None Of Our Business?

Policy Exchange

How Places of Work Can Help to Improve the Health of the Nation

Sean Phillips & Stuart Carroll

Foreword by The Rt Hon The Lord Blunkett PC FAcSS

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About the Authors

Dr Sean Phillips is Head of Health and Social Care at Policy Exchange. His published output includes co-authored reports on tackling the 'waiting list' in elective care, reforms to general practice, the future for vaccines policy and expanding medical school places. In his time at Policy Exchange, the work of the Health and Social Care Unit has been awarded 'Health, science and medicine' think-tank of the year by Prospect Magazine. Prior to joining Policy Exchange, he completed a doctorate in History at the University of Oxford. He previously lived in Berlin, where he worked as a consultant on matters relating to digital health and emergent technologies in healthcare, advising consumer health, insurance, and start-up clients. He holds a DPhil in History and an MSt in Global and Imperial History from the University of Oxford and a BA in History from the University of Exeter.

Stuart Carroll is a senior health economist and epidemiologist with 20 years of experience in health policy, market access, public affairs, health economics and outcomes research. He is currently the Director for Market Access and Policy Affairs for Moderna in the UK and Ireland, and specialises in infectious diseases, vaccines, therapeutics, rare diseases and mental health. Stuart is also a Senior Visiting Research Fellow at the Office of Health Economics, providing strategic policy and analytical advice, and is also a Fellow at the Royal Society of Public Health and Royal Society of Arts. In 2015 and 2019, Stuart was elected as Councillor for Boyn Hill, Maidenhead where he served as the Cabinet Member for Adult Social Care, Health, Mental Health, Children Services and Education as well as Vice Chair of Cabinet. He is a mental health and suicide prevention first aider and a strong advocate in this area. Prior to joining Moderna, he was a Senior Expert Policy & Strategy Adviser in the UK Government's Vaccines Taskforce and the Antiviral and Therapeutic Taskforces. Stuart is currently studying a PhD in social sciences and public health at the University of Nottingham under the supervision of Sir Professor Jonathan Van Tam with a core research focus on the COVID-19 pandemic and vaccination policy.

Stuart Carroll authors this report solely in his capacity as a Senior Fellow at Policy Exchange. For full transparency, it should be noted Mr Carroll is undertaking a PhD at The University of Nottingham, where his research focuses on social policy and its interaction with public health and the COVID-19 pandemic, and which is entirely sponsored by the Office of Health Economics where he also acts as Senior Visiting Fellow. Mr Carroll is also Director of Market Access & Policy Affairs for Moderna UK & Ireland. This report is authored in a fully independent capacity and is not connected to nor influenced by Moderna.

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About the Health and Social Care Unit at Policy Exchange

The Health and Social Care Unit at Policy Exchange looks to tackle the most pressing questions facing the NHS and social care sector today and looks to ensure that the needs of consumers are placed at the forefront of the national conversation. Some of its recent output includes:

- **What Do We Want from the King's Speech?** – Set out proposals for a 'Future Clinical Trials Bill' and a 'Digital Health and Care Bill'.
- **Medical Evolution** – Considered how the 'interface' and transfer of patient care across primary and secondary care settings can be enhanced
- **Double Vision** – A detailed and costed roadmap to enable 15,000 medical students a year to enrol on courses in England by 2029.
- **A Fresh Shot** – Considered the future for vaccines policy in England, setting out fifteen recommendations to reverse the decline to ensure the UK remains a world-leader in vaccine development and delivery.
- **What Do We Want from the Next Prime Minister?** – A manifesto for the new Prime Minister setting out sixteen policy ideas for health and social care
- **Devolve to Evolve?** – A series of proposals to reform NHS specialised services within integrated care, calling for more logical service groupings, an expanded role for patient and carer input, and stronger ministerial and financial oversight.
- **At Your Service** – A proposal to reform general practice in England, with the introduction of a new unified front door for users called 'NHS Gateway'.
- **A Wait on Your Mind** – An assessment of the policy responses required to address the waiting list for elective care in England, setting out a series of practical proposals to address unknown clinical risks, and to introduce greater 'operational transparency' to support patients waiting for diagnosis or further care.

Endorsements

"Policy Exchange's latest report could hardly be timelier. Long-term sickness is the single biggest driver of economic inactivity today. Whilst the Government have made great strides in tackling this issue, a renewed focus on enhancing the link between health services and employers is needed to boost opportunity, productivity and growth in the months ahead.

This report provides a wealth of ideas to drive this agenda forward, from reforms to the 'fit note'; further tax relief for workplace health; improving access to services through community assets and leveraging the Government's Long Term Workforce Plan for the NHS to boost the supply of the healthcare professionals that will be needed to meet future demand.

Helping people to stay and succeed in work is every bit as important as supporting them to start. Hundreds of thousands of people among the economically inactive have said they want to work if the right job and support were possible. Connecting talented people with the opportunity that is out there is a mission and challenge of our times. To fail on this stunts Britain, and wrongly writes people off."

The Rt Hon Chloe Smith MP, Former Secretary of State for Work and Pensions; Member of Parliament for Norwich North

"This is a convincing report which sets out a positive vision for addressing one of the most challenging policy issues facing the country: how to address the rising tide of long-term sickness among those of working-age. Policy Exchange make the persuasive argument that this must be done by prioritising support and incentives for SMEs, whilst innovating to ensure the capacity of occupational health providers can be maximised. The Government should seriously consider proposals set out here for tax relief on effective and evidence-based workplace health services".

Stephen Hammond MP, Former Minister of State for Health & Member of Parliament for Wimbledon

"Policy Exchange have made a compelling intervention into the debate on preventative healthcare in this latest report, which represents a pragmatic set of recommendations about how workplaces can support the health of the nation. It is particularly pleasing to see Policy Exchange make such a positive case for the role that workplaces can play in enhancing access to and early intervention for those with mental ill-health which we know is now a leading cause of long-term sickness and inactivity".

James Morris MP, Former Minister for Primary Care and Patient Safety; Member, Health and Social Care Select Committee; Co-Chair of the APPG for Mental Health and Member of Parliament for Halesowen and Rowley Regis

"Support for people with long-term health conditions to return to,or remain in, work needs to be a priority given our ageing workforce and the steady rise in recent years in numbers of those off work due to a health condition. Employees are struggling to get the work focused recovery and rehabilitation input they need and employers who want to help, don't always know how to. This report is timely and shines a light on the key role that vocational rehabilitation can play alongside that of occupational health in addressing employer and employee's needs. We look forward to hearing about the implementation of the recommendations proposed so that people who need health and work support, get it"

Dr Julie Denning, Chair, Vocational Rehabilitation Association

"I welcome this report from Policy Exchange which recognises the strong economic, clinical and moral case for improving access to occupational health. They are right to suggest that it should be seen as a wise investment and crucial pillar in meeting the challenges associated with a rise of long-term sickness among those of working age. It is particularly pleasing to see recommendations which seek to enhance the visibility of occupational health as a specialism across undergraduate and postgraduate curricula and in encouraging the development of a Centre for Health and Work Research to improve our understanding of the link between work and health, and how workplace-based interventions can enable a more preventative healthcare system. We would urge the Government to build on these recommendations so that universal access to occupational health can be achieved in the coming years."

Nick Pahl, Chief Executive Officer, Society of Occupational Medicine (SOM)

"The case for business and government to work together to improve the health of the UK's workforce has never been clearer. At this Spring Budget, the Government has an opportunity to help employers invest more in health & wellbeing, including by making health investments and other preventative interventions such as Employee Assistance Programmes tax-free. Delivering the promised occupational health subsidy will help small businesses play a more proactive role too."

Matthew Percival, Future of Work & Skills Director, Confederation of British Industry

"In the rapidly evolving landscape of occupational health, "None of Our Business?" emerges as a pivotal report that stands at the crossroads of innovation and practical reform. As the CEO of Latus Group and the mind behind YODHA, the world's first fully remote occupational health system, I have dedicated my career to transforming how we approach workplace health. This report, with its comprehensive analysis and forward-thinking recommendations, aligns closely with our mission of digital transformation in the occupational health industry.

It's call for expanding tax relief for workplace health interventions, alongside innovative proposals such as the creation of a Health in Work online portal, underscores the necessity of adopting new technologies and digital solutions to address occupational health challenges. Its alignment with YODHA's vision of leveraging technology to enhance occupational health services makes it a commendable piece of work that I wholeheartedly endorse."

Jack Latus, CEO, Latus Group

"This report shines a light on the critical importance of employers in understanding the needs of people with cancer in returning to work. We know that support to return to 'good work' at the right time is essential in helping alleviate some of the issues faced after a cancer diagnosis, which include financial insecurity, stigma around disclosure, loneliness and a lack of peer support.

This 'lost workforce' will only continue to grow in the years ahead without concerted attention and action. We know from our 'Cancer in the workplace' programme that employers often want to do the right thing but simply do not know how. Progress cannot be made without the right Government support and we fully endorse the recommendations this report highlights."

Dame Laura Lee, Chief Executive Officer, Maggie's

"Many people with arthritis and musculoskeletal (MSK) conditions want to work but are not able to access the support they need to thrive in the workplace. This is a missed opportunity to enable people to return and remain in employment.

We are pleased this report prioritises prevention and treatment services for people with MSK conditions, which are vital tools in addressing the increase in long-term sickness of working-age people in the UK".

Tracey Loftis, Head of Policy, Public Affairs and Engagement, Versus Arthritis

"With more working age people reporting health long-term conditions than ever before and worrying numbers unable to work due to ill-health, this important report couldn't be more timely. Transforming workplace health is good for the nation's health, good for the economy and too important not to be a priority for employers and Government alike."

William Roberts, Chief Executive, Royal Society for Public Health.

"I am pleased to see this report make such a positive case for the value of occupational health and the benefits it can bring to workplaces across the country. Enhancing the link between work and health at all levels of healthcare education will be an important enabler of this vision, but in doing so can create new possibilities for multi-disciplinary team working and innovation in curricula and placements – these are opportunities which must be grasped"

Janet O'Neill, Deputy Head, National School of Occupational Health

"We fully support the recommendations in this report and there is no time to waste given the perilous state of the nation's health. We would like to see much closer collaboration between the private sector and the NHS enabled through better data sharing and linkage via a personal health account on the NHS app, with local employers and businesses playing a leading role in the health of their communities working with the NHS on pathways more focussed on prevention and engaging people more effectively in their health."

Tina Woods, Founder & CEO of Business for Health

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- **Tina Woods**, Founder and Chief Executive Officer, Business for Health

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Contents

Foreword

The Rt Hon The Lord Blunkett PC FAcSS
Former Secretary of State for Work and Pensions; former Secretary of State for Education and Employment, former Home Secretary, former Shadow Health Secretary and Patron, Society of Occupational Medicine

Ill-health among those of working-age is holding Britain back. It is the great brake upon economic growth, adding to pressures upon the NHS, adding to demand for welfare benefits and impeding productivity.

We now know that almost three million people across the country between the ages of 16-64 are economically inactive due to long-term sickness; and the scandal of lack of support for those with disabilities, with only one in four of working age having a job. Sadly, the figures for the economically inactive are at levels not seen since the early 1990s.

We have long known that work and health are intertwined: "'two sides of same coin", as the Shadow Work and Pensions Secretary recently put it. Quite rightly, there is cross-party recognition of the need to address the drivers of economic inactivity.

Whilst the Government have made progress in reducing the overall number of those 'inactive' since the pandemic, growth in long-term sickness represents a significant and growing challenge. That challenge is felt differently across different sectors and across different parts of our country. The issue has inequality at its core.

The principle that everyone who can work does so is important. We know that working can be extremely positive for health and mental well-being and that the longer you are off sick in the first place, the less likely you are to RTW at all, leaving lasting damage to individuals and communities. There are many people who could benefit enormously from physiotherapy, a chiropractor or mental health support who would then clearly be able to work again.

We need therefore to find new ways for workplaces to be able to support those with work-limiting conditions and disabilities, and to prevent employees dropping out of work in the first place. That is why this report is such an important contribution to the consultation – launched without fanfare by the Department for Work and Pensions – on the issue of developing an occupational health programme. Strengthening workplace health – particularly occupational health – as this excellent new report from Policy Exchange argues, can play a central role in meeting this objective.

This is a topic close to my heart. As former Work and Pensions Secretary with responsibility for the Health & Safety Executive to my current role as Patron of the Society of Occupational Medicine, enhancing workplace health has been a keen interest throughout my life and I have seen countless examples of the positive difference it can make.

There are strong financial, health-related, legal and moral arguments to strengthening occupational health. Whilst it is encouraging that a growing number of employers are investing in workplace health and wellbeing, employers need to be sure that their investments represent good value. This is particularly important for small and medium-size enterprises who require greater support and incentives.

This report clearly analyses the scale of the challenge and sets out a series of thoughtful recommendations to reduce economic inactivity. It lays out effectively the current context and rationale for reform, and its recommendations carefully balance the demand and supply side measures that can encourage employers 'to do the right thing' and create additional capacity across occupational health providers where it is limited at present.

This report is right to highlight the role that tax incentives can play in incentivising businesses and enabling a greater number of partnerships between local business groups to deliver workplace health services 'at scale' where small and medium sized businesses may be unable to do so themselves. The report also makes pragmatic recommendations around future reform to the 'fit note' in aiming to more effectively link it to occupational health guidance. The authors also recognise the opportunities that workplaces can present in expanding the 'NHS Health Check' to boost uptake and improve health outcomes over the long-run.

These recommendations are balanced with a recognition that supply-side measures are needed too. There is a real opportunity to consider how the NHS Long Term Workforce Plan can also help to deliver the multi-disciplinary occupational health workforce of the future and how creating opportunities for research on workplace health will play an important role in improving the evidence-base for workplace-based interventions.

I hope Policy Exchange's report will be widely-read by politicians and opinion formers, not least those running both business and public services, together with clinicians and occupational health professionals with interest or active role in supporting workplace health. For policymakers, there are many fresh ideas here which could help to tackle a complex and growing public policy challenge.

As people work later into their lives and as the number of people with multiple health conditions grows, the need for more effective workplace-based support for health and the rationale for reform will only grow stronger.

Ultimately, the real test of these ideas will be if we can truly deem employee health to have become everyone's business. I hope this report goes some way to persuading readers of the case.

Acronyms and Abbreviations

ABI	Association of British Insurers
AHP(s)	Allied Health Professional(s)
ACPOHE	Association of Occupational Health Physiotherapists in Occupational Health & Ergonomics
BIK	Benefit-In-Kind
BOHS	British Occupational Hygiene Society
BPS	British Psychological Society
CBI	The Confederation of British Industry
CCG	Clinical Commissioning Group
CMD	Common Mental Disorder
COHPA	Commercial Occupational Health Providers Association
CQUIN	Commissioning for Quality and Innovation
CSP	Chartered Society of Physiotherapy
CVD	Cardiovascular Disease
DHSC	Department of Health and Social Care
DOccMED	Diploma in Occupational Medicine
DWP	Department of Work and Pensions
EAP	Employee Assistance Programme
FOM	Faculty of Occupational Medicine
FONH	Faculty of Occupational Health Nursing
FSB	Federation of Small Businesses
GP	General Practitioner
GMC	General Medical Council
GWS	Good Work Standard
HCPC	Health and Care Professions Council
HEE	Health Education England
HSE	The Health and Safety Executive
HWB	Health and Wellbeing Board
HWW	Healthy Working Wales
IAPT	Improving Access to Psychological Therapies
ICS	Integrated Care System
IHPN	Independent Healthcare Provider's Network
ISO	International Organization for Standardization
IPS	Individual Placement and Support
LEP	Local Enterprise Partnerships

MHFA	Mental Health First Aider
MHPP	Mental Health and Productivity Pilot
MSK	Musculoskeletal (Conditions)
NCD	Non-communicable Disease
NMC	Nursing and Midwifery Council
NHS	National Health Service
NICE	The National Institute for Health and Care Excellence
NI	National Insurance
NSOH	National School of Occupational Health
OBR	Office of Budget Responsibility
OHWB	Occupational Health and Wellbeing
OH	Occupational Health
OHT(s)	Occupational Health Technician(s)
ONS	Office of National Statistics
PMI	Private Medical Insurance
RCN	Royal College of Nursing
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
RTW	Return to Work
SCPHN	Specialist Community Public Health Nursing
SEQOHS	Safe, Effective, Quality Occupational Health Service
SME	Small or Medium-Sized Enterprise
SMI	Severe Mental Illness
SOM	Society for Occupational Medicine
SSTI	Services de Sante au Travail Interenterprises
UKHSA	UK Health Security Agency
UKRI	UK Research & Innovation
VRP(s)	Vocational Rehabilitation Practitioners
VR	Vocational Rehabilitation
WCA	Work Capability Assessment
WHU	Work and Health Unit
WAVE	Work and Vocational Advice
WHSS	Working Health Services Scotland

Executive Summary

Should places of work play a greater role in supporting the health of their employees? This report argues that they should and proposes that a clear definition and mission to enhance workplace health across the UK is urgently required. In doing so, it considers the policy framework, partnerships and incentives required to achieve this imperative, with the aim of enabling more proactive intervention and monitoring of work-limiting health conditions. Improving access to and enhancing 'occupational health' and 'vocational rehabilitation' to assess and maintain the "wellbeing of employees, preventing and removing ill-health" or in enabling employees to return to work (RTW), two key specialisms for the delivery of 'workplace health', are central to our proposals.[1]

Current levels of poor health across society are damaging economic growth, and present a drag on employment. The UK has – as Andy Haldane, former chief economist of the Bank of England, describes it – a "weak societal immune system".[2] Last year, 186 million working days were lost due to sickness (or injury).[3] The average sickness absence per employee is currently 7.8 days – the highest level in a decade and two days more on average than it was in 2019.[4] Businesses are spending almost a thousand pounds per year per employee on sickness absence. The total costs of this burden of ill-health is estimated now to cost £150 billion per year. This is almost as large as the entire annual budget allocated to NHS England.[5] Associated costs are split between the Government (24%), the individual (57%) and employers (19%) in lost income, statutory sick pay, state benefits and lost tax receipts.[6]

The Government has made progress in reducing overall 'economic inactivity' and has made tackling this challenge a 'top priority', demonstrated by the recent establishment of a Taskforce on Occupational Health, chaired by Dame Carol Black. This could not be more timely. **The number of people who report 'long-term sickness' as their main reason for not being able to work has reached record levels (2.8 million people) and is at its highest levels since the early 1990s**.[7] The latest statistics from the Health and Safety Executive (HSE) show that mental ill-health and musculoskeletal (MSK) conditions – such as back or neck pain – are the two key drivers of work-limiting ill-health, accounting for 17.1 million days of work lost in the UK in 2022/23, at a cost of £13 billion.[8]

Based on current projections, the growing burden of work-liming ill-health will become an increasingly significant issue for future Governments. The Office for Budget Responsibility (OBR) has recently forecast that disability benefit spending may increase by 35% in the next four years to £52.8bn, with 500,000 new claimants, driven by poor

1. https://www.som.org.uk/what-occupational-health
2. https://www.health.org.uk/publications/reports/health-is-wealth
3. https://assets.publishing.service.gov.uk/media/64b8f7baef5371000d7aef2d/occupational-health-working-better-consultation.pdf (p. 13)
4. https://www.cipd.org/globalassets/media/knowledge/knowledge-hub/reports/2023-pdfs/8436-health-and-wellbeing-report-2023.pdf (p. 2)
5. https://www.kingsfund.org.uk/projects/nhs-in-a-nutshell/nhs-budget#:~:text=What%20is%20the%20NHS%20budget,as%20staff%20salaries%20and%20medicines.
6. This list is not exhaustive, see: https://www.som.org.uk/sites/som.org.uk/files/Occupational_health_the_value_proposition_0.pdf (p. 15)
7. https://www.gov.uk/government/speeches/a-gold-mine-for-growth-and-opportunity. See data from Scotland which mirrors this trend: https://www.gov.scot/publications/economic-inactivity-young-people-aged-16-24-definition-reasons-potential-future-focus/pages/4/
8. https://www.hse.gov.uk/statistics/dayslost.htm#:~:text=Working%20days%20lost%2C%202022%2F23&text=Stress%2C%20depression%20or%20anxiety%20and,around%2015.8%20days%20off%20work.

health.[9] The number of 20-to-69-year-olds living with major illness is predicted to rise by half a million by 2030.[10] The Health Foundation's REAL Centre has estimated that by 2040, 5.6m people will be in-work with a 'work-limiting' condition.[11]

The relationship between health and work is complex. 'Inactivity' rates are impacted by a wide range of factors, including geography and levels of poverty. What you do for work matters too: people working in retail for instance are nearly four times as likely to drop out of work due to long-term sickness than people working in IT services.[12] We also know that 'good work' matters for your health: pay and psychosocial factors, such as job content, effective line management, and career development have all been shown to make a difference.[13]

Whilst recognising the salience of these factors, the focus of this report is in ensuring the right blend of supply and demand-side measures are developed to boost capacity among workplace health providers and to incentivise and reward employers for doing the 'right thing' and maintaining a voluntary approach. After all, it has not been commonplace to think of workplaces as a stakeholder in the health and care ecosystem, even less a site of health provision. For many employers – particularly small and medium size enterprises (SMEs) – occupational health has proven a 'place of last resort' and a 'distressed purchase', rather than a permanent offer or a genuinely preventative service. To some it is regarded as "none of their business". Yet improved employee health is in everyone's interest, with the effect of boosting public finances through increased employment, lower welfare expenditure and improved tax take from more productive employers.

The Government has a key role to play in delivering the incentives required for change. The work and health agenda is too often regarded as a niche interest, not helped by a limited understanding of occupational health – both within the clinical professions themselves and among the general public. In the short-term, the Government should expand tax relief to incentivise greater provision of workplace health services. We propose the creation of an 'Annual Allowance' for every employee, increasing the current threshold for tax exemptible employee benefit and making Employee Assistance Programmes (EAPs) tax-free. To ensure cross-departmental leadership, a Health in Work Council (modelled on the Life Sciences Council) should be established. The Government should also proactively point businesses of all sizes (including the self-employed) in the direction of high-quality providers, well-placed local services or and examples of best practice via a new service and online portal, 'Health in Work'. This quality assurance is needed because knowing 'what good looks like' is a real challenge for most employers. Whilst occupational health professionals are regulated at the individual level, there is no overarching regulator. Meanwhile, many interventions posited as a means of enhancing 'workplace wellness' can be of limited quality and efficacy.[14]

A limited occupational health workforce constrains the capacity of existing suppliers, meaning that universal access to occupational

9. https://www.theguardian.com/commentisfree/2024/jan/12/disability-claims-britain-rishi-sunak-government-health-austerity?CMP=share_btn_tw
10. https://www.health.org.uk/commission-for-healthier-working-lives
11. https://www.health.org.uk/sites/default/files/upload/publications/2023/Projected%20patterns%20of%20illness%20in%20England_WEB.pdf
12. https://www.som.org.uk/sites/som.org.uk/files/SOM_Deep_Dive_Research-compressed.pdf (p. 50)
13. These wider determinants are addressed in, for instance, https://www.instituteofhealthequity.org/resources-reports/the-business-of-health-equity-the-marmot-review-for-industry/read-report.pdf. See also: https://urbanhealth.org.uk/insights/reports/health-and-work
14. https://www.theguardian.com/commentisfree/2024/jan/17/work-wellness-programmes-dont-make-employees-happier-but-i-know-what-does; https://onlinelibrary.wiley.com/doi/10.1111/irj.12418#:~:text=This%20article%20presents%20results%20from,being%20apps%20and%20volunteering%20opportunities.

health should become a longer-term ambition for the Government. We suggest a range of measures to boost the supply of occupational health professionals over the medium term by making the most of the opportunity presented by the NHS Long Term Workforce Plan by boosting the visibility of occupational health in undergraduate and postgraduate curricula; clarifying training and accreditation pathways across all relevant roles and creating a greater number of opportunities for professionals to 'get into' occupational health. The career pathway and professional regulation for occupational health technicians (OHTs) should also be formalised.

Workplace health interventions should be more effectively linked with NHS services over the coming years, with the development of both an employer referral route as well as a primary care referral route to assessment, treatment and rehabilitation services. New models of support for RTW across major conditions, such as cancer, should be developed.

Further reform of the 'fit note' system is urgently required, to encourage more routine referral to occupational health assessment, to vocational support and services which can provide support and treatment for conditions which are the key drivers of long-term sickness. We should more effectively leverage the role the leisure sector and physiotherapy can play in delivering pain management and rehabilitation, as well as the positive impacts these interventions can have upon mental health and in addressing isolationism.

We propose that the proportion of 'NHS Health Checks' delivered in workplaces should be expanded, with eligibility widened to all those above the age of twenty-five in geographic areas where there is a higher prevalence of inactivity, and building on recent reforms to 'digitise' the Health Check.

The report is structured as follows:

- Chapter 1 examines the current drivers of 'economic inactivity', the growing numbers of those in work who report health-limiting conditions and considers the underlying costs.
- Chapter 2 examines current occupational health provision in the UK and compares this to practice internationally.
- Chapter 3 sets out a new vision for workplace health provision.

The case for change is both economic and health-related. Improved occupational health and vocational rehabilitation provision can contribute toward the Government's wider ambitions for everyone to have five extra years of healthy, independent life by 2035. It can also be a key part of broader strategic imperatives for the health and care system: to shift care out of hospital settings and to boost effective preventative interventions. More broadly, occupational health can act as a bridge between the employers, local communities and NHS organisations, encouraging improved partnership working and enabling access a wider range of healthcare services.[15]

15. https://www.mdpi.com/1660-4601/18/7/3632

Summary of Recommendations

1. **The Government should incentivise the growth of effective workplace health interventions by expanding tax relief for workplace health interventions.**

    a. **HM Treasury and HM Revenue and Customs should extend non-taxable employee benefits for effective assessments and treatments through the creation of an 'Annual Allowance', set initially £2,500 for each employee, per year. (Thereby raising the current £500 cap and increasing the range of treatments eligible)**

        i. To ensure value for money, exemptions should focus on well-evidenced preventative medical interventions, including initial assessment as well as treatment services, focused on the main drivers of long-term sickness and inactivity.

        ii. These should include services provided by occupational health and vocational rehabilitation professionals.

        iii. It should include pain management and rehabilitation services delivered by physiotherapists.

        iv. It should also include counselling, Improving Access to Psychological Therapies (IAPT) and other evidence-based sources of mental health support, including digital healthcare solutions which have been approved by The National Institute for Health and Care Excellence (NICE). Mental health first aid training courses should also be considered.

    b. **For all adult vaccinations offered in or by employers to become 'trivial' Benefits-in-Kind, and thereby tax exempt – including those for COVID-19.**

    c. **Employee Assistance Programmes (EAPs) should become a fully tax-free benefit.**

2. **The Government should introduce further reforms to sickness certification and the 'Fit Note'.**

    a. An option should be added to the current form to enable and encourage GPs (and other healthcare professionals) to *"Refer to an occupational health professional"* or to *"Recommend further assessment from an occupational health professional"*.

    b. Linked to this, new categories called 'Additional Assessment' and 'Ongoing Assessment' should be introduced to enable healthcare professionals to recommend further assessment, such as by another healthcare professional, i.e., physiotherapist or from a work coach. This should be applied in all cases where an individual is signed off work for longer than a month, such as those with chronic conditions or long-term illness.

    c. The Government should add paramedics and podiatrists to the list of qualified practitioners legally able to conduct sickness absence assessments.

    d. These changes must be accompanied by enhancing how employment information links with patient health records so that occupational health professionals, in addition to, for example, pharmacists and physiotherapists certified to issue 'fit notes' can request updates to the GP record, or can seamlessly inform GP staff of updates, building on recommendations previously made by Policy Exchange.

3. **The Department of Health and Social Care (DHSC) should boost those eligible for the NHS Health Check – with a focus on expanding its delivery in workplaces**.

    a. The content of the NHS Health Check should be reviewed so that it aligns with areas covered in the Major Conditions Strategy, including MSK health as well as long-term conditions.[16]

    b. The Government should trial extending the service by prioritising geographies which have a higher prevalence of multimorbidity and 'inactivity', including the North East of England and South Wales. Here, the Health Check should be extended to those aged twenty-five and above – with a view to a national rollout.

16. https://www.gov.uk/government/publications/major-conditions-strategy-case-for-change-and-our-strategic-framework/major-conditions-strategy-case-for-change-and-our-strategic-framework--2

4. **The Government should develop a new online service called 'Health in Work'.** This should act as a 'one stop shop', or single portal which brings together essential information about workplace health for all employers (including the self-employed). It should:

    a. Align existing, but fragmented information available, bringing together and building upon the work and recommendations of initiatives, such as the Mental Health at Work Leadership Council;

    b. Have a searchable directory for workplaces so they can identify relevant workplace health providers, contacts in local government or other key stakeholders, such as voluntary organisations operating at a local level who can support provision of services or act as sources of advice and guidance;

    c. Collate information about occupational health providers which meet any new 'minimum standard' (currently being developed by Government) and the Safe Effective Quality Occupational Health Service (SEQOHS) standards to support local government and employers;

    d. Detail digital health solutions – particularly for mental health conditions – which have been NICE approved or which are recommended/commissioned by NHS services which employers may wish to purchase directly, or may want to signpost to employees.

5. **Leadership of this agenda across Government should be enabled through the development of a 'Health in Work Council' (modelled on the Life Sciences Council)**

    a. This should include representatives from the Treasury, Cabinet Office, DHSC and DWP as well as those represented on the Expert Advisory Group and DHSC-DWP Joint Unit on Work and Health to boost the visibility and leadership of the workplace health agenda across Government. It should include occupational health providers, business representatives (particularly from SMEs) and key clinical representative groups.

    b. The Expert Advisory Group and DHSC-DWP Joint Unit on Work and Health should develop dedicated proposals for the expansion of occupational health services for the Self-Employed.

c. The recently-announced Occupational Health Taskforce should draw up proposals to expand provision for self-employed workers.[17]

6. **A Centre for Work and Health Research should be established.**

   a. This should operate as a new, independent organisation but should draw upon current, centrally funded programmes of work by the National Institute for Health Research and Medical Research Council, which feeds into the DHSC-DWP Joint Unit on Work and Health. It should have the responsibility and remit to commission research which enhances the evidence-base for the UK's bespoke workplace health challenges.

   b. A particular focus should be placed on developing the evidence base to support RTW for those with major conditions, such as cancer or for those with long-term conditions.

Demand-Side Measures to Boost SME Offers

7. **The Government should promote ownership and empower local communities to develop services to support their employees' health by providing Business Rates Relief** to local Chambers of Commerce, local business groups or companies who work with others locally (or across their supply chain) to boost occupational health provision to SMEs through the development of 'group service enterprises' (also called inter-company services), thereby creating 'economies of scale' where SMEs cannot develop services 'in-house'.[18]

8. **The Community Ownership Fund should reward local business groups or councils who seek to leverage the use of dormant assets, empty high street units and accessible sites,** such as those in leisure sector to expand occupational health services – particularly for SMEs.

9. Building on the most recent review of the Safe Effective Quality Occupational Health Service (SEQOHS) standards, the **Government should develop a "Check-a-Trade" style system for employers to rate occupational health and vocational rehabilitation providers** to improve the 'feedback loop' and to drive consumer confidence. This would not serve a regulatory purpose.[19]

17. https://www.gov.uk/government/news/new-occupational-health-taskforce-to-tackle-in-work-sickness-and-drive-down-inactivity

18. Such a proposal aligns with the proposals set out in Policy Exchange's recent work on the 'property owning democracy': https://policyexchange.org.uk/publication/the-property-owning-democracy/#:~:text=A%20property%20owning%20democracy%20denotes,of%20ownership%20set%20out%20above.

19. https://www.seqohs.org/

Supply-Side Measures to Boost NHS Capacity

10. **NHS England should appoint a National Clinical Director for Occupational Health by Spring 2025 to raise the visibility of occupational health provision across the NHS** and to oversee the delivery of NHS England's *Growing occupational health and wellbeing together* strategy.

11. **Every Integrated Care System (ICS) in England should develop plans for a consolidated (or shared) occupational health service covering all NHS organisations (including primary and community care services) – where it does not already exist – in the coming twelve months**.

    a. This should be included in Strategic Plans and ought to specify dedicated leadership for its delivery. The focus should be on improve communication and collaboration between existing services and to 'wrap around' providers where there is limited provision.

    b. Plans should consider means to enable how offers can be extended to local social care providers also. Approaches to pool budgets and resources should be considered.

    c. Systems should also seek to develop and pilot new referral routes so that GPs can refer patients into dedicated NHS occupational services and so triaged referral to specialist services from select, high-quality private occupational health services can be enabled.

12. **Building on the 'Fuller stocktake report', NHS England should strengthen primary and community care services which tackle some of the major drivers of inactivity.**[20]

    a. 'Musculoskeletal hubs' (also known as MSK physical activity hubs) should be expanded, with the aim of developing a service across every primary care network footprint**.**

    b. Prediction models for long-term sickness absence, based upon occupational criteria, should become embedded within GP IT systems. This recommendation builds on our recent report, *Medical Evolution*, which called for the increased use of clinical-decision support software to be used in primary care settings.[21]

    c. Building on the Work and Vocational advice (WAVE) project and current WorkWell pilot, the Government should enhance links and the ability for primary care staff to embed or refer individuals to vocational advice services.[22]

20. https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/
21. https://policyexchange.org.uk/publication/medical-evolution/
22. https://www.keele.ac.uk/ctu/researchportfolio/activeresearch/wave/#!

Innovating in Workforce Development

13. The Government should commit to boosting the supply of occupational health and vocational rehabilitation professionals and innovate with current training and career pathways, building on the recently-published NHS Long Term Workforce Plan.

a. Enabling a greater range of professionals to specialize or to gain experience working in occupational health or vocational rehabilitation should be regarded as a means by which to expand opportunities for the NHS workforce and to enable work across a wider variety of settings.

b. Occupational Health is often overlooked (or minimised) in undergraduate and postgraduate medicine and nursing curricula. The Medical Schools Council, Council of Deans of Health and Universities UK (and their members) should work with the National School of Occupational Health (NSOH) to explore ways to enhance exposure to occupational health in curricula and to expand placement opportunities.

c. Training pathways in occupational health for Allied health professionals (AHPs) should be formalised.[23]

d. Create further opportunities for professionals working in occupational health – particularly nursing staff – to be able to develop sub-specialisation in key areas, such as women's health and the menopause or in cardiovascular disease management.

14. DHSC and NHS England should expand the number of clinical placements delivered by occupational health providers by developing a dedicated Tariff.

15. The Occupational Health Technician (OHT) role should be enhanced, with greater formalisation and support.

a. Currently, there is "no governing body or recognised qualification for occupational health technicians".[24] The Government should look to make the Health and Care Professions Council (HCPC) the professional regulator of OHTs in the coming years, following consultation.

b. The HSE should consult on measures which could enable OHTs to practice with greater independence over time in order to create additional capacity and to enable improved professional development. We would add the caveat that this would need to remain within an appropriate clinical governance structure.

23. https://www.nhshealthatwork.co.uk/images/library/files/2023%20Conference/1120_-_IRA_MADAN_.pdf

24. https://www.hse.gov.uk/health-surveillance/occupational-health/assessing-competence.htm

Chapter 1 – The Link Between Economic Performance and Ill-Health: The Rationale for Reform

"A healthy economy is only possible with a healthy workforce."

Helen Whately MP, Minister for Health and Social Care

"There are two great domestic crises facing our country - the economic crisis and the crisis in our NHS. The health of our society and the health of our economy are inextricably linked."[25]

Wes Streeting MP, Shadow Secretary of State for Health and Social Care

"Officials at the Department of Work and Pensions know they are in the grip of a seismic shift in the nature of why people are falling into sickness benefit."[26]

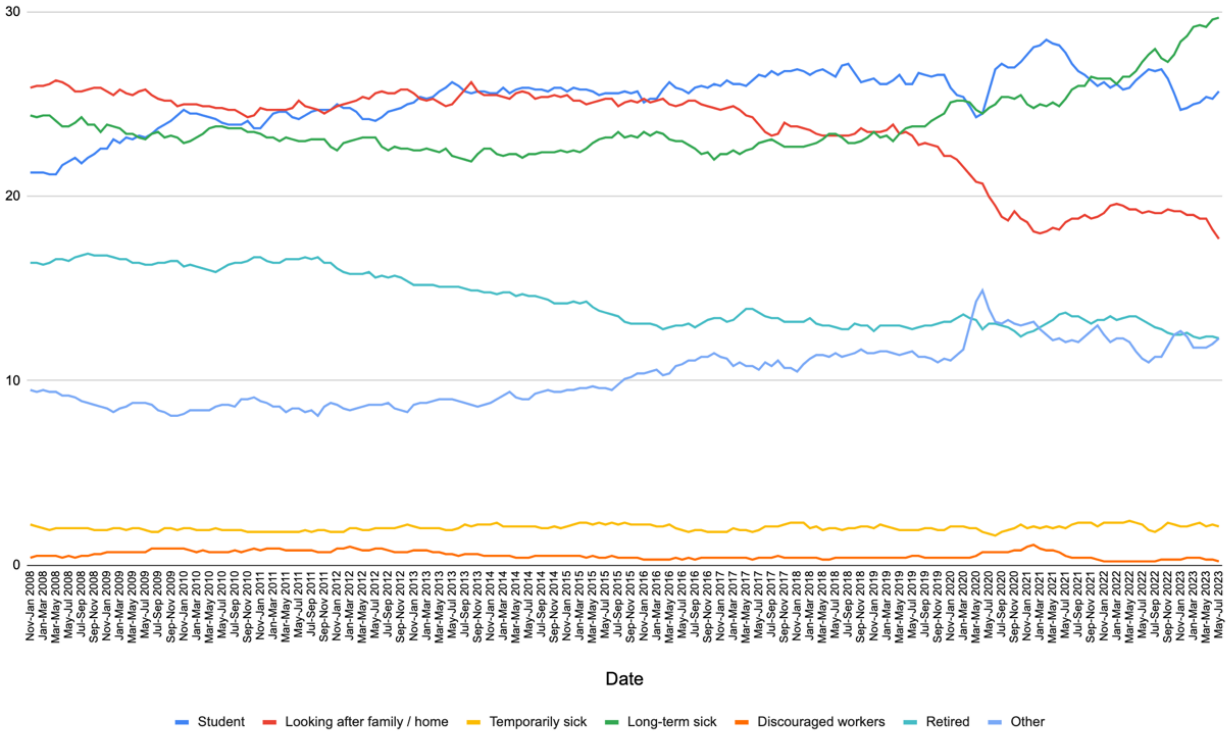
The Rt Hon Sir Iain Duncan Smith MP, Former Secretary of State for Work and Pensions (2010-2016)

Strong labour market participation is a crucial ingredient for a growing economy and a healthy society. Being in good work improves our economic wellbeing; enables a higher standard of living; and enables social inclusion.[27] Those who are unemployed have a higher prevalence of mental illness and a 20–30% greater risk of suicide – the highest killer of men under 50 and rising amongst women.[28] They also have a 20–25% higher mortality rate ten years after becoming unemployed, compared to those who remain in employment.[29]

Yet, the relationship between work and health works in both directions. Although work is good for health, work practices and workplaces can also be a cause and a driver of ill-health. Occupational health is the speciality which seeks to protect against work-related ill-health and seeks to "maintain the wellbeing of employees, preventing and removing ill-health and developing solutions to keep staff with health issues at work."[30] Traditionally, occupational health took the form of managing work-based hazards or occupational illnesses, such as asbestosis. However, over time, the line between work-influenced and work-impacting conditions have become increasingly blurred.

25. https://www.telegraph.co.uk/news/2023/11/14/nhs-league-tables-waiting-lists-labour-wes-streeting/
26. https://www.telegraph.co.uk/news/2023/11/22/autumn-statement-welfare-spending-disabled-work/
27. G. Waddell G & A.K. Burton, *Is work good for your health and well-being?* (London, 2006). See also: https://oem.bmj.com/content/71/10/730
28. https://pubmed.ncbi.nlm.nih.gov/11091806/
29. https://assets.publishing.service.gov.uk/media/5a7eecf2ed915d74e6227559/Review5_Employment_health_inequalities.pdf (p. 10)
30. https://www.som.org.uk/what-occupational-health

Figure 1 – Economic Inactivity: People aged 16 to 64 with reason for inactivity (%)



Source: https://www.ons.gov.uk/employmentandlabourmarket/peoplenotinwork/economicinactivity/datasets/economicinactivitybyreasonseasonallyadjustedinac01sa

As measures to combat COVID-19 stifled economies around the world, all industrialised countries saw people of working age become 'inactive'. Some fell ill; some left to care for relatives; others reassessed their work-life balance and took early retirement. The UK was no outlier in this occurring, but witnessed a slower return to activity rate compared to other major economies. As such, the topic of 'economic inactivity' has been subject to considerable debate in public policy over the past two years, reflected by a significant up-tick in mentions in major news outlets and Hansard.[31] Tackling 'inactivity' and maximising workforce participation meanwhile has been defined as a "top priority" by the Government.[32]

Interventions which can reduce 'inactivity' include encouraging and enabling the over-50s to have a longer working life and improving the provision of childcare so parents can work as well as bringing up children.[33] Reducing 'inactivity' therefore involves trade-offs: young people now spend longer in full-time education away from the labour market. If we had the same employment rates for 16–24-year-olds today as we did thirty years ago, 913,000 more people would be in work, but public policy has focused on full-time education and university-level qualifications which, for its advantages, has come at the expense of work-based learning and

31. On debate on inactivity, see https://www.ft.com/content/b197e9e0-dd53-4d77-a84f-a94824100ed5. See also: https://www.thetimes.co.uk/article/ill-health-takes-500-000-out-of-workforce-kwjv5tvl9; https://www.thetimes.co.uk/article/our-missing-workforce-is-killing-growth-cw7jmj29r. For mentions in Parliament, see: https://hansard.parliament.uk/search/Contributions?searchTerm=%22economic%20inactivity%22&startDate=11%2F08%2F2018%2000%3A00%3A00&endDate=11%2F08%2F2023%2000%3A00%3A00

32. Stated as such in – for instance – the recently published strategic framework for the Major Conditions Strategy: https://www.gov.uk/government/publications/major-conditions-strategy-case-for-change-and-our-strategic-framework/major-conditions-strategy-case-for-change-and-our-strategic-framework--2#:~:text=The%20major%20conditions%20strategy%20will%20consider%20the%20differential%20impact%20on,considering%20wider%20determinants%20of%20health.

33. For a proposal to more effectively childcare, see a recent Policy Exchange report, *Better Childcare*: https://policyexchange.org.uk/wp-content/uploads/2022/08/Better-Childcare.pdf

https://hansard.parliament.uk/Commons/2023-06-19/debates/83FF8692-4395-4A24-ABE3-EF651914F915/EconomicInactivity?highlight=%22economic%20inactivity%22#contribu-

development.[34]

The OBR have recently concluded that the key drivers of 'inactivity' in the UK are owing to:

- a slowdown, and partial reversal, in the rate of improvement in the health of the working-age population over the past decade, reflecting worsening trends in some specific health conditions – particularly mental health conditions – and an increase in the average age of the working-age population;
- the impact of the pandemic on the health of the working-age population both as a direct result of COVID-19 on physical health, and due to the disruptive effects of the pandemic on people's mental health and the treatment of non-Covid health conditions;
- rising onflows to health-related benefits, which may partly reflect the degree of ongoing assessment, conditionality, and return-to-work support for those on health-related benefits versus other out-of-work benefits, alongside the role of a sustained period of weak household income growth and rising cost-of-living pressures increasing the incentives to claim the former, more generous, benefits.[35]

Figures from August 2023 show that over half of the increase in 'economic activity' that occurred during the pandemic has since unwound. 300,000 more people are in work.[36] Yet, whilst overall economic inactivity has been decreasing, inactivity because of 'long-term sickness' has increased (see Fig. 1 above). There are now over 2.8 million people classed as 'long-term sick'; over 600,000 more than before the COVID-19 pandemic, meaning the highest levels of inactivity owing to ill-health since the early 1990s.[37]

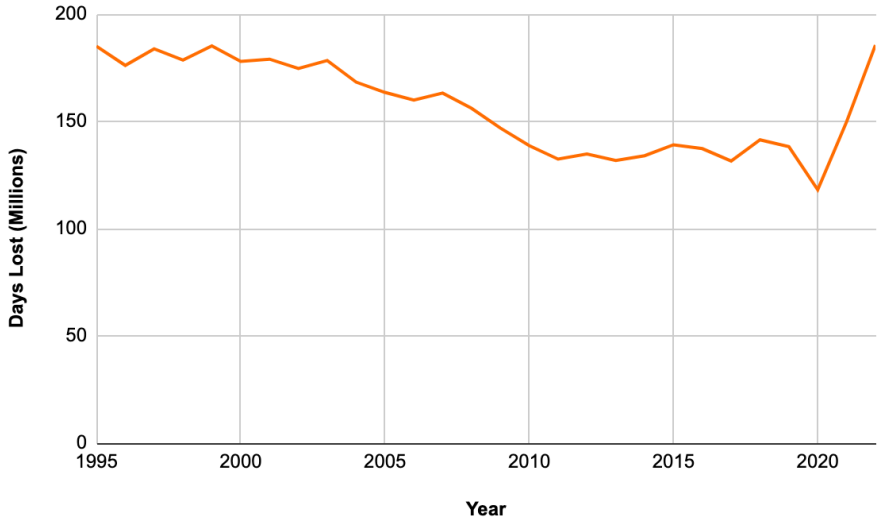
The numbers of those who are in poor health *in-work*, defined as having a 'work-limiting' condition has been growing.[38] Around 50% of the 'long-term sick' currently work, which accounts for about 10% of the total workforce.[39] Nine million people in work meanwhile have a long-term health condition, such as diabetes or hypertension.[40] Poor health is a strong predictor of inactivity and this is a trend which has been observed for some time.[41] Between 1973 and 2009, the relationship between good health and securing and sustaining employment strengthened for men and women.[42]

Sickness Absence and the 'Fit Note'

A useful indicator to test levels of poor health are rates of sickness absence. Fig. 2 below shows a sharp increase in the number of days lost per year due to sickness absence. The rate had steadily decreased over the past decade, but has risen sharply in the past two years, in alignment with growth in those in receipt of a 'fit note'.[43]

34. https://www.cipd.co.uk/knowledge/work/trends/uk-labour-supply#gref Policy Exchange's Education Unit has looked explicitly at how apprenticeships can be reformed: https://policyexchange.org.uk/publication/reforming-the-apprenticeship-levy/
35. https://obr.uk/docs/dlm_uploads/Fiscal_risks_and_sustainability_report_July_2023.pdf
36. https://hansard.parliament.uk/Commons/2023-09-04/debates/C4BF46D2-01A2-44F8-A7EF-9EE3D3916228/LabourMarketInactivity?highlight=%22economic%20inactivity%22#contribu-
37. https://blog.ons.gov.uk/2023/07/26/too-ill-to-work-a-deeper-look-at-what-the-figures-show/. These figures come with the caveat that in recent months, Labour Force Survey (LFS) published by the ONS have been withdrawn "due to concerns around its reliability. The ONS is now intending to publish revised LFS estimates with next month's release (February 2024). In the meantime, the ONS is using 'experimental' data to estimate employment, unemployment and economic inactivity, with this derived from HMRC Pay As You Earn (PAYE) data and the Claimant Count", see https://www.employment-studies.co.uk/resource/labour-market-statistics-january-2024
38. A good overview of recent literature is: https://commonslibrary.parliament.uk/how-is-health-affecting-economic-inactivity/. See also https://www.health.org.uk/news-and-comment/charts-and-infographics/is-poor-health-driving-a-rise-in-economic-inactivity#:~:text=An%20increase%20in%20poor%20health,measures%20needed%20to%20boost%20employment.
39. https://www.som.org.uk/sites/som.org.uk/files/Josh_Martin_Inactivity_and_long-term_sickness_SOM_event_13_Oct.pdf
40. https://assets.publishing.service.gov.uk/media/655df827544aea000dfb3277/E02982473_Autumn_Statement_Nov_23_Accessible_v2.pdf (p. 49)
41. https://www.centreforcities.org/blog/how-is-sickness-related-economic-inactivity-playing-out-across-the-country/
42. https://www.bmj.com/content/344/bmj.e2316
43. See evaluation of the FIT note: https://assets.publishing.service.gov.uk/media/5a7c9a0fe5274a0bb7cb8254/rrep840.pdf

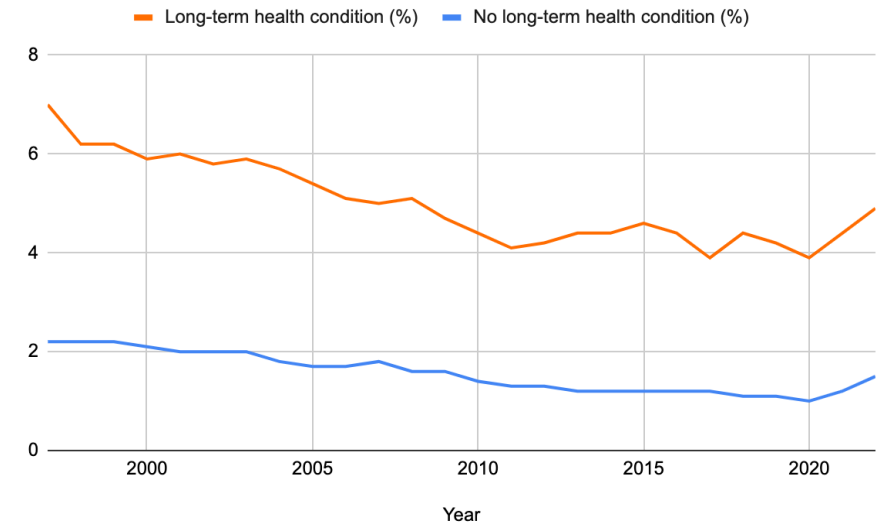
Figure 2 – Number of days (millions) lost through sickness absence in the UK, 1995 to 2022



Source: https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/datasets/sicknessabsenceinthelabourmarket

Fig. 3 below shows that the sickness absence rate is far higher for those with long-term health conditions, than those without. Sickness absence is a strong predictor of permanent work disability. It has been shown that people who are off sick for more than six months with an MSK disorder only have a 50% chance of ever returning to work. The number of those who return after two years of inactivity due to ill-health is exceptionally small.[44]

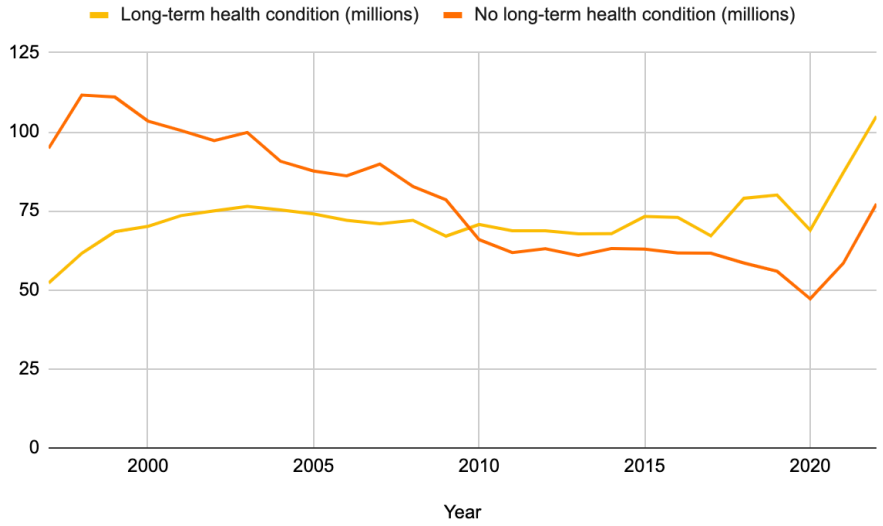
Figure 3 – Sickness absence rate, by those with long-term health conditions (and those without) across UK, 1997 to 2022



Source: https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/datasets/sicknessabsenceinthelabourmarket

44. https://www.rcpjournals.org/content/clinmedicine/21/3/195

Figure 4 – Number of days lost through sickness absence, comparing those with long-term health conditions (and those without), 1997 to 2022, UK



Source: https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/datasets/sicknessabsenceinthelabourmarket

What is the 'Fit Note'?

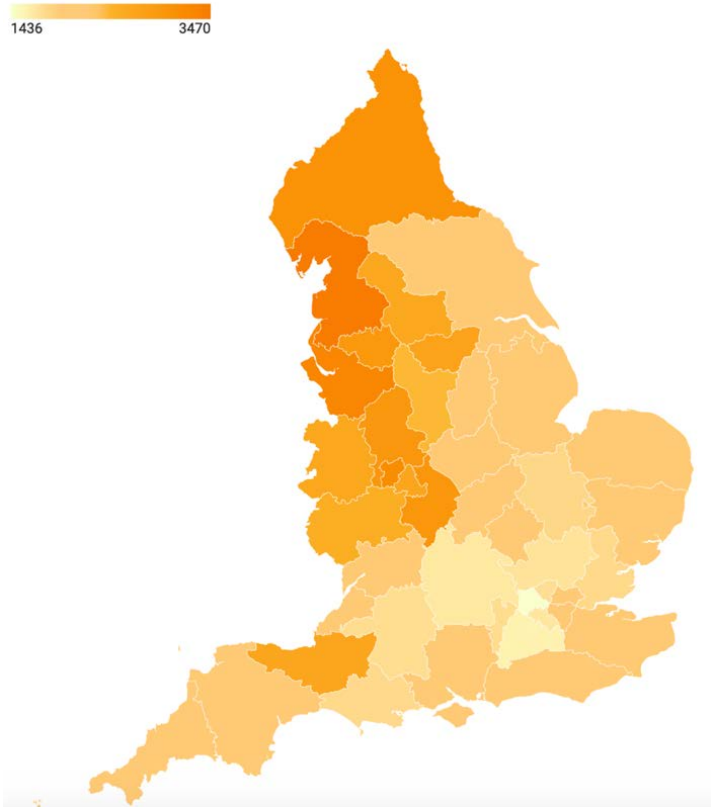
- The 'Fit Note' is a form of medical evidence which acts as a statement of fitness for work. It is the basis upon which an individual can access health-related benefits.
- Legislation "requires a healthcare professional to undertake an assessment, either through a face to face, video call, telephone consultation or through considering a written report by another healthcare professional, in order to complete a fit note".[45]
- Professor Dame Carol Black's review of the working age population, *Working for a healthier tomorrow* (published in 2008) recommended changes to the medical statement that GPs use to give advice on an individual's fitness for work.[46]
- The previous form (the 'sick note') asked a GPs to record diagnoses and indicate whether or not the individual presenting should or should not be working.
- The 'Fit Note' – which was introduced across England, Wales and Scotland in April 2010 brought about a number of changes, including a new option to record that an individual 'may be fit for work taking account of the following advice', increasing space for GPs to provide patients with comments on the functional effects of their condition; and tick boxes to indicate simple adjustments or adaptations that could aid RTW.[47]
- Over the last eighteen months, new 'digital' fit notes have been introduced, allowing the form to be issued using GP IT systems without the need for a signature.
- In recent months, DWP and DHSC have sought to take pressure off GPs by enabling nurses, occupational therapists, pharmacists and physiotherapists to certify 'fit notes', in addition to GPs.[48] A consultation to expand this to further professionals is underway.

45. https://www.gov.uk/government/publications/fit-note-guidance-for-healthcare-professionals/getting-the-most-out-of-the-fit-note-guidance-for-healthcare-professionals
46. https://assets.publishing.service.gov.uk/media/5a7c55bee5274a1b0042313c/hwwb-working-for-a-healthier-tomorrow.pdf
47. https://assets.publishing.service.gov.uk/media/5a7c9a0fe5274a0bb7cb8254/rrep840.pdf (p. 19)
48. https://www.lexology.com/library/detail.aspx?g=6bd-7d6c6-04e5-4789-9a82-207fae8eeda2

Based on latest NHS England data release covered period from April 2021-September 2023, 11,006,806 fit notes were issued across England from April 2022 to March 2033.[49] 93.4% of these 'fit notes' were signed 'not fit for work'.[50] 6.6% of fit notes state an individual "may be fit for work".

There is significant regional variation in the proportion of fit notes issued. Fig. 5 below depicts this variation by number of fit notes issued per 100,000 GP practice population against the geography of each integrated care board. For instance, per 100,000 registered patients during Q1 2023-24 3,040 fit notes were issued in the North West, whilst 1,652 fit notes were issued in London.[51] Recent work from the Resolution Foundation notes that higher rates of long-term sickness are observed in areas that are more deprived.[52]

Figure 5 – Number of fit notes issued per 100,000 GP Practice population of 18- to 65-year-olds by NHS integrated care system boundary, England, April 2021 to September 2023



Source: https://digital.nhs.uk/data-and-information/publications/statistical/fit-notes-issued-by-gp-practices/september-2023. Image created with Datawrapper.

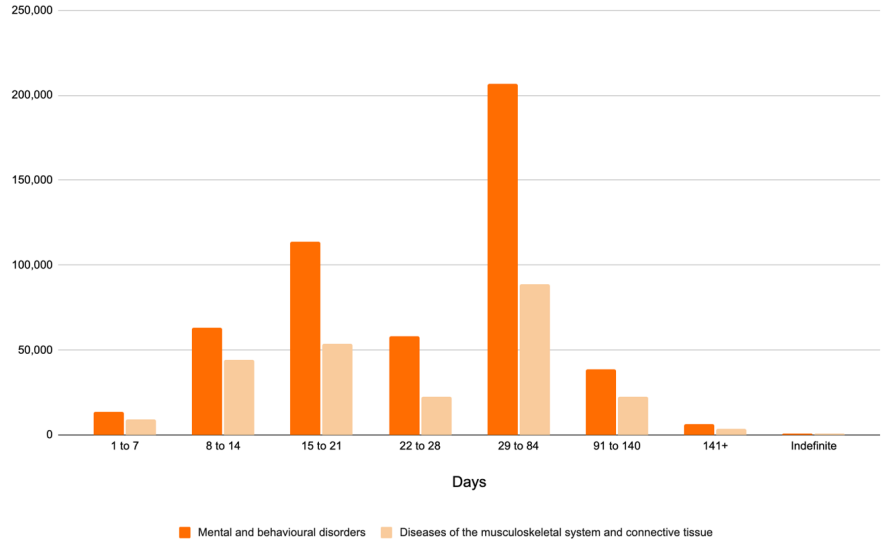
A recent Government consultation suggests that the high proportion of 'fit notes' designated 'not fit for work' reflects several issues: from "time constraints in primary care to limitations of the fit note itself". In short, certifying a patient 'not fit for work' can represent a 'path of least resistance' in a time-pressured, ten-minute GP appointment. As one of

49. https://digital.nhs.uk/data-and-information/publications/statistical/fit-notes-issued-by-gp-practices
50. https://digital.nhs.uk/data-and-information/publications/statistical/fit-notes-issued-by-gp-practices
51. https://digital.nhs.uk/data-and-information/publications/statistical/fit-notes-issued-by-gp-practices/june-2023
52. https://www.resolutionfoundation.org/publications/labour-market-outlook-q1-2024/

the respondents to the consultation said: "*I don't have the power to say to a patient: 'I don't agree with you, I think you should go to work', if a patient says I can't work… As a GP, we only have 10 minutes with the patient, and we're certainly not trained to assess people's occupational health.*"[53]

Based on latest figures available for September 2023 (see Fig. 6 below) mental illness and MSK conditions are the two most prevalent diagnoses detailed in 'fit notes', whilst over a third of fit notes are being given with stipulations for between 29 and 84 days (one and three months).

Figure 6 – Duration of fit notes by diagnosis, England, April 2021 to September 2023



Source: *https://digital.nhs.uk/data-and-information/publications/statistical/fit-notes-issued-by-gp-practices/september-2023*

What is Driving Growing Sickness Absence and 'Inactivity'?

We might instinctively deduce that this growing rate of inactivity due to ill-health is due to long waits for NHS services. Clearly, the wider performance of the NHS and ability for citizens to access swift and effective care is significant, but only a small proportion of those who are 'inactive' for health reasons, however, are on the 'waiting list' for elective care. The majority of working-age adults who are inactive for health reasons have been so since before the pandemic began.[54] Whilst disruption to and difficulties accessing NHS services may have played a role in the worsening physical and mental health of the working-age population, tackling the waiting list alone is likely to make "only a modest difference in the number of people out of work". The OBR estimate that halving the waiting list over five years – returning it to its mid-2015 level of around 3.5 million – would only reduce working-age inactivity by 25,000.[55]

Many of those currently on the elective waiting list are not economically

53. https://assets.publishing.service.gov.uk/media/5f294e94d3bf7f1b111924ac/exploring-perceptions-and-attitudes-towards-extension-of-fit-note-certification.pdf (p. 40)

54. https://obr.uk/docs/dlm_uploads/Fiscal_risks_and_sustainability_report_July_2023.pdf (p. 52)

55. https://obr.uk/docs/dlm_uploads/Fiscal_risks_and_sustainability_report_July_2023.pdf (p. 7)

inactive either, but are likely to have higher rates of sickness leave or may have reduced their hours. Many more will simply be trying to work despite having pain and self-reporting MSK conditions (for example). An Office for National Statistics (ONS) poll of those on the elective 'waiting list' from February 2023 found that 13% of those on the waiting list said their work was impacted.[56] These findings align with the perspectives of those we interviewed who were waiting for care as part of Policy Exchange's research into the elective backlog, published in July 2021, entitled *A Wait on Your Mind*.[57]

It is also important to remember that the majority of those not working or looking for work due to long-term sickness have multiple health conditions. 70% of those with a main health condition that was MSK in nature – back or neck pain, for example – reported that they have more than one type of condition to manage.[58] 36% of all working-age people reported at least one long-term health condition in the first four months of 2023.

The interface between work and health is complex. Health issues may be inherited (or acquired at an early age) or present later in life. Some individuals may have fluctuating levels of impairment (e.g., multiple sclerosis or rheumatoid arthritis) or progress inexorably (e.g., motor neurone disease). Indeed, many long-term conditions might not appear to impact ability to work directly (e.g., diabetes, osteoarthritis or hypertension).[59] However, these conditions can be physically restrictive. Additionally, attending healthcare appointments, such as hospital-based investigations, blood monitoring all impact the working routine – particularly if it is shift-based. Many patients with long-term conditions use their annual leave to attend some of these appointments. [60]

The two key drivers of long-term sickness are mental ill-health and MSK conditions.[61] Of those non-working and citing mental ill-health, the majority will have common mental disorders (CMDs) – an umbrella term for mental health conditions such as depression, anxiety disorders and stress-related disorders, rather than severe mental illness (SMI) which encompasses conditions such as bipolar disorder and schizophrenia.[62] "The number of workers aged 16–34 years who report that their mental health limits the type or amount of work they can do has increased more than four-fold over the past decade".[63] 30.8 million work days meanwhile are lost due to MSK conditions, such as back pain, osteoarthritis, and inflammatory conditions such as rheumatoid arthritis. This accounts for 22.4% of total sickness absence.[64] For those aged between 50-64 years old, MSK conditions were trending down prior to the pandemic, but have since risen.[65] The Richmond Group of Charities has found that people with MSK conditions consult their GP five times more often than those without.[66] Beyond this, airborne respiratory diseases (including COVID-19) are also a key driver of sickness absence.[67] These conditions are driving considerable demand for existing NHS services.

This picture of increased levels of long-term illness as a driver of economic inactivity is complex. Just as in any year a percentage of the

56. https://www.thetimes.co.uk/article/south-end-the-city-where-1-in-5-people-are-on-nhs-waiting-list-3gwj8hb7l
57. https://policyexchange.org.uk/publication/a-wait-on-your-mind/
58. https://www.lancaster.ac.uk/media/lancaster-university/content-assets/documents/lums/work-foundation/409_Complexitieschallenges1-1(1)accessible.pdf
59. https://academic.oup.com/occmed/article/68/1/2/4866336
60. https://www.rcpjournals.org/content/clinmedicine/21/3/195
61. https://www.ons.gov.uk/employmentandlabourmarket/peoplenotinwork/economicinactivity/articles/risingillhealthandeconomicinactivitybecauseoflongtermsicknessuk/2019to2023
62. https://link.springer.com/article/10.1007/s00420-023-01968-7
63. https://www.health.org.uk/publications/long-reads/what-we-know-about-the-uk-s-working-age-health-challenge
64. https://ukhsa.blog.gov.uk/2017/12/06/health-matters-productive-healthy-ageing-and-musculoskeletal-health/
65. https://obr.uk/docs/dlm_uploads/Fiscal_risks_and_sustainability_report_July_2023.pdf (p. 51)
66. https://richmondgroupofcharities.org.uk/sites/default/files/final_rg_mltc_report_a4_0.pdf
67. https://obr.uk/docs/dlm_uploads/Fiscal_risks_and_sustainability_report_July_2023.pdf

workforce will develop flu or other illnesses, a certain level of people experiencing poor mental health will be inevitable.[68] There is an absence of reliable data and consistent use of accepted definitions of mental health and illness. This can make it difficult for businesses to judge exactly which interventions they support and those that will be most effective. Although it is undoubtedly positive that stigma concerning mental ill-health is being reduced – and workplaces have a crucial role to play - 'more medicine' may not in fact always be the best approach in all cases. As the former Minister for Primary Care and Public Health, Neil O'Brien MP has noted, there is a "tendency to "medicalise the human condition".[69] Holistic occupational health is therefore important. Conditions such as arthritis meanwhile may have a limited impact on sickness absence or unemployment, but "appear to be associated with transitions out of employment and to long-term sickness".[70]

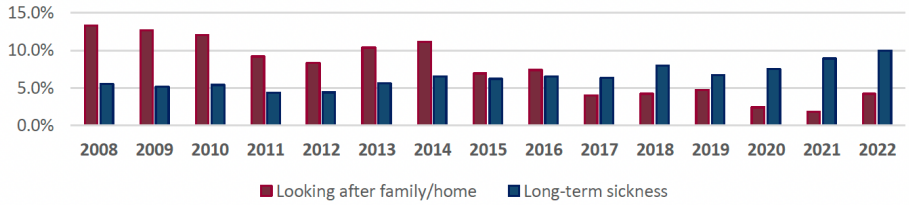
Moreover, we should urge greater clarity – and some caution – over the terminology often deployed in debate on health and work. For instance, Dr Richard Preece has noted in his testimony (which informed the development of recent NICE guidance on workplace health), that: "a lack of clarity about the definition of *presenteeism* has resulted in the assumption that this is a bad thing. This assumption should be challenged – at its simplest level doing any work means a worker is more productive than one doing none". As he has written in the *British Medical Journal*, "only limited evidence suggests that presenteeism leads to significant morbidity (especially when health issues at work are effectively managed)." He concludes: "workers have health issues. Employers need to take action and provide suitable occupational health support."[71]

Cohorts of concern

Between October and December 2022, 54% of people who were economically inactive due to long-term sickness were aged 50 to 64 (around 1.4 million people).[72] Key findings from a recent Society of Occupational Medicine (SOM) report conclude that long-term sickness in women across all age groups has been rising since 2014, with women becoming economically inactive at a higher rate than men.[73] Economic inactivity is meanwhile not just a challenge confined to those of middle-age or those approaching retirement. Young people who are not in employment, education or training (so called 'NEET's) increased in the latest set of statistics, with the figure currently standing at 770,000.[74] Personal Independence Payment claims doubled between July 2021 and July 2022, with 70% of claims of those under twenty-five attributable to mental or behavioural conditions.[75] These young people are more likely to be male.[76] In Scotland over the past fifteen years there has been almost a complete inversion in the reason provided for economic activity among those between 16-24. Fig. 7 shows the percentage young people (aged 16-24) who are economically inactive by reason: looking after family/home and long-term sickness.

68. https://assets.publishing.service.gov.uk/media/5a82180e40f0b6230269acdb/thriving-at-work-stevenson-farmer-review.pdf (p. 26)
69. https://conservativehome.com/2021/02/22/neil-obrien-the-nhs-and-jobs-family-and-community-indispensible-means-of-boosting-our-mental-health/
70. https://ard.bmj.com/content/82/Suppl_1/553
71. https://www.bmj.com/rapid-response/2011/11/03/presenteeism-perspective
72. https://commonslibrary.parliament.uk/how-is-health-affecting-economic-inactivity/#:~:text=Long%2Dterm%20sickness%20accounted%20for,is%20due%20to%20temporary%20sickness
73. https://obr.uk/docs/dlm_uploads/Fiscal_risks_and_sustainability_report_July_2023.pdf (p. 49)
74. https://www.ons.gov.uk/employmentandlabourmarket/peoplenotinwork/unemployment/datasets/youngpeoplenotineducationemploymentortrainingneettable1
75. Joyce et al. *The number of new disability benefit claimants has doubled in a year*. IFS Report R233. Institute for Fiscal Studies. 7 December 2023. Link.
76. https://www.som.org.uk/study-record-number-people-work-long-term-sick#

Figure 7 – Percentage of young people (16-24 years own) economically inactive in Scotland (by reason)



Source: https://www.gov.scot/publications/economic-inactivity-young-people-aged-16-24-definition-reasons-potential-future-focus/pages/4/

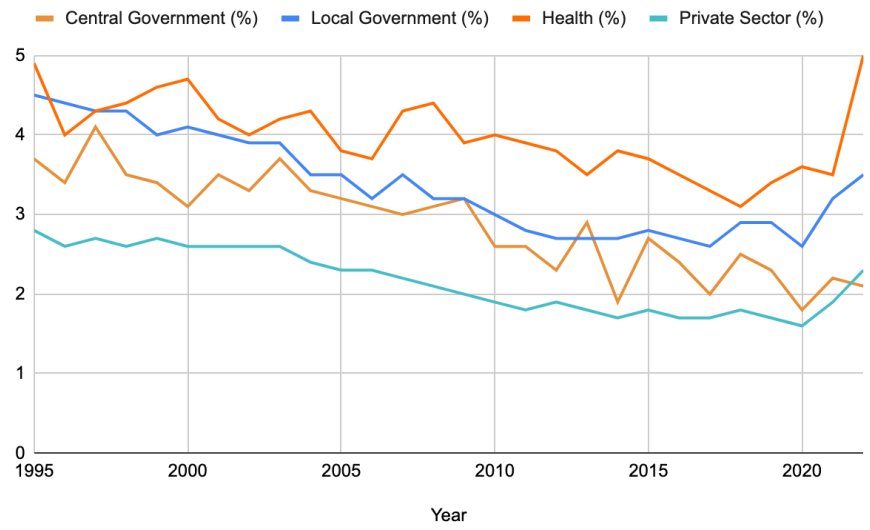
Segmenting by sector?

The most recent report on 'Sickness absence in the UK market' from the ONS, notes that, "in 2022…sickness absence rates were 3.6% for public sector workers and 2.3% for private sector workers, up 0.6 and 0.4 percentage points, respectively, from 2021.[77] Josh Martin and Jonathan Haskel have shown that those in low-paid and 'low skill' jobs have the highest prevalence of long-term sickness.[78] Sector-wise, human health, social work and public administration/defence were found to have the highest rates of work-related ill health and occupations.[79]

As shown by Fig. 8 there has been significant growth in the sickness absence rate across the public sector and local government, but the rise in health and care settings has been the most pronounced of all. The reasons most frequently cited for work-related stress include workload, lack of managerial support and poorly managed organisational change.[80] An overview of the situation across the NHS in England is set out below. Of particular note here are issues in the care sector. At present, it "lacks unifying guidance around workforce health standards, despite facing many of the same occupational hazards and risks", according to a recent paper.[81] A number of dedicated schemes have however emerged in recent years which seek to address particular occupational risks for public sector organisations. For instance, Mind's 'Blue Light Programme' (which ran from 2015 until 2023) was a programme of mental health support for staff and volunteers in the police, fire, ambulance and search and rescue services. Over ten thousand line managers received training in how to support their colleagues' and teams' mental health.[82]

77. https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/labourproductivity/articles/sicknessabsenceinthelabourmarket/2022
78. https://www.imperial.ac.uk/people/j.haskel/document/9802/Haskel%20Martin%20sickness%20inactivity%20v2/?Haskel%20Martin%20sickness%20inactivity%20v2.pdf
79. https://worknest.com/blog/hse-statistics-2022-reveal-a-sharp-rise-in-worker-injuries/
80. https://academic.oup.com/bmb/article/126/1/113/4976608
81. https://journals.sagepub.com/doi/full/10.1177/01410768221090673
82. https://www.mind.org.uk/news-campaigns/campaigns/blue-light-programme/

Figure 8 – Sickness absence rate, in large public sector organisations and the private sector across UK, 1995 to 2022

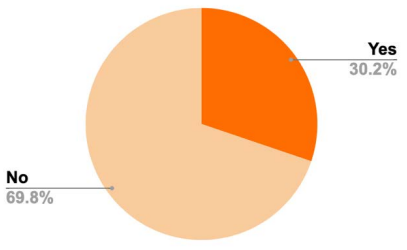
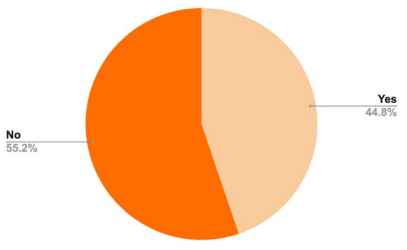


Source: *https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/datasets/sicknessabsenceinthelabourmarket*

The Health of the NHS

- Sickness absence costs the NHS roughly £2.4 billion per year with an annual average of just under ten days absent per employee. In 2016, this was 46% higher than other industries and 27% higher than the average across the public sector.[83]
- This matters not just for the productivity of the NHS, but because of established links between ill-health (particularly mental ill-health) and worse patient outcomes, driven by issues such as medication errors.[84]

Figure 9 – Self-reported ill health from the NHS Staff Survey 2022 – National Results

'In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?'	*'During the last 12 months have you felt unwell as a result of work-related stress?'*
	
Base: 608,269 responses	Base: 607,880 responses
Source: https://www.nhsstaffsurveys.com/	

83. https://pilotfeasibilitystudies.biomedcentral.com/articles/10.1186/s40814-022-01095-z#auth-Tom-Marshall-Aff1

84. https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2698144

Fig. 9 – shows the proportion of total NHS employees across England who have reported either MSK or stress-related issues in the past twelve months. Significant variations can be seen when you drill further into the detail. For instance, 46.4% of those responding who work for The London Ambulance Service Trust stated they had MSK problems as a result of their work, whilst just 21% of those working at the Avon and Wiltshire Mental Health Partnership NHS Trust reported such problems, reflecting the varying nature of work across different providers and specialisms.[85]

Approaches to Boost Occupational Health in the NHS

- **In 2015** – In response to the high levels of staff ill-health and absenteeism, NHS England created a 'Healthy Workforce Programme', supported by the Royal College of Physicians, which included £450m in incentives for Trusts to improve staff health and well-being. A number of recent UK studies have found that a large proportion of healthcare staff do not themselves meet public health guidance in relation to healthy lifestyle behaviours.[86] As such, the scheme sought to expand the provision cardiovascular disease (CVD) health checks for staff in the workplace and to improve access to physiotherapy, mental health, weight management and smoking cessation services.[87]
- **In 2016** – A Commissioning for Quality and Innovation (CQUIN) payment was introduced to provide financial incentives for NHS providers to support staff health and well-being. Payment is dependent on the introduction of workplace health and well-being initiatives, with a particular focus on physical activity, and improving support for mental health and MSK issues; encouraging healthier food choices; and increasing staff uptake of the influenza vaccination.
- **In 2019** – The NHS Staff and Learners' Mental Wellbeing Commission report was published which reviewed good practice and recommended tailored in-house mental health support and signposting to clinical help be developed in every Trust.[88]
- **In 2022** – The Fuller 'Stocktake' on primary care in integrated care calls for integrated care systems (ICSs) to extend occupational health and wellbeing provision across primary care organisations. NHS England will work with systems and stakeholders to consider how best to complement local investment in occupational health and wellbeing (OHWB) services to keep staff well and therefore increase workforce capacity and productivity.
- **In 2023** – NHS England publishes Growing occupational health and wellbeing together: our roadmap for the future which seeks to define the roadmap for "healthcare organisations and system leaders in England to flexibly work toward when articulating their localised vision and steering their investment in occupational health services over the next five years".[89]

85. Q11b – organisational results, see: https://www.nhsstaffsurveys.com/
86. These studies are cited in: https://eprints.whiterose.ac.uk/159878/1/3032265.pdf
87. https://pilotfeasibilitystudies.biomedcentral.com/articles/10.1186/s40814-022-01095-z#ref-CR36
88. https://www.hee.nhs.uk/sites/default/files/documents/NHS%20%28HEE%29%20-%20Mental%20Wellbeing%20Commission%20Report.pdf
89. https://www.england.nhs.uk/long-read/growing-occupational-health-and-wellbeing-together-our-roadmap-for-the-future/

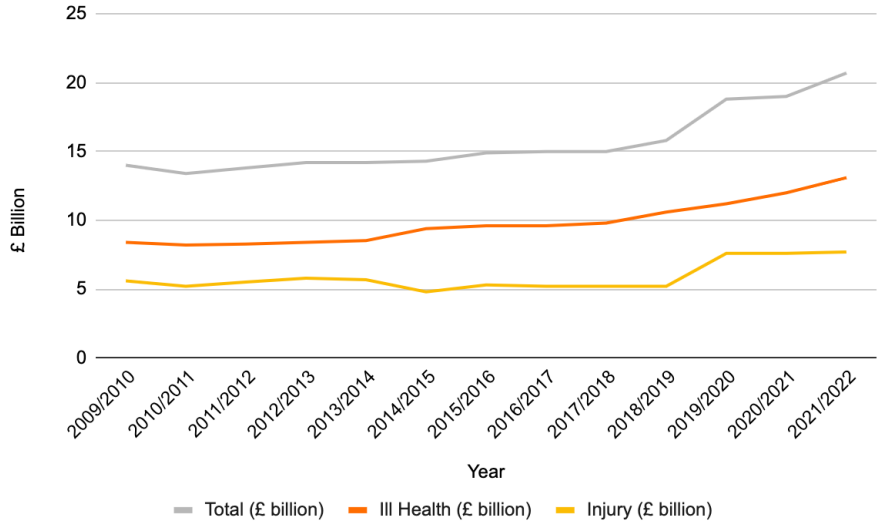
What Is the Impact of Ill-Health Upon Economic Performance?

According to the latest figures, 131 million working days are now lost each year to ill health. The number of those claiming disability benefits meanwhile has risen from under 600,000 in the early 1990s to about 2.2 million today.[90] So what is the cost of all this? The result is higher welfare spending, foregone tax revenues and higher health care spending, reflecting the two-way relationship between the duration of economic inactivity and deterioration in health.[91] Sickness absence is now thought to cost employers on average £781 for each member of staff.[92] The Confederation of British Industry (CBI) have recently estimated that working days lost to ill-health cost the UK economy £300bn a year.[93] ShareAction have suggested that in 2022, £127.9 billion was lost due to workers being less productive, off sick or quitting all together.[94] Oxera, a consultancy commissioned by the Times Health Commission to investigate underlying costs, believe total economic cost of lost output among working-age people due to ill health is around £150bn per annum, equivalent to the current total annual budgetary allocation for NHS England. Additional total costs to the government (in terms of lost tax income, benefits payments and costs to the NHS) are around £70bn (or £1,000 per person). They state that costs have risen by around 60% since 2016.[95]

The Farmer-Stevenson Review recently concluded that mental ill-health costs employers between £33 billion and £42 billion a year, with an annual cost to the UK economy of between £74 billion and £99 billion.[96] These costs are being increasingly borne by the individual as well as the state: the number of people receiving at least one prescription item for antidepressant drugs in England rose 22 per cent between 2015/16 and 2021/22 to 8.3m.[97] Moreover, suicide is the biggest killer of men under the age of 50 and alarmingly rising in women too.[98]

90. https://www.thetimes.co.uk/article/sickness-benefit-kept-workforce-crisis-0cklx-vs50
91. https://obr.uk/docs/dlm_uploads/Fiscal_risks_and_sustainability_report_July_2023.pdf (p. 7)
92. https://www.peoplemanagement.co.uk/article/1789100/sickness-absence-rate-highest-decade-survey-data-shows
93. https://www.cbi.org.uk/articles/unlocking-businesses-potential-to-create-a-healthier-workforce/
94. https://cdn2.assets-servd.host/shareaction-api/production/resources/reports/ShareAction_Workplace-Health_2023.pdf
95. https://www.oxera.com/wp-content/uploads/2023/01/230116_The-Economic-Cost-of-Ill-Health-Among-the-Working-Age-Population.pdf
96. https://www.gov.uk/government/publications/thriving-at-work-a-review-of-mental-health-and-employers.
97. https://www.ft.com/content/e2818aaf-6e79-4c12-bfe5-1864d078f8a7
98. https://www.gov.uk/government/news/men-urged-to-talk-about-mental-health-to-prevent-suicide

Figure 10 – Total costs of self-reported workplace injury and ill health, 2009/2010-2021/2022 (£ billion)



***Source:** Health and Safety Executive (HSE) Annual Reports, 1999/2000-2021/2022, accessible here:* https://qhse.support/index.htm?context=210

Note: All Estimates based on HSE's "Costs to Britain Model". In the past, totals did not include the costs of long latency diseases, such as occupational cancer, due to 'past working conditions'. To address this gap, HSE is finalising estimates of the economic costs of occupational cancer in Great Britain- see: https://questions-statements.parliament.uk/written-questions/detail/2015-03-18/228024

What Steps Are the Government Taking to Tackle 'Inactivity'?

> *"Healthy businesses need healthy workers – employers will benefit from higher retention rates, more productive workers, and fewer work days lost due to sickness. Improving health in the workplace is a vital piece of the puzzle in our drive to increase employment."*
>
> Rt Hon Mel Stride MP, Secretary of State for Work and Pensions[99]

Tackling economic inactivity is regarded as a 'top priority' by the Government. As such, they have recognised the need for a robust policy response to meet the challenges associated with a growing burden of multiple conditions and long-term illness. Moreover, the current size of the UK welfare budget only reinforces the need for action. Measures included in the Government's recently-published *Back to Work* plan, which appeared a few days before the Chancellor's Autumn Statement, is summarised in the table below. The Opposition also recognises the importance of this agenda and has called for improved tailoring of employment support at a

99. https://www.gov.uk/government/news/new-plans-to-boost-health-in-the-workplace-to-keep-people-in-work#:~:text=We%20need%20employers%20to%20keep,our%20drive%20to%20increase%20employment.

local level and for expanding the accessibility of Job Centre support.[100] At the Trades Union Congress in September 2023, the Deputy Leader of the Labour Party, Angela Rayner MP, announced that a Labour Government would boost statutory sick pay and "make it available to all workers by removing the lower earnings limit, which cuts out those on low wages, and remove the waiting period which currently means workers can only access it from day four of sickness."[101]

Table 1 – An Overview of Current Government Policies to Minimise Economic Inactivity

Department	Description of Policy
Department of Health and Social Care (DHSC)	
NHS Talking Therapies	Evidence-based therapies for adults with common mental health conditions, including anxiety disorders and depression. Current policy aims to support an additional 384,000 people over the next five years by increasing the average number of therapy sessions per person.
Individual Placement and Support (IPS)	Model of supported employment, integrated within community mental health teams for people who experience severe mental health conditions or have complex mental health needs, which aims to help people gain and retain employment. Current funding will provide for an additional 100,000 people to access support.
NHS Recovery Plans	The successful delivery of DHSC's recently-published recovery plans, aim to improve performance of core NHS service, as will the recently-published Major Conditions Strategy framework.[102]
Department of Work and Pensions (DWP)	
Additional Jobcentre Support in England and Scotland	Testing how intensive support can help claimants into work who remain unemployed or on low earnings after 7 weeks into their Universal Credit claim.
Extension of Restart Scheme	Work-support programme assisting claimants to get back to work through coaching, CV and interview skills. Claimant referrals being brought forward to six months from nine months.
Claimant review post-Restart	Universal Credit claimants who are still unemployed after the 12-month Restart programme will take part in a claimant review point: a new process whereby a work coach will decide what further work search conditions or employment pathways would best support a claimant into work. If a claimant refuses to accept these new conditions without good reason, their Universal Credit claim will be closed and benefits stopped.

100. https://www.politicshome.com/news/article/labour-would-drop-universal-credit-requirement-for-job-centres

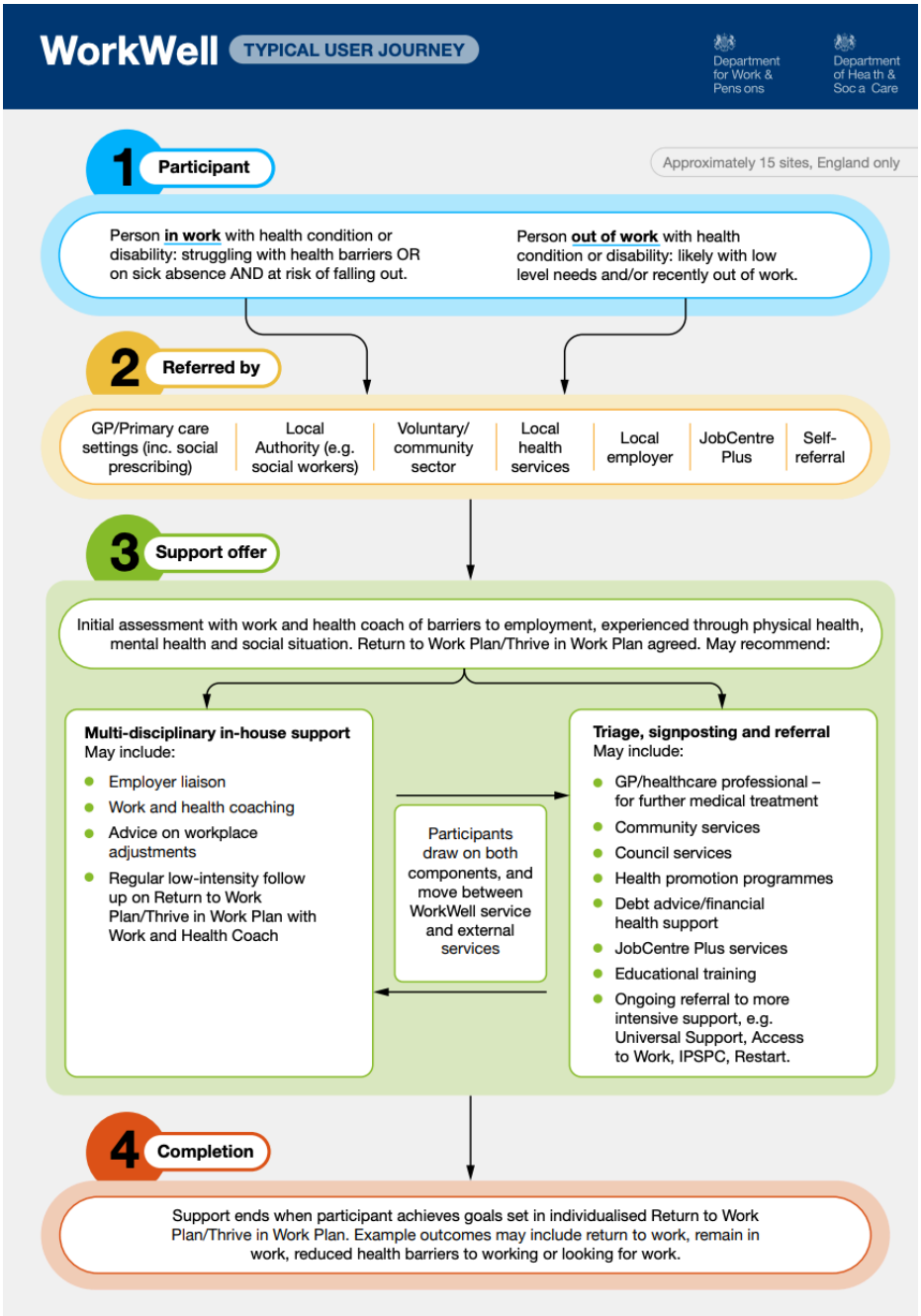
101. https://www.ft.com/content/962a7ebb-5ce6-4a61-aca8-a702417f1251

102. https://www.gov.uk/government/publications/major-conditions-strategy-case-for-change-and-our-strategic-framework/major-conditions-strategy-case-for-change-and-our-strategic-framework--2#:~:text=The%20major%20conditions%20strategy%20will%20consider%20the%20differential%20impact%20on,considering%20wider%20determinants%20of%20health.

Post-Restart pathway trials (including phased rollout of mandatory work placements)	Claimants who have not taken up suitable local job offers at the end of Restart (18 months into claim for those who start Restart at 6 months) will be required to accept time-limited work experience or another intensive activity to improve their employability prospects. This will be gradually rolled out from 2024, so the model can be tested and refined.
Targeted Case Reviews	Rooting out fraud and error using Targeted Case Reviews to review Universal Credit claims of individuals on an open-ended sanction and disengaged for over eight weeks, ensuring they receive the right entitlement.
Universal Support in England and Wales	100,000 people per year will be matched with vacancies. Participants will access up to 12 months of personalised 'place and train' support. The individual will be supported by a dedicated keyworker, with up to £4,000 of funding available to provide each participant with training, help to manage health conditions or for employers to make necessary adjustments.
Joint DWP-DHSC Programmes	
WorkWell	A new service delivered by DWP and DHSC to support 60,000 long-term sick or disabled people to start and stay in work. Integrated Care Systems across England will be encouraged to develop localised work and health strategies. The service will then be delivered in up to 15 pilot areas. The service model is detailed in Fig. 11 below.
'Fit Note' Reform	Government working with healthcare professionals to reform 'fit notes'. Reforms due in 2024, (which will inform further rollout to a small number of local health systems (trailblazer sites)) to improve the assessment of fitness for work, provide easy and rapid access to specialised work and health support, and enable more people to resume work after a period of illness. Reforms "could lead to GPs being out of the 'fit note' system altogether".[103]

103. https://www.thetimes.co.uk/article/jobless-will-lose-free-nhs-prescriptions-if-they-refuse-to-seek-work-xnfxthtgl

Figure 11 – WorkWell Pilot: 'Typical User Journey'



Source: https://assets.publishing.service.gov.uk/media/655618fd046ed-400148b9a2e/workwell_user_journey.pdf

The Current Approach to Occupational Health

Both the Government and Opposition recognise the significance of the link between health and employment, and note that expanding occupational health provision has a key role to play.[104] Luciana Berger, the former Labour MP for Liverpool Wavertree will be leading a review of Labour mental health strategy alongside Shadow Health Secretary Wes Streeting MP and shadow mental health minister Abena Oppong-Asare MP in the coming months which is likely to consider the significance of links between poor

104.https://oem.bmj.com/content/71/4/295.short

mental health and employment.[105] There is a recognition that a failure to tackle and prioritise this imperative comes with both major human and economic costs. Below is a summary of the policy interventions the Government have taken since January 2023:

Date	Intervention	Description
January 2023	**Stimulate Innovation in Occupational Health**	A **£1m fund announced** (in cooperation with Innovate UK, the Department for Work and Pensions, and the Department for Health and Social Care) to promote innovation and enhance employee health outcomes through technology.[106]
March 2023	**Spring Budget 2023**	A **£2 billion package of new measures** to support people living with health conditions to succeed in work. This included the publication of two consultations (*Occupational Health: Working Better* and *Tax Incentives for Occupational Health*). Includes announcement of a targeted SME subsidy for procuring occupational health services, providing a suggested 80% relief on the cost of both OH assessments and treatment.
March 2023	***Occupational Health: Working Better***	Sought views on proposals aimed at increasing employer use of Occupational Health. In scope were views on the introduction of a national 'health at work' standard to provide a baseline for occupational health provision; best practice from other countries and other UK-based employer models that enable employers to provide support for their employees; and how we develop and support a multidisciplinary workforce on work and health, including an expert occupational health workforce. This will build on the existing work with the occupational health sector and explore the opportunities this can offer businesses and providers.
March 2023	***Tax Incentives for Occupational Health***	Aimed at employers and explores the role that tax incentives may play in boosting occupational health provision.[107]

105. https://www.theguardian.com/politics/2024/jan/14/luciana-berger-given-key-labour-role-after-quitting-over-antisemitism
106. https://techround.co.uk/news/boosting-occupational-health-uk-innovations-initiatives/
107. https://www.gov.uk/government/consultations/occupational-health-working-better

March 2023	***Disability Action Plan***	A third consultation, the Disability Action Plan consultation looks to address how disability intersects with occupational health.
November 2023	***Autumn Statement***	Occupational Health: Working Better consultation response outlines plans to establish an Expert Group Task and Finish Group to support development of occupational health Voluntary Minimum Framework.
February 2024	***Occupational Health Taskforce Launched***	Dame Carol Black to lead a new Taskforce to improve employer awareness of the benefits of Occupational Health in the workplace.[108]

108. https://www.gov.uk/government/news/new-occupational-health-taskforce-to-tackle-in-work-sickness-and-drive-down-inactivity

Chapter 2 – Workplace Health Provision in the UK and Across the World Today

What is Workplace Health?

The Local Government Association define 'workplace health' as "promoting and managing the health and wellbeing of staff and includes managing sickness absence and 'presenteeism' (a person physically at work but not fully productive). Workplace health interventions are activities undertaken within the workplace by an employer or others to address these issues; it also includes action to address health and safety risks."[109]

Many healthcare professionals undertake roles which can be considered workplace health, but the two professional groups who specialise in providing services which focus upon how the working environment impacts upon health are occupational health and vocational rehabilitation. These disciplines can overlap – many elements of vocational rehabilitation for instance can be incorporated/included within the offering from occupational health providers.

Occupational Health

Occupational Health is a specialist branch of medicine which focuses on the health of staff in the workplace. Occupational health professionals aim to determine the impact that work has on staff health and to ensure staff are fit to undertake the role they are employed to do (both physically and mentally). The range of occupational health services which can be provided will depend on capacity and capability of the provider as well as the particular needs of the employer, but can include:

- Assessing employees on long-term sick leave and promoting effective RTW;
- Assessing fitness to work regarding ill-health capability dismissal o;
- Helping employers fulfil their duties under the Equality Act 2010 (including disability, pregnancy and age discrimination);
- Advising on temporary or permanent changes to the work or workplace ('reasonable adjustments') to enable someone with a physical or mental health condition or disability to work effectively and safely;

109.https://www.local.gov.uk/publications/work-health-and-growth-guide-local-councils

- Undertaking and interpreting pre-employment or pre-placement health assessments;
- Carrying out legally mandated 'Health Surveillance', including: skin surveillance; audiometry (Hearing); spirometry (lung function) and MSK checks.[110]
- Introducing programmes to support the wider health and wellbeing of the workforce;
- Carrying out specific assessments to determine fitness for work in safety-critical environments – such as transport, food safety and clinical healthcare;
- Advising employers on preventing or minimising exposure of workers to hazardous agents – such as noxious chemicals or excessive noise; and
- Helping compliance with other health and safety regulations, including duties to report occupational injuries and diseases under Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).

Vocational Rehabilitation

Vocational rehabilitation is a multidisciplinary intervention offered to those with physical, psychological and/or social difficulties enabling a RTW or preventing loss of work. Its functions can include[111]:

- Provision of health advice and promotion, in support of returning to work.
- Support for self-management of health conditions.
- Making adjustments to the medical and psychological impact of a disability.
- Case management, referral, and service co-ordination.
- Psychosocial interventions.
- Career counselling, job analysis, job development, and placement services.
- Functional and work capacity evaluations.

110. https://www.hse.gov.uk/health-surveillance/overview.htm#:~:text=Health%20surveillance%20is%20a%20scheme,have%20put%20controls%20in%20place.

111. https://vrassociationuk.com/about/process-vr/

Table 2 – A Brief History of Occupational Health Proposals and Reforms in the UK Since 2005

Year	Initiative(s)

2005	**Publication of *Health, Work and Wellbeing – caring for our future: A strategy for the health and well-being of working age people*,** produced jointly by the Department for Work and Pensions, the Department of Health and the Health and Safety Executive.
	• Calls for "institutional barriers to starting, returning to, or remaining in work [to be] removed".[112]
	Independent review, entitled: *Is Work Good for Your Health and Well-Being?* also published.[113]
	• Examines link between work and health, finding:
	  • Work is central to individual identity, social roles and social status.
	  • There is a strong correlation between worklessness and poor health.
	  • When their health condition permits, sick and disabled people should be encouraged and supported to remain in or to re-enter work as soon as possible.

2008	**Dame Carol Black produces landmark review, *Working for a healthier tomorrow*: *work and health in Britain*.**[114] It proposes: • Reinforcing the significance of work upon health (and vice versa) • Paper-based sick notes should be replaced with an electronic fit note, • A 'Fit for Work' system to provide treatment, advice and guidance for people in the early stages of fitness absence. The Government responded to Black's Review in Improving health and work: changing lives.[115] They introduce: • Fit for Work Service pilots.[116] • Occupational health advice services for small businesses and GPs.[117]
2009	**Publication of *NHS Health and Wellbeing***, authored by Dr Steve Boorman.[118] • Recommends NHS organisations "provide staff health and well-being services that are centred on prevention (of both work-related and life-style-influenced ill-health)."
2010	**The Statement of Fitness for Work** (the Med3 form or 'fit note') is introduced (April) across England, Wales and Scotland. • The 'Fit Note' provides secondary option of 'may be fit for work', where doctors can record details about the functional effects of their patient's condition, as well as suggest simple changes to the work environment or job role aimed to support a RTW. **The Safe Effective Quality Occupational Health Service (SEQOHS) is established** • Provides a set of standards and a voluntary accreditation scheme for occupational health services in the UK and beyond. **The Equality Act (2010)** • Places a legal responsibility on employers to provide reasonable adjustments for people with a disability in the workplace so that they are not disadvantaged.

112. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/209570/health-and-wellbeing.pdf
113. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/214326/hwwb-is-work-good-for-you.pdf
114. https://www.gov.uk/government/publications/working-for-a-healthier-tomorrow-work-and-health-in-britain
115. https://www.gov.uk/government/publications/improving-health-and-work-changing-lives
116. https://webarchive.nationalarchives.gov.uk/ukgwa/20110202185534/http:/dwp.gov.uk/health-work-and-well-being/our-work/fit-for-work-services/
117. https://www.gov.uk/government/publications/2010-to-2015-government-policy-employment/2010-to-2015-government-policy-employment#appendix-3-co-ordinating-the-health-work-and-wellbeing-initiative
118. https://webarchive.nationalarchives.gov.uk/ukgwa/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_108907.pdf

2011	**Publication of *Health at work – an independent review of sickness absence* in *Great Britain* by Dame Carol Black and David Frost.**[119] • Finds strong correlation between sickness absence and lost economic output, concluding that transforming sickness support and employer action in this area would boost productivity. • Concludes annual economic costs of sickness absence and worklessness to be over £100 billion. • Recommends the development of a national health and work service • The Government accepts a number of the recommendations, including the introduction of an occupational health assessment and advice service to help people off sick for four weeks or more to get back to work (Fit for Work).[120] **Public Health Responsibility Deal** launched (March 2011) • Intended to create a partnership between government, health organisations and business, with the aim of improving population health.[121] **NHS Health at Work –** an unincorporated membership association network of NHS occupational health teams launched (replacing NHS Plus). • NHS Plus had been launched in 2001, aiming to sell specialist occupational health service to employers.[122] • It represents 90% of NHS occupational health departments in England, governed by a Network Board, with elected representatives from members in each of the NHS regions in England.
2014	**'Fit for Work' Launched** • Service proposed by Carol Black seeks to support people in work with health conditions and with sickness absence, through: • **Assessment:** After 4 weeks of sickness absence, they would normally be referred by their GP for an assessment by an occupational health professional. This examined the issues preventing the employee from returning to work. • **Advice:** Employers, employees and GPs could access advice via telephone and a website **National School of Occupational Health (NSOH) launched** • Until 2022, was a collaboration between Health Education England (HEE) and the Faculty of Occupational Medicine, hosted by HEE East Midlands. The NSOH is now supported by NHS England Work Training and Education (NHSE WT&E) • Purpose of NSOH is to promote quality training and to quality manage the provision of clinical training for a multidisciplinary occupational health workforce in England and Wales.
2017	**Publication of *Improving Lives: The Future of Work, Health and Disability*.**[123]
2018	**'Fit for Work' Service Ends** • Following low referral rates, however advice functions remain active.
2019	**The Mental Health at Work Leadership Council launched** in response to Government's independent review into workplace mental health, *Thriving at Work*, commissioned by the Prime Minister. Launches the Mental Health at Work Commitment.[124]
2021	*Government response: Health is everyone's business* (2021)[125]

119. https://www.gov.uk/government/publications/review-of-the-sickness-absence-system-in-great-britain; https://webarchive.nationalarchives.gov.uk/ukgwa/20130107013731/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131299
120. https://www.gov.uk/government/publications/government-response-to-the-review-of-the-sickness-absence-system-in-great-britain
121. https://navigator.health.org.uk/theme/public-health-responsibility-deal. For a review of the policy, see: https://academic.oup.com/jpubhealth/article/39/2/373/3002973?searchresult=1
122. https://www.personneltoday.com/hr/how-the-nhs-reforms-will-affect-occupational-health/
123. https://assets.publishing.service.gov.uk/media/5a74af20e5274a529406956a/improving-lives-the-future-of-work-health-and-disability.PDF
124. https://www.mentalhealthatwork.org.uk/commitment/
125. https://www.gov.uk/government/consultations/health-is-everyones-business-proposals-to-reduce-ill-health-related-job-loss/outcome/government-response-health-is-everyones-business

2022	**Expansion of professionals able to certify fit notes** • Nurses, occupational therapists, pharmacists, and physiotherapists able to do so (only doctors could do this previously).[126] **NHS Employers launches the *Growing occupational health and wellbeing strategy*.**[127]

2023	• **NHS England publishes *Growing occupational health and wellbeing together: our roadmap for the future*[128]**
	• **Government launches a competition for businesses to bid for share of £1m to stimulate innovation in Occupational Health (January 2023).**[129]
	• **Rt Hon Jeremy Hunt MP delivers Spring Budget including measures to boost** occupational health **provision**, including:
	  • Expanding a subsidy pilot scheme to support SMEs in England with the cost of purchasing occupational health services;
	  • Launching a joint DWP and DHSC consultation on increasing occupational health provision in the UK by employers, including through the tax system;
	  • Considering the future supply of occupational health professionals to ensure providers can meet expected increased demand.[130]
	• **Publication of the *Health and Disability White Paper* (March 2023).**[131]
	• **Expansion of the Digital NHS Health Check announced.**[132]
	• **In Autumn Statement, Chancellor announces Government's 'Back to Work' Plan.**[133]
	  • Dedicated investment of £1.3bn includes expanding the NHS Talking Therapies programme and Individual Placement and Support to help people with mental health conditions.[134] It also includes establishment of an expert group to develop a new voluntary occupational health framework in Great Britain.

Occupational Health in the UK

Occupational health services provide employees with access to specialist advice to protect, maintain and support health in the workplace. At its origins, the focus of occupational health was the identification and prevention of hazards or diseases which were linked to particular occupations and workplaces. This work sought – for instance – to prevent conditions such as asbestosis, berylliosis and chloracne.[135] When the NHS was established, occupational medicine was not included as a specialty. Occupational, or work-related, health care remained the responsibility of the employer.

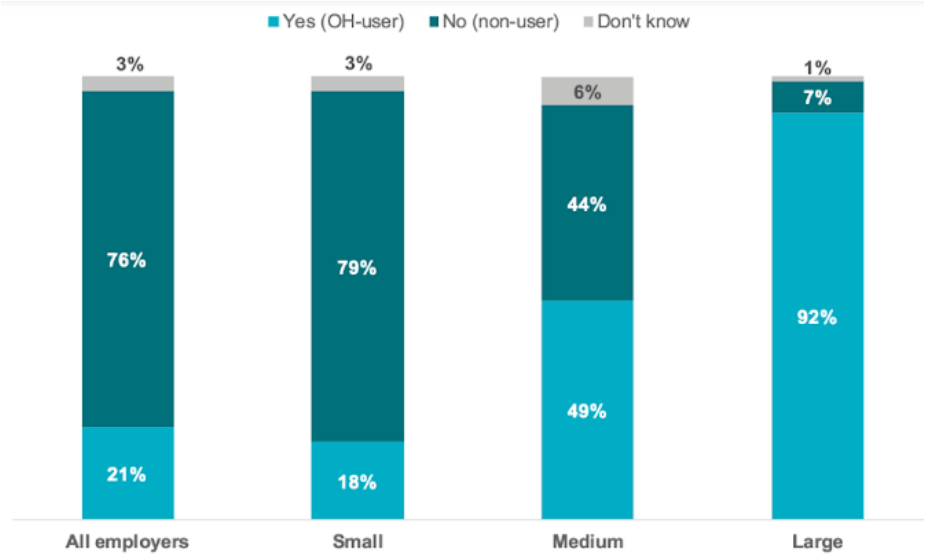
As the nature of work and workplaces have changed, so have the needs of occupational health services. A need to address workplace hazards and risk clearly remains, but the majority of the health conditions which might be regarded work-related (in so far as work may exacerbate them) are not simply found in the workplace. Examples include seasonal illnesses, mental ill-health or MSK disorders. Such conditions are better called work-related.[136]

In terms of occupational health coverage, the UK is 'middle of the pack'. It is estimated that a minority (45%) of workers in Great Britain have access to occupational health services. [137] Some experts consider coverage

135. https://www.rcpjournals.org/content/clinmedicine/21/3/195
136. Definition provided here: https://qhse.support/public/media/uk-health-and-safety-statistics-1999-00.pdf
137. https://www.gov.uk/government/publications/employee-research-phase-1-and-2/employee-research-phase-1-sickness-absence-reasonable-adjustments-and-occupational-health
126. https://www.gov.uk/government/news/more-healthcare-professionals-given-powers-to-certify-fit-notes#:~:text=From%201%20July%202022%20nurses,present%20only%20doctors%20can%20do.
127. https://www.nhsemployers.org/news/growing-occupational-health-and-wellbeing-strategy
128. https://www.england.nhs.uk/long-read/growing-occupational-health-and-wellbeing-together-our-roadmap-for-the-future/
129. https://www.gov.uk/government/news/1-million-fund-for-fresh-ideas-to-boost-health-at-work
130. https://www.gov.uk/government/topical-events/spring-budget-2023
131. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1142474/transforming-support-health-and-disability-white-paper-cp807.pdf
132. https://www.personneltoday.com/hr/digital-nhs-health-checks-for-over-40s-get-go-ahead/#:~:text=Under%20the%20initiative%2C%20people%20aged,checked%20at%20their%20local%20pharmacy.
133. https://www.thetimes.co.uk/article/jobless-will-lose-free-nhs-prescriptions-if-they-refuse-to-seek-work-xnfxthtgl
134. https://assets.publishing.service.gov.uk/media/655df827544aea000dfb3277/E02982473_Autumn_Statement_Nov_23_Accessible_v2.pdf (p. 3)

likely to be lower than this.[138] The truth is we do not have a complete picture of coverage owing to poor data sharing and reporting between relevant stakeholders. This being said, occupational health coverage has certainly grown over the past twenty-five years. In 2004, 14% of workers across the UK benefitted from occupational health support.[139] Recent figures from the Federation of Small Businesses (FSB) indicate that 28% of small employers surveyed offer some occupational health services to staff, a significant increase from just 10% in 2018.[140] Small and medium-sized enterprises account for 99.9% of all UK private sector businesses and employ 15.7 million people (60% of private sector employment) across the country, but they are significantly less likely than large employers to provide occupational health services to employees. Over 90% of large employers do.[141].

Figure 12 – "Provision of OH services by employer size



Base (unweighted): All employers (2,564), small employers (1,457), medium employers (584), large employers (523).

Source: https://assets.publishing.service.gov.uk/media/60f59b6c8fa8f-50c774582d9/sickness-absence-and-health-in-the-workplace-report.pdf *(p. 96)*

Mandatory health checks where there are recognised health hazards in the workplace have been normalised by higher-risk industrial businesses, thereby occupational health provision is routinely 'costed into' their business model. Yet many businesses have not yet bought into the value of occupational health, are not aware of what can be provided, do not know what good looks like, or do not see it as part of their core responsibilities or functions. Of the businesses that the Institute of Directors have recently surveyed who do not offer any occupational health services, 49% of respondents agreed with the statement that 'occupational health has not been an issue for us'.[142] Back in 2011, DWP conducted a survey on occupational health provision with half of businesses believing their

138. https://www.som.org.uk/challenging-data-about-access-occupational-health-services

139. https://watermark.silverchair.com/kqg125.pdf?token=AQECAHi208BE49Ooan9kkhW_Ercy7Dm3ZL_9Cf3qfKAc485ysgAAA1QwggNQBgkqhkiG9w0BBwaggg-NBMIIDPQIBADCCAzYGCSqGSIb3DQEHATAeBglghkgBZQMEAS4wEQQMMw3twUYzWdhz96hs_AgEQgIIDB-5wkhv_aHQYLdZ_xf52mqndo33ewRE-ODocyCzc8wX2oEmHpo4E-pn0uGaCk-G1qZMAAQ1BPHgmydWz6DdQ_CMB-W3tHTYc6mf9j_xMq1FvWz1PhpUI8nG-HhDKj2zkkOQ11DieV10hn-eJ9fu3Kn-FO1t8WHNRNkJnhb-FzMA9AX4zaU-R63aipPO5ZkUoExFEIIKZkfYS6SbW-seAsBS4GTetAcHEn2Tdx8nMAatzarJND-Mg6nYGoJo3wTYXJSvMnZV0Ln-jztPIuvJ4XXG_DIdpIp4U9HF7XzdC-qMEwJIJ5-AiJ3GxLxuJYwor4VV8B-fr9-7mSe5zfBS1uDTkcCjqOrkNcLqjz-kFNPT7hShISU1KnI_jhwGD5L2_tMgJ_Ux5I_habDK1jiqUngHAQymQdDMli-ab1eKojdeac_dA40LAFkEIe6mpn_rG-CXyGAkIMr1JgxU50-Z1dAArV-GfYg-9pvPfbuAw39KSgulMLtkktIHGe-bAVzfyz79d3X1x3qqxP9QsfUcug-fb-MqpSGfFemJso6Kh00D-sheIZL-lYfVbjUm8tB7R2nbfHdlOpWBH3H-fv-h0GsJWMh6LBhNyGA0XVdi7661BoG-f9ToU-7xZql6f08kj4_nag15zVYtgzLHy-orEPYIdXMx8TMFzbMOijoPNqoIfo92r-ZGX38fb9xFyiRX1IpWih3x9zej9Pb_9e9e-lAX_ij7YsdkinMvXJcdPNiUu1ia19YD-45FzfInIZ1gdYYzSFJhSBVmKfKx-0FZ9QxLoTF-cnakPcOQ5Ks2GAlzj-Zd9S-JnMh8UooJeptPdPCsKuqW4DLYYHRLs-fh8Ei3vE4Me-fwj4VQq1NnpyKlu0-R9Ut71C5d6KZIRddEJUE4fUKL2K-7acJHyqWyEqHMpORbwK6Q66ALA-tAn0WKzZbSHn7wyCCisif3dV4CbytZ-vcuex3_Ul3qGtb1uuk596lOCKQj75bdAO-f31l415pBSGclAxMutwV5AwQJYANq9kX-HYsSwNWPf5GEWtCWs6nGRbd-__eY-W9xPLBPPJk

140. https://www.fsb.org.uk/resources-page/small-business-employment-of-disabled-people.html

141. https://www.som.org.uk/sites/som.org.uk/files/Occupational_health_the_value_proposition_0.pdf (p. 7); https://www.gov.uk/government/publications/sickness-absence-and-health-in-the-workplace-understanding-employer-behaviour-and-practice

142. https://www.iod.com/app/uploads/2023/10/IoD-response-to-Tax-incentives-for-occupational-health-consultation-a8ae646fbabceef3442d0541ca781ee2.pdf

employees would 'not want them to intervene in terms of their physical and mental health', and this was more likely to be the case among SMEs.[143] Fewer businesses may see this as the case today, but this view certainly persists.

The cost of occupational health services can often be prohibitive for SMEs.[144] Some business leaders describe a preference for funding provision on a case-by-case basis.[145] A recent analysis from the Government however concludes that whilst cost "appeared to be a key barrier", SMEs "tended to have relatively limited knowledge of actual costs, as well as little knowledge of what health and wellbeing schemes exist or where to purchase them". That review also concluded that uptake of health and wellbeing schemes "could be increased amongst SMEs with the provision of advice, in the form of a needs assessment to help them better understand staff health needs and advice on how to source or implement best-practice schemes to address those needs".[146]

This accords with evidence from interviews undertaken recently with SMEs around Walsall which reveal a lack of awareness of concerning available support; low prioritisation of workplace health and wellbeing; fear of negative consequences of engaging; and practical barriers (e.g., lack of organisational resource).[147] Seventy five per cent of SMEs stated that they had not made use of any of the four main types of free support offered by Walsall Council and its partners in the past twelve months.[148] It is a similar story in Wales. Just 14% of businesses interviewed in 2019 by Public Health Wales had heard of the nationally coordinated Healthy Working Wales scheme.[149]

We should note that this particular policy challenge is not new. The 'Workplace Health Connect' pilot, undertaken in the late 2000s, showed that the service required extensive marketing to achieve target numbers. The most successful marketing methods in terms of driving up user numbers were ones which actively targeted SMEs (e.g., telemarketing and local outreach) rather than methods which relied on SMEs taking the initiative alone (e.g., direct mail).[150]

Schemes to Support SMEs in Scotland and Wales

- **Working Health Services Scotland (WHSS)** is funded by the Scottish Government and Department for Work and Pensions. It is an NHS service that provides free and confidential advice and health support for people who are self-employed or working in companies with employees numbering 250 or less who have a health condition or injury is impacting their work. Referral can be made by the individual, GP, other health professionals and partner organisations. Individuals may be referred to Physiotherapy, Counselling and Occupational therapy.[151] A four-year evaluation of WHSS found that participation was associated with positive changes to health and return-to-work.[152]
- **Healthy Working Wales (HWW)** is a national programme that aims to improve health and prevent ill-health among the working age population by working with and through employers and workplaces. HWW is a national programme delivered by Public Health Wales free of charge to employers in Wales.[153]

143. https://assets.publishing.service.gov.uk/media/5a750e1ce5274a59fa7170bb/rrep750.pdf (p. 11)
144. https://www.iod.com/news/employment-and-skills/iod-press-release-expand-benefit-in-kind-exemptions-to-incentivise-investment-in-occupational-health/
145. https://www.iod.com/app/uploads/2023/10/IoD-response-to-Tax-incentives-for-occupational-health-consultation-a8ae646fbabceef3442d0541ca781ee2.pdf
146. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1142002/incentivising-SME-uptake-of-health-and-wellbeing-schemes-report.pdf
147. https://phirst.nihr.ac.uk/evaluations/an-evaluation-of-workplace-health-and-well-being-support-in-walsall-small-and-medium-sized-enterprises-smes/
148. https://phirst.nihr.ac.uk/wp-content/uploads/2023/09/Walsall-slide-deck-_-final.pdf
149. https://phw.nhs.wales/services-and-teams/healthy-working-wales/reports/employer-attitudes-to-employee-health-and-work-2019/
150. https://www.employment-studies.co.uk/system/files/resources/files/hse_whc_ef.pdf (p. 111)
151. https://www.nhsinform.scot/scotlands-service-directory/health-and-wellbeing-services/10113%201glc1116
152. https://academic.oup.com/occmed/article/68/1/38/4830142
153. https://phw.nhs.wales/services-and-teams/healthy-working-wales/

Who Provides Occupational Health Services, What is Provided and Who Pays?

Almost all (97%) of occupational health providers are paid for directly by employers. Payment for occupational health services via health insurance remains low. 19% of providers deliver services funded by an employer's health insurance; one in twenty (5%) had provided services funded through an individual's health insurance. Around a fifth (17%) are funded through charitable donations.[154]

Nearly all providers (96%) interact with NHS-provided services in some way. For over four-fifths (85%) this takes the form of recommending or initiating self-referrals to NHS treatment, most commonly recommending employees to consult their GP (42%) or to access specialist treatment (37%). Seven in ten (71%) seek to complement NHS treatment, or to follow up on 'fit note' advice (70%). A third of providers (34%) had been in contact with an employee's GP about obtaining medical reports.[155]

A substantial proportion of providers have relatively small-scale capacity: four in ten (39%) occupational health providers had the capacity to provide occupational health support to fewer than 200 individuals at any one time. As might be expected, there was a relationship between the size of provider and their capacity: larger occupational health providers had a larger capacity (8% of occupational health providers had capacity to provide occupational health services to more than 10,000 individuals, most of these had more than 200 employees).[156]

As part of this research, we heard that there would be insufficient capacity among existing occupational health providers – working in their current mode – to cover more than roughly two-thirds of employers. Enabling providers to grow and encouraging new ways of working will therefore be essential if we are to get anywhere near a 'universal' offer for employees.

Of the occupational health services offered by private providers surveyed by the Department for Work and Pensions and the Department of Health and Social Care, here are the proportion of providers offering the following services:

154. https://assets.publishing.service.gov.uk/media/5ddbba3e40f0b650e2545c03/understanding_-private-providers-of-occupational-health-services.pdf

155. https://assets.publishing.service.gov.uk/media/5ddbba3e40f0b650e2545c03/understanding_-private-providers-of-occupational-health-services.pdf

156. https://assets.publishing.service.gov.uk/media/5ddbba3e40f0b650e2545c03/understanding_-private-providers-of-occupational-health-services.pdf

Table 3 – List of occupational health services and frequency they are delivered by private providers

Services Offered	Frequency
Advice about employee adjustments or RTW plans for ill or sick employees	94%
Support with health risk assessments	83%
Health promotion or healthy lifestyle schemes	83%
Training, instruction or capacity building, e.g., for managers or leaders	65%
Clinical interventions to manage health risks	60%
Providing rehabilitation or treatment services, e.g., physiotherapy or cognitive behavioural therapy	49%
Connection to wider services or support to address psychosocial issues, e.g., debt counselling	42%

Source: https://assets.publishing.service.gov.uk/media/5ddbba3e40f-0b650e2545c03/understanding_-private-providers-of-occupation-al-health-services.pdf *(p. 19)*

Broadly speaking, there are two approaches to occupational health service delivery:[157]

- **Internal Occupational Health Services** – where personnel are directly employed by individual companies. These could take the form of:
  - Employee Assistance Programmes (EAPs);
  - Bespoke occupational health offers, tailored to the employer's workforce.
- **External Occupational Health Service**s – where personnel are contracted to provide services for a company, but act as an external unit, often serving several companies.
  - Self-service, with direct access to private providers;
  - Referrals to specialist provision as part of employment programmes;
  - Individual access to specialist NHS vocational rehabilitation-related support.

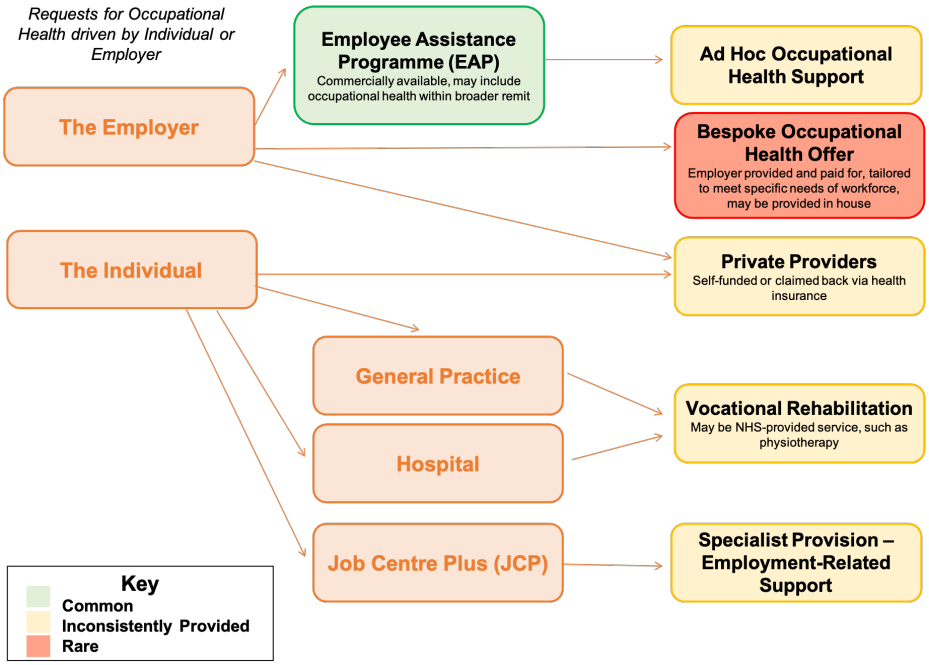
These approaches can also be split into two types of purchases:

- **Reactive purchasers** – who seek ad hoc support with no permanent contract in place;
- **Proactive purchasers** who have permanent contracts in place). Permanent contracts often enable employers to provide more holistic offers.[158]

157. https://allcatsrgrey.org.uk/wp/download/occupational_therapy/RR985-understanding-the-provision-of-OH-and-work-related-MSK-services.pdf (p. 30)

158. https://assets.publishing.service.gov.uk/media/5c9b6741ed915d07af076ea7/employers-motivations-and-practices-a-study-of-the-use-of-occupational-health-services.pdf

Figure 13 – An illustration of pathways to different forms of work and health support



Source: Based upon: https://allcatsrgrey.org.uk/wp/download/occupational_therapy/RR985-understanding-the-provision-of-OH-and-work-related-MSK-services.pdf *(p. 34)*

How and where are schemes delivered?

- Beyond the Government programmes identified in Chapter 1, a **Workplace Wellbeing Charter**, was established by Public Health England (since abolished and subsumed into the UK Health Security Agency) as a national standard for workplace health, and as a benchmarking process which businesses can work toward in order to gain accreditation for their investment in workforce health. Resources are free to use by Local Authorities (LAs) to establish their own schemes, which are now in place in over half of upper-tier LAs.[159]

A huge variety of initiatives are delivered by Local Government and/or Local Authorities in partnership with the Government and/or voluntary sector and local businesses. A small selection include:

- The **Healthy Workplaces Leicestershire** programme from Leicestershire County Council's Public Health which has been designed to help places of work and local organisations achieve a 'Healthy Workplaces Leicestershire Accreditation'.[160]
- The **Mental Health and Productivity Pilot (MHPP)** has been working with Midlands businesses and organisations since 2019

159. https://www.local.gov.uk/sites/default/files/documents/health-work-and-health-re-904.pdf (p. 12)

160. https://www.fsb.org.uk/resources-page/new-scheme-for-healthier-workplaces-launched.html

to improve mental wellbeing in the workplace.[161] Led by Coventry University, MHPP is a Department of Work and Pensions funded collaboration of seven Midlands universities, the mental health charity Mind and other partners across the region. More than a thousand organisations in the Midlands are receiving support from MHPP.

- A **Mental Health Trailblazer** was set up by seven councils in the North East of England to help those with mental health problems find work. The scheme adopts the NICE-approved 'Individual Placement Service' model where each individual receives tailored support to assist with employment while continuing their clinical recovery.[162]
- A **Good Work Standard (GWS**) has been developed by the London Assembly. This new scheme updates what was previously called the 'Healthy Workplace Charter' and the 'London Healthy Workplace Award (LHWA)', which accredited over 340 businesses and covered over 400,000 employees.[163] The London Healthy Workplace Charter was a self-assessment framework that recognised s employers for investing in workplace health and wellbeing.
- Innovative new schemes, such as **Business Health Matters**, a scheme which has been developed in Lancashire brings together local businesses via chambers of commerce, local academic organisations and others to enhance workplace screening provision. Below is a more detailed case study of the scheme to date.

161. https://mhpp.me/
162. https://www.local.gov.uk/sites/default/files/documents/health-work-and-health-re-904.pdf
163. https://www.london.gov.uk/who-we-are/what-london-assembly-does/questions-mayor/find-an-answer/london-healthy-workplace-charter-0

Business Health Matters

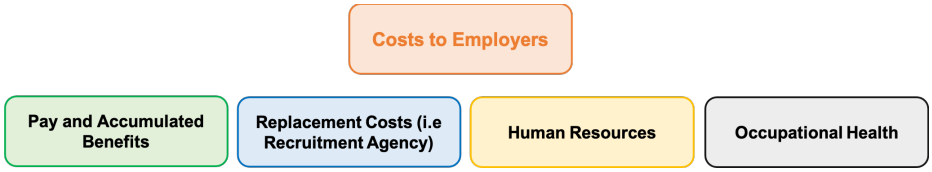
Case Study – Business Health Matters, Active Lancashire[164]

A first-of-its-kind project which aims to improve employee health and wellbeing in Lancashire-based SMEs via two innovative projects:

- A '**Workplace Health Screening'** project will "upskill gym and leisure centre staff to conduct physical and mental health screenings in workplaces across the county, with a focus on employees aged 50+ in SMEs".
  - It aims to deliver more than 15,000 screenings over the next three years.
  - A unique screening tool has been developed by specialists at the University of Central Lancashire's (UCLan) School of Medicine and Lancashire Mind.
  - The initiative recently received a £3million funding boost from the UK Research and Innovation's (UKRI) healthy ageing challenge fund.
- The **Business Health Matters** programme is supported by the Chambers of Commerce and twenty local and national partners, including Active Lancashire, The Lancashire Colleges, Lancashire Mind, UCLan and ukactive.
  - A number of local authorities and leisure trusts in Lancashire are also partnering with Active Lancashire on the programme, as their dedicated Business Health Matters staff deliver screenings and interventions in workplaces across the county, alongside a team of qualified Workplace Health Champion tutors.

What are Employers Doing?

Many employers are responding proactively to the growing challenges associated with economic inactivity and ill-health, set out in Chapter 1, recognising that absence and ill health impacts substantially on attendance and performance (also exacerbated by delays to routine care and access to NHS services). The CBI estimate that an expansion of occupational health provision could save the economy £60bn per year.[165]



165. https://www.cbi.org.uk/articles/unlocking-businesses-potential-to-create-a-healthier-workforce/

164. https://www.businesshealthmatters.org.uk/home-2023/

For instance, for an employee who may be waiting six months for a diagnostic test on the NHS, such as an MRI scan on their back (which may mean they are unable to work until diagnosis), employers could incur the following costs: six-months pay and accumulated benefits; associated Human Resources costs; replacement costs (recruitment agency); occupational health costs. As noted earlier, we also know that the longer the absence, the less likely an employee will RTW.

More employers are turning to private medical insurance (PMI). The number of employees in possession of PMI has increased by more than 8% in the past 2.5 years (from 4 million in 2021 to 4.4 million in 2022). Workplace policies also saw a 15% increase in claims, with 1 million made in 2022 compared to 873,000 in 2021, according to the latest data from the Association of British Insurers (ABI).[166] Demand is growing: at a recent summit organised by the Independent Healthcare Provider's Network (IHPN), Alex Perry, the current CEO of Bupa Insurance Ltd, referenced the fact that in a company of one-thousand employees, in any year, a quarter of employees access some form of treatment being offered under their insurance plan. The ABI finds employers are increasingly turning to PMI: nine in ten (86%) people who were absent from work due to illness or injury, were successfully supported to stay in their employment using services provided by their insurer. Over 42% of those absent were supported back to work in under four weeks and 81% in under six months.[167] *This* produced the equivalent of £6.1 billion a year in benefits, across businesses (£2.6 billion), the wider economy (£2 billion), and the Exchequer (£1.5 billion) in 2021, by reducing the number of days employees needed to take as sick leave.[168]

Many larger businesses, such as John Lewis Partnership have well-established employee healthcare schemes, seeing such approaches as a key means of improving retention. Over £20 million is invested annually in their Partnership Health Services team. This is an in-house multidisciplinary clinical team of fifty professionals including occupational health nurses, a doctor, a physiotherapist and a wellbeing clinical lead. Royal Mail Group have developed a digital tool which provides information and access to occupational health services called 'Help@Hand' which provides employees direct access to health and wellbeing support. The offering consists of: remote GP services – unlimited 24/7 access to a digital private GP service for employees and families (children are eligible up to their 18th or 24th birthday (if in full-time education) as well as physiotherapy and mental health support.

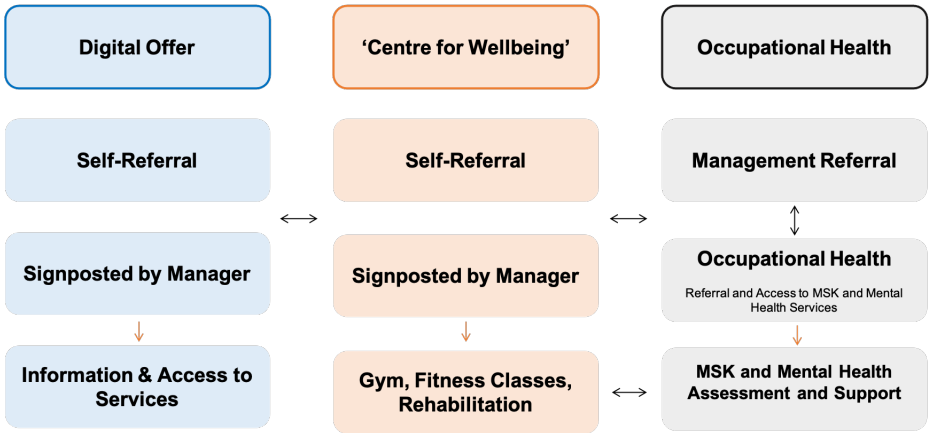
Jaguar Land Rover offer an on-site flu vaccination scheme to their employees, which is available to employees is eligible for a free vaccination through the NHS or not.[169] This is part of their Centre for Wellbeing, which has been designed as a 'one stop shop' for preventartive and reactive service. It consists of three major services (depicted below): a digital offer to employees, access to wellbeing services, including fitness classes and an on-site occupational health service.

166. https://www.abi.org.uk/news/news-articles/2023/11/huge-growth-in-employees-benefiting-from-workplace-health-insurance/

167. https://www.abi.org.uk/globalassets/files/publications/public/health/abi_report_a_sustainable_healthcare_system_for_all_june-2023.pdf

168. https://www.abi.org.uk/news/news-articles/2023/11/health-and-protection-insurance-bolstered-businesses-the-economy-and-exchequer-by-6.1-billion-according-to-new-research/

169. https://wellbeing.jaguarlandrover.com/resources/on-site-flu-clinic-faqs/download?inline=1



In addition to the above models, leading representative groups are developing their own approaches (and policies) with respect to expanding occupational health. One notable example is the CBI who have developed "The Work Health Index" in collaboration with Business for Health to enable businesses to benchmark their health and wellbeing offers.[170]

Is The UK An International Outlier?

The content, capacity, coverage and provision of occupational health varies considerably across national contexts. Some are of the view that occupational health provision should not be necessary in a system with a socialised healthcare system, a view which may explain lower rates of occupational health provision in the UK than in comparable high-income countries.

Occupational health is not presently part of statutory NHS provision and is voluntary under the current legislative framework. Some argue that a national network of high-quality occupational health services available to all employers and workplaces should be developed which is NHS-led. In many European countries, employers are obliged by law to provide occupational health services. This obligation is enforced in countries such as Finland, France, Germany, Italy and Poland. Occupational health in Japan is specified by law which sets out clear responsibilities for the employer. No specific legal requirement for occupational health provision exists in Australia, Canada, or the USA. [171]

Legislative approaches

Whilst legislation with respect to occupational health provision exists in many countries, the prescriptiveness and comprehensiveness of this legislation varies considerably.[172]

170. https://www.workhealthindex.co.uk/
171. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8036601/
172. An overview of international approaches is: https://www.mdpi.com/1660-4601/18/7/3632

	**Finland** has some of the most comprehensive occupational health legal provision. Its Occupational Health Care Act 2001 [Työterveyshuoltolaki] specifies that employers have a duty to ability to work and functional capacity of the employees these services must include preventative healthcare (of work-related illnesses and accidents), as well as defining the professional expertise required by occupational health service units. It also mandates surveillance procedures of the organisation and delivery of such services.[173]
	In **Japan**, all workplaces employing 50 or more workers must appoint an Occupational Physician. Two recent notable policy developments include the Silver Health Plan and the Total Health Promotion Plan, which have both focused on promoting workers' physical and mental health.[174]
	In **Germany**, following intense political discourse, the German Occupational Safety and Health Act was amended in 2013, and now explicitly states that employers have to conduct a risk assessment including 'psychosocial' risks. Measures implemented to follow up risk assessment have to consider both physical and mental health.[175]

The UK, alongside other countries like the Republic of Ireland, Australia and the United States does not currently have legislation which mandates the provision of occupational health services, by either the state or employers.

Laws that are relevant to occupational health in effect in the UK, include the Equality Act (2010), the Employment Rights Act (1996) and the Health and Safety at Work Act (1974), supported by the Management of Health and Safety at Work Regulations (1999). Duties set out in this legislation includes:

- Minimum standards for the protection of employees and the public exposed to risks to their health, safety and welfare.
- Require an employer to appoint one or more competent people to help them implement the measures they need to take to comply with legal requirements.
- Legal protection from discrimination in the workplace, providing particular provisions relating to disability.

173. https://www.ilo.org/dyn/natlex/natlex4.detail?p_lang=en&p_isn=60761
174. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2836247/
175. https://osha.europa.eu/sites/default/files/seminars/documents/en/seminars/eu-osha-seminar-on-psychosocial-risks-in-europe/BAuA%20Statement_Policy%20interventions%20on%20psychosocial%20risks%20at%20work%20in%20Germany.pdf

Sites of Provision

Organisational models for occupational health services vary between countries (according to their legal apparatus), characteristics of their health system, national traditions and social security provision. Accordingly, occupational health models can include a mixture of private market-driven, inter-company and state-provided services. In some countries, employers of a certain size are required by law to provide an in-house service, such as in Japan. Workplaces of more than 1000 employees must appoint a full-time in-house Occupational Physician; those with 50-999 employees require – at a minimum – a part-time in-house Occupational Physician, but there are no requirements for companies with under fifty employees to organise or fund such services. France requires that occupational health be provided be provided either 'in-house' or via group inter-organisation services. This 'group service' model is detailed in the case study below.

The Group-Service Model, or "Services de santé au travail interentreprises" (SSTI) – France

In France, every employer is obliged to organise an occupational health service. In order to satisfy this requirement, companies can create an autonomous prevention and occupational health service (SPST, or SSTI), or join an inter-company SSTI.

The inter-company occupational health service is a non-profit organisation which is:

- Structured in one or more geographical and/or professional sectors
- Administered by a joint board of directors, composed of representatives of employers appointed by the member companies

Non-profit organisations functioning as associations have been established with the objective of offering OH advice, support and surveillance of employees from a group of companies. This is funded by the participating companies who pay a yearly fixed sum contribution per employee.

All of these services must be approved by the French regional departments for employment and work. Each regional office keeps a list of the approved inter-company services as well as the contact details of their head office.

This model is particularly targeted at companies that are not large enough to organise their own in-house or privately sourced services independently.

While in France these inter-company occupational health service organisations are functionally and financially independent from the state (as they are funded by companies themselves), Japan takes a more statist approach. To support SMEs, the Japanese government has established 'Regional Occupational Health Centres' which are funded by the Government and managed by local medical associations. In both Finland and the Netherlands meanwhile, the provision of occupational health services is required by law, but employers are given the option

of choosing which model they wish to use.[176] As has described earlier in this chapter, a number of dedicated occupational health providers operate at a national level across the UK. The industry trade association, the Commercial Occupational Health Providers' Association (COHPA), has over 100 members which covers roughly 70% of the outsourced market.[177]

Financing of Occupational Health Services

Occupational health services can be financed by the state, employers, insurance systems, social security systems or a mix of all the above. It is by no means a pre-requisite that the financing of occupational health services are majorly – or even partially – reliant on taxpayer funding, with many of the existing models in place across Europe deriving their funding primarily from companies themselves. In many countries, occupational health services are typically fund by employers and are market-driven. This is especially the case in countries where occupational health provision is voluntary, but a market-orientated network is also common in countries where employers have a legal requirement to provide services.

In the UK, the existing voluntary system and the absence of any formal integration of occupational health services into the NHS means that taxpayers do not drive the development of occupational health service provision. The UK Government does, however, provide tax relief of up to £500 for medical treatments funded by employers to support the RTW of an ill or injured employee and for employee support through the Access to Work Scheme.

In Canada, employer provided health insurance is fully exempt from tax, meaning that around two thirds of Canadians supplement the publicly funded insurance system with private access to certain parts of the healthcare market, such as prescriptions, dental and eye care.[178] In other jurisdictions, such as Germany, employer contributions to health insurance are compulsory, with both employer and employee contributions set at 7.3%.[179]

Accreditation and Quality Assurance

Occupational health professionals are regulated, but there is no uniform approach or single regulator of occupational health services. Accreditation or certification is the tool by which the quality of occupational health services are assured. A voluntary accreditation system for occupational health services exists in the UK to support employers who choose to outsource provision. The Safe Effective Quality Occupational Health Services (SEQOHS) produces a list of accredited services, and this list is regularly updated as new services achieve accreditation. In 2018, less than half of all occupational health services in the UK had SEQOHS accreditation.[180] There are signs this figure continues to move on a downward trend. As of February 2024, there were 183 accredited services and 107 working towards accreditation. However, this compared to 212 services working towards accreditation and 242 services accredited back in 2017. In other

176. https://www.iloencyclopaedia.org/part-ii-44366/occupational-health-services/item/165-occupational-health-services-in-japan
177. https://cohpa.org/
178. https://www.canada.ca/en/revenue-agency/services/forms-publications/publications/t4130/employers-guide-taxable-benefits-allowances.html#P981_120285
179. PWC. *Germany: Individual – Other Taxes.* 2021. Link.
180. https://www.fom.ac.uk/wp-content/uploads/REPORT_Defining-the-value-of-accredited-specialists.pdf

words, a roughly 30% decline over a four-year period.[181] Most services accredited by SEQOHS are NHS foundation trusts, councils or private sector occupational health providers. Many providers cite prohibitive costs to undertaking the SEQOHS accreditation. In our research, we heard this was a particular challenge for single-handed or small-scale occupational health providers.

There were divergent views amongst those we interviewed for this report as to what the future approach should be. Some were firmly of the view that SEQOHS represented the 'gold standard', and the best indicator of provider quality. One individual suggested that a grant scheme should be developed so that smaller providers could be financially supported to achieve accreditation over a set time period. Others thought that ensuring individual professional standards or achieving International Organization for Standardization (ISO) standards would in fact be sufficient – and the best direction for future travel. It has also been suggested that a comprehensive register of services which can form the basis of a minimum standard would be beneficial. Another theme which emerged was that the link between SEQOHS accreditation and employers was limited. This is the reason why the most recent review of SEQOHS suggested that the development of a 'Check-a-trade' style feature to enable an improved feedback loop for employers themselves could be advantageous.[182]

Vocational rehabilitation professionals are also individually regulated. Some are members of the Institute of Registered Case Managers. Whilst the Vocational Rehabilitation Association have their own code of conduct, services are not accredited by SEQOHS and there is no overarching regulator of services.

The Case to Expand Occupational Health Provision

Potential benefits of workplace-based screening or surveillance for modifiable health risk factors can go further than just reducing the cost of absence or poor performance and include improving an individual's health risk profile, quality of life, motivation and engagement in the workplace. After all, workplaces have the potential advantages of ease of access, the presence of peer pressure and support, and the potential to utilise their established channels of communication with employees. Research from the PAM Group into the benefits of early intervention has found that 91 per cent of those offered support, while still in work, were able to remain in work, compared to just half (53 per cent) of those offered support once they'd become too sick to work.[183] Whilst the "empirical literature is limited", providing Individual Placement and Support (IPS) to young adults with serious mental illness results in a 20% increase in the employment rate.[184] The Confederation of British Industry (CBI) estimate that employers could be responsible for a potential 10- 20% of disease burden reduction in the 20-64 age group.

There is growing alignment between health system leaders, business leaders and voluntary organisations on the benefits of expanding occupational health provision. In 2019, The Academy of Medical Royal

181. https://www.personneltoday.com/hr/could-covid-19-cost-pressures-crunch-seqohs-2/
182. https://www.seqohs.org/CMS_Documents/Scheme/OH/2023%20Standards/2023-SEQOHS-Standards-March-2023.pdf
183. https://www.pamgroup.co.uk/post/benefits-of-early-intervention-report
184. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10221953/#:~:text=Although%20the%20empirical%20literature%20is,gain%20and%20keep%20competitive%20jobs

Colleges published a consensus statement for action concerning health and work.[185] Organisations such as Business for Health have emerged in recent years, producing benchmarking tools, sharing case studies and advocating for improved workplace health, drawing upon leadership of some of the UK's largest and most influential businesses.[186] Representative groups of SMEs – The Federation of Small Businesses are supportive of Government action which seeks to make expanding occupational health provision more cost effective and simple for small businesses.[187] The Society of Occupational Medicine state there is a moral as well as an economic case to be advanced.[188] There is a clear clinical rationale too: the global burden of non-communicable disease (NCD) is expected to increase as the global population increases, with CMDs accounting for a significant proportion of that burden.[189] There are significant opportunities to enhance provision across the public sector too – particularly services, such as policing, whose front-line roles are often been linked with poor physical and mental health.[190] As was set out in Chapter 1, NHS occupational health services face a challenging operational, capacity and financial environment.[191] In 2018, there were 135 in-house NHS occupational health services in England, with many a part of the NHS Health at Work Network. A further forty trusts contract out occupational health provision to external providers.[192]

What is the case for investment? The Local Government Association cite figures which show 'employee wellness' programmes returning between £2 and £10 for every £1 spent. [193] The 2009 Boorman Review indicated a £2.5-£5 ROI for each £1 spent on occupational health services for NHS staff, but also noted that comparisons are difficult because investment in related services, such as access to physiotherapy and counselling are not included as part of the reported occupational health budget in all trusts. The reality is that the value of these investments will depend on the nature of the intervention being provided. Not all employee wellness programmes are equal.

Understanding how employee health impacts productivity has advanced substantially in the past two decades.[194] Yet, there remains no "settled science" yet about relationship between wellbeing and productivity.[195] There is however a growing body of evidence of its value.[196] New initiatives set up in recent years, such as ongoing work by the Centre for Musculoskeletal Health & Work, funded by Versus Arthritis and the Medical Research Council will be instructive.[197]

A recent study from the Wellbeing Research Centre at the University of Oxford shows a "strong positive relationship between employee wellbeing and firm performance".[198] A study of almost 1,800 BT call centre workers shows that a one-point increase in happiness (on a scale of 0 to 10) was associated with a 12% increase in their productivity, as measured by weekly sales data.[199] Another study states that the limited quantitative information available suggests workplace health promotion programmes (WHPPs) could contribute to reducing socioeconomic inequalities.[200]

A recently-published Cochrane Review (recognised as the highest standard in evidence-based healthcare internationally) found moderate-

185. https://www.aomrc.org.uk/wp-content/uploads/2019/04/Health-Work_Consensus_Statement_090419.pdf
186. https://www.businessforhealth.org/
187. https://www.fsb.org.uk/knowledge/fsb-infohub/workplace-wellbeing.html
188. https://www.som.org.uk/sites/som.org.uk/files/Occupational_health_the_value_proposition_0.pdf
189. https://academic.oup.com/bmb/article/126/1/113/4976608
190. https://journals.lww.com/joem/fulltext/2023/06000/primary_care_consultations_among_uk_police.9.aspx
191. https://www.proquest.com/openview/937cb02a3014f8e4bf018ad8a6927bfc/1?pq-origsite=gscholar&cbl=49149
192. https://www.proquest.com/openview/937cb02a3014f8e4bf018ad8a6927bfc/1?pq-origsite=gscholar&cbl=49149
193. https://www.local.gov.uk/publications/work-health-and-growth-guide-local-councils
194. A large body of evidence produced by Public Health England: https://www.gov.uk/government/publications/local-action-on-health-inequalities-evidence-papers
195. https://www.health.org.uk/about-the-health-foundation/get-involved/events/what-will-the-nhs-look-like-at-100?utm_campaign=14208192_REAL%20lecture%202023%20post-event%20%20Nov%202023&utm_medium=email&utm_source=The%20Health%20Foundation&dm_i=4Y2,8GJ40,5AP448,YXSBH,1 (57:00-59:00)
196. See review: https://www.som.org.uk/sites/som.org.uk/files/OH-the_global_evidence_and_value_Apr_2018.pdf. A recent issue of the International Journal of Environmental Research and Public Health should also be consulted: https://www.mdpi.com/journal/ijerph/special_issues/Development_Evaluation_Workplace_Interventions
197. https://www.cmhw.uk/
198. https://wellbeing.hmc.ox.ac.uk/wp-content/uploads/2023/05/2304-WP-Workplace-Wellbeing-and-Firm-Performance-DOI.pdf
199. https://pubsonline.informs.org/doi/10.1287/mnsc.2023.4766
200. https://oem.bmj.com/content/77/9/589.abstract

quality evidence that workplace interventions reduce time to RTW, high-quality evidence that workplace interventions reduce the cumulative duration of sickness absence, low-quality evidence that workplace interventions reduce time to lasting RTW. [201] Overall, the international evidence on the effectiveness of workplace interventions on work disability therefore reveals a mixed picture. There is evidence that workplace interventions reduce time to RTW and improve pain and functional status for workers with MSK disorders, but there is "no evidence of a considerable effect of workplace interventions on time to RTW in workers with mental health problems or cancer".[202] Reviews of trials of workplace-based interventions suggest they can be effective in modifying a range of risk factors including diet, physical activity, obesity, risky alcohol use and tobacco use. However, such interventions are often poorly implemented in workplaces, limiting…impact on employee health." [203] Individual Support and Placement (IPS) can be "effective for people with severe mental illness (SMI)".[204] But this does not apply to people with common mental disorders (CMDs) to the same extent.[205]

That same review finds that the "limited number of trials identified suggests implementation research in the workplace setting is in its infancy, warranting further research to guide evidence translation in this setting".[206] The quality of the evidence meanwhile on the effectiveness of workplace interventions for workers with mental health problems and cancer is low…future research should expand the range of health conditions evaluated with high-quality studies.[207] Clearly there is more to be done. Another study notes that "the presenteeism literature is young and heterogeneous…future research would benefit from standard presenteeism metrics and studies conducted across a broad range of workplace settings."[208]

We ought to be cautious with some interventions too and ensure appropriate enabling environments exist. A review which considers the evidence on the effectiveness of Mental Health First Aid (MHFA) training in the workplace by the HSE found a lack of published occupationally-based studies, with limited evidence the content of MHFA training had been considered for workplace settings and "no evidence that the introduction of MHFA training in workplaces has resulted in sustained actions in those trained, or that it has improved the wider management of mental ill-health".[209] Hugh Robertson of the Trades Union Congress has reflected that '*any employer who thinks they can deal with mental health concerns just by introducing MHFA, offered to a few handpicked 'Mental Health Champions', is very much mistaken". That is absolutely right and accentuates the importance of strategy and culture.*[210]

201. https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD006955.pub3/full
202. https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD006955.pub3/full
203. https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD012439.pub2/full?highlightAbstract=interventions%7Cworkplace%7Cintervent%7Cworkplac
204. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7491619/
205. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9281491/
206. https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD012439.pub2/full?highlightAbstract=interventions%7Cworkplace%7Cintervent%7Cworkplac
207. https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD006955.pub3/full
208. https://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-11-395
209. https://www.hse.gov.uk/research/rrpdf/rr1135.pdf
210. https://www.hazards.org/stress/mental-health.htm

Chapter 3 – A New Vision for Workplace Health in the UK

"Every UK worker should have access to a multidisciplinary occupational health service, able to provide proactive care, to ensure that they remain healthy and productive throughout their working life"

Professor Ira Madan, Consultant in Occupational Medicine, Guy's and St Thomas' NHS Foundation Trust; Co-Director, London Centre for Work and Health

"Trends in health performance across the UK, among both young and old, suggest a lack of resilience in health outcomes and systems. This is having increasingly visible and material side effects, from lower growth to staff shortages, from increased vulnerability to shocks to increased precariousness in fiscal finances…Without policy change, these health problems will worsen and society's immune system will weaken further."

Andy Haldane, 'Health is wealth? Strengthening the UK's immune system, REAL Annual Lecture (December 2022)[211]

"The growth of the knowledge-based economy and the premium on retaining skilled labour means that employers—whether in the public or private sector—will face higher opportunity costs from sickness absence. They will also have to find new ways of retaining and rewarding their staff… In the past "occupational health" has tended to have a heavy health and safety bent to it…"

Alan Milburn MP, Health Secretary, 'A healthier nation and a healthier economy: the contribution of a modern NHS' LSE Health Annual Lecture, 8 March 2000[212]

211.https://reader.health.org.uk/health-is-wealth/conclusion

212.https://publications.parliament.uk/pa/cm200304/cmselect/cmwor-pen/456/456we53.htm

The Government's recent consultation on occupational health states that "a radical shift" is needed to improve access and uptake of occupational health services by employers.[213] So what should this look like and how can it be achieved?

We identify six key themes through which to group recommendations to this new vision for occupational health, examined in this chapter in turn:

1. Definition
2. Direction (at National and Local Level)
3. Capacity
4. Incentives
5. Workforce
6. Integration

1. Definition

There is a need firstly to clarify exactly what encompasses workplace health today. Whilst traditionally, occupational health has been regarded solely as a management tool, it should be regarded far more as a means to proactively support employee health, protection and wellbeing. "Occupational health often only provides an assessment, whereas service and interventions are also needed to both support RTW outcomes and provide earlier support" to ensure that many employees do not need to take time off in the first place.[214] It is also fundamental to the 'hygiene factors' of an organisation and thus has a seminal link with productivity.

This is an important step in stimulating further discussion about the role that workplaces should (or should not) play in supporting the health of their employees. It will be important to further consider what the right balance is between employer-led and state-led action and how we can best balance greater disclosure of health conditions in workplace settings with appropriate levels of confidentiality and consent.

2. National Direction, Local Flexibility

Whilst the delivery mechanism for occupational health services will largely be the preserve of local providers, and it is important for the Government to enable local government in particular to use its assets and relationships to most effectively tackle place-based 'economic inactivity', central Government has a pivotal role to play in raising awareness of the importance of occupational health interventions; creating the incentives for businesses to go further; and in driving reform in key areas, such as in developing the occupational health workforce (discussed at greater length later in this chapter). In short, there will be a space for 'greater devolution' with this agenda, but it requires grip and leadership at the centre.[215]

There is an important role for the Government to play in aligning the fragmented occupational health and practical support available currently – this will be crucial as Access to Work develops and the WorkWell pilots

213. https://www.gov.uk/government/consultations/occupational-health-working-better

214. https://www.abi.org.uk/globalassets/files/publications/public/health/abi-and-wpi-economics-futureproofing-workplace-health-report.pdf

215. On the case for a 'pro devolution mindset', see: https://www.thetimes.co.uk/article/fixing-economic-inactivity-needs-a-radical-pro-devolution-mindset-vqc6jk2tm

get off the ground. Lessons should be learnt from recent initiatives, such as the now-withdrawn 'Fit for Work' scheme, which was designed to enable businesses to make referrals to GPs when employees experienced long-term sickness, but was criticised for poor uptake by both employers and the healthcare sector.[216] A recent review highlighted high dropout rates and a lack of individualisation for SMEs.[217] Ultimately, information needs to be available to all, and must be supported more effectively at the national level.

The Government should encourage uptake of approved digital health solutions to support occupational health, as a means of diversifying providers and boosting access to services, where on-site provision has proven challenging. Digital health solutions which have been approved by NICE or which are already being recommended/commissioned by NHS services should be prioritised here. A particular advantage of digital interventions for employees is that participants can remain anonymous, minimising issues associated with disclosure.[218] The Government can also help to signpost businesses toward accredited occupational health providers or innovative providers, such as Latus Health who offer a remote health screening device that connects to its 'Yodha' platform.[219] Aimed at SMEs, the platform enables employees to book appointments and store notes about medicals, hearing and blood tests. Employees can also have consultations via video with clinicians who guide them through relevant screening processes. As NHS England's recently-produced strategy states, "technology and digital is a significant enabler for occupational health … We have opportunities for 'quick wins', such as improving access through video consultations that became increasingly popular throughout the pandemic. We also have the opportunity to improve the clinical aspects of digital OHWB, such as improving usability and integration of OHWB workflow and patient database systems so that these better support health surveillance, diverse workforce needs, and the investment in preventative OHWB interventions."[220] This is as relevant for boosting occupational health provision for NHS staff as it is for the wider working-age population.

At a local government level

As strategic leaders of people and place, local authorities (LAs) can promote and encourage take up of services and initiatives led by national Government (Access to Work, Adjustment Passport, Intensive Personalised Employment Support, New Enterprise Allowance and the Work and Health programme). [221] Local Enterprise Partnerships (LEPs) should be linked more effectively with Health and Wellbeing Boards (HWBs) to achieve this, via the developed of joint approaches and programmes.[222] The experience of the COVID-19 vaccination rollout provides an array of examples of effective partnership between NHS providers (often GPs), local government and businesses. Primark turned its changing rooms into walk-in vaccine clinics in Birmingham, Bristol and parts of London. In Solihull, local GPs and University Hospital Birmingham delivered vaccines at Jaguar Land Rover's onsite occupational health centre, and set-up

216. https://www.peoplemanagement.co.uk/article/1744835/uk-workers-do-not-have-access-occupational-health
217. https://services.nhslothian.scot/lothian-worksupportservices/wp-content/uploads/sites/37/2022/04/fit-for-work-final-report-of-a-process-evaluation-June-2018.pdf
218. Carolan S, de Visser RO. Employees' Perspectives on the Facilitators and Barriers to Engaging With Digital Mental Health Interventions in the Workplace: Qualitative Study. JMIR mental health. 2018;5(1):e8–e. pmid:29351900.
219. https://latushealth.co.uk/
220. https://www.england.nhs.uk/long-read/growing-occupational-health-and-wellbeing-together-our-roadmap-for-the-future/
221. https://www.local.gov.uk/sites/default/files/documents/health-work-and-health-re-904.pdf
222. https://www.lepnetwork.net/about-leps/the-36-leps/

mobile facilities for walk-in jab for staff as they came off shift. More than 4,500 were vaccinated this way.[223] As part of our own work on the future for vaccines strategy, Policy Exchange has developed proposals to expand vaccination rates across the routine schedule, including for 'Vaccination Collaboratives' to be established which explicitly looks to build on these principles, recognising the importance of approachability and accessibility of vaccination services as a means of driving uptake.[224]

Legislation, Regulation and Guidance

As explored in the previous chapter, many countries have a statutory duty to protect employees from occupational health risks. The UK does not currently have legislation which obliges businesses to provide access to occupational health services for employees. Some suggest that it should. These include Lord Rose of Monewden, the former chief executive of Marks & Spencer's who earlier this year suggested employers should have a legal obligation to support their employee health.[225] There is meanwhile no legal requirement for occupational health provision to be delivered by regulated, qualified professionals, subject to similar accreditation and standards as NHS services.[226] Professor Kevin Bampton, CEO of the British Occupational Hygiene Society has suggested that if provision were to be expanded considerably (largely via the private sector) without proper regulation, there is a risk that "an increasing number [of providers may] never ever step into the workplace and just take the money. There is no explicit legal duty to use qualified health professionals."[227]

Beyond legislation, the Health and Safety Executive (HSE), the national regulator for workplace health and safety, produces 'Management Standards' to help employers conduct risk assessments across key conditions. The HSE also provides guidance to help ensure that employers who have their own approaches can check that they are suitably equivalent. NICE meanwhile produces guidance of relevance, which currently includes *Workplace health: management practices* and *Healthy workplaces: improving employee mental and physical health and wellbeing*.[228]

> *"Recommended standards by government so often become a bureaucratic nightmare that wastes money. Keep out of this stuff and be more direct"* –
>
> Member, Institute of Directors, London, Professional, scientific and technical activities, 50-99 employees.[229]

A 'National Occupational Health Standard' has been proposed as an alternative and is something the Government has committed to explore in the wake of its recent consultation.[230] Whilst clinical governance has been introduced in health care services to improve quality, there is at present no legal duty for commercial occupational providers to adopt this model. This results in a patchwork of quality, but is a national standard required?

Indeed, the Government's consultation noted that there isn't agreement over whether the standard ought to be mandatory or voluntary. We suggest that the development of the Workplace Wellbeing Charter

223. https://www.kingsfund.org.uk/sites/default/files/2022-01/The%20Covid-19%20Vaccination%20Programme%20online%20version_3.pdf (p. 64)
224. https://policyexchange.org.uk/publication/a-fresh-shot/
225. https://www.thetimes.co.uk/article/times-health-commission-law-employers-workers-health-dq2whrr90
226. https://www.hsmsearch.com/BOHS-Working-Better-consultation-concerns
227. https://www.hsmsearch.com/BOHS-Working-Better-consultation-concerns
228. A good overview of these schemes is: https://academic.oup.com/bmb/article/126/1/113/4976608. NICE guidance available here: https://www.nice.org.uk/guidance/ng13
229. https://www.iod.com/app/uploads/2023/10/IoD-response-to-Tax-incentives-for-occupational-health-consultation-a8ae646fbabceef3442d0541ca781ee2.pdf
230. https://assets.publishing.service.gov.uk/media/6560bc741fd90c000dac3b7a/occupational-health-working-better-responses.pdf

standards (which provides a nationally recognised standards system) and existing accreditation of occupational health services mean that the development of a voluntary standard might produce further confusion and fragmentation. A mandatory standard – depending upon its content – is likely to impose further bureaucracy upon organisations where there may already be scepticism regarding the efficacy of occupational health. We note also the limited capacity of providers at present to be able to respond to a significant increase in the near-term of demand for enhanced services.

Policy Recommendations

At national level

1. **The Government should develop a new online service called 'Health in Work'.** This should act as a 'one stop shop', or single portal which brings together essential information about workplace health for all employers (including the self-employed). It should:
   a. Align existing, but fragmented information available, bringing together and building upon the work and recommendations of initiatives, such as the Mental Health at Work Leadership Council;
   b. Have a searchable directory for workplaces so they can identify relevant workplace health providers, contacts in local government or other key stakeholders, such as voluntary organisations operating at a local level who can support provision of services or act as sources of advice and guidance;
   c. Collate information about occupational health providers which meet any new 'minimum standard' (currently being developed by Government) and the Safe Effective Quality Occupational Health Service (SEQOHS) standards to support local government and employers;
   d. Detail digital health solutions – particularly for mental health conditions – which have been NICE approved or which are recommended/commissioned by NHS services which employers may wish to purchase directly, or may want to signpost to employees.
2. **Leadership of this agenda across Government should be enabled through the development of a 'Health in Work Council' (modelled on the Life Sciences Council)**
   a. This should include representatives from the Treasury, Cabinet Office, DHSC and DWP as well as those represented on the Expert Advisory Group and DHSC-DWP Joint Unit on Work and Health to boost the visibility and leadership of the workplace health agenda across Government. It should include occupational health providers, business representatives (particularly from SMEs) and key clinical representative groups.
   b. The Expert Advisory Group and DHSC-DWP Joint Unit on Work and Health should develop dedicated proposals for the expansion of occupational health services for the Self-Employed.
   c. The recently-announced Occupational Health Taskforce should draw up proposals to support the mental health of self-employed workers.[231]
3. **A Centre for Work and Health Research should be established.**
   a. This should operate as a new, independent organisation but should draw upon current, centrally funded programmes of work by the National Institute for Health Research and Medical Research Council, which feeds into the DHSC-DWP Joint Unit on Work and Health. It should have the responsibility and remit to commission research which enhances the evidence-base for the UK's bespoke workplace health challenges.
   b. A particular focus should be placed on developing the evidence base to support RTW for those with major conditions, such as cancer or for those with long-term conditions.

231. https://www.gov.uk/government/news/new-occupational-health-taskforce-to-tackle-in-work-sickness-and-drive-down-inactivity

3. Building Capacity

There is a need to develop capacity across both the public and private sector with respect to occupational health. Investment in NHS occupational health services is recommended by this report, but this alone will not be sufficient to meet demand required. We also know that capacity needs to be developed which specifically targets SMEs. As the previous chapter has shown, SMEs have an appetite to do more, but they lack of resource, with money and time among the key barriers to implementation, along with a lack of knowledge about what support they should invest in. From this, it is apparent that Government can play a positive role in ensuring there is a greater awareness within the business community as to the beneficial effects of strong occupational health provision, as well as ensuring financial support exists which SMEs can utilise to improve access.

The Government clearly understands the importance of the SME and self-employed aspect of expanding occupational health, with the Chancellor announcing in the Spring Budget of 2023 that a subsidy pilot scheme to support SMEs and the self-employed in England with the cost of purchasing occupational health services is to be expanded.

Approximately 77% of SMEs are part of a supply chain, providing goods and services to larger enterprise partners, and so often look for sector-specific support. In this context, we should consider whether inter-company services developed either between business within a particular local geography, or as part of a particular supply chain might prove an effective way of scaling provision.[232]

Recommendations.

- **The Government should promote ownership and empower local communities to develop services to support their employees' health by providing Business Rates Relief** to local Chambers of Commerce, local business groups or companies working with others across their supply chain who boost their occupational health provision to SMEs through the development of 'group service enterprises' (also called inter-company services), thereby creating 'economies of scale' where SMEs cannot develop services 'in-house'.[233]
- **The Community Ownership Fund should reward local business groups or councils who seek to leverage the use of dormant assets, empty high street units and accessible sites,** such as those in leisure sector to expand occupational health services – particularly for SMEs.
- **A dedicated plan to deliver occupational health services for the self-employed should be developed by the Occupational Health Taskforce.** 13% of workforce is self-employed, do we need to think about this growing group and their health.[234]

When we recall statistics about high levels of sickness absence presently among NHS staff, it is clear that a tailored approach is needed.[235] As one interviewee put it to us, "there are many fantastic occupational health departments across the NHS, but it's really patchy". This is also reflected

232. https://www.nihr.ac.uk/documents/nihr-work-and-health-research-funded-development-awards/34636

235. https://www.tandfonline.com/doi/full/10.1080/20008198.2020.1799477

233. Such a proposal aligns with the proposals set out in Policy Exchange's recent work on the 'property owning democracy': https://policyexchange.org.uk/publication/the-property-owning-democracy/#:~:text=A%20property%20owning%20democracy%20denotes,of%20ownership%20set%20out%20above.

234. https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/articles/understandingchangesinselfemploymentintheuk/january2019tomarch2022#:~:text=Since%20then%2C%20the%20numbers%20have,13.0%25%20of%20total%20employment).

in the uptake of key interventions to enhance protection and minimise occupational risks. A recent analysis by the *Health Service Journal* has shown that some 300,000 fewer frontline NHS staff had the winter flu vaccine last year than in 2019 and 2020, with huge variation in uptake among trusts.[236] Echoing the population at large, uptake in the London region is poorest and below 40 per cent. A lack of consistency in the data collected by NHSE and UKHSA has been revealed leaving a limited understanding of the scale of the issue despite the significant toll that seasonal flu can have upon hospital care over the winter months.

Through new integrated care systems (ICSs), there will be opportunities to develop occupational health provision models which effectively pool resources across a wider footprint. This will be an important approach by which to enhance the occupational health offer to NHS staff who work across primary and community care services.

At trust level, occupational health provision could be boosted by the development of what has been called the 'sessional liaison' model. Such a model has been developed at Cambridgeshire and Peterborough Foundation Trust which has enabled a comprehensive staff mental health service to be commissioned by Cambridge and Peterborough Integrated Care System.[237] A close eye should also be kept on a pilot study being undertaken across four hospital trusts in the West Midlands, based on learning from a previous pilot which enabled self-referral to an employee health screening clinic set up at the Queen Elizabeth Hospital Birmingham, which enabled assessment for cardiovascular disease, MSK and mental health problems (the three major causes of staff absenteeism) and onward referral.[238]

236. https://www.hsj.co.uk/workforce/revealed-300000-more-nhs-staff-missing-out-on-flu-jab/7036503.article

237. https://www.england.nhs.uk/long-read/growing-occupational-health-and-wellbeing-together-our-roadmap-for-the-future/

238. https://pilotfeasibilitystudies.biomedcentral.com/articles/10.1186/s40814-022-01095-z#auth-Tom-Marshall-Aff1

Recommendations

1. **NHS England should appoint a National Clinical Director for Occupational Health by Spring 2025 to raise the visibility of occupational health provision across the NHS** and to oversee the delivery of NHS England's *Growing occupational health and wellbeing together* strategy.
2. **Every Integrated Care System (ICS) in England should develop plans for a consolidated (or shared) occupational health service covering all NHS organisations (including primary and community care services) – where it does not already exist – in the coming twelve months**.
    a. This should be included in Strategic Plans and ought to specify dedicated leadership for its delivery. The focus should be on improve communication and collaboration between existing services and to 'wrap around' providers where there is limited provision.
    b. Plans should consider means to enable how offers can be extended to local social care providers also. Approaches to pool budgets and resources should be considered.
    c. Systems should also seek to develop and pilot new referral routes so that GPs can refer patients into dedicated NHS occupational services and so triaged referral to specialist services from select, high-quality private occupational health services can be enabled.

4. Incentives

This report takes the view that tax incentives can form a critical role in both boosting the visibility of occupational health among employers as well as enhancing the attractiveness of investing in them. As the Chancellor of the Exchequer has stated, any tax must be "simple", "fair" and must "support growth".[239] We suggest that tax relief and rationalisation of existing schemes with respect to occupational health represents a compelling case.

Currently, employer-provided occupational health services are a taxable benefit to the employee and are subject to Income Tax and National Insurance. Insurance premiums that are paid for by the employer are considered taxable income.[240] However, as it stands, employers can receive reimbursement of up to £500, if an employee is out of work for more than 28 days as a result of injury or ill-health. For smaller and medium sized employers, the tax rules for incentivising occupational health provision are too complicated and the time-costs of navigating the tax rules outweigh the perceived benefit of providing the occupational health services.[241] Voucher schemes are one way for employers to provide occupational health services but there is evidence that small and medium sized employers find these schemes too involved to maximise uptake.

HM Treasury and HM Revenue and Customs have been consulting on the merit of further tax relief. Relief is offered on a limited number of rehabilitation options currently, such as physiotherapy to facilitate

239. https://www.gov.uk/government/publications/spring-budget-2023/spring-budget-2023-html
240. HMG. *Tax on company benefits.* 13 February 2023. Link.
241. https://www.icaew.com/-/media/corporate/files/technical/icaew-representations/2023/icaew-rep-103-23-tax-incentives-for-occupational-health.ashx

earlier RTW, yet this is not widely known by employers and the overall scheme has limited scope. Increased tax relief therefore for a wider range of health benefits and greater visibility should be a consideration, but it will be important however for the Government to ensure that only those approaches and schemes which have a strong evidential basis as effective interventions. Options that Treasury could consider to encourage employers to deliver more comprehensive occupational health services to their employees include:

1. **Tax credits or rebates** for companies that invest in occupational health services for their employees;
2. **Grants or subsidies** to support the start-up costs of occupational health programmes in SMEs;
3. **Loan guarantees or low-interest loans** to help SMEs finance the implementation of occupational health programmes;
4. **Incentives** for SMEs to work with occupational health providers, such as discounted or subsidised services**;**
5. **Recognition and awards** for SMEs that demonstrate a commitment to employee health and well-being, such as an "Employer of the Year" award; and
6. **Assistance** with navigating the regulatory and legal requirements for providing occupational health services**.**

The most recent consultation proposes introducing income tax and National Insurance (NI) exemptions for the following benefits with the aim of improving employees' health and retaining them within the workforce:

- Health-screenings and medical check-ups within a pre-defined limit;
- Treatments (including preventative treatments) that aim to reduce absences from work or improve employees' performance;
- The cost of 'flu' vaccinations reimbursed by the employer (currently employers are taxed when reimbursing the cost of an employee obtaining a vaccination).

These exemptions should be introduced at the next fiscal statement. The consultation provisionally rejected income tax and NI relief for some specified health-related benefits including private medical insurance, non-clinical treatments (such as gym memberships and fitness classes), and health benefits provided to employees' family members and other non-employees.

Table 4 – Current Benefit in Kind (BiK) Exemptions

Currently Covered by BIK Exemption(s)[242]
• Recommended medical treatment funded by an employer to help employees RTW (unfit for work, or expected to be unfit for work, due to injury or ill health for at least 28 consecutive days and the recommendation is provided for the purposes of assisting the employee to RTW. If the conditions are met, the value of the treatment (up to £500 per year) is not regarded as a taxable benefit.
• Cost of annual health screening and medical check-ups. One health-screening assessment per employee to identify employees at risk of ill-health; one medical check-up (a physical examination of the employee by a health professional solely for determining the employee's state of health).
• Welfare counselling. Welfare counselling is not regarded as a taxable benefit where it does not relate to tax; leisure and recreation; legal; or financial (although can relate to debt management) counselling. Where counselling services are also medical treatment, for example Cognitive Behavioural Therapy or Interpersonal Therapy, they are also not regarded as taxable benefits so long as they are part of a welfare counselling service.
• Eye tests and glasses or contact lenses. Eye tests where required by health and safety legislation for employees who use a computer monitor or other screen, and glasses or contact lenses where required for monitor or screen work.

His Majesty's Revenue and Customs' current view is that, where an employer reimburses an employee for an expense the employee has incurred on their own account, this cannot qualify as a trivial benefit under Section 323A of the Income Tax (Earnings and Pensions) Act 2003.[243] As a result, whilst flu vaccine vouchers (using – for instance – a third-party scheme) given to employees can qualify as a trivial benefit, directly reimbursing an employee who has paid for their own vaccine results in a taxable benefit. This causes practical problems for employers who wish to provide flu vaccines. Some schemes require a minimum number of employees to take up vouchers. This discrepancy makes little sense from a policy and public health point of view. Especially as the tax yield from taxing reimbursements is likely to be small versus the economic costs of employees taking time off with flu, and the costs to the NHS should an employee suffer from severe flu.[244]

Indeed, extending relief on the exemption for flu vaccines incurs a cost to the Exchequer, but this cost needs to considered in relation to the reduction in medium-term healthcare expenditure. In 2017/18, influenza-related admissions resulted in a total of 401,145 bed days and hospital costs of £128,153,810. The average length of stay for a patient was 8.68 days at an average cost of £2773 per admission.[245] We know for instance that

243. https://www.legislation.gov.uk/ukpga/2003/1/section/323A/2016-12-01

244. https://www.att.org.uk/sites/default/files/2023-10/230925%20occupational%20health%20condoc%20response%20FINAL.pdf

245. https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-020-09553-0#:~:text=Influenza%2Drelated%20hospitalisations,-In%20the%202017&text=The%20number%20of%20influenza%2Drelated,in%20the%202017%2F18%20season.

242. Detailed in: https://www.gov.uk/government/consultations/joint-hmt-hmrc-consultation-on-tax-incentives-for-occupational-health/tax-incentives-for-occupational-health-consultation

improved uptake of flu vaccines prevented 25,000 hospitalisations last Winter alone.[246] If we take the cost of a flu jab at the higher end of the price range (offered by community pharmacy), at £19.99, the cost to vaccinate all those individuals would have been £499,750.[247] The cost – based on 2017/2018 figures – had they been hospitalised with an average length of stay would have been £69.3 million. As such, this intervention has in fact saved the Exchequer £68.8 million in a single year.[248] This figure does not include associated benefits to the economy associated with reduced productivity and sickness absence.

Forty one percent of business leaders stated that expanding BiK exemptions is the policy most likely to increase their investment in occupational health.[249] While existing BIK exemptions are generally effective, many view the £500 limit for recommended medical treatment is regarded as too low, whilst differences in tax treatment between reimbursement of treatment costs and directly provided treatment presents practical difficulties for employers, especially smaller employers. In the interests of simplification, the tax distinction between employees being provided with a tax-free benefit or being reimbursed by their employer should be removed. This would reflect the economic reality that the employer has borne the cost. This should be across a range of health-related and other expenses. Consideration for instance should be given to enabling defined fitness classes which are provided onsite by employers to qualify for exemption – specifically those which support employees who have ongoing MSK issues at work.

There is a case that BIK tax treatment should be simplified by the Treasury anyhow**.** At present, there are a number of benefits where the tax treatment differs depending on whether the employer provides the benefit directly or reimburses the employee for the cost of procuring the benefit themselves. For example, employers can provide employees with home working equipment without a tax or NIC charge arising where certain conditions are met, but this does not apply if they seek to reimburse an employee for home-working equipment or services they purchase themselves directly (the temporary easement introduced during COVID no longer applies).[250]

As called for by the Confederation of British Industry (CBI), extending tax relief and exemptions to all Employee Assistance Programmes (EAPs) would be a proportionate, cost-effective measure to expand support. Whilst this measure would incur a fiscal cost to the Exchequer through forgone Income Tax revenue (on the employee side), and reductions in Class 1A National Insurance (on the employer side), as businesses can deduct Class 1A National Insurance from taxable profits, there would be a small gain to the Exchequer via Corporation Tax or Income Tax. This would marginally offset tax losses on the employer. As it stands, a small minority – just 18.43% – of EAPs are treated as taxable benefits, and not subject to exemptions, according to the most recent Employee Assistance Professionals Association report, 'Holding it together'.[251]

Expanding tax relief always comes with a risk of increased Exchequer

246. https://www.gov.uk/government/news/ukhsa-winter-briefing#:~:text=The%20UK%20Health%20Security%20Agency%20(%20UKHSA%20)%20is%20urging%20vulnerable%20groups,around%2025%2C000%20hospitalisations%20in%20England.

247. https://faq.nhsbsa.nhs.uk/knowledgebase/article/KA-03156/en-us; https://www.chemistanddruggist.co.uk/CD137279/Flu-wars-Which-pharmacy-chain-is-offering-the-cheapest-jabs-this-season

248. Calculation based on following presumptions: in 2017/18, influenza-related admissions resulted in a total of 401,145 bed days and hospital costs of £128,153,810 in England. The average length of stay for a patient was 8.68 days at an average cost of £2773 per admission. We know that improved uptake of flu vaccines prevented 25,000 hospitalisations based on Winter 2022 figures. If we take the cost of a flu jab at the higher end of the price range (offered by community pharmacy), at £19.99, the cost to vaccinate each of those individuals would have been £499,750 (figure does not take into account service delivery costs). The cost – based on 2017/2018 figures – had they been hospitalised with an average length of stay would have been £69.3 million (excluding service delivery costs). As such, this intervention has in fact saved the Exchequer £68.8 million in a single year. This figure does not include associated benefits to the economy associated with reduced productivity and sickness absence.

249. https://www.iod.com/news/employment-and-skills/iod-press-release-expand-benefit-in-kind-exemptions-to-incentivise-investment-in-occupational-health/

250. https://kpmg.com/uk/en/home/insights/2023/03/tmd-reimbursing-employee-benefits-are-you-getting-it-right.html

251. https://www.eapa.org.uk/wp-content/uploads/2023/03/EAPA-Holding-It-Together-report-2023.pdf

costs and the potential for abuse. We ought to be conscious of concerns about 'deadweight', whereby tax breaks are offered to those already investing in workplace health. The key is that interventions incentivised must demonstrate a strong evidence-base to support their use.[252] Moreover, drawbacks can be managed if exemptions are tightly drawn and come with sensible compliance measures. For example, for tax free reimbursement, and employee could be asked to provide evidence that they have paid for a flu vaccine or eye test. However, employers will already have systems in place for this and employees will be familiar with the concept from making claims for other reimbursed costs (such as business travel)

As discussed in the previous chapter which drew upon a brief overview of Cochrane Review literature on workplace health, it remains the case that "available evidence regarding the effectiveness of implementation strategies for improving implementation of health-promoting policies and practices in the workplace setting is sparse and inconsistent…The limited number of trials identified suggests implementation research in the workplace setting is in its infancy, warranting further research to guide evidence translation in this setting."[253]

Recommendations.

The Government should incentivise the growth of effective workplace health interventions by expanding tax relief upon employers at the next fiscal event.

- **HM Treasury and HM Revenue and Customs should create an 'Annual Allowance' for Benefit-in-Kind exemption for workplace health interventions, set at £2,500 per employee per year**.
  - To ensure value for money, exemptions should focus on well-evidenced preventative medical interventions, including initial assessment as well as treatment services, focused on the main drivers of long-term sickness and inactivity.
  - These should include services provided by occupational health and vocational rehabilitation. It should also include pain management and physiotherapy services, e.g., 'Musculoskeletal Hubs' delivered in leisure settings and access to mental health support, including digital health solutions which have been approved by NICE.
  - All adult vaccinations should be tax exempt – including COVID-19. Vaccines which exempt should follow the national immunisation schedule (and should be updated accordingly as amendments and additions to the schedule are made).
- **Employee Assistance Programmes (EAPs) should become a fully tax-free benefit.**
- **In addition to these measures,** HM Treasury should simplify the tax treatment of employee Benefits-in-Kind, such that the tax position is determined *by the benefit itself* (rather than by whether the employer incurs the cost directly or reimburses the employee), reducing the current compliance and enforcement burden.

252. https://www.employment-studies.co.uk/news/mental-health-training-managers-case-caveat-emptor

253. https://www.cochrane.org/CD012439/PUBHLTH_improving-implementation-health-promoting-policies-and-practices-workplaces

5. Workforce

Even if all employers across the UK were persuaded of the value of occupational health, there would be a substantial shortage of professionals able to provide the range of services required.[254] There is – as the Government's recent consultation on occupational health makes clear - a need to both grow and reform our present approach to the training of the multi-disciplinary occupational health service.

Since 2015, there has been a 21% reduction on part 3 of the specialist community public health nursing (SCPHN) register.[255] Many occupational health professionals meanwhile work in a siloed fashion, whilst training pathways in occupational health for Allied health professionals (AHPs) should be formalised. There is meanwhile limited exposure to occupational health at undergraduate level for both doctors and nurses and too few placement opportunities. All of these matters will need to be addressed to meet both growing need – and to deliver upon the policy recommendations that this report makes.

The positive news is that the supply of medical professionals is set to increase in the coming years. The number of licensed doctors is growing, with the latest figures from the General Medical Council (GMC) show that doctors joining the register have outnumbered those leaving by more than two to one since 2019.[256] The workforce is forecast to grow considerably over the coming decade, with International Medical Graduates (IMG) joining rates and increased medical school places contributing. The recently-published NHS Long-Term Workforce Plan notes the importance of investing in the occupational health workforce.[257] The Government has meanwhile committed to launching an occupational health workforce expansion scheme (delivered by the National School of Occupational Health), with the scheme aimed at registered doctors and nurses.[258]

Estimates of the ratio of occupational physicians to workers vary widely between and benchmarking with comparator countries is challenging. But the findings of a report from the All-Party Parliamentary Group on Occupational Safety and Health from 2016 highlighted some of these ratios, showing that in Finland (for instance) there was an occupational health worker for every thousand workers (1/1127); one for every ten-thousand in Germany (1/9935) and just one for every 25,000 in the UK.[259] There will be variation depending on factors such as the prevalence of employer-based insurance which necessitates a larger occupational health market, but the proportion of occupational health professionals is certainly lower in the UK than comparable countries. There are roughly 1,500 members of the Faculty of Occupational Medicine – less than 0.5% of all doctors registered to practice in UK. Moreover, almost 75% of occupational health specialists today are over fifty years of age.[260]

An audit of private occupational health providers shows that two-thirds (64%) of employed or subcontracted occupational health staff are medical professionals. Over two-fifths (44%) of providers had roles they were unable to fill. Most commonly, unfilled roles were occupational health nurses or doctors. Providers felt that the main reason they were not able

254. This statement remains as true now as when it was expressed in 2004: https://watermark.silverchair.com/kqg125.pdf?token=AQECAHi208BE49Ooan9kkhW_Ercy7Dm3ZL_9Cf3qfKAc485ysgAAA1QwggNQBgkqhkiG9w0BBwagggNBMIIDPQIBADCCAzYGCSqGSIb3DQEHATAeBglghkgBZQMEAS4wEQQMMw3twUYzWdhz96hs_AgEQgIIDB5wkhv_aHQYLdZ_xf52mqndo33ewREODocyCzc8wX2oEmHpo4E-pn0uGaCkG1qZMAAQ1BPHgmydWz6DdQ_CMBW3tHTYc6mf9j_xMq1FvWz1PhpUl8nGHhDKj2zkkOQ11DieV10hn-eJ9fu3KnFO1t8WHNRNkJnhb-FzMA9AX4zaUR63aipPO5ZkUoExFEIIKZkfYS6SbWseAsBS4GTetAcHEn2Tdx8nMAatzarJNDMg6nYGoJo3wTYXJSvMnZV0Ln-jztPIuvJ4XXG_DIdplp4U9HF7XzdCqMEwJIJ5-AiJ3GxLxuJYwor4VV8Bfr9-7mSe5zfBS1uDTkcCjqOrkNcLqjzkFNPT7hShISU1KnI_jhwGD5L2_tMgJ_Ux5I_habDK1jiqUngHAQymQdDMIiab1eKojdeac_dA40LAFkEIe6mpn_rGCXyGAkIMr1JgxU50-Z1dAArV-GfYg9pvPfbuAw39KSgulMLtkktIHGebAVzfyz79d3X1x3qqxP9QsfUcugfb-MqpSGfFemJso6Kh00D-sheIZLIYfVbjUm8tB7R2nbfHdIOpWBH3Hfv-h0GsJWMh6LBhNyGA0XVdi7661BoGf9ToU-7xZqI6f08kj4_nag15zVYtgzLHyorEPYIdXMx8TMFzbMOijoPNqoIfo92rZGX38fb9xFyiRX1IpWih3x9zej9Pb_9e9eIAX_ij7YsdkinMvXJcdPNiUu1ia19YD45FzfInIZ1gdYYzSFJhSBVmKfKx0FZ9QxLoTF-cnakPcOQ5Ks2GAIzj-Zd9SJnMh8UooJeptPdPCsKuqW4DLYYHRLsfh8Ei3vE4Me-fwj4VQq1NnpyKlu0R9Ut71C5d6KZIRddEJUE4fUKL2K7acJHyqWyEqHMpORbwK6Q66ALAtAn0WKzZbSHn7wyCCisif3dV4CbytZvcuex3_Ul3qGtb1uuk596lOCKQj75bdAOf31l415pBSGclAxMutwV5AwQJYANq9kXHYsSwNWPf5GEWtCWs6nGRbd-__eYW9xPLBPPJk

255. https://www.personneltoday.com/hr/cpd-the-origins-of-the-occupational-health-technicians-role/#:~:text=Origin%20of%20the%20OHT&text=One%20school%20of%20thought%20is,settings%20and%20in%20coal%20mines.

256. https://www.gmc-uk.org/-/media/documents/workforce-report-2023-full-report_pdf-103569478.pdf (p. 84)

257. https://www.england.nhs.uk/long-read/accessible-nhs-long-term-workforce-plan/#:~:text=This%20Plan%20sets%20out%20modelling,over%20the%20next%20two%20years.

258. https://assets.publishing.service.gov.uk/media/64b8f7baef5371000d7aef2d/occupational-health-working-better-consultation.pdf

259. https://d3n8a8pro7vhmx.cloudfront.net/ianlavery/pages/150/attachments/original/1476691067/OM_Workforce_Crisis_2016_pdf.pdf?1476691067 (p. 9)

260. https://www.som.org.uk/dr-rob-hampton-gp

to fill these roles was a lack of clear routes into the sector in recent years, meaning the number of medical professionals with occupational health experience was decreasing.[261]

The Occupational Health Workforce Today

The occupational health workforce is complex. Building up an accurate picture of the current size and capability of the workforce is challenging as there is no readily obtainable comparable data showing the full or part-time status of professionals or levels of qualification and training. As the bulk of occupational health services operate within the private sector, numbers are challenging to track and there is no formal reporting service.

In the table below, we set out a non-exhaustive list of those who provide occupational health services, estimated numbers of professionals currently qualified; by whom they are represented and regulated; and by whom their qualifications are accredited. Occupational health roles not listed below include: Cognitive Behavioural Therapists, Social Prescribers, Health and Wellbeing Leads, Mental Health Practitioners, Mental Health First Aid Trainers and Specialist Dieticians. Vocational rehabilitation practitioners (VRPs) meanwhile have "particular knowledge of employment as well as either generic or specialist health skills (e.g., in severe mental ill-health or traumatic brain injury)".[262]

261. https://assets.publishing.service.gov.uk/media/5ddbba3e40f0b650e2545c03/understanding_-private-providers-of-occupational-health-services.pdf (p. 16)

262. https://academic.oup.com/occmed/article/68/1/2/4866336

Table 5 – Summary of Occupational Health Workforce

Profession	Number	Regulator	Professional Groups	Qualification(s)
Doctors/ Physicians	571 (2018, GMC)	General Medical Council	Faculty of Occupational Medicine (FOM) Society of Occupational Medicine (SOM) iOH The Association of Occupational Health and Wellbeing Professionals	Often registered practitioners in another field such as General Practice.[263] Have taken further training and examination to extend scope of practice. Some will have undertaken the Diploma in Occupational Medicine (DOccMED). Programmes at postgraduate level for medical postgraduate doctors at Certified Training level (CCT), Certificate of Eligibility for Specialist registration (CESR) and a Diplomate qualification for other postgraduate doctors wishing to develop expertise. The National School of Occupational Health and the Faculty of Occupational Medicine work together to provide the required curricula, training quality assurance of courses and examinations.
Nurses	3200 (Council for Work and Health, 2015); Over 6000 nurses who have indicated to the Nursing and Midwifery Council that they work/have worked in OH in the last three years.[264]	Nursing and Midwifery Council (NMC)	Faculty of Occupational Health Nursing (FOHN) Society of Occupational Medicine (SOM) iOH The Association of Occupational Health and Wellbeing Professionals	NMC SCPHN degree/PG Diploma or a pure OH degree/PG Diploma based on the 2016 PHE framework for OH nurse education. The Faculty of Occupational Medicine offer Diploma in Occupational Practice (DipOccPrac) to boost specialist expertise. The Faculty of Occupational Health Nursing is currently launching a new accreditation scheme to enable OH nurses to use a new set of post-nominals.[265]

263. https://www.som.org.uk/sites/som.org.uk/files/The_future_of_the_OH_workforce.pdf
264. https://www.som.org.uk/sites/som.org.uk/files/The_future_of_the_OH_workforce.pdf (p. 4)
265. https://www.personneltoday.com/hr/fohn-oh-accreditation-oh-nurses/

Physiotherapists	60,000 in practice; 350 are members of the Association of Chartered Physiotherapists in Occupational Health and Ergonomics (ACPOHE)	Health and Care Professions Council (HCPC)	Chartered Society of Physiotherapy (CSP) Association of Occupational Health Physiotherapists in Occupational Health and Ergonomics (ACPOHE)	Registered members will either be qualified to master's level in a relevant OH discipline or show evidence of competency achievement, set by ACPOHE, via course work and assessment.
Occupational Therapists *Allied health professionals trained specifically to assess functional capability holistically including paid and unpaid work.* *Work across primary and secondary care & often based within a specialty (e.g., rheumatology).*	34,799 registered with the Health and Care Professions Council (HCPC); 200 specialising in OH (Council for Work and Health, 2016).	Health and Care Professions Council (HCPC)	Royal College of Occupational Therapists	Degree in occupational therapy takes three years full time (or six years part time).
Occupational Psychologists	300 (Council for Work and Health, 2015)	Health and Care Professions Council (HCPC)	British Psychological Society (BPS)	"Occupational Psychologist" is protected and requires psychology degree, but Organisational or Business Psychologists do not require prior psychology degree to practice.
Occupational Health Technicians (OHTs)	Unknown (data not collected centrally)	n/a	n/a	No central register of OHTs, "their role is unregulated, there is no standard entry to employment and there is no defined level of competency or education required."[266] Often possess a health sciences background. Accredited to provide audiometry and spirometry services and will undergo in-house training with supervision to complete assessments such as skin and hand arm vibration syndrome etc. Some may undertake an OFQAL level 3 accredited training program.

266.https://www.personneltoday.com/hr/occupational-health-technician-answer-skills-shortages-oh/

Occupational Hygienists	15,216	Faculty of Occupational Hygiene	British Occupational Hygiene Society (BOHS)	Passing the Diploma of Professional Competence in Occupational Hygiene (DipOH) required to qualify as a 'Chartered Occupational Hygienist'
Ergonomists	800 (qualified); 400 (chartered)	Chartered Institute of Ergonomics and Human Factors (CIEHF)	Chartered Institute of Ergonomics and Human Factors (CIEHF)	Ergonomists working within the workplace are either employed directly within businesses including NHS OH departments, or deliver work as self-employed consultants.

What the above reveals is that for some professions there is a lack of a formal accredited training pathway to specialise in occupational health – this is particularly so for Allied Health Professionals (AHPs).[267] Whilst accreditation is clearer for doctors, the Faculty of Occupational Medicine (FOM) have made clear that the current number of speciality trainees will be inadequate to meet future demand. There are many factors for this which include an ageing consultant workforce, lack of provision of training in the private sector and limitations to current commissioning models.

There needs therefore – as the National School of Occupational Health put it – to be "consistency and quality-assured training products… transferable across the evolving UK workforce" and a particular focus on approaches which can boost the visibility and attractiveness of occupational health at undergraduate level.[268] New routes are already being created in some places, such as a Level 7 apprenticeship for occupational health nurses which has been launched recently by the University of Derby.[269] Postgraduate access to appropriate level training for all professional groups should also be expanded and made more accessible – and it should become increasingly multi-professional.[270]

267. https://www.nhshealthatwork.co.uk/images/library/files/2023%20Conference/1120_-_IRA_MADAN_.pdf
268. https://eastmidlandsdeanery.nhs.uk/sites/default/files/nsoh_strategy_2023_to_2028_final_v2.pdf
269. https://www.personneltoday.com/hr/occupational-health-nurse-apprenticeship-set-to-be-launched-this-summer/
270. https://academic.oup.com/occmed/article/72/9/593/6966493?login=false

NHS
The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Case Study – Expanding OH Placements – Newcastle upon Tyne Hospitals NHS Foundation Trust

- NewcastleOHS is part of the Newcastle upon Tyne Hospitals NHS Foundation Trust and includes postgraduate trainees in general practice, occupational medicine and occupational psychology.
- To boost visibility of OH as a career pathway, NewcastleOHS has recently established placements for undergraduate students in physiotherapy.
- The programme comprises 4-to 6-week student placements of third-year BSc and MSc students.
- The integration into clinical assessments and multi-professional team working enhance the necessary skills to deliver advice to employees and managers through management referrals and self-referrals.

University of Worcester
Occupational Health

Case Study – Emerging Partnerships: Spire Occupational Health & University of Worcester

- Spire Occupational Health is currently in the process of launching a partnership with the University of Worcester to offer occupational health placements to student nurses, return to nursing students and mental health nursing students as part of their degree programme.
- First and second year students will be able to undertake placements of up to 12 weeks to introduce them to this specialised field of healthcare.

The case for this is clear. In the clinical setting, the occupational, or employment consideration is significant. The reality is that lots of health and care professionals are delivering 'occupational health' or 'vocational rehabilitation', but are either unaware they are doing so or infrequently consider the 'occupational' component of the care they are providing. For instance, the authors of a recently-published issue of the *Clinical Medicine Journal* give the following example: "after an epileptic seizure, an office worker who can use public transport is relatively easily able to return to their usual work while a professional driver cannot work in that capacity for at least 12 months".[271] Many AHPs will have to consider their client's or patient's work when formulating treatment and advisory plans.[272] A recent study finds that majority of ophthalmology doctors regard RTW as an important clinical outcome yet most do not routinely discuss work outcomes with patients to inform care planning.[273]

271. https://www.rcpjournals.org/content/clinmedicine/21/3/195
272. https://www.som.org.uk/sites/som.org.uk/files/The_future_of_the_OH_workforce.pdf (p. 2)
273. https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0268997

Strengthening the occupational dimension to the work of healthcare professionals carries many advantages. GPs who have had occupational health training find that they are better able to assess their patient's fitness to work and also issue fewer sickness certificates (fit notes).[274] Evidence suggests the effectiveness of multidisciplinary care (MDC), an approach sometimes used in OH provision involving a team of healthcare professionals with different specialities (e.g. physiotherapy, pain management, counselling, job coaching, occupational health). [275]

The key is to maintain the core features of occupational medicine as a specialism, but to innovate. The GP is usually the first health professional to see a patient who is absent from work due to ill-health. Each GP currently issues roughly twenty sickness certificates per week (over 11m in total were issued last year).[276] As such, as part of their key role in the health system, offering holistic support for undifferentiated issues over the life course, GPs play – and will continue to play – a key role in occupational health. In recent years, wider pressures upon GP have encouraged an expansion of those able to issue 'fit notes', with some GPs reporting they routinely agree to patients' demands for a sickness certificate to avoid conflict. [277] Occupational therapists can now access, assess and sign the Fit Note and DVLA Medical questionnaire, so as to advise people on how to manage their health condition and daily activities. Whilst the vast majority (well over 90%) of all fit notes are completed by a GP, there is some evidence emerging that physiotherapists and occupational therapists make greater use of the "may be fit for work" option.[278]

Enhancing the Role of Occupational Health Technicians (OHTs)

As occupational health practitioners increasingly operate in a multidisciplinary environment, the added value that OHTs can offer is increasingly being recognised with demand increasing, with providers seeking to develop their skills to encompass screening services, health surveillance, audiometry and spirometry.[279] OHTs are largely however trained 'in house' by providers, with no formal training, accreditation or professional regulator.

A wider pool of Accredited Register practitioners meanwhile could provide a useful group for the Government to engage in when looking to grow and develop the occupational health workforce. In 2012, the Professional Standards Association was granted new powers to accredit organisations holding voluntary registers of health and care roles. A recent joint survey with NHS Professionals showed that many practitioners are interested in additional employment opportunities. They too can provide assessments of the ability of individuals to work and can consider wider organisational interventions to improve occupational health. The Government should consider expanding opportunities for counselling and psychotherapy registered practitioners in particular when designing new career pathways for the wider occupational health workforce.[280]

274. https://bjgp.org/content/60/579/721.abstract
275. https://allcatsrgrey.org.uk/wp/download/occupational_therapy/RR985-understanding-the-provision-of-OH-and-work-related-MSK-services.pdf
276. https://bjgp.org/content/62/595/e147
277. https://bjgp.org/content/60/579/721.abstract
278. https://journals.sagepub.com/doi/abs/10.1177/0308022620948763
279. https://www.personneltoday.com/hr/occupational-health-technician-answer-skills-shortages-oh/
280. https://www.professionalstandards.org.uk/docs/default-source/publications/consultation-response/others-consultations/2023/professional-standards-authority-response-to-occupational-health---working-better.pdf?sfvrsn=10e04a20_3

Recommendations

1. **The Government should commit to boosting the supply of occupational health and vocational rehabilitation professionals and innovate with current training and career pathways, building on the recently-published NHS Long Term Workforce Plan.**
    a. Enabling a greater range of professionals to specialize or to gain experience working in occupational health or vocational rehabilitation should be regarded as a means by which to expand opportunities for the NHS workforce and to enable work across a wider variety of settings.
    b. Occupational Health is often overlooked (or minimised) in undergraduate and postgraduate medicine and nursing curricula. The Medical Schools Council, Council of Deans of Health and Universities UK (and their members) should work with the National School of Occupational Health (NSOH) to explore ways to enhance exposure to occupational health in curricula and to expand placement opportunities.
    c. Training pathways in occupational health for Allied health professionals (AHPs) should be formalised.[281]
    d. Create further opportunities for professionals working in occupational health – particularly nursing staff – to be able to develop sub-specialisation in key areas, such as women's health and the menopause or in cardiovascular disease management.
2. **DHSC and NHS England should expand the number of clinical placements delivered by occupational health providers by developing a dedicated Tariff.**
3. **The Occupational Health Technician (OHT) role should be enhanced, with greater formalisation and support.**
    a. Currently, there is "no governing body or recognised qualification for occupational health technicians".[282] The Government should look to make the Health and Care Professions Council (HCPC) the professional regulator of OHTs in the coming years, following consultation.
    b. The Health and Safety Executive (HSE) should consult on measures which could enable OHTs to practice with greater independence over time in order to create additional capacity and to enable improved professional development. We would add the caveat that this would need to remain within an appropriate clinical governance structure.
4. **Opportunities to expand the number of GPs able to attain The Diploma in Occupational Medicine (DOccMED) should be expanded, so those with an interest in** occupational health **can achieve this as an Extended Role (GPwER).** Whilst GPs are not expected to have specialist knowledge of each patient's workplace, enhancing the number of professionals who are able to occupational details should be developed
5. **The NHS should establish new opportunities for professional networks, working closely with organisations such as The Association of Occupational Health and Wellbeing Professionals (iOH), a network of multi-disciplinary Occupational Health & Wellbeing Professionals.**

281. https://www.nhshealthatwork.co.uk/images/library/files/2023%20Conference/1120_-_IRA_MADAN_.pdf
282. https://www.hse.gov.uk/health-surveillance/occupational-health/assessing-competence.htm

6. Integration – Improving the Link Between Workplaces, Occupational Health, Employment Support and NHS Services

> *"[The] detachment of occupational health from mainstream healthcare undermines holistic patient care. A weak and declining academic base combined with the absence of any formal accreditation procedures, a lack of good quality data and a focus solely on those in work, impedes the profession's capacity to analyse and address the full needs of the working age population."*
>
> *Professor Dame Carol Black*[283]

A key finding from our research has been a clear need to more effectively link NHS care with 'occupational' factors. For organisations working beyond formalised health and care settings meanwhile, an improved interface and delivery models are required. The work of Dr Shriti Pattani and colleagues will be instructive here in identifying two pathways to improving the link between health and work: a primary care pathway, which is supported by social prescribing link workers and 'work coaches'. A pilot scheme led by Dr Pattani shows Referrals by work coaches to OH clinicians resulted in 90% of cases returning to work or remaining in work after referral.[284] Then there is the employer pathway – the topic of focus for this report – with a greater range of preventative and treatment services being offered via employers either in-house or by occupational health providers.

Reforming Support Across Primary and Community Care Services

There are significant opportunities to enhance occupational medicine across primary and community care services – or, for the 'occupational lens' to be far more commonplace. There is a strong rationale to expand services which target some of the key conditions and drivers of long-term absence from work. MSK conditions present one significant example, with innovative examples of integrated MSK services being developed which can provide more direct access to support and treatment and reduce the need for patients to access secondary care services.

283. https://assets.publishing.service.gov.uk/media/5a7c55bee5274a1b0042313c/hwwb-working-for-a-healthier-tomorrow.pdf
284. https://rehis.com/events/scottish-occupational-health-action-group-sohag-health-and-work-in-scotland-webinar/

Case Study – Creating an Integrated MSK Service in Darlington

Darlington has a population of just over 100,000 people with life expectancy lower than the England average; 20% of children are from low-income families.

In April 2017, Connect Health were commissioned by the then Clinical Commissioning Group (CCG) to deliver an integrated MSK service which would offer patients a single point of direct access for musculoskeletal needs and physiotherapy support, reducing the need for initial GP assessment for MSK problems.

In addition to enabling swifter access to support, the service sought to address long waiting times for orthopaedic procedures (which have traditionally been the longest for any surgical specialty) and to enhance 'out of hospital' services in the community.

The service provides a single point of access for local MSK referrals with specialist clinical review of incoming referrals and triage patients to the most appropriate setting for further treatment and/or diagnosis.

Results:

- There was a 19% reduction in orthopaedic outpatient first attendances, moving from 2642 in 17/18 prior to SPOA being introduced, to 2145 in 2018/2019
- There was a 15% reduction in outpatient follow up attendances, from 8047 in 17/18 prior to SPOA to 6814 in 2018/2019.
- There was a 13% reduction in secondary care joint injections from 499 in 17/18 prior to SPOA to 435 in 2018/2019.

Information for this case study was kindly shared with Policy Exchange by Connect Health

The Future of the 'Fit Note'

For those that cannot access occupational health services directly via their employer, primary care plays a critical role in "navigating the effects of their health on work and work on health". The fit note acts as an "important backstop", "ensuring contact with a healthcare professional relatively early in a period of sickness absence".[285]

We are not however maximising its effectiveness at present. The Government should introduce further reforms to sickness certification and the 'Fit Note', following further consultation in 2024. A new category called 'Further Assessment' with an addition to the current form which enables and encourages healthcare professionals to *"Recommend further assessment from an occupational health professional"*, supported by a new referral pathway – either to NHS occupational health services where capacity allows, or which encourages employers to utilise occupational health to conduct a more detailed investigation to inform the best route forward.

A new category called 'Ongoing Assessment' should also be introduced to enable healthcare professionals to recommend further or continuing

285.https://academic.oup.com/occmed/article/72/8/503/6881486?searchresult=1

assessment and support (by another healthcare professional, such as a physiotherapist or non-clinical advice, such as from a work coach, linking to the approach being taken through the WorkWell pilot). This should be applied in all cases where an individual is signed off work for longer than a month, such as for those with chronic conditions or long-term illness. Referral to an occupational therapist or social prescribing link worker may be beneficial.

Whilst GP systems can now integrate digital fit notes, meaning they can be emailed to the patient, further changes to sickness certification must be accompanied by enhancing how employment information links with patient health records so that occupational health professionals, in addition to e.g., pharmacists and physiotherapists who are certified to issue 'fit notes' can request updates to the GP record, or can seamlessly inform GP staff of updates, building on recommendations previously made by Policy Exchange.

Improving Information Sharing

According to a review undertaken by the Department of Work and Pensions, seven out of ten (69%) occupational health providers captured data on the outcomes achieved through their support in all or most cases, with 56% capturing it in all or nearly all cases.[286] This means we end up with a fairly limited picture of current occupational health provision activity as a consequence.

When it comes to information gathering beyond traditional health settings (and where conversations take place with individuals who are not regulated health professionals, bound by GMC or NMC rules for instance), care is needed. Employers will want reassurance their confidential medical or health-related information will not be shared with their line managers or co-workers without consent and that it will not be factored into decisions around employability.[287] A study of Rolls Royce reveals the importance of creating a workplace culture that encourages the disclosure of work-relevant pain, enabling organizations to consider improved, tailored support.[288] However, there is a great opportunity here if approached with optimism and care. Effective engagement with businesses – such as via a revamped ONS Health Index – will enhance the availability of more granular data on the overall picture of employee health and could be leveraged to more effectively plan services, and target interventions.

286. https://allcatsrgrey.org.uk/wp/download/occupational_therapy/RR985-understanding-the-provision-of-OH-and-work-related-MSK-services.pdf (p. 53)
287. https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-022-08621-y
288. https://journals.lww.com/joem/fulltext/2023/06000/quantifying_the_burden_of_persistent.21.aspx

The Role of the Workplaces in Boosting the NHS Health Check

What is the NHS Health Check?

What is it? The 'NHS Health Check' is a national health screening programme which was launched in 2009, available for all adults aged between 40-74 to attend voluntarily, on a five yearly recall basis, which is intended to identify cardiovascular disease (CVD) risk factors and to reduce CVD mortality.

What is checked? The Health Check itself includes lifestyle checks (body mass index), exercise level (GPPAQ questionnaire), smoking status and alcohol intake (alcohol use disorders identification test for consumption (AUDIT-C) questionnaire, QRISK2 score alongside clinical measures (pulse, blood pressure, ECG, cholesterol.

Who delivers it? In 2020, Public Health England conducted an audit which found that General Practice (GP) is the most common provider of Health Checks – 93% of responding local authorities (97/104) were commissioning GPs to deliver them. There has been a reduction in the provision of checks by Pharmacies since 2014 which may, in part, be explained by the fact that non-GP providers do not have access to information identifying the eligible population and therefore have to take additional steps to make invitations. [289] Policy Exchange has previously recommended that patient records are accessible to community pharmacy to enable a greater range of preventative interventions, such as vaccination.[290]

What does it cost? Most Local Authorities pay between £21.00 and £40.00 per NHS Health Check.[291]

Uptake? More people do not attend their Health Check when invited than do. See Fig. 14.

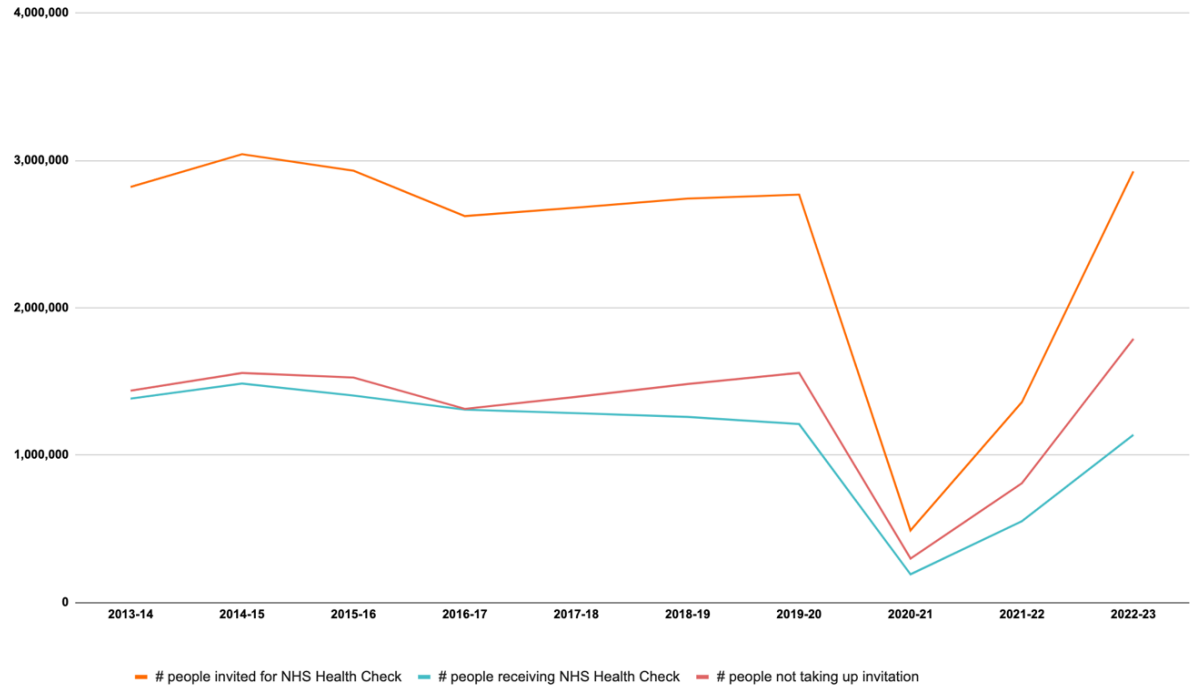
A systematic review of the NHS Health Check published in 2018 highlighted reasons for not attending included lack of awareness, misunderstanding regarding the purpose of the Health Check, time constraints, difficulties with access to general practices, and doubts regarding pharmacies as appropriate settings. The findings highlighted the need for improved communication and publicity around the purpose of the NHS Health Check programme and the personal health benefits of risk factor detection.[292]

Recent Announcements:

- Last year, Professor John Deanfield in a review of the Health Check emphasised the value that a Digital Health Check could provide. [293]
- Professor Deanfield's review advocates an expansion of the NHS Health Check to those of a younger age (i.e., 30 to 39) given preventable risk factors such as smoking, high blood pressure, cholesterol and obesity drive the development of CVD and other diseases from early life.
- These recommendations were taken up with a new approach to the NHS Health Check announced in Spring 2023.[294]

289. https://www.healthcheck.nhs.uk/seecms-file/?id=1603
290. This was something we emphasised in our recent report on the future for vaccines policy: https://policyexchange.org.uk/publication/a-fresh-shot/. We have also more recently proposed a Digital Health and Care Bill to be introduced in order to achieve this: https://policyexchange.org.uk/publication/what-do-we-want-from-the-kings-speech/
291. https://www.healthcheck.nhs.uk/seecms-file/?id=1603
292. https://bjgp.org/content/68/666/e28.short
293. https://www.gov.uk/government/publications/nhs-health-check-programme-review/preventing-illness-and-improving-health-for-all-a-review-of-the-nhs-health-check-programme-and-recommendations
294. https://www.pulsetoday.co.uk/news/clinical-areas/cardiovascular/nhs-health-check-will-become-digitised-spring-budget-confirms/

Figure 14 – Summary of Patients Recorded NHS Health Check Attendance Status, England, 2013/14 - 2022/23



Economic modelling carried out by Public Health England in 2013, found that the NHS Health Check is a cost-effective intervention, creating estimated savings to the NHS budget of around £57 million over four years, rising to £176 million over a fifteen-year period.[295] The clinical evidence is positive too. A recent study finds that the NHS Health Check is "linked to reduced incidence of disease across multiple organ systems, which may be attributed to risk modification through earlier detection and treatment of key risk factors such as hypertension and high cholesterol".[296] The 'NHS Health Check' has also been associated with improvements in health behaviours such as smoking cessation, physical activity, and diet.[297]

Professor John Deanfield's recent review also recognises challenges with accessibility of the scheme, noting that appointments only offered during working hours were a barrier to attendance.[298] As such, there will be advantages to expanding the Health Check so a greater proportion are delivered in workplace settings – or closer to people's place of employment, which in turn is a lever for addressing some prevailing health inequalities. This may not, however, be a silver bullet to boosting attendance. In one recent study, local government employees from deprived areas in North-East England were invited to attend a free health check, conducted within working hours and close to their workplaces. Subjects were invited to repeat screening approximately nine months later.[299] A participation rate of 20% from this study was significantly lower than the annual national participation target set for Health Checks for the general population, demonstrating that accessibility alone is unlikely to drive attendance. Ensuring effective buy-in and endorsement from employers and making

295. https://www.gov.uk/government/publications/productive-healthy-ageing-and-musculoskeletal-health/productive-healthy-ageing-and-musculoskeletal-msk-health
296. https://bmcmedicine.biomedcentral.com/articles/10.1186/s12916-023-03187-w
297. https://bmjopen.bmj.com/content/13/5/e068025
298. https://www.gov.uk/government/publications/nhs-health-check-programme-review/preventing-illness-and-improving-health-for-all-a-review-of-the-nhs-health-check-programme-and-recommendations
299. https://eprints.ncl.ac.uk/file_store/production/231884/3DEDB-6CC-CD51-41F5-A65B-BDF4AB89EC6D.pdf

the offer commonplace is required as well as utilising social environments and community organisations to tackle underling health inequalities and lack of uptake.

More broadly, there is scope for further reform of the 'NHS Health Check'. As organisations such as Versus Arthritis have shown, a significant proportion of MSK cases could be identified earlier and better managed to prevent further pain and disability, through improved detection, minimisation of risk factors, and self-management support. Analysis shows that interventions designed to help stop or slow the development of MSK problems by targeting key modifiable risk factors are cost effective, through the prevention of further disability and the delivery of long-term healthcare cost savings.[300] The content of the NHS Health Check, therefore, ought to be further reviewed so as to align with the Major Conditions Strategy, currently in development, with consideration for the inclusion of musculoskeletal health for instance.

Enhancing 'Return to Work' (RTW)

As this report has emphasised, a variety of models of access to occupational health will be required, in turn influencing the number of occupational practitioners and the skill mix.[301] As one vocational rehabilitation practitioner put it to us, "there isn't a model for rehabilitation- for employer or employees". Much occupational health service activity is invested in preparing staff for work at the start of employment (e.g., screening and immunisation) and also in supporting sickness absence management. Some of these tasks are straightforward and require limited specialist clinical expertise. However, some aspects of these tasks are complex and require specialist occupational health skills and a deep understanding of the NHS workplaces.[302] More effective integration and linking with NHS services and schemes delivered by local government will be required for them to be successful as well as leveraging the power, insights and responsiveness of local community organisations and patient groups.

For this to be efficacious and successful, interventions will need to be able to cater for:

- Workers of a different age profiles
- Those living in remote and rural communities
- People with rare diseases
- Those working in jobs at high-risk of traumatic events
- People whose work status may lead to poor mental or physical health

This also requires employers to be clear about the key opportunities for screening which is being offered to specific age cohorts. Appointments during working hours and inflexibility have been identified as a barrier by Jo's Cervical Cancer Trust as a reason why 1 in 3 women don't attend (when invited) cervical screening (smear tests) at present.[303]

For a series of targeted interventions, Steering Groups which focus

300. https://www.versusarthritis.org/media/2177/physical-activity-msk-health-report.pdf
301. https://eastmidlandsdeanery.nhs.uk/sites/default/files/nsoh_strategy_2023_to_2028_final_v2.pdf (p. 4)
302. https://www.nhshealthatwork.co.uk/images/library/files/Leading%20OH%20service/The_Future_Configuration_of_NHS_Occupational_Health_Services_2010_report.pdf
303. https://www.jostrust.org.uk/get-involved/campaign/time-test

on RTW should be developed. Healthcare professionals should work in collaboration with employers and in order to design more integrated interventions to improve healthcare support for those of working age and for RTW.[304] These partnerships can positively impact the clinical service itself, rather than being seen as a new burden. Consideration of RTW too infrequently factors into the decision-making of clinicians when handling an episode of care; health records do not detail the occupational factors which might assist the decision making a GP, so there are opportunities to more effectively embed this information and to encourage a wider range of professionals to see cases through an 'occupational lens'.

Ultimately, early vocational advice and support has been found to be effective in helping people with musculoskeletal pain to RTW. The Study of Work and Pain, a randomised controlled trial, has shown that introducing a vocational advice service in general practice, led to an average reduction in work absence of five days per employed patient over four months with a Return-on-Investment of £49 per £1 invested.[305] This work has been built upon by The "Work and Vocational advicE (WAVE)"§ study in which vocational support workers (VSWs), deliver advice to those signed-off from work by their GP through receipt of a 'fit note'. Participants were recruited from six practices in three areas of England: West Midlands, South London and Hampshire.[306]

304. https://www.mdpi.com/1660-4601/16/8/1343
305. https://journals.lww.com/pain/full-text/2018/01000/Effectiveness_and_costs_of_a_vocational_advice.17.aspx
306. https://journals.sagepub.com/doi/full/10.1177/13634593221148446

Examples of Targeted Interventions by Condition Area / Age Cohort

 **23-year-old man**, *Common Mental Disorder (Depression)*	• The Health Foundation has found says the proportion of people not working because of mental health issues has almost doubled in 11 years, from more than six per cent in 2012 to 12.7 per cent in 2023.[307] • Two in five young people with a mental health condition do not disclose this in their workplace, as they feel uncomfortable doing so.[308] • Men are three times more likely to take their own lives than women, with males aged between 45 and 49 at the highest risk.[309] • Currently, almost 467,000 young people are economically inactive with 2 out of 3 inactive because of a common mental health disorder (CMD) • Reviews suggest that occupational health (OH) interventions that comprise clinical and workplace multi-components to support RTW following sickness absence due to Common mental disorders (CMD) can be effective.[310] • Whilst the "empirical literature is limited", providing Individual Placement and Support (IPS) to young adults with serious mental illness results in a 20% increase in the employment rate.[311]
 **34-year-old woman,** *Back Pain (Rehabilitation from Injury)*	• A strong majority (62.4%) of people with MSK conditions are employed, but The Society of Occupational Medicine and Versus Arthritis found that almost three-quarters (72%) of workplace professionals did not feel that current workplace wellbeing initiatives are meeting the needs of people with moderate to severe arthritis and other MSK conditions.[312] • MSK problems are predominantly managed in primary care where they account for approximately 14% of General Practitioner (GP) consultations.[313] Trauma and Orthopaedic (T&O) waits are the single largest component of the NHS backlog. 1 in 5 (18%) of those who have not returned to the workplace following the pandemic said they were currently on an NHS waiting list for medical treatment. • For an older cohort of workers, it is worth noting that the number of hip replacement procedures carried out for patients aged 50 years and over in England and Wales more than doubled between 2002 and 2018.[314] By 2030–2035 the majority of Total Knee Replacement patients in the US and UK will already be of working age. • Being on sick leave pre-operatively can be associated with reduced odds of RTW. RTW rates for patients awaiting knee replacements vary between 40 and 98% with a mean time to RTW between 8 and 17 weeks.[315] • Physiotherapists, especially those specialized in occupational health and ergonomics, could also add value because of their knowledge of the physical recovery of the patient and of assessing and (temporarily) adjusting physical job demands.[316] • One study finds a combination of activity, maintenance therapy, stretching, and manual therapy showed promising results in improving RTW.[317]

307. https://www.theguardian.com/society/2023/dec/24/500000-under-35s-out-of-work-long-term-illness-uk#:~:text=The%20Health%20Foundation%20report%20shows,2012%20to%2012.7%25%20in%202023.
308. https://www.employment-studies.co.uk/system/files/resources/files/Young_Peoples_Mental_Health_Report_final.pdf
309. https://www.lscft.nhs.uk/news/supporting-mens-mental-health
310. https://link.springer.com/article/10.1007/s10926-016-9690-x; https://link.springer.com/article/10.1007/s10926-012-9359-z
311. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10221953/#:~:text=Although%20the%20empirical%20literature%20is,gain%20and%20keep%20competitive%20jobs
312. The findings of this survey were kindly shared with Policy Exchange by Versus Arthritis
313. https://bmcmusculoskeletdisord.biomedcentral.com/articles/10.1186/1471-2474-11-144
314. https://www.thelancet.com/journals/lanepe/article/PIIS2666-7762(22)00171-5/fulltext
315. https://link.springer.com/article/10.1007/s10926-022-10068-1
316. https://www.jospt.org/doi/abs/10.2519/jospt.2021.0505
317. https://content.iospress.com/articles/work/wor230277


52 year-old woman, Menopause
	• The management of gender-specific health issues are rarely discussed in the workplace – menopause is an illustrative case.
	• There is an opportunity to link the priorities of the Women's Health Strategy to a renewed approach to workplace health as a key site for effective intervention.[318]
	• More women are now working through their menopause than before.[319] Yet, The Fawcett Society suggests that one-in-ten women leave the workforce entirely due to their symptoms.[320]
	• Five key areas have been identified as particularly significant for employer support:
	  • management awareness of menopause as a possible health problem;
	  • flexible working hours;
	  • information about coping with menopause and work;
	  • better control over temperature and ventilation; a
	  • access to informal sources of support, such as women's networks or telephone helplines.

 **56-year-old man**, Cancer – support for phased return	• There are more than 560,000 people with cancer in the workforce today; this will grow to more than 1.1 million people by 2030, according to findings from a report prepared by UNUM, which was commissioned by Maggie's.[321] 40% of people with cancer in the UK have used annual leave for their appointments rather than telling their employer it is for cancer treatment. • Further findings from research commissioned by Maggie's suggests that with the right support, an extra 63,000 people with cancer could be helped back into the workplace, generating £1.8 billion. • Despite improvements in cancer survival, RTW rates are low – only 60% return within a year of completing treatment. *"Cancer treatments have progressed but ironically in the case of immunotherapies for example, people may need even greater help to continue working due to enduring physical and psychological side effects"* – **Lesley Howell, Lead Psychologist, Maggie's** • Recent reviews show RTW rates between 39 and 93% within 1–2 years after cancer diagnosis. However, the employment pathways of cancer survivors could change after this point because treatment for cancer can, increasingly, be a long process (taking a year or more) and survivors can have persistent long-term effects which may last well beyond 2-year post-diagnosis.[322] Prognostic factors for not returning to work among cancer patients include older age, lower income at diagnosis, comorbidities, but these factors have been investigated in relatively few studies.[323] • A recent study by the Institute of Employment Studies found that over half said medical professionals did not discuss their RTW.[324] • Multi-disciplinary interventions (psychologists, medical social workers, oncology nurses, case managers) which included workplace adjustment exercises led to more cancer patients returning to work than care as usual.[325] • Initiatives, such as Maggie's 'Cancer in the Workplace' sessions, which bring together clinicians as well as local businesses to discuss best-practice are one tool which should be further encouraged and supported so as to design effective interventions for RTW.

318. https://www.gov.uk/government/publications/womens-health-strategy-for-england/womens-health-strategy-for-england
319. https://academic.oup.com/occmed/article/68/9/580/5244620
320. https://www.fawcettsociety.org.uk/menopauseandtheworkplace
321. https://www.maggies.org/get-involved/get-your-company-involved/our-corporate-partnerships/unum/
322. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7182621/
323. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7182621/
324. https://www.employment-studies.co.uk/resource/cancer-and-employment-survey
325. https://pubmed.ncbi.nlm.nih.gov/26405010/

Recommendation(s)

1. **The Government should introduce further reforms to sickness certification and the 'Fit Note'.**
   a. An option should be added to the current form to enable and encourage GPs and other healthcare professionals to *"Refer to an occupational health professional" or to "Recommend further assessment from an occupational health professional"*.
   b. Linked to this, new categories called 'Additional Assessment' and 'Ongoing Assessment' should be introduced to enable healthcare professionals to recommend further assessment, such as by another healthcare professional, i.e., physiotherapist or to non-clinical advice, such as from a work coach. This should be applied in all cases where an individual is signed off work for longer than a month, such as those with chronic conditions or long-term illness.
   c. The Government should add paramedics and podiatrists to the list of qualified practitioners legally able to conduct sickness assessments.
   d. These changes must be accompanied by enhancing how employment information links with patient health records so that occupational health professionals, in addition to e.g., pharmacists and physiotherapists certified to issue 'fit notes' can request updates to the GP record, or can seamlessly inform GP staff of updates, building on recommendations previously made by Policy Exchange.
2. **The Department of Health and Social Care should boost those eligible for the NHS Health Check – with a focus on expanding its delivery in workplaces**.
   a. The content of the NHS Health Check should be reviewed so that it aligns with areas covered in the Major Conditions Strategy, including musculoskeletal health as well as long-term conditions.[326]
   b. The Government should trial extending the service by prioritising geographies which have a higher prevalence of multimorbidity and 'inactivity', including the North East of England and South Wales. Here, the Health Check should be extended to those aged twenty-five and above – with a view to a national rollout.
3. **Building on the 'Fuller stocktake report', NHS England should strengthen primary and community care services which tackle some of the major drivers of inactivity.**[327]
   a. 'Musculoskeletal hubs' (also known as MSK physical activity hubs) should be expanded, with the aim of developing a service across every primary care network footprint.
   b. Prediction models for long-term sickness absence, based upon occupational criteria, should become embedded within GP IT systems. This recommendation builds on our recent report, *Medical Evolution*, which called for the increased use of clinical-decision support software to be used in primary care settings.[328]
   c. Building on the Work and Vocational advice (WAVE) project and current WorkWell pilot, the Government should enhance links and the ability for primary care staff to embed or refer individuals to vocational advice services.[329]

326. https://www.gov.uk/government/publications/major-conditions-strategy-case-for-change-and-our-strategic-framework/major-conditions-strategy-case-for-change-and-our-strategic-framework--2
327. https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/
328. https://policyexchange.org.uk/publication/medical-evolution/
329. https://www.keele.ac.uk/ctu/researchportfolio/activeresearch/wave/#!

Conclusion

Although there are positive signs that 'economic inactivity' has been decreasing overall in recent months, the growing trend of ill-health which has driven an increase in both short- and long-term illness is becoming an increasingly pressing matter for policymakers. This is pertinent to health, economic and social imperatives.

In the immediate days prior to the publication of this report, we have seen political consensus on the salience of the issue. The Government have looked to build on measures set out at last year's fiscal events in announcing an Occupational Health Taskforce, which will target improving access for SMEs. The Leader of the Opposition meanwhile has discussed approaches to address a "perfect storm" of long-term sickness which is "choking off" economic growth.[330]

The number of 20-to-69-year-olds living with major illness is predicted to rise by half a million by 2030.[331] We know the drivers of ill-health among those of working age will grow as citizens work longer than their parents did. As will the numbers of those suffering with chronicity and long-term conditions. If we want to address this growing challenge, we will need to think differently and radically.

The relationship between health and work is complex. We know that the culture of workplaces influences health outcomes, as a do a multitude of connected factors ranging from pay to shift patterns. As Dame Carol Black has stated, "if I could wave a magic wand, the one thing I would do is to improve the relationship between line managers and employees…"[332]

This report has made the practical case for enhancing the role of workplaces as a stakeholder in the healthcare ecosystem by providing a more effective link to existing NHS services and in enabling improved access to services which can support the key drivers of long-term illness: mental ill-health and MSK conditions above all.

Rather than mandating action upon employers, we have focused upon the leadership role that Government can play in supporting and incentivising improved provision. A 'Health in Work Council' (modelled on the Life Sciences Council) which brings together high-level political representatives and stakeholders should be created. A digital 'Health in Work' portal should bring together best-practice and details of high-quality providers of occupational health services so workplaces can easily find 'what good looks like' and make informed decisions on provision to suit their workforce. Reforms to the 'fit note' are urgently required. We should begin with enabling GPs to more readily refer patients to an occupational health professional for a more detailed assessment.

330. https://www.dailymail.co.uk/news/article-13110961/keir-starmer-pledges-curb-number-people-benefits.html

331. https://www.health.org.uk/commission-for-healthier-working-lives

332. Cited in: https://www.employment-studies.co.uk/system/files/resources/files/The%20Squeezed%20Middle%20IES%20Report%20.pdf

Attendance of the 'NHS Health Check' should be increased by utilising workplaces to boost accessibility. In the areas with the greatest levels of inactivity, the Government should explore raising eligibility for the 'NHS Health Check' to those over 25.

Demand-side measures which raise the profile of the value of occupational health and incentivise employers – particularly SMEs – will be vital. We recommend expanding tax relief for effective assessment and treatment services and providing Business Rates Relief for groups of businesses that work together in new ways to scale provision across their locality or supply chain, or who make use of empty units in the local area. These measures should be introduced at the next fiscal event.

We also recognise the importance of supply-side measures – particularly in encouraging the next generation of healthcare professionals to develop experience and expertise in occupational health through their education and training – and throughout their careers. This will be a rate-limiting factor in any ambition toward developing universal access to occupational health, but there is a great opportunity with the NHS Long Term Workforce Plan which must be grasped. This will in turn enhance occupational health provision within the NHS which remains patchy and would benefit from greater visibility both at a national level and throughout each integrated care system.

Whilst expanding access to occupational health and vocational rehabilitation may be regarded as merely the 'tip of the iceberg' in grappling with the wider health and employment public policy challenge, we regard it as a vital component which should remain front-and-centre of the current, and any future, Government's plans.

It must be seen as part of a broader strategic imperative for the health and care system: to shift care out of hospital settings and to boost effective preventative interventions. More broadly, occupational health can act as an effective bridge between the private sector, local government, voluntary sector and NHS services, encouraging improved partnership working and enabling individuals to access a wider range of healthcare services in a more accessible fashion.[333]

Making progress in addressing rising sickness absence will not just benefit employers, but the health service itself, whilst nudging the population into rethinking the determinants of health. Grasping these opportunities and given the strong economic and health-related case for change, it can no longer be the case that health is regarded as 'none of the business' of workplaces.

333.https://www.mdpi.com/1660-4601/18/7/3632

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