Council for Work and Health statement on the UK Government's Get Britain Working White Paper

The Council for Work and Health welcomes the UK Government's *Get Britain Working* White Paper[1] published on 26 November 2024. This response comes from the directors on behalf of the Council, and with contributions from member and other organisations as listed below.

In the context of over nine million people economically inactive, and 2.8 million of these being out of work due to long-term sickness, we note that this intervention aims to promote growth through addressing underlying causes of unemployment and inactivity, as well as bringing coherence to health and employment support, with an emphasis on local action.

The role of the NHS in improving health and work

The White Paper notes ill health as one of the biggest drivers of economic inactivity, and the role of the NHS in addressing this through improvements in timely access to treatment. We welcome expanding access to mental health support and a commitment to increasing talking therapies, and the commitment to integrating health and employment pathways, such as the expansion of employment advisers within mental health and musculoskeletal services. This is a significant step towards enabling individuals with health conditions to re-enter or remain in the workforce, building on existing expertise among occupational therapists in the NHS and social care teams.

We also note the reference to Lord Darzi's report on the NHS[2], that "*having more people in work grows the economy and so creates more tax receipts to fund public services. There is therefore a virtuous circle if the NHS can help more people back into work*." Working is a health outcome. People whose ability to work is at risk, through ill health or disability, may be helped by their treating health professionals to remain in work or make a timely return to working. Some will not be able to return to work, but health professionals may still enable meaningful activity. The Academy of Medical Royal Colleges, Royal College of Nursing and Allied Health Professionals Federation will shortly publish an updated health professionals' consensus on health and work.

Reducing the risk of people falling out of work

We agree that cutting waiting lists is critical to growth, and we welcome the intention that this should be in areas of high economic inactivity, not least to address health inequalities. However, with 50% of people on waiting lists being in employment, and ONS reporting[3] that disabled people are twice as likely to fall out of work, and three times less likely to be able to return to work than non-disabled people, more prioritisation based on the need to prevent people falling out of work may be appropriate. We agree with the Work Foundation[4] that it is essential "*to stem the flow of those leaving the labour market due to ill health in the first place*."

References in the White Paper, to provide "*end-to-end support people need: from treatment to rehabilitation to good work and health*," and urging employers to "*support retention and rehabilitation for disabled employees and those with health conditions*," are welcome.

We also suggest that in addition to existing employee assistance programmes, that Government consider tax incentives for employers to engage services including physiotherapy, vocational rehabilitation and potentially also further investigation and treatment that would enable timely return to work of their employees who might otherwise fall out of work through long waiting lists. Government might also examine the benefit of group income protection, and those schemes that offer healthcare intervention and rehabilitation to support people to return to work.

Preventing ill health and injury at work and the importance of a supportive culture in work

We agree that prevention to stop people becoming ill in the first place is essential. Public health measures to improve risk factors for economic inactivity include promoting mental health, and preventing musculoskeletal conditions, cardiovascular disease and obesity, and also addressing the social determinants of health. Work is a key social determinant of health.

The White Paper cites the publication[5] in which Waddell and Burton state that: "*work is generally good for physical and mental health and well-being. Worklessness is associated with poorer physical and mental health and well-being. Work can be therapeutic and can reverse the adverse health effects of unemployment. … account must be taken of the nature and quality of work and its social context; jobs should be safe and accommodating*."

So good work that is good for health. It is also good for business[6]. Employers who promote healthy working environments, in which employees feel valued and supported, see increased productivity through the enhanced motivation this brings. In turn this benefits the economy.

The reverse applies in toxic work cultures. Better training and preparation for managers may assist. Government might consider measures to promote supportive work cultures. HSE as the Regulator for workplace health makes clear[7] that employers' legal duty to protect people from risks to their health includes protecting workers from stress at work. The key message is that a supportive workplace culture is good for employees' health, good for business, and promotes growth of the economy. Therefore investment in people management capability is important[8].

Employers do need the right advice to protect and support the health of their employees. Whereas it is appropriate for some to come from Government, HSE makes clear that employers must appoint a competent person or people to help them prevent ill health at work. This in turn will help reduce the risk of employees falling out of work. As well as advice on the effect of employees' work on their health, employers also need advice on the impact of health on work, particularly where the disability provisions of the Equality Act 2020 are likely to apply.

We have advised further on protecting and supporting health in the appendix to this statement.

Supporting return to work at scale - the place of a non-clinical work and health workforce

Ways to overcome obstacles to return to work through upskilling work coaches, social prescribers and other non-clinical staff has been trialled in WorkWell pilots and in other settings such as the impact of embedding work coaches in general practices[9] and the WAVE trial of vocational support workers[10]. This approach would be an appropriate way to deliver support to return to work at scale, but these non-clinical staff would need appropriate and effective training, a clear route for escalation, supervision and a governance structure. Given that for many people it is the number and complexity of their health conditions that represent significant obstacles to returning to work, assessment by work and health professionals is needed. There is also the need for advice for employers from work and health professionals.

The White Paper does not specifically mention occupational health or vocational rehabilitation, although we note that these may be considered in the follow-on work. The Council for Work and Health and many of the member organisations listed below contributed to earlier reviews, including membership of expert focus groups run by the Joint Health and Work Directorate.

The need to expand occupational health provision is also noted in the recent publication from Future Health Research[11]. Government might consider support for training the additional work and health professionals that are needed. The Council for Work and Health also agrees that a minimum standards framework for occupational health services is essential. For example, the Faculty of Occupational Medicine (FOM) runs an accreditation scheme for providers, Safe Effective Quality Occupational Health Service (SEQOHS), enabling assurance for purchasers of services that accredited providers meet the agreed standard[12]. Standards are also in place for providers of other services to protect and restore health in work, e.g. occupational hygiene.

Potential for optimisation of health benefits to sustain people in work

In addition to improving the health of the population, supporting employers in creating healthy cultures in workplaces, and advice to support their employees with disabilities, we also suggest Government might consider adjustment to health-related benefits to help people to stay in work. For example, if employees reduce their hours on medical advice due to their health. Some may receive the Personal Independence Payment (PIP), a non-means tested benefit, but we find that not all who we suggest apply for PIP based on our assessments are granted this.

Our offer to Government to achieve sustained improvements in health and work

Noting the intention to engage "*experts and stakeholders in developing reforms*," the Council offers to continue bringing expertise of its diverse membership to support initiatives and round table conversations, and to contribute to shaping future improvements in work and health.

The Council for Work and Health[13] has 37 member bodies representing organisations with an interest in work and health, including health professionals delivering services to prevent ill health and injury relating to work, to support those with health conditions in work, and rehabilitation to restore function in work. The Council for Work and Health brings together these organisations to provide an authoritative and representative 'single voice' on health and work.

Contributions to this statement have been provided from member organisations that include:

Association of Chartered Physiotherapists in Occupational Health and Ergonomics
Association of Occupational Health and Wellbeing Professionals (iOH)
British Association for Counselling and Psychotherapy (BACP)
British Occupational Hygiene Society (BOHS)
Chartered Institute of Personnel and Development (CIPD)
Faculty of Occupational Medicine (FOM)
NHS Health at Work Network
National School of Occupational Health (NSOH)
Royal College of Occupational Therapists (RCOT)
Society of Occupational Medicine (SOM)
Vocational Rehabilitation Association (VRA)

The following aligned groups also contributed to this statement:

British Society of Physical and Rehabilitation Medicine (BSPRM).
Royal College of Psychiatrists (RCPsych) Rehabilitation Faculty

Council for Work and Health
12 December 2024

Appendix

Further observations that may inform follow-on work

The Council for Work and Health highlights that 1.7 million people reported that they were made ill by the workplace last year. The UK does not have a systematic means by which it can be determined the extent to which economic activity as a result of long-term sickness may be attributed to lack of focus on workplace health and unhealthy working conditions.

In diagnosing the problem, it is important that government, employers and the health service take account of the need for workplaces not only to be places which are more accommodating and supportive of people with illness, but also to not (inadvertently) worsen the problems.

In the construction sector alone, the impact of preventable exposures, such as construction dust, contribute thousands of cases of COPD. The lack of modern methods of construction in public sector and infrastructure projects lead to a heavy toll on musculo-skeletal disorders and mental health and suicides, linked to working away from home. The average age of construction workers ceasing to be economically active is estimated to be around 48 years for some trades.

The lack of awareness and data collection at primary care level around occupational relationships to disease and illness giving rise to economic inactivity impedes effective opportunities for early intervention, self-management and informed decision-making. In many cases, occupational factors may be poorly understood by health professionals. The absence of clear information sharing pathways between occupational health providers undertaking health surveillance and primary care providers exacerbates this.

Where clear information pathways are made, then time and money may be saved and retention within the workplace is enabled. At worst, poor understanding of occupational exposures can lead to delays or misdiagnosis, as has been the case with the recent bout of silicosis cases in the engineered stone industry.

A better informed primary care system can do more to help keep people in work and to help people identify occupational risk factors in time to make decisions to avoid working environments which will lessen their ability to continue to contribute.

In many of the UK's workplaces there is failure to recognise and identify basic health risks which may lead to chronic illness. Poor workplace air quality leads to limitations for access to work by those with respiratory conditions such as asthma. Poor management of noise makes a significant impact on all, particularly those with mental health issues and neurodiversity.

Unsatisfactory ergonomic arrangements make some workplaces unsuitable for those with musculoskeletal disorders. By ensuring that workplaces are fit to work in, the number of people exiting work through ill-health would be reduced, and also more workplaces would be more accessible to more people. The investment required to ensure that workplaces are healthy is relatively modest, compared to the cost of exclusion from the workplace through ill-health.

In-work treatment, support and early intervention provides a means by which employee health can be sustained in workplace contexts. Reviews being undertaken of the current limited health surveillance programmes would benefit from a wider consideration of how health profiling within the workplace could better inform risk, treatment and diagnosis of illness, whether caused or exacerbated by work conditions.

In-work assessments can save cost to the NHS and business, as well as informing adjustments to ensure people are effectively supported in the workplace. Financial incentives to enable more in-work health screening in relation to certain conditions, rather than simply related to certain exposures may have a significant benefit, as well as being more cost-effective.

Tax incentives to ensure investment in the control of workplace exposures, for example through the use of local exhaust ventilation, sustainable respiratory protective equipment, noise abatement technology and containment technologies, complemented by AI measurement and control equipment will stimulate the UK industry for such products, while creating healthier workplaces, energy efficiency and a cleaner environment.

The quality of work has a significant impact on its benefits or detriments. Certain populations are more likely to be impacted by poor health equality, poor levels of health education and other factors leading to economic inactivity. These same populations are most likely to work in sectors that have least concern for protecting worker health. A vicious cycle of "dirty" and "unsafe" jobs which recruit from the vulnerable and further contribute to ill-health needs to be broken. The UK should not tolerate industries with low standards of health protection. Because of the nature of this sector, who may be non-compliant with other business rules, it is hard to determine the extent to which they are contributors or confounders of worklessness through ill health. The informal construction sector, security sector, cleaning and personal services, some aspects of social care, agriculture and food, private transport and other parts of the gig economy create significant health risk with limited benefit to the national finances.

Managing stress in work is a significant challenge and requires skills which are not part of the focus of business development and support. Management education and business advice to enable industries to address peaks of demand, labour shortages and other operational factors without creating psychologically damaging environments is needed. This is important if we are to see more people who have mental health problems or are neurodiverse being sustained in work. In a full employment model, the resilience of workplaces cannot be supported by the equal resilience of every individual. This challenge requires some radical rethinking about our models of human resources and management and a major programme of advice and education to support the UK's management in delivering sustainable growth with a diverse workforce.

Thus, alongside management education and advice, comes the need to ensure that there is adequate, accessible, professional and affordable advice on health protection and management. The demand for occupational health and occupational hygiene services in the UK outstrips supply and impacts on quality, affordability and accessibility.

If the UK's workplaces are to carry more of the burden of supporting good health, then the specialist services that are needed to ensure this is done well need to be promoted and developed. This can be partly achieved through setting minimum standards for businesses in terms of accessing occupational health. Those most in need of raising standards in occupational health are those businesses least able and willing to prioritise it. Simplified inspectable standards for the protection of health in the workplace need to be considered within the health and safety regime to ensure that SMEs and the gig economy factor in the cost of health protection for workers and deliver it effectively. For example, in Occupational Hygiene (the identification, recognition and prevention of workplace diseases) the Professional Standards Authority for Health and Social Care accredits a register of competent professionals, while HSE has supported the development of a buyer's guide and a good consultant's guide.

References

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