# What next for health at work?

## Five years on from the Black/Frost review of sickness absence

# Foreword


## Peter O'Donnell

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### Unum UK


In 2011, Unum was proud to be a member of the Taskforce supporting Professor Dame Carol Black and David Frost CBE to carry out their independent review of sickness absence in the UK.

The review produced a powerful critique of how the sickness absence system failed working age people with long term health problems and their employers. The government welcomed it but a little over five years on, it is clear that a number of significant problems it identified remain unchallenged and unresolved. The Centre for Economic and Business Research found long term sickness absence now costs employers £6.71 billion a year.

Too few people with health problems get the right support at the right time to stay in work and reach their potential. That is an injustice and one that is detrimental to those people's mental, physical and financial wellbeing. It also contributes to the continuing low levels of productivity in the UK economy and represents a bad deal for taxpayers.

The government has recognised the ongoing problems with the sickness absence system and is trying to tackle them. At the end of last year, it published a Green Paper on Work, Health and Disability that put preventing people falling out of work for health reasons front and centre of its efforts to halve the disability employment gap. What we require now are strategic, bold and long-term reforms, aggressively implemented, rather than just piecemeal changes.

To that end, Unum approached Dame Carol and many of the original contributors to the 2011 review to write an essay on what more needs to be done to support working people with health problems to stay in and thrive at work. We also invited some other leading thinkers in work and health to contribute their fresh perspectives too.

I am delighted with the result. This essay collection is packed with great ideas from a wide range of viewpoints, all written by leading experts in their field. It is entitled "What next for work and health?" – and it will make an invaluable contribution to that debate.

Let me end by offering my heartfelt thanks to all those who have taken part.

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# Introduction

## Professor Dame Carol Black

### Expert Adviser on Health and Work to Public Health England and the National Health Service England. Principal of Newnham College Cambridge.

These essays bring together current thinking about the relationships between people's health and wellbeing and their working lives, and place them in the social and economic contexts.

The focus of the essays is on working life – entry into working life in the face of ill health or disability, return to working life after sickness absence, and sustained working life despite impaired health and disability, particularly in an ageing workforce.

Running through the essays is a conviction that it is to everyone's benefit to safeguard the health of working age people and to support them to maintain productive and fulfilling working lives when they are not wholly fit and well.

This brings far-reaching responsibilities. Those responsibilities fall on many agencies – in public health, health care, social care and other activities that lie with local authorities, on those who administer the system of welfare, and on employing organisations. And it places on individuals a personal responsibility for protecting and improving their own health as far as they can.

There has been progress. There is a growing realisation of the need to support people in an individual way as they enter and move through the health, social care, welfare, and employment systems. This calls for imaginative service commissioning and effective systems of communication. This is also a pervading feature of the Green Paper, Improving Lives: work, health and disability.

Recent years have seen a better appreciation of the impact of health conditions on the way we function in daily life. Importantly that aspect has come to be accepted as an essential element of clinical encounters.

Health professionals with responsibility for clinical care have a key role in emphasising the importance of work – good work – to those whose working lives are threatened by disability or poor health. Increasingly they are coming to see continued work, or return to work after sickness absence, as an important clinical outcome.

That is why the fit note is important. It gives an early opportunity to provide advice to patient and employer on the ways to recovery, rehabilitation and return to work. It is regrettable that the potential of the fit note has not yet been realised.

Musculoskeletal conditions of many kinds are the most common physical causes of sickness absence. Although the nature of some has become clear, in others, often a cause of long-term sickness, the pathology is poorly understood. But this should not hold back supportive approaches to rehabilitation and work.

Mental health problems are probably the most important yet largely hidden factors underlying sickness and disability in relation to work, and are a major factor in presenteeism. Although factors outside the workplace come to bear on mental health, often before working age, it is clear that work and the working environment are major influences in securing good mental health.

They present our greatest challenge.

A shift in thinking has brought a new emphasis on seeing physical health and mental health not as separate domains but as parts of the whole. Importantly although common mental health problems may exist alone, often they compound the effects of long-term physical conditions.

There is a fuller recognition and growing appreciation of the fact that many common disorders fluctuate in their expression and impact. This is difficult for those who are at work or are seeking work to explain to employers. It may be even more difficult for employers themselves to fully appreciate not only the impact on working life but also the kinds of accommodations and adjustments that might it might be necessary to make if an affected employee is to be enabled to make their fullest valued contribution to that workplace.

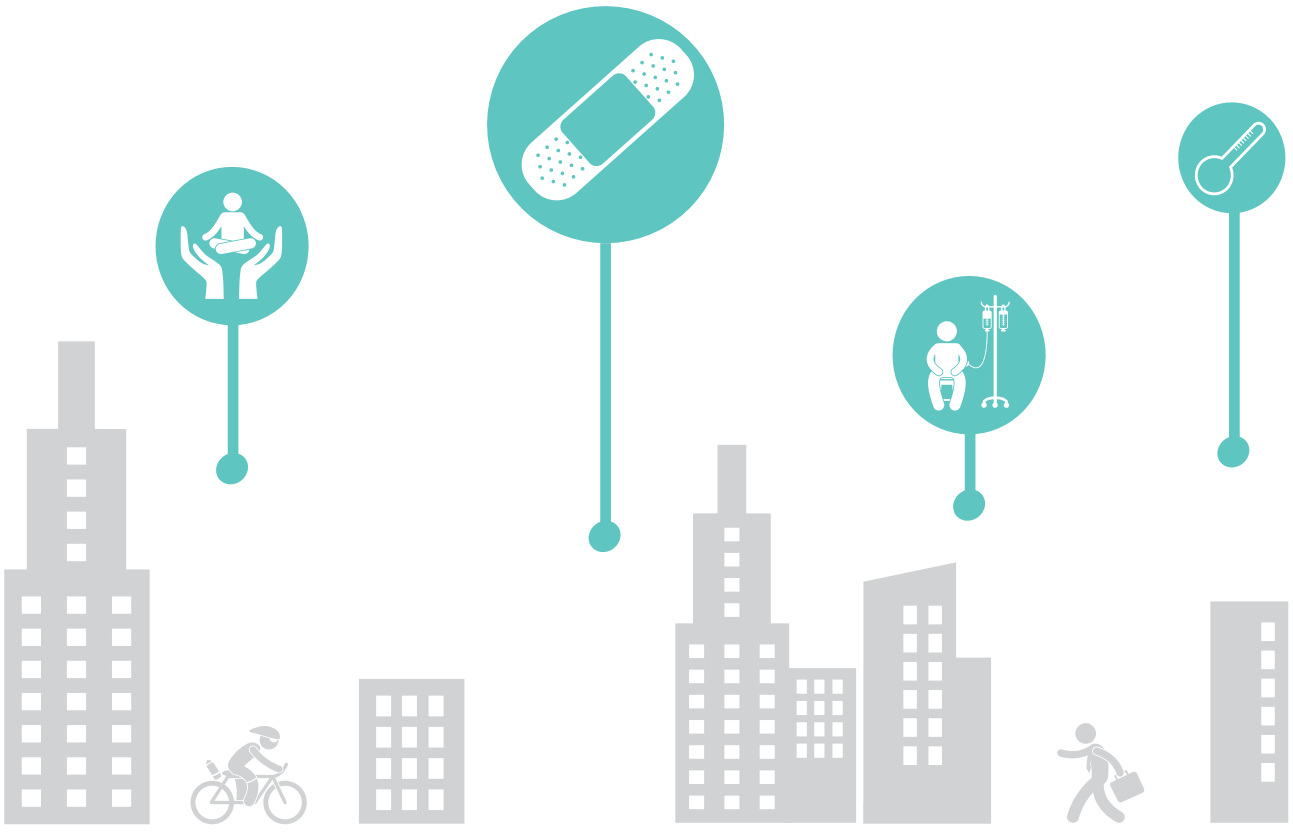
It is a common, one might say a normal expectation, that as people age they are likely to develop some long term condition that may limit the work they are able to do. It is reported that about forty percent of people over the age of fifty will have a work-limiting health condition. Experience shows that with the right support and sufficient workplace adaptation most can keep sustained and fulfilling work.

Many will find the account of fit notes, disability law and the Equality Act very helpful. It clarifies understanding of what is expected in the making of reasonable adjustments and the interaction of advice given in a fit note and legal obligations.

A notable feature of these essays is the importance to all organisations of protecting and nurturing the health of their employees, to develop a culture of health. Placing the worker at the heart of an organisation is key and line managers have a pivotal role in enabling their staff to understand the actions they can take to help remove obstacles that reduce ability to work with illness.

Naturally employers seek to ease the burdens and costs of impaired health. Leading organisations help employees to maintain and improve their health by supporting and encouraging health improving behaviours and lifestyles. Many are looking more closely at the potential returns that investment in employee health can bring.

I am confident that the path mapped out in these essays and the promise of the Green Paper are the way to progress in this endeavour.



# Managing fluctuating health conditions at work

**Stephen Bevan, Head of HR Research Development, Institute for Employment Studies**

For most working age people experiencing health challenges such as a broken ankle or a hip replacement the pain and discomfort involved - and the disruption to working life - can be significant. But at least the pathway to recovery and rehabilitation is, in the majority of cases, predictable and linear and it is clear what needs to be done to support both the restoration of function and a successful return to work. But for the increasing number of people at work who are living with fluctuating health conditions the position is often much more complex and, as a result, more difficult to manage.

It is estimated that by 2030 around 40 per cent of the UK's working age population will have at least one chronic and work-limiting health condition. For people over 50 in 2014 this figure is already at 42 per cent. One of the features of many chronic conditions is that their symptoms can fluctuate significantly from week to week, and from individual to individual. They can involve chronic pain or levels of fatigue which can be disabling and distressing, and which can disrupt independent living, attendance at work, work productivity and career prospects. So what is it about fluctuating conditions which can make vocational rehabilitation so complex? Here is a definition from the MS Society:

"Fluctuating conditions are chronic conditions, physical and/or mental. They are characterised by significant variation in the overall pattern of ill health and/or disability. This may be combined with variations in the type and severity of the symptoms experienced, so while some aspects of health remain relatively stable, other aspects may be highly changeable".

Fluctuating conditions often have distinctive characteristics which make them difficult to manage and even more complex to work with. They can be:

- Individual – two people with the same diagnosis may be affected by different symptoms, different levels of pain and different physical or cognitive impairments.
- Non-linear – many of these conditions will not get 'better' in the conventional sense, although people living with them may feel well for long periods and then experience bouts of pain, inflammation, fatigue or other debilitating symptoms which making working difficult or impossible for a time.
- Chronic – most have symptoms which last for three months or more.
- Invisible – often the symptoms are not visible to others but affect energy levels, pain, vision, joint mobility and mental health.
- Unpredictable – symptoms can appear and disappear without warning.
- Managed not cured – for some people their condition can be managed by drugs, physiotherapy or cognitive behavioural therapy but cannot be 'cured'. While high levels of functional capacity can be attained, especially if the individual is confident and skilled at self-management, this can also be difficult to sustain.

Examples of fluctuating conditions include asthma, depression, multiple sclerosis, rheumatoid arthritis, inflammatory bowel disease and ankylosing spondylitis. Many people will experience more than one. Some of these conditions are first diagnosed when an individual is young and in the early stages of their career, having a life-course impact. Each of them can shorten working lives and is likely to affect a growing proportion of the workforce over the next two decades. This raises questions for employers about how they can manage the reality of fluctuating conditions within their workforce, and what steps they can take to ensure that

this does not have an adverse effect on their business going into the future.

'What works', in terms of supporting someone with a fluctuating condition to remain in work, will vary from person to person, and from job to job. These include, enhancing knowledge about fluctuating conditions and their management across key stakeholders – clinicians, employees and employers – and providing access to occupational health advice. The relationship between the employer and the employee is crucial, with the importance of a culture which makes people feel safe to disclose their health challenges and good people management being especially important, as well as trust and open communication – particularly given that such conditions are often 'invisible' and highly variable, to make person-centred decisions which provide the most appropriate support for that individual.

A fluctuating condition may mean that certain elements of work are difficult or not possible at certain times, requiring (often temporary) changes to hours or specific duties. Flexible working, and in particular short-term emergency leave (e.g. for appointments) is highly valued by people with chronic health conditions. Such modified work has been found to be both effective and cost effective, often allowing an individual to keep working, avoiding the element of the job that is problematic (e.g. working in the morning) rather than stopping work altogether.

In order to identify effective solutions, employers need to be flexible and creative – having an open mind about what might be possible. There may need to be a more flexible approach to work and working models than is traditional, such as enabling home working, or indeed in some cases a more flexible approach to the business and to the expectations of employees. This means a shift away from thinking that a good employee outcome is attendance from 9-5, Monday to Friday, to focus instead on the job/task outcomes, irrespective of whether they are achieved outside of 'normal' business hours. Support via schemes such as Access to Work can help advise employers about simple and cost-effective 'adjustments' at work which can help an employee with a fluctuating condition remain productive and motivated at work.

Perhaps most crucially, it is important that the everyday management of a fluctuating health condition at work is led by the person living with it. Active and supported self-management is critical if the growing number of working age people with chronic and fluctuating health conditions are to be supported to remain active, independent and productive at work.

# The challenge of joining up employee health

Dr Steve Boorman CBE, Director Employee Health, Empactis

**Empactis is a technology company that seeks to improve employee health by supporting employers, employees and managers to improve all aspects of employee health management**

The Green Paper on Work, Health and Disability highlights the systematic silos that surround a sick or disabled employee. Social Care systems, health systems, occupational health, employers and employment supported interventions risk operating in isolation and without common understanding with at best risk of duplication and far too often with misunderstanding and assumptions that impact on employment outcomes.

The last decade has seen improved understanding of the key role that work plays in promoting health. There is also recognition that worklessness due to sickness or disability is a huge cost to employers, society, individuals and their dependents and it is clear we need to work more effectively to address this.

It is sad that the progress made on safety improvements in the workplace – with a focus on prevention and low tolerance of unmanaged risk, has not been mirrored in the health of our workforces. Similar techniques – raising awareness, identifying and removing simple risk factors and ensuring identified issues are swiftly acted upon can work in occupational health too. It is an abdication of responsibility to expect individuals to simply manage their own health without joined up support.

Employers and more specifically line managers have a key role to play, yet are often poorly equipped to support employee health issues. Even large employers rely on policies, processes and systems that are often hard to find, understand or interpret. When a manager first learns of a sick worker, many of them struggle with the competencies and skills to undertake positive interventions to facilitate early access to the positive benefits of good work.

The Green Paper flags the issue of poor communication, and little proactive exchange of information between carers, social support, employers and the person with health needs and the paper supports the need to think differently about future ways of working to improve the retention and access to employment for those with health needs.

Despite becoming ubiquitous and difficult to work without, Information Technology is both a solution and a barrier - complex systems often don't connect and whilst it sounds simple to have a single 'personal record' that is portable between the many stakeholders that need to support an individual, to date only a few areas have successfully piloted means of enabling such.

However, a single record is only one key factor required, as it will only be useful if the correct data is entered at the right time by the right party. A joined up process (workflow), agreed by all stakeholders is just as important.

This exchange of information is key, prompt identification of needs and then clear understanding of who is responsible for doing what and when can avoid the long delays that significantly reduce the likelihood of successful return to work. Our sophisticated care systems are often hard to navigate and simply don't integrate well enough to provide a smooth journey to help understand barriers to work.

Placing the worker at the heart is key and line managers have a key role to enable their staff to understand the actions they can take to help remove the often simple obstacles that reduce ability to work with illness. Many large employers rely on occupational health to help managers identify these actions but the majority of UK workers work in organisations that don't have easy access to such.

I find it strange that we can record a successful operation or treatment, yet the patient is unable to work and faces the consequences that falling out of work brings – social, financial and risks of further ill health. This Green Paper seeks to challenge this and is opportunity to address the silo mentality that has produced the cracks that those with disability or illness can get trapped in.

Innovation and technology needs embracing and exploring to bridge those gaps and help workers to easily benefit from the many sources of expertise and support that can improve workability and identify the measures that employers can take to enable early return and avoid job loss.

Employers need to recognise the benefits that this can bring, employees with health issues are too often seen as problems or costs. Yet well managed, health promoting workplaces have been clearly shown to be a source of competitive success – a simple "win, win" for employee and employer and by reducing the long term reliance on health and social care systems a "win" to society as well!

# Mental health as a business asset

## Jenny Edwards CBE, Chief Executive, Mental Health Foundation

Mental health is a fundamental asset for individuals, communities and organisations. Protecting and improving mental health is vital for keeping staff working well; helping those who have taken sick leave to return to work successfully; and, of course, for retaining and attracting talent.

The Mental Health Foundation's recent research report 'Added Value: Mental Health as a Business Asset' completed with Unum and Oxford Economics, concluded that the gross value added to the UK economy by people who experience mental health problems is around £226 billion - that is 12.1% of total GDP. This is nine times more than the cost of mental health problems to economic output – an estimated £25 billion. We believe that it is time for the debate to shift from a narrative of cost and burden to one promoting the value and case for protecting, nurturing and improving mental health at work.

The OECD in 'Making Mental Health Count' estimated that between one third and one half of all sickness and disability caseloads are related to mental health problems, with mild to moderate problems affecting 1 in 5 of the working age population. Mental ill health is one of the defining societal problems of our time.

All good employers are concerned to recruit and nurture talent. Nurturing talent means that staff opportunities for career progression should not be undermined by periods of ill health. A substantial component of sickness absence is directly related to mental health problems. This must be addressed as an explicit priority by employers, trade unions and government. Equally, we now know that many long-term conditions are associated with comorbid mental health problems and challenge personal resilience so it makes sense to address mental health proactively as a potential factor in all long term sickness absence.

Recent ACAS research points to the risks inherent in the 'anxious organisation' characterised by repeated changes in demand, resource, and working practice and where risk of psychological injury and distress is high. Culture and relationships are key to both productivity and health at work.

We conducted a major survey of working people with mental health problems and line managers as part of the Added Value Report. This research revealed that some 86% of survey respondents considered that work was important or very important in protecting and maintaining their mental health – a conclusion borne out by the qualitative interviews conducted. The people interviewed regarded work as key to their identity and critical to maintaining their recovery.

Around half of those who had a diagnosed mental health problem chose to disclose this to their employer. On the whole this had been positive, resulting in more support but 29% experienced discrimination as a result. All employers need to create a 'disclosure premium' where staff see tangible benefits from coming forward.

The Report reveals the extent of distress at work. While most people with experience of mental health problems have been through times when they felt stressed, overwhelmed or unable to cope at work, so did 4 in 10 of employees with no experience of mental health problems. Almost half of people with mental health problems reported having come to work whilst experiencing suicidal feelings and these are also reported by 1 in 20 without mental health issues. This underlines the challenge employers face in recognising and engaging with 'below the waterline' distress.

It is vitally important that line managers are trained to recognise distress, to feel confident in opening up a discussion with staff about how they are feeling and to know how to respond appropriately. This needs both compassion and the right practical steps to help reduce the distress and, where possible, the causes. The causes may be external to the workplace, such as relationship problems, financial pressures, caring responsibilities or bereavement, in which case good direct routes to advice specific to the problem should be available. Where the causes are work-related, the right immediate practical steps to reduce contributory factors in the

workplace are essential, in addition to the psychological support or self-management techniques to deal with the symptoms.

Just as importantly the organisation needs to be proactive and systematic in learning from the circumstances and to make adjustments to reduce the risk of the same factors creating health risks for the same or other employees. This makes for a working environment that attracts and keeps good people. It requires decisive leadership messages to emphasise that the culture of our workplaces will support people in emerging distress or recovery and that we are open and keen to learn how to prevent workplace related stress for the future.

Public policy also has an important contribution to make. We know that mental health problems increase the risk of people being unemployed for a long period and falling into poverty. National policies that support employers to recruit and then sustain people with mental health problems in work are good for business, good for people and good for our society.

# Improving Sickness Absence UK - keep taking the medicine or try a different prescription?


## Dr Richard JL Heron, Vice-President Health and Chief Medical Officer, BP plc. President, Faculty of Occupational Medicine. Honorary Professor on International Business and Health, University of Nottingham


Professor Dame Carol Black and David Frost's 2011 review of the UK sickness absence system shone a light on the significant numbers of working age people permanently falling out of work each year. It highlighted the negative impacts on individuals, organisations and society.

In reviewing progress since the report it is important to recognise that although most of the recommendations were implemented, some were significantly modified from their original intent.

With a growing, ageing working-age population I see three priority areas to focus on for positive progress in managing health-related absence from work for the benefit of individuals, employers and the national economy. These are primary care-based fitness for work accountabilities (including certification), access (capacity) to specialist 'workability' advice, and incentives for employers to support positive health and wellbeing management of the working-age population.


### Primary-care based fitness for work accountabilities

One key recommendation from the review was for the establishment of an independent, national advisory service. The Fit for Work service was duly established. Originally envisaged to be an in-depth assessment of physical and/or mental fitness for better quality 'fit for work' decisions, the volumes of referrals from general practitioners to meet this aspiration have been disappointing; opportunities to improve working lives, deliver potential savings, and improve economic performance have been missed.

Many positive actions to address this critical barrier to the success of the Fit for Work service should continue. Nevertheless, sub-optimal referral by GPs will continue unless radical steps are taken to address resource pressure and the competing clinical demands with their role in sickness absence management and certification through the 'fit-note'. GPs are acknowledged to be in crisis mode with increasing demands unmatched by increases in funding or staffing. With fewer numbers entering general practice, and increasing demands from an aging population with complex needs, this situation is unlikely to be resolved quickly, which is damaging to the health and wellbeing of the whole population.

Positive work-related actions thus far include heightening awareness of the importance of work as a determinant of health outcomes with specialist campaigns focusing on primary care. Sections of government reports, such as the Chief Medical Officer's report are placing increased emphasis on the importance of work as a health determinant in an aging population. The competence of GPs in managing occupational health issues has been advanced, with over 200 being certified to Diploma in Occupational Medicine (Dip Occ. Med) over the past 18 months. Such actions, each appropriate in their own right, will not

address a fundamental problem faced around the lack of understanding across the health community of the role of occupational health and understanding that work, or return to work, should be seen as a health outcome in and of itself. Occupational health is barely touched upon in medical school/university or foundation training.

As the lynch-pin of successful, holistic care, GPs are an integral component for achieving successful health outcomes in the working-age population. I believe that they should continue to have accountability for the 'formal' sign-off of 'fit-notes.' However, the responsibility for an assessment of 'fitness for work,' for most people, and the recommended actions to achieve it, can be effectively discharged within the primary care environment by nursing or allied health professionals with suitable training. I would recommend the provision of such training in motivational interviewing, assessment and basic sickness certification with the formal certification by a body such as FOM.

### Access to specialist 'work-ability' advice

With a growing, ageing population, where almost half of men aged 55 to 65 who are no longer working cite a chronic condition as a contributory factor in their exit from the workplace, the need for access to specialist 'workability' advice, capable of bridging the needs of workers, employers, and health care professionals is high and will intensify. The current system of access to support and advice is disjointed and inefficient when addressing the multifactorial nature of sickness absence. The end-to-end process still needs to rapidly identify at-risk people falling out of work, provide timely access to a range of support, including job-brokering, and in the more complex cases afford GPs, their patients, and employers  points of referral to safe, effective, and high quality occupational health advice through SEQOHS accredited providers.

For complex cases associated with chronic conditions, access to occupational medicine specialists remains patchy. Reports suggest that only 38% of employees have access to an occupational health service, and less than 13% have access to an occupational physician.

The crisis in occupational physician specialist capacity has been exacerbated by reductions in funding for training combined with an ageing specialist population. The number of UK occupational medicine (OM) specialists fell by 11% between 2011 and 2015. OM resourcing needs should be considered alongside other medical specialty needs assessments within the Joint Strategic needs assessments and commissioning decisions made by Health and Wellbeing boards. This would have the efficiency advantage of leveraging existing NHS resources as points of access for GP referral, currently focused on NHS staff needs as opposed to local population needs. A tactical funded plan to increase OM training posts needs to be agreed urgently by Health Education England, GMC and FOM.

### Incentives for employers to manage employee health matters.

Efforts should be intensified to what incentives will cause employers to provide workers with access to multi-disciplinary occupational health services, and timely health interventions. Effective incentives are currently absent and are likely to be financial or regulatory.

Although the decision to limit exposure to benefit in kind taxation for intervention up to £500 was welcomed, the impact is limited and that of tax credits for employers who pay for health interventions should be explored. For many cases of sickness absence the underlying causative factors are multifactorial, and as links in a chain, failure to address each may result in a poor outcome. As indicated in the report, this requires timely access to and co-ordination of support.

Incentives should include tangible recognition for employers who recruit and sustain workers who have been long-term absentees from the workplace.

# How can the UK generate a fit, healthy, flexible and productive workforce?

Professor Sayeed Khan, Chief Medical Adviser, EEF, and Terry Woolmer, Head of Health and Safety Policy, EEF

## Introduction

When Carol Black and David Frost's review was published, EEF supported many of its recommendations, in particular:

- The creation of the Fit for Work service.
- Changes to Fit Note guidance to assess individual's health for work in general.
- Tax relief for employer expenditure targeted at speeding employees return to work.

The Government's recent Green Paper Improving lives, covers some old ground on long-term health conditions and the role of the employer but focuses on the disability employment gap.

## Fit Note

EEF have monitored Fit Note progress since its inception and were keen advocates.

However, we have seen very little progress over seven years. Our surveys have told us that the fit note has not delivered on its key objectives of returning employees to work earlier and of providing high quality GP advice.

- Two-fifths of employers told us it has not enabled employees to return to work earlier. A further third say that it made no difference in enabling earlier returns to work;
- Only 12% of medical professionals are trained in the use of the fit note;
- Medical professionals are still issuing low numbers of 'may be fit for work' fit notes. A quarter of companies did not receive any;
- Medical professionals are not working with employers, although a quarter of employers provide GPs with information about possible work adjustments.

If we really want the fit note to work and not be permanently discredited in the eyes of employers, then the following actions must be implemented:

- Train all medical professionals in the use of the fit note by a designated date; the RCGP has trained over 4,000 GP in Health and Work but that is a fraction of the number of GPs in the country. Hospital doctors in Casualty, Rheumatology and Orthopaedics have an important role in assessing fitness for work and giving out fit notes. These specialties need to be a priority for training.
- Link evidence of fit note training into medical professional CPD and appraisal systems.
- Four-fifths of employers support a range of professionals (including GPs, physiotherapists, nurses) signing fit notes, compared to two- thirds before the fit note was introduced. We would like this to go ahead with proper training of these healthcare professionals for it to succeed.

## Fit for Work Service

We think the Fit for Work service is an important initiative to help reduce levels of long-term sickness absence, and in particular to tackle two of its most common causes; MSDs and mental ill health.

Our experience of the Fit for Work service so far is that it:

- Has been poorly promoted by DWP & Health Management Ltd.
- Is not reaching the SME's for whom it was designed.
- Has a very low referral rate by medical practitioners.
- relies on employee referrals from employers;
- excludes employers from development of the Return to Work plans;
- has made very few recommendations for medical interventions;
- Has not yet demonstrated whether employees are making earlier returns to work.

EEF's 2016 sickness absence report found only one-fifth of companies were willing to pay for employee medical treatments recommended by the Fit for Work service. Three-quarters (mainly SMEs) were unaware of the £500 tax exemption available for medical treatments.

Two-fifths (mainly SME's) relied exclusively on the NHS to provide medical treatments for their employees and could not fund medical interventions. This is a problem as a third also say that waiting for employee treatment (via the NHS) is the most common cause of long-term sickness absence.

## Fiscal incentives

Following the Black/Frost review, the government introduced a £500 tax break on medical interventions recommended by the Fit for Work service or company Occupational Health professional.

Although the tax exemption is promoted by the government as a benefit for employers, this is misleading. Under existing tax rules, the cost of any medical intervention funded or provided by an employer means that the employee is liable for tax and National Insurance contributions as either a benefit in kind or a payment of earnings. This tax exemption simply means that the employee will no longer be eligible for tax or National Insurance up to £500 a year should they take advantage of a recommended medical treatment. The cost of the treatment still has to be borne by the employer, who will not realise any significant fiscal benefit apart from some small savings in National Insurance contributions, which are negated by administrative costs involved in managing the claim.

## Way forward

The discussion around productivity improvement is often focussed on developing workforce talent, implementing lean initiatives, improving the supply chain or investing in research and development to bring about radical step changes in productivity improvement. Few governments recognise that keeping people fit and in work, as well as accommodating an increasingly aging workforce, can hold the key to bigger productivity gains for the wider economy. Employees in good health can be up to three times more productive than those in poor health.

If the government wishes to see the wider societal benefits of improved workforce health, including improved productivity and lower spending on health and welfare benefits among working age people, then it must be prepared to incentivise employers to act in their own interest, their employees' interests, and in the interests of society at large. In the same way as companies invest in new machinery and research and development to help boost productivity, they must be given the same incentives to invest in the health of the working-age population. The UK's growth prospects depend on people being fit, working and productive.

The EEF believe that there is a very strong business case to support the provision of fiscal incentives by government which has as its objectives, the management and reduction of long-term sickness absence, the promotion of work as a clinical outcome, the reduction of the government's benefit payment bill, the improvement in the nation's health and the increase in UK plc productivity.

# What next for Health at Work?

**Dr James P Kingsland OBE, Senior Partner in General Practice, President National Association of Primary Care, Non Executive Director Royal Liverpool and Broadgreen University Hospitals NHS Trust, Chairman Jhoots Pharmacy Group**

The total annual cost of working age ill health is currently thought to be in the order of the total annual spend in our NHS. Clinicians recognise that there is a strong evidence base that work is generally good for physical and mental health and wellbeing. The Marmot review from 2008 clearly demonstrated that the effect of being employed or unemployed is considerable with respect to the mortality of men in England and Wales, irrespective of socioeconomic status.

So why has it been so difficult to improve health at work?

The review of sickness absence in Working for a Healthier Tomorrow in 2008 highlighted the poor performance of the public sector in managing sickness absence.

Unfortunately however, since the recommendations of the Black/Frost review of 2011, it does not appear that there has been any significant impact in health at work, particularly from the redesign of Statements of Fitness to Work (Med 3 certificates).

In a recent national survey amongst employees in the year to October 2016, the current extent of sickness absence was assessed. The highlights were:

- 25% of employees had been off work with illness.
- 8% had been off work with illness for more than 5 consecutive days.
- 37% stayed at work or continued working despite being unwell (i.e. unwell enough to impact the quality of their work).
- 26% felt under pressure to stay at work for longer than they thought that they should be.
- 5% had been off work with stress.

Younger workers tend to be off work through ill health more than older workers:

- 31% of people under 35 are more likely to be off work with illness compared to other age groups (The next is 25% for the 45-54 age group).
- 29% of under 35s have been off for more than 5 days; more than any other age group.
- Under 35s feel more under pressure to stay at work longer than they think they need to (36%) and half (48%) of the under 35s have worked despite being unwell.

Whilst the duty to provide a Med 3 rests with the doctor who at that time has clinical responsibility for the patient, it remains quite rare for hospital doctors to fulfil this commitment, either as the treating clinician in the outpatient department or on discharge from a hospital inpatient stay. This leads to duplication of work and unnecessary GP consultations for the sole purpose of sickness certification.

There is also considerable inconsistency in the understanding, by both employers and employees, that there is no obligation to supply a Med 3 certificate for the first 7 days of sickness absence.

Improvement in both of the above issues would have significant impact on the workload of GPs.

The reduction in the volume and complexity of sickness certification since 2010 has been of benefit, as has the ability to use telephone consultations as an acceptable form of assessment. However the ability for the GP to carry out an assessment of an individual's capability to work has largely remained unchanged.

Some virtual GP services are starting to show improvements in sickness absence by accessing flexible telephone and video GP appointments through employers' insurance, which can be used whilst people are at work. Treatments can be initiated or immediate assessment for fitness to work carried out.

It is estimated that 2/3 of people in work attend their general practice annually, with around 3 million employees missing GP appointments due to work commitments. Access to GP appointments is a significant issue with almost 40% of employees reporting that remote, virtual access whilst at work would be of great benefit and reduce sickness absence.

It is time for the NHS to lead by example in approaches to improve the sickness absence management of its own staff.

The NHS previously set targets for sickness absence reduction as part of the QIPP initiative. There are examples of excellent occupational health practice across the NHS that have been shown to reduce levels of absence and have the potential to be rolled out across NHS England. The challenge is to learn from these and spread best practice.

The NHS Plus project, which came to an end in March 2013 launched a health for work support service aimed at small and medium sized enterprises. This was a multi-channel service combining an existing advice line with an interactive web site and call centre. Bespoke expert occupational health advice by trained occupational health nurses was provided.

There is still the potential to combine such previous expertise into a new package that could benefit NHS employees and local communities (in addition to the NHS Health at Work Network and the National Primary Care Occupational Health Service).

Historically, the NHS has not included occupational health or health and wellbeing within its commissioning framework. The commissioning of occupational health services could be at three distinct levels:

1. Trust level, addressing health and wellbeing in the hospital workplace with the potential to support organisations often with between 7000 - 8000 employees.
2. Primary care level aimed at enhancing the occupational health advice to GPs and promoting optimal use of the fit note.
3. Community level focussing on areas served by health and wellbeing boards.

Key features of the service could be:

- Accessibility with the use of virtual consultations at flexible times across the full year.
- Speed of response with same day availability.
- Patient focussed formative assessments.
- Credibility (The NHS brand) and high professional standards.
- Quality assurance via clinical governance and SEQOHS accreditation.
- Good communication channels with employers, GPs and referred workers.

The impact could be assessed by:

- Measuring the changes in sickness absence in local provider Trusts.
- Assess both the patient (hospital worker) and employer experience of this new service.
- Evaluate the impact on productivity within the provider service.
- Creation of a value proposition for pilots with an estimate of the return on investment, and if extrapolated, what would be the potential national value of rollout (quality and cost effectiveness).
- An external academic evaluation team.

This might provide a valuable service to reduce sickness absence in the NHS and a process that could be transferred to improve health at work interventions in other sectors.

# Employee health – the rationale for corporate investment

## Kevin Thomson, Head of HealthFirst, BMI Healthcare

Organisations often talk about their employees being their 'number one asset'. As such there are clear commercial imperatives for enabling employees to remain active and well. Indeed employment experts agree that investing in the health of your employees is not only the right thing to do, but has many tangible business benefits. As Kevin Thomson, Head of HealthFirst at BMI Healthcare, remarks:

> "The evidence is compelling for taking action to nurture employee's health at work. Doing so not only benefits employees and makes organisation better places to work, the evidence also shows that people who achieve good levels of health are able to demonstrate a wider range of skills that will also benefit their employer."

Improving employee health contributes to enhanced organisational productivity through lower absenteeism and increased levels of motivation, output and engagement. By creating a working environment that supports employee health, employers help staff to feel happy, competent and satisfied, and more committed to their individual roles and collective corporate purpose.

### More than employee engagement

To help minimise both absenteeism and presenteeism (working while either physically or emotionally unwell), thereby maximising business performance, businesses should think about implementing targeted healthcare strategies. In doing so, it is important to distinguish between employee health and engagement.

While the two are closely linked, improving health requires a more rounded approach than an average employee engagement programme, with a deeper focus on enabling employees to maximise their personal resources by creating good work-life integration. Health and engagement should also be developed equally: where there is high engagement but low levels of health, there is a risk of burn-out over time. Conversely, where there are good levels of health but low engagement, employees are likely to feel disconnected from an organisation's vision, mission and overall strategic direction.

### Preventative, proactive, productive

Healthcare strategies will obviously vary from one organisation to another. A preventative model allows businesses to offer advice and treatment to their employees before small, minor problems become serious issues. It covers everything from health assessments and health education events to flu clinics, vaccinations and advice on lifestyle changes. By investing in these preventative services, businesses can spot, diagnose and treat employee health problems early.

However, as part of an overall healthcare strategy this model should also ensure that, if required, employees also have fast and convenient access to a range of referral based pathways. These could range from occupational health, GP consultations, physiotherapy and psychology as well as outpatient and in-patient healthcare services. Such service provision means employees who do need further support will be back to full health sooner rather than later.

### Empowering employees for mutual success

It's naïve to assume that health and active living is a uniform concern or focus among all employees. However, this highlights a key issue, the fact that employee health is something that employers should care about. This includes the basics of health and safety in terms of protecting employees from risk and poor working conditions. But it goes far beyond that, employers should not just help employees avoid

ill-health, but should support their achievement in good-health; empowering their employees to improve their health behaviour both at home and in the workplace.

When developing these support services, employers should ensure their approach centres on the benefit to their employees. Indeed, organisations shouldn't always seek a monetary return on their investment. Rather, they should focus on assessing the subjective value of their investment. This may provide a more rounded approach to the development of key initiatives within organisations.

By delivering a positive healthy working environment that encourages regular physical activity, healthy eating, work-life integration and healthcare support, businesses will empower their employees and their own organisation. Organisations will then minimise health-related disruptions to their own business and help maintain a healthy, satisfied and effective workforce.

### Developing a culture of health

Finally, the culture of an organisation plays an important role in workplace satisfaction and companies are increasingly investing in the development of their workplace culture. Encouraging and enabling a healthy lifestyle is a key part of this. One positive measure is to ensure that all levels of the organisation are involved creating and maintaining the 'mechanism' to ensure good levels of both job and life satisfaction. In particular, business leaders have an obligation to ensure that they live and breathe the positive values they look to portray, offering trust, respect and autonomy to their work colleagues. In return employees who feel valued by the organisation, will provide high levels of enthusiasm, creativity, put in more discretional effort as well as become a brand advocates. As Kevin Thomson, Head of HealthFirst at BMI Healthcare states:

> "There are few enlightened companies who continually focus on developing a culture of health throughout the organisation, where the employee is considered as important as its customers. In these organisations, there is a simple belief that, if employees are 'healthy and happy' and buy into the brand strategy of the organisation then they in turn will put in maximum effort."

# Investing in prevention: increasing employers' use of Group Income Protection to help more people with health problems to stay in work and return to work after illness

**Liz Walker, Director of Human Resources, Unum and Dr Chris Schenk, Chief Medical Officer, Unum**

Group Income Protection (GIP) is a benefit provided to employees by their employers. When an employee becomes unable to work due to ill health or injury, the insurer, after a qualifying period, will pay a high percentage of the individual's income, typically around 75% while they are unable to work. The insurer will also work hard to help them back to work when they are ready.

We know that 80% of people who have been off work through sickness for more than six months never go back to work again, at least for the next five years. In contrast, in the world of income protection around 70% of people do return to work, a very positive outcome. There are positive outcomes for employers too, with companies losing fewer staff and avoiding the costs of rehiring and training.

Insurers have two incentives to help employers minimise those costs by preventing and managing sickness absence effectively.

Firstly, reducing the frequency and length of absences and helping more people get back to work means insurers pay less in claims. Secondly, insurers strive to provide the best return to work outcomes and employer support.

Interventions are constantly in development but currently include services such as:

- Free training for line managers in subjects such as mental health in the workplace and sickness absence management.
- Confidential access to legal, HR and health support for employees and employers.
- Dedicated vocational rehabilitation.
- Treatment for less acute psychological and musculoskeletal conditions.
- Specialist medical opinions and functional capability assessments that determine what employees can do rather than what they say they cannot do.

Such support might not be available on the NHS or the NHS might not be able to offer it early enough for it to be effective. GIP insurers also add value by coordinating return to work discussions between employers, employees and clinicians in primary care, secondary care and occupational health that otherwise would not take place.

Putting all this together, GIP gives insurers, employers and employees the right incentives, the right expectations and the right tools to "stop as many people as possible from needlessly moving away from work because of ill health": the overarching aim of the Frost/Black review.

Five years on, the government has recognised this in its Green Paper on Work, Health and Disability, stating "We think group income protection insurance policies have a much greater role to play". The Green Paper asks what role insurers should play in increasing recruitment and

retention of disabled people and how to increase the number of employees with GIP protection from different sized employers.

In a highly competitive market, there is already a great deal of innovation to ensure GIP meets the needs of different employers and employees. Historically GIP was seen as an executive benefit but now 55% of people that Unum insures earn less than £40,000 and a 17% earn under £20,000.

The vast majority of employees are included within GIP policies under a 'free cover limit' meaning that all but the very highest earners are included without the need to ask about any health issues. Employees are covered automatically, whether they have existing medical or disability issues or not.

However there are two major barriers to GIP: low awareness of the products and services and perceived cost. Working with the industry, the government can help tackle them both.

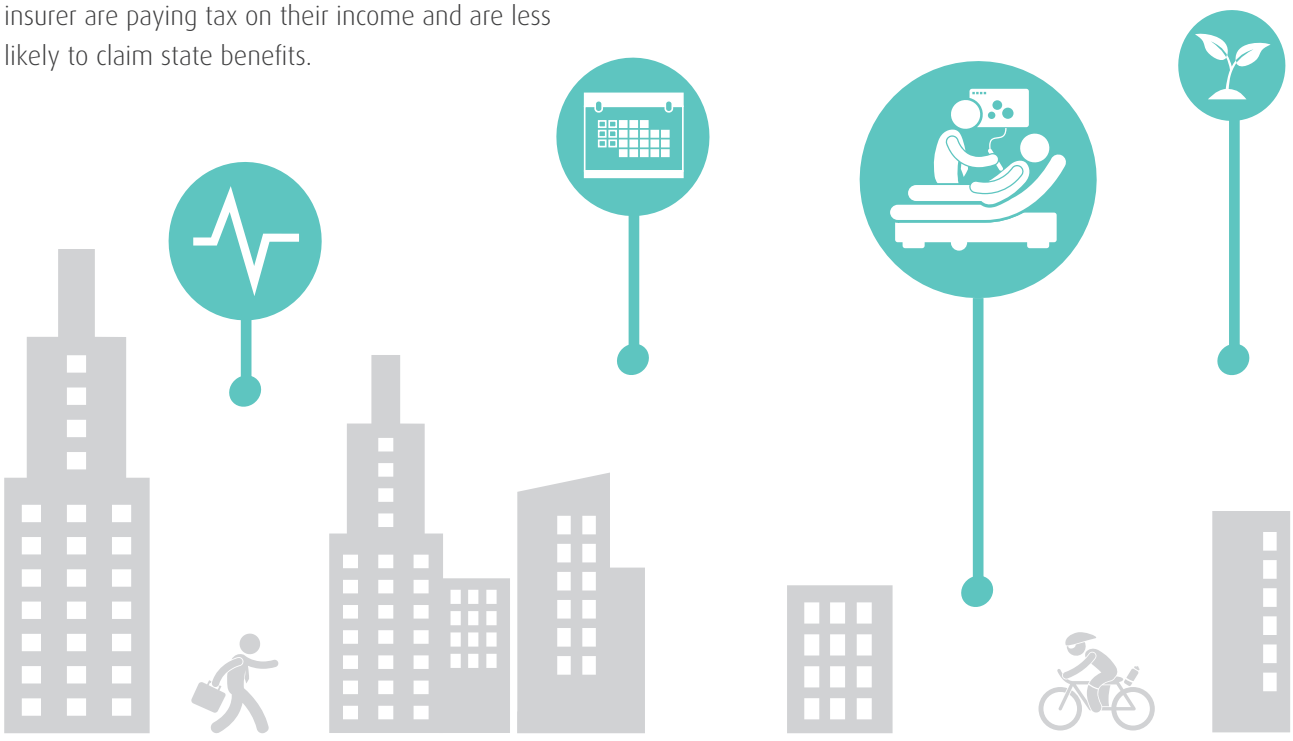
GIP is not an expensive product; it costs from around £150 per employee per year. Once the business benefits of GIP are explained, the return on investment becomes clear. Companies that provide GIP almost never take it away.

GIP is also good for taxpayers. Employees who are covered by GIP and supported, financially, by their insurer are paying tax on their income and are less likely to claim state benefits.

However, only around 10% of the working population is covered. So to encourage many more employers to take out GIP for the first time or to extend it to more staff, Unum, the ABI, EEF and others have called for a temporary tax break for employers that buy GIP. Once they see the benefit that this cover provides, they seldom look back.

Income protection is a tool in the toolbox to help employers manage their workforce effectively. Organisations with GIP can concentrate on their business knowing that employees who are sick or injured will be supported and actively managed by their insurer to help them to return to work. Whether able-bodied or with a disability, insurers find ways to help keep people in work or to return to their workplace after absence, which we know is a positive health outcome. It is in the interest of everyone, employee, employer and insurer, that this is successful.

While not a panacea for all the unresolved problems highlighted by the Frost/Black review, increasing GIP coverage would go a long way to helping more people to stay in work while protecting the households of those can't.



# Fit Notes, disability laws and the Equality Act


## Audrey Williams, Partner, Fox Williams LLP


By a strange coincidence, the advent of Fit Notes introduced in April 2010 coincided with consolidating legislation in the form of the Equality Act 2010 (the Act), to protect those with disabilities (as defined in employment law). The Act consolidated the Disability Discrimination Act 1995 alongside other earlier anti-discrimination laws in areas such as race, religion etc.

In this article I will look at the specific area of reasonable adjustments and the interaction between Fit Note recommendations and obligations under the Act.

### Forms of disability discrimination

Part 5 of the Act (which relates to employment and training) identifies the forms which disability discrimination can take. In addition to unlawful harassment and victimisation the disability provisions identify the ways in which such discrimination can occur:

- Direct discrimination – largely focuses on less favourable treatment just because of a disability.
- Unjustified unfavourable treatment because of something arising in consequence of disability – which addresses detrimental treatment due to the impact which a disability may have rather than the disability itself.
- Indirect discrimination where a provision, criteria or practice (PCP) creates disadvantage for disabled applicants or employees where they need to have the PCP cannot be shown to outweigh the disadvantage.
- Failure(s) to make a reasonable adjustment.

### Who gains protection? A disabled person

There is a distinction in law between a health condition and a disability. The Act defines disability by reference to the impact it has rather than the health condition itself unless a deemed disability. For someone with a health condition to be regarded as a disabled person, and therefore protected against discrimination, they must have a health condition which has a substantial and long term effect on their day-to-day activities. Long term for these purposes includes a condition which has or will last for 12 months or more or will recur (and when it does have a substantial impact) within a 12 month window. Deemed disabilities cover conditions such as visual impairments, severe disfigurements and conditions which are regarded as sufficiently serious from the point of diagnosis but which might not have an immediate substantial or long term impact, such as cancer, HIV and multiple sclerosis.

### Reasonable adjustments

It is in the context of reasonable adjustments and employer practices and arrangements that recommendations which may flow from Fit Notes need to be considered; for example a phased return to work or a return to work plan, may trigger obligations under the Act to accommodate those recommendations: in law, to make adjustments if reasonable to do so.

### Providing aids and support

A return to work plan might make suggestion about support, auxiliary aids or adaptions to enable an individual to return to work. Under the Act there is now a specific provision (which did not exist prior to October 2010) which requires an employer to take reasonable steps to provide auxiliary aids where in the absence of that aid, a disabled person would be put at a substantial disadvantage (Section 20(5)). We are not just talking about kit and equipment however, because

section 20 (11) goes on to confirm that an auxiliary aid includes reference to an auxiliary service, such as a sign language interpreter, counselling or a support worker.

### Recent cases as a guide

A number of cases since the introduction of Fit Notes, brought under the new Act, demonstrate the type of adjustments and assistance the law expects employers to consider and therefore what suggestions in a return to work plan could be regarded as reasonable:

- If the organisation has alternative roles it may be possible to swap employees' responsibilities, alter their duties or move them to an existing vacancy. Most recently G4S Cash Solutions (UK) Limited v Powell, the Employment Appeal Tribunal (EAT) suggested that it may be reasonable to maintain an employee's pay as a reasonable adjustment, even if they are moved to a lower paying role.
- Changing an individual's place of work or working hours might also assist. The Powell case does contrast with an earlier decision from the EAT Newcastle Upon Tyne Hospital NHS Foundation Trust v Bagley where following a part time phased return to work as a radiographer, the EAT stated that paying for work done during a phased return and not topping up Ms Bagley's pay did not amount to a disadvantage – others were in a similar position whatever the reason for their part-time working.

Of course it would not be for the health professional to make any recommendations about maintaining pay but to focus on the health needs and alternative roles and duties which the individual is able to undertake.

### What adjustments are reasonable?

The question of what is reasonable will focus on the financial costs, facilities and resources of the employer as well as the impact on the disabled employee, the organisation as a whole and others. Sometimes the focus will not be on costs but on detrimental or disadvantageous practices which should be addressed. In Roberts v North West Ambulance Service the employee had social anxiety disorder; he was therefore exempt from the usual practice of hot desking and was permitted to have his own, reserved desk. Even though he himself was not required to hot desk, he complained because others would be at his desk when he arrived for work, exacerbating his anxiety. The EAT decided that the hot desking practice, even though he was exempt from it, still placed him at a disadvantage.

### Knowledge and awareness of disability

Finally, it is important to consider the interaction between Fit Notes and obtaining medical input.

The general principles under the Act mean that you cannot discriminate against an individual unless you know they are a disabled person. However, in the case of reasonable adjustments and partly because it is a positive duty, an employer's duty is triggered once they know or ought reasonably to know that an employee is disabled. The most likely point at which this will become clearer to an employer is when an individual is subject to a medical assessment.

Having said this, it is not for the medical adviser to determine the individual's disabled status. What an employer must consider is whether the medical information which is forthcoming and the suggestions around fitness for work and how the individuals could be accommodated, suggests that the individual may have a substantial and long term health condition?

Perhaps rightly, because reasonable adjustments are really about being enabled to return or remain in work, a higher level of responsibility is imposed on employers. It is often for this reason also that when making suggestions in a return to work plan, it is helpful to understand the reason why these recommendations are being made and to describe the symptoms (or impact or disadvantage to use the legal language) that will be addressed or alleviated if adjustments are made.

# Musculoskeletal health and work

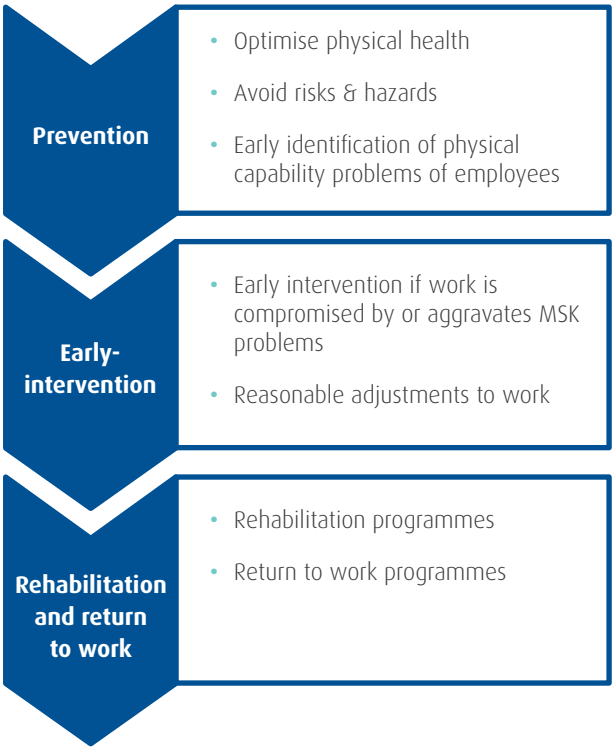
**Professor Anthony D Woolf, Bone and Joint Research Group, Knowledge Spa, Royal Cornwall Hospital Trust. Chair of the Arthritis and Musculoskeletal Alliance**

Musculoskeletal (MSK) problems have a major impact on the ability of people to carry out day-to-day tasks. They are amongst the commonest causes of people's inability to work. They also limit everyday tasks, hobbies and social activities. They are associated with anxiety and depression.

The MSK problems cover a spectrum of issues from general aches and pains to joint diseases such as rheumatoid arthritis. Overall these problems affect 1 in 4 adults. They are common at all adult ages but have a greater impact in older people. The common feature of MSK problems is that they compromise a person's dexterity and mobility which are both necessary in varying levels for all types of work. In 2013 more days of sickness absence were attributed to back, neck and muscle pain than any other cause. 30.6 million days of sickness absence could be attributed to MSK, 23% of all working days lost. The impact of MSK problems on work is predicted to increase and will be a challenge with people working into older ages.

There is a two-way interaction between MSK problems and work. MSK problems may occur if certain risks in the working environment are not recognised and catered for. Additionally, the MSK problems developed outside of work can limit a person's ability to work.

The MSK community is working with Public Health England to develop and promote a proactive approach to reducing risks that may result in MSK problems but also to help employees with MSK problems – whether they be short-term or long-term conditions - to have full working lives. An MSK toolkit is being developed for employers by Business in the Community, commissioned by Public Health England in collaboration with the Arthritis and Musculoskeletal Alliance (ARMA), to support them in reducing MSK related work loss. As the Alliance representing the musculoskeletal community in the UK, ARMA also supports enabling people to work despite MSK problems through its member organisations. The ultimate goal is to provide a workplace that takes **preventative action**, encourages **early-intervention for any MSK problem** and accommodates effective **rehabilitation and return to work** plans. The diagram below highlights the three guiding principles with a summary of their targeted outcomes as the three key-stages of addressing MSK problems in the workplace:




An alternative way to understand **prevention, early-intervention and rehabilitation and return to work** is to think about the role of employers and employees for the actions taken under the three guiding principles. An overarching principle is enabling people to help themselves – whether an employer or employee.

**Prevention** is for everyone.

> **For employers** it will include a business's message to the entire workforce promoting bone and joint health as well as facilitating this through physical activity, healthy diets and avoiding accidents and injuries. It also includes ensuring the work place and work practices avoid any risks or hazards. This can be through equipment, work processes

and by training. There should be mechanisms to recognise any risks to MSK health in the workplace, including feedback from employees. By ensuring that employees are listened to, businesses can become aware of new risks identified by the workforce themselves and can respond. Training and support can be provided that is more closely aligned with employees' needs. "Listening into Action" is the principle.

**For employees** it includes following a bone and joint healthy lifestyle with regular physical activity and healthy diets. It also includes avoiding risks or hazards by good working practices. Where risks are identified, they should be communicated effectively to the employer with the knowledge that they will be responded to. Employees also need to know how to reduce their risks by safe work practices and a healthy lifestyle.

**Early-intervention** is to ensure any MSK problem that affects work is managed promptly and effectively so people can avoid work loss.

**For employees** it means that if they encounter an MSK problem that they can report their problem as early as possible. Then steps to reduce the impact of their problem can be implemented as soon as possible. Employees should not suffer in silence. There is a stigma that prevents employees speaking about physical limitations that affect their ability to do their work.

**For employers**, although this may sound quite simple, they need to ensure a positive culture is in place so that conversations regarding MSK health and any problems can be had easily and freely to help find solutions. This means tackling the stigma related to adjustments an employee may need and improving the general understanding related to MSK problems throughout the workforce. It means ensuring the employee is able to get their MSK problem managed promptly and effectively.

**Rehabilitation and return to work** is to enable an employee to return to the workplace as soon as possible and fulfil their potential despite an on-going MSK problem.

**For employees** with an on-going MSK problem it means putting in place clear actions they can take to ensure their inclusion in the workplace. This includes clear communication of feasible working adjustments (to the working day and to the working tasks themselves) and support that they need. Clarity in the roles and responsibilities, including that of the employee themselves, in facilitating inclusion and the most appropriate return to work plan is essential. Other than the employee themselves this will involve their line manager, in-house health professionals if available (e.g. occupational health), primary healthcare professionals (GPs) and other healthcare service providers (e.g. physiotherapists).

**For employers** it means having those conversations with employees who have an on-going work-limiting MSK problem so that the workplace and work requirements can be adjusted and adapted to the physical limitations of the worker. It means having the support of other professionals to give advice and guidance. Positive support in the workplace from supervisors/managers and colleagues/co-workers with a culture of openness is central to reducing work loss.

Employees can be enabled to have long productive working lives not unnecessarily limited by musculoskeletal problems if this person-centred integrated approach is enabled in their workplace. A key message is the need for open discussion to avoid problems and to find solutions.

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