



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

Summary of evidence submitted

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Executive summary

Dame Carol Black, the National Director for Health and Work, announced a Call for Evidence in October 2007 to inform her Review of the health of the working age population.

Discussion events

Six discussion events were held in November 2007. They provided an opportunity for employers, healthcare professionals and other key stakeholders to engage direct with Dame Carol. Themes raised in these forums included: employers' need for clear guidance on how to improve health in the workplace; the particular challenges for small and medium-sized enterprises (SMEs); the unsatisfactory nature of the current sick note; the importance of extending occupational health (OH) provision to all employees; and the need to tackle misconceptions about mental ill-health in the workplace.

Written evidence

Dame Carol also invited written submissions and posed eight questions as a focus for debate. Over 260 written responses were received from a broad range of stakeholders. The principal themes to emerge from the analysis of the responses were as follows.

1. How can we keep working age people healthy and how can the workplace be used to promote health?

There was strong support for health and well-being initiatives in the workplace reinforced by visible management commitment. Specific measures suggested included the encouragement of physical exercise, greater compliance with health and safety provisions and stronger collaboration between employers and healthcare professionals. Some evidence was offered that the workplace could be an effective forum in which to promote health messages to specific groups.

2. How can people best be helped to remain in or quickly return to work when they develop health conditions including chronic disease or disabilities?

The key factors most often identified were early intervention when health problems develop and the provision of flexible working patterns. Many respondents said that better provision of OH services was required, and an equally large number said that more needed to be done by employers. Some respondents made specific suggestions on how to facilitate the return to work and some suggested that Government should make changes to the relevant regulations and procedures.

3. How does the age of the person affect the support that is needed?

The main view was that the age of a person was not a significant factor in the type of support needed, although slightly more support may be needed at either end of the age spectrum. Rather it was considered more important to take account of individual needs. Suggestions were also made concerning the specific needs of older and younger workers.

4. How can we encourage action to improve employee health?

A key theme was the importance of making the business case for employer investment in employees' health and some respondents drew attention to the lack of evidence on a causal link between specific interventions and health benefits. Economic incentives, particularly tax breaks, were urged. There was also some support for awards for good practice. The need to take account of the particular difficulties faced by SMEs was frequently raised.

5. What underlies the apparent growth in mental health problems in the working age population and how can this be addressed?

There was a consensus that mental ill-health was a major concern, even though the apparent growth could be due to under-reporting in the past. Increased work intensity was the most frequently cited underlying factor. Many respondents also emphasised the strong interaction between workplace, domestic and wider societal factors. The preventative or remedial measures most often proposed were better practice by line managers, more flexible working patterns, and wider provision of support and therapeutic services.

6. What constitutes effective occupational health provision and how can it be made available to all?

Nearly all responses to this question supported some form of national OH provision for all working age people. The other main themes were how to ensure the availability of OH provision, the different elements required for effective OH cover and how to improve the quality of OH services. The responses encompassed a diverse range of suggestions.

7. What would be the impact on poverty and social inclusion of a healthier working age population?

All respondents addressing this question agreed that the impact would be positive, although a few suggested that the causal links might be more complex than was immediately apparent and that further research might be required. Other issues raised were the need for 'good jobs' to improve or maintain health, the special needs of disabled people, the impact on families and communities of a sustained return to employment, and regional variations in ill-health and lack of work.

8. What are the costs of working age ill-health to business and what are the benefits to companies of investing in the health of their staff?

Many respondents cited specific costs and benefits of which the most common were productivity, levels of sickness absence, retention of staff and skills, staff morale and the reputation of the company as a 'good employer'. More generally, many respondents stated that investment in health was cost-effective, while some said that more research was needed (supported by the widely varying figures quoted for the costs of ill-health and the benefits of investing in health).



Introduction

In 2007 the Secretaries of State for Health and for Work and Pensions commissioned the National Director for Health and Work, Dame Carol Black, to undertake the first ever review of the health of Britain's working age population. Dame Carol announced a Call for Evidence at a round-table event with leading business and medical professionals in October 2007. This was held in London and chaired by the two Secretaries of State.

Responses to the Call for Evidence were invited through the Health, Work and Well-being website (www.workingforhealth.gov.uk), and promoted in a variety of media at the national and regional level. They were further supplemented by six discussion events held across Britain during November 2007.

In announcing the Call for Evidence, Dame Carol posed eight questions to indicate the wide remit of the Review and provide a focus for debate. In total, 267 written responses were received from a broad range of sources, of which 152 were from various types of organisation and 115 from individuals. Organisations which responded included representative bodies (e.g. trade associations, employer organisations and trades unions), think tanks, charities, employers, academic institutions, medical bodies, and central and local government. Individuals who responded represented a wide range of backgrounds, including general practitioners (GPs), OH specialists, academics and the general public.

The responses varied from extensive research reports to personal experience and perspectives. Some submissions covered all eight questions and some focused only on specific issues of interest to the respondent. The proportion of responses covering specific questions varied from around 60% (keeping the working age population healthy) to about 35% (impact on poverty and social inclusion).

The responses were considered by Dame Carol and analysed to inform the findings of her Review. This document summarises the evidence contained in the responses and shows how it informed the recommendations in Dame Carol's report.

5 A DAY

Just Eat More Fruit & Veg



1 medium apple



1 cereal bowl of mixed salad



2 halves of Canned Peaches



1

How can we keep working age people healthy and how can the workplace be used to promote health?

Key themes

Around 60% of respondents addressed this question. There was strong support for health and well-being initiatives in the workplace reinforced by visible management commitment. Among the specific measures that could be taken, the encouragement of physical exercise was the most commonly cited (across all categories of respondent).

A significant number of responses (mainly from organisations representing employees' interests) identified compliance with health and safety provisions as key. Stronger collaboration between employers and healthcare professionals was also advocated. Some responses offered evidence of how the workplace could be used to target general health messages at particular groups.

Initiatives to promote health and well-being in the workplace

A substantial proportion of respondents urged the establishment by employers of specific policies or programmes to encourage healthy living and general well-being. The key features of such policies and programmes were wide-ranging and varied. Many responses emphasised the provision of health services at work, including, as a minimum, access to certain basic health checks (e.g. for eyesight, blood pressure or cholesterol) and ranging up to a full OH service. Others drew attention to issues around work management (e.g. workloads and flexible working arrangements) and the design of the physical office environment.

The most frequently recommended measure was the encouragement of physical exercise. Promotion of healthy eating was also often suggested.

Health promotion activities in the workplace can be beneficial, but are more effective if they address the employees' expressed needs through an employer/employee partnership and especially if they involve increasing levels of physical activity [Institute for Employment Studies, Hill et al., 2007].

The proportion of organisations with well-being strategies in place has risen from 26% in 2006 to 47% [Chartered Institute of Personnel and Development survey, 2007].

Many respondents emphasised the importance of strong management commitment and 'leading by example' if such health promotion initiatives were to deliver sustainable results.

'Promoting healthier working environments for staff...is essential in contributing to keeping the workplace healthy and reducing health inequalities. An acknowledgement/approval from senior management... is needed to support effective implementation of health promotion initiatives.'

Sefton Public Health Partnership

Physical activity

All categories of respondent demonstrated very strong support for the promotion of exercise and physical activity. This was often linked to recommendations for the provision of gym facilities at the workplace – or free or subsidised membership of outside gyms. A number of respondents urged action to encourage cycling or walking to work and group exercise activities during breaks.

'Walking and cycling are potentially the most accessible and the least expensive forms of exercise, since they can be built into the normal structure of the day, and because of the low overall costs.'

Sustrans

A few responses included data to illustrate the link between the promotion of physical activity and positive health outcomes.

Physical activity programmes at work reduce absenteeism by up to 20% and physically active employees take 27% fewer sick days [British Heart Foundation].

There may, however, be scope for further investigation into the extent to which initiatives designed to increase physical activity succeed in achieving sustained outcomes.

A review of the effectiveness of workplace interventions concluded that the use of posters and signs to promote the use of stairs had some effect, but possibly only for a short period; promotion of walking could be quite effective; active travel campaigns could increase walking (but not cycling) to work among economically advantaged women; counselling and health screening appeared to have a generally positive impact; and group-led exercise sessions appeared effective for women, but the improvements were not sustained beyond the short term [Dugdill, L et al., *A review of effectiveness of workplace health promotion interventions on physical activity...* 2007].

Compliance with health and safety provisions

Many responses, including most from trades unions or bodies representing employees, urged full compliance with health and safety regulations and rigorous enforcement of them as key to maintaining a healthy workforce. This was often linked with recommendations to make full use of safety committees and trades union safety representatives in the workplace as a means of promoting health and well-being and identifying negative impacts.

Over 15% of respondents to this question commented on the Health and Safety Executive (HSE), indicating a need to expand its role. Many employee representative groups commented on a perceived lack of funding for HSE to fulfil its role in improving workplace health and well-being, or suggested that health and safety regulations be widened to include health and well-being issues.

'Improving HSE inspector knowledge of OH and subsequent OH related enforcement action would arguably reduce occupational ill health and improve employee health.'

Senior Occupational Health Nurse Managers Group, NHS Scotland

Greater co-operation between employers, GPs and OH providers

Some respondents identified close collaboration between employers, GPs and OH providers as a critical factor; there was a view that, currently, GPs had little scope to acquire sufficient understanding of a patient's working conditions and of how a health condition would affect capacity to work. It was also suggested that employers did not fully understand how to deal with ill-health and how appropriate job adjustments could be made to support their staff in remaining in or returning to work.

'Communication, co-operation and common agreed goals between employers, employees, occupational health providers/advisers and primary care professionals could result in faster recovery and less time off work.'

Rotherham Occupational Health Advisory Service

The workplace as a channel for information on better health

Relatively fewer respondents appeared to address explicitly how the workplace could be used to promote health. Several, however, did identify the scope of workplaces as a forum in which a large section of the population could be targeted with messages on how to improve overall health.

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

South Ribble Borough Council

Workplaces were also identified as places in which particular groups might more easily be reached. Some evidence was offered of the effectiveness of such targeting.

'Work Fit [a lifestyle management programme for BT employees] was extremely successful. 4,377 [male participants] lost...an average of 2.3 kg...[and] up to two-thirds of participants reported sustained changes to their lifestyle.'

Men's Health Forum

How the responses informed the recommendations in the report

Chapter 3 (see page 60) recommends the creation of a health and well-being consultancy service to assist employers to recognise and implement many of the initiatives proposed by respondents. The report also proposes an expanded role for safety representatives in promoting health and well-being in the workplace.

Chapter 4 (see page 69) recommends a major drive to promote understanding of the relationship between health and work.

2

How can people best be helped to remain in or quickly return to work when they develop health conditions including chronic disease or disabilities?

Key themes

Around 50% of respondents addressed this question. The two general views expressed were that early intervention when health problems develop and the provision of various forms of flexible working were key factors.

Many respondents said that better provision of OH services was required, and an equally large number said that more needed to be done by employers. Some respondents made specific suggestions on how to facilitate the return to work, and some suggested the Government make changes to the relevant regulations and procedures.

OH and early intervention

Around a third of responses to this question stated that early intervention by health providers was key when health problems developed. Some respondents cited specific types of health conditions as requiring early intervention, such as mental health problems and musculoskeletal disorders (MSDs), but the majority thought that early intervention was critical for all health problems. However, very few of these respondents specified how quickly intervention was needed to be effective.

'Early intervention, with a clear aim of rehabilitation, is the best approach...'

Public and Commercial Services Union

Another third of responses said that better OH provision was required. The main suggestion, of just under half with this view, was that GPs needed better training in OH, and a better understanding of workplace factors and how these interact with health. A significant number simply said that there was a need for more and better-trained OH practitioners.

Of those who stated where OH services should be based, most were in favour of them being provided by the National Health Service (NHS). Almost as many felt that OH services were better provided by the employer or based in the workplace, but very few said that OH services needed to be independent of the employer.

'For doctors, especially General Practitioners, signing a 'sick note' is often the path of least resistance. Therefore, better undergraduate, and postgraduate education and training are needed in occupational health and occupational rehabilitation for all the relevant specialties and in general practice...'

Occupational and Environmental Health Research Group, University of Manchester

Role of the employer and flexible working

Over a third of responses to this question said that employers should offer flexible working options, including workplace adjustments, phased returns to work, reduced hours or part-time weeks, and home-working. Several respondents also suggested that employers should offer retraining where employees were no longer able to continue in their current role.

'Flexibility may be the determining factor as to whether the knowledge, skills and experience of a sufferer can be retained within an organisation'

Investors in People UK

Another third of responses proposed various ways in which employers could improve their handling of employees with health problems. The most common suggestions were: better training for line managers and human resources (HR) staff in dealing with health problems; early and regular contact between staff absent with ill-health and their managers and colleagues (to prevent isolation from the workplace); and more support for absent staff from the line manager and HR staff. Other suggestions were that there should be information and advice readily available for employers, and that employers needed good sickness absence management procedures.

'In the Society's view, line managers are likely to be a key determinant of whether individuals make a successful return to, and remain in, work...'

The British Psychological Society

Return to work

Several respondents made suggestions on how to ensure a prompt return to work. The most common was that a comprehensive rehabilitation programme (involving physiotherapy, cognitive behavioural therapy (CBT) and counselling) based on a case management approach should be available. The next most common was that a return to work plan should be developed as soon as a person was signed off work. A small number also said that it was essential first to identify the cause of the problem, conduct a risk assessment and remove that cause from the workplace.

'...there is an urgent need for a national framework of rehabilitation, underpinned by national standards.'

Trades Union Congress

An agreed rehabilitation plan in which the employee plays an active part is more likely to succeed, while relying on others to drive the process encourages the 'sick role' [Institute for Employment Studies, Thompson et al., 2003].

A number of respondents stated a need for better communication between the GP and employer. Other suggestions made were: there needs to be better communication between GPs and OH providers; there is a general need for better education that work is good for health and worklessness is bad for health; and that SMEs in particular need more support or help in providing OH services to their staff.

'GPs [should] work with local employers and engage with them to understand what constitutes reasonable adjustments.'

Lloyds TSB

64% of GPs did not realise the beneficial effects of being employed [Department for Work and Pensions survey, 2007].

What Government could do

A number of respondents suggested that the current sick note procedures should be revised, with around half of these specifically proposing that the certificate should show what people can do instead of what they cannot.

'People rarely visit their GP for a sick note without the preconceived idea that absence from work is necessary...'

NHS Plus

'We agree that the proposed move to develop and introduce new GP medical certificates that advise on fitness for work (a "fitnote" instead of a "sicknote") could help promote more positive attitudes and beliefs about illness and disability.'

Institution of Occupational Safety and Health

A number of respondents cited the 'Condition Management Programme' and 'Access to Work' as successful schemes for assisting people with health problems back into work and suggested they be extended. Another suggestion was that there should be more rigorous application of the Disability Discrimination Act to change employer attitudes to ill-health and tackle prejudice. A small number of respondents also said that health and safety regulations needed to be more rigorously enforced.

'...the Government's 'Access to Work' scheme and the help it can provide to people with long-term conditions is not widely known about by individuals with Rheumatoid Arthritis.'

National Rheumatoid Arthritis Society

A relatively small number of respondents said that there should be a change to the current sick pay regulations, with some saying the current system encouraged people to take time off work and some that the system discouraged people from taking time off work. A few respondents indicated a need to change the rules around sickness and disability benefits, stating that there were financial disincentives to move from benefits into work.

'If a person has dropped out of work due to sickness they must fundamentally want to return to work to achieve it. Structuring state schemes so that it is more lucrative to be in work than on benefits may help.'

Dr Paul Litchfield, Chief Medical Officer for BT

Some respondents said that employers should be prevented from taking disciplinary action following work-related ill-health absences.

How the responses informed the recommendations in the report

Chapter 4 (see page 69) recommends replacing the sick note with a new 'fit note' as key in enabling a return to work. The report also highlights the important role of healthcare professionals in enabling people to remain in or return to work, and recommends that a return to work should be seen as a key indicator of clinical success.

Chapter 5 (see page 82) sets out proposals for the creation of a new *Fit for Work* service to ensure early intervention is available when health problems develop.

Chapter 6 (see page 91) recommends that Government encourage, the provision of vocational rehabilitation services by employers.

Chapter 7 (see page 100) contains a series of recommendations to improve provision and standards of OH services.



3

How does the age of the person affect the support that is needed?

Key themes

Just over 40% of respondents addressed this question. Of these, around half made general comments, around half made comments specific to older people, and around a quarter made comments specific to younger people.

The main view was that although age did impact on the type of health problems people suffered, age in itself should not be the most significant factor in determining the support needed: it was more important to consider each person's individual needs. Suggestions were also made concerning the specific needs of older and younger workers.

All age groups

The majority view (of around 40% of respondents to this question) was that age was not a significant factor in determining the level of support needed, although slightly more support might be needed at either end of the age spectrum. Instead it was more important to consider individual needs through an assessment of the functional capacity, abilities and health conditions of each person. A few respondents suggested adopting the Finnish 'Work Ability' model in which each individual's 'work ability index' is continually monitored and maintained through appropriate interventions and adjustments throughout working life.

'...the Finnish government sponsored a massive education and training programme to ensure that the work ability approach was adopted...[there is] no reason why the UK government should not look closely at this example and seek to apply any lessons it can usefully learn.'

TAEN – The Age and Employment Network

Several respondents with this view also said that gender and ethnic differences were more important in considering the amount and type of support provided. Other respondents said early interventions to health problems were more effective regardless of age, and that the effectiveness of workplace interventions was not significantly affected by the age of the workforce.

'The important thing, when talking about any age or any other grouping of people, is that the person is treated as an individual, that the assessment process carefully maps out their individual needs and the package of care is tailored to meet these individual needs.'

Richmond Fellowship

'Ethnic minorities are more likely to be unemployed...[and] are less likely to have access to occupational health support either because the employer does not supply it or language barriers prevent effective communication.'

Scottish Trades Union Congress

Some respondents believed that workforces with a good cross-section of workers of all ages performed better than those with a limited demographic mix, with the experience of older workers complementing and enhancing the enthusiasm and energy levels of younger workers. Some also stated that negative employer perceptions of age (both young and old) needed to be tackled by more rigorous application of age-discrimination legislation.

Older people

Many respondents stated that older people were more likely to suffer from chronic health conditions. Specific health conditions viewed as common to older people were arthritis and MSDs (especially in people who previously worked in physical roles), as well as a general decline in physical capability.

'Generally speaking from a 'medical' standpoint, the older the person the more support is needed, as the prevalence of most chronic illness increases with age.'

Occupational and Environmental Health Research Group, University of Manchester

Percentage of people with a long-term condition which affects daily activity is 21% for 45-59 year olds but 40% for 60-74 year olds [2001 Census].

Another common view was that older workers tended to have fewer episodes of sickness absence but that these were for longer periods, partly because older people recovered more slowly from health problems. Several respondents also believed that older workers were more careful at work and so tended to have fewer accidents than their younger colleagues.

'Older workers are less likely to take short-term absences and more likely to be off for long periods'

NHS Plus

Several respondents stated that workplace adjustments would help older people return to work more quickly or prevent them from retiring due to ill-health. Commonly suggested adjustments were phased returns, offering flexible working hours or home-working, and retraining (particularly to facilitate changing from physical roles which may now be beyond older workers).

'For the ageing workforce, OH support needs to be focused on services being provided to help identify physical and capability problems...and to advise both employers and employees on modifying working practices to facilitate the most effective use of those workers.'

Commercial Occupational Health Providers Association

The general view was that health problems began to affect the ability of older people to work in the 50-55 age range, and that this was when a 'career check' would often be required to consider the next stage of their working life and/or workplace adjustments. This was also seen as the age when people had multiple caring responsibilities for children or grandchildren and older relatives, in addition to their normal work, and so could be under more pressure.

The age bracket 40-60 is the most common age for the onset of rheumatoid arthritis [National Rheumatoid Arthritis Society, *I want to work...Employment and RA, a national picture, 2007*].

Several respondents also made reference to the gender differences in ageing, to the lack of research into the different effects of ageing on men and women, and to how these could be countered to allow continued working. Another view was that the most effective means of countering the ill-health effects of ageing were improved diet and light exercise.

'Most occupational health research has focused on men; and in the case of studies on women, the focus has tended to be on younger women and hazards to the reproductive system.'

TAEN – The Age and Employment Network

'Although there is a need to determine the optimal diet and exercise regime for the older body, diet and exercise remain the interventions with the best evidence base for improving health.'

Prof. Janet Lord, British Council for Ageing and MRC Centre for Immune Regulation

Younger people

A commonly expressed view was that younger people tended to suffer more from emotional, stress-related or mental health problems. Possible causes included a lack of social and family support, and economic factors (as younger workers were likely to be in lower paid jobs). Several respondents stated that employers should pay more attention to the emotional needs of younger workers, for example by offering counselling services.

Another common view was that younger workers took larger numbers of short-term sickness absences. Some respondents implied that these were not all 'genuine' absences. Again, the lower status and pay of many younger workers was considered a factor in this by some respondents, and some commented on a lack of work ethic among the young.

Young people are more prone to short-term absences and older people are more prone to long-term absences [Bevan and Hayday, 2001].

The other common viewpoint was that young people needed more training and education in health issues, risk assessment and, in particular, the correct use of computer equipment. Several respondents suggested that this should occur at school, while others said that employers needed to pay more attention to the health and safety training of young workers. It was also said by some respondents that prevention of health conditions was more important for younger people, as any health problems that occurred at this age were more likely to develop into chronic conditions over the course of a long working life.

'Much more must be done to ensure that youngsters, their parents, and teachers, are aware of the risks associated with the use of...[various types of computer equipment] and the ever-increasing use of these.'

RSI Action

How the responses informed the recommendations in the report

Chapter 7 (see page 100) recommends the development of a sound academic base to underpin further research into OH, and the responses highlighted several areas where this might be focused such as gender differences in the effects of ageing on health.

Chapter 8 (see page 106) recognises the need to educate younger people on the benefits of work for health, and to broaden the 'Healthy Schools' approach to create expectations of the health and well-being support employers should offer.



4

How can we encourage action to improve employee health?

Key themes

Around 55% of respondents addressed this question, but the majority did so by referring to or expanding upon the responses made to the first question (see page 9), and only a quarter of responses introduced new themes. The most prominent was the importance of making the business case for investment in employees' health. A number of respondents urged the use of economic incentives, particularly tax breaks. Some proposed awards for good practice as an alternative form of incentive. The need to take account of the particular difficulties of SMEs was frequently raised.

The business case for investment in employees' health

A large number of respondents identified a need for employers to do more. Many suggested that employers needed to be persuaded of the economic benefits of action to improve their employees' health. Several highlighted the need for more research into the business benefits of healthcare provision and investing in health and well-being, particularly the need for better tools to gather data and determine the causal links between interventions and outcomes (see also question 8, page 41).

'There is a need to bring OH to the attention of senior executives and CEOs as a business risk that should be managed in the same way as any other risk.'

Institute of Engineering and Technology

'The business case for promoting and supporting employee health and wellbeing is becoming increasingly clear. Employers can gain clear benefits in reducing employee turnover and increasing the productivity and engagement of their employees.'

Chartered Institute of Personnel and Development

Over four out of five organisations (83%) felt the responsibility in maintaining health and well-being is equally shared between the employer and employee. Whilst most of the remainder (15%) felt it was mostly the responsibility of the employer, only 2% felt the responsibility rests with the employee. [Investors in People UK survey, November 2007].

Incentives for investment

A large proportion of respondents identified a need for positive incentives: tax relief on the provision of OH services or other facilities (such as subsidised gym membership) was the most commonly cited example. Lower insurance premiums for employers with health and well-being strategies and discounted private health insurance were also mentioned. A small number of respondents identified possible disincentives to investment and urged their removal. For example, one OH provider suggested that arrangements for long periods of paid sickness absence within organisations could be a disincentive to purchase OH services.

'...over two thirds responding [to the Chamber's survey] stated that 'tax breaks' would encourage their organisations to offer health/wellbeing initiatives to staff whilst well over half would be encouraged by 'funding/grants' for such activities.'

Northamptonshire Chamber of Commerce

'Changing the tax system to make health improvement and promotion activities deductible against tax, rather than them being included as a taxable benefit as is sometimes the case, would go a long way to making a difference to an employer's decision on investing in health improvement at work.'

Scottish Centre for Healthy Working Lives

Some respondents recommended the use of awards for organisations demonstrating exemplary good practice in promoting employees' health: the Scottish 'Health at Work' scheme was cited as an example.

SMEs

A recurring theme was the need to take special account of the particular difficulties encountered by SMEs which did not have the resources to run health promotion initiatives or provide healthcare services independently.

There was a perception that SMEs might be reluctant to employ people with existing health conditions because of the cost of workplace adjustments or sickness absences; one respondent drew a parallel with press reports that SMEs employed fewer women to avoid maternity pay. There was also a view that SMEs did not actively manage the return to work of sick employees because they lacked the knowledge and skills to implement rehabilitation programmes or feared accusations of harassment which could lead to civil action. Several respondents stated that SMEs needed clear guidance and advice to overcome their lack of resources and knowledge, greater incentives such as tax and insurance breaks, and additional support (possibly from the third sector).

'[The Treasury should consider how]...the tax regime could be used to incentivise SMEs to adopt good occupational health practices.'

The Focus Group

'Small businesses represent over 99% of all businesses and make up over half of UK turnover...it is therefore vital that the interests of small businesses are taken into consideration in the workplace health debate.'

Federation of Small Businesses

SMEs view the main barriers to successfully managing sickness absence as: confusion or lack of clarity around the help available from government agencies and departments; confusion and lack of clarity around both employee and employer rights; lack of access to NHS treatment or diagnosis [Federation of Small Businesses, *Health Matters*, 2006].

How the responses informed the recommendations in the report

Chapter 3 (see page 60) recognises the need to develop a model for measuring the benefits of investing in employee health and recommends promoting employers' understanding of the business case. The report also recommends exploring ways to assist SMEs in establishing health and well-being initiatives.

5

What underlies the apparent growth in mental health problems in the working age population and how can this be addressed?

Key themes

Over 40% of respondents addressed this question. There was a consensus that mental ill-health in the workplace was an issue of significant concern, even though the apparent growth could be due to under-reporting in the past. Respondents generally had firm views as to the causes, with increased work intensity the most commonly cited. There was also recognition that this was an area in which there was strong interaction between workplace, domestic and wider societal factors.

Those who specifically responded to the second part of the question offered a wide range of suggestions, the majority of which related to better practice by line managers, more flexible working practices and wider provision of support and therapeutic services.

Greater acceptability of admitting mental health problems

Many respondents suggested that the increase in recorded cases of mental health problems was, to a significant degree, due to the diminishing stigma attached to the admission of such problems. Most respondents making this point appeared to believe that the reported incidence of mental ill-health was still increasing and was at a level which justified serious concern. Several quoted statistics that around 40% of incapacity benefits claims were based on mental health problems and drew attention to an increased demand for counselling.

BUPA receives around 4,000 calls a month to its telephone advice lines. Around 750 of those callers are referred for face-to-face counselling because of mental health issues; this represents a 17% increase since last year. Around 14% of calls received are about relationship problems, 11% general anxiety and 9% workplace stress [BUPA].

Whilst GPs and occupational health providers supported the view that there was an increasing trend in cases of mental ill-health, psychiatrists did not [Occupational and Environmental Health Research Group, University of Manchester].

Underlying causes: work intensity and societal factors

As to the nature of the underlying causes, many respondents cited stress generated by a range of factors, many of which could be generically characterised as ‘increased work intensity’; having to handle heavier workloads with fewer resources, increased monitoring within more target-driven working environments, and the pace of organisational change were often mentioned. Several respondents also cited bullying, harassment and, more generally, poor relationships with colleagues and managers. The difficulties of reconciling work and domestic responsibilities were also raised; this could be linked to another recurring theme, the breakdown of traditional support structures, particularly family and social networks. Consumerism and increasing aspiration were quite often cited as powerful societal factors.

‘There is little evidence that, universally, psychoses and severe mental health conditions are increasing but the concept of stress as a mental health problem has grown exponentially in recent years.’

British Association for Counselling and Psychotherapy

Relatively fewer respondents identified a possible connection between physical ill-health (or factors such as poor diet and lack of exercise) and symptoms of mental ill-health; some evidence on such a link was, however, submitted by respondents with a specific interest in certain areas of ill-health.

State of the evidence base

While there were some references to specific research in this area, several respondents, particularly from professional bodies, concluded that this was an area in which further research was necessary.

'Good evidence on the causes of the rising trend in incapacity attributed to mental health problems is lacking, and this is a priority for research.'

Faculty of Occupational Medicine and Society of Occupational Medicine

Preventative action through the workplace

A number of respondents referred generally to good management practice or support in the workplace as a means of tackling the work-related underlying causes.

More specific suggestions included greater availability of flexible working arrangements, avoidance of the 'long hours' culture, better design of the physical office environment and addressing travel as a possible stressor. Some responses, mainly from bodies representing employees, proposed stronger compliance with HSE's Management Standards for Work-Related Stress.

'The solution is access to early intervention services, which is crucial to the management of the growth in reported cases of mental health. Employers can assist by increasing the availability of stress management services such as employee assistance programmes (EAP). Mental health services, such as crisis teams which address early onset, should be promoted. This can be facilitated through awareness programmes in schools and youth services and by employers.'

Association of British Insurers

Remedial action

CBT was cited by several as an approach shown to have been effective. One of the most specific solutions proposed was the Mental Health First Aid training course used in Australia.

'Mental Health First Aid training appears to be effective in improving some aspects of mental health literacy, confidence in providing help to others, and the type of help provided. The training also benefits the mental health of participants. The course is highly acceptable in a workplace setting and could be widely applied.'

National Institute for Mental Health in England, part of the Care Services Improvement Partnership

How the responses informed the recommendations in the report

In Chapter 4 the Healthcare Professionals' Consensus Statement on Health and Work (see page 67) includes a commitment to tackle the stigma associated with mental ill-health.

Chapter 6 (see page 90) recommends fully integrating health support with the employment and skills agendas, developing a mental health employment strategy, and reviewing mental health support policies.

6

What constitutes effective occupational health provision and how can it be made available to all?

Key themes

Just under 50% of respondents addressed this question. Nearly all of these supported some form of national OH provision for all working age people.

The other main themes were how to ensure availability of OH provision, the features of effective OH provision and how to improve the quality of OH services. The responses encompassed a diverse range of suggestions.

How OH should be provided

The most common recommendation was that OH services be supplied through either the NHS or a new 'National OH Service'. Some respondents suggested a greater involvement by HSE or workplace health and safety representatives working alongside OH providers. Other responses (from very few respondents in each case) variously suggested that OH not be provided through the NHS; that it be provided by employers, not provided by employers, or provided by a combination of employers and central government; that the 'Access to Work' scheme be extended; or that OH be provided via GPs. Some responses also suggested a greater role for the voluntary sector.

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

Faculty of Occupational Medicine and Society of Occupational Medicine

'Access to occupational health advice should be available via Primary Care, as a complement to GP services.'

Rotherham Occupational Health Advice Service

'Making occupational health provision available to all will necessitate the involvement of all sectors...the private sector, which can tailor services to the needs of individual businesses can deliver occupational health services across the UK economy...'

Association of British Insurers

Some respondents suggested that there be a statutory obligation on employers to provide OH services, and others that there be tax breaks or a change in the tax laws to encourage employers to provide OH. A significant proportion of respondents acknowledged the problems faced by SMEs, but few specific suggestions were made on how to resolve these.

'...[OH provision for SMEs] may be viable where local businesses around the area could support an occupational health presence for the area which all local companies could help finance and help to facilitate.'

Dairy Crest Nottingham

As regards where OH service providers should be based, the few respondents who mentioned this were split equally between GP surgeries, the workplace and regional/local OH centres as the appropriate location. A few responses also suggested the creation of specialist OH centres to deal with specific health conditions.

'...suitable investment in community based healthcare advisors will have to be made if such professionals are to be available to everyone with a long term condition or other health problem who wishes to remain in employment.'

National Rheumatoid Arthritis Society

Other more general comments were that there was not enough access to OH services, that access was concentrated in low-risk sectors and not where needed, and that there were too few OH professionals to provide adequate services. The suggestion was also made that OH contracts be outcome-based and not 'click-point' (i.e. doctors would be paid for enabling a return to work rather than just for seeing each patient).

'In general overall occupational health provision is highest (some 50%) where disease incidence is the least and lowest (some 5%) in primary industries (mining, agriculture, fishing, manufacture) where disease incidence is highest...a striking example of the inverse care law.'

Anthony Newman Taylor, Head of the National Heart and Lung Institute

20% of workers have access to OH provision, while less than 5% have access to more comprehensive support [HSE statistics].

Specific features of effective OH

In considering the specific features that an effective OH service should comprise, several suggestions were made. The most common was that OH services needed to be fit for purpose and varied to meet the specific needs of different sectors or workplaces, rather than being applied uniformly. Other common recommendations were that good OH provision should include: a preventative/proactive approach; promotion of health and well-being in the workplace; early intervention linked to effective absence management procedures; comprehensive rehabilitation services with a clear focus on the return to work; and effective risk assessment and management.

'Occupational Health should be workplace/sector specific. It should be knowledgeable and responsive to the specific problems in the workplace.'

UK National Work-Stress Network

Several respondents said OH should include screening and health monitoring. The few responses that mentioned pre-employment screening were equally divided between those in favour and those against it. Some responses made reference to an 'holistic' approach to OH, or to using the biopsychosocial model to complement OH services. Other respondents said that OH providers should suggest flexible working or workplace adjustments, and that functional capacity assessment to determine fitness for work was required. The inclusion of counselling services was mentioned by some. A small number made reference to the effectiveness of case management, or said that OH needed to encompass a general multi-disciplinary approach.

'...increased employer investment in psychological aspects of occupational health will potentially be offset by savings in the costs of sickness and absence.'

The British Psychological Society

It was also suggested that OH should be confidential, independent, or freely available (so that individuals need not go through an employer) to encourage uptake. Some respondents recommended that effective OH needed to incorporate greater communication and collaboration between GPs, OH providers, employers and employees. A need for a greater understanding of OH issues by both employers and employees was also mentioned.

'...poor communication can impact on the standard of care we exercise in our day-to-day occupational medical practices...[and] can damage the outcome of OH care to the detriment of the working populations which we serve.'

Centre for Health in Employment and the Environment

OH training and standards

Several respondents said that more training on OH issues was needed. The majority of these stated that GPs needed more training in OH and workplace issues. Some respondents said that additional training was needed for OH professionals or for general medical staff. A number of respondents stated that there was a need for accreditation of OH providers or a national framework of standards for OH.

'...there needs to be provision of knowledge and skills for the widespread training of GPs in health and work issues, the evidence for the health benefits of work, handling return-to-work consultations and motivational interviewing.'

Royal College of General Practitioners

Some respondents also stated that more research was needed into OH and the causes of modern occupational diseases.

How the responses informed the recommendations in the report

Chapter 4 (see page 69) proposes establishing a network of GPs interested in health and work as a source of expertise in work-related health issues.

Chapter 5 (see page 82) recommends the creation of a *Fit for Work* service to provide OH support on a national basis.

Chapter 7 (see page 100) recognises the need for better standards in OH provision and makes a number of recommendations to achieve this.

7

What would be the impact on poverty and social inclusion of a healthier working age population?

Key themes

Around 35% of respondents addressed this question. All agreed that improved health would have a positive impact on poverty and social inclusion, and some correspondingly stated that reduced poverty would lead to better health. A few suggested, however, that the causal links might be more complex than was immediately apparent and that further research may be required to justify certain interventions.

Some respondents stated the need for 'good jobs' to improve or maintain health. Other issues raised were the special needs of disabled people, the impact on families and communities of individuals' sustained return to employment, and regional variations in ill-health and lack of work.

Positive impact of improved health on social inclusion

All respondents addressing this question believed that a healthier working age population was directly correlated with reduced poverty and greater social inclusion, less time off work and fewer incapacity benefits claimants. Individuals would benefit from improved economic status and the social networks acquired through employment.

'A healthier working age population should result in better employment prospects for individuals, and better economic prospects for them and their community. Poverty should be alleviated and self-esteem and social inclusion should also increase as result of a healthier working age population.'

Occupational and Environmental Health Research Group, University of Manchester

Many respondents suggested that the connection was so strong as to be self-evident, but a number drew attention to attendant uncertainties which may need to be resolved.

'The impact on poverty and social inclusion cannot be decisively stated here without conducting a detailed study into socioeconomic factors that influence these areas. These factors are constantly changing in the UK and are strongly influenced by migration and economic stability.'

AXA Insurance

'We know that unemployment can lead to poverty and social exclusion, and a reduction in these adverse outcomes would therefore be expected from fuller employment of people with impaired capacity to work. However, it is difficult to quantify the benefits that might be expected.'

Faculty of Occupational Medicine and Society of Occupational Medicine

The need for good jobs

A significant number of respondents (primarily employee representative organisations and individuals) suggested that sustained improvements in health could be compromised by jobs of poor quality, but some also stated that 'good' jobs could be good for health.

'...we caution against the notion, for which we can see no evidence, that all work is automatically good for your health...work does make millions ill.'

National Hazards Campaign

'There is no reason to doubt many recent Government and other reports on the positive effects of work on health and well-being, provided, of course, that the work is well organised and safe.'

Public and Commercial Services Union

Disabled people, communities and regional variations

Some respondents, particularly those representing disability charities, drew attention to the special needs of disabled people, including those suffering mental ill-health.

A third of lone parents out of work also have a disability and high numbers of families living in poverty have a disabled member. Evidence on inter-generational worklessness indicates that improved employment levels also increases the chances of their children being employed in the future [Remploy].

More generally, the ‘ripple’ effect on families and communities of enabling individuals to return to employment was identified by a number of respondents.

‘Although the average risk of a child being poor in 2005/6 was 22% (before housing costs) and 30% (after housing costs), the risk of subgroups of children being poor varies hugely by household characteristics. Children living in workless households are particularly at risk of poverty.’

Child Poverty Action Group, cited by the Sainsbury Centre for Mental Health

Studies by End Child Poverty and the Child Poverty Action Group show a strong correlation between child poverty and households where one or both parents were in receipt of incapacity benefits [Shaw Trust].

Some responses also offered evidence of regional patterns in ill-health and associated unemployment.

‘Significant health inequalities still exist across the UK. There is a marked variation in mortality and morbidity depending on geographical location. These inequalities are often linked to poverty and worklessness.’

Local Government Employers

‘...in addition to the physical delivery of occupational health services consideration has to be given to setting up research functions in each country...’

Scottish Trades Union Congress

How the responses informed the recommendations in the report

Chapter 6 (see pages 90-91) makes various recommendations to improve employment prospects for workless people, particularly those with disabilities.

Chapter 8 (see page 106) recognises the need to raise awareness of the benefits of work, and of the positive effects on families and communities.



Fitter workers boost productivity



...your people



8

What are the costs of working age ill-health to business and what are the benefits to companies of investing in the health of their staff?

Key themes

Over 40% of respondents addressed this question. Many respondents cited specific costs and benefits, of which the most common were productivity, levels of sickness absence, retention of staff and skills, staff morale and the reputation of the company as a 'good employer'.

More generally, many respondents stated that investment in health was cost-effective, while some said that there was insufficient research into the costs and benefits of investing in staff health and the tools for measuring them; this seemed to be borne out by the widely varying figures quoted in responses.

Costs and benefits

A number of responses simply identified the costs and benefits as 'significant' or 'massive'. Several also stated that the costs of working age ill-health were borne not only by the employer, but also by the taxpayer (through benefits payments, NHS costs and lost tax revenue) and by staff themselves.

'We believe that everyone benefits when staff are happy and healthy at work.'

Shaw Trust

A large number of respondents identified specific business costs of ill-health and benefits of investing in the health of staff. The most common costs and benefits (all expressed here, for simplicity, in terms of benefits) were: increased productivity; reduced number of sickness absences; reduced staff turnover and increased retention of skills; and improved staff morale. Also cited were: reduced recruitment and training costs; improved company reputation as a 'good employer'; and improved financial performance and competitiveness.

'Healthy staff are known to be more productive...'

NHS Plus

Higher levels of physical activity are associated with improved quality of work and overall performance [Pronk et al., 2004].

Less common costs and benefits identified (again all expressed as benefits) included: reduced stress levels (from less extra workload to cover staff absence); improved staff motivation and commitment; reduced legal costs (from compensation claims); reduced costs of sick-pay; improved quality and consistency of services; and lower insurance and private health care costs.

'For an employer, the costs of ill-health include production losses, costs of rehabilitation, recruitment and training, legal sanctions, reduced competitiveness and flexibility, loss of quality and damage to reputation...'

Faculty of Occupational Medicine and Society of Occupational Medicine

Other issues identified only as benefits were: fewer accidents and injuries; quicker return from injury; less redundancy pay and early drawing of pensions; and staff able to continue working into old age. Other specific costs were: hiring temporary or agency staff to cover absences; cost of management time spent on absence procedures; presenteeism (lower productivity caused by ill-health at work); rehabilitation costs; and lower quality of life for staff.

'There is increasing evidence to show that active people may be more productive at work and suffer less sickness. Employers therefore have much to gain from helping their staff to enjoy good health...by being physically active.'

Sustrans

The evidence base

A number of respondents stated that there was insufficient research into the business case for investing in the health of staff, with some also pointing out that it was difficult to identify exact causal links. One suggestion was that companies monitor absence rates, staff satisfaction via surveys and overall company reputation. Another respondent stated that it was significant that responsible employers invested in the health of their staff despite the lack of hard data.

'The unwillingness of companies to invest in the health of their workers may stem from the lack of comparative studies setting the costs of the benefits of intervention policies against the costs of a 'do nothing' scenario.'

Royal National Institute of Blind People (RNIB)

'There is actually surprisingly little evidence on what the total costs, both direct and indirect, are to business. That so few businesses spend time calculating the costs could be one explanation for why relatively few of them are investing in employee health measures.'

Association of British Insurers

Many respondents stated that the benefits of investing in the health of staff outweighed the costs. Specific interventions described as cost-effective included: general investment in health and well-being; the provision of OH services; the use of rehabilitation and/or a case management approach; and offering counselling.

'Evidence suggests that workplace health promotion programmes can be cost-effective to employers and potentially valuable disease management tools.'

Oxford Health Alliance

However, where evidence was supplied to substantiate these statements it was often divergent. For example, different responses quoted the rate of return for every £1 invested by employers in health and well-being initiatives, such as rehabilitation, as varying from £1.66 to £4. Other responses quoted various estimates of how many billions of pounds ill-health costs the British economy. This strongly indicated the need for further research both into standard metrics for measuring the return for businesses investing in the health of their staff, and into the overall costs to the economy of ill-health.

'Further work in this area is needed to provide a firm business case that can then be used to influence senior executives and business owners.'

Institute of Engineering and Technology

Only 45% of companies measure the cost of sickness absences [Chartered Institute of Personnel and Development survey].

How the responses informed the recommendations in the report

Chapter 2 establishes the first ever baseline for measuring the health of the working age population and sets out the costs to the economy of ill-health, and Chapter 9 states that this should be updated and assessed on an annual basis. The importance of doing so was illustrated by the divergent estimates of the costs of ill-health to the economy included in the responses.

Chapter 3 (see page 60) recognises the need to promote the business case for employers investing in the health of their staff. The report also recommends developing a robust model for measuring the benefits of employer investment in health and well-being, and the review *Building the case for wellness* (published by PricewaterhouseCoopers alongside this report) provides a framework for employers to implement health and well-being initiatives in the workplace.



Discussion events

Six events were held during November, at which health practitioners, employers and other key stakeholders came together to discuss the Review with Dame Carol and her team.

The venues for the events were:

- Sheffield (9 November 2007) hosted by the Sheffield Occupational Health Advisory Unit; the event was also attended by the Rt. Hon. David Blunkett, who launched the Health and Well-being Strategy in 2005.
- Cardiff (12 November 2007) hosted by the Welsh Assembly Government; the event was also attended by Chris Tudor-Smith, the Head of the Public Health Improvement Division.
- Birmingham (14 November 2007) co-hosted by the Birmingham Health and Well-being Partnership and the Birmingham and Solihull Employment Strategy Group, in association with Eastern Birmingham PCT; the event was also attended by Lord Hunt of Kings Heath, Parliamentary Under Secretary at the Ministry of Justice.
- Edinburgh (16 November 2007) hosted by the Scottish Centre for Healthy Working Lives; the event was also attended by Lord McKenzie of Luton, the Department for Work and Pensions Minister with responsibility for Health and Work.
- Manchester (22 November 2007) hosted by the North West Workplace Health Network.
- Nottingham (26 November 2007) hosted by the ACAS East Midlands Relations Forum.

At these events the attendees were asked to discuss the following questions.

- What can be done to prevent ill-health, accident or injury developing at work in the first place?
- What can be done to promote healthy living within the workplace?

- How can a person be supported at work so that having or developing a health condition does not mean they end up leaving work?
- How can we rehabilitate people with ill-health back to work as quickly as possible?
- What are the key health and well-being features of a 'good job' that employers should consider in helping people be motivated, productive and satisfied within the workplace?
- How can health professionals and employers work together better to reduce sickness absence?
- What should be the interaction between primary care and occupational health?
- What incentives and disincentives are currently in the system, and how should these change?
- How can the healthcare system better support those with mental health problems?
- How does occupational health support need to change to reflect the needs of older workers?

The results of these discussion events were then analysed, and the following common themes were identified.

In the workplace

- Employers need clear guidance on assistance and interventions available to improve workplace health.
- Care should be taken not to over-complicate health and safety measures.
- SMEs find it particularly difficult to deal with workplace health problems.

Sick notes

- The current sick note is too restrictive with employees either signed off work or not, but this overlooks the fact that people can often still work if appropriate consideration is taken of their health conditions – and work can actually aid recovery.
- The sick note needs to be changed to focus more on fitness for work – on what people can do rather than what they cannot. This change must be underpinned by improved communication between employers and GPs.

Occupational health

- OH should be available to all, including SMEs. OH provision needs to be based in primary care as part of the mainstream NHS, and delivered locally using national guidelines on best practice.
- OH must include promotion of employee health and prevention of workplace illness, with a focus on early intervention and rehabilitation using a broad range of medical service providers.

Mental health

- The stigma of mental health issues should be tackled through awareness campaigns to address employer and public perceptions.
- Work can be good for people with mental health problems as it supplies a source of social support and a sense of feeling valued.

In addition, specific themes which emerged from each event are summarised in six Event Summary brochures, which are available on the Health, Work and Well-being website.

www.workingforhealth.gov.uk





Appendix – List of respondents

The following provided a written response to Dame Carol's Call for Evidence:

Organisations:

Active Swindon	British Occupational Hygiene Society
Advisory, Conciliation and Arbitration Service	BUPA
Affinity Health at Work	Burnley Borough Council
Age Concern Training	Business in Sport and Leisure
Arthritis Care	Business in the Community
Association of British Insurers	Calderbank Research Unit
Association of NHS Occupational Physicians	Carers' Support Group
AstraZeneca	Centre for Health in Employment and the Environment
Atos Healthcare	Centre for Workplace Health
Auracle Music	Chartered Institute of Personnel and Development
AXA Insurance	Chartered Society of Physiotherapy
BackCare	Chronic Pain Policy Coalition
Barnsley PCT and Barnsley MBC	College of Occupational Therapists
Berrymans Lace Mawer	Commercial Occupational Health Providers Association (COHPA)
Big Lottery Fund	Communities and Local Government
Blackburn with Darwen tPCT	Confederation of British Industry
Bonnetts Estate Agents	Dairy Crest Nottingham
Brighton and Hove City Council	Department of Wellbeing Safety and Health, University of Leeds
Bristol City Council	Developing Partners Ltd
British Association for Counselling and Psychotherapy	Digital Inclusion Team, City of London
British Heart Foundation	Dyfed-Powys Police
British Medical Association	Economic and Social Research Council
British Occupational Health Research Foundation	

Employee Ownership Association
 Faculty of Occupational Medicine
 and Society of Occupational
 Medicine
 Faculty of Pain Medicine, Royal
 College of Anaesthetists
 Federation of Small Businesses
 First Health Solutions
 Forth Sector
 Glasgow Centre for Population
 Health
 Global Corporate Challenge
 GMB
 Health ClusterNET
 Healthcare Commission
 Healthy Leeds Work and Health
 Partnership, Leeds City Council
 Humberside Police
 Industrial Injuries Advisory Council
 Institute for Employment Studies
 Institute of Employment Rights
 Institute of Engineering and
 Technology
 Institution of Occupational Safety
 and Health
 InterAct
 Investors in People UK
 Joseph Rowntree Foundation
 King's College London
 Lancashire County Council
 Leeds Mind
 Leeds Occupational Health Advisory
 Service
 Lloyds TSB
 Local Authorities Coordinators of
 Regulatory Services
 Local Government Employers
 Macmillan Cancer Support
 Medical Research Council
 Men's Health Forum
 Mind
 National Association of Master
 Bakers
 National Association of Probation
 Officers
 National Hazards Campaign
 National Institute for Mental Health
 in England, part of the Care Services
 Improvement Partnership
 National Institute of Adult Continuing
 Education
 National Rheumatoid Arthritis Society
 National Social Inclusion Programme
 Newcastle City Council
 NHS Employers
 NHS Plus
 NHS Working in Partnership
 Programme
 No Limits Consultancy
 North East Regional Workplace
 Health Group
 North West Leicestershire Council
 for Voluntary Service
 Northamptonshire Chamber of
 Commerce
 Occupational and Environmental
 Health Research Group, University of
 Manchester
 Occupational Health Department,
 Guy's and St. Thomas' NHS
 Foundation Trust
 Occupational Health, Rolls Royce
 PLC
 Oxford Health Alliance
 Positive People Company

Powys Equals Partnership	Sheffield Occupational Health Advisory Service
Premier Therapy	Socialist Health Association
Preston Road Neighbourhood Development Company	South Ribble Borough Council
PsychologyOnline	South West Association of Occupational Physicians
Public and Commercial Services Union	Southampton Action for Employment
Public Sector People Managers' Association with Wellkom	Staffordshire Condition Management Programme
Rape Crisis, England and Wales	Strategic Promotion of Ageing Research Capacity
Regional Development Agencies	Sustrans
Regional Health in the Workplace Group, North East	System Concepts
Remploy	TAEN – The Age and Employment Network
Rethink	The British Pain Society
Richmond Fellowship	The British Psychological Society
Rotherham Occupational Health Advice Service	The Focus Group
Royal College of Anaesthetists	The Papworth Trust
Royal College of General Practitioners	The Work Foundation
Royal College of Nursing	Tomorrow's People
Royal College of Nursing OH Forum Wales	Trades Union Congress
Royal College of Physicians of Edinburgh	Travelchoice Team, Peterborough City Council
Royal National Institute of Blind People (RNIB)	UK National Work-Stress Network
Royal Society for the Prevention of Accidents	Union of Construction Allied Trades and Technicians
RSI Action	Unionlearn Students, TUC Education Department
Sainsbury Centre for Mental Health	UNISON, Joint Branch Officer, Health and Safety
Scottish Centre for Healthy Working Lives	University and College Union
Scottish Trades Union Congress	Vitality Healthcare, Simplyhealth Group
Sefton Public Health Partnership	Warwickshire County Council
Senior Occupational Health Nurse Managers Group, NHS Scotland	WorkDirections UK
Shaw Trust	Workers Health Advice Team, Bradford
	Working Families

Individuals:

Anonymous
Apanowicz, Stephen
Appleton, Dave
Armstrong, Val
Atkinson, Marion
Atkinson, Steve
Attwood, Claire
Austen, Brian
Baker, Paul – Consultant Occupational Physician
Batt, Mark – Consultant in Sport and Exercise Medicine
Bennett, Claire – Service Development Lead Physiotherapist
Betts, Anna – Lead Nurse
Birkin, Richard
Boldison, Martin
Boswell, Tim – Member of Parliament
Bugeja, Martin – Occupational Health and Safety Officer
Bullock, Sarah – Carer / Nursing Auxiliary
Bushell, Jerry – Counsellor / Psychotherapist
Chandler, Phil – Health and Safety Manager
Chapman, Henry
Chauhan, Dipak – Chair of Occupational Health, Safety and Ergonomics Network
Crouch, Pippa
Davies, Nigel
de Groot, Julie – Senior Occupational Advisor; Greenfield, Lesley – Occupational Health Advisor; Miller, Carole – Occupational Health Consultant
Denny, Victoria
Dickson, George
Dugdill, Lindsey – University of Salford; Brettle, A – University of Salford; Hulme, C – University of Leeds; McCluskey, S – University of Leeds; Long, AF – University of Leeds
Findlay, Vernon
Ford, Jim – Consultant Occupational Physician
Frank, Andrew
Galasko, Charles
Glenn, Sandra – Occupational Health Nurse Adviser
Hannon, Michael
Hansen, Liz
Hanson, Margaret – Principal Ergonomist
Hardcastle, Amanda
Hatton, Steven
Hawes, Gary
Head, Jenny – Reader in Medical and Social Statistics
Heasman, David – Lead Occupational Therapist
Hillier, Des – Corporate Health and Safety Manager
Hobbs, Sheila – Senior Nurse
Holland, Philip – Occupational Health Adviser
Holroyd, Gillian
Howell, Linda
Hughes, Mark
Hughes, Rob – Human Resources Director
Hyde, Patrick

Ingram, Alan

James, Pippa – Occupational Health Practitioner

Jewel, Anne – Deputy Head of Occupational Health & Safety

Johnston, Keith; Cross, Charlotte; Davies, Geoff; Graham-Cumming, Andy; Harling, Kit; Horan, Karen; Jarvis, Lionel – Surgeon Commodore Royal Navy; Palmer, Keith

Jones, Colin

Jones, Terry – TU Health and Safety Representative

Kelvin, Wendy

King, Janine

Lambley, Chris

Lee, Stephen-Andrew

Leftwich, Will

Lloyd, Paul

Longstaff, Sylvia

Lord, Janet – Professor of Immune Cell Biology

Marchant, Lynn

Marsh, Doug

Matthews, Kate – Occupational Health Nurse

McGauley, Stephanie

McKay-Harris, Andre

Mercer, Margaret – Occupational Health Manager

Midgley, J.

Mills, Matthew – Specialist Registrar in Occupational Health

Morris, Martin – Workplace Health Adviser; Tancred, Geoff – Health and Fitness Co-ordinator

Naether, Robert

Newman Taylor, Anthony – Head of the National Heart and Lung Institute

Owen, Lindley – Consultant in Public Health

Owens, Andy – Health and Safety Adviser

Parkes, Ken

Peters, Chris

Playford, Diane – Senior Lecturer/ Consultant Neurologist

Poole, Linda

Preece, Richard – Specialist in Occupational Medicine

Price, Malcolm

Purvis, Anne

Quant, Julia

Rayner, Clare – Specialist Occupational Health Physician

Render, Mary – Health Promotion Strategy Manager

Richold, Chris – Head of Health and Safety Services

Roberts, Nora – Health and Wellbeing Advisor

Roberts, Vanessa

Routledge, Julia – Occupational Health Manager

Russo, Stuart

Sainsbury, Roy

Seabrook, Sarah

Sell, Reg

Sheikh, Raian – GP

Sihera, Elaine

Singh, Saminder

Smith, Katherine – Occupational Health Specialist

Smith, Malcolm

Smith, Norman – Health and Safety Representative

Stephens, Rod – Health and Safety Representative

Stevens, Gillian – Senior
Occupational Therapist; Winstanley,
Leonie – Clinical Specialist
Occupational Therapy
Sumner, Steve
Sweetman, Brian – Consultant
Rheumatologist
Thompson, Steve
Thurgood, Judy – Clinical Specialist
Occupational Therapist
Tissiman, Howard
Torrance, Ian – Consultant
Occupational Physician
Turley, Steve – GP & Occupational
Health Physician
Wallis, Gayna – Nurse
Way, Laura
Whatley, Veronica
Wildgoose, Alastair – GP
Williams, Colin – Occupational
Health Manager
Wooley, Julie – Head of Occupational
Health and Safety
Wraith, Graham – Health and Safety
Officer

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