Creating Healthier Workplaces

NorthWest Public Health Observatory

synthesis

bringing together policy, evidence and intelligence

KEY Messages

✳ It is widely recognised that being in 'good' work (which includes opportunities for personal development, flexible working, a degree of control, involvement in key decisions and a fair wage) is vital in promoting the physical and mental health of the working age population.[1,7,6]

✳ The recent *Fair Society Healthy Lives*[6] strategic review of health inequalities states that ensuring more people, across the social gradient, are able to access 'good' work and improving the overall quality of jobs available is a key method for tackling inequalities in health.

✳ However, evidence suggests that work and workplaces are currently a factor in poor health outcomes among the working age population, regionally and nationally. In 2008/09, an estimated 122,000 North West employees, for example, were suffering from an illness they believe was caused or made worse by work, 3.5 million working days (full-day equivalent) were lost across the region due to both work-related ill health and injury combined, sickness absence rates in the public sector nationally are consistently higher than for any other employer and stress is a growing reason for absence generally, but especially in the NHS.

✳ There is growing concern nationally over the issue of 'presenteeism' which (although difficult to measure) refers to when employees come to work unfit to do their job; estimated to cost organisations twice as much as short-term absenteeism from work.

✳ In view of such statistics, the *Improving Health and Work Changing Lives*[10] strategy, challenged the public sector (particularly the NHS) to become an exemplar employer in its commitment to promoting staff wellbeing and supporting employees in ill health to remain in, or return more quickly, to work.

✳ Even within the current economic climate, the business case for creating healthier workplaces remains strong (including such benefits as improved staff morale or service quality and reduced sickness absence). NHS Trusts, for example, that score best on key measures of staff wellness (such as injury rates and employee satisfaction levels) have better NHS performance ratings. It is estimated that if the NHS reduced its current sickness absence by one-third, it would make direct savings of £555 million annually. Blackpool, Fylde and Wyre NHS Foundation Trust have, for example, already reduced cases of stress-related illness by around 40% following the delivery of a stress prevention project, as part of its wider organisational strategy, and with backing from the Trust's board, union members, managers and staff.

✳ A wide variety of resources and evidence are available relevant to creating healthier workplaces and supporting employees in ill health. Critical factors in effectiveness include: commitment at board level, worker involvement, effective line management, early intervention, multi-disciplinary support and work-focussed healthcare. There is an urgent need, however, to improve the evidence about 'what works' among employees with a common mental health condition, such as anxiety or depression.

1. INTRODUCTION

This report follows the *Tackling Health Related Worklessness*[2] synthesis report published in November 2009, in which the North West Public Health Observatory (NWPHO) highlighted the scale of ill health preventing people from working, as well as examples of best practice for preparing the out of work for employment. Of particular focus was the high proportion of individuals in the North West, compared with nationally, who were out of work and claiming Incapacity Benefit (IB) because of a health condition or a disability. Health can worsen the longer someone is out of work, and aspirations to return to a job can lower:[3] after only two years claiming IB a person is more likely to retire or die than work again.[4] However, being in 'good' work can not only help to improve individual health and wellbeing, it can also contribute to tackling health inequalities, achieving better economic productivity and improving organisational performance.[5,6] Social capital - including the quality of relationships in the workplace - along with income, are key characteristics of 'good' work and are identified as particularly important in helping retention in work.[7] Having a degree of control over one's own work is also a key feature of 'good' work and is linked to better health outcomes.[6]

Nationally and in the North West the majority of the working age population - over three-quarters - are already in a job[2] and an estimated three-fifths of most people's waking day is spent at work.[8] In the UK, the annual costs of sickness absence together with ill health related worklessness are an estimated £100 billion or more, greater than the total annual budget for the NHS.[9] Consequently, there is a growing focus nationally and regionally, as outlined in *Improving Health and Work: Changing Lives*[10], upon improving the health and wellbeing of working age adults in work settings. This document outlines plans to reduce sickness absence from work and to improve early intervention services and vocational rehabilitation for when individuals become ill to help ensure greater retention in, or quicker return to, work. There is also an emphasis upon promoting the business case for investment in employee health and wellbeing: including such benefits as increased staff engagement and productivity, and reduced staff turnover and recruitment costs.[9,11] A particular focus is upon the public sector, estimated to employ one in five of the working age population nationally and in the North West.[12] The public sector has some of the worst sickness absence rates of any employer.[13] Part of the strategy specifically includes plans for the NHS - employing the largest single workforce - to become an exemplar public sector employer (in relation to staff health and wellbeing).

Workplace health interventions also have the potential to impact upon wider public health outcomes, such as encouraging healthier lifestyle behaviours, as identified in the *Choosing Health: Making Healthier Choices Easier*[14] White Paper. For example, inactive lifestyles account for 37% of all coronary heart disease (CHD)[ii] deaths nationally - the most common cause of death overall in the UK - and the most recent estimates for the North West show that 13 local authorities are in the 10% worst nationally for early deaths from CHD. Therefore, workplace interventions which

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[i] From October 2008 IB was replaced by new benefit, Employment Support Allowance (ESA). Unlike IB, ESA focuses on what people can rather than cannot do and includes a new Work Capability Assessment.

[ii] NWPHO calculation using data from www.apho.org.uk/default.aspx?QN=P_HEALTH_PROFILES

improve lifestyles could be particularly relevant in helping to maintain the recent improvements in life expectancy across the North West.[15]

This *Creating Healthier Workplaces* report therefore aims to synthesise policy, evidence and intelligence relevant to improving the health and wellbeing status of the North West's working age population who are already in a job. The evidence section is divided into three parts:

1. Staying in work

Focuses upon safety at work and the minimum 'legal' requirements to ensure that employees are not harmed by their job and considers how to tackle sickness absence.

2. Flourishing in work

Shows why employers should take a more proactive role in promoting the wider physical health and mental wellbeing of their employees, including details of what makes a model workplace and examples of best practice in promoting wellness at work.

3. Retention and rehabilitation for when employees become ill

Recognises that despite the best workplace practices some employees - whether through a physical and/or a mental health condition - will still require additional support to remain in, or return to, work. Evidence about the key elements of successful interventions will be presented here.

The intelligence section includes the most up-to-date workplace health and wellbeing information for the North West, compared to nationally, with some reference specifically to local NHS workforce data given the focus upon this at national, and by default, regional level.

The NWPHO's *Creating Healthier Workplaces* and *Tackling Health Related Worklessness*[2] synthesis reports are of relevance to employers across the North West, especially in the public sector, who wish to know the key issues and latest developments in the work and public health agenda. Evidence will be particularly relevant to commissioners of occupational health or wellbeing services. Findings should also help to inform and support a range of regional and local functions including the development of Joint Strategic Needs Assessments (JSNA) and related Local Area Agreements (LAAs).

2. POLICY

Boxes 1 to 3 provide an overview of key national and regional approaches designed to improve the health and wellbeing of the working age population who are in a job.

Box 1: Overarching national approaches to improving employee health and wellbeing

※ **Fair Society Healthy Lives** (2010)[6] aimed to produce an evidence based strategy for reducing health inequalities from 2010. It includes policies and interventions that address the social determinants of health inequalities, information on the role of 'good' work in tackling health inequalities and examples of interventions to improve physical and mental health at work.

※ **The Department of Health Response** (2009)[16] to the **NHS Health and Wellbeing Review** (2009)[40] recognised that improved staff health and wellbeing can enhance quality and productivity in the NHS. The response document outlines how the review's findings will be implemented, for example, through board level ownership of staff health and wellbeing issues. The **NHS Operating Framework for England for 2010/11** (2009)[17] also outlines the need to prioritise staff health and wellbeing, including setting targets for reducing sickness absence.

※ **NHS Constitution: the NHS Belongs to Us All** (2009)[18] recognised that high quality care requires high quality workplaces. It includes a commitment to provide all staff with clear roles and responsibilities and rewarding jobs along with opportunities for improving their health, wellbeing and safety, and engaging in decision making. The **High Quality Workforce: NHS Next Stage Review** (2008)[19] outlined plans to improve leadership and staff skills in the NHS. For example, 60% of staff that will deliver NHS services in ten years time already work in healthcare.

※ **Working Our Way to Better Mental Health: a Framework for Action** (2009)[20] the first ever Great Britain wide mental health and employment strategy. The strategy aimed to improve wellbeing at work for everyone and to specifically improve employment outcomes for people with mental health conditions to ensure that greater numbers can enter into, remain in, or return more quickly to, work following illness.

※ **Improving Health and Work: Changing Lives** (2008),[10] released in response to Dame Carol Black's **Working for a Healthier Tomorrow** (2008)[9] review of working age population health and wellbeing, outlines the importance of improving occupational health support services and developing improved early intervention services.

※ **Workers' Health: Global Plan of Action** (2007)[21] emphasises that employee health is not only determined by occupational risks but also by social characteristics, individual factors and access to health services. The plan also recognises that the health of workers is essential for productivity and economic development.

Box 2: National approaches relevant to each of the three sections in this synthesis report

1) **Staying in work**

❊ **Managing Long-term Sickness Absence and Incapacity for Work** (2009)[48] issued by the National Institute for Health and Clinical Excellence (NICE) for employers and other individuals working in the NHS who are responsible for managing sickness absence.

❊ **Securing Health Together** (2000)[22] outlines a ten year strategy for occupational health. The associated **Revitalising Health and Safety strategy** (2000)[23] includes Britain's first ever health and safety targets. More recently, the **Health and Safety of Great Britain: Be Part of the Solution** (2009)[24] outlines the core principles of health and safety in Great Britain. This strategy sets out three key goals which include the need for: i) strong leadership; ii) competency across the whole workforce in assessing workplace risks; and iii) worker involvement and consultation.

❊ **Management of Health and Safety at Work Regulations** (1999)[25] includes a legal duty to assess the risk of stress-related ill health arising from work activities.

2) **Flourishing in work**

❊ **Healthy Weight Healthy Lives** (2008)[26] recognises that workplaces can have a significant impact on employee health and are sites for promoting healthy lifestyles. It also explores how employers can best promote wellness at work and make healthy workplaces part of their core business model. The strategy is supported by the first ever national social marketing campaign - Change4Life - launched in 2009 to promote healthy weight. Further details of the campaign can be found at: www.dh.gov.uk/en/News/Currentcampaigns/Change4Life/index.htm

❊ **Promoting Physical Activity in the Workplace** (2008), **Workplace Interventions to Promote Smoking Cessation** (2007) and **Obesity** (2006) are all guidance issued by NICE. Further details about each piece of guidance can be found at: http://guidance.nice.org.uk

3) **Retention and rehabilitation for when employees become ill**

❊ The National Institute for Health and Clinical Excellence have issued guidance recommending particular interventions or approaches to support individuals with specific disorders. For example, **Early Management of Persistent Non-specific Low Back Pain** (2009) covers the management of pain that has lasted for longer than six weeks but less than a year and **Depression with a Chronic Physical Health Problem** (2009) includes recommendations for the identification, treatment and management of depression in adults aged 18 years and over, in primary and secondary care. **Computerised Cognitive Behaviour Therapy for Depression and Anxiety** (2006) recommends using Beating the Blues for people with mild and moderate depression and Fear Fighter for people with panic and phobia. Further details about each piece of guidance can be found at: http://guidance.nice.org.uk

Box 3: Regional approaches

❊ **North West Regional Workplace Health strategy** (2007)[27] views workplace health along a 'continuum' of many different intervention points to improve or promote working age health and wellbeing.

3. EVIDENCE

3.1 Staying in work

Work-related injury and illness

Britain has one of the best health and safety records in Europe.[28] The most commonly reported source of information about work-related illness and workplace accidents is the Labour Force Survey (LFS), however, as the survey relies upon "lay people's perceptions of medical matters"[(p.1)] it may be subject to a degree of over or under-reporting.[29] Notwithstanding this caveat, 273,000 reportable injuries occurred at work across Great Britain (GB) in the period 2006/07 - 2008/09 (a rate of 970 per 100,000 people employed in the last 12 months) and rates were higher - although not significantly different - in the North West (1,090 per 100,000 workers).[iii]

In addition, in 2008/09 1.2 million people in GB who were in work during the last year said that they had an illness (whether a pre-existing or new condition) that they believe was caused or made worse by work, of which 122,000 individuals (around one-tenth) were in the North West.[iv] Nationally, individuals working in 'health or social work' or 'public administration' generally report some of the highest rates of self-reported work-related illness.[30] Evidence suggests that nationally and regionally, musculoskeletal disorders (MSDs), including low back pain, joint injuries and repetitive strain injuries, are the most commonly reported work-related illnesses, followed by stress, depression and anxiety.[v]

Despite the LFS including stress alongside common mental health conditions such as depression, there is no agreed definition of what 'stress' is.[31] However, stress is recognised to be a significant workplace issue,[31] it is positively related to health conditions such as heart disease[6] and can lead to anxiety and depression.[31] The *Psychosocial Working Conditions in Britain 2009*[32] survey also suggests that there is no longer a downward trend nationally in the number of employees reporting that their job is very or extremely stressful.

NHS employees in particular report higher levels of stress at work than in other sectors (stress is also higher among NHS staff who reported feeling unable to cope with their job - such individuals were twice as likely to report feeling stressed).[33] Stress is positively related to work-related factors such as length of time in post or type of role (for example, employees who had worked longest in the NHS, reported higher levels of stress than more recent employees and staff working in managerial positions reported higher levels of stress than those employed in lower status roles).[33] Stress is also positively related to lifestyles factors (for example, NHS staff who said that they had money problems or caring responsibilities reported higher levels of stress than staff who did not).[33]

[iii] Based on LFS data taken from Table INJGOR1_3YR - Averaged 2006/07-2008/09 available at: www.hse.gov.uk

[iv] Taken from Table WRIGOR1W12 – 2008/09 at www.hse.gov.uk

[v] See section 4 'Intelligence'

Absenteeism

Levels of sickness absence - as a further measure of employee health and wellbeing - are generally higher in the public sector compared with the private sector.[13] Staff working in the NHS experience particularly high sickness absence levels compared to the public sector average.[34] Evidence also suggests that, despite improvements, local authorities have some of the highest sickness absence rates in the public sector, while staff working in education generally have the lowest rates.[13,35] Among both manual and non-manual employees, across all sectors, 'short-term' sickness absence is generally due to minor illnesses (including colds, stomach upsets and headaches).[36]

Causes of 'long-term' sickness absence, however, differ by type of employee. While manual workers are most likely to be off due to acute medical conditions (such as stroke or heart disease), back pain or musculoskeletal problems, non-manual workers tend to suffer more from stress, followed by acute medical conditions and mental health conditions.[36] It is estimated that around one in twenty of all absences will become long-term (defined here as 20 days or more), however, such absences account for around 50% of the overall time lost in the public sector (compared with 31% in the private sector).[37] There is a Europe wide trend for increasing levels of absence and early retirement due to mental health conditions (particularly stress and depression).[38]

Presenteeism

As well as sickness absence from work, there is growing interest in the issue of 'presenteeism'. This refers to employees being in work but not being fully engaged or productive, either due to a health condition or a personal issue.[39] There are thought to be differences in levels of presenteeism by occupational group, for example, across the NHS, 71% of qualified nurses and midwives aged 21-30 years report being present at work when unfit compared with 45% of staff of the same age in corporate services.[40] There is also some evidence of greater prevalence of presenteeism among staff with higher income levels.[41] Absenteeism, however, tends to be a greater issue for lower paid staff, for example, absence levels among manual workers are estimated to be 10.2 days per employee per year, compared with 6.5 days for non-manual employees.[36]

Costs of injuries, ill health, absenteeism and presenteeism

Work-related accidents and ill health together pose significant socio-economic costs to individuals, employers, society and the economy, ranging from an estimated £10.1 billion to £14.7 billion.[34]

In terms of sickness absence, it is predicted that if the NHS, as one example, reduced its current sickness absence levels by one-third, through such actions as more proactive absence management, there would be 3.4 million additional available working days a year for the organisation.[40] This amounts to an extra 14,900 whole-time equivalent staff and estimated direct savings of £555 million annually.[40]

Although difficult to quantify, recent estimates suggest that presenteeism could cost twice as much as short-term absenteeism.[42]

The role of employers and employees in creating safer workplaces

At a minimum, every employer has a 'duty of care' to ensure that employees are not made ill by, or injured because of, their work[43,44] and every member of staff has a responsibility to work with their employer to create a safe working environment.[45] As part of these commitments, any employer with over five employees must have a written health and safety policy.[45] Further commitments for the employer include performing regular risk assessments, alleviating monotonous tasks, adapting work to the individual and tackling the causes of work-related stress.[45]

As already noted, stress is a growing reason for absence, especially in the public sector. In the Management Standards for Work-related Stress and associated Indicator Tool, the Health and Safety Executive (HSE) outline the specific working conditions necessary for alleviating stress and achieving high levels of general employee health, wellbeing and organisational performance (Box 4). In particular these standards emphasise the importance of senior management commitment, effective line management and worker involvement.

Box 4: The six key areas of work design that if not properly managed are associated with workplace stress

1. **Demands** – includes issues such as workload, work patterns and the work environment.

2. **Control** – considers how much say the person has in the way they do their work.

3. **Support** – includes the encouragement, sponsorship and resources provided by the organisation, line management and colleagues.

4. **Relationships** – includes promoting positive working to avoid conflict and dealing with unacceptable behaviour.

5. **Role** – concerns whether people understand their role within the organisation and whether the organisation ensures that they do not have conflicting roles.

6. **Change** – refers to how organisational change (large or small) is managed and communicated in the organisation.

Further information about the Management Standards and the Indicator Tool can be found at: www.hse.gov.uk/STRESS/standards and www.hse.gov.uk/stress/standards/pdfs/indicatortool.pdf

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Good Jobs

Work is identified as a key social determinant of health[6] and, as such, being in 'good' work can protect and promote both physical and mental health.[1,7] The recent *Fair Society Healthy Lives*[6] strategic review of health inequalities - the *Marmot Review* - states that improving "access to good jobs" and "the quality of jobs across the social gradient" is one of the main methods for reducing inequalities in health.[(p.110)] The review outlines 10 'core components' of good jobs that will protect or promote health and are necessary to tackle health inequalities, these components are broadly similar to the areas of work design for managing stress (Box 4).[6] Such jobs include those in which staff have: a living wage, a degree of control over their work (such as the place and timing of a

job), opportunities for skills building and promotion, mechanisms for participating in organisational decision-making, the option of meeting any conflicting demands between work and outside factors (such as one's family), the support they need to return to work following illness, protection from adverse working conditions, and equality and lack of discrimination in the workplace.[6]

Job control and appropriate reward are identified as particularly important in improving health, these components are, however, most likely to be missing from lower status roles.[6] The *Fair Society Healthy Lives*[6] report also notes emerging evidence that positive health outcomes among the working age population could be strengthened if improvements are made to the workplace (such as employment practices) combined with changes made at the level of the individual (for example, changing a person's attitude). In addition, it is suggested that the current economic climate should not deter employers from creating 'good' jobs given the potential benefits in terms of reduced sickness absence, more committed staff and better productivity.[6]

Tackling sickness absence

There is no commonly agreed definition of what constitutes short-term or long-term sickness absence, however, the National Institute for Health and Clinical Excellence (NICE) and the Chartered Institute of Personnel and Development (CIPD) both define these as, less than four weeks or lasting from four weeks and over, respectively.[13] To tackle sickness absence an employer must first accurately measure the scale and nature of the problem. Current evidence, however, suggests that as many as 40% of organisations do not have a sickness absence policy,[9] only half of organisations have targets for reducing absence and just 39% benchmark themselves against other employers.[36]

Short-term absence

The most effective methods for managing short-term absence, according to employers, are return-to-work interviews followed by using trigger mechanisms and then disciplinary procedures (cited by 70%, 32% and 24% of employers surveyed respectively).[13] It is also suggested that occupational health support, usually only considered for those on long-term absence, could be useful in tackling short-term absence.[13] Across the public sector, a number of further approaches are used to reduce short-term absence including: bringing in occupational health advisers for absences above a given number of days annually; formally monitoring responses to agreed triggers; requesting staff make daily telephone calls into work when off sick for short periods; checking for patterns in absence on a Monday or a Friday; challenging people who self-certificate for more than five working days at a time; and providing greater flexibility in 'special leave' and short-term flexi-days.[46] It is also noted that as most short-term absence is caused by minor illnesses (such as colds or upset stomachs), improvements in hygiene practices in work could help to substantially lower absence rates.[47]

Long-term absence

Employers consistently report that the most effective means of managing long-term sickness absence is through the involvement of occupational health (cited by 53% of survey respondents),

followed by rehabilitation programmes or flexible working (20% and 16% of those surveyed respectively).[13] There is also evidence that long-term sickness absence can be prevented if employers follow basic healthcare principles in the very earliest stages of illness (including proactive management of sickness absence) and make relatively low cost workplace modifications available to all employees who become ill.[69] The HSE's 'ready reckoner' tool can be used to help employers determine the best time to intervene (see www.hse.gov.uk/costs/index.asp).[48]

The National Institute for Health and Clinical Excellence (NICE) have issued *Managing Long-term Sickness Absence and Incapacity for Work*[48] guidance for primary care services and employers based on evidence (largely originating in Scandinavia). Recommendations 1 and 2[vi] of the guidance cover two themes:

✳ 'initial enquiries'

✳ 'detailed assessment'

The guidance recommends that a suitably trained and impartial individual should undertake the initial enquiry with the employee within around 12 weeks (but ideally between 2 and 6 weeks) of a person being off sick. If a more detailed assessment is necessary, a case-worker might be needed (this person does not need to be someone with clinical or occupational health qualifications, but for impartiality this should not be a person's direct line manager). The guidance also states that the detailed assessment could involve referral to an occupational health specialist, a combined interview and work assessment and/or the development of a return to work plan.

Box 5: North West case study examples of short and/or long-term sickness absence management

✳ **Blackpool, Fylde and Wyre NHS Foundation Trust**[40] engaged board members, senior managers and line managers in a project to tackle work-related stress. Sickness absence decreased by 4.69% and there was around a 40% reduction in cases of work-related stress reporting to occupational health. Lower scores for bullying and levels of harassment by managers were also achieved and the Trust is now in the top 20% nationally for participation in the staff opinion survey.

✳ **University Hospitals of Morecombe Bay NHS Trust**[49] has levels of staff sickness below the national average, with staff generally taking 8.53 days off work ill per year. Since 2006, the Trust has developed a number of initiatives to reduce staff stress at work including a Stress Management for Managers course running on a monthly basis, which has trained around 130 managers from Divisional General Managers down to Team Supervisors.

✳ **Fylde Borough Council**[50] has established a 100% Attendance Club to recognise those employees who have not taken any time off work sick throughout the year. The project is also linked to healthy lifestyle promotion and policies to support work-life balance.

[vi] Recommendation 3 of the NICE guidance recommends actions related to 'interventions and services' and is therefore referred to in section 3.3 'Retention and rehabilitation for when employees become ill'

Policies and the role of line managers

Evidence suggests that having in place the necessary policies or procedures associated with 'good' jobs (such as induction processes, sickness absence monitoring, team briefings, performance appraisals, upward feedback channels and equal pay reviews for all staff) is not always sufficient to ensure that jobs are 'good'.[7] Line managers have a critical role in implementing many workplace policies and it is recognised that they often have responsibility for carrying out a variety of the tasks traditionally within the remit of personnel, such as providing guidance, recruiting and selecting staff or handling grievances.[45] There is some evidence for reduced sickness absence if line managers specifically receive appropriate training in absence management. For example, the CIPD, HSE and Advisory, Conciliation and Arbitration Service (Acas) have launched a free online Tackling Absence Management Toolkit to help line managers, especially those working in small and medium sized enterprises (see www.hse.gov.uk/sicknessabsence /toolkit.htm). Managers are also identified as one of the major causes of work-related stress due to the impact of their skills to manage staff and stress in the work place (see www.hse.gov.uk/ stress/research.htm). Therefore, it is essential that line managers have the appropriate training, skills and competencies.

3.2 Flourishing in work

Definitions of health and wellbeing

The recent *Health and Wellbeing at Work in the United Kingdom Review*[34] stated that health and wellbeing at work should be understood in terms of the World Health Organisation (WHO) definition of health:

"a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity."[(p.6)]

There is an increasing focus upon how workplaces can promote and protect 'mental wellbeing', defined in the recent Foresight *Mental Capital and Wellbeing Project*[51] final report as:

"a dynamic state, in which the individual is able to develop their potential, work productively and creatively, build strong and positive relationships with others, and contribute to their community."[(p.19)]

Mental wellbeing is identified as vital to the healthy functioning of families, communities and societies,[51] it is something that everyone has and can seek to enhance[52] with improved levels of mental wellbeing linked to high economic and social benefits.[51] The recent *North West Mental Wellbeing Survey*[52] found, for example, strong positive associations across the region between high levels of mental wellbeing and being in work or living in an employed status household. Mental health conditions (such as the most common disorders of mild to moderate depression or anxiety) are considered part of the broader construct of mental wellbeing.[31] Yet, importantly, some of the determinants of mental wellbeing are not the same as those for mental health conditions.[53] As such, staying mentally well is about more than treating or preventing the onset of a mental health condition.[52]

What are the benefits of improving staff health and mental wellbeing at work?

Evidence suggests that employers tend to underestimate the scale and cost of poor mental health and wellbeing at work.[54] Yet, at any one point in time around one in six British workers can be experiencing symptoms (such as sleep problems or worry) associated with having a mental health condition[54] and a further one in six have symptoms sufficient to warrant a clinical diagnosis and/or treatment.[54] Poor mental health and wellbeing account for an estimated 25% of short-term absence (of less than seven days) and 47% of all long-term absences,[54] costing employers an estimated £26 billion annually (through, for example, raised sickness absence or reduced productivity).[75] However, many working age individuals with a common mental health condition, such as anxiety, and the small proportion (around 1 in 100) of individuals with a severe mental health condition, such as schizophrenia or severe depression, can and do work successfully with appropriate support.[54] Evidence relating to identifying signs of, or supporting individuals with, a mental health condition at work is included in section 3.3 'Retention and rehabilitation for when employees become ill.'

Building on the information presented in section 3.1'Staying in work', there is growing evidence about the direct and positive impacts that actively promoting staff health and mental wellbeing through workplaces can bring to an organisation, including improving sickness absence levels, reducing employee turnover or legal risk and increasing performance, employee engagement and productivity.[55,56] PricewaterhouseCoopers found that one public sector health provider's wellness programme achieved a return on investment at a ratio of 9.2 over two years (meaning that for every £1 spent the organisation achieved £9.20 in programme benefits).[56]

Specifically in terms of the NHS, the recent *NHS Health and Wellbeing Review*[40] found that those NHS Trusts who scored better on key measures of staff health and wellbeing (such as injury rates, stress levels, job satisfaction and turnover intentions) had better patient satisfaction levels, Annual Health Check[vii] ratings and Methicillin-resistant Staphylococcus aureus (MRSA) rates. Further socio-economic benefits of actively promoting worker health include helping to achieve wider public health priorities (such as tackling obesity by encouraging people to become more physically active and eat healthier) and helping to achieve social inclusion for all.[38] The *NHS Health and Wellbeing Review*[33] interim report, for example, found that NHS staff who reported drinking more than 10 units of alcohol a week, were 10 to 15% more likely to report feeling stressed.

Who currently promotes physical and mental wellness at work?

Despite strong evidence, the extent to which employers actively promote staff wellness at work is thought to vary considerably. Some estimates suggest that less than 50% of organisations actively promote health and wellbeing in the workplace and even fewer consider staff wellness part of their overall strategy for improving 'top line growth' and 'bottom line performance.'[57] Further estimates, specifically relating to local authorities, found that 88.1% in total had introduced some form of employee wellness programme (largely counselling or help to quit smoking) and 92

[vii] Also known as the NHS performance ratings process, the Annual Health Check is used to measure performance of all NHS trusts in England, for example, in terms of quality and financial management.

authorities used the HSE Management Standards for Work-related Stress.[35] The recent *NHS Health and Wellbeing Review*[33] found that, despite many examples of good practice, commitment to staff wellness in the NHS varied: NHS staff tended to feel that the organisation as a whole, and local NHS managers, did not currently prioritise staff health or wellbeing and that wellbeing services tended to focus upon responding to illness when it occurred rather than proactively promoting staff health.[33]

It is suggested that the economic recession could negatively affect some employers' commitment to invest in staff wellbeing[36] and may even hide the signs of poor staff health and wellbeing. For example, sickness absence may drop because staff take fewer days off due to fear of losing their jobs.[7] Small organisations also face particular challenges in promoting staff wellness, for example, although an estimated two-thirds of small businesses overall say that investing in employees' health makes economic sense, one-third were worried about costs.[58] Such employers are a key focus of current policy nationally, including the launch of a £20 million Capital Fund to extend occupational health services to small businesses (see www.workingforhealth.gov.uk/initiatives /ChallengeFund/faqs/Default.aspx). The majority of the estimated 265,095 North West businesses[viii] in 2008 were small, over three-fifths (176,655) had under five employees and a further 39,590 businesses had five to nine employees.[59]

How to improve staff wellness in workplaces - a model workplace

Prior to establishing any service or intervention, effective wellness programmes rely upon both senior management commitment and employee engagement. The recent *NHS Health and Wellbeing Review*[40] for example noted that the NHS must "go beyond meeting legislative obligations"[(p.19)] and should ensure that staff health and wellbeing is:

"at the heart of the way in which they [Trusts] do business [and be] aligned with wider public health and health promotion strategies and is central to training, development and appraisal of managers."[(p.15)]

The *Improving Health and Work Changing Lives*[10] strategy outlines plans for the NHS - as the largest employer in the country - to set the standard across the public sector in terms of becoming a model workplace. Evidence suggests that the most commonly provided wellness activities nationally include access to counselling (with nearly half of employers offering this) followed by employee assistance programmes (EAPs), stop-smoking support, subsidised gym membership and flexible working.[36] A further key example of a staff wellness programme is occupational health support, others include lifestyle management advisors or access to health screening interventions.[40]

The National Institute for Health and Clinical Excellence (NICE) have issued guidance relating to improving staff health and wellbeing through workplace interventions. For example, their *Promoting Physical Activity in the Workplace*[60] guidance recommends developing and monitoring an

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[viii] Using VAT and PAYE based enterprises.

organisation-wide strategy to promote physical activity at work (including plans to encourage staff to build greater physical activity into their route to work and/or their working day). The *Workplace Interventions to Promote Smoking Cessation*[61] guidance issued by NICE outlines the most effective and cost effective approaches, such as providing information on local stop smoking services and allowing people who smoke to attend these services during working hours without losing income, to the provision of these services at work itself. The Cochrane Colloboration found that established interventions to help people stop-smoking, such as group therapy, individual counselling and nicotine replacement therapy, are just as effective when accessed through work.[62] However, evidence for self-help methods is more variable and social or environmental support (such as from a spouse or workmate or from anti-smoking posters in the workplace), and competitions or incentives do not appear to offer further help for smokers to give up at work.[62] The *Fair Society Healthy Lives*[6] report also notes several studies showing that by combining healthy lifestyle interventions with actions designed to change the work environment (as outlined in section 3.1 'Staying in work'), employees are much more likely to adopt healthier behaviours.

Box 6: General resources for creating healthier workplaces

Working for Health (www.workingforhealth.gov.uk)
Official site of the government's Health, Work and Wellbeing initiative. Resources section provides many links to useful tools and evidence summaries.

NHS Employers (www.nhsemployers.org)
Healthy Workplaces pages offer a range of advice on topics including mental health, stress and health, work and wellbeing, specifically for NHS employers.

Local Government Employers (www.lge.gov.uk/lge/core/page.do?pageId=119861)
Guidance and publications on managing sickness absence.

Health and Safety Executive (www.hse.gov.uk)
Leaflet, guidance and tools on occupational health issues such as stress, managing sickness absence and return to work advice for all employers.

Advisory, Conciliation and Arbitration Service (www.acas.co.uk)
Health, work and wellbeing pages, including a Health, Work and Wellbeing Information Booklet specifically aimed at smaller employers.

National Institute for Health and Clinical Excellence (http://guidance.nice.org.uk)
Guidance on evidence for workplace interventions.

WorkSmart (www.worksmart.org.uk)
Trade Union Congress (TUC) backed site, Your Health section includes advice on drugs and alcohol for employers and employees.

Chartered Institute of Personnel Development (www.cipd.co.uk)
Information on short and long-term absence management.

British Heart Foundation (www.bhf.org.uk/thinkfit)
Information and advice on promoting physical activity and health in the workplace.

Box 7: North West case study examples of staff wellness programmes

Knowsley PCT[63] is in the top 20% of PCTs nationally for its commitment to staff work life balance, for example, 75% of employees engage in flexible working arrangements. The number of staff who said that they experienced work-related stress is similar to the England average (33%). The PCT runs a mandatory Essential Skills for Managers stress awareness course and publishes a leaflet highlighting the different benefits and support available to staff. Given the importance of the staff survey in annual planning, contributions are encouraged by allocating each employee 30 minutes of working time to participate. More recent evidence shows the Trust also has a Stress Working Party, chaired by the Director of Human Resources, to help develop tailored strategies for tackling stress.[64]

Chorley Metropolitan Borough Council[65] achieved significant improvements in sickness absence and staff engagement following a new commitment to staff wellness at senior level. While the council was ranked 15th best for its staff's health and wellbeing in 2008 on the Times 'Best Councils to Work For' list, it moved to a rank of 1st (and the most improved council) by 2009. Chorley also significantly reduced its average days lost through sickness absence between 2004 and 2009 by over half.

Burnley Borough Council[66] includes a wellbeing group (sponsored by the lead director for health and safety) with representatives from across the workforce. As part of a wider wellbeing strategy, the group has carried out a number of interventions (including blood pressure testing days, stress management workshops, smoking cessation classes in work time and the revision or introduction of new policies). The strategy has senior management support and measures of success include a reduction in rates of sickness absence due to stress from 3.35 days in 2006/07 to 2.55 days in 2007/08.

Trafford PCT[67] has a weight management initiative and a comprehensive health and wellbeing programme (evidence of success includes improved staff satisfaction and morale among employees).

Improving mental wellbeing through workplaces

The *Foresight*[51] report has identified five simple, evidence based steps that if built into everyday life are proven to make a real difference to a person's mental wellbeing at home and work:

❋ **Connect**
Develop relationships to enrich your life and bring you support.

❋ **Be active**
Participate in sports, hobbies or a daily stroll to increase good feelings, mobility and fitness.

❋ **Be curious**
Appreciate and reflect on everyday moments as well as the unusual.

❋ **Learn**
Master a new skill to bring challenge, satisfaction, enjoyment and confidence.

❋ **Give**
Help friends and strangers and link your happiness to a wider community to reap the rewards.

Liverpool NHS primary care trust (PCT), in partnership with Liverpool City Council, have already adopted these five steps to mental wellbeing as the framework for their 2010 Year of Health and Wellbeing (see www.2010healthandwellbeing.org.uk/index.php?page=about).

The recent *Promoting Mental Wellbeing Through Productive and Healthy Working Conditions Guidance for Employers* issued by NICE[68] and endorsed in the *NHS Health and Wellbeing Review*[40] is based upon current evidence, economic analysis, advice from experts in the field and feedback from key stakeholders. The final recommendations cover five key themes which, if adopted in the workplace, will help to promote and improve staff mental wellbeing:

1. **A strategic and co-ordinated approach** (including working in partnership with staff to promote a culture of participation and raising awareness and understanding of mental wellbeing).

2. **Assessing opportunities for promoting employees' mental wellbeing and managing risks** (for example, carrying out an employee attitude survey and using staff absence data to ensure appropriate assessment and monitoring of staff mental wellbeing).

3. **Flexible working** (including where reasonably practicable the provision of opportunities for staff to, for example, undertake part-time working, home-working and job sharing).

4. **The role of line managers** (including ensuring that managers are aware of the types of management style and practices that can help promote staff mental wellbeing, can identify and respond to the signs and symptoms of poor staff wellbeing and consider using the competency framework for managers developed by the CIPD, the HSE and Investors in People). The recent *NHS Health and Wellbeing Review*,[33] for example, suggested that 'management attitudes and practices' were a significant factor in poor mental wellbeing among staff.[p.31]

5. **Supporting micro, small and medium sized businesses** (offering advice and a range of support and services).

Box 8: General resources for improving mental wellbeing in the workplace

Shift (www.shift.org.uk/employers)
The Department of Health's programme to reduce the stigma and discrimination around mental health issues includes practical guidance (a guide, video resources and case studies) for managing and supporting people with experience of mental health conditions in the workplace.

Mindful Employer (www.mindfulemployer.net)
Charter and resources to help employers promote awareness of mental wellbeing at work.

Sainsbury Centre for Mental Health (www.scmh.org.uk/employment/index.aspx)
Information and evidence on promoting new ways to help people with mental health conditions find and keep work.

Mental Health First Aid England (www.mhfaengland.org.uk)
A tool to help organisations improve the mental wellbeing of their staff through education on a range of mental health conditions and action to reduce stigma and encourage early intervention.

3.3 Retention and rehabilitation for when employees become ill

Occupational health and vocational rehabilitation

Even in the best or 'model' workplaces it is estimated that a minority of employees (around 5-10%) will be off work sick long-term (defined here as over six weeks).[69] As multiple factors impact upon a person's health and wellbeing, effectively supporting employees in ill health will require a holistic approach.[9] For example, evidence shows that medical interventions alone are unlikely to positively affect work outcomes and do not necessarily help recovery.[31,69] The *Working for a Healthier Tomorrow*[9] review of working age health, emphasised that to develop an "integrated and effective approach" to improving health and wellbeing among the working age population, occupational health needs to become part of mainstream healthcare services.[(p.95)] In the more recent *NHS Health and Wellbeing Review*,[40] NHS staff noted that occupational health was largely a reactive service and many commissioners felt it was essentially concerned with pre-employment screening, immunisation and managing sickness absence. The review also found that staff throughout the NHS wanted to be able to access occupational health services through self-referral as well as a managerial referral, the former of which was especially useful for staff with substance misuse issues or mental health conditions who might have concerns over confidentiality or stigma.

As already noted, common health conditions account for the majority of current sickness absence or long-term incapacity from work and it is argued that the majority of these should be manageable through appropriate and timely intervention.[69] Coupled to the negative effects that being out of work can have upon individual health and wellbeing, and upon employers and society, there is a growing focus upon Vocational Rehabilitation (VR). As a comparatively new concept in the UK, VR is defined as "whatever helps someone with a health problem to stay at, return to, or remain in work."[69(p.10)] It therefore describes an approach rather than a specific intervention and has the overall aim of ensuring that people who become ill are not off sick from work longer than necessary or have to leave their job altogether.[69]

Vocational Rehabilitation is different from rehabilitation which traditionally focuses upon people with only the most severe health conditions.[69] The *Working for a Healthier Tomorrow*[9] review, for example, found that access to VR (which can include occupational therapists, case managers, psychologists, job centre staff or actions such as access to medical treatment or flexible working) was fragmented and only available to a small number of people. To help raise the profile, quality and value for money of VR, new standards have therefore been released (see www.vocationalrehabilitationassociation.org.uk) with specific focus upon securing better outcomes among those furthest from the labour market.[41]

Such developments in VR are set against an evolving policy context. For example, from April 2010 a new Fit Note has replaced the original 'sick' note. Fit Notes aim to help GPs better advise patients who are off work sick for more than seven days whether, with extra support from their employer, they could return to work earlier (see www.dwp.gov.uk/fitnote). Related to this, Fit for Work Services (FFWS) are being piloted to help provide working age people in ill health with 'personalised and timely back to work support' including health, employability and wider social support components (see www.workingforhealth.gov.uk/Initiatives/fit-for-work-service).

Existing reviews of the evidence base - what works?

A number of authors have already reviewed evidence about interventions to support workers with common health conditions (Box 9). Although some are systematic in their approach (mainly considering results of Randomised Control Trials) other reviews, for example, use a 'best' evidence synthesis, which although introducing greater subjectivity, greatly enhances the number of studies or types of information that can be included for review.[31,48] The majority of reviews emphasise the need to improve the available evidence base in relation to mental health conditions, the cost effectiveness of interventions[34,48,69,74] and the impacts of organisational level interventions (such as modifications in employment practices) compared with individual level interventions (including changes in worker behaviour).[6,31]

Box 9: Evidence reviews relevant to developing workplace interventions

✳ **Health and Wellbeing at Work in the United Kingdom** (2009)[34] commissioned to support the **NHS Health and Wellbeing Review** (2009).[40] Considers literature on the effectiveness of interventions, in terms of health and work-related outcomes, and classifies interventions according to two broad groups: i) those targeted at specific disease; and ii) worksite health promotion activities (addressing the general risk-factors associated with illness).

✳ **Vocational Rehabilitation, What Works for Whom and When?** (2008)[69] aimed to provide an evidence base for developing VR policy among people with common health problems. Considers data from 450 scientific reviews and reports about the effectiveness and cost effectiveness of interventions. Uses a best evidence synthesis to produce evidence statements.

✳ **Management of Long-term Sickness and Incapacity for Work: Evidence Review 1** (2008)[74] considered the effectiveness and cost effectiveness of interventions, strategies, programmes and policies to reduce the number of employees who move from short-term to long-term sickness absence and to help employees on long-term sickness absence to return to work. Includes 45 articles covering five broad themes: i) Exercise-based interventions for musculoskeletal disorders; ii) Psychological-based interventions; iii) Multi-disciplinary interventions; iv) Patient management programmes; and v) Other interventions.

✳ **Management of Long-term Sickness and Incapacity for Work: Evidence Review 2** (2008)[73] considered the effectiveness and cost effectiveness of interventions, strategies, programmes and policies to reduce the number of employees who take long-term sickness absence on a recurring basis. Includes seven articles covering three broad intervention themes: i) Exercise and education programmes to prevent occurrence of lower back pain; ii) Pain management through group learning; and iii) Clinical interventions to treat lower back pain.

✳ **What Works at Work?** (2007)[31] reviews existing evidence (from systematic and other high quality evidence reviews) assessing the effectiveness of workplace interventions to prevent and manage common health problems.

✳ **Workplace Interventions for People with Common Mental Health Problems** (2005)[71] used a systematic approach and did not exclude studies describing non-work based interventions (as long as employment was one of the outcome measures).

✳ **Concepts of Rehabilitation for the Management of Common Health Problems** (2004)[72] included work as the key goal and outcome measure of rehabilitation in the review. Provides a theoretical and conceptual basis for rehabilitation of common health problems rather than a systematic review of the evidence.

Drawing upon evidence from across different reviews, it is possible to identify some key elements that should be considered when developing effective interventions for workers with common health conditions (Box 10).

Box 10: Some key elements for employers to consider when developing effective interventions

❊ **Early intervention**

The longer someone is off work, the greater the barriers are to returning[69,73,74] and early intervention is especially important for workers with mental health conditions.[31] In the North West for example, the NHS is piloting Beyond Blue training among managers with the aim of strengthening their awareness of how to recognise and respond to the early signs of poor mental wellbeing (further details are available from www.scmh.org.uk/pdfs/workplace_programme_NorthWest_region.pdf).

❊ **Employer involvement**

Healthcare alone is insufficient and the involvement of employers (in terms of, for example, proactively managing sickness absence or temporarily adapting work) is crucial in achieving retention in, or return to, work among workers with common health conditions.[69,73,74] It is also important that healthcare places greater emphasis upon return to work as an outcome.[34,69] Staff tend to be less likely to report a mental rather than a physical health condition at work;[75] non-stigmatising and accommodating workplaces are therefore important factors in supporting workers with a mental health condition (see details of the Shift and the Mindful Employer initiatives - Box 8).

❊ **Individual and/or organisational level intervention**

There is stronger evidence for intervention at the level of individual (for example, in terms of behaviour change) compared with the organisation level (such as changes in employment practices), but often due to limited data.[6,31,71] Evidence shows that Cognitive Behavioural Therapy (CBT), for example, is most effective for workers with common mental health conditions who have high levels of job control and when provided in short courses (of up to eight weeks) after two weeks sickness absence.[71] Evidence also suggests that CBT is useful in small groups for women with musculoskeletal pain.[48]

An Improving Access to Psychological Therapies (IAPT) programme is available to workers nationwide and includes specialist job retention support for people with common mental health conditions (see www.iapt.nhs.uk).

❊ **Targeted and/or generic intervention**

There is some evidence that, to achieve greatest return, interventions should be targeted at those workers most at risk of not returning to work or of developing particular work-related conditions. For example, among lower back pain suffers[31] or workers with common mental health conditions.[71]

❊ **Multi-disciplinary (multi-modal) or singular intervention approaches**

There is evidence that multi-disciplinary approaches can be the most effective.[31,73] It is also recommended by NICE that 'actively doing something with people' (such as physiotherapy) is generally more effective than 'advising' them about something.[48] In addition, NICE recommend that intensive programmes should be offered to individuals who are the most unlikely to return to work (including multi-disciplinary support over a number of weeks as well as usual care and treatment), while less intensive interventions along with usual care should be offered to workers with a better likelihood of returning to work (such as encouraging greater physical activity or learning to use relaxation techniques).[48]

❊ **Preventative and/or rehabilitative intervention**

It is suggested that a combination of preventative, supportive and/or rehabilitative interventions are necessary for many of the common health conditions.[34] Studies have shown that exercise can effectively prevent musculoskeletal disorders.[31] It has also been shown that a range of stress management interventions can improve health and work outcomes among employees who have not yet developed a common mental health condition.[71]

Evidence shows that CBT can positively impact upon the number of sick days taken among employees who already have a disability related to back or neck pain (compared to treatment or advice from a GP) and that contact between health staff and employers can reduce the length of time someone is off work ill.[31] Early use of modified work is also shown to cut sickness absence by 30% among staff who already have back pain.[31]

4. INTELLIGENCE

Occupational safety and ill health

The Health and Safety Executive (HSE) publish a variety of occupational safety and ill health intelligence on their website (www.hse.gov.uk) from a range of sources. For example, the HSE commission questions in the Labour Force Survey (LFS) - a national survey of around 53,000 private UK households - measuring the level of self-reported work-related illness and workplace injury. As already noted such data could be subject to a degree of over or under-reporting.[29] Further data is available via the HSE from RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995), which legally requires employers to report incidents occurring at work.

Self-reported illness caused or made worse by work

The most recent data available from the HSE is for 2008/09, however, only a limited amount of such data is currently available, especially at a regional level. For the purpose of this analysis, 2008/09 will be used to provide headline statistics about the estimated prevalence of self-reported illness among those working in the last 12 months across the North West compared with nationally. However, earlier data (from 2007/08) will be used to help provide more detailed analyses, for example, about the most common types of self-reported illness at a regional level.

In 2008/09, an estimated 122,000 people in the North West, who were in work in the last year, believed they were suffering from an illness caused or made worse by work (long standing as well as new cases of illness), equating to a prevalence rate of 3,610 per 100,000 people (3.6%) working in the last 12 months (Figure 1). This rate was below, although not significantly different to, the estimated prevalence of self-reported illness across England in 2008/09 (3,930 per 100,000 people - 3.9%) and not significantly different to estimated rates in the other English Government Office Regions.

Figure 1: Estimated rate of self-reported illness caused or made worse by work for people employed in the last 12 months. England and Government Office Regions, 2008/09.

Source: NWPHO using data from HSE (Table WRIGOR1W12-2008/09).

While prevalence refers to the number of people with a work-related illness in a given time period, incidence refers to new cases of work-related illness occurring during the time period. Incidence data for 2008/09 show that of the 122,000 people in the North West working in the last year who were suffering from a work-related illness, around two-fifths (47,000 individuals) were new cases of work-related illness occurring in the last 12 months. This equates to an incidence rate of 1,400 in 2008/09 per 100,000 people employed in the last 12 months, not significantly different to the incidence rate across England (1,820 per 100,000 people).

Musculoskeletal disorders caused or made worse by work

The most recent data available, for 2007/08, showed that the estimated rate of musculoskeletal disorders caused or made worse by work across the North West was not significantly different to the England average (1,700 and 1,810 respectively per 100,000 people working in the last 12 months) (Figure 2). This equates to an estimated prevalence of 474,000 people across England in 2007/08 who said that they were suffering from a musculoskeletal disorder, 57,000 of whom were in the North West.

Stress, depression or anxiety caused or made worse by work

In 2007/08, the estimated rate of stress, depression or anxiety caused or made worse by work in the North West, among those working in the last 12 months, was also similar - not significantly

different - to the rate across England (1,450 and 1,440 respectively per 100,000 people employed in the last 12 months) (Figure 2). This equates to an estimated prevalence of 376,000 people across England who said that they were suffering from work-related stress, anxiety or depression in 2007/08, 49,000 of whom were in the North West.

Figure 2: Estimated rate of self-reported musculoskeletal disorders and stress, depression or anxiety for people employed in the last 12 months. England and Government Office Regions, 2007/08.
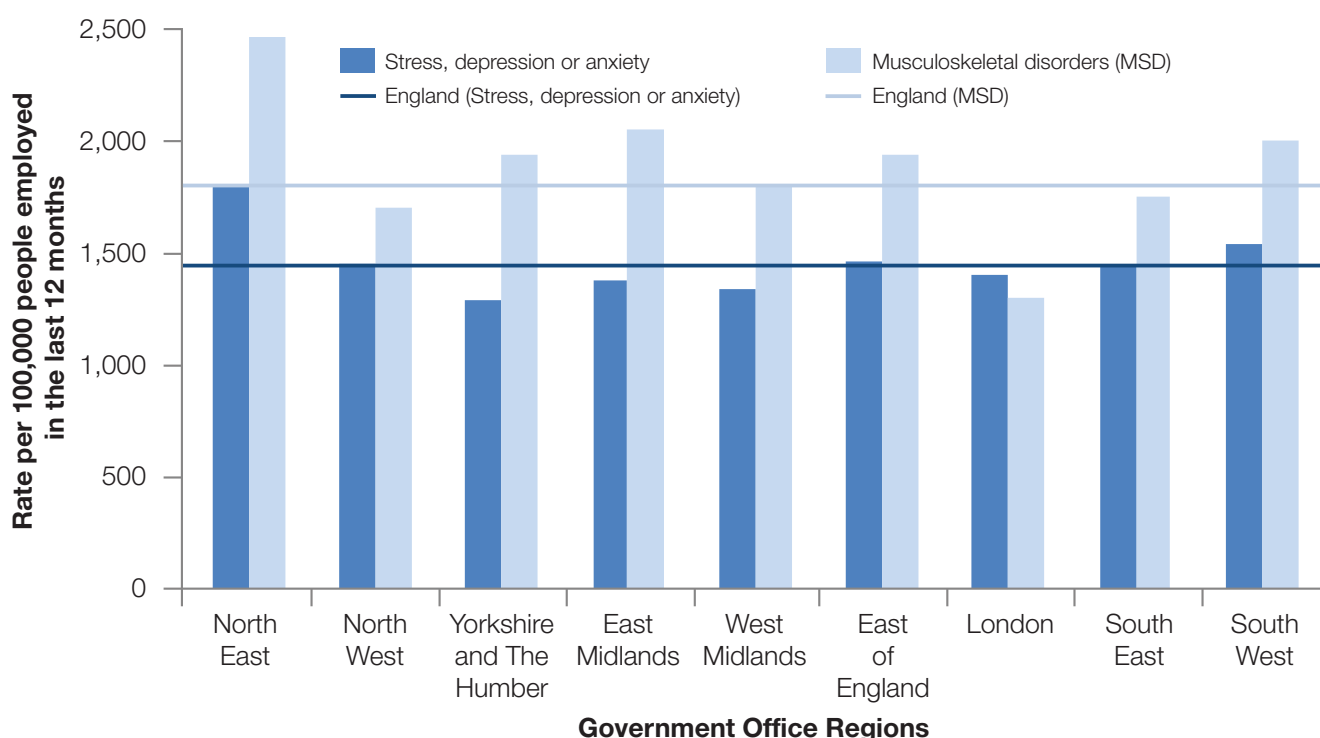
Source: NWPHO using data from HSE (Table MSDGOR1W12-2007/08 and Table STRGOR1W12-2007/08).

Work-related injury

Reportable non-fatal workplace injury

Injury data from the LFS asking people if they had suffered a workplace injury in the last year is only available at regional level as a three year average. Data for the period 2006/07-2008/09 showed the incidence rate of reportable non-fatal injury[x] to workers in the North West was 1,090 per 100,000 workers employed in the last 12 months (1.09%). The North West figure was not significantly different to the England average (970 per 100,000, or 0.97%). These figures equate to an average estimated incidence of 235,000 non-fatal workplace injuries to workers across England in the period 2006/07-2008/09 (of which 34,000 occurred among individuals from the North West).

[x] Non-fatal workplace injuries include all those resulting from non-road traffic accidents and causing over three days sickness absence.

Fatal injury, reported major injury and reported injury resulting in over three days of absence

In 2008/09, provisional data from RIDDOR showed that there were 22 fatal injuries to workers in the North West (including both employees and the self-employed), 3,281 reported major injuries to employees and 12,901 employees who suffered injuries that resulted in over three days absence from work.

In the North West in 2008/09, the total injury rate was 543.0 per 100,000 employees compared with a rate of 492.1 across England.[xi] Specifically, a rate of 110.5 per 100,000 employees for fatal and major injuries across the North West (England: 101.8) and 432.6 for injuries resulting in over three days absence in the North West (England: 390.4).

It is important to note that differences between injuries across different regions are strongly influenced by the composition of employment in an area, for example, the mix of industries and occupations and have not been explored here.

Working days lost due to work-related illness or injury

In 2008/09, an estimated 3.5 million working days (full-day equivalent) were lost in the North West due to work-related ill health and workplace injury together (2,846,000 due to illness and 672,000 due to injury). This amounted to 1.36 average days lost (full-time equivalent) per worker in 2008/09, due to work-related illness or injury across the North West. This figure was not significantly different to the England average (1.21 average days per worker).

Sickness absence

A greater amount of data are available in relation to general sickness absence than for work-related absence. Although this is not always reportable at a regional level, the scale of the problem nationally and further key issues are presented in two annual surveys. The Chartered Institute of Personnel and Development (CIPD) annual survey report for 2008[13] and the Confederation of British Industry (CBI) survey 2008[37] produced with health insurer AXA (both relating to the period 1st January 2007 to 31st December 2007) reveal a number of headline statistics. It is important to note that as each of these surveys question just a sample of all employers nationally, the findings only provide an indication of key issues or trends in absence management. A more recent CIPD survey is available for 2009, however, this is not used here as the findings (which relate to 2008) would not be comparable with the most recent CBI report above. As outlined in the *North West Regional Workplace Health Strategy*,[27] it is however important to note that sickness absence figures can be strongly influenced by a range of determinants including availability of sick pay, human resource policies or practices and access to occupational health support.[27]

[xi] Details of significance were not available.

## Average levels of absence by sector

The CIPD 2008 survey states that average absence per employee, per year fell 0.4 days to 8.0 days (from 8.4 days in the 2007 survey), while the CBI/AXA survey estimated average absence levels to be slightly lower overall in 2008 (6.7 days per employee, per year), a decrease of 0.3 days (from 7.0 days per employee, per year in 2007) (Figure 3).

Common to both surveys, sickness absence remained highest in the public sector (CIPD: 9.8 days in the public sector compared with 7.2 days in the private sector; and CBI/AXA: 9.0 days in the public sector compared with 5.8 days in the private sector [Figure 3]). However, research by the HSE shows that differences in workforce demographics are likely to account for some of the public or private sector variation. For example, the public sector generally employs more women and includes a larger workforce, both of which are associated with higher sickness absence levels generally. The CIPD 2008 also showed that the health sector had the highest rate of sickness absence across the public sector (11.7 days) and education the lowest (7.8 days). A similar pattern was evident in the CBI/AXA 2008 survey (12.6 days lost on average in health/social care and 7.5 days in education).

Average levels of absence by size

Both the CIPD and CBI/AXA 2008 surveys found that the size of the organisation was a factor in absence, with smaller organisations having lower average absence levels (CIPD: employers with below 100 employers reported average absence levels of 6.1 days per employee per year compared with 9.9 days among employers with over 2,000 employees; and CBI: employers with below 50 employees had an average absence level of 3.6 days a year, compared with 8.5 days among those with over 5,000 people) (Figure 3).

Figure 3: Average sickness absence rates by sector and size of organisation. UK, 2008.
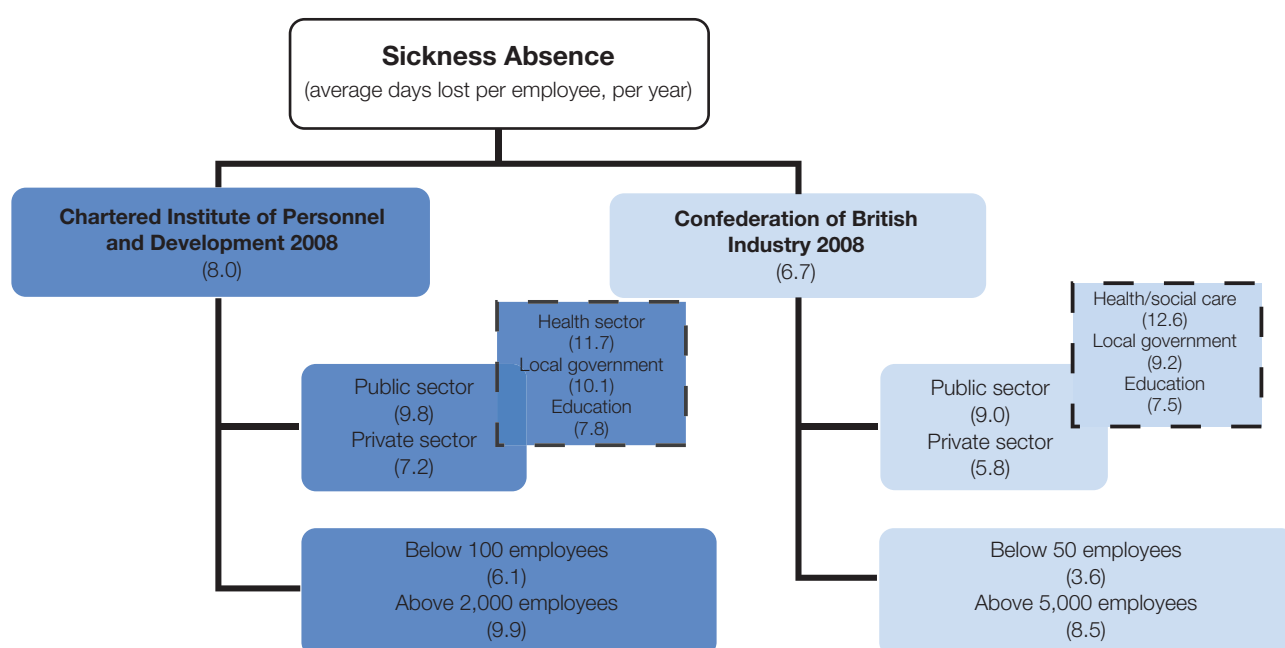
Source: NWPHO using data from Chartered Institute of Personnel and Development 2008 and Confederation of British Industry 2008.

Regional absence

The CIPD 2008 survey has the benefit of also providing some regional level comparisons and these showed that across the English regions, the North West had the joint highest average working time lost per year (4.2%, along with the East Midlands and West Midlands). The North West had the third highest average days lost per employee per year (9.3 days, the same as in East Anglia). The highest average days lost per employee, per year was 9.5 days in the West Midlands and the lowest was 6.0 days in London. According to the CBI/AXA 2008 survey, the North West had the highest rate nationally along with Yorkshire and Humberside (both 8.9 days).

Costs of absence

The estimated average costs of sickness absence per employee per year according to the CIPD 2008 survey were £666 and were highest overall in the public sector, an estimated £906 per employee per year. The CBI 2008 estimated that the direct costs of absence, such as hiring temporary replacements when staff are off work, were 3.1% of payroll for the average employer.

Reasons for short-term or long-term absence

There are clear differences in reasons for absence by length of absence and type of employee. The CIPD 2008, for example, found that minor illnesses (such as colds and upset stomachs) were the most common cause of short-term absence among both manual and non-manual workers. Short-term illness here was defined as absence lasting four weeks or less.

The second most common causes of short-term illness among manual workers were back pain, followed by musculoskeletal disorders (such as repetitive strain injury), stress, and home or family responsibilities. Stress was, however, the second most common reason for short-term absence among non-manual workers, followed by musculoskeletal disorders, back pain and home and family responsibilities.

For long-term sickness absence, employers said that the top five causes of long-term absence among manual employees were:

✳ acute medical conditions (such as stroke, heart attack and cancer);
✳ back pain;
✳ musculoskeletal disorders (such as neck strains but excluding back pain);
✳ stress; and
✳ mental health conditions (such as anxiety or depression).

Among non-manual employees the major causes of long-term sickness absence were:

✳ stress;
✳ acute medical conditions;
✳ mental health conditions;
✳ musculoskeletal disorders; and
✳ back pain.

Sickness absence rates among NHS staff

Statistics are available from the NHS Information Centre using data from the Electronic Staff Record (ESR) to show NHS sickness absence rates between April and September 2009. This is the first time such data has been published from the ESR and, as such, it is considered 'experimental' at this stage. There is an important caveat with this data: although low sickness absence rates generally indicate low levels of sickness absence, they could also be a sign of under reporting by individual NHS Trusts. In addition, sickness absence can vary throughout different times of the year.

The most recent data will be presented below to provide a snapshot of sickness absence among staff working in the NHS across the North West.

Strategic Health Authority (SHA) areas

The data suggests that the North West Strategic Health Authority (SHA) area consistently had some of the highest sickness absence rates among staff compared to other SHA areas. The North West SHA area was the second highest in April, May June, August and September 2009 (4.50%, 4.53%, 4.49%, 4.68% and 4.60% respectively) after the North East and also had a higher rate than the England average in each of the five months. In July 2009, the North West SHA area had the third highest rate of sickness absence (5.12%) after the North East and East Midlands (5.35% and 5.13% respectively), however, the North West rate was still higher than the England average (Figure 4).

Figure 4: Sickness absence rates. Strategic Health Authority (SHA) areas, September 2009.
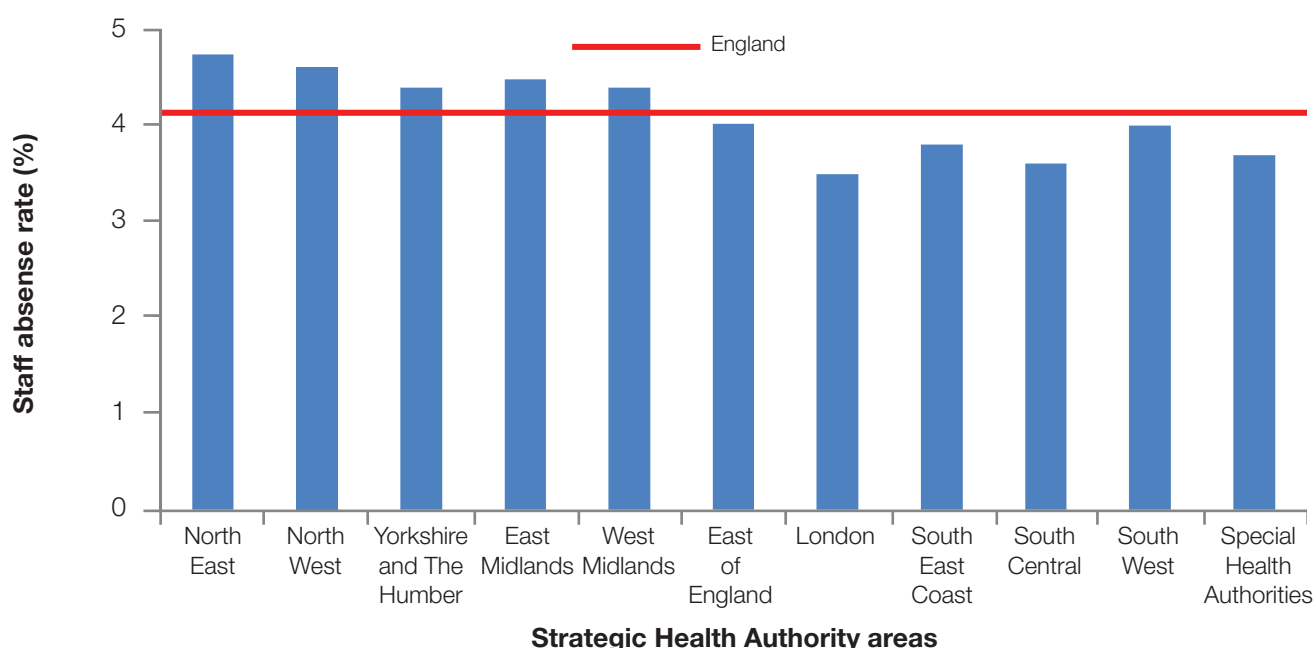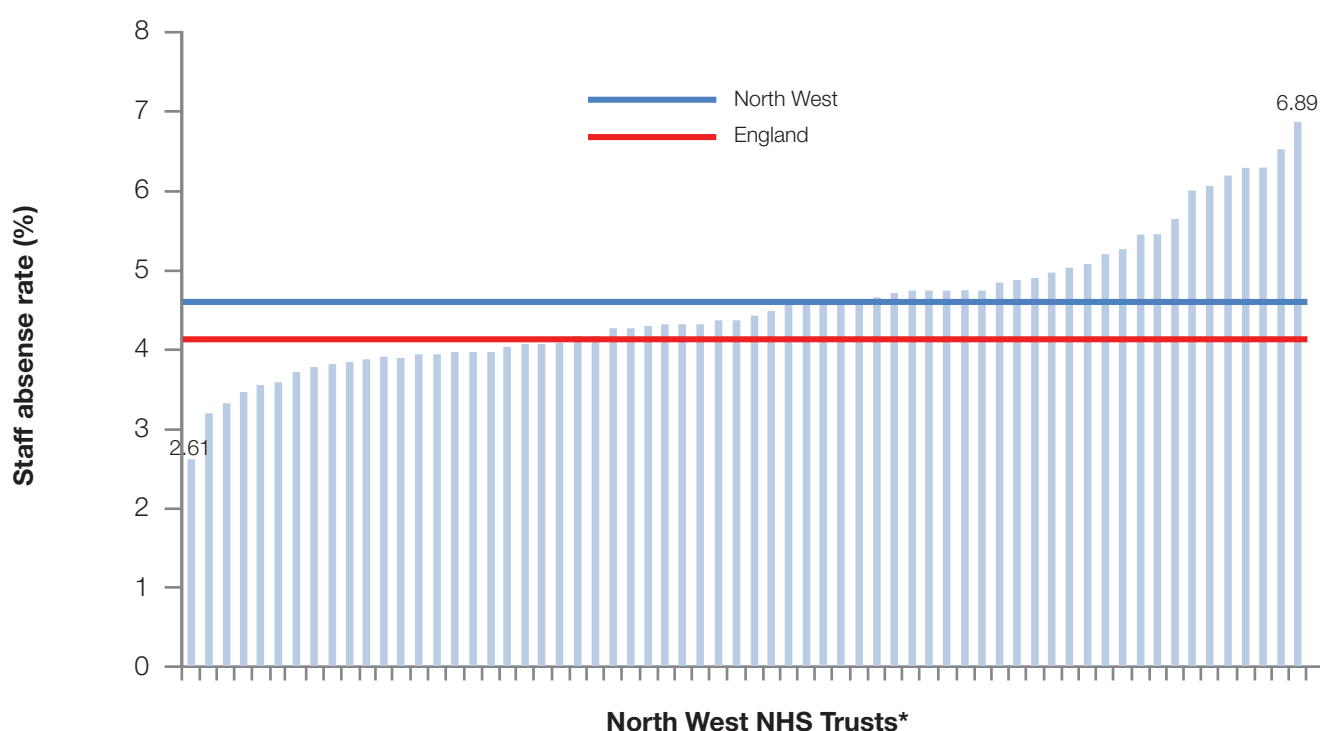

Source: NWPHO using data from the NHS Information Centre (Electronic Staff Record).

Note: Special Health Authorities include organisations such as NHS Direct, the National Blood Service and NICE.

North West NHS Trusts

Sickness absence experimental data is also available for individual NHS Trusts in England. In September 2009, staff sickness absence rates across the 64 North West NHS Trusts ranged from 2.61% to 6.89% (Figure 5). Around two out of five North West NHS Trusts (28 Trusts) had a sickness absence rate that was higher than the regional average in September 2009 (4.60%), while more than three-out-of-five (43 Trusts) had a higher rate of sickness absence than the England average in September 2009 (4.12%).

Figure 5: Sickness absence rates. North West NHS Trusts, September 2009.

Source: NWPHO using data from the NHS Information Centre (Electronic Staff Record).

* As statistics are only currently 'experimental' individual North West NHS Trusts have not been labelled on this chart. More details are available from: www.ic.nhs.uk/statistics-and-data-collections/workforce/nhs-sickness-and-absence

Individual profiles are also now available from the Work Foundation for each NHS Trust across key measures of staff health and wellbeing, including the same experimental data as above on sickness absence rates along with a number of other indicators such as: the percentage of staff suffering from work-related stress or work-related injury; staff job satisfaction; staff intention to leave; and non-medical or medical staff leaver rates.

5. CONCLUSIONS AND RECOMMENDATIONS

This *Creating Healthier Workplaces* synthesis report outlines the current scale and nature of ill health among the working age population. This report is being produced at a time when the public sector is tasked with becoming an 'exemplar' employer, particularly in terms of how it supports and promotes the physical and mental wellbeing of its employees. Along with NWPHO's related *Tackling Health Related Worklessness*[2] report produced in November 2009, this report highlights the crucial role of work and workplaces in significantly improving physical and mental wellbeing and in tackling health inequalities across the region.

'Good' jobs

❋ Good quality work improves employee's health outcomes and improves productivity.

❋ The public sector has a high level of sickness absence and therefore ensuring staff are working in 'good jobs' is a necessary key intervention. It is recommended that the HSE Management Standards for Work Related Stress are used throughout the public sector to improve the quality of work and improve psychological wellbeing.

❋ Line managers are the lynch pin in organisations for delivering policies appropriately and in themselves can be a major cause of stress. It is critical that line managers are trained in the necessary management skills and competences.

Tackling sickness absence

❋ The relative impact on reducing long-term sickness absence is higher in the public sector than the private sector. Early intervention and vocational rehabilitation services should be made readily available through occupational health providers to reduce this burden and assist in returning employees to work from absence.

❋ The causes of long-term (generally described as over four weeks) and short-term sickness absence are similar with the omission of minor illness such as colds. Employers should monitor short-term absence recurrences that may indicate a potential ongoing issue particularly with regards to stress, mental health and musculoskeletal disorders and use early intervention services where necessary.

❋ Sickness absence is amenable to active line management and this should be considered a key employer intervention alongside other interventions.

❋ Consideration of rapid access to key evidence based services, such as case management and physiotherapy, to assist individuals to remain in work should be considered in primary care for those who do not have access to comprehensive occupational health services.

❋ There is a need to strengthen the evidence base on effective workplace interventions to support employees with common mental health conditions.

Holistic approaches - improving physical health and mental wellbeing through work

✳ Workplace health programmes need to create a holistic view of wellbeing. Integrating approaches to promoting physical and mental health can help reduce health-risk behaviours, address health inequalities and improve health outcomes.

✳ Workplace health and wellbeing programmes offer on average a high return of investment. Employee wellbeing should be considered part of core business due the efficiencies it offers within the workplace, particularly within the public sector where costs are high. There is a need for a cultural change from services that focus on employee ill health to services that promote health.

✳ Readily available guidance, such as that produced by the National Institute for Health and Clinical Excellence (NICE), should be actively promoted in all workplaces to assist improving absence and promoting healthy choices.

✳ Smaller businesses require greater assistance to adopt good work practices and deliver the rewards of promoting and managing employee health and wellbeing.

✳ There is strong evidence for the effectiveness of preventative stress management interventions at work in reducing work-related stress and sickness absence. Co-ordinated approaches to work-based mental health promotion can also promote the mental wellbeing of employees, as well as tackling stigma and discrimination around mental ill health in the workplace.

✳ The Five Ways to Wellbeing are an evidence based set of messages which can be used by organisations as part of a broader framework to promote mental wellbeing in the workplace.

✳ Flexible working has a positive impact on mental wellbeing at work and should be made available in all employment.

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Glossary

Acas	Advisory, Conciliation and Arbitration Service
IB	Incapacity Benefit
CBI	Confederation of British Industry
CBT	Cognitive Behavioural Therapy
CG	Clinical Guidance
CHD	Coronary Heart Disease
CIPD	Chartered Institute for Personnel and Development
EAP	Employee Assistance Programme
ESA	Employment Support Allowance
FFWS	Fit for Work Service
GB	Great Britain
HSE	Health and Safety Executive
IAPT	Improving Access to Psychological Therapies
JSNA	Joint Strategic Needs Assessment
LAA	Local Area Agreements
LFS	Labour Force Survey
MHFA	Mental Health First Aid
MRSA	Methicillin-resistant Staphylococcus aureus
MSD	Musculoskeletal Disorder
NICE	National Institute for Health and Clinical Excellence
NHS	National Health Service
NWPHO	North West Public Health Observatory
PCT	Primary Care Trust
PHG	Public Health Guidance
RCT	Randomised Control Trial
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences 1995
TUC	Trade Union Congress
VR	Vocational Rehabilitation
WHO	World Health Organisation

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