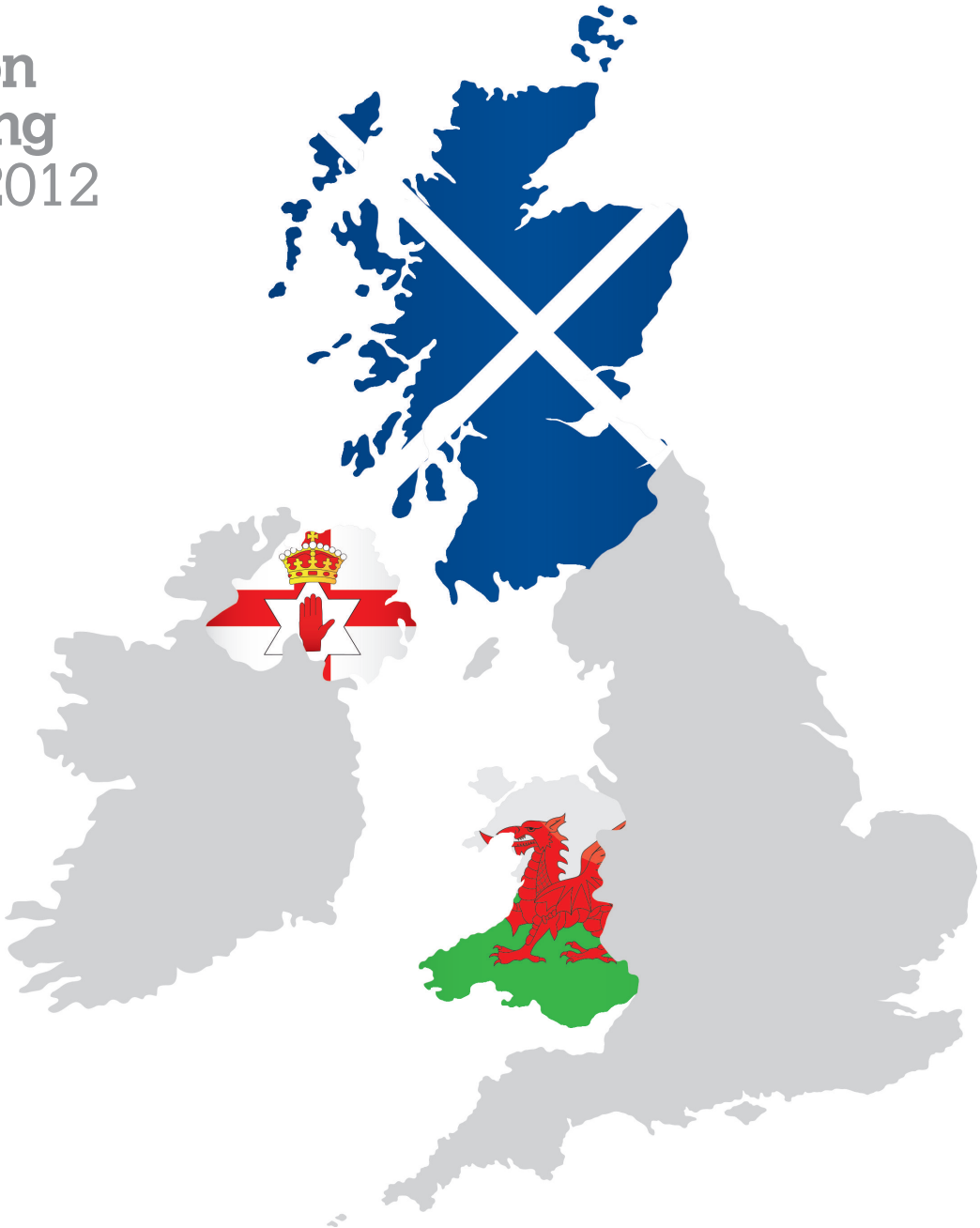
Work as a Health Outcome in the Devolved Nations:

How Scotland, Wales and Northern Ireland Tackle Sickness-Related Worklessness

Mark Weston
Julia Manning
December 2012



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About this publication

In June 2010 we published the report 'Health, disease and unemployment: the Bermuda Triangle of Society' which recommended that getting people back to work should become a key objective and outcome indicator for all health services.

Following this, in 2011, we published the report 'Working Together: promoting work as a health outcome as the NHS reforms'. We found that England performs poorly by international standards in tackling sickness related worklessness. Moreover, the proportion of adults in Britain who are unable to work due to health problems has tripled since the 1970s. These are statistics which can be, and should be, improved on.

Drawing on our findings, this third publication looks at the responsibilities and opportunities that the newly established Health and Wellbeing Boards have in improving sickness related worklessness. This report gathers lessons from Scotland, Wales and Northern Ireland, whose efforts are often more developed than in England, and make recommendations for Health and Wellbeing Boards as well as those with whom they will be working.

We feel this report is timely as we wait for the Department for Work and Pensions response to the 'Sickness absence review' and also following the 'Work Capability Assessment' (WCA) programme.

We are indebted to Abbott who enabled this report to be undertaken with an unrestricted educational grant. As well as driving our on-going work such support enables us to communicate with and involve officials and policy makers in the work that we do. Involvement in the work of 2020health is never conditional on being a sponsor.

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1 Executive Summary

The proportion of adults in Britain who are unable to work because of health problems has more than tripled since the 1970s, at an estimated annual cost to the economy of over £100 billion. While half of those in Scandinavia who suffer a major injury return to work, in Britain the proportion is just one in six. In England alone, 2.1 million people claim health-related benefits, a number that despite health improvements has barely shifted in the past decade.

Work is clearly needed to improve our record on reducing sickness-related worklessness, therefore. This report gathers lessons from Scotland, Wales and Northern Ireland and draws on them to make recommendations for policy-makers and practitioners in England, as well as identifying areas for improvement in the devolved nations themselves. Efforts in the latter are often more advanced than those in England, and each boasts innovative programs that provide useful lessons for the Health and Wellbeing Boards that will bear primary responsibility for redressing England's deficit in this area.

Based on our review of the literature, in-depth telephone interviews with high-level stakeholders in the field, a field visit to Glasgow, and a London workshop with members of Health and Wellbeing Boards, we make the following recommendations for those wishing to reduce sickness-related worklessness in England and in the devolved nations:

1. **The importance of leadership:** The success of Wales and Scotland in this area has been founded on strong leadership from the centre. England's Health and Wellbeing Boards should press the case for action to high levels of government as well as locally.

2. **Clear national strategies:** The governments of Scotland and Wales developed strategies that held the various stakeholders to account and defined clear timelines and responsibilities for action. These resulted in the establishment of effective national bodies to promote workplace health and return to work services, and in a flurry of local-level initiatives to see policies through. England and Northern Ireland currently lack such well-defined strategies.

3. **Get your own house in order:** The Northern Ireland Civil Service and RCN Wales have shown leadership in developing effective workplace health strategies. Sickness absence costs the NHS over £500 million each year (Black, 2008), and private sector firms are likely to look more favourably on efforts to reach them with work and health schemes if those delivering them look after their own staff well. Improving the health of those working for the NHS can have the added effect of persuading them of the importance of the work and health nexus.

4. **Goal-directed joint working:** Involving a range of stakeholders in the development of policies and the delivery of programmes is vital for effective implementation. Engaging the most relevant stakeholders for achieving particular objectives and securing their sign up to targets increases accountability and renders goals more likely to be met.

5. **Consistent communications:** The value of communicating consistently to all audiences was repeatedly highlighted by our interview respondents. Strong and clear messages can assist in the creation of a coherent "national brand" for health and work.

6. **The value of hubs:** Employers and health care practitioners are likely to benefit from one-stop shops that provide a single point of contact to which they can turn for assistance and information, and which can direct them to the relevant service.

7. **The value of hubs for programme implementers:** To avoid reinventing the wheel, those designing and delivering health and work programmes would benefit from a central hub – either national or UK-wide – where case studies and data on programme effectiveness are collated and disseminated.

8. **Inclusion of cost-benefit analysis in evaluations:** Evaluation of programmes in the devolved nations has been consistent and quite rigorous. However, few analyses have assessed the benefits of projects in comparison with their costs. Practitioners in all four home nations should endeavour to incorporate cost-benefit analysis into policy and programme evaluation.

9. **Targeting of "other" health professionals:** Allied Health Professionals, practice nurses, optometrists and even practice receptionists can transmit valuable messages to those with health conditions, and rather than expending all their time and effort trying to convince GPs, advocates of programmes should focus part of their communication campaigns on these non-GP audiences.

10. **Take a long view:** Prevention is vital to reducing sickness-related worklessness, and there is much that employers and health and social service providers can do to help stop people needing to take time off work. If a health problem develops, early intervention is needed to prevent it causing prolonged absence. Care and guidance should not stop when a client returns to work, moreover – the steps on the road back to employability should be valued and built into targets, and continued assistance in the period after re-employment reduces the risk of clients being placed in unsuitable jobs in order to meet targets, and helps with adjustments that lead to sustained employment.

Introduction

Background

Sickness-related worklessness is a blight on individuals, families, communities and economies. For many, being forced out of work or unable to find employment because of illness or disability is a disaster, setting them on a downhill path of benefit dependency, isolation from society, spiralling mental and physical health problems and poverty.[i] Family members must cope with an additional burden on their physical and financial resources, making it harder for them to work and, through the fatigue and stress of having to look after a sick relative, increasing their own risk of ill health. Society suffers through having a less productive workforce, through the creation of geographical pockets where ill health and health-related poverty are endemic, and through the drain on public finances of healthcare spending, benefit payments and forgone tax revenues. The proportion of adults in Britain who are unable to work because of health problems has more than tripled since the 1970s, at an estimated annual cost to the economy of over £100 billion (Black, 2008).

Worklessness due to ill health is often an unnecessary evil. Early diagnosis and treatment of health problems and adaptations made by employers and employees can help prevent long spells of sickness absence. Effective signposting of patients to rehabilitation programmes and medical services that increase their employability can help those on incapacity benefit to return to work. The current economic climate means that unemployment is rising across the board, and not just among those with health conditions, but the recovery will be slowed both by the burden of incapacity benefits and if employers have a weakened pool of workers on which to draw when the economy improves they attempt to regain lost ground. It is unfortunate that so much of the press coverage of those who the government are already attempting to support back into work is negatively spun. Many people who are out of work would love to be able to get back into work, but the lack of support and benefits traps both mitigate against this.

In our 2011 report, "Working Together: promoting work as a health outcome as the NHS reforms," we found that England performs poorly by international standards in tackling sickness-related worklessness (2020health, 2011). The number of adults who are economically inactive and classed as long-term sick has increased in the past two years and stood at 1.7 million in September 2011. The number who are economically inactive and temporarily sick was 153,300. 2.1 million people in England claim health-related benefits, a number that despite health improvements has barely shifted in the past decade (ONS, undated).[ii] Tellingly, while half of those in Scandinavia who suffer a major injury return to work, in Britain the proportion is just one in six (Black, 2008).

A large part of the responsibility for improving the country's performance will lie with the newly-established Health and Wellbeing Boards (HWBs). As we explained in our 2011 report:

It is hoped that the inclusion of public health directors in 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 programs that Local Authorities have already put in place. HWBs also have the potential to break down silos and bring together stakeholders from across the health and employment fields. And with Clinical Commissioning Groups 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.

Health and Wellbeing Boards remain at a fledgling stage. Our 2011 report made a number of recommendations for how they could tackle the task of reducing sickness-related worklessness, including involving health practitioners in developing local health and wellbeing strategies; inviting local employers' representatives to sit on the Board, and creating work and health stakeholder forums to feed into them.; encouraging third sector involvement in making the case for reducing sickness-related worklessness and bringing stakeholders together; and encouraging people recovering from health problems to consider voluntary work where paid employment is unavailable.

In this report, we cast a wider net, and look at how Scotland, Wales and Northern Ireland are addressing the sickness-absence issue. Efforts in the devolved nations are more advanced than those in England, and each boasts innovative programs that provide useful lessons for English HWBs. Our recommendations from the 2011 report are

i. An extensive review of the academic literature found that unemployment leads to increased overall mortality rates, declining physical and mental health, and higher rates of medical consultation, medication consumption and hospital admission. (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.)

ii. Employment support allowance and incapacity benefits.

complemented by those gleaned from our study of the devolved nations – we hope therefore that those working on Health and Wellbeing Boards might benefit from reading both reports, therefore. At the same time, we hope that our study will also assist policy-makers in the devolved nations themselves, both by sharing information and good practice from the other countries and identifying areas where approaches could be strengthened.

Methodology

Our study comprised four stages. Each stage has been supported by an external steering group of unpaid experts, with whom 2020health discussed the process and the findings from the research in face-to-face and online meetings.

The first stage was a review of the online literature covering efforts to reduce sickness-related worklessness in Scotland, Wales and Northern Ireland. The second involved seventeen in-depth telephone interviews with high-level stakeholders in the field (eight from Scotland, six from Wales and three from Northern Ireland – for a list of respondents, see appendix 1). The interviews, conducted between May and July 2012, 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).

The third stage took in a field visit by the research team to Glasgow, to meet the group behind the Glasgow Works project, which has been instrumental in bringing down sickness benefit claimant rates in the city from 19% to 12% in the past 12 years. The final stage was a London workshop with HWB members from across England, where the findings from the first three stages were presented and participants given the opportunity to discuss the feasibility of our recommendations and make suggestions for the final report.

This report presents our findings. As with the Working Together study, we do not present them as a definitive guide for how HWBs should respond to the challenge of sickness-absence, nor as a prescription for how the devolved nations can improve their efforts. We hope, however, that along with Working Together it will serve as a helpful tool, and that it contains enough examples of robust policies, innovative ideas and good practice to provide a basis for action going forward.

The report is structured as follows.

Part 1 lays out the policy context in each of the devolved nations. It discusses the need for action on sickness-related worklessness and the policies that have been put in place, and looks at how the issue has gained prominence on the policy agenda.

Part 2 narrows the focus and presents a series of case studies of good practice in the three countries.

Part 3 assesses the strengths of policy-making and implementation in Scotland, Wales and Northern Ireland and the consequent lessons for policy-makers in England and in the devolved nations themselves.

Part 4 summarises the main findings and recommendations.

1 The policy environment

The need

According to the official labour market statistics produced by the Office for National Statistics (ONS), in November 2011 8.3% of Scotland's working age population were claiming health-related benefits.(ONS, 2011)[iii] 3.3 million working days are lost annually due to ill health (Kennedy, 2011), at an estimated cost of £10 billion, which roughly equates to the entire cost of the National Health Service (NHS) in Scotland (Scottish Centre for Healthy Working Lives, 2010). Among those in work, Scotland has a higher rate of sickness absence than the UK average, with 2.1% of hours lost annually (the UK average is 1.8%) (ONS, 2012).

The proportion of health-related benefit claimants in Scotland varies widely by age, type of health condition and location. Overall, for example, 50% of disabled people are in work, compared with 80% of non-disabled people, but the employment rate among disabled people with mental health problems is just 21% (NHS Greater Glasgow and Clyde, 2011). Among those with long-term conditions such as rheumatoid arthritis meanwhile, surveys have found that as many as 40% are out of work, with over half of these attributing their worklessness to their condition (NRAS, 2010). And while in Scotland as a whole 16% of 55-59 year olds were claiming incapacity benefit in 2009, in Glasgow the proportion was 30% (Brown et al, 2011).

In Wales, 9.4% of the working-age population was claiming health-related benefits in November 2011. Over 2 million working days are lost annually due to ill health (Workboost Wales, undated). Like Scotland, average sickness absence among workers in Wales is above the UK average, at 2.5% per year (Department for Employment and Learning, 2008).

Data for Northern Ireland are not available on the ONS Nomis website, but 2007 data put the proportion of the working-age population claiming health-related benefits at 10% (ONS, 2012). Sickness absence rates among workers in Northern Ireland are below the UK average, at 1.6% (NHS Health Scotland, 2010).

Scotland and Wales have had some success in reducing health-related benefit claimant rates (we do not have data on this for Northern Ireland). The rate in Scotland has fallen from 10.1% to 8.3% in the past ten years. Rates in Wales have fallen from 12.1% to 9.4% over the same period. Both countries have seen a much steeper decline than England. While the claimant rate in England has fallen by 10%, in Scotland and Wales it has declined by 18% and 22% respectively.

The policy framework

Scotland

In 2004, recognising the workplace as a promising setting for health improvement activities, the Scottish Executive launched Healthy Working Lives: A Plan for Action. This strategy aimed to maximise the functional capacity of those of working age, help employers to promote a healthy workplace, and promote employability among those who are out of work (Scottish Centre for Healthy Working Lives, 2010).

A major output of this strategy was the Scottish Centre for Healthy Working Lives (SCHWL), which was established in 2006 as a national centre of expertise on workplace health. A Directorate of NHS Health Scotland, whose services are delivered in conjunction with Scotland's fourteen local health boards, the Centre's remit includes workplace health promotion, occupational health and safety, and job retention (Scottish Government, 2009). Although it does not cover those who are out of work, it works to encourage and help employers to employ people with health conditions.

SCHWL's main services include a national telephone advice line for businesses, which is delivered by NHS Lanarkshire; a website with information on workplace health promotion; a network of advisers providing consultancy to employers; a Learning and Development Programme which provides free or discounted training to businesses; and the Healthy Working Lives Award Programme, in which 1,200 firms are currently participating. The Centre also works with enterprise agencies to promote the importance of workplace health among the latter's members. Its work is overseen by the National Advisory and Advocacy Group for Healthy Working Lives, which includes representatives from enterprise agencies, the Health and Safety Executive, the Scottish Trade Union Council, health boards and academia. It has provided face-to-face or telephone support to over 11,500 employers covering 1 million employees, and its website receives over 20,000 visits per month.

iii. Defined by ONS as "ESA and incapacity benefits".

The Healthy Working Lives strategy was reviewed in 2009 after the publication of Dame Carol Black's study of the health of Britain's working age population, Working for a Healthier Tomorrow. The review resulted in the launch of Health Works, which sets out 25 actions a range of public sector bodies should take in conjunction with employers in order to reduce sickness-related worklessness in the Scottish population (Welsh Assembly Government, 2011). The main strands among the 25 actions are:

- raising awareness among employers, and particularly among small and medium enterprises (SMEs), of the importance of workplace health;
- establishing minimum standards of support to individuals in need of assistance to stay in or return to work;
- encouraging and training health staff to include work-related outcomes in patient care plans;
- fostering links between senior staff in NHS Boards and those managing employability programmes;
- bringing together stakeholders from the Scottish Government, the Convention of Scottish Local Authorities (COSLA) and NHS Scotland to promote good practice by public sector bodies in improving workforce health and wellbeing;
- working with partners such as the STUC to integrate health and work messages into education resources for schools and colleges.

A consequence of the Scottish Government's continued focus on reducing sickness-related worklessness has been the inclusion of the issue in a number of key health and social policies. The 2007 Better Health, Better Care Action Plan, which set targets for NHS Boards related to reducing health inequalities, recognised the importance of obtaining and remaining in work, and actions to help realise these targets were set out in the 2008 COSLA/Scottish Government health inequalities strategy, Equally Well. Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009-11 included mentally healthy employment and working life among its six priority areas and set out actions for improving mental health among the working-age population. Preventing Overweight and Obesity in Scotland: A Route Map Towards Healthy Weight (2010) recognised the workplace as a promising setting for efforts to reduce obesity. And workplace programmes to tackle alcohol abuse are recommended in Changing Scotland's Relationship with Alcohol: A Framework for Action.

Going forward, the Scottish Government has pledged to collaborate with the Healthy Working Lives National Advisory and Advocacy Group and the Scottish Employability Forum to ensure that there is a clear, national, strategic lead for Health Works. It is developing a set of outcomes and performance measures that can assist in the monitoring and evaluation of the projects involved.

Wales

In 2009, the Welsh Assembly Government launched 'Our Healthy Future,' a strategic public health framework for Wales. This included improving health in the workplace as one of its ten priority outcomes. Specifically, three goals were outlined:

- helping people to have a healthy and fulfilled working life;
- creating safe and healthy workplaces and reducing the impact of common health problems;
- stopping people falling out of work from ill health.

Our Healthy Future committed to developing the Health, Work and Wellbeing Action Plan for Wales, a working document which was produced in 2011. The action plan *'aims to provide a basis for collaborative working between key stakeholders with an influence on health professionals, employers and individuals. It will align work to achieve our shared objectives, to:*

- *improve health and well-being at work;*
- *reduce the impact of ill-health at work; and*
- *encourage early intervention to rehabilitate those who have become ill or injured'* (Department for Employment and Learning, 2012).

The Welsh Government's 'Healthy Working Wales' programme is a major plank of the action plan. This provides a range of services to various stakeholders, including a Health at Work Advice Line for SMEs and their employees; a Corporate Health Standard programme; health and work advice for GPs and other health professionals; the Welsh Backs scheme to provide advice on reducing back pain; and Workboost Wales, a free advisory service for SMEs on issues such as workplace health and safety, management of sickness absence, and

1 The policy environment

return to work (some of these schemes are discussed in detail in part 2).

A variety of stakeholders came together to create the Health, Work and Wellbeing Action Plan, including Public Health Wales, Jobcentre Plus, NHS Wales, Wales Council for Voluntary Action, the Chartered Society of Physiotherapy, the Department for Work and Pensions (DWP), the Welsh Local Government Association, Wales TUC, Business in the Community, the Health and Safety Executive and Cardiff University. A Health, Work and Wellbeing Implementation Group has been appointed to lead work in this area. The action plan contains 29 recommendations with clear responsibilities and timelines, for parties including Public Health Wales, the Department for Public Health and Health Professions, NHS Wales, Local Health Boards, Cardiff University, the General Practitioners Committee Wales, Jobcentre Plus, Wales TUC and the Welsh Local Government Association.

Northern Ireland

Unlike Wales and Scotland, Northern Ireland lacks an overarching policy framework for reducing sickness-related worklessness. It is possible that the new strategic framework for public health, due for publication late in 2012, will include work outcomes as goals, but in the meantime the country has no central direction of programmes in this area.

The Northern Ireland Executive's principal programme for helping those in receipt of health-related benefits to return to work is Pathways to Work, a UK-wide scheme. Managed in Northern Ireland by the Department for Employment and Learning (DELNI), this consists of a trained Jobcentre-based Employment Service Adviser helping individuals to choose among pathways, including financial support to return to work or attend job interviews, and a Condition Management Programme - a 12 week course run by health professionals who advise participants on how to manage their condition so that they can return to work.

Northern Ireland also has a Disability Employment Service under the auspices of DELNI. This both supports employers to recruit and retain people with health problems or disabilities and helps disabled people find employment. It includes a Job Introduction Scheme, which subsidises employers to provide employment trials for 13 weeks to disabled potential employees; Access to Work payments, which assist disabled people to travel to work and to make modifications to the workplace so that return to work is easier; and 'Workable,' a scheme that provides longer-term support to help disabled people overcome employment barriers, including a Job Coach, extra training, disability awareness training to colleagues and employers, and payment of developmental costs to the employer (Addley, Burke and McQuillan, 2010).

For people who are in work, the Health and Safety Executive (HSENI) has a team of Workplace Health Advisers who assist businesses to improve workplace health and wellbeing. HSENI has also produced guidance on improving mental health at work. As we discuss in section 2, moreover, with the public sector being a major employer in Northern Ireland, state bodies' own workplace health and wellbeing programmes are an important factor in reducing sickness-related worklessness in the country.

Although currently lacking in central direction of health and work efforts, Northern Ireland has structures in place that are likely to facilitate effective policy implementation should the issue become a priority in years to come. In particular, unlike in the other home nations, health and social care are integrated in Northern Ireland via Health and Social Care Trusts. These fall under the remit of the Department of Health, Social Services and Public Safety, and mean that the country has a single Regional Health and Social Care Board. This deals with Commissioning, Resource Allocation, Performance Management and Improvement; five local commissioning groups; a regional Agency for Public Health and Social Wellbeing (which has responsibility for addressing health inequalities and public health issues); and 40 new health and social care centres (one-stop shops where individuals can access GP practices, social care professionals, nurses, diagnostic and treatment rooms for specialist services) and services for those with learning and mental health difficulties.

There is obvious potential for services designed to reduce sickness-related worklessness to be incorporated into the above structures. As we discussed in our 2011 Working Together report, the separation of health and social care services has in the past limited the effectiveness of such services, and in England Health and Wellbeing Boards offer a chance to redress this. If health-related worklessness can be raised up the Northern Irish policy agenda, its integration into existing policies is likely to be smoother than in the other home nations.

Raising the profile

Although policy-makers in Northern Ireland, then, do not yet see sickness-related worklessness as a high priority, momentum has built elsewhere in the UK. A number of our telephone interview respondents acknowledged the impact of Dame Carol Black's work on the issue, and several observed that the current economic climate has given governments an additional incentive to move people off costly benefits and back into productive work.

On the other hand, it was pointed out that cuts in public spending may imperil sickness-related worklessness programmes. A few respondents complained that pilot projects, for example, are often discontinued even where their results appear promising. *'Mainstreaming this work is difficult in this economy,'* said an interviewee from Scotland. Although keeping people in work and helping them to return to work is beneficial for economies in the long run, there is a sense that policy-makers tend to adopt a short-term approach which results in cuts even to cost-saving programmes.

Those advocating for continued investment in such programmes have adopted a variety of tactics. Employers themselves have lobbied for more intensive work by governments, and have at the same time implemented more effective internal policies in the realisation that ill health among their workforces imposes an avoidable cost on business. Employers in Scotland and Wales in particular were reported by telephone interviewees to be highly receptive to government programmes.

Research evidence has also helped give prominence to the issue. In Wales, for example, studies published by the University of Cardiff have shown government the cost of sickness-related worklessness both to the public purse and the wider economy and thereby persuaded it to take health, work and wellbeing more seriously. In Northern Ireland, periodic reports by the Audit Office demonstrating the cost of absenteeism to the Treasury and to business make headlines when they are released and, we were told, *'instigate an operational reaction whereby senior staff and human resources managers are reminded of their responsibilities in the area.'*

Finally, individual champions have played an important role. People working within government who are convinced of the value of tackling sickness-related worklessness have repeatedly and determinedly made the case to ministers and senior officials, showing how the health and work agenda links to other policy areas such as business productivity, health inequalities, poverty traps and social breakdown. In the Northern Ireland Civil Service (NICS), for example, a small group of engaged staff established a project team with the intention of pushing the issue onto the policy agenda at senior NICS levels. The team included academics from Belfast University who provided the evidence base, and was eventually successful in garnering support from senior staff, including the Human Resources department, and in securing the development of the NICS Well programme for civil service staff which we discuss in more detail in part 2.

In making the case for action, one respondent from Northern Ireland highlighted the fact that politicians are often reluctant to adopt too strident a stance in the worklessness arena (the UK's Work and Pensions Secretary Ian Duncan Smith's pronouncements about the value of returning to work are a notable exception in this regard). There are cultural issues around benefit dependency, he said, which make it politically risky to be seen to be rebuking the most vulnerable members of society. *'It's hard to get politicians to take these issues on,'* he said, and recommended that advocates take account of these competing pressures on their target audiences.

2 Case studies

Having discussed the broad national policy framework in Scotland, Wales and Northern Ireland, in this section we present case studies of individual programmes. The list is by no means exhaustive, but is intended to showcase a variety of effective methods across the three devolved nations. We start by looking at the internal programmes of government departments.

Leading by example

Several of our interview respondents told us about their organisations' internal health and wellbeing practices. Four of these stand out as examples of effectiveness.

The Northern Ireland Civil Service aims to be an example of good practice to other public sector bodies in the country. With 26,000 staff it is one of Northern Ireland's largest employers and its health and wellbeing programme has helped reduce sickness absence from 15-16 days per person per year in 2002 to 10 days in 2012. Thanks to the sustained advocacy described above, there is a strong focus on the programme among senior staff, with management given targets for managing attendance and assisted in reaching them by the occupational health service. Services include prevention education to managers and their teams, workplace assessment, and rehabilitation. Phased return to work is available to those who have been off sick for long periods – that is, they are allowed to return part-time while they readjust to working conditions – while an Employment Assessment Programme provides counselling for mental health problems to staff and their families. In 2012, NICS extended its work by launching a three-year NICS Well pilot programme. Aimed at NICS staff, the programme includes a Charter for Health and Wellbeing, an internet health hub, an HWB support team and HWB champions across NICS departments. Although the lessons learned from these efforts are shared with other public sector organisations, however, they are only infrequently shared with private sector firms.

Also in Northern Ireland, the Social Security Agency has used a range of methods to reduce the high rates of sickness absence among its 5,500 employees. Deploying a combination of stick and carrot, the human resources department has developed an electronic system for recording absence, with clear trigger points where an individual's repeated or continued absence should prompt an interview to discuss whether he or she would benefit from being referred to health services or other return-to-work programmes, or whether continuing in employment is likely to be impossible. Clear procedures on absence have been developed in consultation with trade unions, and these are communicated to staff with the aim of reassuring all employees that they will be treated equally, regardless of seniority, and of showing the benefits to them and their colleagues of them staying at work. For staff who have been off sick for long periods phased return-to-work is used, so that they may gradually reintegrate into the workplace rather than facing the shock of an immediate return to full-time employment. An interview respondent who discussed the programme with us emphasised the importance of fairness and transparency, and of communicating the new procedures to all members of staff. He reported that in the three years since the new procedures were introduced sickness absence has fallen from over 7% per year to 4.2%.

The third example of effective internal health and wellbeing policies is provided by Cardiff Council, whose Work-life Balance Project aims to improve employee morale and wellbeing by offering a more flexible working schedule. The new working arrangements, which included removal of 'core hours', lengthening the hours of the working day and allowing flexible start and finish times within them, offering more flexible break times, allowing occasional working from home, and increasing the number of accrued "flexidays", were discussed in detail with staff, managers and unions, and guidelines and FAQs were developed and briefing meetings held to explain how the scheme would work. In an evaluation of the project, 95% of employees reported an improved work-life balance and managers reported improved morale and reduced sickness levels. Improvements in productivity were also noted.

Finally, the successful sickness management policy of the Royal College of Nursing in Wales is run by senior management and the human resources team in partnership with trade unions. Like the Northern Ireland Social Security Agency, the RCN uses a trigger point system to identify employees who would benefit from referral to the internal occupational health programme or from adjustments to the workplace or working schedule. For those on long-term sick leave, the RCN team maintains close contact throughout the illness, including regular reviews with line managers, the occupational health team and counsellors, and assists with eventual return to work by providing flexibility and a phased reintegration process. Bearing in mind the difficulty of returning to the working environment after a prolonged absence, the RCN has a programme of "keeping in touch days" where recovering employees come into work for a day to meet colleagues and reacquaint themselves with

the workplace, with no obligation to begin working until they are mentally and physically ready. These tasters are particularly valuable for staff who have been absent because of stress or violence at work.

The success of the RCN programme is borne out by its sickness absence rate of 2.5% per year, compared with a national average of 4.5%.

Programmes targeting those in work

NICS Early Return to Work pilot

This NICS pilot emphasises the value of early interventions to prevent prolonged sickness absence. Civil service welfare officers attended a 4-day training course in motivational interviewing, to enable them to conduct structured interviews with civil service workers who had been absent for less than 20 weeks and engage with them to discuss the issues they faced and identify and find ways to overcome the barriers that stood in the way of returning to work. Officers agree a return to work plan with the employee and signpost them to external counselling, physiotherapy or rehabilitation services. The 4-month pilot, which has now been rolled out across NICS, had 70% uptake, and subjective reports by patients found that absence was reduced by an average of 4-6 weeks. A more rigorous analysis is planned for the next stage of the programme, with the Northern Ireland Statistical Research Agency being brought on board to track users' experiences against those of a control group to establish whether length of absence differs.

Northern Ireland Direct Access Occupational Physiotherapy Treatment pilot

An example of an effective occupational physiotherapy programme is the direct access scheme piloted by the Northern Ireland Civil Service (Laurie et al, 2008). Employees accessed the treatment service by self-referring to it through their line manager. A course of treatment containing up to six sessions was provided, with an average of five sessions. Overall, Work Function Score improved by 63% following treatment, and adjusted Clinical Score by an average of 84%. The majority of respondents who began the programme while still in work reported that the treatment prevented them going off sick and reduced the likelihood of future absence. Only a very small number of people absent from work were treated, but most of these reported that the programme accelerated their return to work.

Fife Job Retention pilot

A pilot scheme that was not rolled out more widely despite evidence of effectiveness was carried out by NHS Fife and Fife Council (WHSS website, undated). The project aimed to help NHS Fife and Fife Council employees with mental health problems to stay in their jobs, and to help unemployed people with mental health problems to find work with NHS Fife and Fife Council, with the lessons learned in the job retention strand informing the vocational rehabilitation strand. Here we discuss the job retention strand, while the vocation rehabilitation strand is discussed later in this section.

For the job retention strand, each client was allocated an individual rehabilitation consultant who brought together key stakeholders such as the line manager, a human resources officer and an occupational health clinician to draw up an action plan with the client based on a workplace assessment. The action plan might include referral to a specialist occupational therapy service, adjustment of work tasks to reduce anxiety or accommodate a medication regime, target setting in re-engaging with work tasks, assistance in accessing community services such as debt counselling or housing services that might affect the client's mental health, and condition management approaches such as anxiety management, depression management, relaxation training, and relapse prevention planning.

To publicise the service, two press releases were issued, and leaflets were distributed across NHS Fife and Fife Council, in Jobcentres, GP surgeries and libraries. Mental health teams also promoted the service to clients, while Human Resources teams and managers in NHS Fife and Fife Council received presentations about the project.

An evaluation of the job retention scheme showed that of the 35 individuals who completed pre- and post-programme assessments, 27 were absent from work either on sick pay or without pay, while six were at work but performing restricted or alternative duties. By the end of the programme patients reported significant improvements in psychological functioning and occupational performance and satisfaction, and the proportion on sick leave fell from 75% at the start of the programme to 25% at its completion.

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Working Health Services Scotland

In recognition of the lack of occupational health services or employee assistance programmes among SMEs in Scotland, the Scottish Government and DWP set up Working Health Services Scotland (WHSS) to assist employees of firms with less than 250 staff to stay in work or return rapidly to work after a health problem develops (NHS Health Scotland, 2011).

Employees of firms that sign up to the scheme are allocated a case manager, accessed by telephone and delivered by the social enterprise firm Salus. There are case managers based in Health Boards across the country, so that clients may be referred to local services including physiotherapy, occupational therapy, counselling or other employability services. Client data are recorded on an electronic database, and the case manager monitors progress throughout the 2-12 week programme.

Referrals to the service can be made by employers, GPs or by clients themselves. We were told that those promoting the service have found it difficult to persuade GPs to make referrals despite a marketing campaign that included training for GPs and flyers placed in surgeries. Reaching SMEs has proved slightly easier, with the assistance of chambers of commerce, links with trade unions and the Scottish Centre for Healthy Working Lives' awards database of 1500 firms.

Measurable indicators were included in the programme from the start, including rates of return to work, use of medication and GP visits. These were developed and are evaluated by a group including policy leads in the Scottish Government, the Centre for Healthy Working Lives, Health Board and Jobcentre representatives, Allied Health Professionals and academics.

A pilot of the programme was delivered in three areas – the Borders, Dundee and Lothian – for between 12 and 24 months. 1,247 cases were seen, and as well as improvements in health (for example, more than half of those who had been taking medication on entry to the programme had seen sufficient improvement in their health to stop taking it by the time they left, while GP appointments were reduced by an average of one), 83% of clients who were absent from work on entering the programme had returned to work at discharge (Glasgow City Council, 2011).

Workboost Wales

Another service targeting small businesses in Workplace Wales. Part of the Healthy Working Wales scheme, Workboost Wales is a government funded service that provides free advice to SMEs on workplace health and safety, management of sickness absence and return to work issues. The service has an enquiry line and website where specialist advisers supply firms with information and resources that they may otherwise be unable to access due to financial constraints. Firms can also request a site visit from a Public Health Wales practitioner.

Welsh Government workplace health awards

The Welsh Government has two major workplace health awards. The Corporate Health Standard, delivered free by Public Health Wales, presents bronze, silver, gold and platinum awards to public, private and third sector organisations that promote the health and well-being of their employees. Participating organisations are assessed every three years.

The Small Workplace Health Award is a similar programme for businesses and organisations employing fewer than 50 people. This scheme is complemented by free support and advice for small firms to develop workplace health and well-being initiatives, including a Health at Work Advice Line Wales. Telephone interview respondents highlighted the small business scheme as a valuable tool for helping health and wellbeing practitioners to find and access SMEs to deliver messages and services.

Programmes targeting the unemployed

Glasgow Works

In the past few decades, the proportion of the working-age population claiming incapacity benefit (IB) has been higher in the city of Glasgow than in most other parts of the UK. In 2000 the overall city-wide rate stood at 18%, but in some districts up to half of working-age adults were on IB.

Impetus for change came from employers, who complained to local policy-makers that the pool of healthy workers on which they could draw was diminishing, and from individuals within the city's governing bodies who realised that poor health was imperilling the local economy and creating vicious spirals whereby those who dropped out of work for health reasons became progressively sicker because of inactivity and isolation, and therefore moved still further away from the labour market.

In 2006 awareness of the problem was translated into action. The Department for Work and Pensions (DWP) funded pilots in a number of UK cities to establish local employment partnerships, with city councils given flexibility to develop tailored programmes for their own localities. Glasgow was given £10 million to deliver its strategy, and Glasgow Works launched in 2008. Targeting those who had dropped out of work - including but not limited to those receiving IB - contracts were awarded to five local regeneration authorities (LRAs), and a total of £24 million was invested over three years (the £10 million from DWP supplemented by City Council funds and a grant from the European Social Fund).

The aim of Glasgow Works was to change how employability services were delivered in the city. Previously, service providers had been assessed purely on the numbers of clients they helped move into jobs. With people on IB, however, this approach was unhelpful. To meet targets, clients were frequently shoehorned into jobs for which they were unsuitable. Particularly for those with mental health problems, this risked aggravating the illness, and anyway was unlikely to result in sustainable employment. Nor did the approach take account of improvements made that did not directly result in employment. IB recipients who had been out of work for long periods were often considered so unlikely to be able to find jobs that they were neglected by target-driven employability services. They therefore drifted further away from the possibility of re-engaging in work and in society. Glasgow Works adopted a new approach, with softer targets complementing the harder, job-focused goals. Clients would now be moved along a pathway, with LRAs paid for each stage the client reached. For example, engaging with a service would be a point along the pathway, as would partaking in preparation for work activities or in voluntary work. This approach encourages even the hardest to reach clients to participate in meaningful activities, and moves them closer to the ultimate goal of work. Once they have found a job, moreover, there are further targets for Glasgow Works in terms of whether employment is sustained over 13 weeks and then 26 weeks, and whether the client gains an additional qualification or a promotion while in work. These targets require Glasgow Works to provide ongoing support to help clients adjust to working, and help ensure that clients are placed in suitable jobs, rather than job placement by itself being the target.

Glasgow Works contains many strands, including programmes for long-term disabled people, young offenders, young parents, people with learning disabilities, and the Roma community. All of these seek to move clients who are cut off from the workplace along a pathway towards employment.

We met with advisers from one of these schemes, Glasgow's Regeneration Agency Bridging Service, an employability programme for people being supported by health or social care services. Partly funded by the NHS and partly by Glasgow Works, the Bridging Service targets the most difficult to reach sections of society, those furthest from the labour market. All its clients have been referred to the service by either health or social care practitioners. Many are in receipt of IB.

To publicise the Bridging Service, staff visit health and social care services to persuade them of the benefits of the pathway approach, showing concrete case studies of GPs' patients, for example, or former drug addicts who have been successfully moved along it and have therefore relieved the burden on practitioners' time. These visits also take care to reassure health and social care staff that fragile clients will not be pushed into unsuitable jobs, but will gradually be brought back towards employability. This work is supported by 'Keep Well,' a programme to deliver employability training to healthcare professionals, and by liaison work with Jobcentres to help them to understand that although engaging with the Bridging Service occupies clients' time that could be spent directly seeking jobs, such engagement is likely in the long run to relieve the pressures on Jobcentre advisers by strengthening clients' job-seeking skills and, ultimately, reducing unemployment.

Co-location helps strengthen working relationships between Bridging Service advisers and health and social care practitioners. It also helps clients. Advisers located in Jobcentres or in healthcare services not only give health and social care services an immediate point of referral for clients and show them that the support provided is of high quality; they also mean that the client can meet an indentified individual rather than being sent to an anonymous employability service. The first meeting between the client and the Bridging Service Adviser is therefore conducted in the presence of the health or social care professional, and normally in the GP's surgery. This is seen by many patients, and particularly by those suffering mental health problems, as a more comfortable, less threatening environment in which to meet a stranger. After this initial meeting, the Bridging Service adviser sees the client on a one-to-one basis every week for 30-60 minutes. A plan of action is discussed and agreed upon, which might include obtaining a full-time job but also

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softer goals such as socialising more often or building confidence or improving diet. Where needed, advisers refer patients to other services such as debt advice, life skills training or occupational therapy. Those who move sufficiently far along the pathway are given voluntary opportunities to work for health boards or helped to find voluntary work for the third sector. Voluntary work can be an important step on the way to paid work, and particularly in the current economic climate is a valuable outlet for those wishing to perform meaningful activities in the absence of available paid positions.

As well as working closely with health and social services, the Glasgow Works Bridging Service also collaborates with local employers. The service has "Job Brokers" who visit local firms to ensure it can access jobs for its clients. Acting as what the Glasgow Works team described as a "free recruitment service," Job Brokers vet clients and attempt to place them in appropriate positions. They also make arrangements with firms to provide quotas of places for Glasgow Works clients. For firms working on city-funded projects such as 2014 Commonwealth Games developments or a new hospital, such quotas are tied into contracts.

The results of Glasgow Works's programmes have been impressive. Over the first three years of the scheme, from July 2008 to June 2011, 6,900 clients who were on IB were engaged (that is, they registered and had at least two appointments) and 900 moved back into work. Incapacity benefit rates in the city have declined from 19% in 2000 to 12% today. An evaluation of the scheme among 86 clients in two Glasgow Regeneration Agency areas found major improvements in measures of wellbeing and self-efficacy. In addition, the proportion highlighting mental health as a barrier to looking for work dropped from 52% to 31% in six months, while that reporting physical health as a barrier fell from 38% to 14% (Glasgow City Council, 2011).

Some of the key lessons learned by the Glasgow Works team are set out below:

- The importance of soft targets: rewarding providers not just for employment outcomes but for achieving steps on the way to employment means that those furthest from the labour market are less likely to be neglected. Employment targets for the Bridging Service are not as high as those for other employability services, meaning advisers can focus on increasing clients' long-term employability by strengthening life skills and promoting personal development. This also reassures health and social care practitioners that those they refer to the service will not be pushed into unsuitable and potentially counter-productive jobs.

- Continued follow-up: targets do not stop with the acquisition of a job; they continue for several months afterwards. This reduces the risk of clients being placed in unsuitable jobs in order to tick off employment targets, while also assisting client and employer to adjust to the working environment.

- Co-location: placing Bridging Service advisers in health and social care venues helps build rapport between these parties, and ensures a smoother and less stressful transition for the client from health and social services to employability services.

- A focus on meaningful activity: paid employment, particularly in a recession, may not be available to all of those receiving IB, but "meaningful activity" is not limited to paid work. Voluntary work, training and education are all extremely useful activities which help improve clients' physical and mental wellbeing as well as their employability until paid work becomes possible.

- Case studies: real-world examples of clients who have benefited from Glasgow Works' services have proved a useful tool in persuading health and social care practitioners of their value. If a GP can see that the wellbeing of a patient has improved, perhaps resulting in fewer visits to the GP surgery, he or she is more likely to make referrals in future. Glasgow Works sends case studies every two months to GPs, practice nurses, practice managers and Jobcentre advisers.

- Showing the value of work: at the beginning of their engagement with Glasgow Works, all clients receive a "Better off in Work" calculation, showing them the economic benefit to them of moving off benefits and into employment. In nearly all cases this calculation shows that employment would be economically beneficial, and clients are also apprised of the non-monetary benefits of working, such as health improvements, socialisation, and job satisfaction.

- The importance of long-term funding: after two years of the Glasgow Works programme, results were unimpressive – it was only in the third year that large benefits were seen in terms of people returning to work or achieving important steps along the way to employment. Had the funding ceased after two years the effort may have been written off as a waste of resources; it is essential, therefore, to give programmes time to demonstrate their worth. This in turn relies on realistic planning and target-setting at the outset.

Why it matters: A Glasgow cabbie's story

While in Glasgow, the 2020health research team were ferried to the meeting with Glasgow Works in a taxi. The taxi driver, interested in our study, told us that he himself had sciatica, a painful back condition caused, he thought, by spending many hours each day sitting motionless in his cab. The condition makes it difficult for him to walk even quite short distances and leaves him in severe pain by the end of each day. His GP told him to take time off work, but the cabbie refused, saying he would become depressed if he was stuck at home.

The GP also recommended physiotherapy, but although this is provided free by the NHS the cabbie prefers to spend £25 on a session with a chiropractor. *'That means I can go when I want, not when the hospital wants,'* he explained, *'and I hate going to hospitals anyway.'* The vast majority of the chiropractor's clients, he told us, are taxi drivers. When we suggested that he should perhaps try to move around or exercise between rides, he replied that although he knows he would benefit from this, he prefers to sit back in his seat and watch TV on his iPad because his colleagues would take the mickey if they saw him exercising on the rank.

Fife vocational rehabilitation pilot

The second strand of the Fife mental health pilot programme whose job retention strand was discussed above aimed to help people who were out of work find employment with NHS Fife and Fife Council.

A community-based agency, the Fife Employment Access Trust (FEAT), was commissioned to provide pre-employment support to clients. A FEAT Employment Adviser held a series of discussions with a client to map the latter's vocational profile and thereby establish which working environments might be suitable for the client given his or her illness and medication and support needs. This led to the drawing up of an action plan which included training in interview methods, help in completing application forms, support in making choices and, once the client was in employment, ongoing support to help employee and employer adjust to the new role. Clients also had access to a support worker and a counsellor, who could help with problems in other areas that might affect their employability.

Of the eleven clients who completed pre- and post-intervention evaluations, four had found a job having been unemployed for between 14 months and 16 years. Self-efficacy scores in job seeking showed significant improvement, and satisfaction ratings with the programme were high. On the other hand, no effect on psychological functioning was found. Like Glasgow Works, the pilot shows the value of intensive one-to-one guidance by an employment adviser, and of involving employers in assisting with return to work.

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Programmes targeting health practitioners

Glasgow West GP Employability Pilot Project

Persuading GPs to refer patients is a difficult challenge across the UK, and one which we highlighted in our 2011 'Working Together' report on health and work in England.

This 2009-2010 pilot, which ran parallel with the Glasgow Works programme and was established by Glasgow Works, the Glasgow West Community Health and Care Partnership, and Glasgow West Regeneration Agency (GWRA), aimed to strengthen links between GWRA and GP practices, and to increase the rate of referrals by GPs to employability services (MCM Associates Ltd, 2010).

The pilot provided a financial incentive to GPs if they referred at least two to three patients a week per average practice of 5,000 patients. This was supported by an awareness raising programme in GP practices, and by the production of a simplified employability referral form accompanied by stamped addressed envelopes to make it as easy and fast as possible for GPs to make referrals.

Evaluation of the project found that 24 of the 45 Glasgow West GP practices referred patients. The number of referrals increased from 11 in the six months prior to the pilot to 148 during the pilot period. There were 85 referrals in the six months after the pilot finished. Despite these promising results, however, the pilot was not rolled out more widely, although its success points to the utility of providing financial incentives and simple referral methods to GPs.

Welsh Backs

Another strand of Healthy Working Wales, Welsh Backs supports health professionals and employers to manage patients and employees with back pain. Health professionals are provided with an interactive desk aid and other online resources to support consultations, while for employers there is a free telephone advice line with information on managing back pain in the workplace. Welsh Backs has also produced an information leaflet containing advice for the general public on self-managing back conditions.

Network building projects

Two recent projects highlight the potential of networks in spreading knowledge and developing new methods.

Scottish Vocational Rehabilitation Network

A group of interested health professionals from across Scotland has formed a network to share knowledge and good practice on vocational rehabilitation. Regular meetings are held in Edinburgh or by teleconference, and there is a community of practice online forum for continued exchange between meetings. Recent discussions have covered the possibility of developing a Scotland-wide set of assessments to make measuring vocational rehabilitation more easily quantifiable, and the practicalities of using electronic record keeping to record such assessments. Although currently limited to health professionals, we were told that opening the network up to social care practitioners, employers, Jobcentre Plus representatives and trade unions is being considered for the future.

DWP health, work and wellbeing coordinator network

Similar in spirit to the Scottish Vocational Rehabilitation Network was the DWP-funded Britain-wide health, work and wellbeing coordinator network, a two-year programme which came to an end in 2011 (Department for Work and Pensions, undated). The network comprised 11 coordinators who championed the health and employment agenda at a local level and promoted best practice in the field. Among the network's activities was to bring together various stakeholders – including coordinators themselves, Business Link, the Trade Union Congress, the Confederation of British Industry and other business organisations – to share experiences and knowledge and forge a stronger health and employment network in the 11 localities. One of our respondents reported that the meetings gave those interested in the topic a valuable forum for exchanging ideas – *'if you share experiences with others,'* he said, *'you don't need to reinvent the wheel.'* The project was of only short duration, because it was intended to "pump-prime" local health and work activity across Great Britain.

3 Lessons learned

In our 2011 report, Working Together: promoting work as a health outcome as the NHS reforms, we highlighted four key broad actions that will facilitate the task of those attempting to improve England's performance in reducing sickness-related worklessness. The first involves assessing the local need for efforts to promote work as a health outcome, establishing whether the problem lies with those in or out of work and identifying the gaps in efforts to keep people in work or rehabilitate those forced out of work by ill health. The second is to bring together the most relevant local stakeholders to draw up strategies for improvement. These might include employers, business associations, local authorities, the third sector, health professionals and patients themselves. We argued that Health and Wellbeing Boards are well placed to act as a convenor and facilitator of this stage.

The third action is to set and agree upon clear and measurable outcomes, against which those who sign up to them can be held to account. Clear definition of roles is crucial, and allowing parties to define their own roles was found to be a promising means of reducing conflict later on. Finally, monitoring progress against these outcomes should be an intrinsic part of their ongoing operation. *'In a fledgling field,'* we suggested, *'the gathering of evidence and flexibility in responding to it are likely to be central to success.'* Regular contact between stakeholders to discuss results and necessary amendments will keep parties apprised of developments and promote this flexibility.

Within these broad overarching themes, we noted a number of suggestions for Health and Wellbeing Boards, including:

- incorporating work as a health outcome into Joint Strategic Needs Assessments, and involving GPs in the latter's development;
- including employers' representatives on the board, either in a permanent or occasional capacity;
- creating a larger stakeholder forum to advise the board on reducing sickness-related worklessness, and present evidence to it from pilot studies or programmes used by other localities;
- involving the third sector as a neutral arbiter between stakeholders;
- valuing voluntary work rather than just paid work as a means of improving health, providing value to society, and progressing people towards paid employment.

In this section of the paper, we collate good practice from work in Scotland, Wales and Northern Ireland. We hope this will be a useful reference for advocates and policy-makers aiming to reduce sickness-related worklessness in England (including Health and Wellbeing Boards, but also third sector organisations, employers and business associations, health care providers, social services and local authorities). We also hope that practitioners in the devolved nations will benefit from learning from good practice elsewhere, and that by highlighting areas for improvement in individual nations, our study will show where remedial work is needed. We group the lessons learned under several broad themes.

The value of leadership

One of the great strengths of the approach to sickness-related worklessness in Scotland and Wales is the leadership shown by the two countries' governments. Recognition at high levels of the importance of the issue to national and local economies and to individuals' health has resulted in clear programmes of action, with clear definition of different stakeholders' roles. The impetus for action has filtered down to the local level and secured buy-in from local health boards, triggering many of the successful programmes discussed in part 2.

Sickness-related worklessness has been on the Scottish Executive's agenda for over a decade, resulting in a series of strategies of which Health Works is the latest, and in the establishment of the Scottish Centre for Healthy Working Lives as the national centre for expertise on workplace health. Health Works sets out 25 clearly defined actions for a range of public sector bodies to take in conjunction with employers to reduce sickness-related worklessness. Because of the leadership shown by the government, the issue has received prominence in key health and social care policy documents – the emphasis on the topic has permeated through central government and to local government.

The Welsh Government has also taken a lead on the issue, with Public Health Wales and the Chief Medical Officer at the forefront. Reducing sickness absence was listed as one of ten priority outcomes of the 2009 'Our Healthy Future' strategic framework for public health. This led to

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the Health, Work and Wellbeing Action Plan for Wales which focused specifically on work and, like Health Works in Scotland, included 29 recommendations with clear responsibilities and timelines. Healthy Working Wales was set up to implement the plan, and a National Occupational Health Service has been created, which will initially focus on those working in or with NHS Wales and then expand its focus to the rest of the public sector and the private sector. Wales's seven health boards, meanwhile, each have a programme to reduce sickness-related worklessness.

The Northern Ireland Executive is yet to demonstrate such leadership, but some public sector bodies in the country have led by example by introducing effective, transparent and fair health, work and wellbeing policies. RCN Wales has also taken a lead with its internal policies, and if government statements and policies are to be credible they should be supported by effective internal programmes to reduce sickness absence among their own staff and to provide employment and support to people with or recovering from health conditions.

The leadership demonstrated in Scotland and Wales is currently lacking in England and in Northern Ireland, where national strategies and national implementation bodies are absent. It was felt by several telephone respondents that after a brief flurry of interest in the wake of Dame Carol Black's Working for a Healthier Tomorrow report, the issue is in danger of slipping off the policy radar in England, with Dame Carol's own substantial position to be discontinued (although the Health, Work and Wellbeing Directorate continues to operate). And while health at work has been included as one of the five planks of the government's Public Health Responsibility Deal, it is not yet clear whether beyond raising the profile of the issue, a voluntary scheme for businesses will improve workplace health.

The devolved nations offer some lessons for advocates wishing to halt this slide. In Wales, academic research by the University of Cardiff has helped show government the cost to the public purse of doing nothing. Reports by Northern Ireland's audit office have had a similar effect, as has the enlistment of Belfast University researchers to make the case for more concerted action to the Northern Ireland Civil Service.

Individual champions have also been effective advocates. A group of staff came together to persuade the Northern Ireland Civil Service to develop the NICS Well programme for civil service employees. Networks of champions such as the Scottish Vocational Rehabilitation Network and the DWP Health, Work and Wellbeing Coordinator Network pilot offer great promise in creating a critical mass of champions to drive change both at the policy level and in implementation. Resuscitating the English arm of the DWP pilot and including in it a broader range of engaged stakeholders, including representatives from Health and Wellbeing Boards across the country, would be a positive step in building momentum for improvement.

Working together

An inclusive approach has been a feature of efforts to reduce sickness-related worklessness in the devolved nations. As we suggested in our 2011 report, bringing a variety of stakeholders on board and securing their agreement to strategies and targets is likely to enhance the smooth running of programmes and render goals more likely to be met. England currently lags behind in this area – for example, as one Wales-based interview respondent told us, there is interesting work being done in both occupational health and public health in England, but there is little communication between the two so efforts are not joined up and common, and clear messages are therefore lacking.

An impetus from the centre helps foster stronger collaboration. In Wales, occupational health is part of the remit of Public Health Wales, and the Welsh Government has promoted links between Public Health Wales and the RCGP, local health boards, Jobcentre Plus, local councils and business associations. Responding to direction from the centre, each local area has a public health team collaborating with the local authority and local health board. As one of our interviewees suggested, with the current restructuring of public health and the NHS, there is an opportunity to establish a similarly broad NHS occupational health approach in England, perhaps by building the issue into commissioning arrangements.

Policy development in Scotland and Wales has encompassed a broad church. Those responsible for the development and implementation of Scotland's Health Works strategy include stakeholders from the Scottish Government, health boards, employability programmes, COSLA, and STUC. Each is given roles and targets in the Health Works Action Plan. Representatives from STUC and health boards also sit on the advisory group of the Scottish Centre for Healthy Working Lives, along with academics, enterprise agencies and the Health and

Safety Executive. The development of Wales's Health, Work and Wellbeing Action Plan also included a range of stakeholders, from health services, social services, DWP, Wales TUC, Cardiff University and third sector organisations. The action plan contains recommendations for all these parties.

There was recognition among some interviewees that unlike England, the devolved nations are small, and it is therefore easier to bring people together. It may be useful, therefore, for Health and Wellbeing Boards working on the sickness absence agenda to form regional HWB groupings to share experience and reduce the risk of duplicating work. Coalitions of HWBs could, for example, pool investment in pilot studies, and would have access to larger sample sizes for research. They may also be able to establish joint services such as telephone advice lines for businesses or internet hubs.

Effective co-working requires not just bringing relevant parties together, but in planning partnerships so that they achieve specified goals. Jobcentre Plus has worked with NHS Boards and the Scottish Government to place Jobcentre Plus advisers and healthcare professionals in over sixty GP practices in Scotland, offering support and advice to patients seeking information on moving towards employment. Northern Ireland's Social Security Agency, meanwhile, engages trade unions in the development and communication of workplace health policies. This not only makes policies fairer; it also gives them greater credibility among staff. '*Unions will take on a case if someone is treated harshly,'* we were told, *'but officials understand that absence management policies are essential for the business, including in reducing the burden on those left in work by others' absence.'*

Working Health Services Scotland, too, uses its network of stakeholders operationally, both to help it reach SMEs and to assist in monitoring. To reach SMEs the project has made use of its links with chambers of commerce, trade unions and the Scottish Centre for Healthy Working Lives. To draw up measurable indicators it enlisted the help of a range of stakeholders. Public Health Wales has adopted a similar approach for reaching small businesses – 'we are a small team,' an interview told us, 'but we are able to reach many more employers because we work with partners such as business associations and trade unions.'

Working together is also a feature of some of the most successful local programmes. Glasgow Works' Bridging Service and its clients, for example, benefit from advisers being located within health centres or Jobcentres. England's Health and Wellbeing Boards are well placed to encourage similar co-location strategies. Glasgow Works also has secondees from social service agencies, again strengthening the links between social care and health care stakeholders. The programme's Job Brokers, meanwhile, develop close links with local employers, so that the latter know where to turn to for new and well prepared recruits.

Inclusiveness by itself, therefore, should not be the primary objective; bringing relevant stakeholders together in ways that enhance service delivery to clients is the approach adopted by the programmes above, and such targeted collaboration should be the aim of programme designers in England.

Consistent communications

Successful joint working is enhanced by consistent communications. Several of our interviewees remarked on the importance of *'singing from the same hymn sheet,'* with all involved stakeholders repeating the same clear messages to their various audiences. The Welsh Backs campaign is an example of this, with the same messages on why the issue matters, what to do about it, and where to access help disseminated to employers, trade unions, business associations, the public, local authorities and health care providers.

In Northern Ireland, we were told, *'consistent communication is lacking.'* Scotland and Wales are felt to be improving in this area, although several felt there was room yet for much more improvement, and we noted that those we met at the Glasgow Works project were unaware, for example, of Working Health Services Scotland.

Consistent messages for employers are thought to be particularly important. Businesses are persuaded by evidence of cost-effectiveness, and government and trade bodies should develop campaigns to persuade employers large and small of the importance of improving health, and to show them where to turn for help (one interviewee suggested including trade unions, too, as a target audience for such messages). Campaigns should include examples of success with individual firms and workers, combined with robust evidence of the cost of absence to businesses and of the effectiveness of programmes and services. In terms of showing employers where to turn for help, it may be that a one-stop shop or hub is more useful for employers than a range of different health and employability services, with that central body then finding the appropriate service for the firm or the individual

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worker involved. The services to small businesses detailed in section 2 are an important step towards creating such a hub.

Consistent messaging can help in the creation of a national "brand" for health and work services, an idea suggested at a 2010 meeting of Health Works in Scotland (Health Works, 2010). Both the high-level leadership on the issue and the joint working arrangements discussed above render more feasible the creation of such an overarching brand, and for strong nationwide momentum to be built to reduce sickness-related worklessness in the same way as city-wide momentum has been built by Glasgow Works in Glasgow, a brand supported by clear messages and straightforward access to services is a promising avenue.

The value of evidence

The momentum sparked by the Scottish and Welsh governments has created a ferment of experimentation in those countries. Glasgow Works began as a pilot programme and has since run several pilot studies itself. Working Health Services was established on the back of pilot studies in three localities which demonstrated its value before further investment was committed. The Fife mental health pilot demonstrated clear evidence of the effectiveness of a case managed approach. Northern Ireland's civil service has run studies to establish the effectiveness of workplace health programmes, although without the central strategic direction that has provided the framework for studies in Scotland and Wales.

To learn from pilots, the information they produce must be shared widely. It is important in a resource-constrained environment not to waste funds in reinventing the wheel, and pilots should therefore include dissemination of results in their lists of outputs. A pilot that itself offered great promise as a centre for producing and collating evidence was the Scottish Observatory for Work & Health, which was trialled from 2008-2011. The Observatory aimed to collate data on those receiving benefits for health-related worklessness, and to understand the relationships between health and worklessness in Scotland. The project was discontinued, but such a centre is an obvious step for practitioners in England who wish first to lift work as a health outcome up the policy agenda by presenting evidence to policy-makers, and then maintain its prominence by demonstrating the ongoing benefits of programmes.

If learning from pilots is to be absorbed widely, it is vital for those commissioning studies to explain why they are to be rolled out or discontinued. Some pilots are discontinued without clear reasoning, thereby making it difficult both for those who are supposed to refer patients to them to know whether the programmes will still be in operation a few months later, and for other researchers to know whether similar studies are worthwhile in other locations.

Running out of money is likely to be a common explanation for discontinuing apparently effective pilots, and this points to the importance of measuring not just their benefits but their benefits in comparison with their cost. Glasgow Works has proved effective in reducing incapacity benefit rates in Glasgow, but the programme has been highly intensive, involving long-term one-to-one guidance of clients by advisers, and, as a consequence, very expensive. The benefits of the scheme have not yet been measured in terms of the cost, and the same is true of many other pilots and programmes in this area. In an era characterised by cuts to programmes and by rigorous evaluation by NICE of the cost of schemes relative to their benefits, programme designers who wish to convince those pulling the purse strings of the value of their efforts can no longer afford to bypass such analysis.

Engaging health services

Both consistent communications and evidence of effectiveness and cost savings are likely to prove vital for engaging health care practitioners in the work as a health outcome agenda. The difficulty of this task was a major theme in our 2011 Working Together report, and neither has co-opting this group proved easy in the devolved nations. This research has now unearthed several promising approaches.

The first is the provision of simplified referral tools. Some respondents suggested that a simple telephone number to call would be of great help to GPs. The employability pilot project in Glasgow West developed a simplified employability form containing the patient's basic details and the address of the surgery and accompanied by a stamped addressed envelope. This appears to have been effective in increasing the number of referrals. More ambitious was the suggestion to set up a team of health and work experts in each health board. This is already being piloted in three sites in Scotland, with a multidisciplinary team including health and Jobcentre staff, counsellors, and housing, addictions and other

experts sitting under one roof and available for GPs to make rapid referrals. It is not clear whether this is cost-effective, however, and further research is needed to determine the value of such a resource-intensive approach.

The second approach involves consistent advocacy and marketing. The Glasgow West project supported its simplified tool with an awareness raising programme in GP practices. The Glasgow Works Bridging Service has adopted similar methods, presenting health practitioners with evidence of effectiveness including case studies, to show the positive impacts on health services of helping people back to work. Experts from Cardiff University, meanwhile, have pressed the economic case for action in Wales, presenting health professionals with peer-reviewed cost-effectiveness studies from the academic literature, and have also had some success by presenting the moral case for action. One interviewee told us that in seminars and meetings with health professionals he has highlighted the fact that the latter joined the profession in order to help people, and that by neglecting the "medicine" of work, which is proven to improve health, they are condemning patients to a vicious spiral of deteriorating physical and mental health and, on average, an earlier death.

A third idea for enlisting the support of health professionals is being tested by Wales's fledgling Occupational Health Service. Called Health for Healthcare Professionals, this programme focuses on the health of practitioners themselves. It is important, of course, for those delivering health care to be healthy themselves, but this programme may also have the side-effect of demonstrating to practitioners how schemes to keep people healthy at work function and why they are important.

Finally, some interview respondents recommended bypassing GPs altogether. One told us of a musculoskeletal disorder programme in Scotland where physiotherapists ask whether a patient's condition affects their work and refer them to the relevant service. Another recommended educating Allied Health Professionals (AHPs) to ask work-related questions in interactions with patients with the aim of referring them to appropriate services if their health is impeding their work.[iv] The Scottish Centre for Healthy Working Lives has developed a training programme to increase interest among AHPs in vocational rehabilitation. SCHWL sponsors 35 AHPs to study a masters level course at Queen Margaret University in Edinburgh. It is intended that in the long-term, AHPs will become a point of reference to which GPs can direct patients in need of employment support, with AHPs then either providing support themselves or referring the patient to the appropriate specialist provider. Developing such a hub offers promise for simplifying GPs' task and relieving the burden on them in England as well as Scotland, thereby ensuring that more people receive the employability assistance they need.

Taking the long view

Once engaged, health care practitioners and others working to keep people with health conditions in work or return them to work would benefit from taking a long-term view.

This starts with a focus on prevention. Employers have a key role here, ideally supported by information and advice from occupational health care providers and others. Cardiff Council's Work-life Balance Project is a good example of introducing more flexible, employee-friendly arrangements that reduce the risk of health problems, as is the Northern Ireland Civil Service's Direct Access pilot project, wherein physiotherapy sessions helped prevent workers from going off sick.

Where prevention fails, however, early intervention is needed to stop health problems becoming so bad that time off is needed, and to encourage a rapid return to work for those who have to take leave. The case management approach that is a feature of programmes such as Working Health Services Scotland and the Fife mental health pilot is an example of a proactive rather than a reactive approach to tackling a health condition, and firms that have systems in place to identify a problem early and direct the affected individual to a case manager are likely to see reductions in sickness absence rates.

A long-term view requires a recognition that all stages are important in the process of keeping people in work or helping them return to work. As Glasgow Works and its Bridging Service have shown, employment itself is not the only valuable outcome; the steps on the road back to employability are equally significant, and a focus on these steps – and payments for accomplishing them - means that those furthest from the labour market in terms of their

iv. The allied health professions include chiropody, diagnostic radiography, dietetics, occupational therapy, physiotherapy, paramedics, arts therapy, orthoptics, prosthetics and orthotics and speech and language therapy.

3 Lessons learned

condition or the length of time since they last worked will not be neglected. It is important in this regard to keep in mind the value to individuals and society of "meaningful activity," including voluntary work, studying, training or personal development - even if paid employment is the ultimate goal, there are many vital steps on the road to it whose achievement provides great benefits to health and wellbeing.

As well as beginning as early as possible, efforts to reduce sickness-related worklessness should be enduring. The Glasgow Works project would not have appeared effective had its funding been cut after a year or two, but in the third year, as its efforts bore fruit, results were impressive. Funders and project designers must collaborate to set and stick with realistic timelines – strengthening employability is seldom a short-term task, and patience is needed to allow programmes to reach their full potential.

Glasgow Works has also shown the value of long-term goals that continue after an individual has found a job; payment-triggering targets 3 months and 6 months into the individual's employment not only encourage the employability team to find that person a suitable job in which he or she is likely to remain – they also mean that advisers will continue to work with the client and the employer to help with the adjustment process. Some programmes have sullied the reputation of employability work by shoehorning inadequately-prepared clients into unsuitable jobs and then leaving them to sink or swim as soon as they begin working. This has often reversed any health gains made, and rendered clients less willing to look for work subsequently. To restore the trust of health and social care practitioners, and encourage them to make more referrals to programmes, an approach where clients are engaged for the long-term is needed, with sustainable and meaningful employment the target.

Finally, a long view should also aim to be a broad view. Staying in and returning to work if you have a health condition is not always a purely medical issue. Other factors – family problems, financial difficulties, housing, alcohol, drugs, education and so on – contribute to sickness-related worklessness, and comprehensive programmes such as Glasgow Works and Wellbeing Through Work, a new Welsh project that aims to tackle the issue in parts of Wales that have high incapacity benefit and disability rates, recognise this. Prevention of health setbacks requires a focus on the whole person, not only on physical aspects, and on involving, for example, addictions specialists, housing and debt experts, and mental health professionals in case-managing an individual back into full employment. Health and Wellbeing Boards in England will play a key role in bringing such networks together.

4 Conclusion and recommendations

Summary

Scotland and Wales have made concerted efforts to tackle high health related benefit rates in the past ten years. Consistent advocacy and presentation of evidence by employers, academics and champions in the public and third sectors has persuaded high-level policy-makers of the importance of reducing sickness-related worklessness, and resulted in the development of major policy documents and the establishment of inclusive bodies charged with implementing them. The two countries have been very successful in bringing down sickness absence, and have built great momentum to keep improving.

Northern Ireland has made less progress. While strong job retention programmes have been developed for public sector employees, services have not been extended to the private sector. This may be due to the fact that the country is at a fledgling stage in this area, and that if services are to be based on solid experience and evidence of effectiveness it is sensible to get one's own house in order before targeting others. Given the integration of health and social care, the structures are in place for effective rollout of health and work services to the private sector and to those on health related benefits, but it is likely that impetus from the top will be needed if the country is to make that leap.

Recommendations

Drawing on the telephone interviews, the field visit to Glasgow and the literature review, we make the following recommendations for those wishing to reduce sickness-related worklessness in England and in the devolved nations. Several of the recommendations will apply more strongly to some countries than others, but we hope that each will be of some value to practitioners in all four home nations, as well as specifically to Health and Wellbeing Boards in England.

1. The importance of leadership: The success of Wales and Scotland in this area has been founded on strong leadership from the centre. This has been lacking in England and Northern Ireland, and the lessons of Wales and Scotland are that policy-makers respond to hard evidence of cost savings and health improvements, and to continued and determined advocacy by individual champions and by networks of engaged academics and practitioners. Such networks should be encouraged, and England's Health and Wellbeing Boards should look to join or create such networks and press the case for action to high levels of government as well as locally.

2. Clear national strategies: The governments of Scotland and Wales did not just make statements about the importance of reducing sickness-related worklessness; these statements were backed up by strategies that held the various stakeholders to account and defined clear timelines and responsibilities for action. These resulted in the establishment of effective national bodies to promote workplace health and return to work services, and in a flurry of local-level initiatives to see policies through. England and Northern Ireland currently lack such well-defined strategies – indeed, in England, the issue appears to be slipping off the radar - and work is likely to continue to be patchy in the absence of steering from the centre. In particular, downsizing the work of the Health, Work and Wellbeing Directorate is a move that is unlikely to assist in keeping sickness-related worklessness on the policy agenda.

3. Get your own house in order: The Northern Ireland Civil Service and RCN Wales have shown leadership in developing effective workplace health strategies. Fairness and transparency are vital to the smooth running of such programmes, and involving trade unions in their creation and communicating them clearly to employees appears a helpful means of acquiring buy-in from staff. Sickness absence costs the NHS over £500 million each year (Black, 2008), and private sector firms are likely to look more favourably on efforts to reach them with work and health schemes if those delivering them look after their own staff well. As Wales's Health for Healthcare Professionals programme aims to show, moreover, improving the health of those working for the NHS can have the added effect of persuading them of the importance of the work and health nexus. The NHS's Health at Work Network is a step in the right direction in this regard.

4. Goal-directed joint working: Involving a range of stakeholders in the development of policies and the delivery of programmes is vital for effective implementation. Engaging the most relevant stakeholders for achieving particular objectives and securing their sign up to targets increases accountability and renders goals more likely to be met. Such joint working is useful with national policies and at a local level, and it may also be

4 Conclusion and recommendations

possible for Health and Wellbeing Boards in England to coalesce into regional groupings to tackle the health and work issue, and to pool knowledge and resources and provide services jointly.

5. Consistent communications: The value of communicating consistently to all audiences was repeatedly highlighted by our interview respondents. Strong and clear messages can assist in the creation of a coherent "national brand" for health and work, so that all interested parties know where to turn for help and what policy-makers and programme implementers are trying to achieve.

6. The value of hubs for employers: Employers, and particularly SMEs, may benefit from having a one-stop-shop to turn to for assistance on work retention and back to work issues. An array of services and pilot programmes is likely to be confusing to time-strapped businesses and managers, and if hubs such as Workboost Wales and Working Health Services Scotland can act as a focal point which fields queries and directs employers and employees to the relevant service, referrals are likely to increase.

7. The value of hubs for health care practitioners: Hubs such as Glasgow Works's Bridging Service are also useful for health professionals. As with employers, the latter's time is limited and a wide range of options for referral is more likely to be off-putting than alluring. Providing GPs and other health care practitioners with a single point of contact, which can then direct the patient to the appropriate service, is an important step in simplifying the process.

8. The value of hubs for programme implementers: To avoid reinventing the wheel, those designing and delivering health and work programmes would benefit from a central hub – either national or UK-wide – where case studies and data on programme effectiveness are collated and disseminated. The Scottish Observatory for Work & Health was a promising step in this direction, and such a centre could play an invaluable role not only in compiling evidence to press the case to policy-makers, but in inspiring local practitioners with examples of good practice and facilitating the design of programmes.

9. Inclusion of cost-benefit analysis in evaluations: Evaluation of programmes in the devolved nations has been consistent and quite rigorous. However, few analyses have assessed the benefits of projects in comparison with their costs. Stakeholders who need to be convinced of the worth of accessing health and work services – be they policy-makers, employers or GPs – are all more likely to be impressed by those that save them money. Although many of the projects we have reviewed have made great strides in reducing sickness-related worklessness, we are not aware of any that has quantified the savings made against the cost of delivery. Moving forward, practitioners in all four home nations should endeavour to incorporate cost-benefit analysis into policy and programme evaluation.

10. Targeting of "other" health professionals: GPs are not the only health care practitioners who can advise patients on the importance of work and how to avoid sickness-related worklessness. Allied Health Professionals, practice nurses, optometrists and even practice receptionists can transmit valuable messages to those with health conditions, and rather than expending all their time and effort trying to convince GPs, advocates of programmes should focus part of their communication campaigns on these non-GP audiences.

11. Take a long view: Prevention is vital to reducing sickness-related worklessness, and there is much that employers and health and social service providers can do to help stop people needing to take time off work. If a health problem develops, early intervention is needed to prevent it causing prolonged absence – case management is a proactive solution here, and seems more effective than a reactive approach. Care and guidance should not stop when a client returns to work, moreover – the steps on the road back to employability should be valued and built into targets, and continued assistance in the period after re-employment reduces the risk of clients being placed in unsuitable jobs in order to meet targets, and helps with adjustments that lead to sustained employment.

Appendix One: Interviewees

Telephone interviews

Professor Ken Addley,
NICS Occupational Health Service

Robert Atkinson,
Development Manager, Scottish Centre for Healthy Working Lives

Professor Mansel Aylward,
Chair, Public Health Wales

Dr Steve Boorman,
Abermed

Debbie Cohen,
Senior Medical Research Fellow and Director of The Individual Support Programme, Centre for Psychosocial and Disability Research

Tina Donnelly,
Director, Royal College of Nursing, Wales

Roddy Duncan,
Directorate of Health & Healthcare Improvement, Health Improvement Division, The Scottish Government

Fraser Ferguson,
Clinical Coordinator, NHS 24 and Glasgow Back Pain Service

Catrina Henderson,
Health at Work, Glasgow

Kathleen Houston,
Scottish Centre for Healthy Working Lives

Ali Hynie,
Rehabilitation Consultant, OHSAS NHS Fife

Richard Lewis,
Workplace Health Specialist, Health Improvement Division, Welsh Government Directorate for Public Health and Health Professions

Dr Paul Myres,
Public Health Wales

Tommy O'Reilly,
Chief Executive, Northern Ireland Social Security Agency

Terry Park,
Disability Employment Service, Department for Employment and Learning, N. Ireland

Dan Smith,
Reader of Mental Health, Glasgow University Institute of Health & Wellbeing

Sally Venn,
Public Health Wales

Glasgow Works interviews

Sharon Thomson,
Programme Manager, Glasgow Works

Mary Theresa Smith,
Head of Employability, Glasgow's Regeneration Agency

Tom Golcher,
Employability Liaison, Social Work Services

Ian Jamieson,
Bridging Service adviser

Elaine Kerr,
Bridging Service adviser

John MacNeil,
Bridging Service adviser

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Work as a Health Outcome in the Devolved Nations:

How Scotland, Wales and Northern Ireland Tackle Sickness-Related Worklessness

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