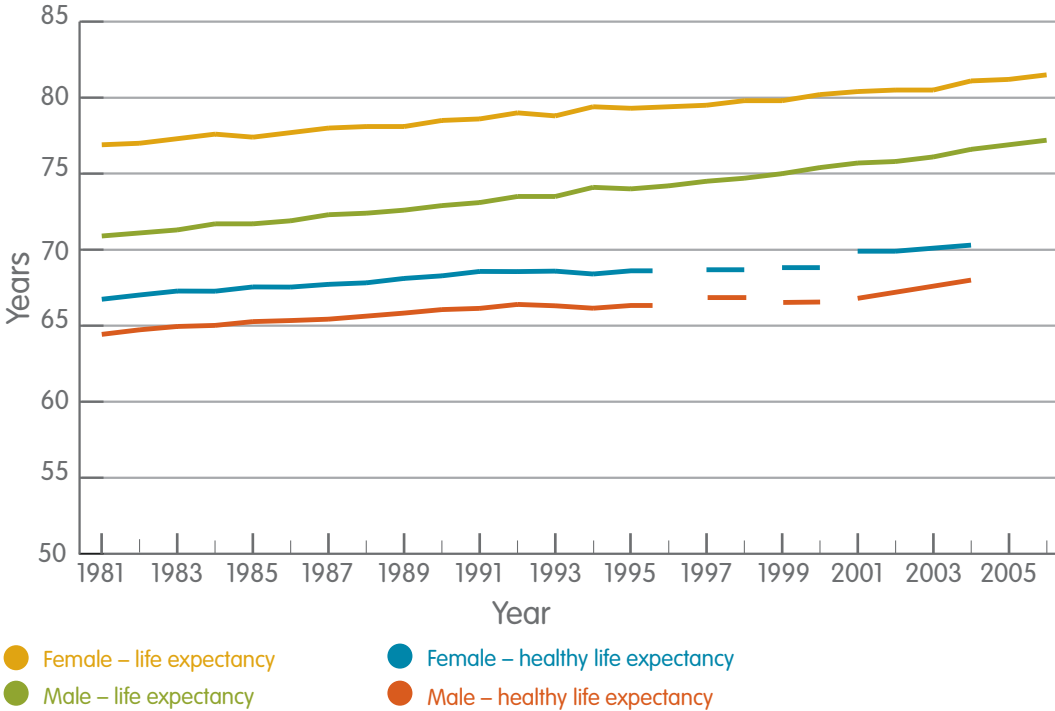
⁹ Calculations based on 2006 life tables. Source: Office for National Statistics (2006).

Health can also be assessed by asking people how they feel. One such measure is derived from the General Household Survey (GHS), which asks people in Britain about self-perceived general health. In 2005, 89% of the working age population reported being in good or fairly good health, leaving 11% in poor health.

Healthy life expectancy combines life expectancy with self-reported health as reported by the GHS and estimates how many years an individual can expect to live in good or fairly good health. It has increased since the 1980s, though at a slower pace than overall life expectancy. This implies that individuals can expect to live longer in good health as well as longer in poor health.

In 2004, at birth the average male could expect to live 68 years in good or fairly good health and 8.6 years in poor health; for females the numbers were 70.3 and 11.3 respectively. A significant part of the years in poor health is likely to be experienced during working age¹⁰.

Figure 2.1 Male and female life and healthy life expectancy at birth



Note: Healthy life expectancy is not calculated for the years 1996, 1998 and 2000 as relevant data were not available.

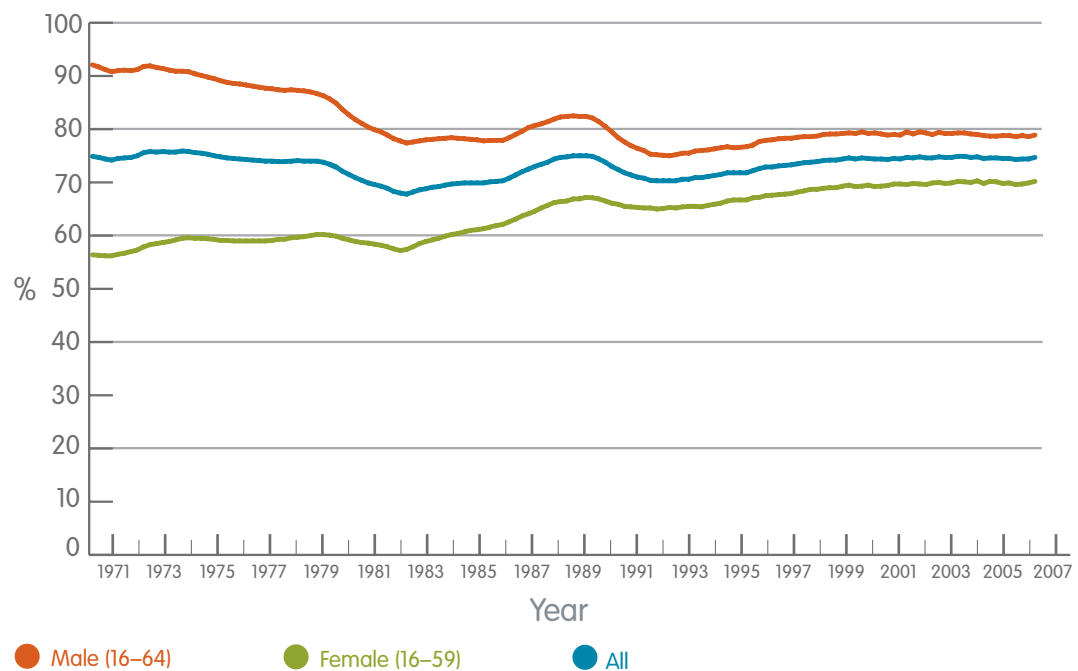
Source: Office for National Statistics

¹⁰ Office for National Statistics.

Employment

Employment levels provide a high-level indicator of the health of the working age population. Being in employment is a reflection of the health status of individuals, but also of the probability of being in work with a given health status. With over 28 million people employed, the number of people in work in Britain is the highest it has ever been. At 74.9% of working age people, the employment rate is also close to a record high (see Figure 2.2). By international and historical standards, the British labour market is performing very well. The Government has set an aspiration of an 80% employment rate so that more adults and their children can move out of poverty and society will be better able to deal with an ageing population.

Figure 2.2 Employment rate

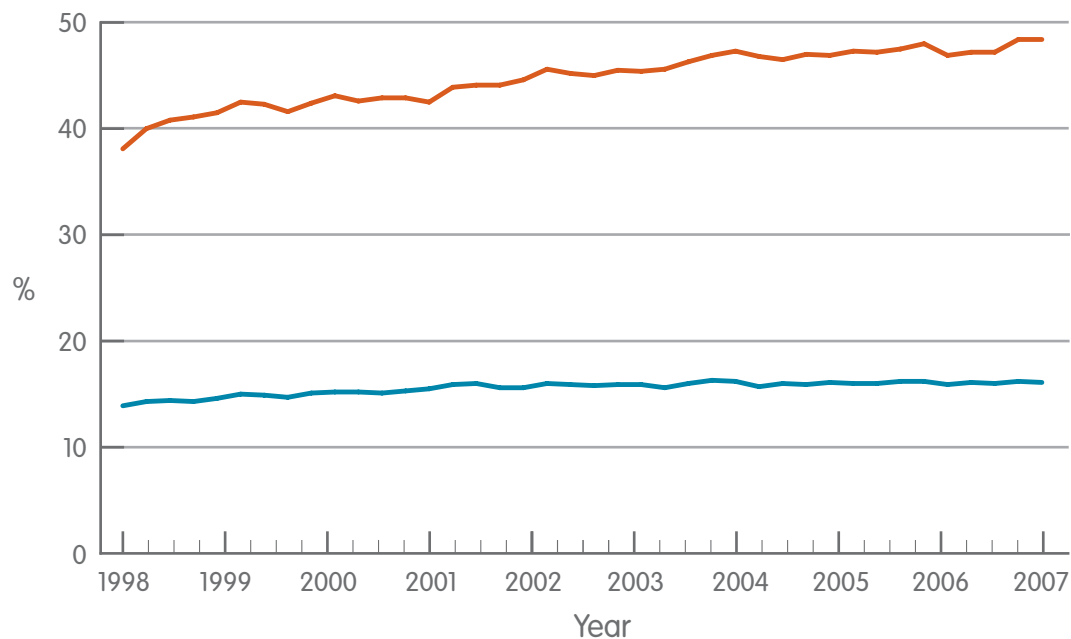


Note: UK coverage.

Source: Labour Force Survey, Office for National Statistics

Supporting more people with a health condition into work will help to achieve the Government's aim of higher employment. The employment rate for disabled people has gradually increased since 1998 from 38% to 48%, against the background of a small increase in the percentage of the working age population reporting themselves as disabled (see Figure 2.3).

Figure 2.3 Employment rate for disabled people



- Employment rate for disabled people (DDA)
- Percentage of working age population reporting themselves as disabled (DDA)

Note: The definition of disabled people refers to those covered by the Disability Discrimination Act (DDA).

Source: Labour Force Survey, Office for National Statistics

Ill-health in work

When employees develop a health condition, it does not always lead to absence from work, but can lead to reduced performance on the job. This may be the result of relatively minor illnesses, such as common colds, or due to more serious conditions. Some cases of serious illness will be undiagnosed and, in other cases, people may try to hide or fail to acknowledge their condition, especially if they have mental health problems. One initial estimate for the UK suggests that, for those with mental health conditions, reduced productivity accounts for 1.5 times as much working time lost as sickness absence¹¹.

Lower productivity may also be linked to lower job satisfaction and well-being, which in turn may be due to workplaces that sap morale and energy. There is growing evidence that links employee morale and satisfaction with health outcomes as well as business performance measures¹².

¹¹ *Mental Health at Work: Developing the business case* (2007), Policy Paper 8, London: The Sainsbury Centre for Mental Health.

¹² See for example Veldhoven, M. van (2005), *Financial performance and the long-term link with HR practices, work climate and job stress*. *Human Resource Management Journal*, Vol 15, no 4.

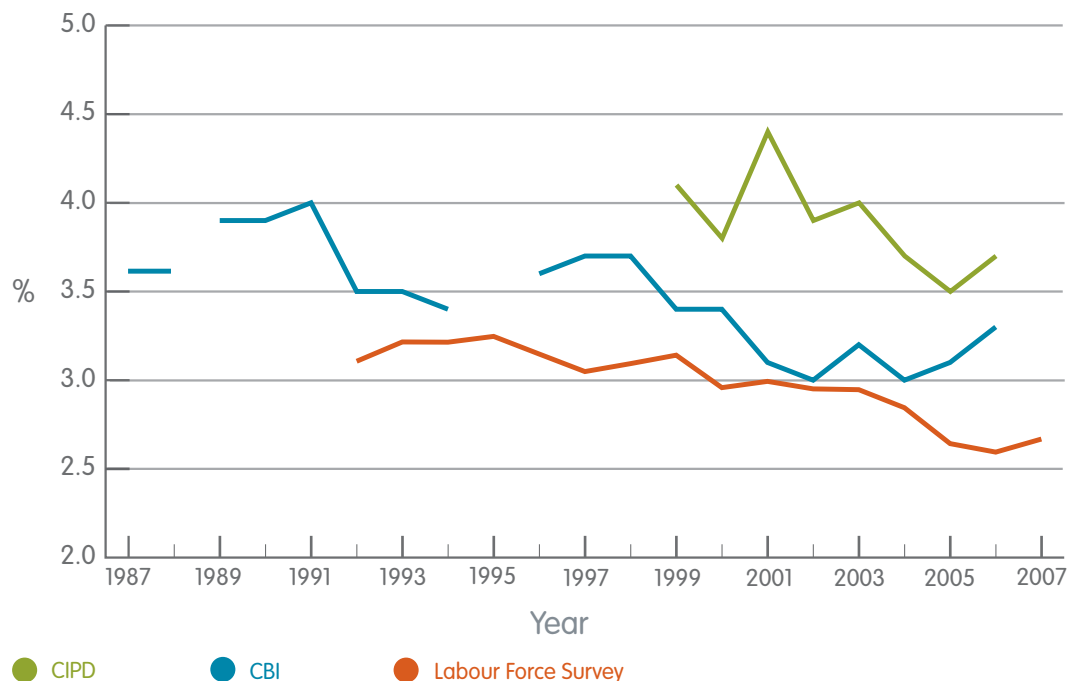
Absence from work

Sickness absence is generally lower than it was in the 1990s, but is still substantial. There are various sources available that measure the level of sickness absence in the British economy. Both the Confederation of British Industry (CBI) and the Chartered Institute of Personnel and Development (CIPD) have surveyed employers and arrived at similar estimates of time off due to illness in 2006: seven days per employee in the CBI survey and 8.4 days in the CIPD survey. In total, the CBI calculates 175 million days are lost to sickness absence each year.

The Labour Force Survey (LFS), carried out by the Office for National Statistics, also asks employees about sickness absence. Based on their responses, it is estimated that 2.4% of working time is lost because of sickness. This is a little lower than the CBI and CIPD estimates, roughly comparable to six days per worker per year, and amounting to a total of around 150 million working days of annual time off (see Figure 2.4).

The CBI estimates that absences over four weeks make up about 6% of the number of absences, although they represent around 43% of days lost.

Figure 2.4 Sickness absence as a proportion of working time



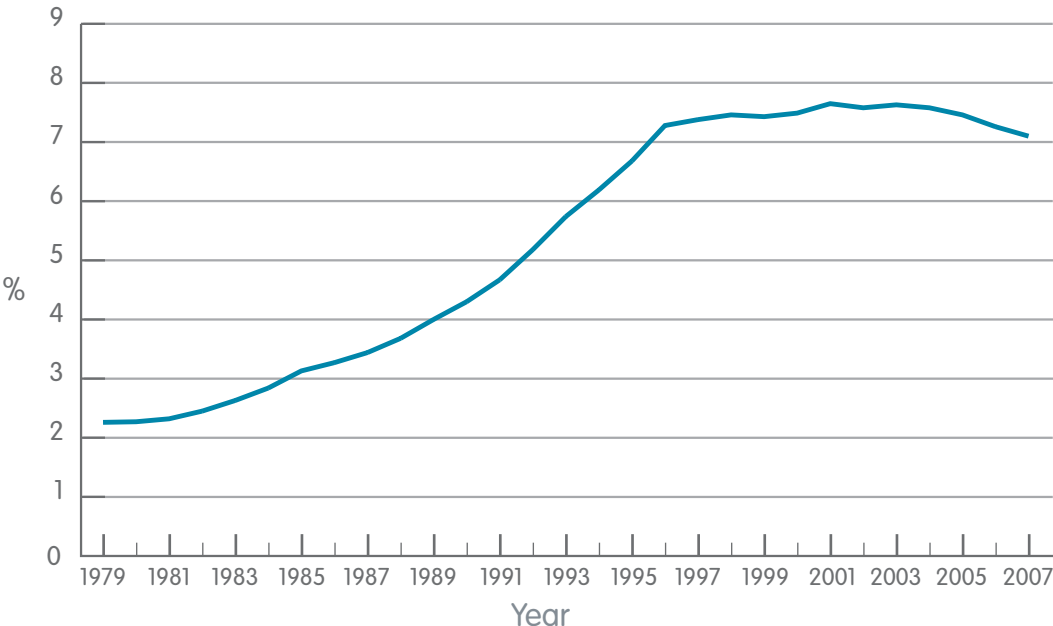
Note: CBI data not collected in 1988 and 1995.

Source: Labour Force Survey, Office for National Statistics; CBI; CIPD

Incapacity benefits

Incapacity benefits are paid to those who are unable to work because of ill-health or disability. The proportion of the working age population on incapacity benefits – or the equivalent benefits that preceded it – has increased from just over 2% in the 1970s to around 7% today. Much of the increase occurred between the late 1970s and mid-1990s, with a small decline in recent years (see Figure 2.5).

Figure 2.5 Proportion of working age population in receipt of incapacity benefits



Note: Discontinuity prior to 1995 due to exclusion of incapacity benefits short term lower rate.

Source: DWP Administrative Data

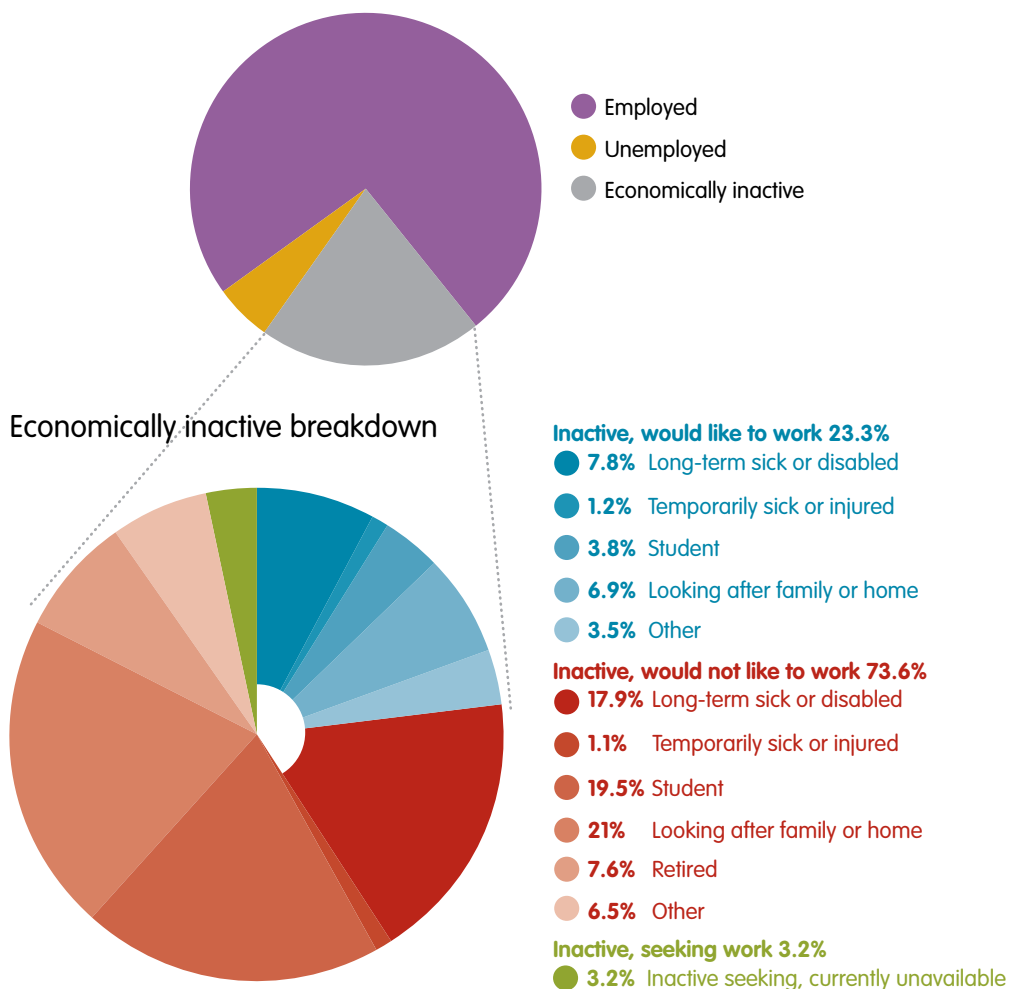
Inflows to incapacity benefits have fallen by nearly 40% over the last decade. Currently, the annual number of new claimants is around 600,000. This has not led to a large fall in the number of benefit recipients because outflows have fallen by nearly 35% over the same period.

Worklessness

Around a quarter of the working age population are not in work. Of these, approximately 20% are unemployed but actively seeking work. The remainder have a variety of reasons for being out of the labour market, only one of which is ill-health. According to LFS data, 28% of those economically inactive are so because of sickness, injury or disability (see Figure 2.6).¹³

Figure 2.6 Reasons for being out of work

Working age population



Note: Definition of unemployed follows that of the International Labour Organisation (ILO).

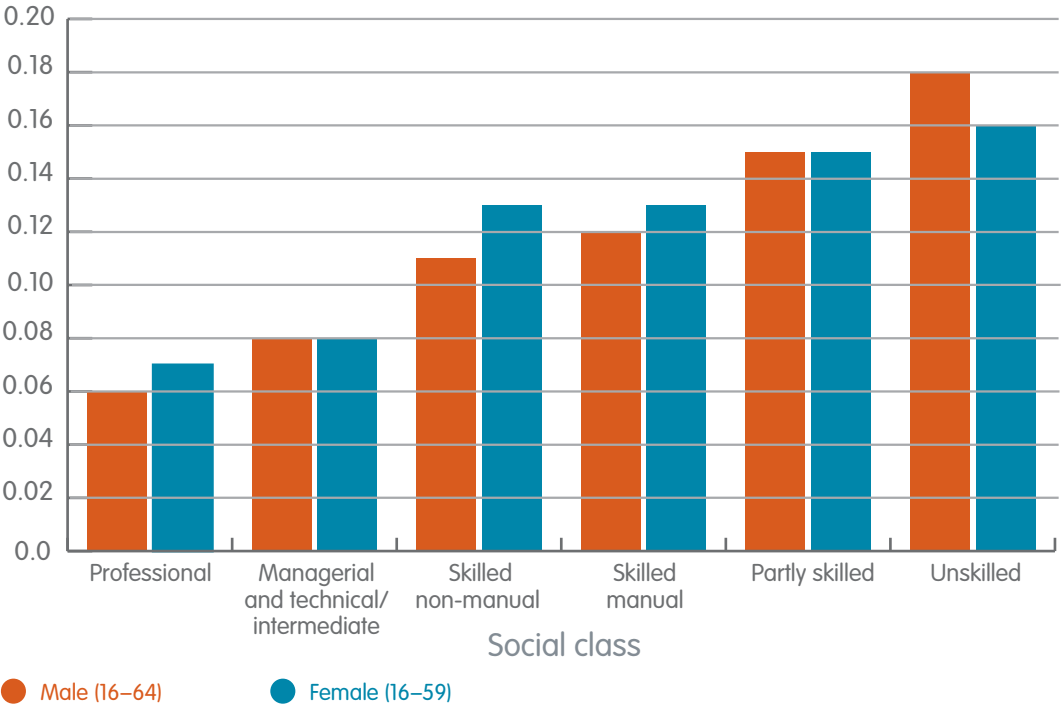
Source: Labour Force Survey, Office for National Statistics

¹³ This group is based on self-reported health status and will therefore not be exactly the same as incapacity benefits; there will be some people who report being ill without receiving incapacity benefits, and others who are in receipt of incapacity benefits but do not report being workless because of a health problem on the LFS.

Health inequalities

There is considerable evidence that there is a fundamental link between health and other socio-economic indicators such as educational qualifications, job status and income. As a result, health inequalities often go hand-in-hand with other socio-economic inequalities. Geographical variations are also evident, but appear to reflect concentrations of people with certain characteristics, rather than specific locations having an inherently perverse effect on health. Inequalities can be illustrated by the Quality Adjusted Life Year (QALY) health measure, as distributed between different social classes¹⁴. Figure 2.7 shows how individuals in lower social classes on average have a worse health status, here measured as the deviation from good health.

Figure 2.7 Proportion of deviation from perfect health by social class



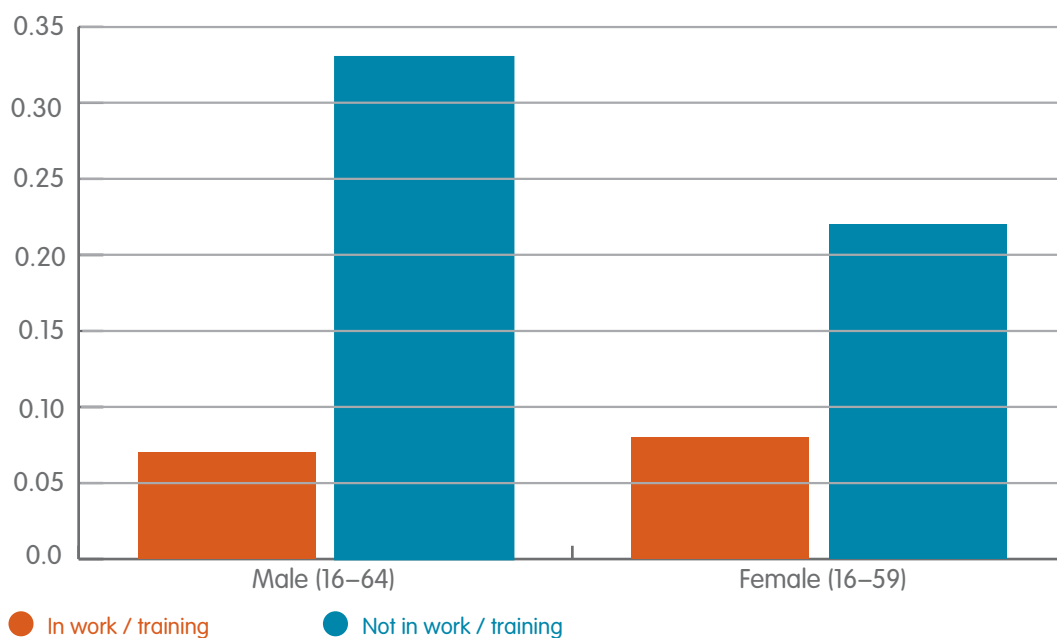
Note: Based on QALY measure of self-reported health. Does not cover Scotland and Wales.

Source: Health Survey for England 2005, age adjusted, analysis by Department of Health

¹⁴ The EQ-5D QALY measure is based on self-reported health. It has a scale in which 1 represents perfect health, and 0 represents death. The vast majority of individuals at any given time will have a QALY of 1. Long-term illness or disability typically leads to a deviation from a QALY of 1.0 (deviation from perfect health) of between 0.2-0.4. Only the very few individuals with severe illness will have a QALY deviation of 0.6 or more.

The link between health and wealth can run in both directions. Having a higher income is likely to improve a person's health status, while being in good health increases a person's earnings potential. There is something of a self-sustaining cycle of good health and good wealth, just as there is a similar cycle of poor health and poor wealth. These inequalities are illustrated by Figure 2.8 which shows the difference in health status between those in and out of work. This is supported by a recent study which found a clear link between an individual's health status and the probability of being in work, and also earnings levels for those in work¹⁵. The same study found a significant association between the health status of the working age population and economic growth.

Figure 2.8 Proportion of deviation from perfect health by work status



Note: Based on QALY measure of self-reported health. Does not cover Scotland and Wales.
 Source: Health Survey for England 2005, age adjusted, analysis by Department of Health

The public health challenge and lifestyle trends

So far this chapter has concentrated on outcome measures of health, or how ill-health in the working age population might manifest itself. However, it is important to give equal consideration to the drivers of health. The improvements in health and life expectancy in recent decades were largely the result of better healthcare and improvement in certain lifestyle factors, particularly smoking.

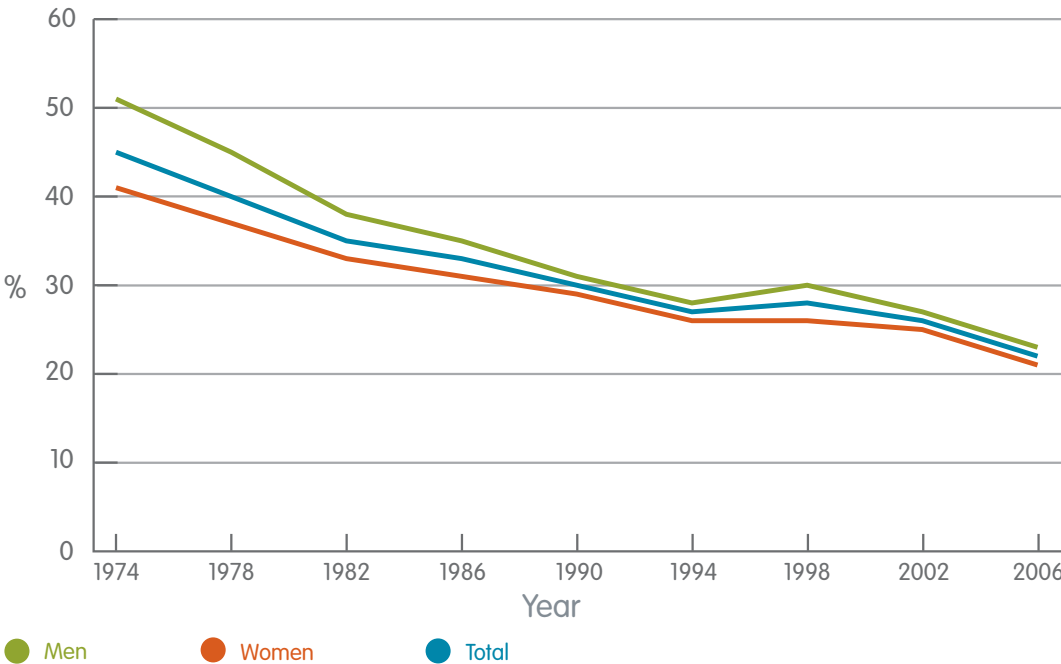
¹⁵ Bell, Matthew, Y. Kossykh, M. Ridge and N. Woolley, *An empirical analysis of the effect of health and economic growth in the UK*, Health and Safety Executive (HSE) Research Report, (forthcoming).

The greater increase in life expectancy than in healthy life expectancy indicates that society has been comparatively more successful in controlling life-threatening and life-shortening disease than it has in delaying the onset of long-term conditions that impair health.

Through their lifestyles, individuals can have a significant impact on their own long-term health status. The most important indicators of healthy living relate to how and what people eat and drink, how active they are and whether they smoke or not. Unhealthy lifestyles can be threatening to the working age population as the onset of poor health might impact on the ability to work. This can eventually lead to worklessness which further exacerbates health problems.

The trends in some public health indicators have been encouraging in recent decades. Smoking in the adult population has decreased from 50% for men and 40% for women in the mid 1970s to 23% for men and 21% for women today (see Figure 2.9). The recent introduction of smoking bans in Scotland, Wales and England is likely to bring these numbers down further.

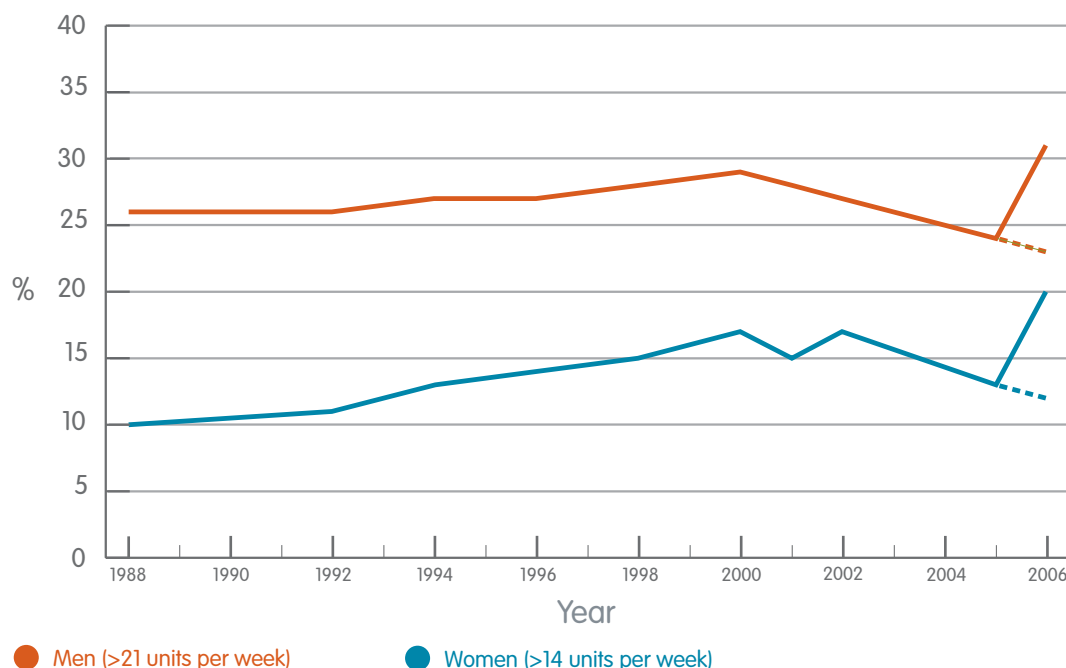
Figure 2.9 Proportion of adult population who smoke



Source: General Household Survey, Office for National Statistics

In contrast to trends in smoking, alcohol consumption has increased in recent decades. As a result, alcohol-related deaths have doubled over the last 15 years. Figure 2.10 shows the magnitude of the problem of excessive drinking.

Figure 2.10 Proportion of the adult population drinking more than the recommended amount



Note: The methodology for analysing alcohol consumption was changed for the 2006 data; the improved methodology takes account of the fact that alcohol content and glass sizes have increased over the years. Alcohol consumption is therefore estimated to be notably higher, especially for women. For 2006, data using the original method is provided for context.

Source: General Household Survey, Office for National Statistics

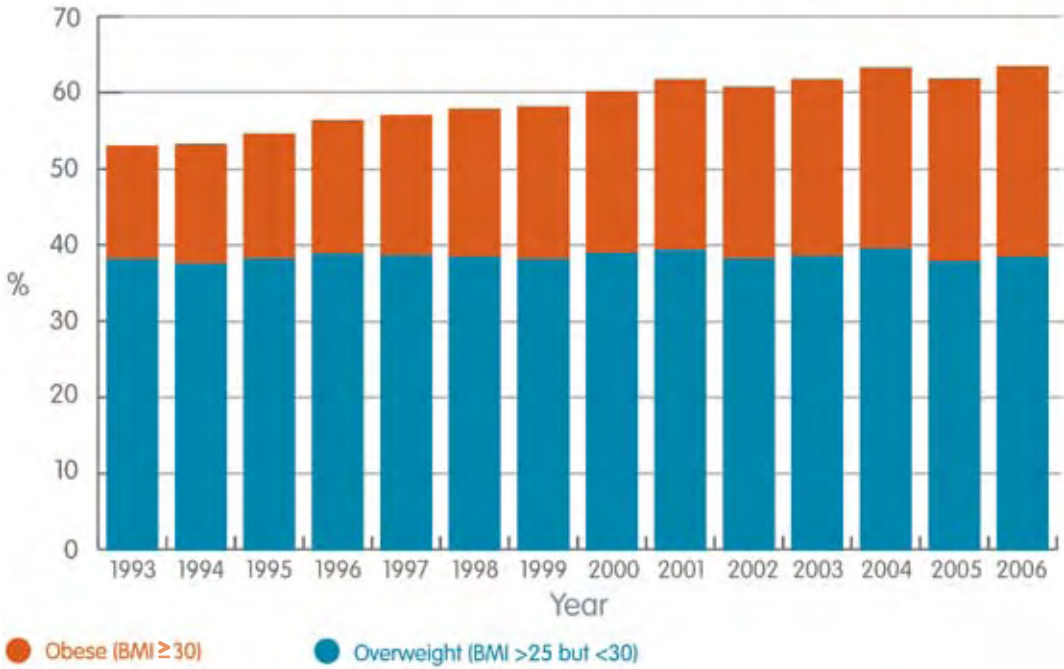
Trends in our dietary and exercise habits also threaten health. Only 30% of adults eat at least five portions of fruit and vegetables a day. We are becoming more sedentary in our lifestyles, with participation in physical activity at low levels. Twenty per cent of men and around 40% of women meet recommended physical activity guidelines¹⁶.

As a result, over two-thirds of men and over half of women are overweight (see Figure 2.11). If current trends continue, levels of working age adults who are obese or overweight will rise to around 90% in men and 80% in women by 2050¹⁷.

¹⁶ Health Survey from England (2006).

¹⁷ *Healthy Weight, Healthy Lives: A Cross-Government Strategy for England* (2008), p.1.

Figure 2.11 Proportion of the adult population overweight and obese



Note: Does not cover Scotland and Wales.

Source: Health Survey for England

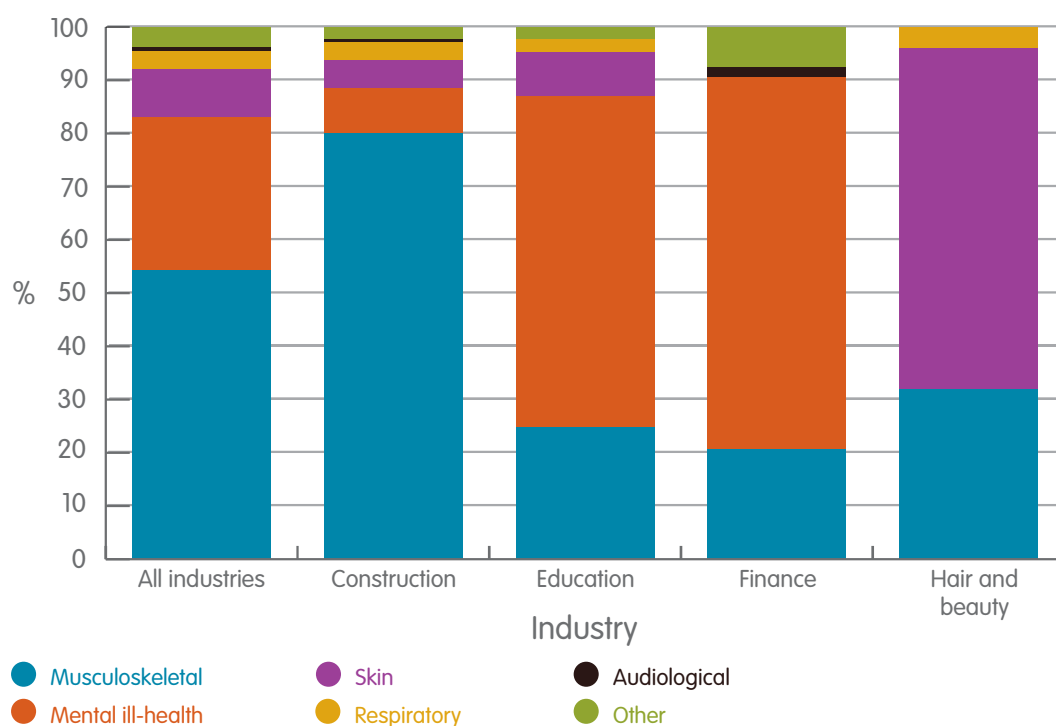
Lifestyle factors, such as smoking, drinking and obesity, have a significant impact on health conditions experienced by the working age population. Poor health outcomes related to these factors can include high blood pressure, diabetes, coronary heart disease and respiratory diseases such as chronic obstructive pulmonary disease (COPD). Other common conditions affecting the working age population are mental illness and musculoskeletal disorders (MSDs) which, along with cardio-respiratory conditions, account for two-thirds of sickness absence, long-term incapacity and early retirement¹⁸.

¹⁸ Waddel and Burton (2004); *Concepts of Rehabilitation for the Management of Common Health Problems*. London: TSO.

What keeps people out of work?

There is an obvious link between an individual's health status and ability to work. However, this relationship is not always straightforward and is influenced by a number of factors. First, work itself can be a cause of illness. Health and Safety Executive (HSE) figures suggest that around a quarter of days lost through absence may be due to work-related ill-health.¹⁹ Figure 2.12 shows how different industries are likely to be associated with different patterns of work-related ill-health. Therefore, preventative measures need to be tailored to the industry sector, rather than adopting a 'one size fits all' approach. Second, timely diagnosis and intervention that could keep people in or help them to return to work is often unavailable, resulting in high numbers of people absent with relatively mild conditions and at risk of falling out of work. This can be illustrated by the examples of common mental health conditions and MSDs²⁰.

Figure 2.12 Work-related illness by industry



Note: Based on number of cases. Does not cover Scotland and Wales.

Source: Health and Occupation Reporting Network (THOR), a research programme of the Occupational and Environmental Health Research Group of the University of Manchester

¹⁹ *Health and safety statistics 2006/07*, Health and Safety Executive.

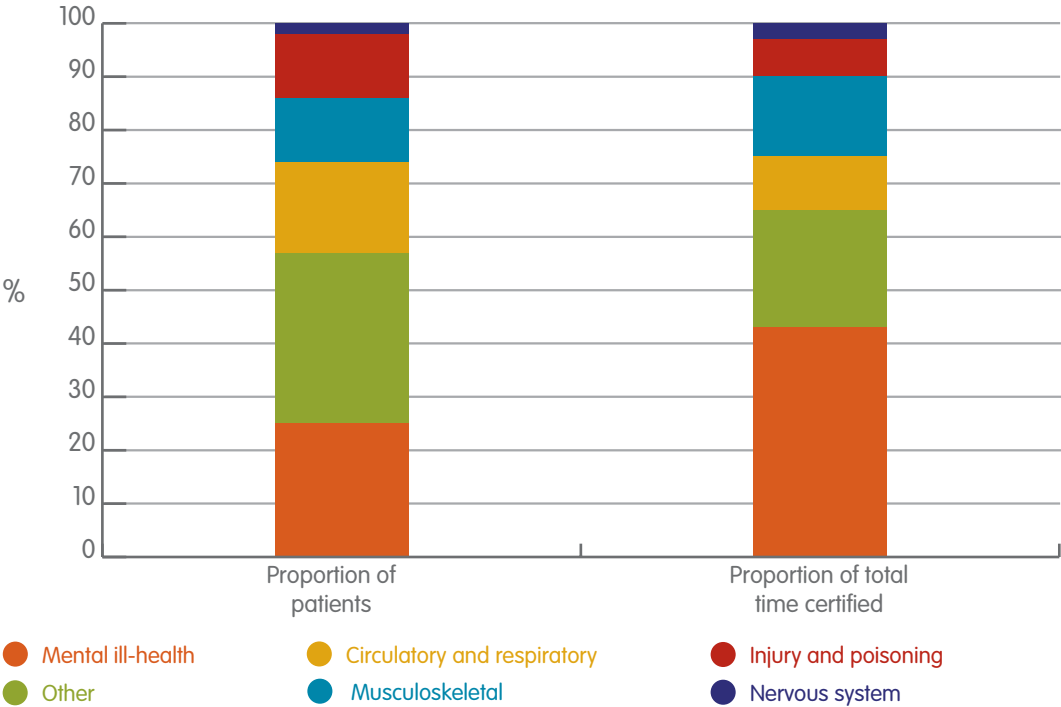
²⁰ It can be difficult to categorise individuals as having a specific condition, as many suffer from more than one. For example, of recent medically examined incapacity benefits claimants 27% had only a mental health condition, whereas 53% had a mental health primary condition and a physical condition, and an additional 17% were affected by a mental illness as a secondary condition, which means around 70% are affected by a mental health condition. Source: DWP administrative data and medical examination data.

Mental health

Five million people of working age have a common mental health disorder and just under a million a severe condition²¹. Mental health conditions are an important cause of absence, both work-related and non-work-related, and of worklessness due to ill-health. There is also evidence to suggest they are one of the main causes of lower productivity due to illness while in work.

Analysis of sick notes issued to people in the Merseyside area over a 12-month period showed that one in four people had a mental ill-health diagnosis²². However, mental ill-health accounted for over 40% of the total time covered by sick notes (see Figure 2.13). The average time certified for a person with mental ill-health (15 weeks) was nearly twice as long as the average for all conditions (8 weeks).

Figure 2.13 Sick notes issued by medical condition



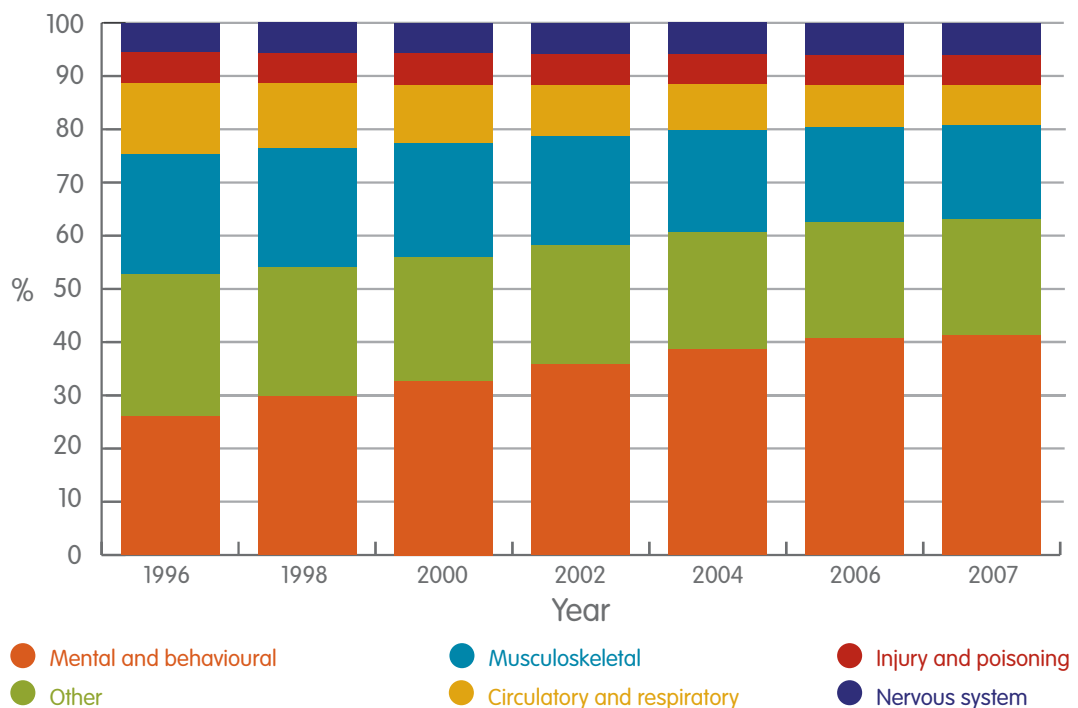
Source: Gabbay and Shiels

²¹ *Mental Health and Work*, a report commissioned for this Review from the Royal College of Psychiatrists.

²² Gabbay and Shiels. *An analysis of medical certificates issued over a 12-month period by general practices in the Merseyside area, between 2000 and 2002*. University of Liverpool.

The numbers on incapacity benefits reveal that the proportion with mental health conditions has increased dramatically over the last decade, from 26% in 1996 to 41% in 2006 (see Figure 2.14). This is due to a longer than average claim period as well as a relatively high share of people with mental illness among new claimants. However, this is the result of a fall in the number of new claims related to other conditions, rather than an absolute increase in the number of cases of mental illness, which has remained fairly stable at around 200,000 per year.

Figure 2.14 Incapacity benefits claimants by primary medical condition



Source: DWP Administrative Data

More than many other illnesses, mental health conditions are often undiagnosed, or diagnosed only when they have become severe enough that an individual may have to be absent from work for a substantial period. Part of the problem lies with the stigma and discrimination attached to mental health conditions. Many people go to great lengths to prevent colleagues and managers knowing they are or have been ill. They may be reluctant to request time off for therapy and so reduce their chances of getting appropriate help. Moreover, line managers are often ill-equipped to recognise early signs of mental illness.

Even when individuals seek medical help they are often reluctant to admit mental symptoms. Evidence suggests only about half of those affected are diagnosed as having a mental disorder at the first consultation with their GP and often, in the case of depression or anxiety, patients receive treatment that is considered sub-optimal. The position is even less satisfactory for people whose mental health problems present as physical symptoms or for people with physical illness who have co-existing mental health problems.

Secondary mental healthcare providers have the specialist skills to detect and treat less obvious forms of common mental disorders, but their priority is severe mental illness.

Evidence submitted in the course of the Review included a report of a pilot occupational health case-management programme for staff within two regions of NHS Scotland²³. The case-management approach entails the integration of the assessment, co-ordination, implementation and monitoring of the interventions necessary to achieve a desired goal. Typically, it would involve a single case manager responsible for referral to specialist healthcare. The pilot programme indicated that the approach was effective (and cost-effective).

Musculoskeletal disorders

MSDs are an important cause of work-related ill-health and certified sick leave, as illustrated by Figures 2.12²⁴ and 2.13. An MSD accounted for around one in eight people who were issued a sick note. The average length of time certified for those with MSDs was 10 weeks, almost two weeks more than the average for all conditions. Interestingly, the numbers claiming incapacity benefits due to MSDs have shown a reduction in recent years (see Figure 2.14). Once in receipt of incapacity benefits, those with MSDs have a greater probability of returning to work than those with mental health conditions.

Evidence-based approaches to the management of back pain have been established since the early 1990s. These are based on the rapid assessment of early-warning symptoms and signs by appropriate healthcare practitioners, such as nurses, physiotherapists and GPs. Where no serious risk factors are identified, the emphasis is on advice, pain relief and rapid rehabilitation through self-help, staying active and supportive physical therapies, to minimise the need for sickness absence.

²³ Hanson M et al. (July 2007) Evaluation of the OHSxtra, a pilot occupational health case-management programme within NHS Fife and NHS Lanarkshire.

²⁴ See also *Health and safety statistics 2006/07*, Health and Safety Executive.

Good evidence for similar approaches to the management of shoulder, neck and other types of MSDs has recently become available²⁵.

Overall, the key finding appears to be that early intervention is critical to achieving speedy and sustained recovery. In this connection, the pilot occupational health case-management programme in two regions of NHS Scotland, referred to in the preceding section, offered evidence of an active case-management approach to MSDs. This was reinforced by the findings of research into the costs and benefits of active case management and rehabilitation for musculoskeletal disorders which was recently published by the Health and Safety Executive.²⁶

Costs of poor health

The cost of poor health among the working age population affects everyone.

For individuals themselves, it is not just a question of loss of income if poor health leads to worklessness. There are also the emotional costs of ill-health to themselves and their families to be considered. Related to this is the risk of losing valuable years of life spent in a state of poor health and the associated costs of informal care by friends and family.

For employers, there are the costs of health-related productivity losses often resulting in absence. There are also associated costs of staff turnover, loss of skills base, downtime, recruitment and re-training.

For the NHS, there is the cost of treating working age people who are sick. This covers the full range from GP consultation through to specialist care. The additional cost of treating health conditions that keep people out of work is estimated to be £5-11 billion per year.

For the Government, there are the costs to the NHS as well as the costs of benefits related to working age ill-health (£29 billion a year). These direct costs increase the burden on the taxpayer by £34-40 billion a year. In addition, the Government loses out on additional income taxes of £28-36 billion a year as a result of lost productivity, which brings the overall cost to the taxpayer up to £62-76 billion.

²⁵ Waddell and Burton (2004); *Concepts of Rehabilitation for the Management of Common Health Problems*. London: TSO.

²⁶ Hanson M et al. (2006). *The costs and benefits of active case-management and rehabilitation for musculoskeletal disorders*. Prepared by Hu-Tech Associated Ltd for the Health and Safety Executive.

Finally, there is a cost to the economy as a whole. This will include the forgone taxes and healthcare costs to Government, but not the benefit cost of worklessness as the latter is a transfer within the economy, resulting in a cost to Government but not the economy as a whole. The lost productivity of those who are out of the workforce is in excess of £60 billion a year. Including the costs of sickness absence brings these costs to over £70 billion each year. Adding healthcare costs and a conservative estimate of the costs of informal care brings this number to over £100 billion (see Figure 2.15). This is greater than the current annual budget for the NHS and equivalent to the entire Gross Domestic Product (GDP) of Portugal.

These estimates do not include the costs of health-related productivity losses that do not lead to absence. Preliminary calculations suggest that these costs could be in the order of £30 billion per year.

Figure 2.15 Costs of working age ill-health (£ billions)

	2007 (£ billions)
Worklessness – benefits	29
Healthcare	5-11
Forgone taxes	28-36
	<hr/>
Total Government	62-76
Worklessness – lost production	63
Sickness absence	10
Informal care	25-45
Healthcare	5-11
	<hr/>
Total economy	103-129

The following table shows a collection of indicators which together make up the very first baseline of the health of the working age population.

Figure 2.16 Baseline indicators of working age health

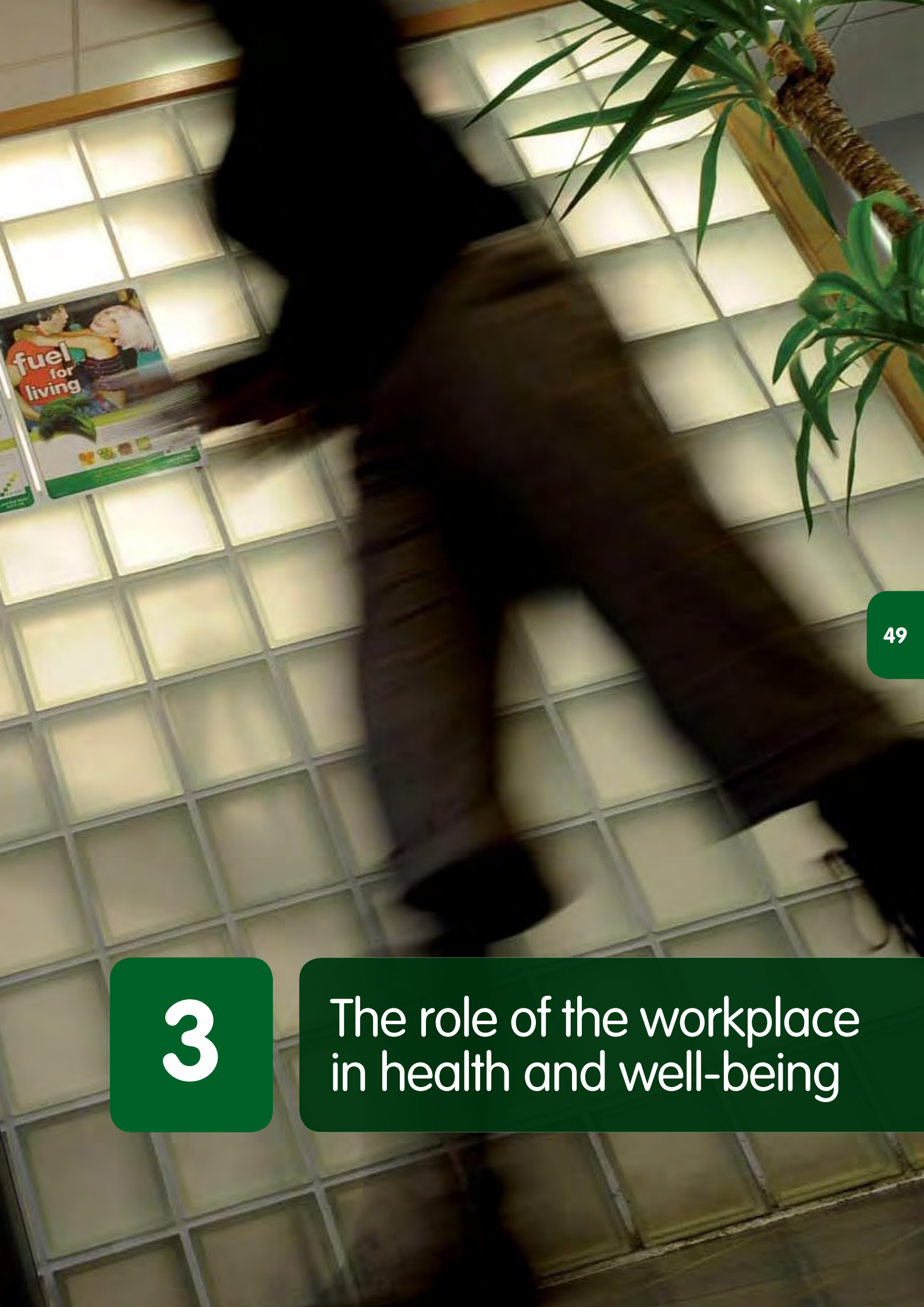
Indicator	Latest data	Source
Employment rate	74.7%	LFS (2007)
Employment rate for DDA disabled	48.4%	LFS (2007)
Proportion out of work due to sickness or disability	6%	LFS (2007)
Incapacity benefits caseload	2.64m, 7% of working age population	DWP administrative data (2007)
Inflow to incapacity benefits caseload	607,000	DWP administrative data (2007)
Inflow caseload due to mental ill-health	212,000	DWP administrative data (2007)
Sickness absence	2.6% 3.3% 3.7%	LFS (2007) CBI (2006) CIPD (2006)
Life expectancy	81 (F) / 77 (M)	ONS (2006)
Mortality during working age	6% (F) / 16% (M)	ONS (2006)
Healthy life expectancy	70 (F) / 68 (M)	ONS (2004)

Conclusion

There is a compelling economic and social case to act decisively to improve the health of the working age population.

Chapter 3 sets out the first elements of a new vision for health and work in Britain, by considering the role of the workplace in preventing illness and promoting health and well-being.





3

The role of the workplace in health and well-being

Chapter 3 – The role of the workplace in health and well-being

With almost 75% of working age people in employment, Britain has one of the highest employment rates in the world. Although working hours and patterns are relatively flexible, those in employment spend a significant portion of their waking hours in a working environment. There they help to define and progress society; they provide for themselves and their families; and contribute to the economy and the profits of their employers or their own businesses.

Although there is now widespread understanding of the risks of damaging someone's health through the workplace, the role it can have in promoting employees' health and well-being is less well understood. The Introduction drew attention to recent evidence that work is, on the whole, good for an individual's health and well-being, and the reverse is true of worklessness.

'Most people in employment spend 60% of their waking hours in work... the workplace is a great place to promote the benefits of enjoying a healthy, active lifestyle.'

South Ribble Borough Council

Good health improves an individual's quality of life, and a focus on their well-being can also add value to organisations by promoting better health and increasing motivation and engagement of employees, in turn helping to drive increases in productivity and profitability. In other words the benefits of health and well-being extend far beyond avoiding or reducing the costs of absence or poor performance. But this requires a changed perception of health and well-being, and a willingness from both employers and employees to invest resources and change behaviour.

The importance of prevention

The arguments for preventing work-related injury, disease and death are morally, socially and economically irrefutable. There has been significant improvement in the past 30 years – the number of injuries suffered at work has decreased by 70% since the introduction of the Health and Safety at Work Act 1974²⁷. Some of this decrease is the result of the decline of heavy industry and manufacturing, but much of the decrease is due to better management of health and safety in the workplace and a better recognition

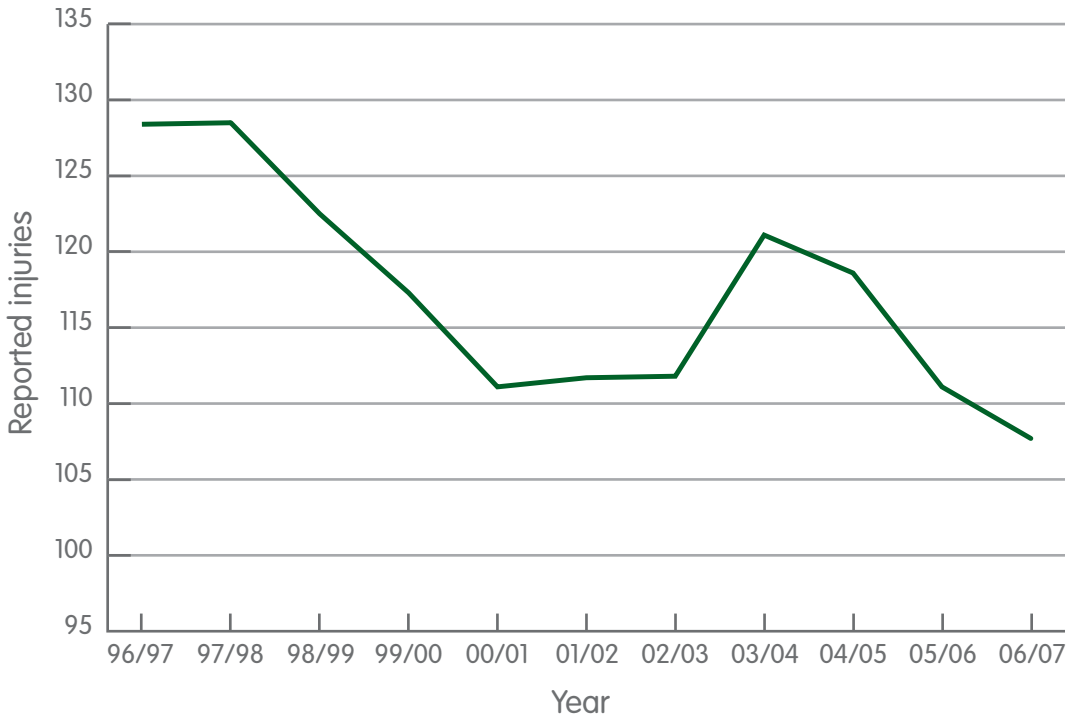
²⁷ <http://www.hse.gov.uk/statistics/history/index.htm>

of the risks and how to control them. This is a tribute to the efforts of employers, trades unions, occupational health services, the Health and Safety Executive (HSE), local authorities and others who have developed healthier and safer workplaces and ways of working, raising awareness of the importance of health and safety in the working environment.

The UK compares well with other industrialised countries in terms of workplace health and safety. Nonetheless 241 people lost their life last year as a result of a workplace injury and an estimated 274,000 people suffered a reportable non-fatal workplace injury (of which 141,350 were reported)²⁸.

The health and safety system is on track to meet the target, set in 2000²⁹, to reduce fatal and major injury, but targets for reducing the incidence of work-related ill-health and the number of working days lost from work-related injury and ill-health are unlikely to be met. It is essential that employers, local authorities, the HSE and partners continue to work towards meeting them.

Figure 3.1 Annual rate of reported fatal and major injuries, per 100,000 employees



Source: Health and Safety Executive

²⁸ <http://www.hse.gov.uk/statistics/index.htm>
²⁹ <http://www.hse.gov.uk/revitalising/strategy.pdf>

Not just health and safety but also health and well-being

All organisations must ensure compliance with health and safety and other relevant employment law, through good health and safety management, prevention, and reducing exposure to risk. This will undoubtedly help to save costs and prevent ill-health and accidents. However, in order to realise the potential added value of raised productivity, organisations will need to extend their agenda to health and well-being.

The workplace can be a key setting for improving people's health and well-being. Responses to the Call for Evidence highlighted various health and well-being initiatives set in the workplace. These ranged from increasing physical activity (by subsidising gym membership and sports pitches, and encouraging active travel to and from work), subsidising healthy food in the canteen, through to the provision of health screening and GP consultations in the workplace. All of these initiatives are welcome and encouraged, providing they are carried out in consultation with the workforce.

'Employers are in a unique position of being able to educate, motivate and support their employees in understanding and actively maintaining their fitness and well-being.'

Commercial Occupational Health Providers Association

It was also clear from responses to the Call for Evidence that the reason health and well-being initiatives are not more numerous in the workplace today is the lack of a well-developed business case as to why employers should invest in them. Limited access to information for both employees and employers on the effectiveness and cost-effectiveness of these schemes has led to a lack of action. The question that needs to be answered is whether employers could expect improved performance from their staff if they invest in their health and well-being.

Is there a business case to invest?

Many organisations have invested in health and well-being initiatives for reasons other than to obtain a direct financial gain. The main reasons include:

- corporate social responsibility; improving the quality of life of the workforce and their families as well as of the local community and society at large;
- competition; in an increasingly competitive labour market there is more pressure on employers to distinguish themselves in order to attract and keep quality staff; and

- high costs; for some it has become clear that, unless an initiative is introduced, the costs of sickness absence could threaten the business itself.

In many of these cases, data on effectiveness have not been systematically collected, but as part of this Review, PricewaterhouseCoopers (PwC) were commissioned to consider the wider business case and specifically the economic case for employers to invest in wellness programmes for their staff. The detailed findings of this work are being published separately alongside this Review³⁰.

PwC found considerable evidence from literature reviews and over 50 UK-based case studies that health and well-being programmes have a positive impact on intermediate and bottom-line benefits. Intermediate business benefits include reduced sickness absence, reduced staff turnover, reduced accidents and injuries, reduced resource allocation, increased employee satisfaction, a higher company profile, and higher productivity.

‘The business case for promoting and supporting employee health and well-being is becoming increasingly clear. Employers can gain clear benefits in reducing employee turnover and increasing the productivity and engagement of employees.’

Chartered Institute of Personnel and Development

The available evidence suggests that initial programme costs can quickly be translated into financial benefits, either through cost savings or additional revenue generation. Quantifiable and significant financial benefits from organisations’ initiatives were found in a number of cases, including large, private-sector business, public-sector organisations and small and medium-sized enterprises. The message is clear: good health is good business.

Good health is good business

There are key elements to making any initiative work well. These are well recognised and supported through PwC’s work:

- successful programmes were those that were specifically designed to meet employee needs. There is no ‘one size fits all’ – what might be right for one set of employees may not be for another, even within one organisation. Employees must be engaged with the process and any programme must take account of their needs and what they value;

³⁰ PwC *Building the case for wellness* (2008) www.workingforhealth.gov.uk

- senior management buy-in is also fundamental to success. Leadership goes beyond endorsement of programmes and involves active and visible participation of senior management in health and well-being programmes;
- any programme or initiative also needs to be aligned with the business' overall aims and goals. Rather than these programmes being an afterthought, they will be more effective if they are related to the vision, principles and overall business plan;
- employees' views should drive ongoing change and influence programmes and initiatives that are offered. Communication is key, both in terms of employees being informed and updated on any health and well-being initiative, and their being continually consulted; and
- finally, if organisations are to form their own business case and share the value of health and well-being programmes with their directors, shareholders and other organisations, then it is imperative that they measure the outcomes of these programmes.

There is a need to build on this work. An evaluation tool would help businesses and organisations to understand the impacts of their health and well-being initiatives, and to share best practice. An accounting framework would enable them to report on the financial impacts in the boardroom and in company accounts as recommended by the Accounting Standards Board.

Advice and guidance for employers

A lack of information is the most common barrier to employers investing in the health and well-being of their workforce. Because the market is currently underdeveloped, there is a role for Government to facilitate the provision of information and practical advice for employers on investing in similar initiatives and ensuring the benefits are felt by both themselves and their staff.

Workplace Health Connect was a two-year pilot run by the HSE, designed to give free, confidential and practical advice to small and medium-sized businesses in England and Wales, on workplace health, safety and return-to-work issues. The pilot has now ended, with the final evaluation expected in early 2009. The service continues through Workboost Wales and Safe and Healthy Working in Scotland.

The responses to the Call for Evidence revealed that many organisations, especially smaller ones, would use an advice and guidance service providing it was tailored closely to their needs. Many would be willing to pay for a service of a suitable quality were it at a price which did not exclude smaller organisations. The market is currently underdeveloped, leading to a lack of information and a shortage of occupational health cover for the workforce.

The current absence of a Government-backed service in England provides an opportunity to test the market for a new business-led information, advice and consultancy service. The service should be trialled at a price that reflects the quality and value of the service. Advice should be business and provider-led. Best practice, knowledge and expertise are most advanced in the private and voluntary sector. Business is more likely to listen to business than take advice from Government.

The service should also aim to increase the coverage of occupational health support to the workforce, especially for those in smaller organisations. This could be through signposting to existing occupational health services, or directly marketing its own. The service could operate through regional or local partnerships to increase local employer engagement.

Smaller organisations

The business landscape and priorities are usually very different for small employers. Fewer staff, lower turnover, smaller profit margins and often no dedicated human resource function, can make it very difficult for them to engage in the health and well-being agenda. It is also more likely that one person being absent through sickness can have a substantial impact on the rest of the organisation if their key role or skills are removed.

Existing occupational health services are often aimed at larger organisations, including the public sector. The market is less developed for smaller organisations which may be less able to afford the costs of these services, and service providers may also find it more difficult to tailor their products to small organisations.

Yet smaller organisations can still implement health and well-being initiatives. There is little cost in promoting schemes to encourage active travel to work, ensuring sickness-absence management policies are set and adhered to, and providing advice and guidance on healthy working and living to their own staff.

The new health and well-being consultancy service must be geared towards working with small organisations. One option is for the consultancy to work with groups of small employers who share similar characteristics in terms of their business sector and workforce, so that there are economies of scale to reduce costs.

'The pragmatic way forward is to ensure that the strongest players are asked to build a new interface with SMEs in order to encourage their participation in occupational health.'

The Focus Group

The service could also link smaller employers to those larger employers who have already developed good practice in health and well-being. Business is more likely to take heed of advice that comes from business. Larger employers could run seminars, offer advice and guidance themselves and provide opportunities for wider business discussion besides health and well-being. They could also extend their own occupational health services down their supply chain to smaller organisations.

In England, NHS Plus provides occupational health support for NHS staff, and aims to reach out to medium-sized businesses and offer a service on a commercial basis. In Scotland, SALUS and OHSAS have similar aims. There is a need for Government to evaluate the success of these initiatives in broadening access to occupational health and extending the understanding among businesses of the scope of occupational health to add value to their enterprises.

Taxation can be a disincentive for smaller organisations to invest in health and well-being programmes. Certain anomalies exist, for example, larger organisations can build a gym onsite without incurring any additional tax liability. However, if an organisation is too small to justify building an on-site gym, it would incur an additional tax liability were it to subsidise membership of external gyms for its employees. Employers also incur a tax liability if they pay for the rehabilitation of an injury incurred outside of work.

It is not just a medical issue

This chapter has so far commented on health and well-being in terms of promoting health and preventing ill-health and injury. But the way in which the workplace affects someone's health and well-being is not simply a medical issue. The quality of the experience that someone has in their workplace can also impact on health and well-being.

In designing jobs and developing management arrangements, companies need to think about how staff will feel valued by the organisation, and what will motivate them to deliver a quality product or service without undue stress that might lead to poor health. In describing their ideal job, one individual will differ from another in the weight they place on factors such as salary, level of responsibility, convenience of location and overall workload. However, there are several key dimensions which are useful in describing desirable job attributes. Employees are likely to have worse health if³¹:

- employment is insecure;
- work is monotonous and repetitive;
- workers have little or no autonomy, control and task discretion;
- there is an imbalance between effort and reward so that workers feel exploited or 'taken for granted' (wider than just the wage packet);
- there are few supportive social networks; and
- there is an absence of procedural justice in the workplace i.e. workers cannot be confident that they will be fairly treated by their employer.

The advice in HSE's *Management Standards for Work-Related Stress*³², and similar guidance from a range of other bodies, is designed to help organisations avoid these problems.

The public sector has a critical role to play in leading by example. Recent changes in the Civil Service including, for example, Senior Management Master Classes and more frequent reporting of sickness absence tied to the objectives of Permanent Secretaries, signal an important new commitment to getting its own house in order. Although a good deal of work has been done to improve health and attendance management in the public sector, more can and should be done to contribute to improved services to the public. It is essential that the public sector steps up its efforts and works collaboratively with all organisations seeking to promote employee health and well-being.

³¹ *Healthy work, productive workplaces: why the UK needs more good jobs* – David Coats, Catherine Max, 2005 - http://theworkfoundation.com/Assets/PDFs/Healthy_Work.pdf

³² <http://www.hse.gov.uk/stress/standards/>

Line management

Senior management interest in these issues and leadership from the very top are vital. In addition, line managers have a key role in ensuring the workplace is a setting that promotes good health and well-being. Good management can lead to good health, well-being and improved performance. The reverse can be true of bad management. Good health equals good business, and the line manager is a key agent of change.

Line managers should be supported to understand that the health and well-being of employees is their responsibility, and should be willing to take action when health and well-being are at risk. This ranges from identification of the potential risks, hazards and causes, to support for people who have, or are at risk of developing, health conditions. Support may mean adjusting or adapting working practices, patterns or job roles where appropriate to do so.

Better workplaces have better financial results

The conclusions of the PwC work are supported by other studies which demonstrate that good working practices lead to improved financial performance.

Evidence from the US³³ analysed the relationship between employee satisfaction and long-run stock market performance. The balanced portfolio of the 'Best companies to work for in America' earned 14% per year from 1998-2005, over double the market return, outperforming industry and characteristic matched companies.

Evidence from the Sunday Times' 'Best Companies to work for in the UK'³⁴ shows that companies who have higher levels of staff engagement (as measured by looking at parameters such as employee well-being, line management and team-working) have 13% lower staff turnover, less than half the sickness absence of the UK average, and on the stock market they have consistently out-performed the FTSE 100.

³³ *Does the Stock Market Fully Value Intangibles? Employee Satisfaction and Equity Prices* – Edmans, Jan 2008.

³⁴ *Employee engagement and the bottom line* – Bradon, 2006.

Recommendations

- Government should work with employers and representative bodies to develop a robust model for measuring and reporting on the benefits of employer investment in health and well-being. Employers should use this to report on health and well-being in the board room and company accounts.
- Safety and Health practitioners and, where present, trades union safety representatives should play an expanded role in acting to promote the benefits of such investment.
- Government should initiate a business-led health and well-being consultancy service, offering tailored advice and support, and access to occupational health at a market rate. It should aim to be self-sustaining in the medium-term, and be fully evaluated and tested against free-to-use services.
- Government agencies, and other bodies concerned with economic development and business, should promote employers' understanding of the economic case for investing in health and well-being.
- Government should explore practical ways to make it easier for smaller employers and organisations to establish health and well-being initiatives.



4

Changing perceptions
of fitness for work

Chapter 4 – Changing perceptions of fitness for work

This Review sets out a new vision for health and work in Britain, based on an acknowledgement of the positive relationship between health and work and its importance in relation to the well-being and prosperity of individuals, families, organisations and society as a whole. Achieving this vision will require abandoning the idea that it is inappropriate to be at work unless 100% fit and that being at work normally impedes recovery.

This chapter sets out the implications for achieving such a change in understanding and the steps needed to bring it about. All those with an interest in working age health will be affected.

Employers' perceptions of ill-health

Even when the most effective strategies are in place to promote and protect their health and well-being, employees can still become unwell. When this happens, employers need arrangements to enable an early return to productive employment, accelerating where possible, but never compromising, the individual's sustained recovery.

Employers have significant scope to facilitate an employee's early return from sickness absence. Early, regular and sensitive contact with employees during sickness absences can be a key factor in enabling an early return to work. It ensures absent employees feel valued and do not become isolated from the workplace, and it assists line managers in understanding the consequences of the health problem and how to enable a return to work. Yet as many as 40%³⁵ of organisations have no sickness absence management policy at all and this is of concern given the high costs of sickness. There is evidence that some employers are reluctant to contact absent staff for fear of being accused of harassment. However, where contact with sick employees takes place in the context of clearly stated policies on sickness absence management, there should be no grounds for such fears.

Secondly, employers are often unaware of the evidence that work can be good for health and therapeutic in recovery. Employers have much to gain from acceptance that people do not have to be 100% fit to return to work. In many cases, an early return to work, with appropriate adjustments, can accelerate recovery without causing harm. For employers' sickness absence management policies to be successful, line managers need to be trained appropriately to implement them.

³⁵ *Health of the Workplace Report* – Norwich Union Healthcare – June 2006.

Line managers may need training in how best to regularly contact absent staff to stay in touch, offer support, and suggest back-to-work plans. It is important that line managers feel equipped and confident about approaching sensitive or difficult areas of conversation.

Lord Leitch's 2006 Review of Skills³⁶ in the UK discussed the need to improve management skills. In order to be effective, this needs to include management skills in sickness absence, as well as management of the health and well-being of the workforce more holistically. The development of a health standard in Investors in People will provide a benchmark for employers on these aspects.

Employers are also often reluctant to contact GPs about the options for a return to work and instead believe they should wait for the GP to produce a health report. In contrast, some employers take a proactive approach to proposing a return-to-work plan to the GP and ask the GP to confirm that this will not aggravate the health condition. Organisations that take this approach have generally found that GPs are receptive to being contacted in this way and that such an approach often facilitates an earlier return to work.

Case study

ClinPhone is a company which uses internet and telecommunications technology to accelerate the drug development process for the pharmaceutical industry. They employ 726 staff and have an annual turnover of £33.9 million. As soon as a member of staff is signed off work with a sick note, the line manager and HR team proactively work with their occupational health adviser, the employee and the GP to formulate a tailored return-to-work plan. As a result of this, and their other health and well-being strategies, ClinPhone have a low staff absence rate, averaging just 3.2 days per employee per year.

The public

In parallel with a change in perceptions among employers, there is an urgent need for a shift in public attitudes. Too many people think that work is bad for health, that work should be avoided when they are unwell and that they should only return to work when they are 100% fit. These misconceptions are reinforced by family and friends, resulting in many people seeking to be signed off work by their GP while awaiting or undergoing treatment. We need to change this behaviour if we are to make real progress.

³⁶ Leitch Review of Skills: *Prosperity for all in the global economy – world class skills* – 2006.

A change in public attitudes towards health and work will only be achieved through consistent messages reinforced by healthcare professionals, employers, trades unions, government and media. Healthy workplaces need to become the expected norm. As will be seen in Chapter 8, schools, further education and higher education have a role in embedding these expectations in the next generation.

The role of healthcare professionals

Healthcare professionals are key to providing much of the support people need to stay in or return to work. Their advice is often crucial in influencing a person's belief about their ability to work and available courses of action. GPs are particularly important here, as they are usually a person's first port of call when they fall ill and need advice about fitness for work. This advice has a huge impact on whether a person is absent from work, for how long and whether they take steps to return to work.

Yet despite the importance of work in maintaining health, until recently many GPs and other healthcare professionals have not seen it as their role to offer advice in this area. They are often concerned that being in work could be bad for health or that an early return to work could aggravate a health condition. Also, they may be concerned about damaging the doctor-patient relationship and they often have to rely, to some extent, on patients' own perceptions of the nature of the condition, especially with mental health.

At the heart of this problem is a wider lack of understanding about the impact of work on patient health and the role healthcare professionals can play in helping their patients to stay in or return to work. In spite of a growing evidence base on health and work, these issues have not been incorporated into the training of healthcare professionals. The result is that, despite their best intentions, the advice that healthcare professionals give to their patients can be naturally cautious and may not be in the best interests of the patient for the long term.

This was highlighted by recent research carried out for Government by Doctors.net.uk which found that, of 1,500 GPs surveyed, two-thirds did not know of recent evidence showing that work is good for health. It is encouraging that almost 90% said that this evidence could help to change their behaviour.

Developments in professional education, training and practice

Healthcare professionals have been working with the Department for Work and Pensions and the Health Departments to raise awareness of the evidence base where it is available, improving the training of future and existing healthcare professionals, and providing practical support to help them in their day-to-day work.

Leaders of the healthcare profession have demonstrated their commitment to promoting the link between good work and good health by signing the Healthcare Professionals' Consensus Statement on Health and Work. Focused on recognising that work can be good for patients and that supporting patients to remain in or return to work should be part of a healthcare professional's clinical function, this groundbreaking statement represents a significant step forward.

The opportunity exists to build on this consensus. Healthcare professionals, supported by Government, must take responsibility for helping to translate this pledge into reality.

Commissioners of health services

It is not enough to focus on those providing services. There needs to be a change in understanding by those responsible for commissioning services. To help bring this about, Government needs to ensure that commissioners of health services understand the importance of tackling working age ill-health, the needs of working age people and the interventions that are most effective in tackling the health conditions suffered by them. In England, the Department of Health's *Commissioning Framework for Health and Well-being* contained a very welcome chapter on work and health. However, Government needs to ensure that positive intentions, such as these, are translated into real action at a local level. Simple guidance for commissioners would help.

Moving from a sick note to a 'fit note'

The current sick note asks a GP to state briefly what a person's health condition is and for how long they should be absent from work as a result of this. In short, it focuses on what a person cannot do. The sick note includes a 'remarks' section which can, for example, be used by the GP to suggest amended duties as an aid to rehabilitation. However, it does not readily encourage GPs to explore with patients and employers the options for prompt return to work and the workplace adjustments which would facilitate this. Dating in its current form from 1922, it reflects an age when an employer expected an employee to do a specific job rather than today's more flexible workplace.

Healthcare Professionals' Consensus Statement

Statement on Health and Work

“Work which is appropriate to an individual’s knowledge, skills and circumstances, and undertaken in a safe, healthy and supportive working environment, promotes good physical and mental health, helps to prevent ill-health and can play an active part in helping people recover from illness. Good work also rewards the individual with a greater sense of self-worth and has beneficial effects on social functioning.

People who have never worked, but who have the potential, should be encouraged and helped to gain the necessary skills and experience to get a job, and be supported throughout this process. Similarly, those who have been unable to work because of illness or disability, but who have the potential to work, should be supported to make a timely return to appropriate work.

The crucial relationship between work and health dictates that, where appropriate, remaining in or returning to suitable work must be a critical outcome measure for success in the treatment and support of working age people.

Supporting employees’ occupational health is also a fundamental responsibility for employers. It is central to good management and – through its impact on productivity – good business. Whatever the nature of the business and wherever the place of work may be, we look to employers of all sizes to make use of the advice available from experts in employee health; and in the light of that advice to seek to:

- prevent ill-health by assessing and controlling the risks to employee health, safety and well-being;
- promote healthy lifestyles;
- tackle all forms of discrimination – especially the stigma too often associated with mental health conditions;
- support people to help keep them in work;
- facilitate a timely return to work, should ill-health occur, including, for example, the use of amended duties, flexible working options or rehabilitation services.

Statement of action

“We, the undersigned, will work with government, other healthcare workers, the voluntary sector, employers and trades unions, to promote and develop ways of supporting individuals to achieve the socio-economic and health benefits of work.

This pledge includes a commitment to continue to educate the healthcare community, employers and people of working age about the benefits that work can provide; and, as appropriate, to do all we can to help people enter, stay in or return to work.”

Signatories

Association of UK University Hospitals	Council of Heads and Deans of Dental Schools	Royal College of Anaesthetists	Royal College of Physicians of Edinburgh
Barts and the London School of Medicine and Dentistry	Ergonomics Society	Royal College of General Practitioners	Royal College of Physicians of London
British Medical Association	Faculty of Occupational Medicine	Royal College of Nursing	Royal College of Psychiatrists
British Psychological Society	Faculty of Public Health	Royal College of Obstetricians and Gynaecologists	Royal College of Radiologists
British Society for Rheumatology	General Medical Council	Royal College of Ophthalmologists	Royal College of Surgeons of Edinburgh
British Society of Rehabilitation Medicine	Institution of Occupational Safety and Health	Royal College of Paediatrics and Child Health	Royal College of Surgeons of England
Chartered Society of Physiotherapy	London Deanery	Professional Organisation in Occupational Safety and Health	Society of Occupational Medicine
College of Chiropractors	Medical Schools Council	Royal College of Pathologists	UNISON
College of Occupational Therapists	NHS Alliance	Royal College of Physicians and Surgeons of Glasgow	Vocational Rehabilitation Association
	Postgraduate Medical Education and Training Board		
	Queen Mary, University of London		

The Department for Work and Pensions is currently carrying out a review of the sick note system, working in partnership with stakeholders to ensure that it is more positive in outlook and supports GPs to offer helpful advice to patients and, ultimately, employers as well. The Government should take this opportunity to be radical and facilitate a process allowing GPs to create an entirely new 'fit note' system, focused on what patients can do. Drawing on the expertise of the *Fit for Work* teams proposed in the next chapter the 'fit note' can become a vehicle for providing practical advice to both the patient, and potentially their employer, about how a return to work can be achieved.

Currently the sickness certification scheme is paper-based. This has resulted in a lack of robust information on how many sick notes are issued, how many are received by employers and what they are used for. Improved recording and analysis of certification would prove helpful to both the healthcare profession and employers. It would allow GPs to compare standards of clinical practice with their peers and so improve treatment of their patients – as well as facilitating easier identification of regional or local health issues, public health surveillance and service planning. It would enable employers to identify patterns of absence within particular departments or roles and so deal with possible health problems in the workplace.

Data collection would be improved by the introduction of an electronic certification system across Britain, linked to GP computing systems. Such a system could also be used to promote quicker and easier communication between GPs and employers – with the potential for 'fit notes' to be passed between them electronically if patients agrees.

However, even the most supportive healthcare professional can only have a limited impact if the appropriate treatments and interventions are not available for them to refer their patients to. Often, GPs sign sick notes because they feel they have no alternative available.

The next chapter sets out proposals for a new model of early intervention which will give GPs new options for referral and provide a minimum level of work-related health support to all employees, preventing mild to moderate conditions becoming chronic and ending the mutual frustration for patient, GP and employer of an often long wait for appropriate treatment.

Recommendations

- Government should launch a major drive to promote understanding of the positive relationship between health and work among employers, healthcare professionals and the general public.
- Building on the commitment from the leaders of the healthcare profession in the recent consensus statement, GPs and other healthcare professionals should be supported to adapt the advice they provide, where appropriate doing all they can to help people enter, stay in or return to work.
- The paper-based sick note should be replaced with an electronic fit note, switching the focus to what people can do and improving communication between employers, employees and GPs.
- NHS professionals and their organisations – along with their regulators – should recognise retention in or return to work as a key indicator of the successful treatment of working age people and appropriate data should be collected to monitor it.
- Medical professional bodies, together with Government, should consider the establishment of a network of GPs interested in health and work to be a source of growing expertise at a regional and local level.





5

Developing a new model
for early intervention

Chapter 5 – Developing a new model for early intervention

In any given year, many employed people will become sick or ill and require some time off work to recover. Depending on the survey, illness results in an average of six to eight working days lost per employee. For most, it will be a brief absence for just a few days; for others it will be for much longer.

As Chapter 2 highlighted, the CBI reported that 175 million working days were lost in 2006. Averages and totals hide the significant variation between different parts of the economy. For example, average days lost per employee varies between sector, size, country and region. Even more importantly, sickness absence varies between individuals, averages hide the fact that many have no days off sick at all, and some are off sick for half the year or more. The CBI estimates that 43% of the 175 million working days lost are due to long-term sickness of 20 days and over. Critically, they estimate that just 6% of employees account for this 43% of total working days lost³⁷.

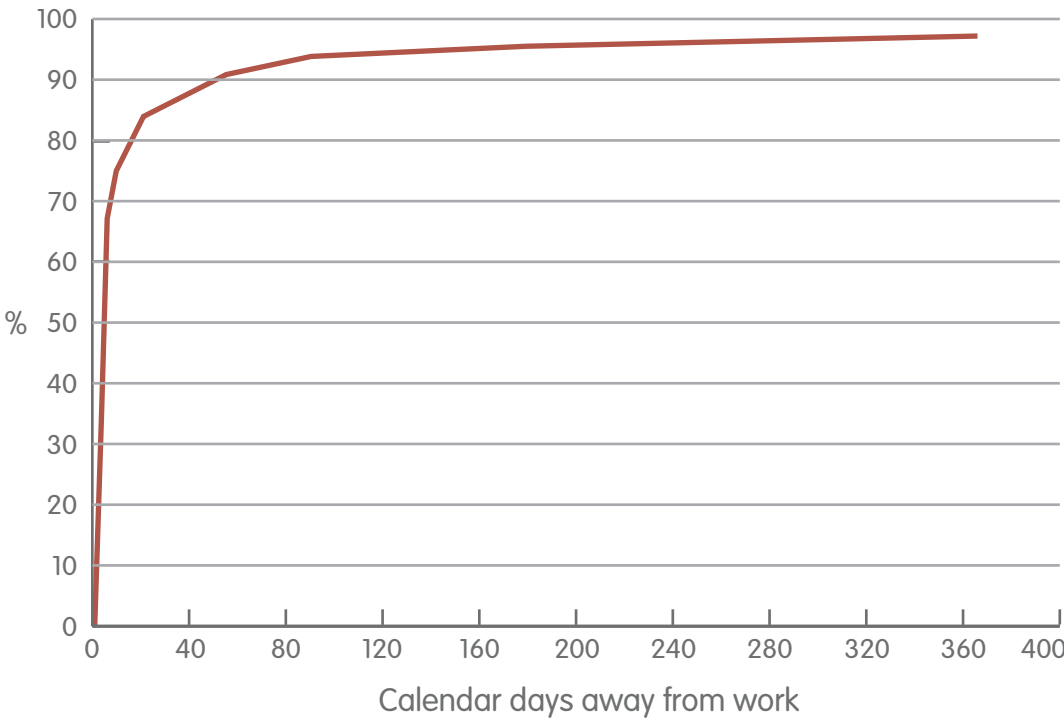
Figure 5.1 shows an estimate of the duration of sickness absence and the rate of return to work for those absent with back pain³⁸: 35% have returned to work within two days and 67% within seven days; this rises to 75% within 14 days and further to 84% by the end of four weeks of sickness absence.

Thus, although the majority of people return to work relatively quickly after starting a period of sickness absence, a significant minority are off sick for much longer and may ultimately progress to worklessness. There is a turning point in the curve where the propensity to return to work rapidly falls. As Figure 5.1 shows, for people with back pain this point is reached after four to six weeks, but this may differ for other conditions.

³⁷ CBI/AXA – *Attending to absence, Absence and labour turnover*, Surrey 2007.

³⁸ Back Pain. Clinical Standards Advisory Group. London HMSO; 1994.

Figure 5.1 Proportion of people returned to work with back pain



Note: Cumulative proportion.

Source: Back Pain. Clinical Standards Advisory Group. London HMSO; 1994

Current care pathways and services

Under the current system an individual is usually able to self-certify their sick leave from work for one week. Beyond this, it is normal that the employer will require a sick note, usually signed by the individual's General Practitioner (GP). This enables payment of sick pay, either the statutory minimum or an employer's own, more generous occupational sick pay.

Chapter 4 set out proposals for reform of the sick note together with a range of additional information and support for GPs in giving fitness for work advice. This will help to change attitudes towards the potential role of work in aiding recovery. However, alone it will be insufficient if the GP is unable to make timely referrals to specific treatments or secondary care which may be necessary to support recovery or enable a return to work.

For example, for a patient with back pain whose condition has not resolved quickly, the clinician may decide to refer to physiotherapy. Yet the waiting time to see a physiotherapist and start a course of treatment is often long. It is likely that the patient will continue to be signed off work until they are seen and treated by a physiotherapist.

‘The issue of “fast track” access to necessary interventions (physiotherapy, counselling) needs to be addressed. The current situation of employees subjected to NHS waiting list times of 6-9 months for such treatments is currently a barrier.’

Royal College of Nursing

Furthermore, over this time it is possible that the back pain could become chronic and may start to affect the patient in other ways. Common mental health problems such as depression and anxiety may appear, perhaps through being removed from normal work and social settings or possibly from seeing a reduction in income and being unsure of the future. By the time a course of physiotherapy for the original condition is complete, the patient may be unable to return to work for a multitude of other reasons.

For those patients who do not return to work quickly after starting a period of sickness absence, the inability to access timely interventions can further compound the barriers they face in returning to work. There appears to be a strong case for considering the potential effectiveness of earlier interventions for this group.

Evidence suggests early interventions are effective

As part of this Review, Peninsula Medical School were commissioned to undertake a literature review of the evidence base for early intervention in sickness absence.³⁹

The literature review found that early intervention occupational health services can play a key role in assessing how and when employees can return to appropriate work. However, these occupational health services cover a wide range of support, from simple sickness absence management tools through to high-quality, multidisciplinary teams supporting people to either stay in or return to work.

In considering a range of service models, the literature review highlighted the importance of three key principles for effective early intervention.

- **Holistic care in line with the ‘biopsychosocial’ model.** This simultaneously considers the biological (the disease or condition), the psychological (the impact and perceived impact on mental health and well-being) and the social (wider determinants that can have a negative impact on health and well-being including work, home or family situation) and the links between all three factors.

³⁹ Peninsula Medical School report: www.workingforhealth.gov.uk

- **Multidisciplinary teams** able to deliver a range of services tailored to the needs of the individual patient. Effective interventions have included exercise, cognitive behavioural therapy, organisational elements (workplace review or adjustment), educational elements (such as on back care) and more holistic support to address broader determinants of poor health such as housing or financial concerns.
- **Case managers** or support workers who can help the individual navigate the system and facilitate communication between the individual, their employer, their GP and other clinicians.

Several studies⁴⁰ have shown that a comprehensive early intervention service based on these principles can result in good clinical outcomes, as well as a significant reduction in time spent off work, shifting the curve in Figure 5.1 to the left. For employees with lower back pain, interventions have been shown not only to return employees to work up to five weeks earlier than under normal care, but also to reduce the recurrence of back pain in the following year by up to 40%.

However, these studies have been undertaken outside Britain, in countries such as Denmark, Finland, the Netherlands and Canada, where the benefits of comprehensive occupational health support are widely recognised.

'Britain is certainly lagging behind many other countries when it comes to rehabilitation. Within Scandinavia 50% of people return to work after a major injury. In the USA it is roughly a third. In the UK the figure is 1 in 6.'

Trades Union Congress

Much of the available evidence for early intervention has focused on analysis of back pain. Similar evidence is needed for those with other conditions, especially mental ill-health. With a natural recovery rate of only 20% for depression and 5% for anxiety disorders, the majority of people need support to achieve recovery from common mental health problems and to help keep them in work.⁴¹

The recent expansion of psychological therapies in England will provide further valuable evidence on the effectiveness of interventions for common mental health conditions. As Box 5.1 illustrates, there is emerging evidence from the demonstration sites in Doncaster and Newham of the potential impact this programme can have on helping people achieve measurable recovery and thereby improving their ability to work.

⁴⁰ Peninsula Medical School report: www.workingforhealth.gov.uk

⁴¹ Layard, Clark, Knapp and Mayraz. *Implementing the NICE guidelines for depression and anxiety* (2006).

Box 5.1 – Impact of improving access to psychological therapies

- **Well-being and effectiveness:** 56% achieved measurable recovery, no matter how long they had been ill, comparing favourably with the National Institute for Health and Clinical Excellence's evidence from clinical trials, and with natural recovery rates.
- **Demonstrating health gain:** 90% patient outcome data has been recorded, where previously there was very little recording of this kind.
- **Improving access to treatment:** more than 4,800 appropriate referrals to pilot services in 12 months.
- **Savings for the wider economy:** 5% net reduction in patients on Statutory Sick Pay due to return to work, in line with the programme's expectations (range: 4% Doncaster, 11% Newham).

A Fit for Work service

Insufficient access to support for patients in the early stages of sickness absence can lead to longer-term or repeated episodes of absence.

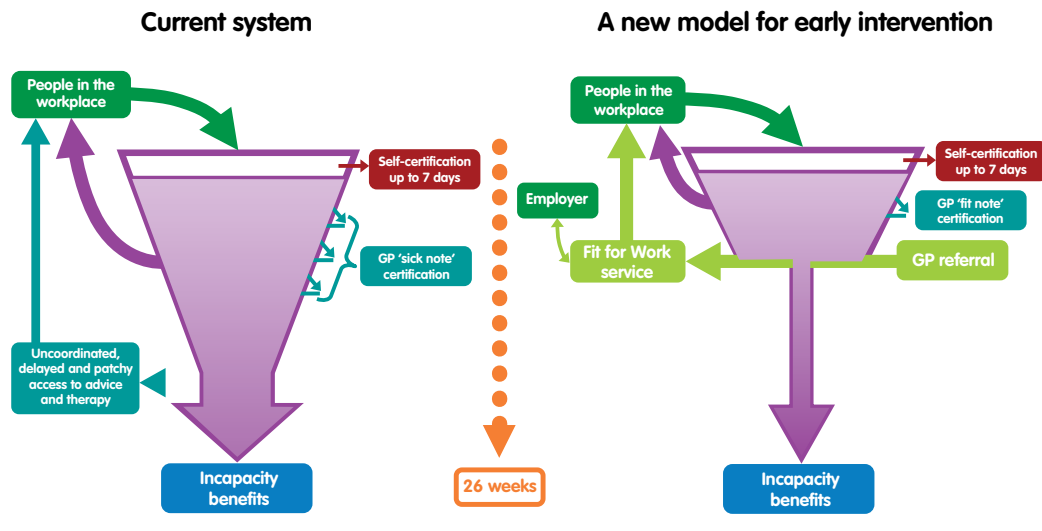
A new model of early intervention should support GPs with new options for referral. It should provide a minimum level of work-related health support to all employees, especially important for those in organisations without any form of occupational health provision.

A suggested approach to achieving this would be through the creation of a *Fit for Work* service.

Based on the biopsychosocial model, a case-managed, multidisciplinary *Fit for Work* service would ensure a prompt, holistic assessment of patients' needs. It would then provide them with an individualised action plan for achieving recovery, with a focus on return to appropriate work at the appropriate time as a key part of that plan. Such a service would also ensure that those with more serious underlying conditions, often referred to as 'red flag' conditions, would be referred onwards at the earliest possible opportunity.

Figure 5.2 illustrates how the new model could work in contrast with the current system.

Figure 5.2



Instead of having to write multiple sick notes as patients slide towards incapacity benefits, in the new model a GP could refer a patient through the electronic fit note system to the multidisciplinary *Fit for Work* service.

As Figure 2.12 in Chapter 2 shows, different types of work result in different work-related ill-health profiles. The *Fit for Work* service might therefore vary to meet different local needs. This would be achieved through a hub and spoke approach with a case manager able to navigate a patient through a personally tailored programme of support. Options for support would not be restricted to medical treatment and could include:

- exercise and physical training and activity;
- cognitive behavioural therapy and counselling;
- physiotherapy, occupational therapy and other clinical interventions;
- occupational health interventions, including assessment of appropriateness of returning to work, e.g. workplace risk factor assessment and modification; and
- advice and support for social concerns, e.g. financial, housing, family and childcare issues.

The case manager would regularly update the patient's GP. The *Fit for Work* service would also contact the employer to discuss the patient's work situation with a view to facilitating a return to work as soon as appropriate. This could involve discussing adaptations or changes to the patient's work situation that might include a phased return to specific restricted duties, flexible working or a change to their job role and responsibilities.

Such a service could initially be piloted to test the effectiveness of the interventions in reducing the length of sickness absence, improving the support for GPs in helping their patients and stemming the flow onto incapacity benefits, benefiting not only the patient, but also his or her family and wider community.

Encouragingly, Scotland and Wales are already exploring many of the principles at the heart of the proposed *Fit for Work* service. An early intervention approach is now being piloted in Dundee by the Scottish Centre for Healthy Working Lives. In addition, the Welsh Assembly Government is piloting work-focused rapid access to physiotherapy along with online health and work resources that provide GPs with access to occupational health advice.

The role of the NHS

Occupational health has traditionally never been part of the NHS, other than for its own employees. When the NHS was set up, the view was that the provision of 'industrial medicine', as it was then known, was largely for the employers' benefit and thus should be paid for by employers. The provision of occupational healthcare was therefore excluded from the list of services provided to the public by the NHS funded through general taxation.

Chapter 7 will set out the challenges facing occupational health in Britain today and the need to develop greater professional expertise to support the health of all working age people. One of the fundamental problems it will identify is the historical detachment of occupational health from mainstream healthcare provision and the resulting consequences for the provision of holistic care.

To be effective, the *Fit for Work* team would have to be based in or close to primary care. Different models for their delivery should be trialled: they could be based in health centres and cover a number of GP practices.

'The current occupational health regime where most occupational health provision is provided by the private sector does not deliver for workers.'

Scottish Trades Union Congress

With many employers to date having failed to provide access to adequate occupational health, and the associated cost to the taxpayer and the economy, there is a strong case for the NHS being involved in the provision of these work-related health interventions. While there would clearly be significant costs in providing such a service through the NHS, these are likely to be outweighed by significant savings to the taxpayer and the economy overall.

Pilots of the *Fit for Work* service should test different models of service delivery and could explore giving private and voluntary-sector providers the opportunity to deliver services under NHS arrangements. This would allow the best possible mix of service providers with the greatest expertise and available workforce capacity to deliver elements of the service, irrespective of whether they are from public, private or voluntary sectors.

If found to be effective, the *Fit for Work* service should be rolled out nationally so that access to work-related health support becomes available to all employees – no longer the preserve of the few.

The timing of early intervention

The relative costs and potential savings from the *Fit for Work* service will depend significantly on the point at which GPs are able to refer patients to the new service. As Figure 5.1 highlighted, many who go off sick will return to work quickly and it is a relatively small proportion of patients who account for a disproportionate amount of the total working days lost to sickness in Britain.

Detailed modelling is needed to ascertain the most effective point for the service to commence, but piloting could test variations in the timing of intervention. Pilots could also test earlier access for those experiencing second or repetitive episodes of sickness absence within a given period.

During the earliest stages of sickness absence before referral to the new service, there are still important steps that can be undertaken to help speed up recovery and return to work.

The new consultancy service recommended in Chapter 3 could provide support for employees in organisations without access to occupational services of their own. Additionally, primary healthcare professionals, especially GPs, are key influencers in getting people to improve self-care and self-management. If commissioned by primary care organisations, self-care courses, such as those developed by, and currently being evaluated under, the NHS Working in Partnership Programme in England, could be made available through a broad range of community, private and voluntary sector providers to help people prevent and better manage common conditions such as stress and back pain in their early stages.

Case study

Primary healthcare in the Defence Medical Services provides day-to-day healthcare and occupational health, both meeting the individual's immediate healthcare needs and assessing the effect of any reduction in functional capacity on fitness to work. The aim is to convey to the employer an assessment of the employability of all Service men and women, whilst maintaining the individual's medical confidentiality, protecting and promoting their health and facilitating their most appropriate employment within the organisation. Rehabilitation is immediately accessible and available on site at all major primary care centres, with more extensive in-patient rehabilitation at the MOD's dedicated centre as required.

Potential benefits of a *Fit for Work* service

The current profile of sickness absence leads to costs to individuals, employers, the economy and taxpayers. After 28 weeks of sickness absence many will lose their contract of employment and move instead onto incapacity benefits. Around 350,000⁴² people made the transition from employment to incapacity benefits last year. It is estimated that a further 460,000 people had a spell of sickness absence of between four and 28 weeks in duration.⁴³

The cost to the public purse of each incapacity benefits claimant is roughly £5,250 per year, plus likely Housing Benefit costs of at least a further £500. Using a conservative gross wage assumption of £11,250 per year, the net saving to taxpayers of moving people from incapacity benefits to work or helping someone remain in work is almost £3,000 per year.⁴⁴

⁴² DWP administrative data and Kemp and Davidson: *Routes onto Incapacity Benefit: Findings from a survey of recent claimants* (2007).

⁴³ Shiels, Gabbay and Ford: *Patient factors associated with duration of certified sickness absence and transition to long-term incapacity* (2003); Shiels and Gabbay: *Patient, Clinician and general practice factors in long-term certified sickness*.

⁴⁴ Figures derived from DWP employment programme cost benefits analysis.

If the *Fit for Work* service was successful in reducing the flow from work to incapacity benefits by just 1%, it would save taxpayers £10.5 million. If it could help 10% (35,000) people remain in work, it would save taxpayers over £100 million. Realistically, savings are likely to extend into the second and third years as well.

There are also potential benefits to employers and the economy. The CBI estimates that the cost to the economy of a working day lost to sickness is roughly £77. If the *Fit for Work* service could help half of the people on long-term sickness absence to return to work just one week earlier, this could potentially save the economy £88 million per year, and double that for returning two weeks earlier.

Finally there are potential savings to the healthcare system in terms of reduced GP consultations and secondary care referrals with an estimated value in excess of £130 million that could help fund the *Fit for Work* service.⁴⁵

Recommendations

- Government should pilot a new *Fit for Work* service based on case-managed, multidisciplinary support for patients in the early stages of sickness absence, with the aim of making access to work-related health support available to all – no longer the preserve of the few.
- Pilots should test various models of service delivery, including variations in the timing of intervention and the mix of providers from public, private and voluntary sectors. The service should be comprehensively evaluated.

⁴⁵ Derived from: Shiels, Gabbay and Ford: Patient factors associated with duration of certified sickness absence and transition to long-term incapacity (2003); Shiels and Gabbay: Patient, Clinician and general practice factors in long-term certified sickness; Gabbay and Shiels; An analysis of medical certificates issued over a 12-month period by general practices in the Merseyside area, between 2000 and 2002. University of Liverpool; PSSRU Unit Costs of Health and Social Care 2007; NHS Reference Costs (PCT & NHS Trusts combined) 2005-06.



Confidential
Advice

83

6

Helping workless people

Chapter 6 – Helping workless people

The sheer scale of the numbers of people on incapacity benefits represents an historical failure of healthcare and employment support to address the needs of the working age population in Britain.

The numbers on incapacity benefits trebled during the 1980s and early 1990s⁴⁶, despite improvements to general health. Social and structural economic changes, together with limited healthcare and employment support, led to many being written off to a life of incapacity. A passive benefit regime meant that once an entitlement to incapacity benefits had been established there was little expected of claimants, with no interventions to help those who were interested in returning to work.

Today, 1.5 million of the caseload have been in receipt of incapacity benefits for over five years⁴⁷. For many this will stretch into decades, and a return to work seems a near impossibility.

This group must not be overlooked and dismissed as a problem beyond remedy. With the right help and support, the right job and a supportive employer, the majority of people can be helped into work, and can be helped to progress in work. The current strength of the labour market, with over half a million unfilled vacancies, means there are plentiful jobs available.

Annual on-flow to incapacity benefits

The problem is not just with the existing caseload. Six hundred thousand people move onto incapacity benefits each year. Rather than the stereotypical prime-aged male from an industrial background, this flow comes from across the age range, young and old, both sexes, in every region and from all sorts of occupations. The system is still failing those with common health conditions, who, with the right support, could continue in work and progress in the workplace.

Common mental health conditions

The most common primary health conditions among those flowing onto incapacity benefits are those associated with mental ill-health. While there has been a decline in the on-flow for almost all other health conditions, the on-flow with mental health conditions has remained stubbornly high at over 200,000 each year for the last decade. Adding in claimants who have other primary health conditions, but also have mental health conditions, is likely to bring the proportion of those coming onto incapacity benefits with mental health conditions to well over a half.

⁴⁶ DWP administration data.

⁴⁷ Ibid.

On-flow from other benefits

The routes onto incapacity benefits also show that a significant proportion of the on-flow comes from other working-age benefits. While around 55% of the on-flow comes from work or a period of sickness absence from work, a further 28% were claiming Jobseeker's Allowance or Income Support immediately prior to claiming incapacity benefits⁴⁸. This suggests that people are joining those caseloads with undiagnosed or unsupported health conditions, or that they develop health problems while on them.

The Government is shortly to replace incapacity benefits with the 'Employment and Support Allowance' – a move which is welcome for its focus on what people can do rather than what they cannot. However, this will not be sufficient in itself to address the problems faced by people made workless through disability or ill-health and more needs to be done to raise aspiration and motivation, and address health conditions.

The *Fit for Work* service for those out of work

Chapter 5 outlined a new *Fit for Work* service for those off work on sickness absence, the objectives of which are to help people recover from or manage their health condition to enable a return to productive employment. The same objective is necessary for those who are out of work, and many would benefit from the work-focused, case-managed, multidisciplinary approach offering services such as cognitive behavioural therapy, physiotherapy, and advice and counselling for wider social problems, such as debt management.

When appropriate models for the *Fit for Work* service are established, incapacity benefits claimants who would benefit should be referred to the *Fit for Work* service by either their own GP or by their Jobcentre Plus personal adviser, both of whom would need to link with the case manager. Where claimants use private and voluntary-sector provision through Pathways to Work or the New Deal for Disabled People, referrals could also be made to the *Fit for Work* service.

The Government announced in the 2008 Budget that a Work Capability Assessment for incapacity benefits claimants would be introduced from 2010. It will be important that Work Capability Assessments identify which claimants would benefit from the *Fit for Work* service and that there is sufficient capacity in the *Fit for Work* service to meet the needs of claimants as well as existing employees.

⁴⁸ Kemp and Davidson: *Rates onto Incapacity Benefit: Findings from a survey of recent claimants* (2007).

As discussed, it is not only those on incapacity benefits who might benefit from the *Fit for Work* service. Almost 200,000 people moved from Jobseeker's Allowance or Income Support to incapacity benefits last year. Those with health conditions on other working age benefits could also be referred, where they, their GP, and their adviser think this will be helpful.

It would be highly advantageous to identify and deal with such cases before they move onto incapacity benefits. Such an approach would be consistent with the emphasis, discussed in the preceding chapters, on early intervention to tackle ill-health among those in work.

Pathways to Work

The Government introduced Pathways to Work pilots in 2003, and is committed to national roll out by October this year. Evaluation of Pathways pilots has shown an increase of around eight percentage points in six month off-flow rates compared to national figures. Fifty-six per cent of those coming off incapacity benefits in Pathways pilots enter employment of 16 hours or more, indicating the increase in off-flow is not resulting in a disproportionately high movement of people onto other benefits.⁴⁹ Another encouraging finding is the early indication that this increase in off-flows is leading to a reduction in the total number of incapacity benefits claimants in the pilot districts.

To date, Pathways has rightly been focused on those coming onto incapacity benefits. However, with the majority of claimants having been registered long-term, there is also a need to extend the policy to include them if we are to make significant inroads into the numbers of people currently workless due to ill-health or disability. Encouragingly, the Want to Work programme is already providing support and opportunities for long-term claimants in Wales.

Those with mental health conditions

As part of this Review, the Royal College of Psychiatrists were commissioned to review the evidence on mental health and work. Their report is published alongside this Review.⁵⁰

Although Pathways to Work results have been encouraging, evidence shows the impact for those with mental health conditions is much more limited.⁵¹ The number flowing onto incapacity benefits with mental health conditions has remained stubbornly high, and now accounts for over 40% of the overall caseload. Government is unlikely to meet its aims to reduce the number of incapacity claimants by a million, or its full employment aspiration, unless more of this group are helped back into work. It is essential that more innovative support is offered and targeted at their particular needs.

⁴⁹ Bewley, Dorsett and Haile: *The impact of Pathways to Work* (2007).

⁵⁰ RC Psych Report: *Mental Health and Work* (2008) www.workingforhealth.gov.uk

⁵¹ Blyth: *Incapacity Benefit reforms – Pathways to work Pilots performance and analysis* (2006).

The Government has announced its intention to draw up a mental health and employment strategy, to ensure a more comprehensive and co-ordinated approach across Government. In developing this strategy, the Government urgently needs to consider how the particular needs of those who are workless due to mental ill-health can be addressed. This should involve a wide-ranging, systematic review and evaluation of current policies and their effectiveness for those with mental health problems. This should include Pathways to Work and the recent Increasing Access to Psychological Therapies (IAPT) pilots.

Those with severe health conditions

Help and support to find work will not be appropriate for all, especially those with more severe health conditions. However, equally important is to ensure that help and support does remain available should individuals wish to pursue a return to work. No-one should be denied access to support, and no-one should ever be written off to a life of incapacity again.

For those workless people with severe mental illness, evidence shows that individual placement and support is better than ‘train and place’ initiatives for those who are ready for paid employment. However, the economic benefits are not yet proven.⁵²

Healthcare provision

One of the most important aspects in enabling a return to work for people with health problems or disabilities is adequate provision of appropriate and targeted health services. In particular, vocational rehabilitation services address the specific health barriers to an individual’s employment, as well as providing a source of information for the patient on the types of work which may be most suitable. Government is currently reviewing vocational rehabilitation services and will be providing guidance for employers.

Healthcare professionals should consider a return to appropriate work as an important outcome in the treatment and support of patients. The NHS is currently considering patient pathways for those with major long-term conditions. For those of working age, this should, where appropriate, include a consideration of work-related health and the steps necessary to help the patient to move back into employment.

⁵² RC Psych: *Mental Health and Work*, www.workingforhealth.gov.uk

Local partnerships

The Government has recently introduced a new local performance framework which places local partners at the heart of delivery of policy. Working together, partners will be able to identify priorities for their area and negotiate a Local Area Agreement (LAA) with central government. This is very welcome as only through local empowerment, accountability and partnership will we meet the varied needs of local people.

While the new framework is a very positive step, Government must encourage partnerships to consider the health of working age people and the employment of people with health conditions within their LAA. Without doing so, the new partnership arrangements will be a missed opportunity for Government.

There are many good examples of local partnership activity already underway focused on health and work, for example the Sheffield Health and Work Strategy Group and the health@work project in Liverpool. Alongside these, Local Employment Partnerships were introduced by DWP last year, where Jobcentre Plus provides a premium job-broking service to local employers in return for a greater than normal commitment to employing people from disadvantaged groups, including those who are workless due to ill-health.

However, we need to do more to encourage similar local partnership activity and help partnerships overcome the barriers they meet. Local projects could include initiatives such as the Faculty of Occupational Medicine project to improve the training of occupational health clinicians and the Federation of Small Businesses' plans for healthy-workplace initiatives with SMEs.

Working with employers

A common barrier preventing those who are workless through ill-health from returning to work is the attitude of others towards them. One of the changes required will be for employers to recognise the value and potential of disabled people and those with chronic health conditions. Too often employers believe, wrongly, that productivity would be lower and costs higher, whereas the majority will require little or no extra support to perform in the right job.

Many organisations already employ people with health conditions without realising it. This is partly due to employers having a narrow view of disability as a state that is plainly discernible, for example a physical handicap, impaired hearing or vision. Furthermore, those affected often do not wish to disclose their condition. This is particularly true for people suffering from mental ill-health where the associated stigma is often a significant barrier to employment. However, a recent study has found that 85% of employers who have taken on staff with mental health problems did not regret doing so.⁵³

Simple adjustments to the actual workplace, such as improving physical access for disabled people, are only part of the solution. There is also a need for a willingness to adjust and refine workplace practices – for example, the provision of phased returns to work and a willingness to offer flexible working patterns would enable many people, currently workless through ill-health, to return to work.

Recommendations

- When appropriate models for the *Fit for Work* service are established, access to the service should be open to those on incapacity benefits and other out-of-work benefits.
- Government should fully integrate health support with employment and skills programmes, including mental health support where appropriate.
- Government should expand the provision of Pathways to Work to cover all incapacity benefits claimants as soon as resources allow, including appropriate provision for those with mental health conditions.
- To support the development of its proposed mental health employment strategy, Government should review mental health support within current policies and seek to determine the most effective method of assisting this group of people back into work.
- Government should consider offering advice and limited funding to help local partnerships kick-start health and work activity.

⁵³ RC Psych: *Mental Health and Work*, www.workingforhealth.gov.uk

- Government should encourage the provision of vocational rehabilitation services by employers, building on the findings of their ongoing vocational rehabilitation review and providing guidance for employers.
- Government should consider the use of incentives for employers to support the employment of those with disabilities or health conditions.

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7

Developing professional expertise for working age health

Chapter 7 – Developing professional expertise for working age health

The previous chapters have laid the foundations for a new approach to promoting and sustaining the health and well-being of working age people in Britain. Delivering this change will depend upon having a workforce of health professionals who are equipped to meet current and future needs. For this they need the right skills, evidence base and organisational structures.

Strong professional leadership is key to ensuring that these elements are in place and to promoting working age health.

Traditionally, this was a matter for occupational health and this specialty will always have a leading role. Rehabilitation and public-health specialties also have interests and expertise related to this area. And, in practice, most patients receive advice about health and work from their GPs and the primary care team. A coordinated approach to working age health must involve all of these specialties.

Professional leadership will require the development of some form of over-arching framework that embraces all of these professions.

The challenges facing occupational health

If we are to fundamentally change the way we support the health of working age people, then we have to address a number of the challenges which face occupational health as it is currently configured. These include:

- **Detachment from mainstream healthcare:** The historical separation of occupational health from mainstream healthcare has resulted in an inability to provide holistic support to patients of working age. As Chapter 5 set out, from its inception in 1948, the NHS only provided occupational health services for its own staff. Providing and funding occupational health for other workers was made the responsibility of their employers. These arrangements might have been right at the time, but it is clear they are failing to meet current needs.

‘A major obstacle to the provision of effective occupational health services for all is the historical exclusion of occupational health from the remit of the NHS.’

Faculty of Occupational Medicine and Society of Occupational Medicine

- **Limited remit:** Traditionally, occupational health has been restricted solely to helping those in employment. Helping workers to stay in work or return to work after sickness absence will always rightly be a priority for occupational health. However, supporting working age health requires us to go even further. At one end of the spectrum it is about improving health at work and supporting workers with health problems to stay at work. But at the other, as discussed in Chapter 6, it is about helping people who are workless to enter or return to the workforce. Even more broadly, it is about improving the health of all working age people. This will require occupational health to address a wider remit and to embrace closer working with public health, general practice and vocational rehabilitation in meeting the needs of all working age people. Occupational health is already changing to begin to meet the needs of the 21st century. As described in Chapter 4, in some leading organisations, the traditional role of being concerned with safety and controlling hazards in the workplace is already expanding to include the promotion of health and well-being. But we need to go much further.
- **Uneven provision:** The uneven provision of occupational health and rehabilitation services, particularly for workers in small and medium-sized enterprises, represents a fundamental problem. Indeed, provision is often least concentrated where it is most needed, a striking example of the inverse care law.

'The proportion of the general working population with access to an occupational physician varies enormously, from 43% in the health and social services to 1% in agriculture, forestry and fishing.'

McDonald J. C. *Occup. Med* 2002; 52:401-6 cited by Tony Newman-Taylor

- **Inconsistent quality:** Furthermore, where occupational health is provided, the absence of formal standards or accreditation of providers means there are no guarantees of quality. The same has been true for vocational rehabilitation, although there is now broad and welcome agreement among all the key stakeholders on the need to improve vocational rehabilitation support and to build on recent initiatives to develop explicit service standards.

- **Diminishing workforce:** The challenges facing occupational health are compounded by a potentially diminishing workforce in this field. Evidence submitted to the Review by both the Faculty of Occupational Medicine and the Society of Occupational Medicine suggests that the age profile of occupational health doctors and nurses is older than the average for other healthcare professions. The British Society of Rehabilitation Medicine has emphasised that rehabilitation has been a ‘Cinderella’ service for many years, and that the NHS has largely lost the culture and skills of facilitating a return to work. Both specialties currently face challenges in the recruitment and training of doctors, nurses and therapists. Unless reversed, these factors could lead to a shortage of the essential professionals upon which the present proposals depend.
- **Shrinking academic base:** Occupational health has been weakened by a small and declining academic base. There has been a lack of systematic surveillance and monitoring in the field of health and work. There are few institutions with a research facility or deep interest in workforce health issues, including vocational rehabilitation, and there is little funding available for research.

‘The Research Assessment Exercise for academic institutions gives fewer points for occupational medicine than comparable disciplines.’

Faculty of Occupational Medicine and Society of Occupational Medicine

- **Lack of good quality data:** There are considerable gaps in our understanding of the health of the working age population in Britain. For example, there is limited information on the size and nature of work-related ill-health and incapacity, and its causes. We need to gather more data that can be analysed at national, regional and local level. Similarly, there is little evidence to inform how clinical interventions can best reach beyond restoring health to help more people return to work. The recently formed Occupational Health Clinical Effectiveness Unit has made a good start in synthesising the evidence base, but this work needs to be given a higher profile and accelerated.
- **Image and perception:** In developing working age health, it is important to take account of the challenges posed by the historical image of occupational health in the eyes of some service users. While employees and trades unions generally recognise the importance of health at work, some regard occupational health with suspicion, perceiving it to be part of sickness absence management and even shouldering responsibilities which sit more properly with human resources.

‘Referral to OH is often regarded by staff as a punishment, this image needs to be changed and a more positive and enabling one created. This requires a more enlightened vision of the role of OH by management.’

Royal College of Nursing

Meeting these challenges demands a fundamental shift in the approach to working age health.

‘There is no realistic prospect that the current paradigm of delivery of OH support could be scaled up to provide services to all those currently employed or those currently not in work.’

NHS Plus

A vision for the future of working age health

Developing an integrated approach to working age health requires occupational health to be brought into the mainstream of healthcare provision. Its practitioners must address a wider remit and embrace closer working with public health, general practice and vocational rehabilitation in meeting the needs of all working age people. This should be underpinned by clear workforce plans, a strengthened academic base, good quality data and analysis, and formal accreditation of all providers.

It is a vision for the future based on four fundamental principles:

- **Working age health incorporated as part of the NHS:** Occupational health, along with vocational rehabilitation, needs to be fully integrated into the NHS. This is clearly a long-term goal that will require the NHS to consider a much more radical approach to the organisation of its services to support working age health. This would include, for example, a more co-ordinated approach to the commissioning of its services, working across the full range of disciplines to ensure work-focused outcomes form part of patient care. The proposed *Fit for Work* pilots would provide an evidential basis on which to take this forward. If successful, it could, for the first time, embed the fundamental principle of the NHS at the heart of occupational health – making such treatment universally available on the basis of need, not ability to pay.

- **Forward thinking professional leadership:** Achieving a comprehensive service for the future requires much more than simply integration. It demands leadership from the professions to seize this opportunity and to make the specialty of occupational health relevant to present-day needs. It can only be done by expanding the remit of occupational health to include all those of working age, and working with other specialities – both medical and non-medical – in order to achieve this.
- **Guaranteed quality of delivery:** The Faculty of Occupational Medicine, NHS Plus and the Vocational Rehabilitation Association have recently undertaken initiatives to develop explicit service standards. Nevertheless, the absence of formal standards or accreditation of occupational health and vocational rehabilitation providers was a consistent theme highlighted in the submissions received from the Call for Evidence. A nationally-recognised system of accreditation would give commissioners, employers and patients greater assurance in the commissioning and use of services.

'In many cases, employers do not have clarity around the types of interventions and practices which will assist in keeping employees at work. Standardisation and accreditation of healthcare providers' service skills, together with regulation of service costs, can reduce this uncertainty.'

Association of British Insurers

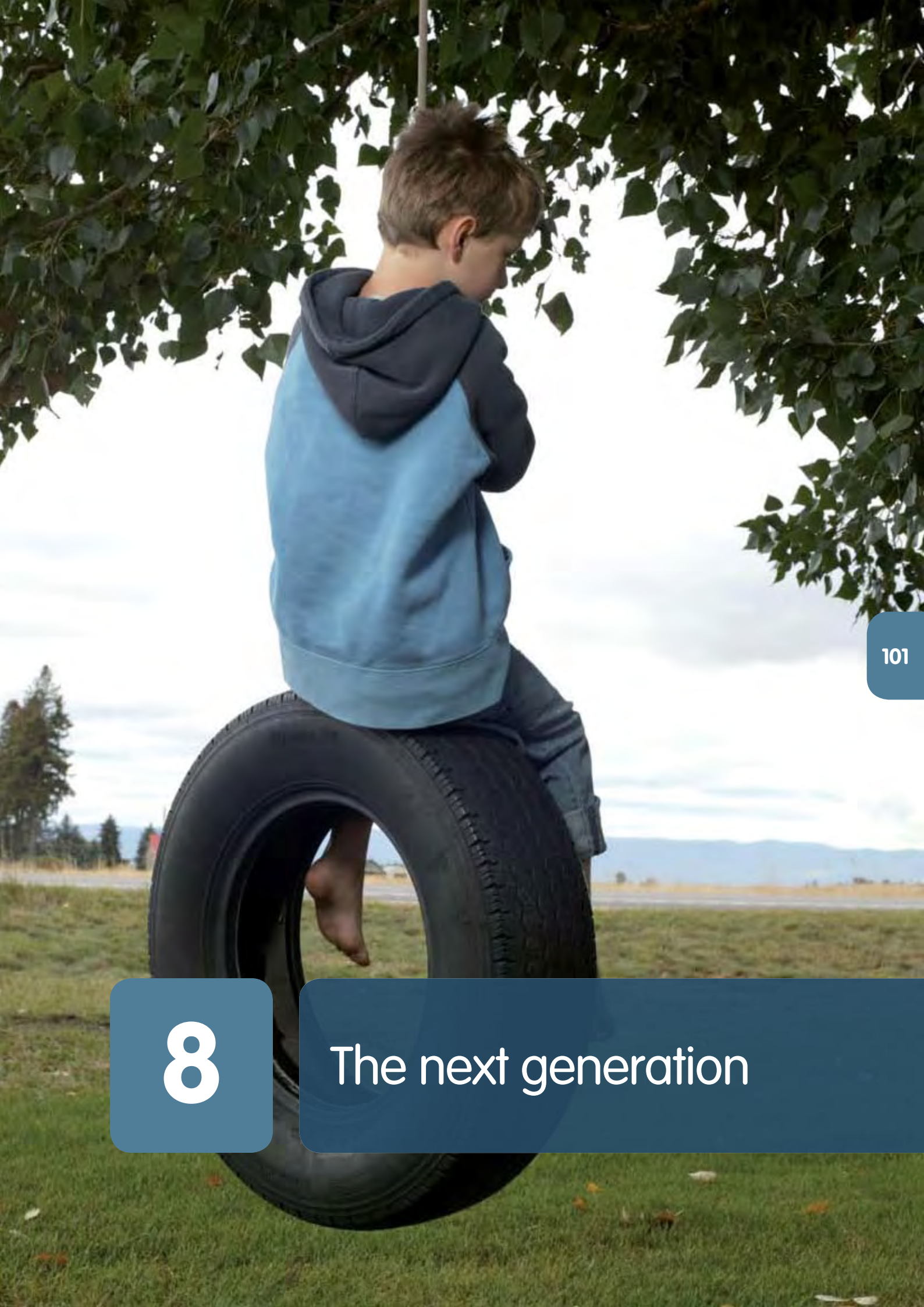
- **A revitalised professional workforce:** Occupational health is a specialty unknown to most trainee health professionals. As recommended in Chapter 3, the inclusion of health and work in the core curriculum of undergraduates and postgraduates would be an important step forwards. But making the specialty broader based and more mainstreamed within healthcare would also make this a more attractive area for professionals to enter and provide a much more stimulating and challenging career. Broadening of the base would allow a wider range of professionals to participate, thus helping to address the workforce challenges.
- **A strong academic base:** The workforce must, in turn, be supported by a strengthened academic community able to draw on more systematically collected and analysed data, both for surveillance and for monitoring trends against the baseline measures set out in this Review. Nationally, there must be the capability to plan, commission and manage research to build the evidence base about work and health. This should include the effect of health interventions on employment and the effect of labour market interventions on health. Such evidence must be made available across the full range of health professionals involved in working age health.

There is a new and exciting opportunity for the occupational health specialty in Britain today to seize the initiative and lead a development that unites all those engaged in improving, safeguarding or restoring the health of all working age people. This would ensure a dynamic specialty into which it would be much easier to recruit new professionals who would have a rewarding role and a secure and exciting career. It is a once-in-a-generation opportunity to build on the successes of the past to make a real difference in the future.

Recommendation

There should be an integrated approach to working age health underpinned by:

- the inclusion of occupational health and vocational rehabilitation within mainstream healthcare;
- clear professional leadership from the occupational health and vocational rehabilitation communities to expand their remits and work with new partners in supporting the health of all working age people;
- clear standards of practice and formal accreditation for all providers engaged in supporting working age people;
- a revitalised workforce with the development of a sound academic base to provide research and support in relation to the health of all working age people;
- systematic gathering and analysis of data at national, regional and local level to inform the development of policy and the commissioning of services relating to the health of working age people; and
- a universal awareness and understanding of the latest evidence on the most effective interventions developed by organisations such as the Occupational Health Clinical Effectiveness Unit.



8

The next generation

Chapter 8 – The next generation

This review so far has concentrated on the current working age population. It has given a snapshot of their health and the implications this has for work, employers, the NHS and the economy more widely. We must also consider what might happen over the coming years and decades, when many of today's working age population will be in retirement and today's children take on the responsibilities of work.

The health of the current working age population affects the potential of the next generation too. When an adult is prevented from working, the resulting low family income may not just lead to children living in poverty; it also tends to lead to worse health outcomes for those children. Children living in workless households are also more likely to experience worklessness themselves during adult life⁵⁴.

'Preventing workers being made ill and driven out of work, onto benefits, or into less well paid work or lifelong disability, would reduce the poverty, deprivation and social exclusion that they and their families suffer. Committing money, staffing and other resources to reducing work-related ill-health, we believe, would have a major impact of reducing poverty and increasing social inclusion of working age people and their families.'

National Hazards Campaign

'Working sets an example to family members and children such that worklessness is less likely to be seen as the norm.'

Local Government Employers

Health and work impacts on children

When a parent or carer is unable to work due to ill-health or disability, the household's income usually declines. This leads to a greater risk of poverty among children whose parents have a health condition. Around a quarter of children in poverty live in a household with a disabled adult, and the average risk of poverty for this group is 31%, higher than the average for the population as a whole which is 22%⁵⁵.

⁵⁴ NAO: *Helping People from workless households into work* (2007).

⁵⁵ *Households Below Average Income (HBAI) 1994/95 – 2005/06* (2007).

The Government has set an ambitious target to eradicate child poverty by 2020⁵⁶. Without addressing the health and work agenda, it is unlikely that this will be met.

The impact of parental ill-health and worklessness goes further than poverty; it also increases the risk of childhood stress, behavioural problems, and poor educational achievement. Children who grow up in low-income or workless households are also more likely to suffer worse health themselves, be workless and live in poverty when they become adults.

The prevalence of psychiatric disorders among children in families whose parents have never worked is almost double that among children with parents in low-skilled jobs, and five times greater than that among children whose parents are in professional occupations⁵⁷. Similar evidence is found in Scandinavian countries, with children in families where no parent is working having a higher prevalence of recurrent psychosomatic problems, chronic illness and low well-being⁵⁸.

It is clear that children's health, aspirations and positive expectations need to be supported and encouraged, and one of the key factors in achieving this is to help keep parents healthy and in work.

The transition from childhood to young adulthood

Moving into adulthood is a key milestone for all young people. We should encourage young people, as they near working age, to understand what a 'good job' is and what a healthy workplace offers. They can then make an informed decision about the health benefits of being in work and the organisations for which they choose to work. For many, the transition to adulthood is an exciting time offering many opportunities, but some are not so fortunate.

In England, 10% of 16 to 18 year olds are classed as Not in Education, Employment or Training (NEET)⁵⁹. Since 2000, the number of young adults (those under the age of 25) who have been on incapacity benefits for five years or more has more than doubled from 21,000 to 54,000⁶⁰. Those who have little or no qualifications or experience of working need particular support to help them back on the path to success.

⁵⁶ *Public Service Agreement: Halve the number of children in poverty by 2010-11, on the way to eradicating child poverty by 2020* (HM Treasury 2007).

⁵⁷ ONS: *The health of children and young people* (2001).

⁵⁸ Reinhardt Pedersen, C. and Madsen, M. (2002) *Parents' labour market participation as a predictor of children's health and well-being: a comparative study in five Nordic countries*, *Journal of Epidemiology and Community Health*, 56, pp.861-867.

⁵⁹ Statistics First Release 22/2007 (http://www.dfes.gov.uk/rsgateway/DB/SFR/s000734/sfr22_2007.pdf).

⁶⁰ DWP administrative data.

The health of children today

The work, well-being and health of their parents and carers clearly have a strong influence on children. But we must also remember that the health of today's children will largely determine the health of the working age population of the future.

Children's health is not just about keeping young people well. It is about the environment they live, learn and play in. It is underpinned by healthy schools and a healthy family life, and must be supported by an education which includes developing an understanding of maintaining a healthy lifestyle, the benefits of work, and the skills and resilience needed to be successful in the modern workplace.

Seventy per cent of boys and 59% of girls are now taking part in 60 minutes or more of physical activity per day⁶¹. Eighty-six per cent of school children now do at least two hours of quality sport a week and this is expected to continue rising. Yet a third of children are overweight or obese and if current trends continue, this is forecast to rise to two-thirds of children by 2050⁶². The proportion of 11-15 year old children in England who smoke is down from 13% ten years ago to 9% in 2006⁶³. However, alcohol consumption by children and young people is of widespread concern. There is a need to acknowledge the impact poor health can have on our children's future, and recognise that prevention is better than cure.

There is a clear and continuing role for schools and further education (FE) colleges to play, not just in promoting health among children, but also in providing education about the benefits and risks of health and work.

Many children already receive Personal, Health and Social Education at school. There is a great opportunity for the links between health, skills and work to be made clear as part of this curriculum. The National Healthy Schools Programme and the Welsh Network of Healthy Schools Scheme are ideally placed to deliver the message to children that being in work is good for their future health and well-being. It can also help schools ensure they are healthy workplaces for teachers, administrators and support staff, and that schools are playing their part in the promotion of health in the wider community.

⁶¹ *Health Survey for England 2006: CVD and risk factors adults, obesity and risk factors children.*

⁶² *Healthy Weight, Healthy Lives: A Cross-Government Strategy for England* (HM Government 2008).

⁶³ *Smoking, drinking and drug use among young people in England in 2006* (National Centre for Social Research/National Foundation for Educational Research 2007).

Case study

Young Visions is a partnership between four schools in deprived areas of Southwark in South London and a voluntary organisation, Pembroke House. Students use workshops to identify areas of work in the professions which they might aspire to, and then interview representatives of such work. The workshops are reinforced by workplace visits, organised through the visiting professionals, as well as university visits.

The Children's Centres and the Extended Schools programmes also have a role to play in promoting the links between healthy lifestyles and life skills to children and their parents.

The children of today are the working age population of tomorrow. They should be supported in being healthy, educated about the benefits of being in work, and empowered to choose to work and to choose a healthy workplace.

This will not only benefit current workers by boosting the economy so they are supported in their retirement. It will help the children of today maximise their potential for health and well-being, job satisfaction and personal fulfilment in the future. It will also benefit their children – helping to break the intergenerational cycle of poverty and worklessness which can plague whole communities.

Recommendations

- Schools and Further Education colleges should consider including the benefits of work in their health promotion for children and young people.
- Any awareness-raising campaign about health, work and well-being should aim to demonstrate the benefits of being in work – not just for parents and carers but also the knock-on positive effects for their families and communities.
- Government should accelerate and broaden its work in applying the 'Healthy Schools' approach to further education to create expectations among new entrants to the workforce on the health and well-being support employers should offer.

9

Taking the agenda forward



Chapter 9 – Taking the agenda forward

This report has set out the challenges which must be met if a significant and sustainable improvement in the health of Britain's working age population is to be realised. It has presented a vision of a new approach to health and work which can only be achieved with the active involvement and support of all those with an interest in the health of the working age population.

Individuals

Individuals have a fundamental personal responsibility to maintain their own health. Ultimately, no efforts from Government, employers or healthcare professionals will be effective unless individuals actively seek to remain in or return to work and do not assume that being signed off work with a health condition is always necessary or beneficial.

Health and safety professionals, trades unions and other representative bodies

Health and safety professionals, trades unions and other representative bodies play a valuable part in influencing how employers tackle health and safety issues in the workplace. This Review has highlighted the opportunity for these groups to play an expanded role in promoting the benefits of employers investing in health and well-being.

One important element of this role is the promotion of a working environment that offers employees a degree of responsibility and a sense of worth. The concept of 'good work' is fundamental to the evidence on the positive effects of work on health for individuals, and to the productivity of business. This provides trades unions, in particular, with an important opportunity to encourage employees to see healthy workplaces as a fundamental employment right and to demonstrate to employers the importance that employees attach to it.

Employers

Employers bear the primary responsibility for establishing the conditions and practices in the workplace which minimise the likelihood of people being made ill by their jobs.

But, as the Review has shown, there is also a compelling case for organisations of all sectors and sizes to move beyond the traditional health and safety agenda to embed health and well-being at their heart and to create an empowering and rewarding work environment for all employees.

The business case for health and well-being is not, however, confined to health promotion, prevention of illness or even good line management. The costs of sickness absence dictate that it is in employers' interests to work with healthcare professionals and employees to consider potential adjustments which could enable employees to remain in or return to work while recovering from ill-health. It is hoped that the proposals in this report, such as the electronic fit note and the *Fit for Work* service, if taken forward, would provide employers with new opportunities and support to achieve this.

Healthcare professionals

The proposals in this report can only be realised with the input, expertise and commitment of the healthcare profession. It is a central tenet of this Review that GPs and other healthcare professionals are inadequately supported at present to provide advice on fitness for work. Furthermore, they do not have appropriate options for referral to timely interventions. This must change and the proposals seek to achieve this with improved support and options for referral through the new fit note and *Fit for Work* service.

But these new services can only be developed in partnership with the healthcare profession and will only work with its support.

The Healthcare Professionals' Consensus Statement on health and work marked a significant commitment to promoting the links between good work and good health. Healthcare professionals, supported by Government, must now take responsibility for helping to translate this pledge into a reality.

The Review has additionally highlighted the challenge and opportunity for the occupational health specialty to unite all those engaged in improving, safeguarding or restoring the health of all working age people. It is a once-in-a-generation opportunity to build on the successes of the past and make a real difference in the future.

Government

The challenge for Government is to establish the framework within which change can be achieved and sustained. Government should set out how it will meet the challenges and take forward the recommendations made in this Review.

This will include ensuring that policies across different departments are consistent and complementary – and that Government itself acts as an exemplar.

For Government to fulfil its role successfully there needs to be an effective cross-departmental leadership structure accountable to both Ministers and external stakeholders.

It also falls to Government to monitor both the effectiveness of new frameworks and the changing scale and nature of the problems which they were designed to address.

Chapter 2 set out a baseline of the health of the working age population, which should be updated as and when future data are released and should be assessed on an annual basis. If the recommendations set out in this report are taken forward and implemented, it is likely that there will be a significant impact on the indicators included in the baseline.

Government also needs to review the research commissioned on health and work, and the data collected and analysed. This Review found several areas where research evidence and data were lacking. For example, there is a dearth of research into sickness absence despite the high costs to employers and the economy. There is little evidence on how effective health interventions are in promoting return to work or how effective work interventions are in promoting positive health outcomes. It is, therefore, almost impossible to conduct any meaningful cost-effectiveness analysis of the health and work agenda. The relevant parts of the key departments should consider and commission further research and analysis in conjunction with key stakeholders.

Conclusion

This Review has shown that the annual economic costs of sickness absence and worklessness associated with ill-health are over £100 billion a year – greater than the current annual NHS budget. It is an unsustainable burden in a competitive global economy.

Left unchecked, it will diminish the quality of life for individuals and families in Britain, undermining efforts to reach full employment and denying business the talent and contributions of a potential workforce it can ill afford to lose. It will condemn workless families to a cycle of poverty and dependency that will widen inequalities in our society, perpetuating social injustice at the heart of our most deprived communities and obstructing efforts to eradicate child poverty in Britain.

We must act now if we are to prevent this from happening.

Together we have the opportunity to deliver long-term change. We will not secure the future health of the working age population without it.

Recommendations

- Government, healthcare professionals, employers, trades unions and all with an interest in the health of the working age population should adopt a new approach to health and work in Britain based on the foundations laid out in this Review.
- The existing cross-Government structure should be strengthened to incorporate the relevant functions of those departments whose policies influence the health of Britain's working age population.
- Government should monitor the baseline set out in this Review and commission a coordinated programme of further research to inform future action with a comprehensive evidence base.





Appendix

Appendix – Glossary

Body mass index (BMI)	<p>A measure of body fat based on height and weight which applies to adult men and women. BMI is calculated as: (weight in kilograms) / [(height in metres) x (height in metres)].</p> <p>BMI categories are:</p> <ul style="list-style-type: none">• Underweight = under 18.5• Normal weight = 18.5 to 24.9• Overweight = 25 to 29.9• Obese = 30 or over
Cognitive behavioural therapy (CBT)	<p>A treatment for mental health conditions which combines cognitive therapy (which can modify or eliminate unwanted thoughts and beliefs) with behavioural therapy (which can help change behaviour in response to those thoughts).</p>
Children’s Centres	<p>Places, for which local authorities have strategic responsibility, where children under five and their families can receive integrated services and information, and where they can access help from multi-disciplinary teams of professionals.</p>
Corporate social responsibility	<p>Acknowledgement by companies that they should be accountable, not only for their financial performance, but also for the impact of their activities on society and/or the environment.</p>
Disability	<p>The Disability Discrimination Act (DDA) defines a disabled person as someone who has a physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities.</p>

Employment and Support Allowance (ESA)

A Government benefit which, from October 2008, will replace Incapacity Benefit (see below) and Income Support (see below) for new claimants. Eligibility for ESA will be based on a new assessment of what individuals are capable of and what help they need to manage their condition and return to work.

Extended Schools

A scheme to use the location of schools at the heart of their communities as a means of offering access to a range of services for children, young people, their families and communities.

Extended Schools Programme

A scheme in which schools work with the local authority, local providers and other schools to provide access to a range of integrated services for children and their families, often occurring beyond the school day.

Food and Fitness Implementation Plan for children and young people

A Welsh Assembly Government initiative, launched in June 2006, setting out ways of helping children and young people to eat well, stay fit and achieve the highest standard of health possible, through the encouragement of a balanced diet and appropriate levels of physical activity.

Group of Eight (G8)

The eight major industrial democracies: Canada, France, Germany, Italy, Japan, Russia, the United Kingdom and the United States.

Gross Domestic Product (GDP)

The total market value of all final goods and services produced within a given country or region in a given period of time (usually a calendar year).

Health

A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

Health inequalities	Differences in health status or in the distribution of health determinants between different population groups.
Healthy Weight, Healthy Lives Strategy	A cross-Government strategy published in January 2008 to support people to maintain a healthy weight, with the ambition of reversing the rising tide of obesity, and with an initial focus on aiming to reduce the proportion of overweight and obese children to 2000 levels by the year 2020.
Housing Benefit	A Government benefit (sometimes called 'rent rebate' or 'rent allowance') paid by local authorities to people on low income who pay rent.
Ill-health/illness	A state in which a health condition impacts on well-being, activities or participation, or quality of life, and not merely the presence of disease or a medical diagnosis, nor of symptoms.
Improving Access to Psychological Therapies (IAPT)	A pilot project launched in May 2006, seeking to provide improved access to psychological therapies for people with common mental health problems such as anxiety and depression who require the help of mental health services. The IAPT programme comprises two national demonstration sites in Newham and Doncaster, as well as a national network of local psychological therapy programmes.
Incapacity Benefit (IB)	A Government benefit payable to those of working age who are unable to work because of illness or disability and who are not eligible for Statutory Sick Pay (see below).
Incapacity benefits	The group of Government benefits which those unable to work because of illness or disability may be receiving. They include IB (see above), Income Support (see below) supplemented by a disability premium, and Severe Disablement Allowance (which has been closed to new claimants since 2001).

Income Support

A Government benefit payable to anyone over the age of 16 whose income, from all sources, is below a minimum level. From October 2008, it will be replaced, for new claimants, by ESA (see above).

Investors in People (IiP)

An internationally recognised quality standard for the development of businesses and organisations through good workforce development practice. Planned to include health and well-being in 2009.

Jobcentre Plus

The Government agency which provides advice and support to those of working age who are workless, administers claims for certain welfare benefits, and helps employers to fill vacancies.

Jobseeker's Allowance (JSA)

A Government benefit payable to unemployed people who are available for and actively seeking work.

Labour Force Survey (LFS)

A quarterly sample survey of households living at private addresses in Britain, carried out by the Social and Vital Statistics Division of the Office for National Statistics (see below). It provides information on the UK labour market that can then be used to develop, manage, evaluate and report on labour market policies.

Leadership and Management Advisory Panel

A panel established in 2005, to offer strategic advice to Government Ministers, the boards of non-departmental public bodies and other major agencies on routes to improve the quality of leadership and management across the private, public and voluntary sectors in the UK.

Local Area Agreements

Agreements between central and local government in a local area designed to achieve local solutions that meet local needs, while also contributing to national priorities and the achievement of standards set by central government.

Local Strategic Partnership	A non-statutory body which brings together partners, including the police, health services and the private and voluntary sectors to develop a long-term vision to improve the quality of life and services in the local area.
Musculoskeletal disorders (MSDs)	A range of health problems such as low back pain, joint injuries and repetitive strain injuries of various sorts.
National Healthy Schools Programme (NHSP)	An initiative launched in March 2007 to support the links between health, behaviour and achievement based on a whole-school approach to physical and emotional well-being and focused on four core themes: personal, social and health education; healthy eating; physical activity; and emotional health and well-being.
National Vocational Qualifications (NVQs)	Work-related, competence-based qualifications which reflect the skills and knowledge needed to do a job.
New Deal	A programme, managed by Jobcentre Plus (see above), that provides people on benefits with the help and support they need to look for work, including training and preparing for work.
New Deal for Disabled People	A programme of advice and practical support which helps people move from disability and health-related benefits into paid employment.
NHS Plus	A network of NHS occupational health departments across England which supply services to non-NHS employers, with a special focus on small and medium-sized enterprises.
NHS Trusts	Organisations which take responsibility for managing delivery of different types of NHS services in local communities.

Occupational health

The promotion and maintenance of the highest degree of physical, mental and social well-being of workers in all occupations by preventing departures from health, controlling risks and the adaptation of work to people, and people to their jobs.

Occupational Health and Safety Advisory Service (OHSAS)

An autonomous multi-disciplinary organisation formed in January 2001 in Fife and Tayside within the structure of the NHS, with expertise in occupational health and safety skills, providing advice and support to companies in the areas of occupational health, health and safety, occupational hygiene, counselling and psychology, and asbestos management.

Occupational Health Clinical Effectiveness Unit (OHCEU)

A part of NHS Plus which aims to improve the effectiveness of occupational health services through activities such as the development of clinical management guidelines and national comparative audits, in collaboration with stakeholders such as the Faculty of Occupational Medicine.

Pathways to Work

A programme overseen by Jobcentre Plus to provide extra support and opportunities to help people with health problems and disabilities find jobs and retain them.

Personal, Health and Social Education (PHSE)

A non-statutory part of the National Curriculum since 2000, taught throughout all four key stages (ages 5-16), structured to provide pupils with the knowledge, skills and understanding to take responsibility for themselves, show respect for others and to develop the self-awareness and confidence needed for life.

Poverty

The most commonly used threshold of poverty (low income) is a household income that is 60% or less of the average (median) household income in that year.

Primary Care Trusts (PCTs)	The local organisations in England which decide and arrange provision of the health services a local community needs. These services include GPs, dentists, pharmacists and opticians. PCTs also make decisions about the type of services that hospitals provide and are responsible for making sure that the quality of service is high enough.
Public health	The science and art of preventing disease, prolonging life and promoting health through the organised efforts and informed choices of society, public and private organisations, communities and individuals.
Safe and Healthy Working	A part of the Scottish Centre for Healthy Working Lives, providing a free and confidential occupational health and safety service for small and medium-sized enterprises in Scotland.
SALUS	An NHS-based multi-disciplinary team of professionals in Scotland, providing a range of occupational health and safety services to a wide range of commercial clients.
Sector Skills Councils	Twenty-five employer-led independent organisations, each covering a specific sector across the UK, whose key goals are to reduce skills gaps and shortages, to improve productivity and business and public service performance, to increase opportunities to boost the skills and productivity of everyone in the sector's workforce, and to improve learning supply.
Sick note	The sickness certification form issued by healthcare professionals to people of working age, normally required to claim Statutory Sick Pay (see below).
State Pension age	For women 60 years, and for men 65 years. Due to rise to 68 years for both men and women by 2046.

Statutory Sick Pay (SSP)	A payment which is made, for a period of up to 28 weeks, by an employer to an employee unable to work because of illness.
Train to Gain	A service offered by the Government's Learning and Skills Council (LSC) to help businesses acquire the training they need. It offers skills advice and matches business needs with further education and training providers.
Vocational rehabilitation	A process to overcome the barriers an individual faces in returning to employment which result from injury, illness or disability. It encompasses the support an individual (and the employer) needs to ensure the individual remains in or returns to work, or accesses employment for the first time.
Well-being	The subjective state of being healthy, happy, contented, comfortable and satisfied with one's quality of life. It includes physical, material, social, emotional ('happiness'), and development and activity dimensions [Waddell & Burton, 2006].
Welsh Network of Healthy Schools Scheme	A scheme encouraging the development of local healthy school schemes within a national framework, incorporating national aims and guidance on local and national roles offered to local schemes through publications and national networking events.
Workboost Wales	A government-funded service providing confidential, practical and free advice to small businesses in Wales on workplace health and safety, management of sickness absence and return to work issues.
Working age population	For data analysis purposes, all females in Britain aged between 16-59 and all males aged between 16-64; currently 36.6 million. In the narrative of this report, people in employment beyond State Pension age (see above) are also included in the definition of the working age population.

Working in Partnership Programme (WiPP)

An NHS programme designed to help GPs manage their workload.

Worklessness

A state which includes not being in paid employment and not actively seeking employment.

Workplace Health Connect

A two-year pilot service, funded and managed by the Health and Safety Executive, but independently delivered. It was designed to give advice on workplace health, safety and return-to-work issues to small and medium-sized businesses in England and Wales. The pilot ended in February 2008.



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