Public Health England

UCL Institute of Health Equity

Local action on health inequalities:

Increasing employment opportunities and improving workplace health

Health Equity Evidence Review 5: September 2014

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The UCL Institute of Health Equity (IHE) is led by Professor Sir Michael Marmot and seeks to increase health equity through action on the social determinants of health, specifically in four areas: influencing global, national and local policies; advising on and learning from practice; building the evidence base; and capacity building. The Institute builds on previous work to tackle inequalities in health led by Professor Sir Michael Marmot and his team, including the 'Commission on Social Determinants of Health', 'Fair Society Healthy Lives' (The Marmot Review) and the 'Review of Social Determinants of Health and the Health Divide for the WHO European Region'.
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About this evidence review

This evidence review was commissioned by PHE and researched, analysed and written by the IHE. There are related evidence reviews available in this series. There is a companion summary briefing note available on this and other related topics from the same series. This review is intended primarily for directors of public health, public health teams and local authorities. This review and the accompanying briefing are part of a series commissioned by PHE to describe and demonstrate effective, practical local action on a range of social determinants of health.

This evidence review was written for IHE by Ellen Bloomer.

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Key messages

1. There is a social gradient in unemployment, with those in more disadvantaged socioeconomic positions more likely to be unemployed than those in more advantaged positions. Unemployed people have a greater risk of poor health than those in employment, contributing to health inequalities.[1 2]
2. The way work is organised and the work climate are contributory factors to the social gradient in health.[3] Lower paid workers with fewer skills or qualifications are more likely to experience poor psychosocial working conditions and worse health.[4-6]
3. There is evidence that psychosocial working conditions can be improved in a variety of ways, for example by increasing employee control over their work and allowing participation in decision-making, ensuring effective leadership and line management training, adoption of flexible working practices, and with interventions to reduce stress and improve mental health at work – leading causes of sickness absence. Measures to improve the quality of work and working conditions that focus more attention on workers in lower grade occupations may help to reduce inequalities in work-related health problems.
4. There is clear evidence that local authorities can work with employers to promote good work with many examples of good practice. Local authorities have a number of levers including provision of advice, enforcement of employer legal obligations, partnership working, incentivisation and accreditation, and contractual levers of procurement using the Social Value Act 2012.
5. Personalised, tailored support has been shown to be effective in supporting people with disabilities and long-term conditions into work or training. Local authorities can play a role in promoting and increasing employer awareness of national programmes, guidance and legislation on employment of disabled people and those with long-term or fluctuating health conditions. They may be able to influence provision of employment services by ensuring that employment service providers are members of health and wellbeing boards and take part in joint strategic needs assessments.
6. Poor working conditions are among the determinants of early retirement. Therefore, measures to improve working conditions, including those that aim to make conditions more suitable for older workers, are likely to increase the chances of retaining older staff. Approaches to consider include promotion of fair recruitment practices that encourage applications from older people, flexible working, phased retirement and flexible retirement options and training for managers on issues of age.

Introduction

The Marmot Review recognised the important role of good employment in improving health and reducing health inequalities: "Being without work is rarely good for one's health, but while 'good work' is linked to positive health outcomes, jobs that are insecure, low-paid and that fail to protect employees from stress and danger make people ill".[1]

This paper builds on that position and provides a summary of evidence on the effects of unemployment and poor working conditions on health and the unequal distribution of these effects. It then outlines the potential actions that can be taken in local areas around four specific topics:

- workplace interventions to improve health and wellbeing
- work with local employers to encourage, incentivise and enforce good quality work
- interventions to increase employment opportunities and retention for people with a long-term health condition or disability
- interventions to increase employment opportunities and retention for older people

Each section will explain how and why such interventions will contribute to reducing unemployment, improving working conditions and reducing health inequalities. Examples of effective interventions are provided and briefly assessed in each area. A large number of interventions have been implemented by employers and local and national government on these topic areas but the there is a lack of strong evaluation evidence on intervention impacts. Recommendations for further research are made in section 5.

This paper takes a 'social determinants' approach. People's health and social position are seen as shaped by, and related to, inequities in power, money and resources, and the conditions in which they are born, grow, live, work and age[7] – these are the sources of health inequalities that are seen in society. The purpose of this document is to show that taking action to increase employment opportunities and improve working conditions is possible and necessary – both for the benefits achieved by employers and business, and also as an important way to improve public health and reduce health inequalities.

This document is part of a collection of evidence reviews commissioned by Public Health England (PHE) and written by the UCL Institute of Health Equity. A corresponding short briefing on this topic is also available, as are additional evidence reviews: the reviews on young people not in employment, education and training (NEET), and on the increasing the number of people receiving a living wage are particularly complementary to this evidence review on employment.

Throughout the paper, we have highlighted certain evidence and resources in boxes such as this one. These are labelled in the following ways:

Intervention – an example of a strategy, programme or initiative, taken by a local area, organisation or national government, that it is felt may contribute to reducing health inequalities by acting on the social determinants of health. It has either been evaluated and shown to be effective, or is considered to be an example of promising action.

Key message(s) – summaries of the key findings or action proposed in this paper.

Key literature – summaries of academic studies or other reports which provide key information relevant to the chapter, often taking into account a range of different programmes or projects.

1. Key concepts used in this paper

In this report, we use several key concepts related to employment or an individual's position in the labour market.

1. People in **employment** are in paid work, whereas those who are **unemployed** are jobless but available to work, and are actively seeking employment.[8]
2. **Long-term unemployment** is defined as referring to people who have been unemployed for 12 months or more.[9]
3. **Economically inactive** people are out of work and not actively looking for work (for example, because they are a student or looking after the family/home).[10]
4. **Good work** is characterised by a living wage, having control over work, in-work development, flexibility, protection from adverse working conditions, ill health prevention and stress management strategies and support for sick and disabled people that facilitates a return to work.[1] Both the psychosocial and physical environments at work are important. The psychosocial work environment includes the organisation of work and the organisational culture; the attitudes, values, beliefs and practices that are demonstrated on a daily basis in the enterprise, and which affect the mental and physical wellbeing of employees. These are sometimes generally referred to as workplace stressors, which may cause emotional or mental stress to workers.[11]
5. **Disabled people** have a physical or mental impairment that has a 'substantial' and 'long-term' negative effect on their ability to do day-to-day activities. The Equality Act 2010 defines 'long-term' as 12 months or more.[12]
6. A **long-term health condition** is a condition that cannot, at present, be cured but is controlled by medication and/or other treatment/therapies.[13]
7. **'Older people'** for the purposes of this report, refers to people aged over 65. However, some of the evidence presented in this report uses a different definition, and we specify where this is the case.

All of these concepts are related to and have a role in improving health and reducing health inequalities. Unemployed people and those experiencing poor working conditions have a greater risk of poor health than people not in those situations.[1 14] There is a social gradient in employment status and working conditions in England, with those in lower socio-economic groups at higher risk of unemployment and, if employed, of poor working conditions.[15] This will, in turn, result in a greater risk of poor physical and mental health for those lower on the social gradien.[16]

2. Employment and health inequalities

2.1: Unemployment and health inequalities

There is a social gradient in unemployment, with those in more disadvantaged socio-economic positions more likely to be unemployed. Unemployed people have a greater risk of poor health than those in employment, contributing to health inequalities.[1 2] Unemployment has been associated with an increased risk of mortality for all socio-economic groups and increased morbidity, including higher risks of limiting illness, cardiovascular disease, poor mental health, suicide and health damaging behaviours such as smoking (box 1).[14 15 17-23]

Research has shown that there are immediate health impacts as well as longer-term effects that progressively damage health over time.[1] Those who experience long-term unemployment experience the greatest health-adverse effects.[14] Re-employment can often improve health, though the health effects sometimes continue beyond the period of unemployment.[14 24]

Being in employment has health benefits:

- employment is generally the most important means of obtaining adequate economic resources, which are essential for material wellbeing and full participation in today's society
- work meets important psychosocial needs in societies where employment is the norm
- work is central to individual identity, social roles and social status
- employment and socio-economic status are the main drivers of social gradients in health[25]

Unemployment causes the loss of regular income. The material and psychosocial impacts of low income, outlined in the complementary evidence review on the living wage, may contribute to the link between unemployment and poor health. However, unemployment can cause additional psychological stressors related to status and self-esteem, identity and the loss of a core role in life, which impact on health.[26 27] Unemployment is also associated with unhealthy behaviours, including increased smoking and alcohol consumption and decreased physical exercise.[28]

Unemployment early in life can impact negatively on later employment opportunities and wages, while resultant health impacts such as depression may similarly increase chances of subsequent unemployment.[29 30] Further, unemployment can have effects beyond the individual directly affected, with evidence suggesting that financial difficulties or associated stress can increase the risk of poor mental health among the families of those unemployed.[31 32]

Box 1. Key literature: how much impact does unemployment have on health inequalities?

Individual studies have quantified the increased risk of unemployment on health and the increased health risks for those lower on the social gradient. These can help to provide a better understanding of the overall contribution of unemployment to health inequalities in England.

- unemployed people have a 20–25% higher mortality rate over the ten years following unemployment than employed people in the equivalent occupational group (UK Census)[14]
- unemployment was associated with a greater likelihood of limiting illness (hazard ratio [HR] = 2.41/2.06 for men/women) in the following year compared with those in employment, among a sample of people in good health at the beginning of the period, controlling for marital status, social class, employment status, income, and educational qualifications (British Household Panel Survey)[17]
- acute myocardial infarction (AMI) risks were significantly higher among the unemployed (HR = 1.35) and risks increased incrementally from one job loss (HR = 1.22) to four or more cumulative job losses (HR = 1.63) compared with no job loss. Risks for AMI were particularly elevated within the first year of unemployment (HR = 1.27) but not thereafter. Results were adjusted for multiple clinical, socio-economic and behavioural risk factors (US Health & Retirement Survey)[18]
- workers who had experienced involuntary job loss had a more than twofold increase in the risk of subsequent AMI (HR = 2.48) and stroke (HR = 2.43) relative to working persons, after controlling for established predictors of the outcomes (US Health & Retirement Survey)[19]
- unemployment[i] was associated on a 24-year follow-up, with a higher relative risk of mortality (relative risk [RR] = 1.3/1.4 for men/women), suicide (RR = 1/2.7 for men/women) and mortality by external undetermined causes (RR = 5.8/10.7 for men/women), adjusted for age, marital status, smoking status, alcohol consumption, use of tranquilizers/ sleeping pills, unstable/ extroverted personality, and long-lasting serious illness (Swedish Twin Registry)[21]
- unemployed people showed more distress than employed people (average overall effect size of d=0.51). The average number of people with psychological problems among the unemployed was 34%, compared with 16% among employed individuals (meta-analysis of 324 research studies)[20]

Economic activity among people with a disability or long-term condition

Studies show that workless individuals are more likely to have health problems compared with the general population, and this is likely to be attributable partly to the health effects of unemployment and partly to the reduced likelihood of people with a disability or long-term illness being in employment.[33 34] People with a disability or long-term health condition have far lower employment rates than other people and the numbers on economically inactive health-related benefits have risen considerably over the past 35 years (see section 3.2). It is estimated that the difference between the proportion of disabled people in work, and what that proportion would have been if those same people were not disabled after adjusting for qualifications and other demographic characteristics (the 'employment penalty') is around 40%.[34]

[i] In that study, unemployment was measured by asking a sample of people if they had ever been unemployed.

The negative impacts of long-term health conditions on employment are greater among those in more disadvantaged socio-economic groups compared with those in more advantaged groups. One research study found that those in non-manual occupations are more likely than manual workers to remain in work if they have a limiting illness.[35] This is likely to contribute further to the social gradient in health.

Those with a long-term health condition or disability already experience worse health than the general population, and being unemployed can cause further health deterioration, as it takes away the protective health effects of good employment. Many of these mechanisms through which unemployment negatively impacts on health may also hold true for those people with a disability or long-term health condition who are economically inactive. Individuals in families with disabled members are more likely to be in poverty: 19% of individuals in families with at least one disabled member live in relative income poverty before housing costs, compared with 15% of individuals in families with no disabled member.[36]

There are many people living with a disability or long-term condition who are unable to work and it is important that they continue to receive the necessary support to live a healthy life. Dame Carol Black's report, 'Working for a healthier tomorrow', highlighted the need for changing perspectives on health and work: that it is not necessary to be 100% fit to be at work, and that for many, work can be beneficial for recovery from illness.[37] Section 4.3 discusses how local areas can support these people into employment.

2.2: Working conditions and health inequalities

Working conditions can impact health in a number of ways. Physical, chemical or ergonomic hazards in the workplace, such as solvents, pesticides, asbestos, noise, radiation, vibration, repetition and heavy lifting, can result in a range of diseases and injuries including lung fibrosis, neuropathy, deafness, organ damage, and cancers, among those who are exposed.[38]

The psychosocial working environment includes "the organisation of work and the organisational culture; the attitudes, values, beliefs and practices that are demonstrated on a daily basis in the enterprise, and which affect the mental and physical wellbeing of employees [… and] which may cause emotional or mental stress to workers".[11]

The link between a poor psychosocial work environment and health has been explained primarily by two models: the 'demand-control model' and 'effort–reward imbalance'.[15] The former explains that stress is caused in jobs with high employer demands combined with low employee control over their work because they limit control while generating continued pressure.[16 39 40] Having a low level of social support at work has been suggested to further increase this work stress.[41] The second model suggests that if employee effort is not matched by reward by the employer (such as money, esteem and career opportunities), this can cause stress and increase the risk of poor employee health if the employee has no alternative choice in the labour market.[15]

High demand combined with low control and/or effort–reward imbalance at work are associated with higher risks of fatal or non-fatal cardiovascular events and cardiovascular risk factors such as metabolic syndrome, type 2 diabetes, hypertension and obesity, health-damaging behaviours, depression, reduced physical and mental functioning, musculoskeletal disorders and sickness absence.[15] In jobs which combine the two models, with low control, low reward and high demand, the likelihood of poor health increases to an even greater extent.[42]

'Organisational injustice', whereby decision-making processes and treatment of employees are perceived to be unfair, may provide a further explanation of the link between psychosocial working conditions and employee health.[15] Organisational injustice is associated with several prevalent chronic diseases, including an increased cardiovascular risk.[43 44]

The level of job security afforded by an employment contract can affect health. A study of manual workers in Spain showed that mental health was better among those with a permanent contract compared with those on a temporary contract, with both groups experiencing better mental health than workers with no contract.[45] Temporary and other non-standard contracts can create significant insecurity for those who would prefer a permanent work arrangement. Temporary work arrangements have been associated with health problems including poor self-perceived health, liver disease, mental disorders, absenteeism, stress and alcohol- and smoking-related deaths.[45-54]

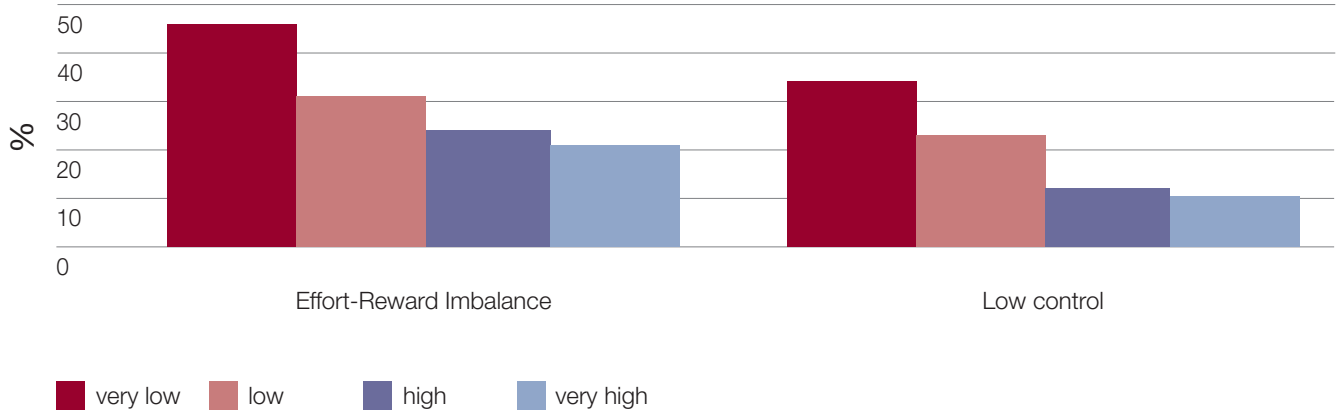
In one study, temporary workers who were dissatisfied with the insecure work situation or who took on temporary work involuntarily were found to have a much higher risk of mortality compared with permanent employees.[55]

Long or irregular working hours or shift work can affect health. Working more than 11 hours a day is associated with an increased risk of myocardial infarction and type 2 diabetes.[56-58] Shift workers have a higher risk of cardiovascular disease, metabolic syndrome and accidents than daytime workers, particularly for those who have been shift workers for longer.[59-66] Night shifts have been linked with more work accidents, cardiovascular and gastro-intestinal problems and eventually cancer.[67]

Inequalities are evident in poor working conditions. Research has shown that workers with fewer skills and qualifications are more likely to experience hazardous physical, chemical, ergonomic and psychosocial working conditions, as well as worse self-reported health and a large number of health outcomes than people who are more skilled/qualified.[4-6] There is a social gradient in psychosocial working conditions, as shown in figure 1. Those lower on the socio-economic scale are more likely to work in 'precarious' jobs, defined by a lack of safety at work, and exposure to multiple stressors including strenuous tasks with low control, low wage and high job instability.[68 69]

The Whitehall Studies compared health data of people employed at different levels in the British Civil Service and found that there was a social gradient in mortality and a range of diseases, including heart disease, some cancers, chronic lung disease, gastrointestinal disease, depression, suicide, sickness absence, back pain and general feelings of ill-health.[70] The Whitehall II study showed that the way work is organised and the work climate (eg, monotonous work characterised by low control and low satisfaction) are contributing factors to the social gradient in health.[3]

Occupational Class



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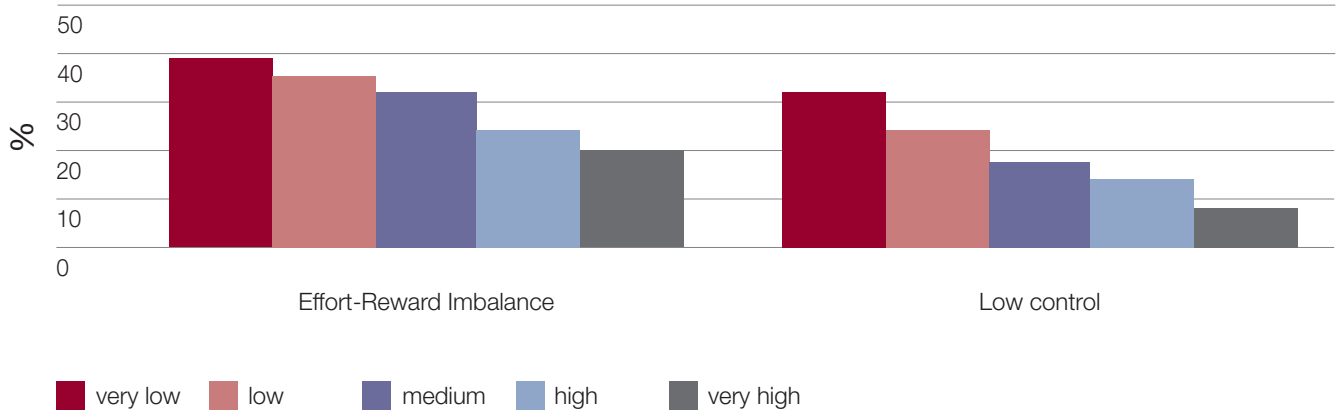
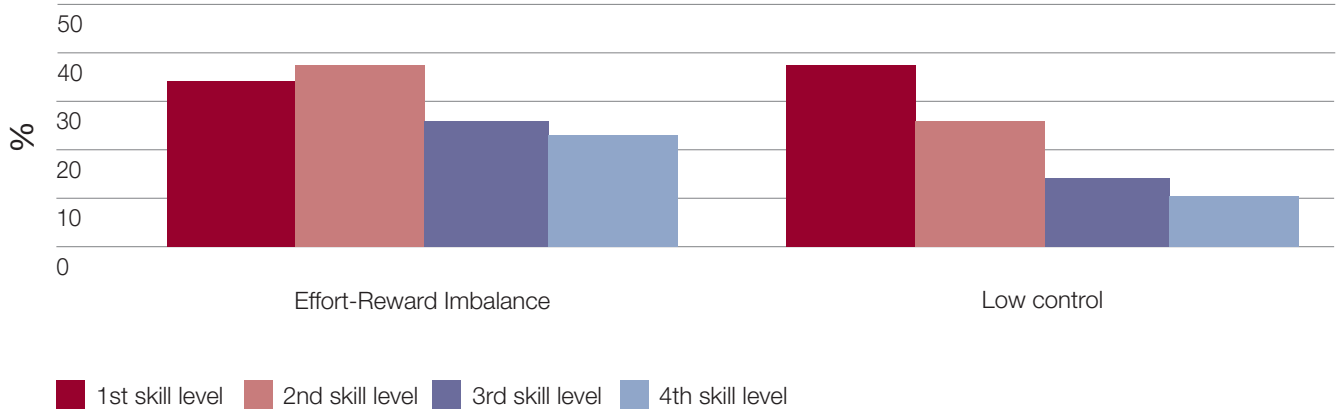


Skill Level



Source:71

Box 2. Key literature: how much impact do working conditions have on health and health inequalities?

1. Individual studies have quantified the increased risk of poor working conditions on health and the increased risks for those lower on the social gradient. These can help to gain a better understanding of the overall contribution of poor working conditions to health inequalities in England
2. One survey found that the most consistent predictors of back pain[ii] were decision control (lowest odds ratio [OR] = 0.68), empowering leadership (lowest OR = 0.59) and fair leadership (lowest OR = 0.54), after adjustment for age, sex, skill level, back pain severity and other potential confounders (survey of employees from 28 organisations in Norway)[72]
3. Temporary employees who felt their insecure situation was unsatisfactory had a 1.95-fold higher risk of mortality than permanent employees after adjusting for background, health- and work-related factors. Employees with a temporary job on an involuntarily basis had a 2.59-fold higher risk of mortality than permanent employees (survey of Finnish employees and register-based follow-up data)[55]
4. A greater proportion of those of a lower occupational class experienced poor psychosocial working conditions:
    - the proportion experiencing effort–reward imbalance was 21.1% among those with 'very high' occupational class, 23.0% among those with 'high' occupational class, 29.2% among those with 'low' occupational class and 44.5% among those with 'very low' occupational class
    - the proportion experiencing low control was 9.3% of those with 'very high' occupational class, 12.0% of those with 'high' occupational class, 19.6% of those with 'low' occupational class and 32.3% of those with 'very low' occupational class (Survey of Health, Ageing and Retirement in Europe)[71]

[ii] Out of 14 psychological/social and two mechanical exposures measured.

3. Scale of the problem

3.1 Employment and unemployment

Unemployment has been high in recent years during and in the aftermath of the 2008-09 and 2011-12 recessions, as shown in figure 2. Increasing employment is a key priority for local areas.

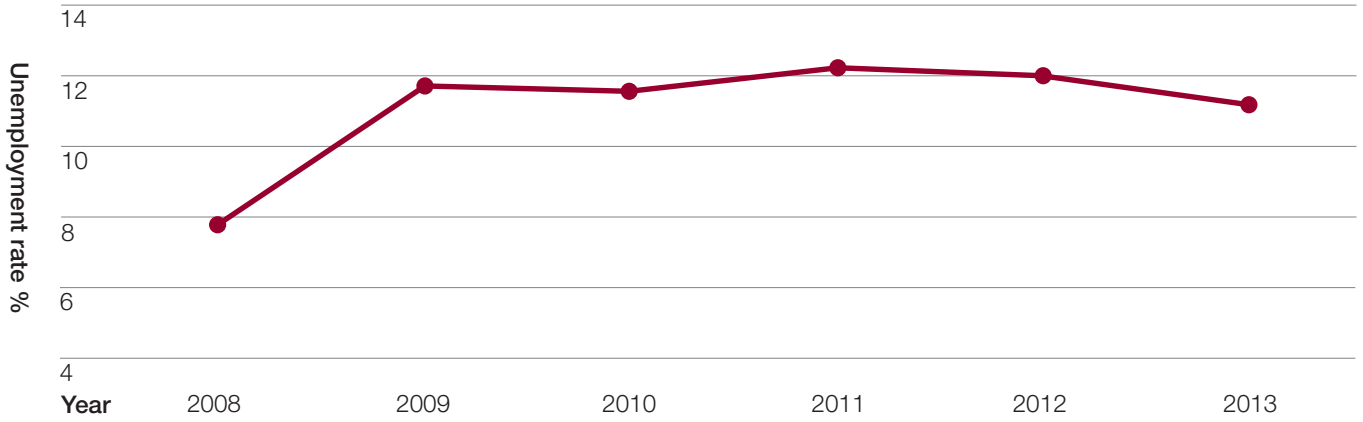


Figure 2. Working-age unemployment rate in England, 2008–13
Source:73

There are many others in employment not working sufficient hours for an adequate income. In 2012, 10.5% of adult workers in the UK (3.05 million people) wanted to work more hours, rising to around a quarter of part-time workers.[74] From 2008–12 the number of all workers who wanted to work more hours increased by one million (or 47.3%).[74]

Changes to the welfare system aim to make work pay for the majority, and if successful may move people from benefits into employment. However, as yet these changes have not been fully implemented and there is no satisfactory evidence of success.

There are particular challenges facing different age groups, notably young adults, who are discussed in the complementary evidence review on NEETs. There are also demographic changes in the UK resulting in an ageing population, with impacts on the make-up of the working population. The proportion of older workers aged 55 and above planning to work beyond the state pension age is 54%, according to a recent survey.[75] By 2020, 36% of the working population will be over 50.[76] This is causing the government to give greater consideration to how to retain these older people in the workforce, particularly given the increasing likelihood of disability and long-term illness in older age groups.

3.2 Employment and disability or long-term health conditions

There are 11.5 million working-age people in Britain with a long-term health condition, with 6.5 million classified as disabled.[77] Around one-quarter of the 28 million workers in Britain have a long-term health condition or impairment but people with a disability or long-term health condition have far lower employment rates than other people, as shown in figure 3.[77 78]

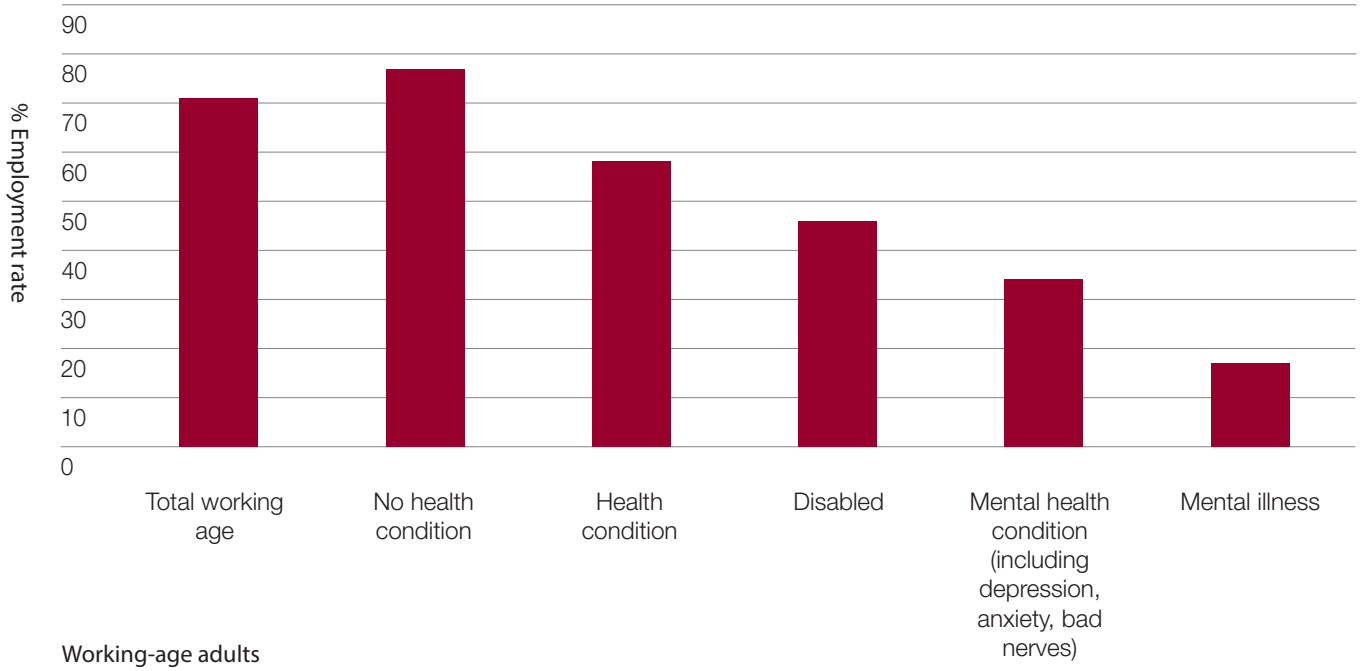


Figure 3. Employment rates of people in the working-age population, Great Britain, Q2 2013
Source:78

This graph reflects the exceptionally low rates of employment among those with mental health problems, also leading causes of sickness absence in the UK. The employment rate for all people with mental health problems is 37%, compared with 45% of disabled people, 58% of the population with a long-term health condition and 71% of the working-age population as a whole.[77] The estimated cost of mental health problems to the economy is £30-£40 billion, arising from lost production from people with mental health problems, the costs of informal care, and NHS costs.[77]

It is estimated that the difference between the proportion of disabled people in work, and what that proportion would have been if those same people were not disabled after adjusting for qualifications and other demographic characteristics (the 'employment penalty'), is around 40%.[34] Further, mean hourly wages for British working-age adults were £12.30 for disabled people compared with £13.49 for non-disabled people in Q2 2013.[79]

Figure 4 shows that around half of the population develop a disability before the age of 65. Disability at a younger age is more common among those living in more disadvantaged neighbourhoods reflecting the impact of social disadvantage on health and disability.

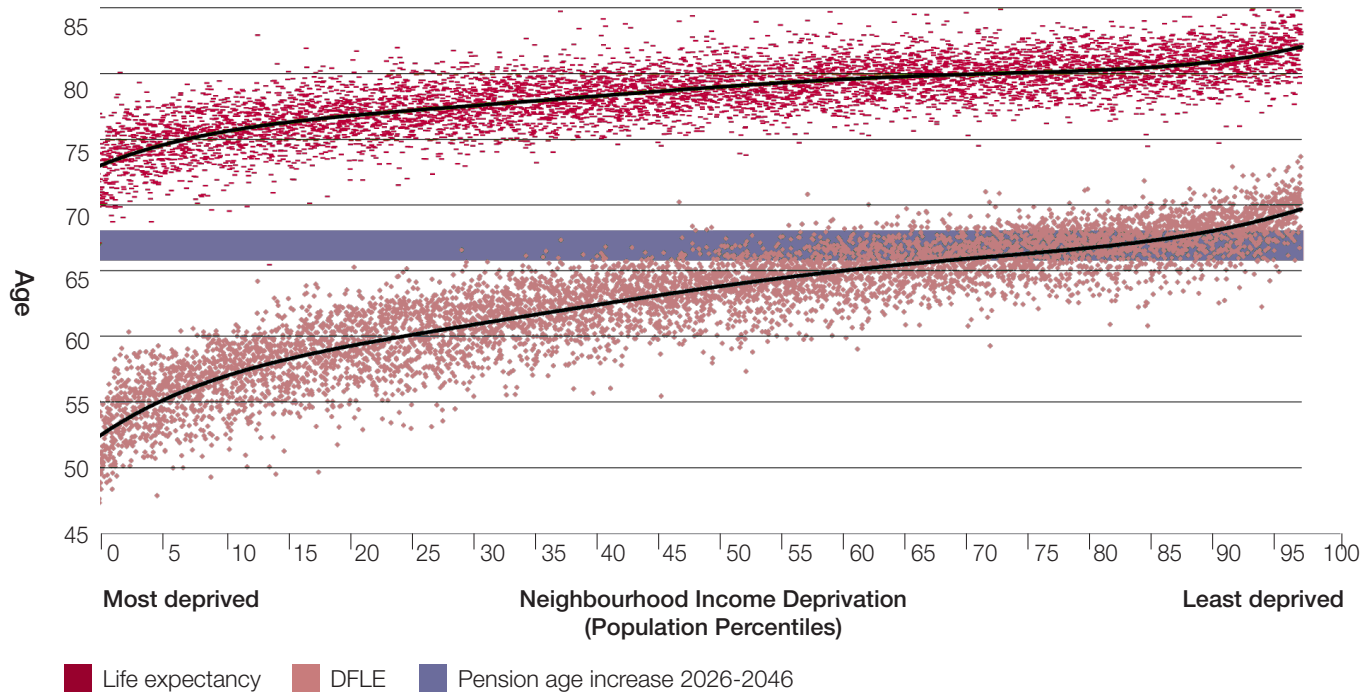


Figure 4. Life expectancy and disability-free life expectancy (DFLE) at birth, persons by neighbourhood income level, England, 1999–2003
Source:[1]

Aside from the disadvantages experienced by disabled people and people with health conditions on out-of-work benefits, the large numbers of people in this position place a large burden on the social welfare system. In August 2013 there were 2.4 million people of working-age in England claiming incapacity-related benefits, representing 6.1% of the working-age population.[80] Figure 5 shows that there was a considerable increase in the late 1980s and early 1990s.

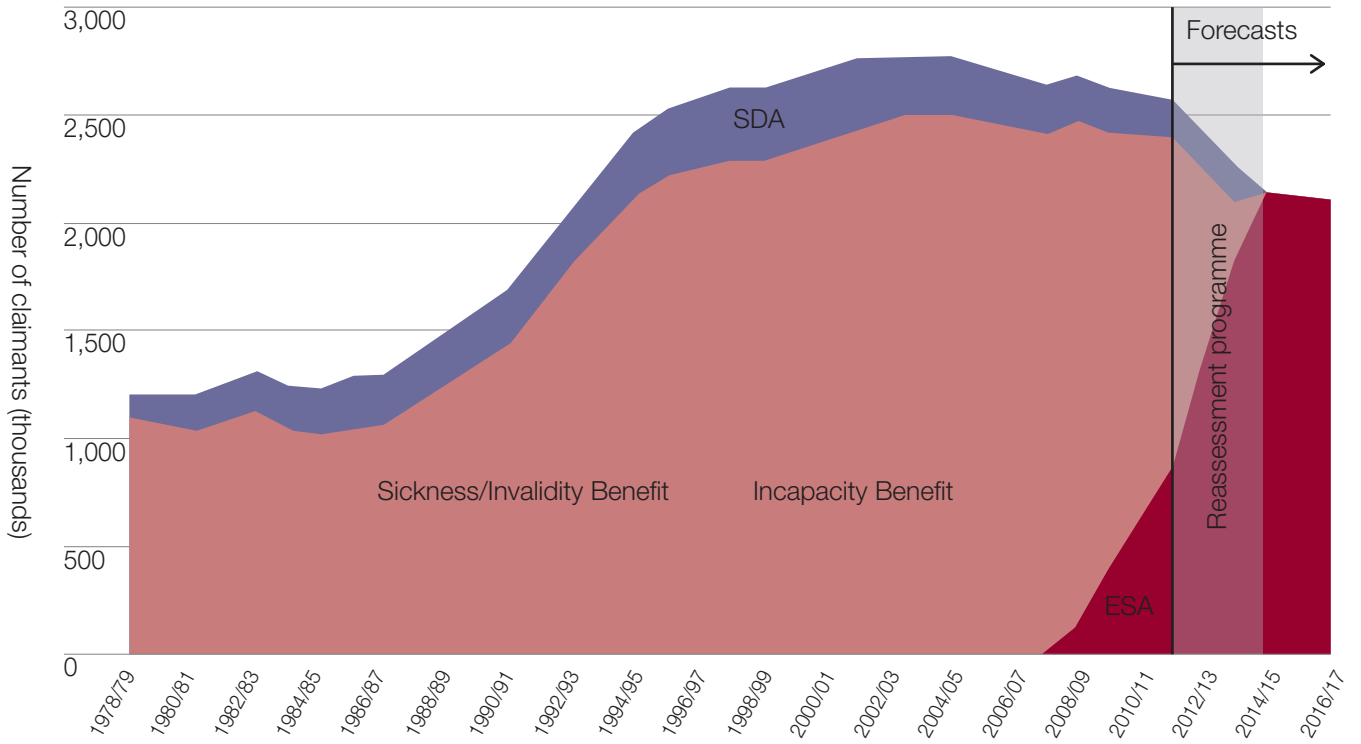


Figure 5. Working-age claimants of Employment and Support Allowance (ESA) and predecessor incapacity benefits, Great Britain, 1978 to present day
Source:81

The government predicts that the reassessment of those receiving incapacity-related benefits, due to recent national policy changes, will move more people into employment and reduce the numbers receiving incapacity benefits, as shown in figure 5.

3.3 Job security

Around a third of temporary employees reported in 2011 that they were working as a temporary employee because they could not find a permanent job.[82] Between December 2010 and December 2012 the number of involuntary temporary workers had more than doubled to 655,000.[83]

The Skills and Employment Survey, 2012, found that 52% of employees reported anxiety about loss of job status, while 11% were very insecure, believing their chances of losing their job were evens or worse, and this proportion had risen from 7% in 2006; 31% of employees were anxious about unfair treatment at work and this had increased since 2000, particularly in relation to fear of arbitrary dismissal.[84]

The Office for National Statistics (ONS) has estimated that there were 583,000 people on zero-hours contracts[iii] in Great Britain from October-December 2013.[85] This is more than twice the number of people who reported in the same period in 2012 (250,000), and almost four times the number in 2008 (143,000).[85 86] Just over a third of these people want more hours, with most

[iii] As Section 2 of the government's consultation on zero-hours contracts sets out: "In general terms, a zero-hours contract is an employment contract in which an employer does not guarantee the individual any work and the individual is not obliged to accept any work offered."

wanting them in their current job.[85] The Chartered Institute of Personnel and Development (CIPD) collected information from 1,000 businesses in 2013 and estimated that around one million people, or about 3% of the workforce, were on zero-hours contracts, almost double the ONS estimate, though the CIPD used a slightly different definition.[85]

3.4 Workplace health

Across Britain, around 646,000 workers had an accident at work in 2012-13.[87] This included 19,707 major injuries to employees, while 148 were fatally injured.[87] There were 428,000 cases of work-related stress in 2011-12.[88] Though the number of self-reported workplace injuries has fallen substantially over the last decade, work-related stress has remained broadly similar.[87 88]

Every year, around 140 million working days are lost to sickness absence (this equates to 2.2% of all working time, or 4.9 days for each worker each year) and over 300,000 people fall out of work onto health-related benefits.[89] Around 27 million of the days lost to sickness absence in 2011-12 were work-related, with 10.4 million days lost to work-related stress, depression or anxiety.[90]

Common mental health problems are a leading cause of sickness absence and claims to health-related benefits. 44% of individuals claiming Employment and Support Allowance (ESA) report a mental health problem and 23% of Jobseeker's Allowance (JSA) claimants have a common mental health problem.[77]

There are considerable economic costs to employers, employees, the state and healthcare system of unemployment and ill-health. An independent review of health and work in 2008 estimated that the total economic costs of sickness absence and worklessness associated with working-age ill health, to industries, employers, NHS, government and the economy as a whole, is over £100 billion a year.[37] A national review of sickness absence calculated that employers pay £9 billion a year in sick pay and associated costs, while the state spends £13 billion a year on health-related benefits.[89]

4. What works to increase employment and improve working conditions

Employment is a priority area for local authority action following the economic downturn which began in 2008. Local authorities play several roles, including employer and service commissioner. There are around 2.4 million people employed by local government across the UK,[91] and they involve large numbers of people through procurement and have a further role in supporting and regulating local employment.

Section 3 identified that unemployment and poor working conditions have negative health impacts and increase health inequalities, whereas good quality, secure employment can have positive health effects and can reduce health inequalities if implemented effectively.

The remainder of this report is organised in four sections, each of which looks specifically at one of the following areas for local authority intervention:

- workplace interventions to improve health and wellbeing
- working with local employers to encourage, incentivise and enforce good quality work
- interventions to increase employment opportunities and retention for those with a long-term illness or disability
- interventions to increase employment opportunities and retention for older people

In each section we present information about effectiveness of interventions with the particular aim in mind of improving health and reducing health inequalities in general. We then identify a range of specific interventions, primarily from across the UK, that have been effective in improving employment, health and health equity outcomes. Four separate briefings have been provided on these topics.

There is activity in these areas at national level, in terms of policy, legislation, guidance, programmes and interventions to improve health and wellbeing at work. This includes the cross-government health, work and wellbeing Initiative, which aims to improve the general health and wellbeing of the working-age population and support more people with health conditions to stay in work or enter employment; Dame Carol Black's review of the health and the working age population 'Working for a healthier tomorrow'; her subsequent work with David Frost on an independent review of sickness absence; and the resultant implementation of recommendations arising from each review.[37 89 92] This national government activity, which is wider than the subjects covered by this report, provides valuable evidence, guidance and recommendations for developing workplace health interventions and good employment practices.

It should be noted that this is not an exhaustive list of areas for intervention within the topic of employment. Other areas for future review include interventions to get long-term unemployed people into work, attracting employers and creating good quality jobs for local people, and improving job security.

4.1: Workplace interventions to improve health and wellbeing

Box 3. Key messages: what works to improve psychosocial working conditions?

Psychosocial working conditions can be improved in a variety of ways, including through:

- greater employee control over their work
- greater employee participation in decision-making
- line management training
- effective leadership and good relationships between leaders and their employees
- engaging employees, ensuring they are committed to the organisation's goals and motivated to contribute to its success
- providing employees with the in-work training and development they need to develop job satisfaction
- providing greater flexibility within a role to increase an employee's sense of control and allow them to improve their work–life balance
- reducing stress and improving mental health at work as these are leading causes of sickness absence
- addressing the effort–reward imbalance

Local authorities and other local employers can adapt many of the existing actions identified in this section for implementation.

It is important that employers ensure interventions are available to everyone, that all employees are made aware of the opportunities through effective communications and that all employees are considered during the design of the intervention. This is particularly true for those in semi-skilled and unskilled manual jobs and temporary or fixed-term workers.

Why implement workplace interventions to improve health and wellbeing?

There are many examples of successful workplace health and wellbeing interventions that also report business benefits, including reduced sickness absence, improved staff wellbeing and morale and increased productivity and performance, to varying degrees of reliability.[93 94] A majority of these programmes encourage behaviour change, implementing programmes to encourage healthy eating, physical exercise, smoking cessation and stress management (for examples, see[95]). Such programmes have been found to return £2–£10 for every £1 spent.[96] Others address physical, chemical and ergonomic hazards in the workplace, either through implementing legislation and guidance in this area, or interventions to address musculoskeletal problems.

However, to reduce health inequalities and effectively improve health and wellbeing in the workplace, health and wellbeing programmes should extend beyond improving healthy behaviours and physical hazards to improving the psychosocial work environment. Both the physical and the psychosocial aspects of the work environment are critical, yet this report focuses on the psychosocial environment as there is less understanding in this area. Section 2.2 explains the mechanisms through which a good psychosocial work environment can improve health and reduce health inequalities.

At a practical level, there are many ways through which to tap into these mechanisms and improve health and wellbeing among employees, reduce health inequalities and improve the psychosocial work environment. As reflected in the Marmot Review's definition of good work, increasing employee control over work, in-work development opportunities, flexible working arrangements, and protection from adverse working conditions, are also important features, alongside ill-health prevention and stress management strategies.[1] Local authorities might choose to implement interventions such as those in the next section to improve the health and wellbeing of their own staff, or work to increase their uptake among other local employers (suggestions of how the latter can be achieved can be found in section 4.2).

Interventions to improve psychosocial working conditions, health and wellbeing

Job control and employee participation

Control and autonomy over work and life outside of work contribute to good health. Those lower on the socio-economic scale are more likely to lack autonomy in both their work and home life, and this impacts on their health and wellbeing. Systematic reviews of the health effects of improvements to the psychosocial work environment have found that interventions increasing participants' job control and degree of autonomy at work produced fairly consistent results showing positive effects on mental health and sickness absence.[97] Box 4 illustrates that allowing employees of an engineering consultancy autonomy over their work and involving employees in company decision-making can have business benefits.

Box 4. Intervention: staff participation and control – Expedition Engineering[98]

Who? Expedition Engineering is an engineering and design consultancy.

Description: staff were involved in company decision-making, encouraged to manage their own workload, work from home and produce new ideas for the company in dedicated 'thinking' space. Staff were offered a menu of benefits to choose from to suit their needs, such as travel card or bicycle loans, private health insurance or gym membership. They introduced the 'Tenth Day' scheme, whereby staff had every tenth working day off. A welfare policy, stress policy and parental policy embed these practical benefits in the business strategy of the company.

Impact: the company enjoys minimal staff turnover and strong loyalty from customers, which it ascribes to its high levels of staff wellbeing. The company has seen clear business benefits.

Increasing staff participation and involvement in an organisation are likely to have a positive impact on health and wellbeing: a systematic review found workplace interventions characterised by a participatory approach involving employee representatives and management personnel worked well, with 'health circles' (staff meetings to discuss ways to improve the work environment) appearing to improve workers' health and wellbeing and reduce sickness absence.[99] Interventions in Middlesbrough (box 5) and by Axiom Housing Association (box 6) also take a participatory approach, involving staff and gaining positive health and business results.

Box 5. Intervention: a participatory approach to staff wellbeing – Middlesbrough Environment City[100]

Who and why? Middlesbrough Environment City (MEC) is a small charity with 18 employees who were given advice and support by their local authority to implement a health and wellbeing programme.

Description: to identify issues to be addressed, MEC used health assessment questionnaires, involving staff in the formation of the programme. Initiatives included family days, health walks, team-building days, free fresh fruit, supplying bicycles, health assessments, discounted gym schemes, men's health activities and tackling depression.
Each staff member received a personal health budget of £100 to improve health and wellbeing at work, giving them a sense of control. Managers visited staff at home when they were ill and, if possible, took them out for lunch. One manager completed the mental health first aid certificate to help deal with any future mental health issues. MEC has accommodated the needs of a staff member with multiple caring responsibilities to take additional ad hoc time off without her losing holiday entitlement, to ensure it is as stress-free as possible. The team-building exercises improved morale and developed closer working relationships. The family days enabled staff to understand the effect of work pressures on colleagues' home life.

Impact: the annual sickness rate per employee reduced from 4.25 days to 2.4 days. The charity achieved the gold standard of the better health at work award in November 2011 and their health and wellbeing programme has been used as a case study by the Department for Work and Pensions.

Effective leadership and line management training

Effective leadership and line management were further features of the MEC intervention (box 5). Line management training has been emphasised as an important intervention to improve workplace health and wellbeing. Line managers have a key role in improving workplace health and wellbeing. Good line management focuses on effective and open communication with employees, ability to identify and support people with health conditions and recognise early signs of mental health problems, an understanding that the health and wellbeing of employees is their responsibility, and adapting working practices or job roles where necessary.[37] Effective line management can lead to improved health, wellbeing and improved performance, and the reverse can be true of bad management.[37]

Senior management support and leadership are important for the success of interventions. A 2010 systematic review of empirical research found that leader behaviours (such as support or empowerment), the relationship between leaders and their employees and specific leadership styles were all associated with employee stress and wellbeing.[101] However, the processes linking leaders with employee stress remain unclear and more research is needed for a better understanding.[101] Axiom Housing Association is an example of an organisation that has used a participatory approach to leadership and management, empowering a staff consultative group as part of its overall strategy to improve health and wellbeing (box 6).

Box 6. Intervention: effective management in health and wellbeing – Axiom[102-104]

Who? Axiom Housing Association is a not-for-profit organisation that provides affordable mixed-tenure housing to over 5,000 people and employs around 170 staff.

Description: the organisation has a health and wellbeing programme involving staff-led team building days, an annual family sports day, training sessions, health checks and a reward and recognition programme. It has corporate targets and clear policies for managing sickness absence, with a focus on working with the employees to get them back to work as quickly as possible.

The staff consultative group is empowered to manage health and wellbeing programme initiatives, rather than taking a top-down approach of managing through corporate leadership. However, it still has the crucial leadership buy-in. Axiom found that the initiatives have more success if led by middle management, where staff engage 'horizontally' across 24 locations. Peer-to-peer management of projects and activities have been successful and are more likely to be sustained. Axiom has invested considerable time and resources into the staff consultative group and as a result it is a powerful body, with the position of chair now seen as a prestigious role within the organisation. Any HR matter is taken to the group first and they have representatives at the personnel committee. Here, they have the right to ask the executive to leave the room at any time if they wish to speak to the employee alone.

Impact: this management approach and health and wellbeing programme have had positive results. Annual sickness levels fell from around 13 days to 6.2 days per person between 2010 and March 2014. Axiom was awarded the Investors in People gold award (which looks at how employers work with, reward and develop their staff) and was listed as a Sunday Times Top 100 Employer in the not-for-profit sector in 2013.

Cost-benefit: the small budget for health and wellbeing is more than covered by the savings from reduced sickness absence.

Employee engagement

Employee engagement is, "a workplace approach designed to ensure that employees are committed to their organisation's goals and values, motivated to contribute to organisational success, and are able at the same time to enhance their own sense of wellbeing".[105] Employee engagement has been associated with business benefits including reduced sickness absence, and there are indications that work is more effective at improving health and wellbeing among more engaged employees. Evidence from the Sunday Times' 'Best Companies to work for in the UK' shows that companies who have higher levels of staff engagement (as measured by looking at parameters such as employee wellbeing, 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.[37] One estimate cited by Engaging for Success (box 7) suggests that engaged employees in the UK take an average of 2.69 sick days per year, whereas the disengaged take 6.19.[105] The Gallup Management Journal Employee Engagement Index survey of American employees found that among engaged employees, 62% feel their work lives positively affect their physical health, falling to 39% among not-engaged employees and 22%

among actively disengaged employees. In terms of mental health, 78% of engaged employees, 48% of not-engaged employees and 15% of actively disengaged employees feel their work lives benefit them psychologically.[106]

Engage for Success is a movement supported by organisations and individuals in the public, private and third sectors, committed to growing awareness about the power and potential of employee engagement, inspiring action among individuals and organisations. In 2008, the then Secretary of State for Business asked Engage for Success to report on the potential benefits of employee engagement for companies, organisations and individual employees. The report, Engaging for Success (the MacLeod Report), found extensive evidence of business benefits including reduced sickness absence, lower staff turnover and increased productivity and performance.[105] The report identified a number of drivers behind a successful engagement approach, outlined in box 7.

Box 7. Key literature: Engaging for Success: the drivers behind a successful engagement approach[105]

Engaging for Success (the MacLeod Report) was published in 2009. The report identified a number of drivers behind a successful engagement approach, and these were found to include:

- leadership which ensures a strong, transparent and explicit organisational culture which gives employees a line of sight between their job and the vision of the organisation
- engaging managers who offer clarity, appreciation of employees' effort and contribution, who treat their people as individuals and who ensure that work is organised effectively so that employees feel they are valued, and equipped and supported to do their job
- employees feeling they are able to voice their ideas and be listened to, both about how they do their job and in decision-making in their own department, with joint sharing of problems and challenges and a commitment to arrive at joint solutions
- a belief among employees that the organisation lives its values, and that espoused behavioural norms are adhered to, resulting in trust and a sense of integrity

Employee engagement is linked to many other identified features of a psychosocial work environment, including staff participation and control, effective leadership and line management and balance of effort and reward. Digital Outlook Communications and Artizian are examples of workplaces that have integrated a number of those 'drivers' described above, to implement a health and wellbeing programme, and both have experienced reduced staff turnover and sickness absence (boxes 8 and 9). Digital Outlook Communications implemented a programme in their workplace that included increasing employee control (flexible working), reward (promoting employee benefits), development (mentoring and development scheme) and reducing demand (reducing reliance on long working hours).

Box 8. Intervention: addressing the long hours culture – Digital Outlook Communications[93]

Who and why? Digital Outlook Communications is a London-based digital marketing and creative agency. The company sought to ensure that the intense, long hours culture of its industry did not become a barrier to sound health and wellbeing principles.

Description: the company conducted a best companies survey to obtain employees' feedback on their wellbeing and the perceived quality of leadership and management. A wellbeing team, supported by senior management, was established to gather suggestions for, and implement, initiatives which included: the introduction of flexible working; promotion of the employee benefits system; revamping the agency's charging system to enable employees to reduce working hours while still meeting financial targets; a mentoring and development scheme; improving the ergonomic working environment; and establishing health and wellbeing as a key performance indicator for all senior managers.

Impact: health and wellbeing survey scores improved 11%, better than for all other small media companies surveyed in 2008. Sickness absence rates improved 95% from four days per person in 2006 to 0.22 days per person in 2008. Staff turnover was reduced from 34% in 2007 to 9% in 2008, resulting in savings in recruitment, training and induction costs.

Box 9. Intervention: engagement through a shared company vision – Artizian[1]

Who and why? Artizian is a medium sized catering company which maintains a strong focus on the health and wellbeing of its staff.

Description: Artizian has a strong belief in a shared company vision, integrating employees' views into its work strategy, and making all senior management are known to all workers, keeping them visible and seen to work. The company offers yearly health and safety training for all staff, rather than the statutory requirement of training every three years. Artizian has highly visible policies on stress at work and seeks to ensure that staff are aware that their health will be a priority. The company employs a consultant and a nutritionist to monitor sickness and provide advice to staff. Its sickness benefits are comparable to similar companies, though staff do not often use these benefits, instead depending on other forms of support offered.

Artizian attributes the main elements of its success to:

- providing learning and development opportunities for staff at all levels
- committing to its values, even when times are difficult, including looking after redundancies and not cutting the training budget
- with permission, liaising with GPs to provide support to get employees back to work
- consulting with staff beyond formal statutory requirements
- rewarding the 'employee of the month' with a day off
- recruiting staff who hold similar values to the company and training managers to understand the company's values and its benefits

Impact: Artizian won the 2009 health, work and wellbeing award at the National Business Awards, for improving the health and wellbeing of the workforce in a way that also benefits the organisation. The company and its employees benefit from low levels of accidents, low staff turnover at all levels and low levels of sickness absence. This demonstrates that there are inexpensive methods to meet employees' psychosocial needs and provide a healthy workplace.

In-work development and training

The National Institute for Health and Care Excellence (NICE) recommends that employers promote mental wellbeing among employees through "motivate[ing] employees and provid[ing] them with the training and support they need to develop their performance and job satisfaction".[107] Developing staff through in-work training and development is featured in the interventions by Artizian and Digital Outlook Communications. This is likely to contribute to increased engagement among employees.

Flexible working

Flexible working is a way of working that suits an employee's needs, e.g. having flexible start and finish times, or working from home.[108] Greater flexibility within a role can increase the sense of control that an individual feels at work and give them an opportunity to improve their work–life balance, which is an important feature of good health that is less evident among those on lower job grades. Flexible employment can reduce barriers to employment for people with caring responsibilities and health conditions. However, flexibility should not come at the expense of job security (for example, via zero-hours contracts).

Where flexible working is part of a wider health and wellbeing strategy, there has appeared to be some positive results, though further and more robust research is needed. The pharmaceutical company GSK has understood the importance of flexible working arrangements, as well as other support for individuals in their life outside of work, such as family support services, stress management and resilience training (box 10). It has reported very good outcomes from its health and wellbeing programme and has exported the model to other organisations, showing that it is a transferable approach.

Box 10. Intervention: resilience, flexible working and health and wellbeing – GSK[93]

Who and why? GSK is a large, global company based in Brentford, London, that produces medicines, vaccines and healthcare products. It wanted to ensure employees remained physically energised, mentally focussed, emotionally connected and spiritually aligned to the mission of the company: to improve the quality of human life by enabling people to do more, feel better and live longer.

Description: a company-wide personal and team resilience programme was created, incorporating health and wellbeing initiatives which focussed on expertise, execution, behaviours and self-awareness. The range of initiatives supporting and enhancing employee wellbeing included on-site health and fitness centres, flexible working arrangements and family support services. Healthcare benefits focussed on prevention and access to innovative and proven treatments, including musculoskeletal and ergonomic improvement programmes, smoking cessation support, walking programmes, weight management programmes, blood pressure machines, health promotion and sleep road shows.

Impact: the company reports that its global work-related mental ill-health levels fell by 60%, working days lost fell by 29%, staff satisfaction increased by 21% and performance and productivity increased by 7-13%.

Reducing stress at work

The key feature of the GSK approach is its positive impact on mental health. This is particularly significant to employers, employees and health services, given that mental health is a leading cause of sickness absence.[90] Work-related stress and mental health problems in general, are more common among those of lower socio-economic status. Section 4.3 considers interventions that increase employment opportunities and retention for people with mental health problems; workplace stress management programmes and adapting working practices can contribute to these outcomes. Work by Transport for London (box 11) provides a further example of a workplace stress reduction programme that has shown positive impacts on mental health and sickness absence in the short and medium term.

Box 11 Intervention: stress reduction programme – Transport for London[109]

Who? Transport for London (TfL) is a public sector organisation responsible for managing and implementing most aspects of London's transport system. TfL employs almost 23,000 permanent employees, and around 60% of them work in operational roles.

Description: the organisation runs a stress reduction programme for employees that incorporates cognitive behavioural therapy, mindfulness and other techniques. It guides employees to master their symptoms of stress and develop a healthier approach to life. It is a very practical programme. Monthly follow-up sessions are offered and people can return at any time if they run into difficulty in the future.

Impact: the programme has been internally evaluated. Since 2009 around 600 employees have participated in the programme. Immediately following participation in the programme, nearly all participants said they made changes to their life as a result. The number of days off for stress, anxiety and depression among participants fell by 71% over the following three years, and continued to fall for up to five years. Absences for all conditions dropped by 50% over the three years following the programme. 80% participants reported improvement in their relationships; 79% reported improvements in their ability to relax; 64% improvement in sleep patterns; 53% improvements in happiness at work.

Addressing the effort–reward imbalance

Many of these interventions also address the effort–reward imbalance mechanism through which employees may experience poor health, identified in section 2.2. For example, Artizian achieves this by rewarding the employee of the month with a day off, Digital Outlook Communications and Expedition Engineering both offer practical employee benefits, and many of the interventions provide development opportunities. A study of health centre workers in the USA found that providing workers with rewards such as personal recognition, career promotion, and skill development opportunities, was associated with improvements in staff morale and reduced likelihood of staff burnout.[110]

Implementing a strategy to improve the psychosocial work environment

A review of staff health and wellbeing in the NHS by Dr Steve Boorman was published in 2009. It includes a number of recommendations to improve the psychosocial work environment, including health and wellbeing training for managers and engagement with staff (box 12). This shows how public sector employers can lead by example and it may be useful to local authorities and other local employers in setting up their own workplace health and wellbeing interventions.

Box 12. Intervention: the Boorman review and NHS workplace health and wellbeing[111]

Who and why? The 2009 NHS Health and Wellbeing report (the Boorman Review) made a number of recommendations to improve workplace health and wellbeing in the NHS.

Description: the recommendations included:

1. Develop and implement strategies for improving workforce health and wellbeing that provide services focussed on prevention and have a focus on the health issues that affect their staff and the wider population. This should include an assessment of key health priorities and risk factors, and an assessment of staff needs (to inform both the range of services and the way they are provided) through engagement with staff. As well as core services, strategies should include a range of properly resourced additional health and wellbeing services targeted at the needs of their organisation. All services should be available to all staff on an equitable basis.
2. Ensure leaders and managers are developed and trained in health and wellbeing (and the link between staff health and wellbeing and organisational performance) and have the skills and tools to support staff with mental health problems.
3. Clearly identify board-level champion and senior managerial support.
4. Implement NICE guidance on promoting mental health and wellbeing at work and National Mental Health and Employment Strategy guidance.
5. Provide consistent access to early and effective interventions for common musculoskeletal and mental health problems.
6. Develop the approach to improving support for staff health and wellbeing in consultation and partnership with staff and trade unions.
7. Routinely monitor, assess and review the implementation and delivery of staff health and wellbeing services, including discussion with staff and their representatives.
8. Embed staff health and wellbeing into NHS systems and infrastructure – including the NHS Operating Framework, the Care Quality Commission and Monitor.

Impact: an audit of workplace health and wellbeing services for NHS staff published in 2013 suggests that the recommendations have not been effectively implemented in many NHS Trusts, with 37% of trusts that responded admitting to not having a health and wellbeing strategy in place and sickness absence rates still high.[112]

However, the lack of success in implementing this strategy suggests that there are still questions around how best to implement workplace interventions to improve health and wellbeing.[112] A 2008 review of workplace stress and wellbeing interventions found that a lack of sustained management support was one of the most cited obstacles to successful intervention at the organisational level.[113]

Reducing health inequalities

People in lower paid jobs are more likely to experience poor working conditions, therefore general improvements in the quality of work and working conditions may help to reduce inequalities in work-related health problems.[114] Lack of control and lack of reward at work have been shown to

be critical determinants of a variety of stress-related disorders and to be more prevalent among lower occupational status groups. Focusing interventions around these dimensions and targeting less privileged groups within the workforce is a high priority.[1]

With health problems in organisations generally greater in lower employment grades, employers might gain the most benefit in terms of better employee health and reduced sickness absence by addressing the gradient in ill health and improving workplace practices in a proportionate way: that is, by focusing attention and effort increasingly down the social scale.[115]

It is particularly important that employers with a large number of low paid staff are engaged and encouraged to improve employment and working conditions, if health inequalities are to be reduced. Within individual organisations efforts should be made to ensure that interventions intended to improve health and wellbeing are available to everyone, and that those on lower job grades are considered during the design of the intervention and made aware of the opportunities available to them. Those working long or irregular hours or on non-permanent contracts are more likely to experience poor health (see section 2.2), so a focus on these employees may also contribute to reducing health inequalities.

4.2: Working with local employers to encourage, incentivise and enforce good quality work

Box 13. Key messages: how to work with local employers

There is clear evidence that local authorities can work with local employers to encourage, enforce and incentivise good work with many examples of good practice.

Local authorities have a number of levers: i) advice, ii) enforcement, iii) partnership, iv) incentives and accreditation, and v) procurement.

Local authorities can promote a considerable amount of guidance to local employers. Evidence-based sources of guidance include NICE guidance on promoting wellbeing at work, and Health and Safety Executive (HSE) guidelines on stress management and other aspects of work. They can also provide evidence on business benefits and the impact on sickness absence rates.

Local authorities can work in partnership with the HSE and others to ensure that local employers abide by their legal obligations, particularly around health and safety and non-discrimination.

There is evidence of programmes to incentivise employers to take action on workplace health and wellbeing. The incentives are provided through one or more of the following mechanisms:

- support and advice around how to implement effective policies and interventions, facilitating partnership working and promoting best practice
- provision of funding
- accreditation and rewards, providing the organisation with reputational benefits, making them more attractive to potential employees, customers and other stakeholders

Local authorities can encourage improvement in employee health and working conditions through the contractual levers of procurement.

There is also value in using the Social Value Act. Good working practices and providing employment opportunities for local disadvantaged people might be considered to bring social value and improve wellbeing locally.

Section 2.2 provides evidence of the link between good quality work and health inequalities. Local authorities can work with employers, to ensure that physical and psychological working conditions are to the best possible standard. Possible ways of doing this are discussed below, illustrated with existing interventions.

The figures on reductions in sickness absence and staff turnover found in many of the interventions in the previous section indicate that workplace health, wellbeing and engagement programmes are likely to have financial benefits for the employer. They can be used as part of a business case to inform engagement with local employers.

Promoting available evidence and guidance

There is a considerable amount of guidance available that local authorities can promote to local employers and use to inform their efforts. Evidence-based sources of guidance include Acas and NICE guidance on promoting wellbeing at work, Health and Safety Executive (HSE) guidelines on stress management and other aspects of work, and a range of charitable organisations. Some examples of the best evidence-based sources of guidance are provided in boxes 14 and 15.

Box 14. Key literature: Health and Safety Executive (HSE) stress management standards[116]

The HSE stress management standards provide a preventative approach to reduce work-related stress by targeting six main working conditions that, if not properly managed, are associated with poor health and wellbeing, lower productivity and increased sickness absence. It specifies management practices that help to ensure that these potential sources of stress do not act as stressors for employees.

The management standards are:

- demands – this includes issues such as workload, work patterns and the work environment
- control – how much say the person has in the way they do their work
- support – this includes the encouragement, sponsorship and resources provided by the organisation, line management and colleagues
- relationships – this includes promoting positive working to avoid conflict and dealing with unacceptable behaviour
- role – whether people understand their role within the organisation and whether the organisation ensures that they do not have conflicting roles
- change – how organisational change (large or small) is managed and communicated in the organisation

A report prepared by the University of London for the HSE in 2006 reviewed existing literature to determine the extent that effectively managing these stressors is associated with beneficial business outcomes. It found evidence that each of the six working conditions led to some improved business outcome(s), such as better performance, less absenteeism, less turnover intention and/or less withdrawal behaviours.[117]

An example of a local authority adopting the stress management standards is Doncaster Metropolitan Borough Council. More detail on how they implemented the standards, what they found and the challenges they faced, can be found on the HSE website.[118] The number of stress-related sickness days lost fell by 13,194 from 39,699 days for 2008-09 to 26,505 days for 2009-10.[118]

The standards were designed to help employers meet their general obligation to assess and manage physical and mental health risks but are not legally enforceable, and employers are free to take other action.[119]

The HSE provides further guidance on safety and preventing physical injuries and accidents in the workplace.

Box 15. Key literature: NICE – promoting mental wellbeing at work

NICE guidance is particularly helpful, given that it is based on the most robust available evidence and takes into account the cost-effectiveness of a range of interventions. Relevant NICE guidance includes 'Workplace interventions to promote smoking cessation' and 'Promoting physical activity in the workplace', both of which provide guidelines and recommendations on why and how to intervene effectively to improve healthy behaviours.

Guidance on 'Promoting mental wellbeing at work' makes recommendations in the following areas:

1. taking a strategic and coordinated approach to promoting employees' mental wellbeing
2. assessing opportunities for promoting employees' mental wellbeing and managing risks
3. flexible working
4. the role of line managers
5. supporting micro, small and medium-sized businesses

Enforcing legal obligations

Employers have legal obligations to abide by a number of Acts and statutory instruments relevant to the working environment.

The Health and Safety at Work etc. Act 1974 covers occupational safety in Great Britain, and it is the responsibility of the HSE and local authorities to enforce this as well as a number of other Acts and statutory instruments. Local authorities are responsible for regulating health and safety in over a million workplaces, employing about half the British workforce, and the HSE is responsible for the rest.[120] There are examples of local authorities working in partnership with the HSE to enforce health and safety regulations in the workplace, to prevent accidents and injuries – several interventions are discussed in box 16. These partnerships are likely to be equally valuable if they are used to encourage good psychosocial working conditions, for example to encourage the adoption of the HSE stress management standards.

Box 16. Interventions: local authorities working in partnership with the HSE to enforce health and safety legislation[120]

Improving workplace safety and reducing crime: an innovative idea saw one council's health and safety regulatory officers working with police crime prevention staff to use health and safety powers to reduce crime at retail premises where staff had been violently assaulted during the course of a robbery. Modifying the counter and repositioning door signs have improved the safety of the workplace and brought about a reduction in crime.

HSE and council regulatory officers working together to improve standards among aerial installers: in anticipation of increased activity among aerial installers prior to the switchover of UK TV signal from analogue to digital, the six North Wales local councils and HSE worked together to target health and safety in the industry. In order to ensure that both HSE inspectors and council regulatory officers had appropriate knowledge of the safe systems of work for work at height during domestic aerial installations, they attended the industry training course on work at height and became familiar with the industry-developed code of practice. Council officers were given flexible warrants so that they could take enforcement action across the board on behalf of the HSE. This meant that council officers were not limited to dealing with issues at retail shops but could also challenge and inspect installers during installation of aerials and satellite dishes in domestic premises. The initiative has led to a significant number of improvement notices requiring installers to undergo training in safe work at heights.

Improving manual handling in licensed premises: following a successful joint HSE/council pilot in Blaenau Gwent and Cardiff, all 22 local authorities in Wales participated in a project to improve manual handling practices in pubs and other licensed premises. During the pilot, a training DVD was developed to assist landlords in providing suitable manual handling training for what is sometimes a transient workforce. Approximately 600 premises were visited by council regulatory officers using an inspection toolkit including benchmark standards, ensuring a consistent enforcement approach across Wales. Initial evaluation indicates substantial improvement within both the drinks delivery sector and the licensed trade, and further visits are planned.

Partnership to reduce radon exposure for employees: in Cornwall, Penwith and Kerrier District Councils joined forces to tackle radon exposure in local workplaces. Located in high-risk radon areas, the local councils' health and safety regulation teams provided practical advice to businesses on how to reduce radon exposure to their employees. Actions included a letter drop, visits and an evening seminar for business managers, supported by an HSE specialist and the National Radiological Protection Board. The key message delivered to business was that doing a risk assessment and introducing control measures could minimise exposure to radon, and therefore reduce the risk of cancer incidence in local workers.

Preventive action with leisure workers: health and safety regulatory officers from five Scottish councils worked with HSE to inform and advise employers who work at leisure venues ranging from golf courses to sports grounds and hotels undertaking outside maintenance jobs such as grass cutting, hedge trimming and weed control. Safety awareness days gave employers and employees the opportunity to see a number of health and safety scenarios relevant to their industry and learn how to control the risks to themselves and others. At the end, delegates were asked to identify areas in which they could improve.

Reducing employee exposure to asbestos: a campaign to highlight the 'Asbestos: Duty to Manage' requirements took place in Suffolk. All seven councils within the county participated, together with HSE inspectors, targeting premises across a range of sectors. The project was organised by councils and delivered by 35 regulatory officers and HSE inspectors. Over 1000 duty-holders were contacted by mail. Press notices resulted in three radio interviews and two press articles, which helped to increase awareness and impact. This project enabled council regulatory officers and HSE inspectors to work together on a proactive campaign across sectors and geographical boundaries, testing the use of their flexible warrants – breaking down barriers to enforcement. Over 450 visits took place in seven days, 24 enforcement notices were served and action resulted in significant improvements in over 200 premises.

Other legislation contributes towards a positive psychosocial work environment. The government will extend the right to request flexible working to all employees from April 2014. The Equality Act 2010 makes it more difficult for specified 'equality groups' including disabled people, those of a particular age or gender or minority ethnic groups, to be discriminated against at work or in recruitment processes. Given that local authorities have a duty to consider how their activities as employers affect people from these different equality groups, and how the decisions they make and the services they deliver affect these groups,[121] they might also consider how other local employers consider these groups, particularly those employers with which they have contractual agreements. We were unable to find evidence of how local authorities might engage with employers in this area, and we would welcome further research.

Enforcing legal obligations will prevent injuries and accidents associated with physical, chemical and ergonomic workplace hazards, and improve the psychosocial work environment. Given the greater likelihood of poor working conditions among those lower on the socio-economic scale, enforcement is likely to have resulting health and health equity impacts.

Incentivising action through support, funding and/or accreditation

There is evidence of programmes to incentivise employers to take action on workplace health and wellbeing. At a national level, the occupational health advice lines provide free support to small and medium sized businesses that face challenges in accessing occupational health; 92% of users found the service useful in an evaluation (box 17).

Box 17. Intervention: occupational health advice services[122]

Who? The Department for Work and Pensions piloted the occupational health advice lines from 2009–14.

Description: The advice lines provided British small and medium sized enterprises (SMEs) with access to high quality, professional advice in response to individual employee health issues. Occupational health advice services were provided free of charge to SMEs and their employees who faced challenges accessing occupational health advice.

Impact: The service was evaluated and an employer survey found that 92% of users found the service useful, and around the same proportion said they would recommend it to others. The majority of questions from employers were about sickness absence, attendance management issues or advice on the fit note, and sometimes the service was a gateway to other services such as legal advice. The pilot was extended to 2014 and developed an interactive web resource. The service was also made available to GPs following the launch of the fit note in 2010. (See 'Supporting employees on long-term sick leave back into work', section 4.3 below, for more on the fit note.)

Two initiatives ran from 2009 to 2012, the health, work and wellbeing coordinators and Challenge Fund (box 18). The coordinators' role was aimed at developing partnerships between employment and health networks, coordinating health, work and wellbeing strategies and activities within and between regions, promoting best practice and innovation in firms (including via the Challenge Fund). The Challenge Fund was aimed at small and medium sized enterprises (SMEs) and local partnerships to encourage initiatives to improve workplace health and wellbeing through innovative approach which ensured employee engagement.

Box 18. Intervention: Health, Work and Wellbeing Challenge Fund[123]

Who? The Health, Work and Wellbeing Challenge Fund was funded by the Department for Work and Pensions and ran from October 2009 to April 2012.

Description: it was established to encourage SMEs and local partnerships to implement initiatives to improve workplace health and wellbeing through innovative approaches that ensured worker engagement. The fund of £4 million invited applications for grants of between £1,000 and £50,000. Research found that helpful aspects of project implementation included good project design, flexibility, availability and reliability of local providers. Employees' participation in activities was influenced by their timing, location, content, format and cost, and by people's personal motivation.

Impact: 86% of fund winners surveyed thought the fund had been necessary for implementing activities, either by supplying money or by providing the idea about putting measures in place. Over 60% of fund initiatives were expected to continue beyond the funding period.

Factors with a positive effect on sustainability included activities perceived to be successful, management commitment, initiatives that had become established within workplace practices, positive employee motivation, and external factors such as government promotion and local accreditation schemes. Whether and how activities would be funded was also important – a lack of funding was cited in over 50% of the instances where an initiative would not continue.

The most immediate impacts of the fund reported by those managing projects were on workplace culture and increased knowledge about work and health. The greatest impact reported on employee health was on mental wellbeing.

The research concluded that grants provided by the fund for a specific agenda can kick-start new activity, though not necessarily guarantee sustainable change. Sustainability was more likely when there was a permanent change in the physical environment, where the benefits were clear and considered worthy of investment of time and money, and where local supportive schemes were in place.

The North East Better Health at Work Award also provided support for workplace health programmes and similarly was found to be a success at engaging employers, though at a regional level. The focus of this intervention was accrediting successful employers, according to set criteria, providing the organisation with reputational benefits, making them more attractive to potential employees, customers and other stakeholders.

Box 19. Intervention: North East Better Health at Work Award[124]

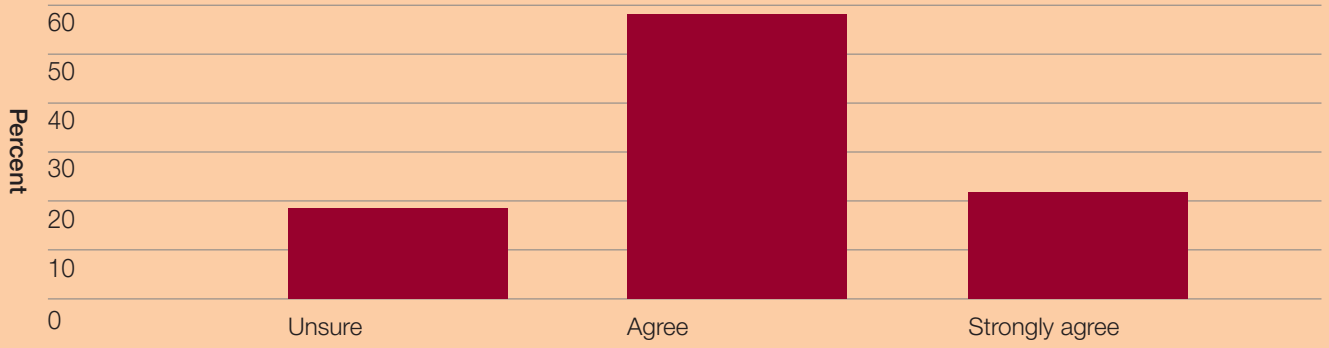
Who? The North East Better Health at Work Award (BHWA) is a structured and evidence-based workplace health programme coordinated regionally by the Northern Trades Union Congress (TUC), in partnership with the 12 local authorities in the region, the Association of North East Councils and the NHS and delivered locally through workplace health specialists.

Description: each stage of the BHWA (bronze, silver, gold, continuous excellence) is usually completed within a year and is characterised by a set of outcomes and distinct assessment criteria. Participation in the BHWA is free of charge but requires investment from workplaces in the form of staff time, training and resources. All organisations joining the BHWA sign up to the Better Health at Work Charter, in which they agree to work to improve the health of their employees.

Impact: an evaluation found that:

- 232 businesses and organisations with 209,319 employees actively participated in the BHWA from 2009–12 and covered 21.4% of the working-age population in the North East
- 232 bronze, 116 silver, 56 gold and 19 continuous excellence awards were achieved. 86 businesses and organisations withdrew without receiving an award
- there was a high level of organisational agreement (81%) that the BHWA improved staff health (see figure 6), while 66% agreed or strongly agreed that the scheme improved staff morale

Figure 6. Bar chart indicating levels of organisational agreement (%) that the BHWA improved staff health



Source:124

- mean reductions in sickness absence were between 0.26 and 2.0 days per employee depending on the length and level of participation in the BHWA and sector of employment. Public service organisations seemed to benefit most
- generally it was felt that the programme and the award criteria for each level were appropriate for larger businesses and organisations, though there was no consensus about the minimum size of organisation that would benefit

Cost-benefit: the cost of the regional coordination was £80,000 per annum and the overall cost to the NHS was estimated at £615,000 per annum. The estimated cost of the BHWA to the NHS (PCTs and public health) which funded the programme was £3 per sickness-absence day saved. Employers saw a reduction of 0.007–1.1 days of sickness-absence for every pound they invested, depending on the level of the award (suggesting bronze offered best value for money). The evaluation concludes that the BHWA is an efficient and cost-effective workplace health improvement programme.

National standards for the Workplace Health and Wellbeing Charter will be published shortly by PHE. This is a local accreditation scheme for businesses engaging in improvement actions for staff wellbeing, led by local government for local businesses. It builds on the 2009 Liverpool Workplace Wellbeing Charter.

The Public Health Responsibility Deal is a national intervention offering a set of pledges for organisations, including a section on health at work. As yet, there has been no evaluation to ascertain how effective this programme has been in incentivising employers to improve health at work or in improving the health and wellbeing of employees. Plymouth Better Together demonstrates how local areas can work in partnership to encourage employers to sign up to these pledges, though again this has not been evaluated.

Box 20. Intervention: Public Health Responsibility Deal[125]

Who? The Department of Health

Description: the Public Health Responsibility Deal has a section on health at work, and has a set of collective pledges to which organisations can sign up, and a health at work network which can be beneficial both by allowing organisations to share good practice in improving workplace health and wellbeing, and by providing the incentive of a business network for those who participate. A further benefit is, similar to a form of accreditation, that they will gain reputational benefits among employees, potential employees and the public.

The Public Health Responsibility Deal includes a set of Health at Work Pledges, which support the workforce to lead healthier lives. Annual progress on delivering the pledges will be reported and published on the Responsibility Deal website. The collective pledges are as follows:

1. Chronic conditions guide[168]
2. Occupational health standards[218]
3. Board reporting on health and wellbeing[238]
4. Healthier staff restaurants[166]
5. Smoking cessation/respiratory health[106]
6. Staff health checks[120]
7. Mental health in the workplace[86]
8. Young person's health at work[21]
9. Domestic violence[37]
10. A pledge specific to the construction industry[58]

Impact: there has been no evaluation of this programme, though the number of signatories for each pledge (in brackets after each pledge in the list above) indicates that it has successfully engaged some employers to some extent.

Box 21. Intervention: Plymouth Better Together partnership[126]

Who and why? Plymouth Better Together is an ongoing partnership initiative between Plymouth Chamber of Commerce and Industry, Plymouth 2020 (Local Strategic Partnership) and Business in the Community.

Description: it aims to promote the economic, social and environmental wellbeing of the city through active engagement with the local business community. It encourages businesses to sign up to pledges including those to encourage staff to exercise, stop smoking and eat healthily, offer staff health advice, have and publicise a stress reduction policy, consider personal issues affecting people at work and help them cope, and win a health at work award. It also identifies local partners that have the facilities to help companies deliver their pledges. The project is run by a project manager working two days a week.

The partnership holds better business breakfast workshops, giving advice and guidance on a variety of health at work-related topics, including how a healthier workforce can make a healthy and sustainable business and further extend to the wider community, and how organisations have used these principles and applied them to the workplace.

Impact: 187 companies had signed up by April 2013, representing over 23,000 employees.

Encouraging action through procurement using the Social Value Act

The Public Services (Social Value) Act 2012 requires local authorities to consider how what is being procured through contracts might improve the economic, social and environmental wellbeing of the local area. Good working practices and providing employment opportunities for local disadvantaged people might be considered to bring social value and improve wellbeing locally. Box 22 shows how the Social Value Act has been used to provide training for long-term unemployed people.

Box 22. Intervention: Waltham Forest procurement of transport services[127]

Who and why? The London Borough of Waltham Forest re-tendered a seven year contract for the provision of transport services in September 2011.

Description: the procurement officers included a scored question in the tender, asking bidders to demonstrate how they could contribute to efficiencies and give added value to the service, encouraging bidders to think about how they could achieve a wider impact from their services for the local community.

Impact: the contract was won by HCT Group, a social enterprise group with a focus on creating employment opportunities for those furthest from the labour market. There was also space on the contract to set out the additional social impact of the approach, explaining that any profits it made on the contract would be reinvested into a learning centre that would provide training for long-term unemployed local people. This demonstrates how procurement can be used to act on employment in the local area.

Action through procurement, improving working conditions and the health of outsourced and contracted staff, might help to reduce health inequalities. This is because those staff are less likely to enjoy certain benefits given to directly employed staff. A recent report of an audit of NHS Trusts in England found that their knowledge of contract workers and outsourced services, often on low pay, was poor, despite the fact that they often worked alongside NHS staff. They found that only 52% of trusts allow outsourced staff access to their services to promote mental wellbeing, 66% required the contractor to provide flexible working and 68% required contractors to be paid the living wage, though a higher proportion (83%) report that fair terms and conditions are included in procurement conditions.[128]

4.3: Interventions to increase employment opportunities and retention for people with a long-term health condition or disability

Box 23. Key messages: long-term health condition and disability interventions

There is a role for local government to promote and increase awareness of national programmes (such as Access to Work), guidance (such as the Line Manager's Resource) and legislation (such as the Equality Act 2010 and the right to request flexible working) among local employers. Local authorities may be able to influence provision of employment services by ensuring that employment service providers are members of health and wellbeing boards and take part in joint strategic needs assessments.

Barriers to employment faced by people with a disability or long-term health condition include a health-related inability to do some jobs, employer discrimination, disruption to education and individual motivation.

Campaigns such as Time to Change help to break down stigma and discrimination around mental health problems.

Some workplace barriers can be overcome through physical adaptations to the workplace and help with travel arrangements. Greater awareness of Access to Work can support this.

Personalised, tailored support has been shown to be effective in supporting disabled people and people with long-term health conditions into work or training. This requires action across a range of services, employment and health services in particular, to address a range of needs.

Local areas can work with and support both employees and employers to increase employment opportunities and retention for disabled people. There are examples of effective supported employment programmes and employment support services for local people with mental health problems.

While a 'work first' approach has generally been adopted that prioritises job goals and work activity to help people with long-term health conditions into employment, an alternative 'health first' service has the objective of improving the health of participants as a way of improving employability. It is recommended by NICE, and a local pilot in County Durham had some promising results.

There is good evidence that individual placement and support programmes are effective for unemployed people with severe mental health problems.

Supporting employees on long-term sick leave back into work might be facilitated by the fit note and the new health and work service. Interventions by companies such as Tate & Lyle to support long-term ill people back into work have reported reduced staff absence.

Why implement interventions to increase employment opportunities and retention for those with a long-term illness or disability?

In addition to the detrimental impacts of unemployment on health, being in poor health may limit opportunities for employment. This suggests that action on unemployment is likely to have health benefits, and that unemployment cannot be addressed without considering the additional health needs of many of those who are out of work.

There are a number of barriers to employment for people with a disability or long-term health condition that can be addressed by a combination of working with the individual and implementing or encouraging actions which break down these barriers. Barriers include a health-related inability to do some jobs, employer discrimination, disruption to education and individual motivation.[129]

The Work Foundation carried out some research of young people with chronic conditions and found that negative employer attitudes (and fear of these attitudes) meant almost all participants continued to go to work even when experiencing negative side effects of their condition. The research found that 'self-stigma' was also a significant barrier to employment, and affected career aspirations, job-seeking activities and help-seeking behaviours.[130]

This research also found that many of the participants had experienced disruption to their education and training in earlier life because of their conditions, and one of the main reported reasons for this was educational establishments being unable or unwilling to make adjustments. Many participants felt that they had not reached their full education potential, which is likely to have inhibited their later employment opportunities.[130]

The symptoms of impairment and long-term health conditions can affect an individual's capability for work, and therefore unemployment cannot be addressed without considering health. Reasonable workplace adjustments, as required by law, should help to accommodate people with health problems at work: for example, flexible working opportunities are likely to facilitate the employment or retention of someone with an unpredictable chronic condition that may require frequent visits to the doctor. For others, however, more personalised assistance which addresses their health and employment needs will be required.

Examples of existing interventions

There have been some reviews of interventions for people with a long-term illness or disability to stay in or return to work, though it is noted that robust evaluation and cost-benefit analyses are rare. Key messages from two of these reviews are given in boxes 24 and 25. They highlight the importance of an individualised approach, a change of perception of their abilities among disabled people, physical adaptations in the workplace and help with travel arrangements, specialist rather than generalist personal advisers and additional support for long-term unemployed. There is reasonably strong evidence for workplace interventions for those with musculoskeletal disorders; cognitive behavioural therapy (CBT), vocational rehabilitation and workplace rehabilitation for low back pain; supported employment for people with severe mental health conditions; and psychological interventions for depression.

Box 24. Key literature: local initiatives to help workless people with a long-term health condition or disability find and keep work[129]

A study of local initiatives to help workless people find and keep work concluded that the key messages arising from all the evaluations concerning long-term illness and disability are:

- an individualised approach is essential
- participants need help to change their perception of themselves and to shift their focus from what they cannot do to what they can
- physical adaptations in the workplace and help with travel arrangements can have a marked impact for those with physical disabilities
- personal advisers who have developed expertise in the needs of particular types of client and the requirements of particular employers are more effective for long-term sick and disabled people than generalists are
- those who have not worked for a long time need help in adapting to the workplace

Box 25. Key literature: quantifying the effectiveness of interventions for employees with common health conditions in enabling them to stay in or return to work – a rapid evidence assessment[131]

A review of interventions for people with common health conditions in enabling them to stay in or return to work considered evidence from 2008-11. It found the following results:

- studies generally lack robust quantification of employment outcomes and cost-benefit analyses of interventions; relatively little quantitative evidence is apparent for interventions carried out in the UK
- areas for which there is a reasonably strong body of evidence with positive effects include:
  - workplace-based interventions for those with musculoskeletal disorders particularly for low back pain
  - CBT, vocational rehabilitation and workplace rehabilitation for low back pain
  - supported employment for people with severe mental health conditions and psychological interventions for depression
- there is some evidence of the benefits gained for coordination between rehabilitation professionals and the value of a case management approach among studies examining interventions for people with general health conditions
- little evidence exists on the effectiveness of interventions for employment outcomes among people with mental health problems
- there are very few studies on cardio-respiratory conditions, and none for respiratory illness
- it is difficult to assess employment outcomes even when they are available, as many studies do not include mention of whether return to work is sustained

See appendix 1 for a table summary of health conditions, interventions, evidence base and effects, based on this literature.

National level programmes to increase employment opportunities and retention
Several nationwide programmes exist to help people with a long-term illness or disability, to find and keep a job. Local authorities can engage with these programmes for their own employees and work to ensure that local employers are aware of them.

People with health conditions have been less likely to leave benefits and enter employment than those without.[77] The Work Programme is an integrated welfare-to-work measure introduced nationally in June 2011, targeted at people who have been out of work longer-term, including long-term sick or disabled people, and providing support for up to two years to help them into sustainable work. It gives 'prime' providers and specialist subcontractors considerable freedom to develop innovative provision for the individuals they support.[132] Funding is provided through staged payments at engagement, sustained job outcomes of three or six months, and further sustainment in work thereafter with the aim of ensuring there is a focus on sustaining people in work as well as getting them a job in the first place.[133] Early evaluations of the Work Programme have identified some challenges with ensuring personalised appropriate support generally, and in particular for people with health conditions, addictions or more complex needs – full outcomes remain to be seen.[132 134]

Work Choice is a voluntary, specialist national programme providing support for disabled people in finding and sustaining a job or becoming self-employed. Evaluations showed that Work Choice had some success, though less so for people with mental health problems.

Box 26. Intervention: Work Choice[77 133 135]

Who? Work Choice is a government-funded national programme, introduced in 2010.

Description: the scheme is a specialist, voluntary employment programme for disabled people, providing help through all stages of finding and getting a job, help to stay in work, and help for those who want to become self-employed.

Impact: an evaluation of the 2011 and 2012 phases identified areas for improvement, such as with access to the programme and the commissioning strategy. However overall, participants and providers reported that the programme had a positive impact in terms of participants' ability to secure and maintain employment. Its performance appears to have improved over time.

From October 2010 to March 2013, Work Choice supported 16,840 people into paid employment, representing 31.2% of programme users. However, only 2,060 job starts were recorded for people with mild to moderate mental health conditions and only 130 for people with severe mental health problems.

Aside from Work Choice, we were unable to find evidence of successful interventions to support people with a disability or long-term health condition into self-employment. This is particularly relevant to some groups such as gypsy and traveller communities where there is a preference for self-employed work. Further, it is a potential area where future action could be developed.

Access to Work is a DWP programme for disabled employees or those with a firm job offer, that provides money towards the extra costs that will help a disabled person do their job, beyond what is reasonable for their employer to meet (box 27). It is accessed by the employee contacting the scheme directly. The programme evaluation found that levels of awareness of the scheme were low among employers, and there was widespread support for increasing awareness. Therefore, local authorities raising awareness of the programme among local employers and employees is likely to be welcome and valuable.

Box 27. Intervention: Access to Work[136]

Who? Access to Work is a national programme funded by DWP.

Description: the programme is designed for people with long-term health conditions or disabilities who need additional practical support to gain or remain in work, in addition to the 'reasonable adjustment' made by employers in accordance with the Equality Act 2010. The types of support provided includes special aids and equipment, adaptations to premises and equipment, travel to work grants, support workers and communicator support at interview.

Impact: a qualitative evaluation including in-depth interviews with a range of stakeholders found the following results:

1. Fairly low levels of awareness of Access to Work among employers.
2. Customers and employers were generally very happy with the amount and quality of support that had been put in place, and received a broad range of support.
3. Customers who received ongoing support were most likely to report high levels of satisfaction. Customers who received one-off types of help were most likely to experience some difficulties, although these cases were still in the minority.
4. Customers reported positive impacts of the programme including:
    - reduced levels of sickness and absenteeism
    - provided a level playing field in employment
    - allowed them to stay in work
    - saved them significant work-related expense
    - improved their general feelings of wellbeing
    - being more in control at work and more autonomous
5. employers reported that Access to Work had:
    - helped them to understand the needs of their disabled employees
    - improved employee wellbeing
    - increased productivity
    - improved their staff retention rates
    - enabled them to recruit disabled people (in a few cases)

National legislation and guidance may be of use for local authorities in efforts to increase employment opportunities and retention of people with a disability or long-term illness, among their own existing and potential employees, and other local employees. The Equality Act 2010 requires that long-term ill and disabled people are not discriminated against at the recruitment stage or during their period of employment. The right to request flexible working, according to a DWP report, "reflects the fact that greater access to flexible and part-time working opportunities can help employees of all ages to stay in employment while managing a health condition or other pressures, such as caring".[77] Guidance, such as the line managers' resource, a practical guide to managing and supporting people with mental health problems in the workplace (box 28), are available for staff at all levels.[137]

Box 28. Key literature: line manager's resource – managing and supporting people with mental health problems in the workplace[137]

This resource aims to provide line managers with advice and information on how best to promote the mental wellbeing of employees, practical guidance on how best to manage situations that can arise at work when staff experience mental health problems, and to reduce the fear and lack of understanding around engaging with someone experiencing mental health problems. The areas for action are:

- the recruitment process
- promoting wellbeing
- identifying the early warning signs and talking at an early stage
- keeping in touch during sickness absence
- returning to work and reasonable adjustments
- managing an ongoing illness while at work

Action by private organisations to increase employment opportunities or retention
Interventions to increase employment opportunities and retention of people with a long-term illness or disability have been delivered by individual private companies, as shown in box 29. These illustrate how companies can be supported by national programmes (eg, Remploy and Access to Work) and how such action can be positive for both employees and employers.

Box 29. Interventions: companies that have increased employment opportunities and retention of people with a disability or long-term condition[77]

Sainsbury's has recruited over 2,000 disabled people in four years by working with Remploy Employment Services to encourage and support greater numbers of applications from disabled people. The company has reported a positive impact on business, both from the reaction of non-disabled people in their workforce – due to the positive feelings of inclusion from working in a more diverse environment, and from customers – due to the experience of encountering a more representative workforce.

E.ON has developed its recruitment supply chain to ensure that all employment agencies supplying staff to them demonstrate their commitment to fair and inclusive practices.

BT has developed passports for members of staff that reflect individuals' requirements, facilitating easier moves between teams and jobs. This approach helps to overcome anxieties which otherwise can reduce the possibilities of progression, resulting in more confident employees and increased overall morale and productivity.

Lloyds Banking Group has developed a comprehensive reasonable adjustments programme. This has included using Access to Work to finance necessary adjustments and support. The result has been an environment in which disabled people are given the necessary tools and assistance to work effectively. Reasonable adjustments can be key to retaining valuable employees who may otherwise be unable to continue working.

Local authority action to get people into employment

There are many examples of councils that have had success with programmes providing support for people with a disability to find employment. Innovative approaches can help to remove the barriers to employment – examples from Kent and Sheffield are provided in boxes 30 and 31. In Kent, tailored support is provided to the unemployed individual, and support is also offered to employers looking to recruit. In Sheffield, a plan brings together actors from different sectors, particularly health and employment, to overcome the barriers to employment for disabled people.

Box 30. Intervention: Kent Supported Employment Programme[138]

Who? Kent local authority funds the Kent Supported Employment Programme.

Description: the programme provides support for disabled people who are looking for a job, to enable them to have the same opportunities for employment as non-disabled people. An employment adviser meets with the jobseeker on a regular basis and provides tailored help to prepare them for work. The ongoing support helps them to retain a job and progress and develop in that job role. The council also provides employers who are looking to recruit to a role with the right help and support so that both the employer and the employee have a positive experience of employment.

Impact: a study of this programme in the period March 2009–February 2010 found that 118 people were supported in paid jobs (57 were employees with learning difficulties; the remainder were people with mostly mental health problems, severe physical disabilities and autism), all of whom had been identified as requiring specialist employment provision.

Cost-benefit: using the whole client group and the total budget of the programme, a cost-benefit analysis was carried out. The cost of the programme was estimated to be £9,910 per person, 88% of the cost of a day service place or a potential saving of £1,290 to the local authority. From the taxpayer's perspective, the programme has a net saving of £3,564 per person per year compared with a day service alternative.

Box 31. Intervention: Sheffield Health, Disability and Employment Plan[139]

Who and why? The Sheffield Employment Strategy was agreed by Sheffield Executive Board in 2010 and established five priority areas for action, one of which was around removing and managing health barriers to work. This priority was reflected in the city's health and wellbeing strategy, which recognised specific areas where the health and wellbeing board could make a difference by creating 'work programmes'. It was agreed that one of these work programmes should be 'health and disability and employment', overseen by the leader of the council and the chair of the clinical commissioning group (CCG).

Description: the Health, Disability and Employment Plan is based around overcoming disability and health barriers to employment. It is based on a premise that good work is generally good for health for disabled people and non-disabled people, that there are barriers to employment for disabled people that are possible to overcome and that the employment and health worlds are insufficiently joined up.

The plan has been developed through engaging expertise from a range of stakeholders, including Sheffield City Council, Sheffield Health and Social Care Trust, Sheffield Occupational Health Advisory Service, the Department for Work and Pensions, Sheffield and Sheffield Hallam Universities and Sheffield CCG. At a practical level, the plan outlines actions for individuals at different stages of employment (those in work and at work, those in work but struggling, those in work but not currently working, and those who are unemployed), to ensure that it supports people to both obtain and maintain work. An example of action is the proposal for the development of a referral pathway from primary care (GP surgeries) into employment support. This is still at development stage but has secured funding support from public health and has been agreed in principle by the Cities Employment Task Force and the health and wellbeing board.

One particular approach, recommended by NICE, is the 'health first' approach. This focuses on improving and managing the ill health of Incapacity Benefit recipients before addressing any employability issues. This approach was piloted in County Durham (Box 32) and had some promising results, including improvements in both the general and mental health of participants. A review states: "It was a small scale pilot, and while its success may not be replicable in different contexts, it does offer a potential model for local public health partnership working. It is one example of how local CCGs, local Work Programme providers and local authorities could work together in the future."[140] Further work to confirm these pilot findings would be helpful.

Box 32. Intervention: County Durham Worklessness and Health Model[140 141]

Who and why? County Durham and Darlington Primary Care Trust piloted a 'health first' approach to reducing worklessness in partnership with Durham County Council and the South of Tyne and Wear Jobcentre Plus. In 2009 they commissioned a 'health first' case management service for those in receipt of Incapacity Benefit (IB).

Description: the programme used telephone and face-to-face case management to identify individual health needs and any other related barriers to employment an individual may be experiencing, such as around debt or housing. The scheme complemented mainstream services with case-managers, signposting patients to relevant NHS, DWP and third sector health and welfare services such as Citizens Advice. Patients were referred onto the programme by other NHS services, their GPs, or they could self-refer. The intervention lasted an average of six months and involved around 500 patients on a voluntary basis. The objective of the service was to improve the health of participants as a way of improving employability and reducing health inequalities for those in and out of work for three years or more.

Impact: the evaluation of the pilot programme found that, within six months, both the general health and mental health of participants improved. For example, general health scores (measured on a scale of 0 (low) to 1 (high)) almost doubled from 0.3 before the intervention to 0.5 after six months.

There was less improvement in terms of physical or musculoskeletal health. This may have been because the service was not intensive enough, of sufficient duration, or because the point of intervention (ie, after three years of receiving IB) was too late. There is evidence to suggest that musculoskeletal conditions require early intervention and that longer absence from work diminishes intervention effectiveness.

The pilot suggested that 'health first' initiatives can be successful, but:
Must be targeted carefully at those with the greatest health needs and with mental health problems as a primary condition; and
Require an awareness of the local context, including other services and the levels of social support in the locality.

Cost-benefit: Overall, the intervention cost £2,530 per participant – meeting NICE cost guidance for case management interventions. Tentative estimates of cost-utility suggest an intervention cost in the region of £16,700–£23,500 per quality-adjusted life year (QALY).[iv]

[iv] For more information about QALYs, see accompanying evidence review on "measures of economic impact".

Local authorities may be able to influence provision of employment services by ensuring that employment service providers are members of health and wellbeing boards and take part in joint strategic needs assessments.

Interventions for people with mental health problems

Around one in six people of working age has a common mental health problem like anxiety or depression at any point in time,[142] and this becomes a disability if it has a long-term effect on normal day-to-day activity[143] although often mental health problems will not be diagnosed. People with mental health problems face many of the same barriers to employment as those with a physical disability, including experience of stigma and discrimination, a need for employers to adjust their normal working practices to accommodate their disability, and low expectations from employers, health professionals and themselves. They will also face additional challenges to overcome in gaining and maintaining employment, which will require different solutions. Though there are programmes available to support people to find and keep a job, adequate support is not available to all: a 2012 survey of community mental health service users found that 43% of the 2,780 respondents said they would have liked support to find or keep a job but did not receive any.[133]

Box 33 summarises a recent report by the Work Foundation, which provides a review of the evidence around getting people with schizophrenia into employment. It highlights ways in which working with people who are excluded from the labour market because of a severe mental health condition can be successful in terms of health and employment outcomes.

The national Time to Change programme has been addressing mental health stigma and discrimination since 2007 and an evaluation has found some positive results including improved employer recognition of mental health problems and likely financial benefits (box 34).

Box 33. Key literature: working with schizophrenia – pathways to employment, recovery and inclusion[144]

This report by the Work Foundation is based on a review of previous studies, in-depth interviews with people with lived experience of schizophrenia and telephone interviews with experts.

People with schizophrenia encounter one of the lowest employment rates among all vocationally disadvantaged groups – around 8% in the UK.

The research provides evaluative evidence that, in the right circumstances and when delivered effectively, the following interventions can deliver improved clinical and employment outcomes for people with schizophrenia who wish to play a more active role in the labour market:

- psychosocial interventions
- pharmaceutical interventions
- individual placement and support (IPS) vocational interventions
- other community mental health interventions

However, these interventions are often poorly implemented, and the report attributes this to the following reasons:

- individual differences – because no one with schizophrenia is the same, it is challenging to develop an employment support service strategy that would work for all
- attitudes and expectations – many employers have low expectations; other have stigma, which often leads to self-stigma
- timeliness of interventions – efforts tend to focus on getting those who are unemployed into work, rather than supporting those already in education or employment to remain

The report concludes that better coordinated support and increased understanding of the condition and the importance of work for recovery, could lead to considerably larger numbers of people with schizophrenia both gaining access to, and remaining within, the labour market.

Increasing employment opportunities and retention for people with mental health problems

Boxes 35-38 provide examples of other local interventions to increase employment opportunities for people with mental health problems, particularly those with more complex needs. These have shown some positive results and highlight the importance of supporting people with mental health problems to find work or enter education or training. They show that charities and other organisations that offer employment and training opportunities for people with mental health problems can be successful and highlight the value of a partnership approach.

Box 34. Intervention: Time to Change – let's end mental health discrimination

Who and why? The Time to Change campaign is a national programme run by mental health charities Mind and Rethink Mental Illness.

Description: it aims to challenge and reduce mental health stigma and discrimination in the general population and among specific groups such as employers, through a range of methods.

Impact: a telephone survey of British employers found an increased awareness of common mental health problems, and formal policies on mental health and the use of workplace accommodations became increasingly common. Employers continued to believe that job candidates should disclose a mental health problem, but became less likely to view colleagues' attitudes as a barrier to employing someone with such a problem. These results are consistent with those of the Time to Change national public attitudes and the Viewpoint survey of service users between 2008 and 2010, which showed improved public attitudes to mental illness and a reduction in experiences of discrimination in employment.[145] Evaluations of other measures such as improved knowledge and behaviour among the general public, or user reports of discrimination by mental health professionals, did not identify change.[146]

Cost-benefit: the programme was funded close to £321 million for the four years to 2011.[146] An economic evaluation suggests a likely benefit from the programme, though variations in the assumptions used leaves a wide range of uncertainty: from a net cost to a benefit of £223 million.[146]

Box 35. Intervention: User Employment Programme at South West London and St George's Mental Health NHS Trust[147]

Who and why? South West London and St George's Mental Health NHS Trust commissioned the programme to support people with mental health problems across the trust.

Description: the User Employment Programme helps people with mental health problems to retain or find new paid employment or voluntary work, or enter mainstream education or training. Established in 1995, the key aims of the programme are to provide support for people who have experienced mental health problems in existing posts in the Trust and help reduce employment discrimination against people who have experienced mental health difficulties throughout the trust.

Impact: in 1995–2009, the programme supported people with mental health problems in 223 jobs within all clinical professions across the Trust. Of those who no longer need support from the programme, 86% have continued employment in the trust, or moved into professional education such as nursing or clinical psychology training. The programme is recognised as a model of good practice. It has also become a full partner in the Sainsbury Centre for Mental Health's Centre of Excellence in Employment programme.

Since 1995, the programme has:

- helped people to gain or retain employment in other health and social care organisations
- ensured that, since 1999, at least 15% of all employees recruited to the trust have personal experience of mental health problems (this figure rose to 17% in 2007)
- provided short-term work preparation for 113 people, 47% of whom have moved into employment within or outside the trust

Box 36. Intervention: Socially Minded and Responsible Trading (SMaRT) project[148]

Who and why? The First Step Trust is a registered charity that provides work schemes to people who are long-term unemployed and not yet ready for work because of mental health problems or other disadvantages.

Description: the trust manages SMaRT – a small business enterprise based in Salford, operating a range of garage services and an end of life vehicles de-pollution and recycling facility. SMaRT provides real work in a demanding, commercial environment that challenges the workforce to learn to handle the everyday stresses and pressures of work. It also provides formal work-based training and access to a range of qualifications.

Impact: in the first approximately 18 months, SMaRT provided 250 work experience places. 82% had previously been unemployed for more than one year, and 45% had been unemployed for more than five years or had never worked. Following the placement, 27 people have moved on to open employment.

Box 37. Intervention: Employment Support for Camden and Islingtonmental health service users[149]

Who and why? Mental Health Working is funded by health and social care budgets in the London Boroughs of Camden and Islington, and delivered by Remploy in partnership with local organisations.

Description: Mental Health Working is an employment support service for people in Camden and Islington with mental health needs which began in August 2012. The service uses a pathway-based approach ranging from providing support for individuals to become job ready, to supporting someone already in employment to retain their job. Participants are supported to acquire the necessary skills to access employment, training, education and volunteering opportunities.

Impact: by September 2013, over 448 Islington residents with mental health needs enrolled in the service. Of these, 58 people gained or retained paid employment or became self-employed, 67 people were supported to undertake a mainstream education or training course and 115 people started a work experience or volunteering placement. Over the same period in Camden, 421 people with mental health needs registered and enrolled with the service. Of these, 41 people were helped to gain or retain paid employment, 41 people were supported to begin a mainstream education or training course and 98 people were helped to access work experience or volunteering opportunities.

In addition to providing employment opportunities through work placements, shown to be cost-effective, the NHS Tower Hamlets intervention (box 38) provides support to people with mental health problems while they are in work through training, which it is hoped will support them to remain in employment.

Box 38. Intervention: NHS Tower Hamlets[94]

Who and why? NHS Tower Hamlets, East London, has taken action to address low rates of working and poor health, through its health and work strategy. It claims it has reduced levels of sickness absence among staff. The strategy includes:

'Work It Out' – description: a scheme offering work placements to service users with a history of poor health conditions (mainly mental health). The placements are office based, two to three days per week for six to 13 weeks, and travel, lunch and childcare costs are included.

Impact: 19 people took part in the project and seven of them have succeeded in finding a job.

Cost-benefit: this policy was found to generate £17.07 of social return for every £1 spent in employment support, with the main returns coming from increased work, volunteering, reduced demand on health services and increased taxation.[94]

Mental health model employer project – Description: staff and managers were interviewed to find out their knowledge of, and attitudes to, mental health, and provided with training.

Impact: this led to a reported average of 50% increase in mental health awareness among staff and managers. Mental health awareness is now embedded in induction and management training, and a mental health policy has been introduced.

Workplace interventions to reduce stress and improve mental health, highlighted in section 4.1, further contribute to supporting people with mental health problems while they are in work.

Individual placement and support (IPS) is a well-established 'place then train' method and is considered to be the most effective and efficient way to support unemployed people with severe mental illness into work.[150 151] IPS is an approach to employment support that is tailored to each individual's needs and consists of intensive support to search quickly for a paid job, followed by time-unlimited support for both employer and employee. Time-unlimited support helps individuals maintain employment and promotes career development.[151]

A 'fidelity review' is a way of checking the extent to which a service is faithful to the IPS approach, and those programmes that have high levels of fidelity to the IPS principles have been shown to have higher competitive employment rates than low fidelity programmes.[152] These principles are:

- it aims to get people into competitive employment
- it is open to all those who want to work
- it tries to find jobs consistent with people's preferences
- it works quickly
- it brings employment specialists into clinical teams
- employment specialists develop relationships with employers based on a person's work preferences
- it provides time-unlimited, individualised support for the person and their employer
- benefits counselling is included[150]

Box 39. Key literature: individual placement and support (IPS) for severe mental illness

The Cochrane Review of vocational rehabilitation for people with severe mental illness
Eighteen randomised controlled trials were identified. The main finding was that IPS was significantly more effective than pre-vocational training (a period of preparation before entering the job market) in getting people into competitive employment (34 and 12% respectively at 18 months). Clients in supported employment earned more and worked more hours per month than those in pre-vocational training. There was no evidence that pre-vocational training was more effective than standard community care in helping clients to obtain competitive employment.[153]

EQOLISE Project
A randomised controlled trial (the EQOLISE project) compared 'place-then-train' IPS with high-quality 'train-and-place' vocational rehabilitation services, which addressed deficits deriving directly from the illness plus provided skills training to enhance competitiveness in the job market, in six European countries.[154] It found that, after 18 months IPS clients were twice as likely to gain employment (55% compared with 28%) and sustained employment for significantly longer.
The total costs for IPS were generally lower than standard services over the first six months.
Clients who had worked for at least one month in the previous five years had better outcomes.
Individuals who gained employment had reduced hospitalisation rates.[150]

Long-term employment effects
Most published studies of IPS report only short-term employment outcomes, at around 12-24 months, and less is known about outcomes over the longer term.[155] However, a small number of studies which do provide this information report positive findings. For example, one study which followed up a sample of IPS participants 8-12 years after enrolment found that all did some work during the follow-up period, 82% in competitive jobs, and 71% worked for more than half of all months in the follow-up period.[156]

Cost-benefit analysis
The Centre for Mental Health has carried out a cost-benefit analysis of IPS programmes. Employment support for people with mental health problems will bring cost savings to the health system and DWP. The total cost of the service is about £50,000 per IPS worker[155] and evidence suggest that each IPS worker would support at least 14 people into employment per year and maintain them in work, giving a cost per job outcome of £3,600. Payments to Work Programme providers for sustained work outcomes are set at £4,395 for jobseekers aged 25 or over who have been claiming Jobseeker's Allowance for a year, £6,600 for jobseekers with significant disadvantage and £13,720 for Employment Support Allowance claimants who had previously claimed Incapacity Benefit and who volunteer for the Work Programme. The Centre for Mental Health recommends an innovative local arrangement of pooling current budget allocations from health, social care and DWP to fund IPS workers for people with severe mental health problems.[133]

Boxes 40 and 41 provide examples of local IPS programmes that had positive and cost-effective employment outcomes.

Box 40. Intervention: individual placement and support (IPS) Programme, South West London[148 157]

Who? South West London and St George's NHS Mental Health Trust introduced an IPS programme for people with severe mental illness.

Description: employment specialists were integrated into each of the Community Mental Health Teams and collaborated with the mental health professionals to provide optimal support to address the service users' vocational needs. The employment specialists were not clinicians, but people with experience of mental health and employment and were trained in both the IPS approach and welfare benefits (in relation to work/education). The IPS service also provided supported education services.

Impact: the IPS service shows advantages over a neighbouring borough that has well-established pre-vocational services that are not integrated, and operated a step-wise 'train and place' approach: during the first 12 months of the IPS programme, 37% of service users were supported to open employment compared with only 17% in the pre-vocational service. More people were placed in mainstream education or training or voluntary work in the IPS service compared with the pre-vocational service.

Cost-benefit: the costs of getting someone into open employment in the IPS service were 6.7 times lower than in the pre-vocational service.

Box 41. Intervention: IPS regional trainer in Sussex[151]

Who and why? The Sussex Partnership NHS Foundation Trust and Southdown Supported Employment, a not-for-profit sector provider of employment services, piloted a project based on the state trainer project that has produced successful results in the US for over ten years.

Description: a 12-month pilot project began in 2010, using a 'regional trainer' to speed up implementation of IPS across mental health services in Sussex.

The role of the regional trainer:

- external person 'on hand' to support the planning and preparation for fidelity reviews, conduct fidelity reviews and assist with the development of action plans.
- demonstrates a learning culture. Explains why fidelity is important to the clinical team and employment specialist and trains vocational champions.
- provides reports to Trust executive team and designs employment-related key indicators for the mental health services and employment targets for clinical teams.
- demonstrates field-mentoring in practice and supports supervisors to adopt this approach with employment specialists.
- acts as a 'culture carrier', ie, an individual representing evidence-based practice, who actively works to implement that practice.

Impact: after a year in post, awareness of employment issues among practitioners, team leaders and senior managers in the trust had increased; 284 people were supported into employment in a job that anyone can apply for, far exceeding the 200 target and more than doubling the standard annual target of 125.

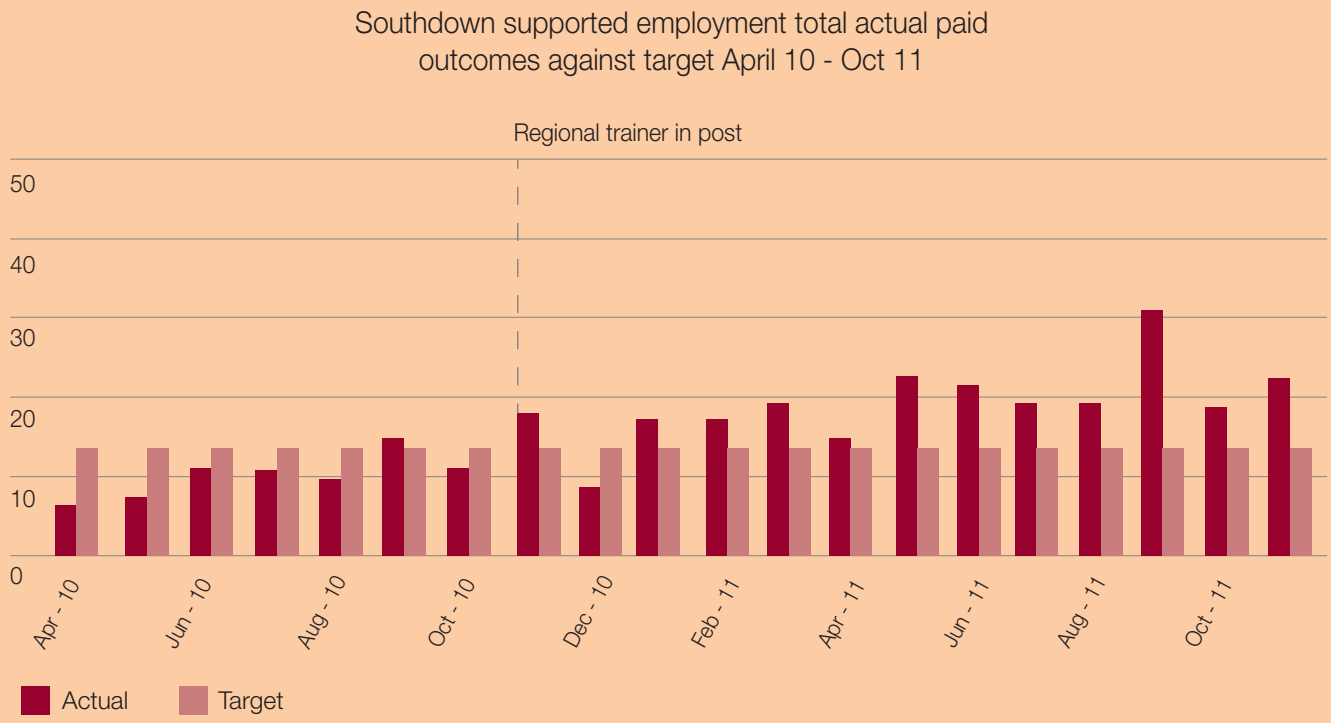


Figure 7: Employment outcomes following introduction of the regional trainer in November, 2010
Source:151

The Centre for Mental Health has highlighted some promising examples of the success of aligning IPS with Improving Access to Psychological Therapy (IAPT) services (eg, Wolverhampton Healthy Minds and Wellbeing Service), and using IPS with ex-offenders (eg, a new study being undertaken by the Centre for Mental Health and Enable, Shropshire).[133]

There is good evidence for IPS for people with severe mental health problems. However, there is no robust evidence that it is effective for people with common mental health problems such as anxiety and depression, which affect the overwhelming majority of the people receiving illness-related benefits.

In its report 'Psychological wellbeing and work: improving service provision and outcomes', RAND Europe proposed testing whether an IPS-type model would be successful in improving the employment outcomes for people with common mental health conditions in a primary care setting (like improving access to psychological therapies (IAPT)).[158] DWP and the Department of Health are taking forward a pilot to test whether offering IAPT treatment, plus a specified model of employment support based on the IPS model, can result in better benefit off flows for ESA claimants with common mental health problem than usual Jobcentre support or usual IAPT support.

Supporting employees on long-term sick leave back into work

Retaining staff on long-term sick leave and getting them back into work has been a focus of national government policy in recent years. Working for a Tomorrow highlighted a number of factors that can speed up the reintegration of employees into work following a period of sickness absence, including: early, regular and sensitive contact with employees during sickness absence; training for line managers on sickness absence policies; cross-sector working between employers, employees and healthcare professionals; and access to occupational health resources.[37]

Early intervention is important. Fit for Work service pilots ran from 2010-13 and were established to provide employees in the early stages of sickness absence with case-managed personalised support to help them return to and stay in work (box 42). Following a recommendation in the 2011 independent review of sickness absence, the new health and work service will be introduced in late 2014. The service will provide a return to work plan for employees who have reached or are expected to reach four weeks sickness absence, and general health and work advices for GPs, employers and employees to help individuals with health conditions to stay in or return to work.[92]

Box 42. Intervention: Fit for Work service pilots[159]

Who and why? The pilots were commissioned by the government following the recommendations of Dame Carol Black's 2008 review of the health of Britain's working age population.[37]

Description: the Fit for Work service pilots ran from 2010-13 and were established to provide employees (particularly those working in small and medium sized enterprises) in the early stages of sickness absence with case-managed, multidisciplinary and personalised support to enable return to work and support job retention.

Impact: an evaluation for the first year of the programme found:

- the services were well liked by clients and stakeholders and appeared to be meeting a genuine need for this type of service
- 6,700 clients took up the service – significantly less than expected; they were much more likely to be people struggling at work with a health condition rather than the primary target of people on sickness absence
- most clients had multiple and wide-ranging needs, confirming the need for multidisciplinary support

There is some qualitative evidence that most clients would not have received the interventions they had without the support of the service and that it had helped people get back to work more quickly or more easily than they would otherwise have done.

The evidence from service providers and clients suggests that a successful approach to helping sickness absentees back to work includes:

- quick access to an holistic initial assessment
- ongoing case management to identify latent concerns (often non-medical) and maintain momentum towards a return to work goal
- fast access to physiotherapy if required
- facilitating better communication between employee and employer and providing advice for return to work options
- advice to improve and manage longer-term health conditions

The ‘fit note’ was introduced in 2010 to help change perceptions of being fit for work, to reflect that it was not always necessary to be 100% fit to attend work and that steps can be taken to quicken an employee’s return to work.

Box 43. Intervention: fit note

Who and why? The fit note was introduced by the government in 2010 to replace the sick note.

Description: the fit note is a form issued by doctors and provides advice about the individual’s fitness for work, and details the functional effects of the patient’s condition. It provides more details about the individual’s functional capacities than the previous sick note, so that individuals and employers can consider ways to help the individual return to work.

Impact: an evaluation of the fit note compared sick note data from seven practices in the North West of England in 2002 with fit note data from the same practices in 2011-13. The evaluation found the following results:

- at five of the practices, the likelihood of a long-term sickness certificate being issued in the fit note evaluation was significantly reduced, compared with the sick note study, after controlling for patient and diagnostic factors
- at three of the practices, the use of the fit note was independently associated with a reduction in sickness absence episodes of longer than 12 weeks
- the proportion of long-term (over four weeks) medical statements issued to patients decreased between studies, from 42% to 36%. A higher proportion of fit notes suggested absence from work for less than a week (10%, compared with 7% of sick notes)
- it is evident that the introduction of the fit note has facilitated greater communication between GPs, patients and employers[160]

This evaluation suggests that the fit note has brought business benefits in the form of reduced employee absence.

Some organisations have made a conscious effort to give extra support to employees on long-term sick leave, with some positive results reported (boxes 44 and 45).

Box 44 Intervention: Tate & Lyle – vocational rehabilitation[161]

Who and why? In partnership with Neylon OH Ltd, Tate & Lyle has implemented a programme to support those on long-term sick leave back into work.

Description: the organisation provides a programme of clinical and occupational services that reduce or prevent illness or injury, and, in the case of absence, support the employee's prompt return to work through a rehabilitation programme. It has adopted a number of new principles where early return to work in a well-managed workplace improves both mental and physical recovery and is a treatment for people recovering from sickness.

Tate & Lyle has developed communication programmes with employees and GPs to broaden understanding that a sick certificate does not preclude working in a different role tailored to individual ability. Also provided are discussion, counselling, focus groups and employee assistance programmes in order to support employees suffering from stress to remain at work.

Impact: since the programme was implemented in 2002, there has been a 75% reduction in ill-health early retirement, 69% reduction in back injuries, 60% reduction in long-term sickness absence and 50% reduction in physiotherapy provided. However, the programme was much wider than the element supporting employees return to work. Tate & Lyle has won a number of awards, notably gold in the FDF Community Partnership Awards 2008 in the 'workplace community' category, and the company was winner of the Vocational Rehabilitation Award 2007 from Occupational Health magazine.

Box 45. Intervention: ClinPhone – supporting staff on sickness absence back into work[37]

Who? ClinPhone is a company that uses internet and telecommunications technology to accelerate the drug development process for the pharmaceutical industry. It employs 726 staff and has an annual turnover of £33.9 million.

Description: 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.

Impact: as a result of this, and their other health and wellbeing strategies, ClinPhone has a low staff absence rate, averaging 3.2 days per employee per year.

4.4: Interventions to increase employment opportunities and retention for older people

Box 46. Key messages: employment for older people

Being in good work is protective of health and wellbeing for people of all age groups, whereas not being in work is associated with poor physical and mental health and wellbeing.[25]

Research has found that poor working conditions are among the determinants of early retirement.[71 162-164] Therefore, improving working conditions is likely to increase the chances of retaining older staff. This can entail both improving physical and psychosocial working conditions and specific interventions that make the conditions of working suitable for older people.

Based on DWP suggestions[165] and the interventions highlighted in this section, specific areas to be considered in an organisation's efforts to attract, recruit and retain older workers include:

- improvements to the physical and psychosocial work environment
- fair recruitment practices that encourage applications from older people
- encouraging and making accessible training opportunities for workers regardless of age
- flexible working
- phased retirement and flexible retirement options
- performance discussions for employees of all ages to alleviate concerns that managing the performance of older workers is more difficult than younger workers
- succession management
- training for managers on issues of age
- regularly seeking workforce feedback
- risk assessment for workers with additional health/mobility needs

Why implement interventions to increase employment opportunities and retention for older people?

It is well known that the English population is ageing – people are living longer and face the prospect of spending longer periods of life in retirement and years spent in poor health, with likely increased costs for taxpayers. The state pension age is increasing to 68 years and the default retirement age has been phased out, allowing people to work for longer. Many people may wish to work longer for financial, health or social reasons.

A 2013 review found that being retired decreases physical, mental and self-assessed health, with the adverse effects increasing as the number of years spent in retirement increases.[166] Being in good work is protective of health and wellbeing for people of all age groups, whereas not being in work is associated with poor physical and mental health and wellbeing.[25] Therefore, effective actions to remove the barriers preventing older people from finding and staying in work should help to improve health and wellbeing within this demographic.

Anecdotal evidence from the company B&Q in its 1995 survey of older staff (aged over 50) found that these staff thought the main benefits of being in work were financial security, friendship, teamwork and lively atmosphere, and being able to use their life experience to meet and help customers.[167] A UK study found that being isolated from family and friends was associated with a 26% higher risk of death over seven years among older people (aged over 52), suggesting that the social aspects of staying in employment are beneficial for older people's health.

Older people in more disadvantaged socio-economic positions are more likely to face difficulties in finding and retaining employment, as they are less likely to have built up skills over the life course and they are more likely to have a disability at an earlier stage in life – both of which are factors that reduce the likelihood of being in employment. Further, they are more likely to face problems if they become unemployed as they are less likely to have savings or other means to buffer a sudden drop in income than older people higher on the socio-economic scale. Therefore, reducing the barriers faced by older people in the workforce should improve health and wellbeing and reduce socio-economic inequalities among older people.

Research has found that poor working conditions are determinants of early retirement.[71 162-164] Therefore, improving working conditions is likely to increase the chances of retaining older staff. This can entail both improving physical and psychosocial working conditions (see section 4.1) and specific interventions that make the conditions of working suitable for older people.

Older people may face barriers to accessing and returning to the labour market, as well as to remaining or progressing within employment.[168] Many organisations that have implemented interventions to increase employment and retention of older workers report initial fears about their performance, yet in the interventions below this was not found to be any more of a problem than at other ages. Research by B&Q of its Macclesfield store, which is staffed entirely by over-50s, compared with its other stores, reported that profits were 18% higher, staff turnover six times lower, there was 39% less absenteeism and 58% less shrinkage. Further, there was an improved perception of customer service and an overall increase in the skills base.[167]

There is an additional chance of health or mobility problems among older workers and self-reported illnesses are most prevalent among workers closest to retirement age.[169] However, this is not inevitable, can be compensated for by greater experience, and aspects such as physical strength and cognitive ability are specific to the individual more than a factor of the ageing process.[169] Even so, employers should assess how to facilitate work for older people who may have additional health or mobility needs.

Other problems faced by older people in the workplace include a lack of training because of perceptions that they will leave before the organisation reaps the benefits of their new skills. This can impact on their motivation, productivity and ongoing job options.[170 171] Besides, this logic is flawed, as most training returns an investment within a year[172] and the risk of an employee leaving the company after receiving training is the same across all age groups.[173]

Examples of existing interventions to promote employment opportunities and retention among older people

Local authorities have a role as both an employer and as a strong local influence to improve employment opportunities for and retention of older people. National legislation can be enforced and guidance disseminated by local authorities. It is against the law to discriminate directly or indirectly on grounds of age in the workplace, and in recruitment and dismissal, except where it is objectively justified.[173] The Department for Work and Pensions' Age Positive initiative brings together research and information from employers on effectively managing an ageing workforce and can be helpful for providing information and solutions to recruiting, employing and getting the best out of workers of all ages.

Boxes 47-49 provide examples of local authorities that have taken action to improve the employment and retention of older workers, in Falkirk, Hertfordshire and North Warwickshire.

Box 47. Intervention: Falkirk Council – flexible working and phased retirement[165]

Who? Falkirk Council is a unitary authority and a large employer. It has a workforce of around 8,000 and serves a population of around 152,000.

Description: the council implemented a flexible working policy in 2005. It applies to all council employees, and there is a parallel scheme for teachers. One of the objectives was to broaden options for staff who wished to continue working after 65. There are a range of options available, including: phased retirement with a staggered reduction of hours approaching planned retirement; a raft of flexible working options (part-time, job share, reduced time, compressed hours, term-time working, home-working); continuation as per current working arrangements.

Implementation of the policy was relatively straightforward once the decision was made. The only resistance came from some managers concerned about their ability to deal with performance issues arising with older employees. The council's existing performance management policy was fit for employees at any age and required no significant alteration and initial concerns were quickly allayed. There was also that concern apprenticeship numbers could be affected, but they were not.

Impact: since 2005 the council has seen a modest but steadily growing uptake for working beyond 65 among a wide range of employees, all taking advantage of the flexible retirement arrangements. In 2010, there were 193 employees aged 65 or over, in a variety of roles.

The greatest benefits to the council as an employer were where jobs had typically been hard to fill. By allowing valued workers to continue in their roles longer, the council was able to benefit from a larger potential labour market, without incurring additional recruitment costs. Added to this was the opportunity to benefit from the experience and knowledge held by such staff, through inter-employee mentoring.

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Box 48. Intervention: Hertfordshire County Council (HCC) – management training and flexible retirement[165]

Who and why? HCC employs around 35,000 people (including school staff). 34% employees are aged over 50; 48% are 40-54; and more than 60% of the workforce is over 40 years old. Therefore there were concerns that a wealth of experience and knowledge could be lost if the council did not manage the career aspirations of its older workers.

Description: HCC removed the mandatory retirement age in 2006 and implemented a flexible retirement scheme. With their employer's agreement, employees can gain access to all or some of their pension benefits while continuing to work. The council allows all staff to work flexibly and highlights the options available to them if they want to ease into retirement by reducing their hours. The council also offers a one-day pre-retirement course, focusing on the transition from employment to retirement.

The council has built the concept of 'age neutrality' into its management training programme, so that issues of age discrimination are specifically discussed when managers attend short courses on other topics. It has developed its performance management guidance to include tips for managers around issues of age. The council requires all its managers to proactively deal with the issues of negative attitudes and stereotypes including age. It trains employees in the behaviours and language required for a diverse working environment. Typically there can be a tendency for managers to apply a 'hands-off' approach to management of employees who are approaching retirement age; this is no longer acceptable at HCC which requires a shift in perception and management style.

Impact: the council reports that this has led to reduced staff turnover and recruitment costs (turnover is currently 13.3%), and positive employee feedback (eg, in the latest staff survey, 65 year old respondents were the most engaged staff group). The council suggests that the intervention has benefitted it as it is able to retain key skills, and because its public face reflects the diversity of its clients. It found that, rather than restrict opportunities for younger workers, encouraging flexible retirement models can actually support and enable a better transfer of skills and organisational knowledge to younger staff. Further, HCC has seen an increase in take-up of flexible working options over the last year with 94% of requests being granted.

A clear communications strategy to cascade messages about the council's expectations of its staff, together with management training, has helped to make this approach work well.

Box 49. Intervention: North Warwickshire Borough Council – phased retirement and succession planning[165]

Who and why? The council serves a population of around 62,000 in a predominantly rural area. 31% of staff are aged 51-plus, with 9% aged 60 and over.

Description: the phased retirement policy applies to all employees and includes:

- no prior assumptions made about whether staff will wish to retire at a certain age
- flexible retirement options as part of the local government pension scheme
- informal but structured conversations, at least six-monthly, between all staff and their managers on their future plans and expectations as part of the regular appraisal process
- effective approach to workforce and succession planning, including a regular review and risk assessment of each staffing role as part of divisional team planning where the potential impact of loss of each staff member is assessed alongside corresponding mitigation plans. This takes much of the uncertainty out of sudden loss of staff, at any age, and allows teams to better plan around the unexpected
- a flexible approach to re-deployment and re-training
- briefing of all senior managers and team leaders on the new policy by the HR manager
- all staff have access to the policy either as part of their induction, via the intranet or in hard copy in locations where staff do not have easy network access

The council's criteria for accepting phased retirement are if there will be no detrimental effect on delivery; it will be economically beneficial, and be fair to other team members.

Impact: since October 2006, 52% of workers reaching age 65 chose to leave; a further 9% stayed for less than a year; 18% chose to leave within three years; and 15% stayed longer on reduced hours.

The interventions above provide examples of policies and practices that local authorities can implement to bring positive benefits including reduced turnover and recruitment costs, positive employee feedback and retaining and transferring key skills and experience. These include flexible retirement options including phased retirement and flexible working, management training on age-related issues, inter-employee mentoring and succession planning. It is also emphasised that many of the policies and practices, such as conversations on future plans and expectations and flexible working options, should be available to all staff, rather than age-specific.

Boxes 50-52 provide examples of other organisations that have taken action to improve the employment and retention of older workers.

Box 50. Intervention: B&Q – removing the barriers to employing older workers[167]

Who and why? B&Q employs over 39,000 members of staff. B&Q's approach to employment is "based on a philosophy of attitude, not age".

In 1989, B&Q opened two stores staffed entirely by over-50s. It also removed its retirement age to allow employees to continue to work beyond 60 and undertook an audit to remove all other age barriers. A 1991 survey of one of these stores (in Macclesfield), benchmarking it against four other B&Q supercentres, provided the following results:

- profits were 18% higher
- staff turnover was six times lower
- there was 39% less absenteeism and 58% less shrinkage
- improved perception of customer service and an overall increase in the skills base

Description: B&Q has identified a number of benefits in employing older workers and has made deliberate efforts to remove any barriers that might restrict who it recruits, retains or promotes. It has removed the retirement age and provides flexible retirement options. It has a range of contract types which offer hours to suit all individuals, and age-related criteria have been removed from its rewards and benefits. There is a learning and development framework for all customer advisers that offers them choice and flexibility around how and when they learn. Flexible working is offered to everyone, irrespective of age, length of service or caring responsibilities. Currently over 62% of B&Q's employees work flexibly.

B&Q regularly seeks feedback and views from the workforce. Diversity Insights reporting is used to regularly review the company's attraction and workforce statistics. All stores are encouraged to employ a diversity champion, and a diversity e-learning programme has been developed and forms part of the induction programme for every new employee and manager. Age positive case studies and media are used in all internal and external communications. Each store has been audited for disability.

Box 51. Intervention: South West Forgemasters – succession planning, recruitment and retention, and training[165]

Who and why? South West Forgemasters is a medium-sized engineering company which supplies forgings to the automotive industry. Most of the company's older workers started with the company as young people and have seen no reason to leave. Their practical knowledge is seen to be an asset.

Description: the company removed the retirement age years ago and some workers choose to work beyond retirement age. To reduce the risk of sudden loss of skills and expertise, the company examines its age profile to determine when people are likely to retire and makes the necessary contingency plans. An example of this was where a skilled toolmaker, thinking of retiring, was involved in the development of a new trainee who worked with him to learn all aspects of the job. Another previously retired individual had been asked to return to work to develop designs for a new project.

The company factors age out of all of its recruitment and retention policies. All employees undergo a formal induction period, after which the company and employee agree any necessary training and draw up a training plan. The company assesses the abilities of all employees annually, matching these to the work within the plant and arranging any necessary training.

When the company found that some older workers felt reluctant to undertake training, they made the style in which it was delivered more flexible. This makes the workers feel more comfortable within a learning environment, andappreciate the benefits training can bring. An older worker who was recently trained in basic computer literacy has continued to learn more about computers and software. He has been instrumental in helping to install some preventative maintenance software into the organisation's computer system.

Impact: South West Forgemasters reported that its approach to age diversity has helped to recruit and retain skills in a business where it is hard to attract workers into heavy-duty metal processing. It reports a very low turnover of staff (in the last four years only two people have left), and finds that older workers support new workers from a practical and personal perspective.

Box 52. Intervention: British Gas – recruitment and apprenticeships[165]

Who and why? British Gas in a UK energy and home services provider of more than 12,000 call centre staff and over 8,000 engineers.

Description: When age discrimination legislation was introduced, British Gas positively ensured all its recruitment policies and practices were free from age bias.

Impact: Opening up apprenticeships to older people was a real culture change in the organisation and resulted in reduced apprenticeships grant funding, but the impact of the initiative was extremely positive: the oldest apprentice taken on was 56. The greater age diversity in the training groups improved the behaviour and maturity of the group as a whole, and older trainees often acted as life mentors for less experienced team members.

A bigger target recruitment market has meant reduced costs and a wider diversity in the applicant pool. The company's reputation has been enhanced as an employer of choice.

B&Q focuses on removing barriers to older people, including removing the retirement age, carrying out disability audits (addressing the additional health needs of some older workers) and removing age criteria from rewards and benefits. It also highlights the importance of employee feedback, conducting research in the 1990s and regularly seeking workforce views and feedback. South West Forgemasters also emphasises the importance of making training available to all and ensuring that it was sufficiently flexible to encourage older people to take it up, while British Gas opened up its apprenticeships to older people. Ensuring recruitment practices were free from age bias was highlighted in all three interventions.

5. Areas for further research

The evidence linking employment and working conditions with health and health inequalities is well established and robust. We have also identified what factors make up a good working environment. There are a number of national and local programmes that have been evaluated and provide employment outcomes. Similarly, many workplace health and wellbeing programmes (particularly those with a focus on behaviour change) provide information about business benefits that have occurred as a result of the programme (such as reduced sickness absence, reduced turnover, increased productivity), though these vary with regard to their robustness and often include many methodological weaknesses.

However, there is little methodologically sound research indicating which interventions are effective in improving health and reducing health inequalities. This is partly because health and equity are often not the main focus of an employment or workplace intervention, particularly among employers, who are usually the ones evaluating a workplace programme. Methodological weaknesses often include: a failure to include control groups; small sample sizes; measuring impacts only for a short timeframe; using 'take-up' as the only measure of a programme's success; too much reliance on self-reported measures of success; not accounting for other factors that could have caused the reported business/health benefits. Another major problem is that usually only the immediate benefits of an intervention are measured, meaning that longer-term outcomes are not known. More and better-quality research is needed to identify which interventions are effective, particularly in terms of improving health and reducing health inequalities. Future research should ensure that it takes into account the short- and long-term benefits, and identifies which aspects of an intervention make it more effective. Further, research looking at the effects of workplace wellness programmes on physical diseases such as coronary heart disease, in addition to mental health and wellbeing and sickness absence, would be a valuable addition to the evidence base.

There is a need for information regarding what approaches are effective and cost-effective for particular groups of employees – for example, employees of different age, gender, race/ethnicity, socio-economic status, disability, sexual orientation, or for part-time, shift workers and migrant workers. Which approaches are effective among employees in lower grade jobs? Ensuring that their health and wellbeing is addressed will contribute to reducing health inequalities.

There is a lack of information available in the literature around how local authorities have successfully worked with local employers to encourage, incentivise and enforce good quality work. It is unclear who has responsibility for good quality work at a national or local level, which makes it difficult to establish where partnerships have existed, so more research to establish where responsibility does or should exist, or where local areas have worked effectively with local employers to implement good quality work, would be welcome. Further, evaluations are needed of schemes and programmes that may incentivise employers to implement good quality work – such as the Public Health Responsibility Deal.

There is a lack of economic evaluation of the interventions identified. Cost-benefit analyses have been carried out for many health and wellbeing initiatives in the workplace, though these are for those that focus on behaviour change rather than working conditions and the social determinants. However, they do show that improving the health of the workforce has financial benefits for organisations. More research is needed on the cost-effectiveness of interventions to improve the psychosocial work environment and interventions to increase employment opportunities and retention for people with a disability or a long-term condition, and for older people.

In relation to increasing employment opportunities for people with a disability or long-term condition, more work is needed to identify the features of different programmes that have led to successful outcomes, and greater clarity and consistency of outcome measures across programmes would be valuable in order to improve evaluations and make comparisons. Aside from Work Choice, we were unable to find evidence of successful interventions to support people with a disability or long-term condition into self-employment, and this is a potential area for future action. Further work to confirm the pilot findings of the 'health first' approach would be valuable.

This report does not exhaustively cover areas for intervention on employment. Other areas for future review include interventions to get long-term unemployed people into work, attracting employers and creating good quality jobs for local people, and improving job security.

Conclusion

The evidence is clear that unemployment, particularly long-term unemployment, and poor working conditions, are bad for health and contribute to health inequalities. This evidence review has highlighted that these are important issues to be addressed by public health in local areas, and has identified a number of interventions, specifically in the following areas: workplace interventions to improve health and wellbeing; working with local employers to encourage, incentivise and enforce good quality work; interventions to increase employment opportunities and retention for people with a long-term illness or disability; and interventions to increase employment opportunities and retention for older people. Many of these interventions have shown successful health, employment and business outcomes. Further research is needed to develop the evidence base, particularly to the key elements of success.

Appendix 1. Evidence base on employment outcomes of interventions for employees with common health conditions

Table of health conditions, interventions, evidence base and effects for employees with health conditions to enable them to stay in or return to work (from DWP rapid evidence assessment, 2012)

Health condition	Intervention type	Quantity of evidence	Quality of evidence	Evidence of effectiveness
Musculoskeletal disorder (MSDs)	Cognitive behavioural therapy (CBT)	Reasonable	Reasonable	Mixed
	Workplace based	Reasonable	Reasonable	Positive
Low back pain	Graded activity/ excercise	Reasonable	Weak	Mixed/no effect
	CBT	Reasonable	Reasonable	Positive
	Patient education	Quite weak	Quite weak	Positive
	Vocational rehabilitation	Reasonable	Reasonable	Positive
	Workplace based	Reasonable	Reasonable	Positive
Other MSDs		Weak		
Cardiorespitory	Workplace based	Weak	Reasonable	Positive
Mental health conditions (MHCs)	Psychological/ CBT	Weak – very mixed	Reasonable	Positive
	Workplace based	Weak	Quite weak	Inconclusive
Depression	Psychological/ work- based	Mixed types	Reasonable	Positive
Severe MHCs	Vocational rehabilitation	Weak	Reasonable	Positive/mixed
Supported employment		Reasonable	Reasonable	Positive
Stress/distress and burnout	Psychological/ stress management	Reasonable	Weak	Mixed/no effect

Source:131

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