Working Together

Promoting work as a health outcome as the NHS reforms

Mark Weston
Eleanor Winpenny
Julia Manning

December 2011

Supported by an educational grant from

Abbott
A Promise for Life

2020health.org

Contents

About this publication

In June 2010 we published 'Health, disease and unemployment: the Bermuda Triangle of Society', which recommended that 'getting people back to productive and sustainable work should become a key objective and outcome indicator for all health services'. With the advent of the government's July 2011 Equity and Excellence white paper came the proposal that all Local Authorities should set up Health and Wellbeing Boards. The aim would be to embed the knowledge that physical, social and mental health all contribute to the prosperity of a community, and that includes having a population that is fit for work.

This project looked at the practicalities of the new Health and Wellbeing Boards working together with the new Clinical Commissioning Groups, as well as with established Public Health departments, employers, charities and the public. It sought to highlight ways in which employers, health services, Health and Wellbeing Boards, Public Health Directors and Local Authorities could translate national-level policy objectives intended to promote work as a health outcome into local action and achievement.

During the course of this work we benefited from interviews and discussions with many of those working in this field. We would like to thank all those who contributed to this piece of work, and in particular we would like to thank our steering group for their advice and support throughout the project.

This report was funded by an unrestricted educational grant from Abbott, within the guidance of the ABPI code of practice. We are indebted to Abbott for their support and to all our sponsors. As well as driving our on-going work, involving frontline professionals in policy development, sponsorship enables us to communicate with and involve officials and policymakers in the work that we do. Involvement in the work of 2020health.org is never conditional on being a sponsor.

Julia Manning
Chief Executive
December 2011

2020health.org
83 Victoria Street London SW1H 0HW
T 020 3170 7702 E admin@2020health.org

Published by 2020health.org

Disclaimer
The views expressed in this document are those of the authors alone and do not necessarily reflect those of Abbott, or any associated representative organisation. All facts have been crosschecked for accuracy in so far as possible.

About the authors

Mark Weston

Mark is a policy consultant, researcher and writer, whose previous reports for 2020health included Not Immune: UK Vaccination Policy in a Changing World, and Take Care: The Future of Funding for Social Care. He has close links with the Harvard School of Public Health, UK policy consultancy River Path Associates, and UCLAs David Geffen School of Medicine, and is a contributor to Global Dashboard, the foreign affairs blog.

Eleanor Winpenny

Eleanor is a researcher specialising in UK health policy, looking at ways that changes in policy and delivery can improve patient outcomes. Her particular interests are in the role of technology in the delivery of healthcare, preventative healthcare and public health.

Eleanor studied Natural Sciences at Cambridge University, specialising in Neuroscience, and then went on to complete a PhD in Developmental Neuroscience, looking at the growth and development of new neurons in the adult brain.

Julia Manning

Julia studied visual science at City University and became a member of the College of Optometrists in 1991. While in private practice, she was at various times a visiting lecturer at City University, a visiting clinician at the Royal Free Hospital, a Primary Care Trust advisor and a Director of the UK Institute of Optometry. She also specialised in diabetes and founded Julia Manning Eyecare to meet the needs of people with mental and physical disabilities. In 2006 she established 2020health.org, an independent Think Tank for Health and Technology. Research publications have covered public health, telehealth, work-ability, pricing of medicines, biotechnology and genetics, alcohol, commissioning, NHS reform and fraud.

Please address all correspondence to:
info@2020health.org
2020health.org
83 Victoria Street
London
SW1H 0HW

Executive summary

Drawing on findings from expert interviews and local workshops in four venues across the country, this report identifies concrete actions various parties can take in promoting work as a health outcome. It aims to help actors at the local level translate national-level policy objectives to encourage those with health conditions back to work, and enable others to remain employed when health problems arise.

Recommended actions for employers and for those working to strengthen employers' role in health promotion include:

- Making work more meaningful. Employers who set up health programmes without providing workers with a meaningful role are likely to find that their efforts are less successful than those of companies with high rates of job satisfaction.
- Planning ahead in order to reduce the disruption caused by illness. Worked out with the employee, rehabilitation programmes, occupational health appointments and workplace adjustments can greatly reduce absence time and the disruption caused to the business.
- Increasing the use of home-based working, which can assist those with illnesses or disabilities by reducing travel demands.
- Bringing health services provided by the NHS into the workplace. Cardiac and cancer screening and the NHS Health Check are examples of services that could be provided at work.
- Providing evidence of effective interventions to those working with employers to address staff health issues. Evidence can also help obtain buy-in from large employer organisations, such as Chambers of Commerce, the Federation of Small Businesses or the Confederation of British Industry.
- Strengthening lines of communication between employers and GPs, to map out what the worker can do now and what he or she will be able to do in the future.
- Promoting occupational health among smaller firms unable to provide their own OH services. Consideration should be given to appointing an occupational physician to local public health teams; integrating an occupational health nurse into GPs' teams; bringing large and small organisations together so that the latter might benefit from occupational health services provided by the former; and raising awareness among small firms of the occupational health advice line for small businesses.

Recommended actions for health services include:

- Allowing people to register with health services that are close to their workplaces. This provision appears in the recent Health Bill.
- Providing outreach in services in workplaces, including through occupational health assessments or the provision of screening.
- Hosting back-to-work services in GPs' surgeries. This has proved effective in some areas, and provides patients with a convenient one-stop-shop on the route back into work.
- Proposing skills refresher courses or voluntary work to unemployed patients.
- Discussing care pathways with patients and designing treatment regimens – at both primary and secondary care level – that allow them to continue working and improve their prospects of remaining in work in the future.
- Encouraging a role for Pharmacists and physiotherapists, particularly in early identification of health problems; perhaps also in advising patients about back-to-work services. They should be involved in wider strategies to reduce health-related worklessness.
- Informing GPs about the operational practices of industries in their locality. By helping them understand the tasks that individuals perform, this is likely to increase the utility and accuracy of Fit Notes.
- Adding a question on work as a health outcome to the Fit Note to increase GPs' engagement. The forthcoming electronic version of the Fit Note should ask whether GPs have considered referring the patient to back-to-work services.

Executive summary

Recommended actions for Health and Wellbeing Boards include:

- Involving GPs in developing Joint Strategic Needs Assessments (JSNA), which should take more account of work as a health outcome.
- Considering including a local employers' representative on the board, perhaps along with local authority representatives working on local regeneration and economic development.
- Considering having a larger stakeholder forum feeding into the board, including employers, providers of back-to-work services and other interested parties. The latter could meet less frequently than the main board, and make recommendations to it based on pilot programmes or evidence from other localities on how to reduce health-related worklessness.
- Considering a permanent 'open position' to be filled by the stakeholder considered most relevant for each particular meeting. The position could be filled, for example, by a key local employer or a representative of a patient group (or both).
- Involving third sector organisations in bringing health services and local authorities to the table. The third sector has a strong track record in considering the wider determinants of wellbeing, and is knowledge-able about those it represents. The sector has a role in making the case for the importance of work and, since it is widely seen as a neutral arbiter, can help convene and facilitate contact between stakeholders, and monitor and evaluate projects.

Recommendations for public health directors (PHDs), whose new role as members of HWBs is seen as crucial to advancing the 'work as a health outcome' agenda, include:

- Highlighting the importance of work to health care providers.
- Comparing local rates of sick certification with those in other areas and challenging health and employment services to improve.
- Finding and nurturing 'GP champions' to advocate the importance of work to their peers.
- Working with employers to promote a healthy workplace, and advising them about what services are available.
- Considering a statutory reqirement that PHDs produce an independent annual report on the health of the local population, and that this report should take into account employment issues.

Finally, recommendations for Local Authorities include:

- Building health provision into the commissioning process, so that supplier firms that invest in workforce health are favoured when contracts are awarded.
- Making stronger efforts to increase health services' awareness of back-to-work programmes, thereby becoming a repository for information on health and work. These efforts might include council representatives visiting Clinical Commissioning Groups to inform them about services, and the provision to GPs' surgeries of marketing materials publicising the services.
- Sharing premises with healthcare professionals. This would enable patients and jobseekers to access employment and health services in the same location, and strengthen links between Local Authorities and health services.
- Providing information to employers on what is available in terms of back-to-work services and programmes.
- Raising awareness of Access to Work payments, which are given to employers of those who have been off work to help adapt the workplace to the new needs of the employee.
- Expanding the role of Local Authority health and safety inspectors to provide information on employee health, such as diet, the importance of exercise, and workstation setup.
- Creating a new position of regional occupational health director, who could work alongside the regional public health director in local government. This would ensure continuity in enabling the public health agenda to be delivered through the workplace.

Introduction

Health and work

The importance of health to economies is well established. Good health improves educational outcomes, enhances performance at work, increases savings rates (because those who expect to live longer are more likely to put money aside for the future), and reduces the burden on the public purse by decreasing the demand for health services and benefits payments, while boosting taxation revenues. Bad health does the opposite.

Two recent studies bear out this link. Bloom et al (2004) have calculated that for each one-year improvement in the life expectancy of a population, labour productivity increases by 4%.[1] And Bloom and Canning (2000) found that if two countries are compared that are identical in all respects except that one has a five-year advantage in life expectancy, income per capita is likely to grow between 0.3% and 0.5% faster in the healthier country.[2]

The impact of health on work is of profound economic relevance. Ill health has a devastating effect on the performance of Britain's labour force. Nearly half of people in Britain who have disabilities are economically inactive.[3] Around two-thirds of those with rheumatoid arthritis who do not work have had to leave their jobs because of their condition.[4] And while 70% of the general working-age population is in work, the figure for those with common mental illnesses is just 60%.[5]

Britain is failing to break the cycle that leads from ill health to unemployment. 2.6 million people are in receipt of Employment and Support Allowance or Incapacity Benefit. 1.5 million of these have claimed the benefit for more than five years.[6] Since the 1970s, and although health improvements have led to substantial increases in life expectancy, the proportion of working-age adults who are unable to work due to health problems has increased from 2% to 6.6%; in some localities the proportion is as high as 16%. That in Scandinavia half of those who suffer a major injury return to work, compared with just 1 in 6 in Britain, is a further indicator of the latter's historic failure to promote work as a health outcome.[7]

It is not only those who are off work for the long-term that are of economic relevance, however. At any one time, 3% of the active workforce is off sick, with 175 million working days lost each year due to ill health.[8] The National Health Service alone – Europe's largest employer – has estimated that it could save 3.4 million working days annually if it improved workforce health. This is the equivalent of 14,900 full time staff.[9] The costs of workforce ill health are huge. The NHS loses £555 million per year due to staff sickness, while the total cost to Britain's economy is estimated at over £100 billion.[10]

Reducing the amount of working days lost to ill health would clearly be of enormous economic benefit to Britain. It would also benefit the nation's health. The effect of wealth on health is even longer-established than the reverse impact. People with higher incomes can afford better food and better health care; that they are generally better educated, moreover, means they have greater knowledge of how to stay healthy. Wealthier countries have much higher average life expectancy than poor countries,[11] and individuals who are in work tend to be healthier than the unemployed. In an extensive review of academic literature, Waddell and Burton (2006) found that unemployment is associated with higher overall mortality rates, poorer physical and mental health, and higher rates of medical consultation, medication consumption and hospital admission. Unemployment, they found, is a causal factor in these adverse health outcomes.[12] Only among a small minority of people (below 10%) does unemployment lead to improvements in health and wellbeing.

1. David Bloom, David Canning, Jaypee Sevilla (2004): The Effect of Health on Economic Growth: A Production Function Approach. World Development, Vol. 32, No. 1,1.
2. David Bloom, David Canning (2000): The Health and Wealth of Nations, Science, 2000, Vol. 287: 1207-1208.
3. Department for Work and Pensions (2004): Building Capacity for Work: A UK Framework for Vocational Rehabilitation. October.
4. Health, Work and Wellbeing directorate (2009): Working our way to better mental health: a framework for action. Crown, December.
5. Fitch C, Daw R, Balmer N, Gray K and Skipper M (2008): Fair Deal for Mental Health. Policy Unity, Royal College of Psychiatrists.
6. House of Commons (2011): ESA and incapacity benefits – constituency statistics for Great Britain. Social and General Statistics. 15 June.
7. Dame Carol Black (2008): Working for a Healthier Tomorrow. Review of the health of Britain's working age population. DOH, DWP. 17 March.
8. Black (2008): ibid.
9. Boorman M (2009): NHS Health and Wellbeing Review. Crown, Department of Health, November.
10. Black (2008) op. cit.
11. Pritchett, Lant, and Lawrence H. Summers (1996): Wealthier is Healthier. Journal of Human Resources 31 (4): 842-68.
12. G Waddell, A Kim Burton (2006): Is work good for your health and well-being. Report commissioned by the Department for Work and Pensions. The Stationery Office. London.

Introduction

Policy catches up

In the past four years, and particularly in the wake of Dame Carol Black's 2008 review of the health of Britain's working age population, 'Working for a Healthier Tomorrow', efforts have begun to be made to promote work as a health outcome. In the Outcomes Framework of its 2010 public health white paper, 'Healthy Lives, Healthy People', the government included the employment of people with long-term conditions and those with mental illnesses as key outcomes. The paper emphasised that 'enabling more people to work, safeguarding and improving their health at work, and supporting disabled people or people who have health conditions to enter, stay in or return to work are critical components of our public health challenge.'[13] The employment of people with mental health problems is also a crucial priority area in the new Mental Health Strategy.[14] And the 2011/12 NHS Outcomes Framework highlights the employment of people with mental illness and long-term conditions as areas for improvement in the second of its five 'domains', which is concerned with enhancing quality of life for such people.[15]

There has been a series of initiatives to put these commitments into practice. At a local level, the most important innovation that is likely to impact the health and work field is the establishment of Health and Wellbeing Boards (HWBs). These are intended to encourage health care providers and local councils to work together to plan appropriate services for their local area. According to the Department of Health, the boards will 'look at all health and care needs together, rather than creating artificial divisions between services.'[16] Boards consist of at least one local authority councillor, the local authority directors of adult social services, children's services, and public health, a representative of the local healthwatch organisation, and a representative of each relevant commissioning consortium. They will develop Joint Strategic Needs Assessments to identify the most important local priorities, as well as a Joint Health and Wellbeing Strategy. In many areas it is likely that workplace health or unemployment due to ill health will be pressing problems, and it is hoped that HWBs will bring together stakeholders from the health, social services and business fields to drive improvements.

Other notable initiatives in the health and work field include:

- A national occupational health (OH) advice line to help small and medium-sized businesses that cannot afford their own OH departments.
- Pilots of 'Fit for Work' services, which provide multidisciplinary support to those at risk of having to spend long periods off work due to health problems. The results of the pilots are due in 2013.
- A 'Fit Note', which has replaced sick notes so that instead of simply signing someone off work, GPs can state whether a patient is fit to perform certain tasks.
- Training given on the Fit Note by the Royal College of General Practitioners to 5,000 GPs, with a view to improving their understanding of how their duty of care extends beyond clinical outcomes to the overall wellbeing of the person.
- Health, Work and Wellbeing Coordinators being placed in each public health region to encourage social care providers, doctors and medical staff to incorporate work into care pathways, and to encourage employers to provide a healthy and safe environment and manage sickness. Coordinators put firms in touch with each other, act as champions, and disseminate good practice.
- The Healthy Working UK website: an online resource providing GPs and other primary healthcare professionals with information, training and decision aids to support the management of health and work. The website was developed by the Royal College of General Practitioners, the Society of Occupational Medicine and the Faculty of Occupational Medicine, with support from the Department for Work and Pensions.

13. Department of Health (2010): Healthy Lives, Healthy People: our strategy for public health in England. DOH. 30 November.
14. Department of Health (2011): No health without mental health: a cross-Government mental health strategy for people of all ages. DOH. 2 February.
15. Department of Health (2010): NHS Outcomes Framework 2011/12. DOH. 20 December.
16. Department of Health (2011): Early implementers of health and wellbeing boards announced. 16 March. Available at http://healthandcare.dh.gov.uk/early-implementers-of-health-and-wellbeing-boards-announced/

Introduction

Working together

In June 2010, 2020health published 'Health, Disease and Unemployment: The Bermuda Triangle of Society', which discussed whether being at work is or could be considered a clinical outcome of successful health treatment. The report recommended that 'getting people back to productive and sustainable work should become a key objective and outcome indicator for all health services'; it suggested that the social and psychological aspects of an illness, as well as its physical manifestations, should be included in the diagnostic process; and argued that 'treatment should be aimed at ameliorating patients' ability to return to work.'[17]

This new study is a follow-up to that project. Whereas the previous report reviewed the literature on the links between health and work and made broad policy recommendations, the new undertaking narrows its focus to the local level, and endeavours to make practical suggestions for how local bodies can advance this agenda in a changing policy environment. Health and Wellbeing Boards and CCGs (Clinical Commissioning Groups) are in their formative stages, and Local Authorities and public health directors are being given new responsibilities in the health and employment arena. How these groups work together will determine whether Britain can close the gap on its European peers and realise the government's goal of making work a key outcome of healthcare. 'Working Together: Promoting Work as a Health Outcome as the NHS Reforms' asks how such work can be made most effective, and looks at the incentives, tools and checks required for success.

Methodology

This report takes 'Health, Disease and Unemployment: The Bermuda Triangle of Society' as its starting point. That report discussed the findings from a literature review, 25 interviews with senior figures (from state and private sector healthcare bodies, the voluntary sector, employment services and business), and three workshops with local stakeholders. For this follow-up project, undertaken between March and May 2011, we conducted in-depth telephone interviews with a further 28 high-level healthcare, local government, private sector and voluntary sector stakeholders (for a list of respondents, see appendix 1). The interviews were based on a semi-structured interview schedule which gave respondents the opportunity to explore specific issues in depth, depending on their particular interests or field of expertise (interviewees were assured that their comments would remain unattributed, and were encouraged to provide their personal opinions).

From our analysis of the interviews we drew together a number of recurring themes and suggestions for action, which we then tested at workshops with representatives of HWBs, Local Authorities, health services, public health teams, Chambers of Commerce and other business organisations, and MPs. Workshops were held in Lambeth (London), Lincoln, Warwick and Durham in September 2011. Participants discussed the feasibility and likely effectiveness of the ideas raised in the interviews and made suggestions for taking them forward at the local level. The sessions took the format of a presentation of the findings by 2020health, followed by group discussions, whose conclusions were reported back in plenary at the end of the workshop. Each stage of the project has been supported by an external steering group of unpaid experts. 2020health discussed the process and the findings from the research with these experts in a number of meetings.

This report presents the results from these research stages. It is not intended to be either exhaustive or prescriptive, but we hope it will serve as a useful guide and catalyst for discussion as local stakeholders work out how best to break the link between ill health and worklessness. Part 1 of the report describes the context within which the new initiatives are taking place. Part 2 presents the bulk of the findings, laying out suggestions for each different stakeholder group, from employers through to Health and Wellbeing Boards and Local Authorities. Part 3, the concluding section, summarises the key challenges and raises issues for consideration by local stakeholders as they develop their plans of action.

17. J Shapiro, E Hill, J Manning (2010): Health, disease and unemployment: The Bermuda Triangle of Society. 2020health. London.

1 Work as a health outcome: the need for change

The importance of work as a health outcome has until recently been undervalued in Britain. Healthcare providers have generally shown little interest in the professional lives of their clients, and the small minority of GPs who acknowledge the vital link between work and health often lack the confidence and knowledge to help patients back into employment. Local authority employment services, in turn, have paid little attention to health, while mental health services have sought to protect patients from work, in the belief that the stress it causes is likely to exacerbate mental illness.

Interactions between health and employment service providers, and between these groups and employers, have traditionally been weak. Healthcare practitioners have viewed work as the remit of Local Authorities, and Local Authorities have left healthcare to GPs. Only in very few cases, moreover, has either group worked with employers to help prevent sickness absence or to smooth the path back to work of those restricted by ill health. As a consequence, many employers who have shown a concern for workforce health have had nobody to turn to for assistance. GPs, too, are often unaware of the back-to-work services that are available in their localities, and their ignorance of the physical and psychological requirements of local industries has led to a default position of signing patients off work regardless of the fact that they might still be able to perform useful tasks.

Before turning to the roles of the various stakeholder groups in addressing these problems and promoting work as a health outcome, we first highlight two overarching themes that were regarded by telephone interviewees as crucially important and which merit consideration by all those involved. The first relates to prevention of worklessness, and the second to the outcomes of health and work initiatives.

The importance of prevention

There was a widespread perception among interviewees that employers and healthcare providers respond to the health problems of workers only when those problems have become so serious that a return to work is difficult. GPs only see people who are already unwell, occupational health departments react to rather than forestall crises, and employers pay for sick leave rather than adjust working conditions so that employees do not fall ill in the first place. Too little attention, in short, is paid to preventing people from falling out of work.

It was felt that the new health service structure, whereby government is devolving commissioning responsibilities to the primary care setting, will encourage primary care providers to focus on prevention in order to save money on treatment. Once GPs see that back-to-work initiatives produce a high return on investment in terms of cost-savings, they are likely to make more use of such schemes. (A workshop group in Lambeth suggested that in inner city districts where there is high mobility into and out of local areas, a synchronised city-wide approach might be needed, with HWBs perhaps pooling funds so that both the investment and the rewards are shared.) With Public Health Directors sitting on Health and Wellbeing Boards, healthcare practitioners will be encouraged to take a population-based view, assessing the needs of the entire local population and then designing programmes and services to prevent the most common health problems.

Prevention of health-related worklessness can take two forms. Primary prevention involves identifying those most at risk of developing health problems and putting in place measures to minimise those risks. Secondary prevention involves detecting a health complaint and taking action to ensure it does not worsen. Currently, secondary is more common than primary prevention, at least in part because there is little evidence of what works in terms of fending off health problems in the workplace. As the population ages and the number of people with long-term conditions (LTCs) potentially rises, early secondary prevention of these conditions is likely to reap increasing benefits in terms of mitigating their impacts on patients' functional ability and reducing later treatment costs. The Department of Health estimates that of the one-third of people in Britain living with a long-term condition, the proportion in work is one-third lower than that among those without LTCs – earlier preventative action could help to close this gap.[18]

18. Department of Health (2011): Then things you need to know about long term conditions. Available at: http://www.dh.gov.uk/en/Healthcare/Longtermconditions/tenthingsyouneedtoknow/index.htm

1 Work as a health outcome: the need for change

Early identification of health problems among workers will be facilitated by closer links between health services and employers. Giving employers the tools and knowledge to promote prevention among employees, for example by identifying and assisting those who face health risks due to obesity, stress, or harmful behaviours, could help reduce the burden on GPs at the same time as maintaining or increasing productivity in the workplace. As one telephone interview respondent argued:

'Workers need to feel that there are structures in place, both at work and in the health service, to manage problems before they become so serious that time off work is required. If employees felt more confident that they would be pro-actively managed they might be more engaged with employers.'

Employers also have a role in secondary prevention. Flexibility over an employee's duties, working hours and workstation, as well as the provision of occupational therapy and other treatments, can help ensure that a long-term condition does not worsen needlessly. A rapid response by the NHS is important, too, in complementing the employer's efforts by securing access to appointments, treatments and interventions at a sufficiently early point in the care pathway to ensure the patient retains the functional ability to work.

Employers may need incentives to take prevention more seriously. One of the roles of Health, Work and Wellbeing Coordinators will be to persuade employers to provide a healthy and safe environment and to manage staff health problems. It might be possible, as one interviewee proposed, for early identification of health problems and prompt secondary prevention to be included as an indicator in the new Investors in People Health & Wellbeing Good Practice Award, which assesses the extent to which companies promote workforce health. Liverpool already has a workplace wellbeing charter, with employers signing up to prove that their workplace meets standards. Other localities might also benefit from such schemes.

The importance of outcomes

There was a strong emphasis in the interviews on the importance of defining clear outcomes and developing measures to monitor progress towards them. In what is a fledgling field, deciding whether to expand, scrap or improve interventions aimed at preventing health-related worklessness will be impossible without evidence. Ongoing evaluation of the work of healthcare providers, back-to-work schemes and employers is vital – all these stakeholders need to be able to evaluate the progress made in keeping people in work or assisting them in returning to work.

An example of an initiative that had both clear outcomes and clear signposts regarding its effectiveness is the Improving Access to Psychological Therapies (IAPT) Employment Support Services. This programme integrates a range of health and employment services and has a specific focus on getting people with mental health problems back to work or keeping them in work. The intended outcomes include the employment of those who go through the programme and a reduction in the proportion claiming benefits. Data collected from five IAPT sites in London showed that of 865 people who entered the programme, 11% were supported to move into work, with a further 5% supported to move into education and training having been unemployed. 30% were supported to stay in work. An economic evaluation of the five sites, undertaken after 18 months, found that for every £1 spent by the state, there is a total benefit return of £2.79, with over two-thirds of the benefit accruing to the state (in the form of tax and national insurance paid by those returning to work, and income saved by not having to pay benefits) and the remainder to the individual (in the form of income gained from returning to work).[19]

In developing measures and monitoring effectiveness, third parties might play a useful part. Patient groups, third sector organisations and patients themselves can provide valuable input and can help keep the focus on patients' needs. Commissioning Boards should insist that health service providers gather employment status details as a benchmark for monitoring. And Local Authorities that contract out back-to-work services should incorporate a strong focus on outcomes into contracts, ensuring that the employment of those with health problems is a key indicator.

Achieving outcomes will be easier if buy-in is obtained from all parties. As one interview respondent from a local authority told us, if local bodies – employers, GPs, employment services, social care trusts and patient groups, for example – sign up to agreed locality-wide targets, they are more likely to focus on implementation. Such targets also mean that the leaders of these bodies will be held to account. An interviewee from the voluntary sector suggested that within this overarching framework, social care, health care and employment stakeholders should be allowed to decide on their own roles, thereby reducing the likelihood of conflict at a later stage and ensuring that each party plays to its strengths.

19. Working for Wellness (2011): IAPT Employment Support Services in London: Assessment of the Economic Impact. Office for Public Management. March.

2 What can different stakeholder groups do to promote work as a health outcome?

In this section we discuss how employers, health service providers, Health and Wellbeing Boards, public health teams and Local Authorities can contribute to a greater focus on work as a health outcome. For each group we make suggestions, based on the interviews, our analysis and the workshops, for how to improve performance in reducing health-related worklessness. As emphasised above, it is unlikely that all these suggestions will prove useful in all contexts, but we hope that they will form a basis for discussion and help guide stakeholders as they plan for change.

The role of employers

Employers are well placed to take a leading role in reducing health-related worklessness, both by helping prevent employees from having to leave or take time off work and by facilitating the return to work of the unemployed.

In the former area employers' responsibilities include: providing a safe and healthy workplace (assisted, where possible, by occupational health services), tackling stigma around ill health and disability within the organisation, identifying and responding to health problems at an early stage, and managing employee absence so that disruption to both company and individual is minimised.

In the latter area, increased flexibility over working hours, location and tasks, a less discriminatory attitude towards those with mental health problems, recruitment policies that are equitable towards those with disabilities or other long-term conditions, and the provision of internships or voluntary roles to people who are struggling to get back on the employment ladder can all help in addressing worklessness among those restricted by ill health.

Large numbers of firms already have health policies in place. Workplace wellness programs designed to prevent health problems are increasingly popular; many firms offer sick pay on top of the statutory requirement, and some take on the long-term unemployed to help them back to work. On the whole, however, employers' potential in this field is not being realised. Only one in eight workers in Britain has access to occupational health services,[20] many employers have no knowledge of the back-to-work services that are available, and few have concrete plans in place to deal with incipient or advanced health problems among staff. As several of our interview respondents argued, attitudinal change is needed so that employers, realising the effect ill health can have on their bottom line, on staff morale and loyalty, and understanding that an illness or disability does not automatically mean an incapacity to work, switch to a prevention-focused view of worker health.

In recent years the government has acted to strengthen the role of employers as promoters of health. In the 2010 public health white paper, the government pledged to provide the evidence and data needed to raise awareness among employers of the case for investing in the health of their employees. Included in this is the promotion of a Workplace Wellbeing Tool to help organisations assess progress and understand further steps, the development of an accreditation process for occupational health providers, and a Health and Wellbeing Challenge Fund for small and medium enterprises (SMEs), which provides funds for small firms to improve workplace health. The white paper also cites workplace health as one of the five strands of the Public Health Responsibility Deal, under which major employers have made commitments to take specific actions to improve workplace health. Under the 2010 Equality Act, moreover, employers are prohibited from asking health or health-related questions before offering employment, except where it is an intrinsic function of the job. As well as opening up opportunities for those with health problems, this should free up occupational health professionals to divert resources away from pre-employment health screening towards preventive initiatives for all members of staff.

20. Black (2008) op. cit.

2 What can different stakeholder groups do to promote work as a health outcome?

Still more effort is needed, however, on the part of employers and the health services and other stakeholders that interact with them in this area. A number of ideas for improvement emerged from our study, encompassing the roles of various parties.

- Participants at both the Lambeth and Durham workshops argued strongly that employers can make a large contribution to workforce health by making work itself more meaningful. GPs reported receiving many fewer requests for sick notes from those who are in fulfilling work, while certain jobs, such as those in call centres or fast food restaurants, have high rates of sick leave. A number of studies have shown that a worker's degree of autonomy has a close correlation with his or her health, with lower death rates among those with greater control (see, for example, Marmot et al (1978)); and employers who set up health programmes without providing workers with a meaningful role are likely to find that their efforts are less successful than those of companies with high rates of job satisfaction.

- Employers need support if they are to take a more proactive approach to health promotion. For example, to make informed decisions regarding workplace health they need evidence of effective interventions. Although there are many leaflets telling employers what they can do, there is a dearth of evidence. Third parties – be they governmental or non-governmental bodies – are well placed to fill the research gap, and are likely to find that hard evidence is a strong driver of employer action.

- Evidence can also help obtain buy-in from large employer organisations, such as Chambers of Commerce, the Federation of Small Businesses or the Confederation of British Industry, to encourage workplace health. The latter's support is important, as they spread knowledge and good practice among firms and can also conduct research into the effects of ill health on business and the most effective means of preventing it.

- Employers need a better understanding of what it is reasonable to expect an employee with a health problem to do. This requires developing stronger lines of communication with health services, to map out what the worker can do now and what he or she will be able to do in the future.

- Businesses should plan ahead in order to reduce the disruption caused by illness. A significant proportion of sickness management involves people having pre-planned surgery or interventions, and it is possible for rehabilitation programmes, occupational health appointments and workplace adjustments to be considered before they go off sick, rather than as a reactive measure once the absence begins. Such planning can greatly reduce the time off that the individual must take and the disruption caused to the business. Arthroscopy, for example, a keyhole surgery procedure which is used to detect and repair joint damage, is a routine procedure where most people will follow the same recovery path.

- There is scope for employers to be more flexible with home-based working. They may also consider the use of work hubs nearer to the employee's home, with the provision of technological support such as telephone, internet, video-conferencing and meeting rooms. Such flexibility can assist those with illnesses or disabilities by reducing travel demands and enabling them to spend more time at home.

- Engaged employers should consider bringing health services provided by the NHS into the workplace. Services such as cardiac and cancer screening, which are currently delivered through GPs' surgeries, could be provided at work. The NHS Health Check, aimed at those between the ages of 40 and 74, could also be provided within workplaces. An added benefit of this for the NHS would be that workplace services would reach men, who are hard to reach through traditional channels and often reluctant to attend GPs' surgeries.

- Local Enterprise Partnerships, wherein Local Authorities and businesses collaborate to support local economic development, could include health and work in their discussions, and could contribute to the health and work discussions and planning of other bodies such as Health and Wellbeing Boards.

2 What can different stakeholder groups do to promote work as a health outcome?

- With regard to occupational health, there were several suggestions for addressing the problem small firms have of investing in what can be a costly service. These included:

    - Appointing an occupational physician to local public health teams, to provide input on health and work.

    - Integrating an occupational health nurse into GPs' teams. A group chaired by the Work Foundation has reviewed OH provision within the NHS and recommended that the NHS locally should provide OH services for small employers in the area. This should enable small firms to have access to job retention and back-to-work services, perhaps including visits to firms by nurses to provide OH advice, although take-up is likely to depend on the price at which such services are offered.

    - Bringing large and small firms together so that the latter might benefit from occupational health services provided by the former. County Councils themselves, for example, often have occupational health departments, and these could be made available to small private sector organisations.

    - Raising awareness among small firms of the occupational health advice line for small businesses. Knowledge of this service is currently limited, and awareness-raising campaigns are needed to increase usage.

Case study

Coventry Chamber of Commerce

A pilot programme by Coventry Chamber of Commerce works with employers across the city to promote workplace health. Funded by Coventry NHS, the scheme aims to prevent health problems through early diagnosis and preventative information. It began by offering free health screening to participant firms' employees, with those who needed further examination or treatment referred to the NHS. Follow-up work has included workplace wellbeing events, workplace interventions such as smoking cessation schemes, and an additional project to support unemployed people with health problems back into work. More than 500 businesses are involved in the programme, and the Chamber of Commerce hopes to continue it by asking firms to pay for the services provided.

2 What can different stakeholder groups do to promote work as a health outcome?

The role of health services

Along with employers, health services are at the frontline of efforts to reduce health-related worklessness. In identifying health problems at an early stage, providing treatment that reduces the need to take time off work, completing Fit Notes to facilitate a timely, phased return to work, and referring patients to back-to-work programmes, health services are pivotal to keeping the employed in work and enabling the unemployed to return to work.

As with employers, however, GPs and other health service providers are falling short of their potential. Health services focus overwhelmingly on physical health rather than a person's overall wellbeing, even when other factors such as work stress or living conditions might be causing physical problems. Many GPs consider work as something to be avoided by those who fall sick, rather than as part of the cure, while some see their role as a patient advocate and are unwilling to suggest that a reluctant patient can return to work. Few health care providers refer patients to back-to-work schemes. Mental health care trusts, too, frequently adopt a protective view of people in services and, rather than try to lift patients out of the living circumstances that might have caused the problem, focus on the illness itself and on avoiding aggravating it. One interviewee described a 'signing-off culture', wherein the tendency to focus only on symptoms and to fall back on recommending time off work is leading to increased worklessness and exacerbating health problems. As another respondent added, 'Work is a solution, not a problem.'

The Fit Note is an attempt to address this deficit, and it is already proving popular with GPs and employers. The RCGP, meanwhile, has developed training on work and health for GPs. Additional support is available at the Healthy Working UK website, an online resource for GPs and other primary healthcare professionals that provides information, training and decision aids to support the management of health and work. Under new Clinical Commissioning Groups, GPs will be part of the groups that hold the budget and therefore more aware of referral costs, so it is likely that there will be peer pressure to keep costs down. This could lead to a greater focus on preventing costly secondary treatment, and potentially more use by GPs of back-to-work services that are proven to be cost-effective. Our research unearthed a number of ideas for health services to consider as they attempt to comply with government requirements that they give more consideration to work:

- To reduce the time taken off work by those who are employed, people should be allowed to register with health services that are close to their workplaces. This provision appears in the recent Health Bill. Outreach into workplaces can also help in this regard, including through occupational health assessments or the provision of screening or other services in the workplace.

- GPs lack knowledge of back-to-work services: these services are often pilot programmes which are discontinued after a short period, so GPs are reluctant to access them. However, many longer-term programmes also receive few referrals, and die out because of lack of interest. Closer links are needed between providers of these services and health professionals, both to raise the latter's awareness of what is available and to help tailor the services so that their value is transparent.

- Rigorous evaluations of back-to-work services are needed to encourage health providers to focus on work. It is hoped that the results of Fit For Work pilots, which are due to be published in 2013, will help bridge the evidence gap.

- In localities where health-related unemployment is a significant problem, GPs should consider hosting back-to-work services in their surgeries. This has proved effective in some areas, and provides patients with a convenient one-stop-shop on the route back into work. Occupational therapy or physiotherapy are other relevant services which could be provided in GPs' surgeries, and it might also be possible for surgeries to host Job Centre-style computerised work stations, which provide information on the jobs available in a locality.

- Local NHS bodies (as noted above) could perhaps provide occupational health services to small businesses in their area. This idea received some support in the workshops.

- Pharmacists and physiotherapists also have a role to play, particularly in early identification of health problems and perhaps in advising patients about back-to-work services. They should also be involved in wider strategies to reduce health-related worklessness.

2 What can different stakeholder groups do to promote work as a health outcome?

- As discussed above, secondary prevention is essential if health problems are to be tackled before they reduce a patient's ability to work. Secondary care consultants also have a role, therefore, in discussing care pathways with patients and designing treatment regimens that allow them to continue working and improve their prospects of remaining in work in the future.

- GPs have a privileged position as trusted advisers of patients. A recommendation by a GP that an unemployed patient attend a skills refresher course, or seek voluntary work as a step towards paid work, could help reduce long-term worklessness. Several of our interviewees recommended voluntary work as a means of learning new skills, making contacts, securing references and gaining confidence. One respondent from a leading charity reported that her organisation has 100 work placement volunteers at any one time, three-quarters of whom subsequently find paid work. Few GPs currently take advantage of such opportunities, however, and efforts are needed to raise their awareness of the value of voluntary work.

- For health services to take more effective action in these areas, however, they need knowledge and incentives. Many GPs lack confidence when discussing work. Until recently, work as a health outcome has not been part of their training, and knowledge both of how to broach the subject with patients and of which services to use is weak. For real progress to be made, work (and other broader aspects of wellbeing) must become an intrinsic part of all GPs' training. The RCGP has responded to this need by developing training on work, but it has so far reached only a minority of GPs. There was a suggestion by one of the workshop groups for an aide memoire to be developed by Local Authorities to inform primary care staff, including practice nurses, about back-to-work services.

- An additional training suggestion is to advise GPs about how the main industries in their locality function. By helping them understand the tasks that individuals perform, this is likely to increase the utility and accuracy of Fit Notes.

- There is as yet no reference to incentivising GPs to take account of work or to talk to patients about work in the NHS Quality and Outcomes Framework (QOF). The links between Oversight and Scrutiny Committees and Health and Wellbeing Boards, moreover, are as yet unclear, although it is hoped that the requirement that CCGs show they have taken account of local Joint Health and Wellbeing Strategies will act as a stick to encourage action. One suggestion for incentives that arose in our interviews and workshops, in addition to formalising work in the QOF, was for GPs to be paid to deliver desired work outcomes.

- Adding a question on work as a health outcome to the Fit Note is a further promising trigger for increasing GPs' engagement. Participants at the Lincolnshire workshop suggested that the forthcoming electronic version of the Fit Note should ask whether GPs have considered referring the patient to back-to-work services. This would remind GPs of the availability of services as well as encouraging them to make use of them.

2 What can different stakeholder groups do to promote work as a health outcome?

The role of Health and Wellbeing Boards

Health and Wellbeing Boards have been designed to decide overall priorities for a locality and bring together health services, Local Authorities and other relevant stakeholders to address them. They are intended to improve the health and wellbeing of the population as a whole, rather than focusing on individuals, and to reduce the health inequalities which contribute to income disparities. The boards will be lead commissioners for certain services and will oversee pooled budgets and joint commissioning between the social care and health sectors.

Although HWBs are currently at a fledgling stage, their potential for exploring and acting on the links between health and worklessness was widely recognised by those consulted in our research. It is hoped that HWBs will help GPs and Local Authorities understand the connections between health and worklessness and the ways in which health services can assist rehabilitation and back-to-work programmes that Local Authorities have in place. HWBs also have the potential to break down silos and bring together stakeholders from across the health and employment fields. And with CCGs being obliged to show that their commissioning plans have taken account of Joint Health and Wellbeing Strategies, HWBs have some power to encourage healthcare providers to abide by local priorities and help tackle worklessness.

The following ideas from our research might facilitate the task of HWBs as they chart their course along the health and social care nexus:

- Joint Strategic Needs Assessments (JSNA) should take more account of work as a health outcome, and HWBs should endeavour to involve GPs in their development. In Essex, for example, where as elsewhere each Clinical Commissioning Group must show that it has taken the local JSNA into account, the Health and Wellbeing Board has advised GPs to participate in the design of the strategy. In this way, the GPs will not be burdened with a potentially unworkable strategy, imposed on them against their will.

- It is not yet clear how HWBs will connect with the local businesses, whose input is so crucial to reducing health-related worklessness. Nor are there clear links between those responsible for local economic plans and HWBs. There were suggestions in our research for a local employers' representative to have a seat on the board, perhaps along with Local Authority representatives working on local regeneration and economic development.

- HWBs include Council members, key officers, GPs, service user representatives, district council representatives and voluntary sector representatives. To promote work as a health outcome and help achieve the targets in the NHS and public health frameworks, HWBs should consider having a larger stakeholder forum feeding into the board, including employers, providers of back-to-work services and other interested parties. The latter could meet less frequently than the main board, and make recommendations to it based on pilot programmes or evidence from other localities on how to reduce health-related worklessness.

- One HWB member told us that on her board there is a permanent 'open position', which is filled by the stakeholder considered most relevant for each particular meeting. This gives the HWB greater flexibility; the position could be filled, for example, by a key local employer or a representative of a patient group (or both).

- HWBs may benefit from involving third sector organisations in bringing health services and Local Authorities to the table. The third sector has a strong track record in considering the wider determinants of wellbeing, and is very knowledgeable about those it represents. As one interview respondent told us, 'third sector organisations have a strong focus on the patient, and are good at keeping that focus throughout projects.' The sector has a role in making the case for the importance of work and, since it is widely seen as a neutral arbiter, can help convene and facilitate contact between stakeholders. This reputation for impartiality makes the third sector a logical party to conduct monitoring and evaluation of projects.

- HWBs should not neglect voluntary work as a worthwhile target. Voluntary work can be as valuable to society as paid work, and for individuals too it provides numerous benefits (as listed above). HWBs should consider involving third sector organisations and the private sector in helping people move into voluntary positions if there are no paid positions available. There were also suggestions regarding public health directors (PHDs), whose new role as members of HWBs is seen as crucial to advancing the 'work as a health outcome' agenda:

2 What can different stakeholder groups do to promote work as a health outcome?

- 'Public health directors respond to evidence,' as one telephone interview respondent said. Demonstrator projects are needed to show them how back-to-work schemes and greater engagement by health services can be effective in improving population health. Government bodies or third sector organisations wishing to make the case for work as an important health outcome need to invest in research and present evidence to PHDs.

- Once convinced of its value, PHDs have an advocacy role in highlighting the importance of work to health care providers. They will be able to compare local rates of sick certification with those in other areas and challenge health and employment services to improve.

- Convincing GPs of the value of work is widely seen as a major barrier to advancing the 'work as a health outcome' agenda. Finding and nurturing 'GP champions' to advocate the importance of work to their peers might help public health professionals overcome this obstacle.

- Public health professionals also have a role in working with employers to promote a healthy workplace, and in advising employers about what services are available. A regional Health, Work and Wellbeing Coordinator we spoke to reported that many employers she has met are keen to do more but do not know what they can do. 'Public health teams are not very good at linking with employers,' she added. 'It's quite a hard task to get them to see that public health messages can be delivered through the workplace, to populations they don't normally reach.'

- It is important for PHDs on HWBs to be independent and to be allowed to speak out when things are not working, even if that is not what the Local Authority wants to hear. One respondent suggested that there be a statutory requirement for PHDs to produce an independent annual report on the health of the local population, and that this report should include consideration of employment issues.

Case study

North East Better Health at Work Award

The twelve Directors of Public Health in the North East region have come together to launch the North East Better Health at Work Award. This is intended as a structure for promoting health in the workplace. It gives employers who excel in the field bronze, silver and gold awards. Public health professionals carry out a 'health needs assessment' on an employer's premises, during which employees have the opportunity to express their views on the company's commitment to health and to make suggestions for improvements. The scheme also trains in-company health advocates to spread the public health message among their colleagues.
Its organisers, in conjunction with Durham University, plan to conduct a sickness absence review of participating firms in order to show the benefits of health interventions in terms of reduced absence and increased productivity.
As at September 2011, 300 businesses were engaged in the programme.

2 What can different stakeholder groups do to promote work as a health outcome?

Case study

RNIB low-vision services programme

An example of third sector effectiveness in promoting work as a health outcome was provided by a respondent from RNIB. When people suffered sight loss in the past, the aids they required were provided by hospitals and by rehabilitation teams from the social care sector. But collaboration between the two was disjointed and communication weak. This resulted, for example, in people being given magnifiers in hospital but not using them because social care failed to show them how they worked.

In 1998, therefore, RNIB instigated a cross-sector low vision services programme, to provide people with the aids they need after sight loss. The programme began by consulting people on the services they wanted, and found that a one-stop coordinated service where everything was available in one place and all stakeholders were linked was high on patients' wish-list. RNIB looked elsewhere in the world for ideas and then conducted pilots. The organisation provided a subsidy to get the project off the ground, and now oversees one-stop shops where a patient can have an eye test, then see a rehabilitation officer from social care who assesses the person's needs in home and elsewhere, and then see an optometrist. The three parties work out together which aids are the most useful: the rehabilitation officer has information on lifestyle aids such as large-print newspapers, stickers for ovens and talking microwaves, while the optometrist brings knowledge of sight-oriented aids such as magnifiers. The rehabilitation officer also assesses other wellbeing aspects such as mental health needs and other social needs, and thereafter puts the patient in contact with the relevant parts of the social care system. Once the patient is back in the community, the officer follows up to ensure the aids are working to the patient's satisfaction, and reconvenes with the optometrist to fine tune them if not.

The RNIB programme focuses consistently on the patient and on how to improve service quality. The service comes to patients rather than the latter having to find out everything for themselves. Rehabilitation officers interact with health service providers to ascertain the exact nature of the problem so that responses can be tailored individually; and there is ongoing monitoring of the situation involving all three parties to ensure that effectiveness is sustained. Funding is provided by both health and social care sectors. Despite initial difficulties, with our interviewee reporting suspicion between health and social care providers, disputes over funding, and language barriers (one entire meeting was needed to decide if users should be known as 'patients' or 'service users'), RNIB acting as a neutral arbiter helped overcome these challenges. As well as adjudicating on disputes, the organisation hosted monthly meetings with health and social care representatives to build trust and understanding of each other's roles and problems. An indicator of the programme's success is that as the relationship has strengthened, these meetings now need to be held much less frequently.

2 What can different stakeholder groups do to promote work as a health outcome?

The role of Local Authorities

Local Authorities play a key role in tackling unemployment. They offer advice and support to the unemployed through JobCentre Plus, are responsible for social care services which allow those with relatives in need of care to go out to work, and are major local employers. Through the Work Programme, which is supported by the Department for Work and Pensions (DWP), they assist those with health problems who are in receipt of Employment and Support Allowance to return to work.

Local Authorities are also active in promoting wellbeing, for example by providing quality housing and carrying out health and safety inspections in workplaces. They assist those with disabilities through Access to Work payments, which like the Work Programme is supported by the DWP, with advice and support from Disability Employment Advisers.

Case study

Lambeth Business Awards Best Workplace Category

The Lambeth public health team worked with the enterprise department of the Local Authority to include 'Best Workplace' as a category in the Lambeth Business Awards. This rewards firms who promote health in the workplace and devote resources to improving wellbeing at work. A health promotion specialist judges the performance of companies that enter the award scheme, and the prize is awarded at the annual Business Awards event.

Links between Local Authorities and health services, however, are generally quite weak. In the 'work as a health outcome' field, each tends to see health and work as the other's problem. There were several reports in our research, for example, of Job Centres sending people referred to them by GPs back to the GP to obtain a note saying he or she cannot work. It was also observed that Local Authorities do not play as active a role as in the past in helping employers adapt to the physical and mental needs of someone who is returning to work after a health-related absence, or in assisting applicants themselves in negotiating adaptations.

With Local Authorities and health services coming together to sit on Health and Wellbeing Boards, it is hoped that the links between the two will strengthen. This will not happen automatically, however, and the following themes emerged during our research as worthy of consideration as the two sectors collaborate to promote work as a health outcome:

- Workshop participants in Lambeth suggested that in contracting services, Councils could build health provision into the commissioning process, so that supplier firms that invest in workforce health are favoured when contracts are awarded.

- Local Authorities should make stronger efforts to increase health services' awareness of back-to-work programmes, and thereby become a repository for information on health and work. Many GPs, for example, are unaware that worklessness programmes, skills programmes and self-help groups exist to help people return to work, and efforts to publicise such activities are likely to have a major impact on uptake. As one workshop group suggested, these efforts might include council representatives visiting Clinical Commissioning Groups to inform them about services, and the provision to GPs' surgeries of marketing materials publicising the services.

- Relationships between Local Authorities and healthcare professionals might be strengthened if they shared premises. This would enable patients and jobseekers, moreover, to access both employment and health services in the same location.

- Local Authorities also have a role in providing information to employers. Employers that pay attention to health often only focus on the Fit Note and on interaction with local GPs, rather than considering the wider services that might be available. Local Authorities can apprise employers of what is available in terms of services and programmes.

2 What can different stakeholder groups do to promote work as a health outcome?

- Awareness of Access to Work payments is weak, particularly among small firms. These payments are given to employers of those who have been off work to help them adapt the workplace to the new needs of the employee. This reduces the risk for employers and smoothes the path back into work of those who have been off sick. Local Authorities should make more effort to publicise these payments, and consideration should be given to extending them to the unemployed rather than limiting them to those who have found jobs. Such payments would make job applicants who have had health problems more attractive to employers.

- There was a widespread feeling that Local Authority services would benefit from greater flexibility. It was suggested that the role of Local Authority health and safety inspectors might be expanded to offer advice on employee health, such as diet, the importance of exercise, and workstation setup. This is already beginning to happen in Warwick – the site of one of our workshops – and we found that some inspectors would welcome a broader role.

- As one interviewee suggested, flexibility could be shown by the creation of a new position of regional occupational health director, who could work alongside the regional public health director in local government. This would ensure continuity in enabling the public health agenda to be delivered through the workplace, thereby facilitating progress towards the employment goals laid out in the outcomes framework.

Case study

Individual Placement and Support

Individual Placement and Support is the best-established method of 'place then train' in mental health. According to the Centre for Mental Health, IPS follows seven principles:

1. It aims to get people with mental health problems into competitive employment
2. It is open to all those who want to work
3. It attempts to find jobs that are consistent with people's preferences, and works with them and the employer to identify and negotiate any workplace adjustments that may be needed
4. It works quickly: contact is made with employers during the first month, direct assistance in finding jobs is provided, and there is an emphasis on on-the-job training with support
5. It brings employment specialists into clinical teams, encouraging frequent contact with mental health care coordinators. Mental health team meetings include employment specialists and consideration of employment plans, which ensures that care programme plans and employment plans are mutually supportive
6. It provides time-unlimited, individualised support for the person and their employer
7. Benefits counselling is included.[21]

Burns and Catty (2008) compared IPS with other high-quality vocational or rehabilitation services in six European countries. They studied 312 individuals who had been ill for at least two years and in contact with their mental health service for at least six months. The individuals had also been continuously unemployed for at least one year. During the eighteen-month follow-up period, 85 IPS patients (54.5%) worked for at least one day compared with 43 Vocational Service patients (27.6%). IPS patients were also significantly less likely to be rehospitalised. IPS, the authors concluded, 'doubles the access to work of people with psychotic illnesses, without any evidence of increased relapse.'[22]

21. CMH (2011): Individual Placement and Support. Available at http://www.centreformentalhealth.org.uk/employment/ips.aspx
22. Burns T, Catty J (2008): IPS in Europe: The Eqolise Trial. Psychiatr Rehabil J. 2008 Spring;31(4):313-7.

3 Conclusions

Policy-makers in Britain have only in recent years begun to recognise the importance of work as a health outcome, both to the economy as a whole and to individuals' quality of life. The task of persuading those working at the coalface – health care providers, Local Authorities, public health teams and employers – that they should devote more attention to keeping people with health problems in work and assisting the unemployed to return to work is also at a fledgling stage.

Some progress has been made, however, with the formation of Health and Wellbeing Boards and the provisions in the NHS Outcomes Framework and the Public Health white paper offering the potential to reverse the historic neglect of this field. Collaboration between individuals and entities working at the local level will be crucial to successful implementation of these policies, and we hope that some of the suggestions in this report will facilitate closer working.

As they incorporate work as a health outcome into their planning, HWBs and other interested parties will have to address a number of challenges. The first step will be to assess the need to promote work as a health outcome, by establishing how many local people are in receipt of Incapacity Benefit or Employment and Support Allowance, and review the efforts of local businesses to keep people in work. Comparing performance with other localities is a useful means of benchmarking both the initial need and the progress made.

The second step will be to identify and bring together the most relevant local stakeholders to draw up plans. HWBs are well placed to act as a convenor, and the third sector, as a trusted and impartial observer, can help in bringing stakeholders to the table and encouraging them to work together for patients' benefit.

The third step involves setting and agreeing on clear and measurable outcomes, against which those who sign up to them can be held to account. Within this overarching framework, allowing stakeholders to define their own roles appears a promising means of reducing conflict. The experience of several of those we interviewed suggests that collaboration often works more smoothly as projects progress and those involved become more familiar with each other's ways of working. Ensuring autonomy and clarity in the early stages can hasten this process, and will also have benefits in terms of accountability.

The final step, once programmes are underway, is to monitor progress against the agreed outcomes, with the flexibility to make amendments where initiatives can be improved. Regular contact between stakeholders – keeping all those involved in the loop and apprised of developments – will be required both to assess progress and to tweak programmes. In what is a nascent field, the gathering of evidence and flexibility in responding to it are likely to be central to success.

Health and Wellbeing Boards will be pivotal in encouraging co-working. Health services, Local Authorities and employers have a patchy record of working together effectively. The 'work as a health outcome' agenda offers an opportunity to reverse this trend, with the potential to provide lessons for other areas of co-working. The establishment of HWBs is an explicit statement by government that such collaboration must become institutionalised. Now that they have been given power to enforce consideration of work by Clinical Commissioning Groups, boards in areas where health-related worklessness is a problem have an important lever to implement back-to-work strategies. If the health of Britain's workforce is to be significantly improved, Health and Wellbeing Boards, directing and facilitating local-level action, are likely to be at the forefront of change.

Appendix 1: Project participants

Steering group members

Jonathan Shapiro	2020health (Chair)
Nicholas Kendall	Independent Consultant
Lee Eplett	Cross-Government Health, Work, Well-being Strategy Unit
Rod Halstead	Public Services Consultant, Cisco
Ross Carroll	Abbott
Clare Whelan	Lambeth Councillor
Ailsa Bosworth	Chief Exec, National Rheumatoid Arthritis Society
Anita Lightstone	RNIB
Deborah Rutter	SCIE
Angela Brady	GP and Warwickshire County Councillor
Mark Weston	2020health
Eleanor Winpenny	2020health
Julia Manning	2020health

Telephone interviewees

Dr Mark Ratnarajah	Business Development Director for Health and Wellbeing Services, Capita
Kirstie Haines	North West Health Work and Wellbeing Coordinator
Guy Bailey	Principal policy adviser, CBI
David Coggon	President, Faculty of Occupational Medicine
Chris Shaw	Director of Health Improvement, Sheffield City Council
John Ashton	Joint Director of Public Health for Cumbria Primary Care Trust and Cumbria County Council
Prof David Croisdale-Appleby	Chair, Skills for Care
Chris Bull	Chief Executive, Herefordshire PCT/LA
Dr Alan Nye	Director, Pennine MSK Partnership Ltd.
David Behan	Director General for Social Care, Department of Health
Dr Androulla Johnstone	Chief Executive, HASCAS
Clare Hardy	Senior Manager Adults, Health & Community Wellbeing, Essex County Council
Dr Steve Boorman	Chief Medical Officer, Royal Mail
Mary Bradley	Director, Age UK West Cumbria
Tony Johnson	Governor at Stockport NHS Foundation Trust and a Core Group member of Stockport LINK
Steve Bevan	Managing Director, The Work Foundation
Steve Shrubb	Director of the Mental Health Network, NHS Confederation
Dr David Colin-Thomé	Retired from Department of Health
Dr Bob Grove	Chief Executive, Centre for Mental health
Brendan McLoughlin	Programme Director: Wellbeing, Inclusion and Psychological Therapies, NHS London Development Centre

Appendix 1: Project participants

Telephone interviewees (continued)

John O'Dowd	Director, Realhealth Institute
Mark Lovell	Executive Chairman, A4e
Jane Abraham	South West Regional Health, Work and Well-being Co-ordinator
Liam Hughes	National Adviser, Local Government Improvement and Development
Andrew Cozens	Strategic Adviser for Child, Adults and Health Services, Local Government Improvement and Development
Jim Hillage	Director of Research, Institute for Employment Studies
Prof Roy Sainsbury	Research Director, Welfare and Employment Team, University of York
Dr Charles Alessi	GP Partner, Churchill Medical Centre
Dr Debbie Cohen	Senior Medical Research Fellow, University of Cardiff

Warwickshire workshop

John Linanne	Director of Public Health
Julie Richardson	Chamber of Commerce
Chris White	MP
Richard Hall	Warwick District Council (WDC)
Ruth Pickering	County Health, Safety & Well-being Manager (WCC)
Bob Stevens	Warwickshire (WCC) County Councillor (and Portfolio Holder Public Health)
Angela Brady	GP/County Councillor
Lorraine Holtom	JobCentre Plus

Lambeth workshop

Jim Lusby	Kings Health Partners
Dr Mitra	Lambeth CCG
Graham Laylee	NHS Lambeth
Sue Gallagher	NHS Lambeth
Helen Charlesworth-May	NHS Lambeth
Zoe Reed	SLaM/KHP
Jacob West	King's Hospital/KHP
Angela Dawe	GSTT/KHP
Lucy Smith	NHS Lambeth
Sarah Gerlett	NHS Lambeth
Dr Patricia Kirkman	NHS Lambeth CCB
Ruth Jeffery	LCCB
R. Heywood	Lambeth Council
Pete Robbins	London Borough Lambeth
Kieron Williams	London Borough Lambeth
Aisling Duffy	Certitude

Appendix 1: Project participants

Lambeth workshop (continued)

Nicola Kingston	Lambeth LINk
Andrew Eyres	NHS Lambeth
John Moxham	Kings College London
Adrian McLachlan	GP commissioner
Ed Davie	LB Lambeth Health Scrutiny
Jane Pickard	LB Lambeth, Cabinet member for older people
Jim Dickson	Cabinet member for health and wellbeing
John Balazs	GP Lambeth

Durham workshop

Darren Archer	Head of Joint Planning, NHS County Durham and Darlington
Anna Lynch	Director of Public Health, NHS County Durham and Darlington
John Tindale	Area Regeneration Manager, County Council
Paul Kelly	Training Services Manager, County Council
Graham Wood	Economic Regeneration Manager, County Council
Cynthia Bartley	Health and Wellbeing Coordinator, County Council
Sarah Robson	Head of Economic Development, County Council
Jane Hartley	The Pioneering Care Partnership

Lincolnshire workshop

Dr Tony Hill	Director of Public Health, NHS Lincolnshire and Lincolnshire County Council
David Stacey	Programme Manager – Public Health, Lincolnshire County Council
Danica Gilland	Employment Support Manager, Dimensions Community Enterprises
Jane Tuxworth	Lead Occupational Therapist, Lincolnshire Partnership Foundation Trust
Stuart Carlton	Lincolnshire County Council
Jane Bond	Individual Placement and Support Service Manager, Lincolnshire Partnership Foundation Trust
Barry Fippard	Lincolnshire LINk
Andrew Brooks	Employment and Skills Team Leader, Lincolnshire County Council
Cllr Ric Metcalfe	Leader, City of Lincoln Council
Lorraine Palmer	Birchwood Access & Training Centre
Derrick Brown	Employer & Partnership Manager, DWP
Clare Parker	Carers Team, Lincolnshire County Council
Dr Kevin Hill	South Holland CCG
Dr Sunil Hindocha	GP, CCG and HWBB Vice Chair, Lincolnshire West CCG

Appendix 1: Project participants

Lincolnshire workshop (continued)

Claire Flavell	Work Related Learning Manager, Education Business Partnership
Dr Kerry Tyerman	GP and CCG, East Lindsey CCG
Kim Jones	Princes Trust Quality Manager, Lincolnshire Fire and Rescue
Barbara Stewart	Lincolnshire Partnership Foundation Trust
Cllr Mrs Marion Brighton OBE	Leader, North Kesteven District Council
Jennie Chapman	Partnership Manager, Local Strategic Partnership Manager
Dr Vindi Bhandal GP and CCG	Lincolnshire South West CCG
Lisa Holmes	Public Health
Graham Metcalfe	JobCentre Plus

Bibliography

Dame Carol Black (2008): Working for a Healthier Tomorrow. Review of the health of Britain's working age population. DOH, DWP. 17 March.

David Bloom, David Canning (2000): The Health and Wealth of Nations, Science, 2000, Vol. 287: 1207–1208

David Bloom, David Canning, Jaypee Sevilla (2004): The Effect of Health on Economic Growth: A Production Function Approach. World Development, Vol. 32, No. 1,1.

David Bloom, David Canning, Mark Weston (2005): The Value of Vaccination. World Economics, Vol. 6, No. 3: 15–39.

Boorman M (2009): NHS Health and Wellbeing Review. Crown, Department of Health, November.

Burns T, Catty J (2008): IPS in Europe: The Eqolise Trial. Psychiatr Rehabil J. 2008 Spring; 31(4): 313–17.

House of Commons (2011): ESA and incapacity benefits – constituency statistics for Great Britain. Social and General Statistics. 15 June.

M G Marmot, G Rose, M Shipley, and P J Hamilton (1978): Employment grade and coronary heart disease in British civil servants. J Epidemiol Community Health. 1978 December; 32(4): 244–49.

Sir Michael Marmot (2010): Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England post-2010.

Nokes, C., Grantham-McGregor, S. M., Sawyer, A. W., Cooper, E. S., Robinson, B. A., Bundy, D. A. P. (1992): Moderate-to-heavy infection of trichuris trichiura affect cognitive function in Jamaican school children. Parasitology, 104: 539–47.

Pritchett, Lant, and Lawrence H. Summers (1996): Wealthier is Healthier. Journal of Human Resources 31 (4): 842–68.

J Shapiro, E Hill, J Manning (2010): Health, disease and unemployment: The Bermuda Triangle of Society. 2020health, June. London.

G Waddell, A Kim Burton (2006): Is work good for your health and wellbeing. Report commissioned by the Department for Work and Pensions. The Stationery Office. London.

Working for Wellness (2011): IAPT Employment Support Services in London: Assessment of the Economic Impact. Office for Public Management. March.

2020health.org
83 Victoria Street
London SW1H 0HW

T 020 3170 7702
E admin@2020health.org

Published December 2011 by 2020health.org

Price: £10

ISBN No: 978-1-907635-17-5

2020health.org