

**London's business case for employee health
and well-being**



Greater London Authority
May 2012

Published by

Greater London Authority
City Hall
The Queen's Walk
London SE1 2AA

www.london.gov.uk

enquiries 020 7983 4922

minicom 020 7983 4458

ISBN **978-1-84781-511-8**

Front Cover Photograph

© Getty Images

For more information about this publication, please contact:

The GLA Intelligence Unit

telephone 020 7983 4922

email glaeconomics@london.gov.uk

Data and analysis from the GLA Intelligence Unit form a basis for the policy and investment decisions facing the Mayor of London and the GLA group.

The GLA Intelligence Unit uses a wide range of information and data sourced from third party suppliers within its analysis and reports. The GLA Intelligence Unit cannot be held responsible for the accuracy or timeliness of this information and data.

The GLA will not be liable for any losses suffered or liabilities incurred by a party as a result of that party relying in any way on the information contained in this report.

Copyright

Contents

| | |
|---|-----------|
| Executive summary | 4 |
| Introduction | 6 |
| The state of ill-health and absence in the UK and London | 8 |
| The cost of absenteeism/ill-health | 18 |
| The case for intervention | 22 |
| Conclusion | 32 |
| Appendix A | 34 |
| Appendix B | 48 |
| Appendix C | 50 |
| Appendix D | 68 |
| Appendix E | 70 |
| Appendix F | 72 |
| Bibliography | 74 |
| Endnotes | 80 |

Executive summary

This report focuses on the impact that workplace wellness programmes can have on ill-health, where a workplace wellness or employee well-being programme is defined as a programme that combines three components: health and safety, managing ill health and prevention of ill-health and promotion of employee well-being.¹

Given that an average London firm of 250 employees loses around £4,800 per week (or around £250,000 a year) due to sickness absence,² employers have a clear interest in reducing the ill-health of their employees. Moreover, given that a significant proportion of an individual's life is spent at work, the workplace offers the opportunity to influence the behaviour of large numbers of people.

Employee ill-health has costs:

- To the individuals: as well as the physical and mental 'cost' of ill-health to the employee there is a potential loss of income and, where ill-health is prolonged, a potential loss of employment.
- To employers: output losses due to reduced productivity, sick pay, inefficiencies in the use of agency staff and recruitment costs amongst other costs.
- And to society as a whole: cost of healthcare, benefits incurred, taxes forgone and negative impact to friends and family.

Whilst estimates of the total cost of ill-health to the economy vary, a relatively recent and comprehensive review put the cost of poor health in the UK working age population in 2007 at between £103-129 billion.³

To that end, numerous studies find that employee well-being programmes can be designed so that the returns to employers from investing in employee well-being programmes outweigh the cost of the programme. To support this analysis, this report compares data on ill-health and absence from work between London and the UK and occupation type. In addition, it looks at the cost of absenteeism and ill-health and the business case for organisations to ensure workplaces promote and protect employee health and well-being.

This report is of interest to a number of audiences, from public health practitioners to economic development teams and business partnerships. The recent independent review into sickness absence and the inclusion of sickness absence⁴ as an indicator in the national Public Health outcomes framework highlights employee health and well-being as an increasingly important health issue. This reflects demographic changes such as an older working age population in addition to building an evidence base on how workplaces can negatively and positively impact health. This information is also of interest to London's business sector, setting out why the benefits of investing in workplace health support better business outcomes, such as productivity, improved staff engagement and better retention.

As a result, the public sector will have an interest in promoting this information because the benefits from such workplace interventions will not only accrue to employers themselves but also to employees and society; a healthier working population supports society as a whole, providing health and economic benefits for London.

Introduction

Ill-health and absence from work have costs for the individuals concerned, employers and society.

Further, given the proportion of an individual's life spent at work, workplace well-being programmes have the potential to impact significantly on individuals' well-being. Indeed it has been recognised that work, paid or unpaid, has the potential to greatly increase a person's physical and mental health. In particular London faces a number of health/work related issues which include:

- Low employment of people with health problems – 43 per cent of male Londoners with a health problem are workless compared with 36 per cent nationally (the figures are 54 per cent versus 49 per cent for women).⁵
- Employment of people with disabilities – London has the lowest rate of people with disabilities in employment in England, 45 per cent compared to 50 per cent nationally.⁶
- Failure to return to work following ill-health – London has the highest proportion of individuals on incapacity benefit for greater than six months in England and the greatest proportion of individuals falling out of work within six months following a return.⁷
- Prevalence of preventable illness – The majority of Londoners on incapacity benefit have preventable and / or treatable conditions, ie,; 47 per cent mental health; 15 per cent musculoskeletal; 6 per cent circulatory or respiratory; 5 per cent nervous system; 4 per cent injury, poison, etc.; and 26 per cent other.⁸

Moreover London has a generally more ambivalent attitude to the benefits of work for health than other UK regions. For example a lower proportion of Londoners think that paid work is generally good for physical health when compared to the rest of the country.⁹ In addition, London has one of the lowest proportions thinking that work is good for mental health.

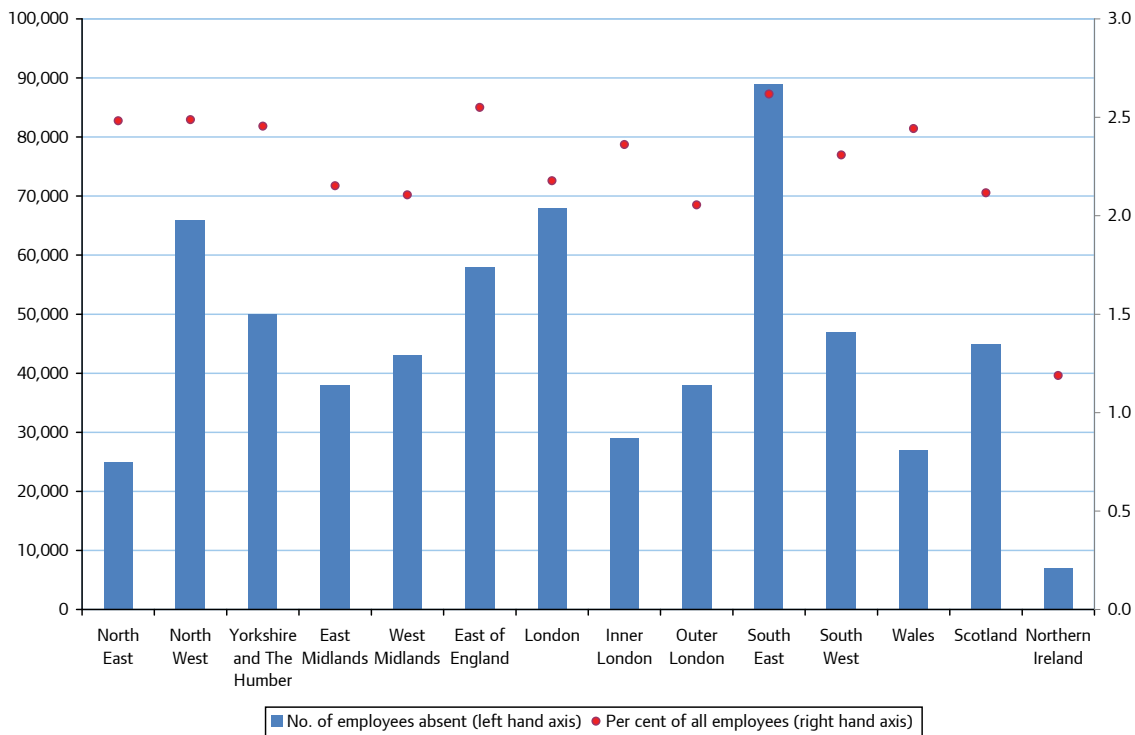
This report examines the case for workplace health and well-being policies in terms of both the cost of ill-health to the employee, employer and society as a whole and the benefits of tackling employee ill-health. The report starts by examining the state of ill-health and absence in London and the UK. It then looks at the cost of ill-health and absence from work to individuals, employers and society. The report then looks at various workplace interventions by firms and government before concluding on the findings from this analysis.

The state of ill-health and absence in the UK and London

Employee absence varies by region in the UK, as shown by Figure 1, with absent employees in London as a percentage of total employees being slightly lower than average compared to other regions.

There is some disparity between the percentage of employees absent from work between inner and outer London, with outer London firms suffering slightly less absence than inner London firms.

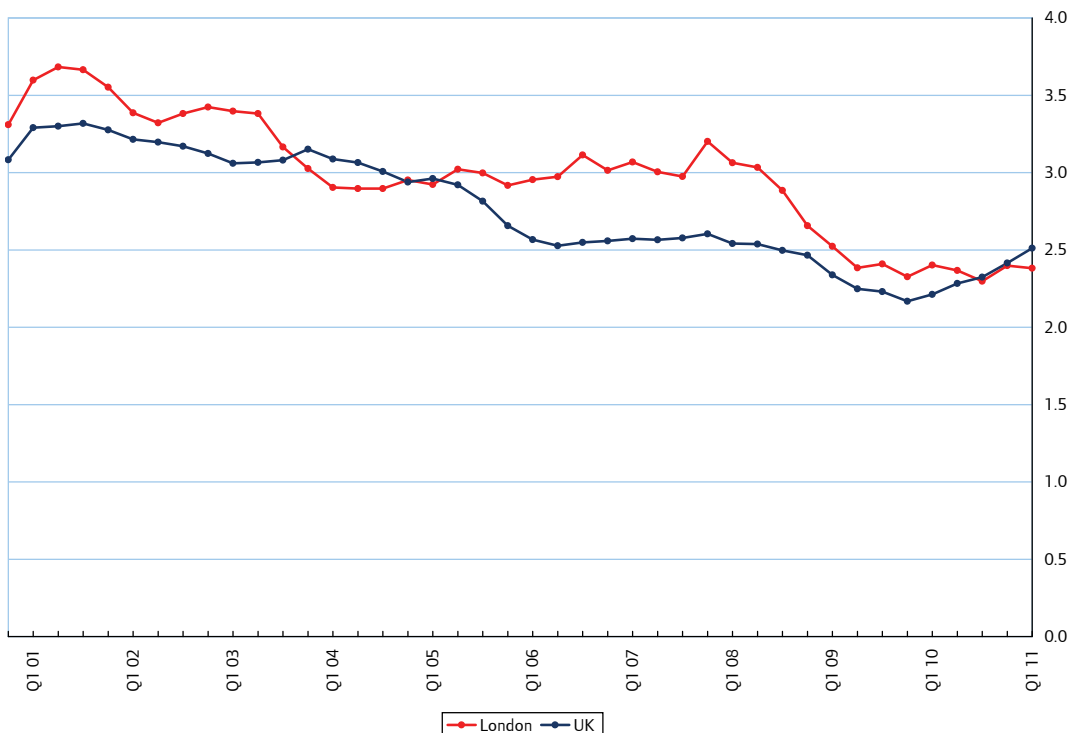
Figure 1: UK's employee absence from work by region Jan-Dec 2010



Source: ONS Labour Force Survey

When the rate of absence in London is compared against the UK over the past decade (see Figure 2) London's sickness absence has broadly followed the same trend as the UK, though it remained higher than the UK absence rate over the middle part of the decade.

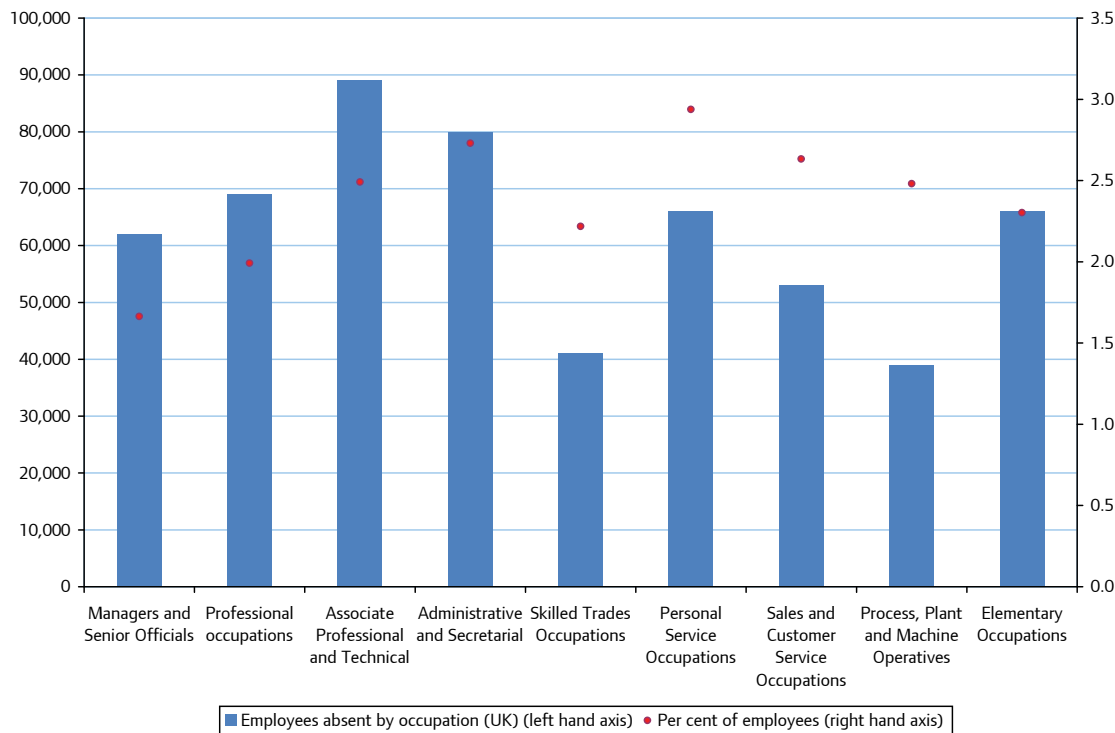
Figure 2: Sickness Absence in London and the UK (4 quarter rolling average)



Source: ONS Labour Force Survey

Examining the absence rate by occupation (see Figure 3) it can be seen that, as a percentage, managers and senior officials had the lowest rate of absence at 1.7 per cent of employees, whilst personal service occupations experienced the highest incidence of absence. In noting this it is important to remember that the lower absence rate amongst managers and senior officials does not necessarily indicate that they suffer from less ill-health than other workers. Rather it may reflect presenteeism where workers are present at work but not fully engaged or active. The costs of such activity can be high but are harder to measure than the costs of employee absence to the firm and the wider society.

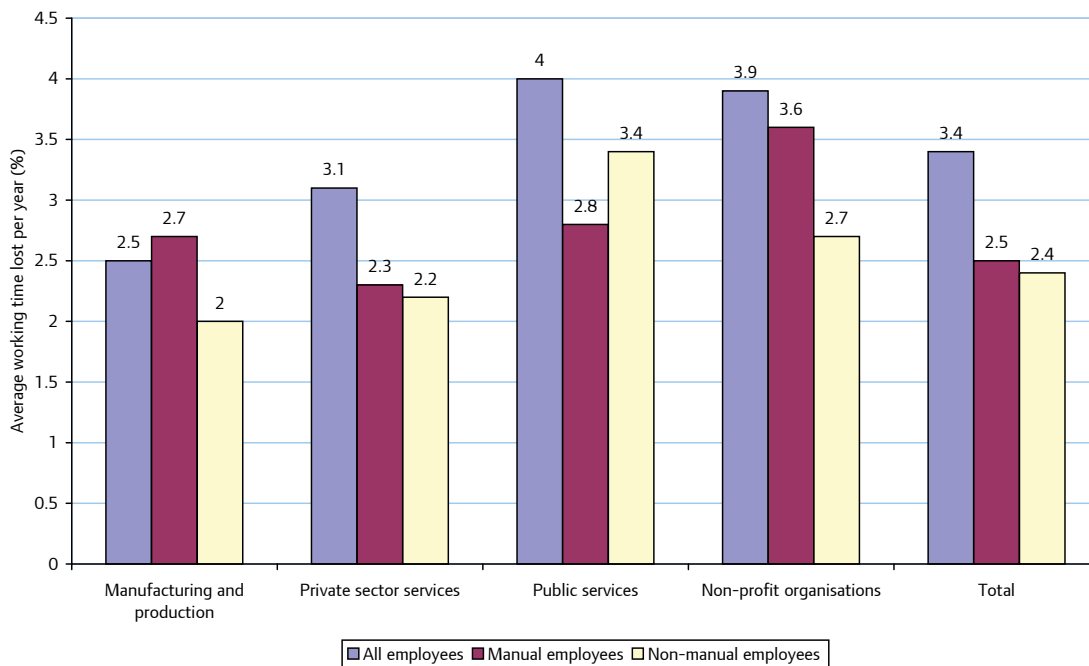
Figure 3: Absent employees by occupation (UK Jan-Dec 2010)



Source: ONS Labour Force Survey

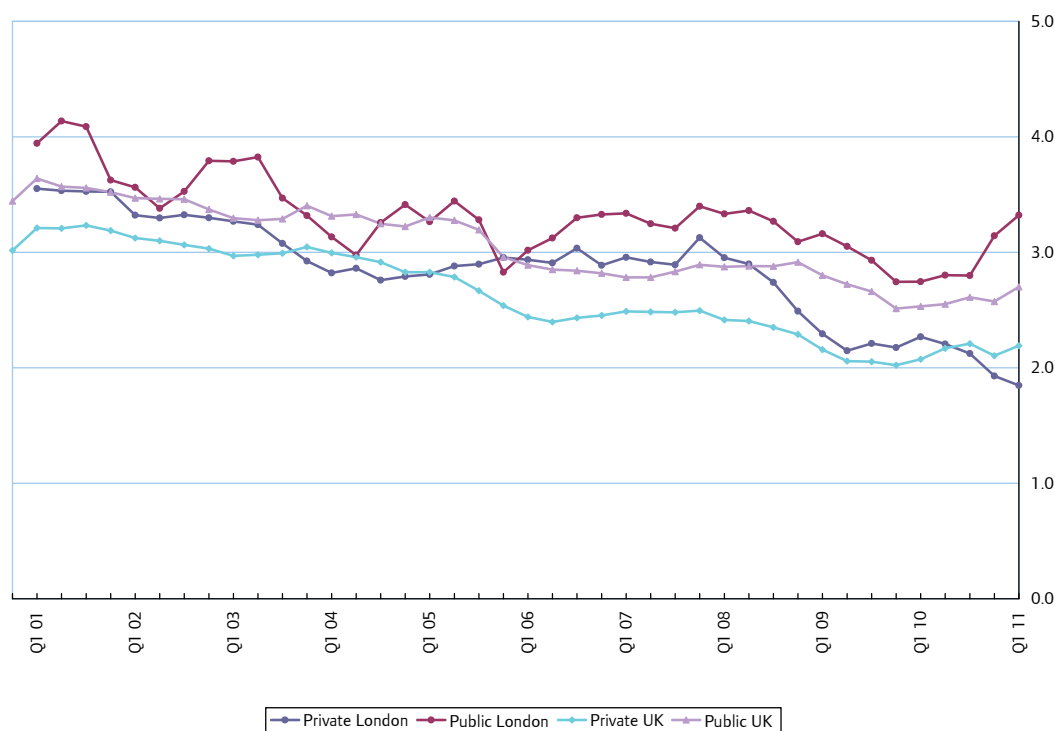
Variations in absence rates also occur between sectors of the economy with CIPD (Chartered Institute of Personnel and Development) finding that employees working in the public sector generally lose more of the working year due to absence than employees in other sectors of the economy (see Figure 4). This result is also consistent over time in London (see Figure 5) with the public sector having experienced higher rates of absence than the private sector over the whole of the first decade of the 21st Century. The relationship between absences in the public and private sector in London compared to the rest of the UK is however complex (see Figure 5) with absences in the private sector in London being similar to that of the UK private sector as a whole in Q1 2011, whilst absences in the public sector were slightly higher in London than the UK as a whole.

Figure 4: Average working time lost per year (%) by employment and occupation type for the UK¹⁰



Source: CIPD¹¹

Figure 5: London and the UK's employee absence by sector (4 quarter rolling average)



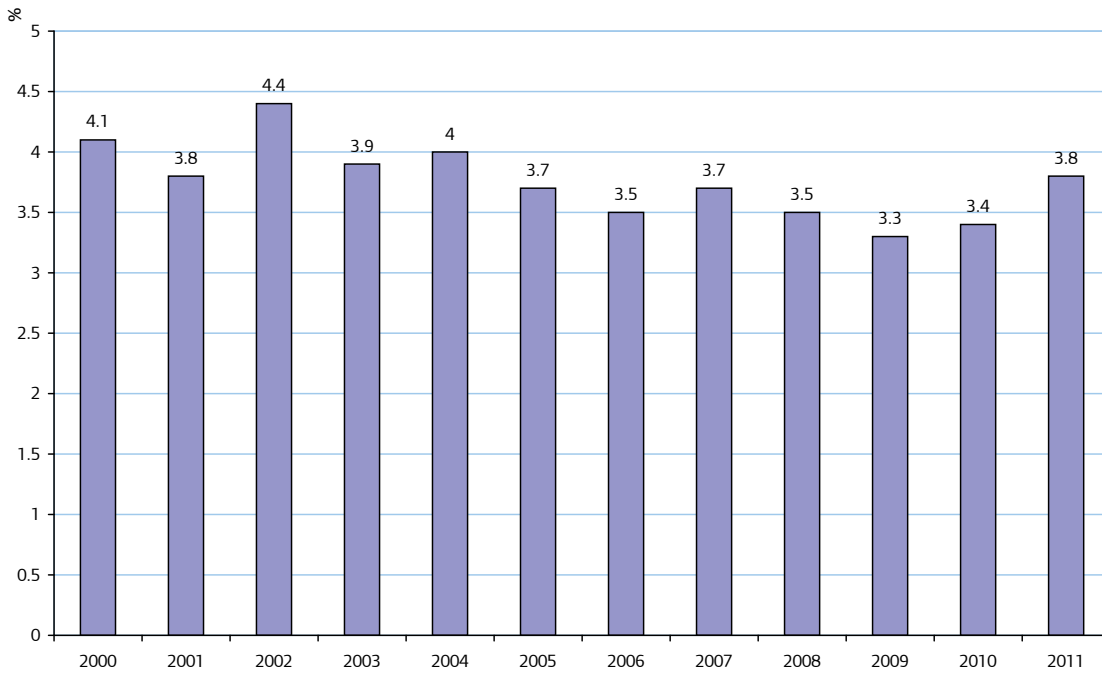
Source: ONS Labour Force Survey

As can also be observed from Figure 5 employee absences were on a general downward trajectory over the past decade before picking up somewhat at the end of the decade in the public sector. This downward trend in absences is supported by the CBI which has found that “since the first CBI surveys of absence in the mid-1980s absence levels have followed an overall downward trend”.¹² Further highlighting this downward trend in absences is research by CIPD shown in Figure 6 which shows that over the previous

London's business case for employee health and well-being

decade the average working time lost per year due to employee absence has declined from 4.1 per cent to 3.4 per cent, before picking up to 3.8 per cent in 2011.

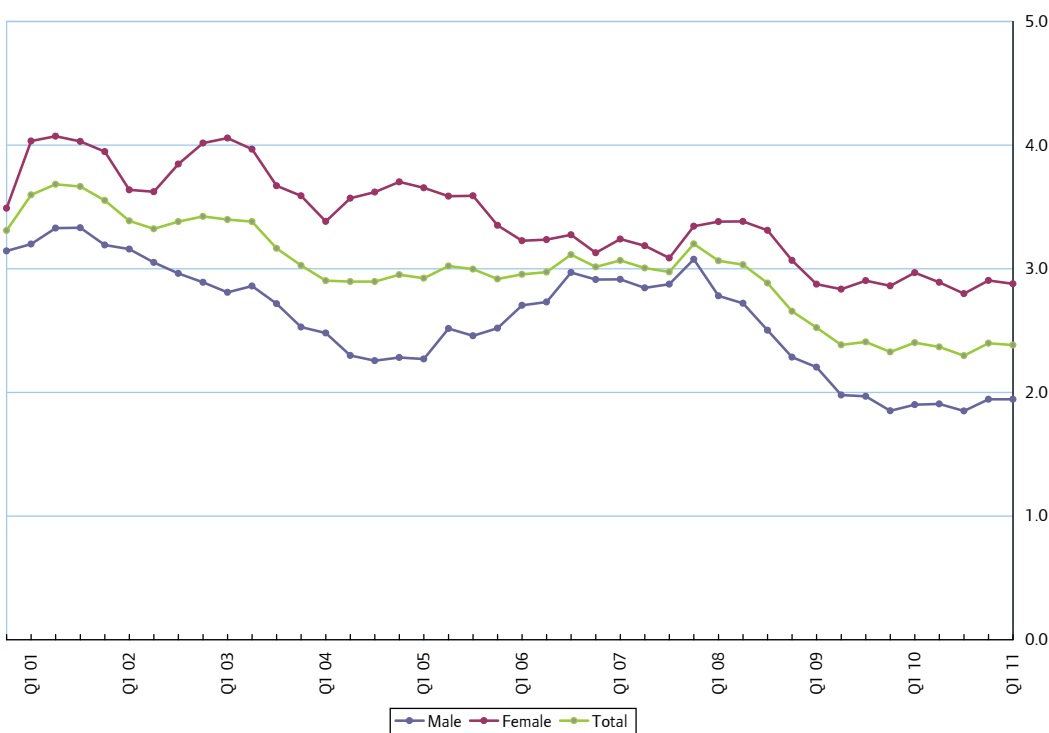
Figure 6: Average working time lost per year due to employee absence in the UK (%)



Source: CIPD¹³

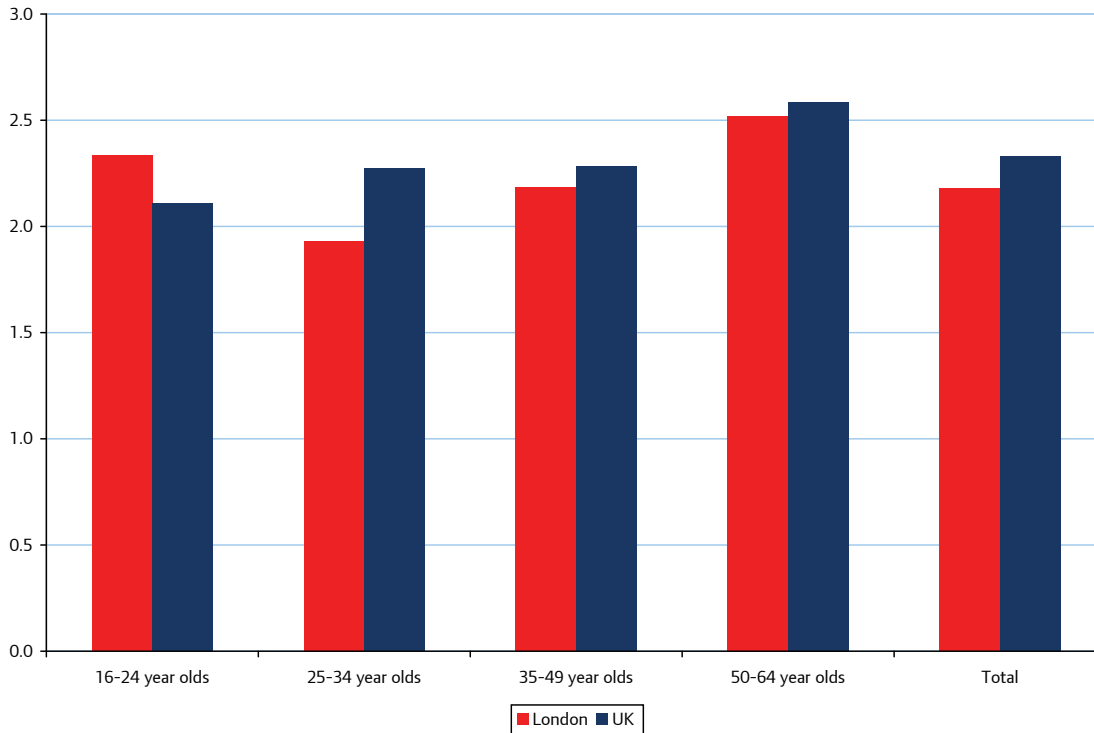
Variation in absence by gender is also apparent in London (see Figure 7) with women experiencing greater rates of absence than men; this also holds for the UK as a whole. However, the variance in absence by age is generally small as shown in Figure 8, although workers in the 50-64 years old age bracket experienced the longest amount of absence of any age group in both the UK and London.

Figure 7: London's working age sickness absence by sex (4 quarter rolling average)



Source: ONS Labour Force Survey

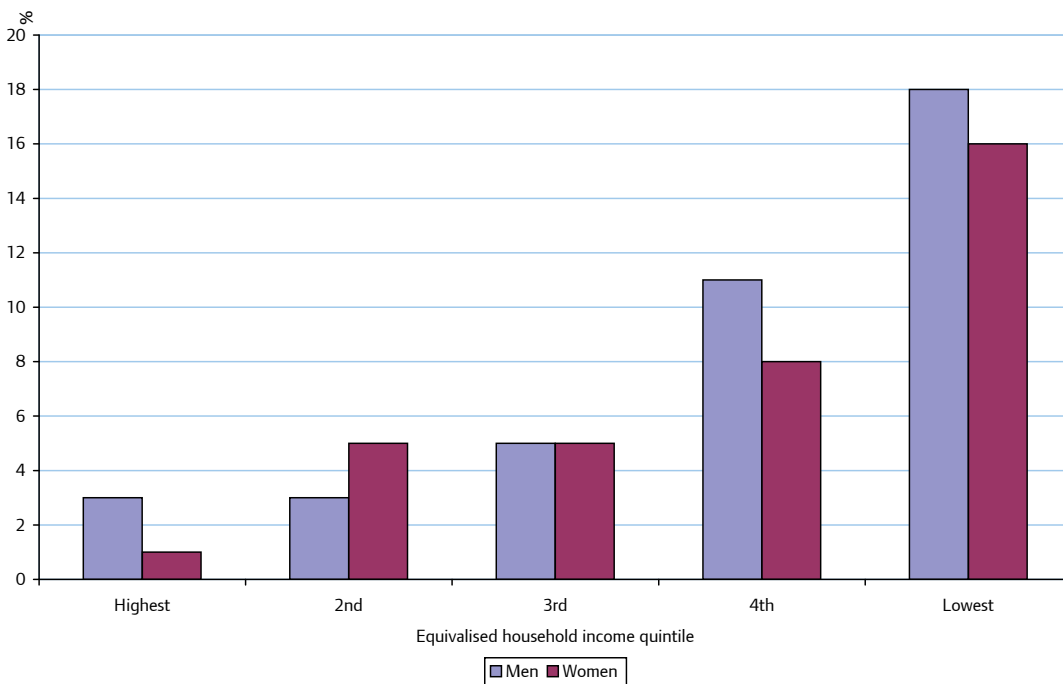
Figure 8: Percentage of employees absent from work due to sickness or injury by age group in the UK and London, Jan-Dec 2010



Source: ONS Labour Force Survey

Perhaps unsurprisingly, ill-health also has a socioeconomic element (see Figure 9) with those individuals in the lowest household income quintile (ie, income in the bottom 20 per cent of incomes) more likely to self-report that they suffer from bad or very bad health.

Figure 9: Prevalence of self-reported bad or very bad health, by equivalised household income and sex in England

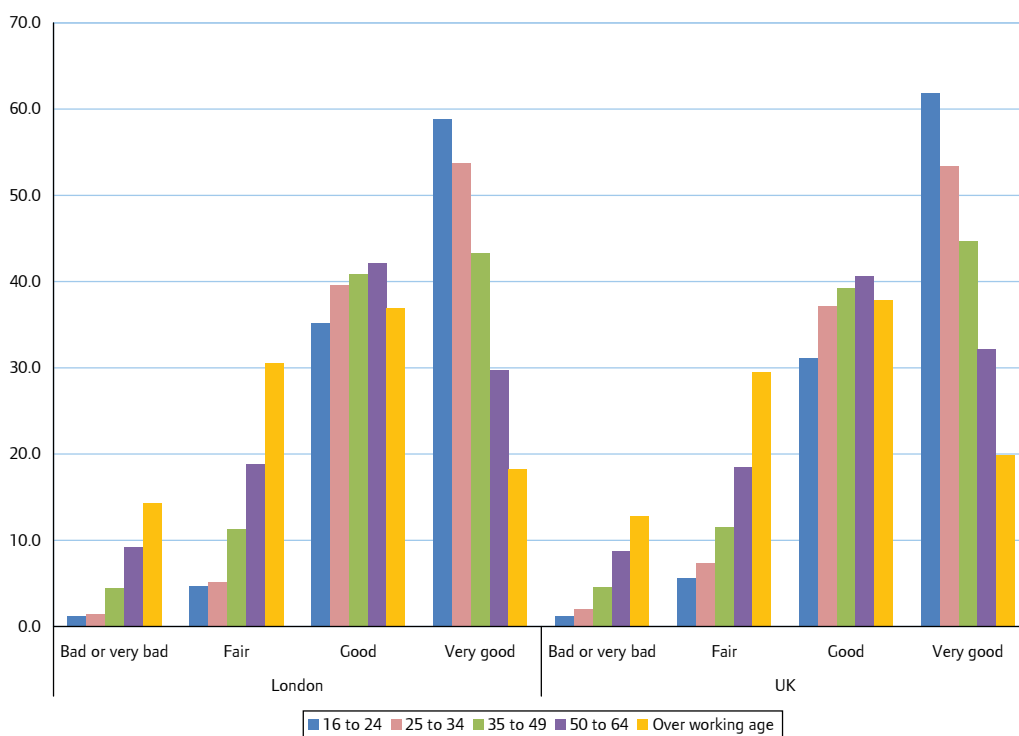


Source: Health survey for England 2009

It has been found that “more than three-quarters of the population do not have disability-free life expectancy as far as the age of 68. If society wishes to have a healthy population, working until 68 years, it is essential to take action to both raise the general level of health and flatten the social gradient”.¹⁴ It is also expected that workforce health will become an increasing issue in coming decades with Dame Carol Black and David Frost’s independent review of sickness absence noting “there is evidence to suggest that the health of the population – and thus the workforce – will deteriorate in the coming decades. Levels of disease in the workforce will increase, due partly to lifestyle. Coupled with an ageing workforce this represents a major challenge for the economy. It will become increasingly important to emphasise that work is compatible with less than perfect health”.¹⁵ Alcohol related problems and obesity are two examples of lifestyle related issues that inflict a significant cost to the economy.¹⁶

If we examine the quality of health in London compared to the UK as a whole we can see that Londoners are generally slightly more likely to suffer from bad or very bad health and slightly less likely on average to be in very good health (see Figure 10). As can also be observed people with bad and very bad health increases with age, which given the aging of the UK workforce gives a demographic imperative to tackling employee ill-health.

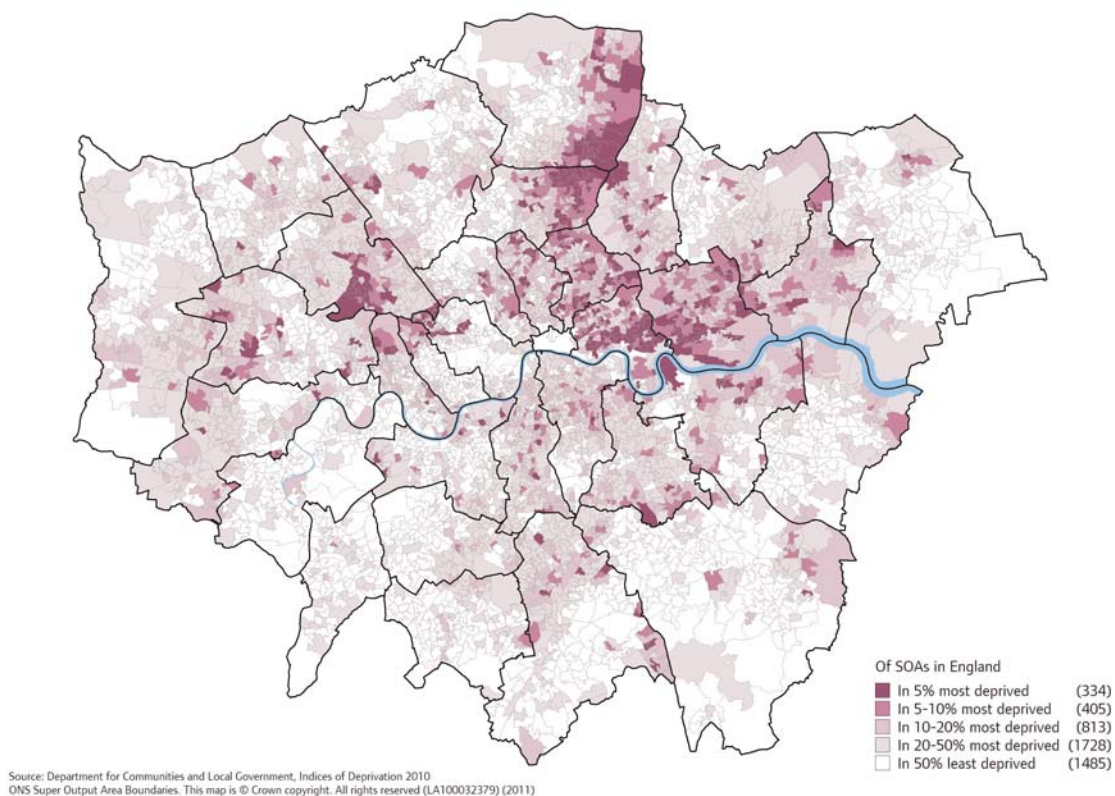
Figure 10: Health status by age group in London and the UK, Jan-Dec 2010 (per cent)



Source: ONS¹⁷

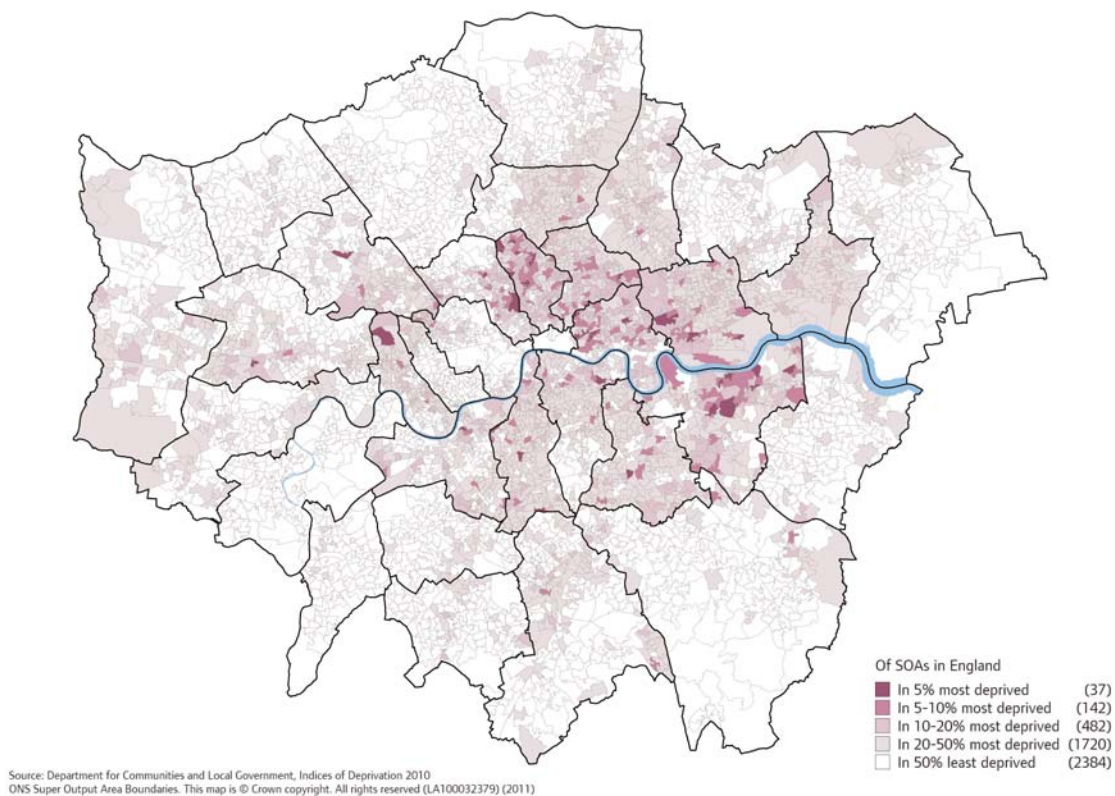
Figures 11 and 12 show an overlap between areas with income deprivation and areas of health deprivation in the capital. This is also highlighted by Figure 13 which plots London’s wards income rank against its health rank, and shows a positive relationship between the two ranks. These result support findings in the Marmot Review which showed a “finely graded relationship between the socioeconomic characteristics of ... neighbourhoods and both life expectancy and disability-free life expectancy. Not only are there dramatic differences between best-off and worst-off in England, but the relationship between social circumstances and health is also a graded one”.¹⁸

Figure 11: Income Deprivation Domain in London in 2010

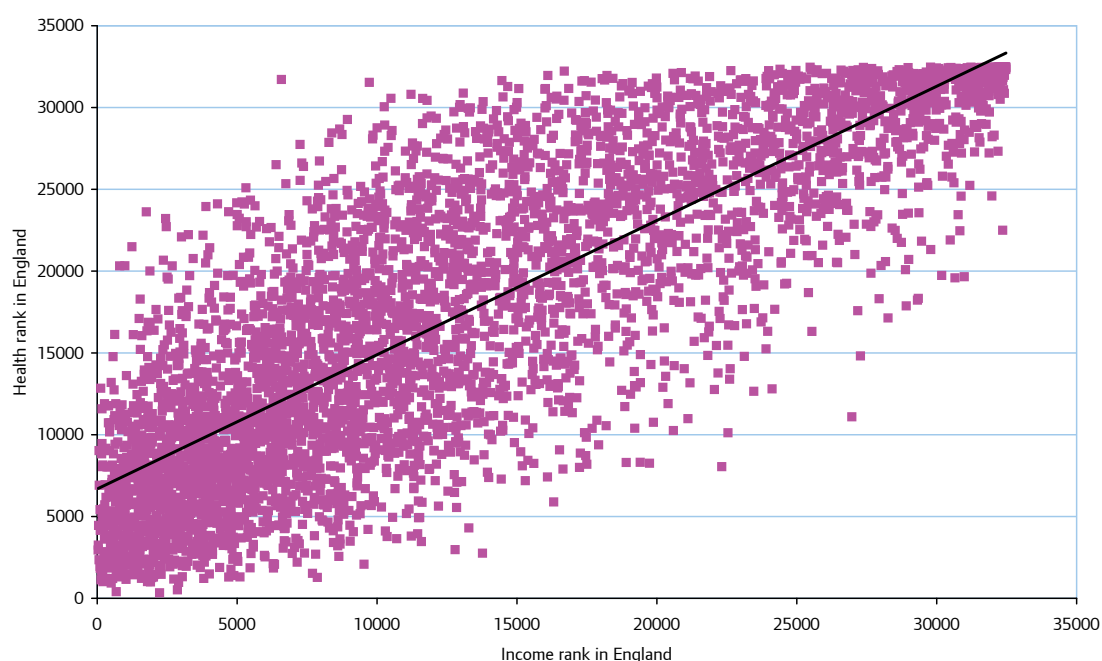


Source: Greater London Authority¹⁹

Figure 12: Health Deprivation and Disability Domain in London in 2010



Source: Greater London Authority²⁰

Figure 13: Plot of Income Rank in England against Health Rank in England of London Wards in 2010

Source: DCLG, *Index of Deprivation 2010*

Employee absence can be separated into short-term and long-term absence, with short-term being defined as absence of up to four weeks whilst long-term absence is an absence of four weeks or longer. The most recent survey from CIPD²¹ sheds light on the nature of absences suffered by UK firms in which it found that two-thirds of absences were seven days or less, with private sector and small organisations absences being more likely to be short-term than public sector or larger organisations. These findings are supported by research for the CBI,²² which found that 32 per cent of absences were long-term with this rising to 47 per cent when examining the public sector alone.

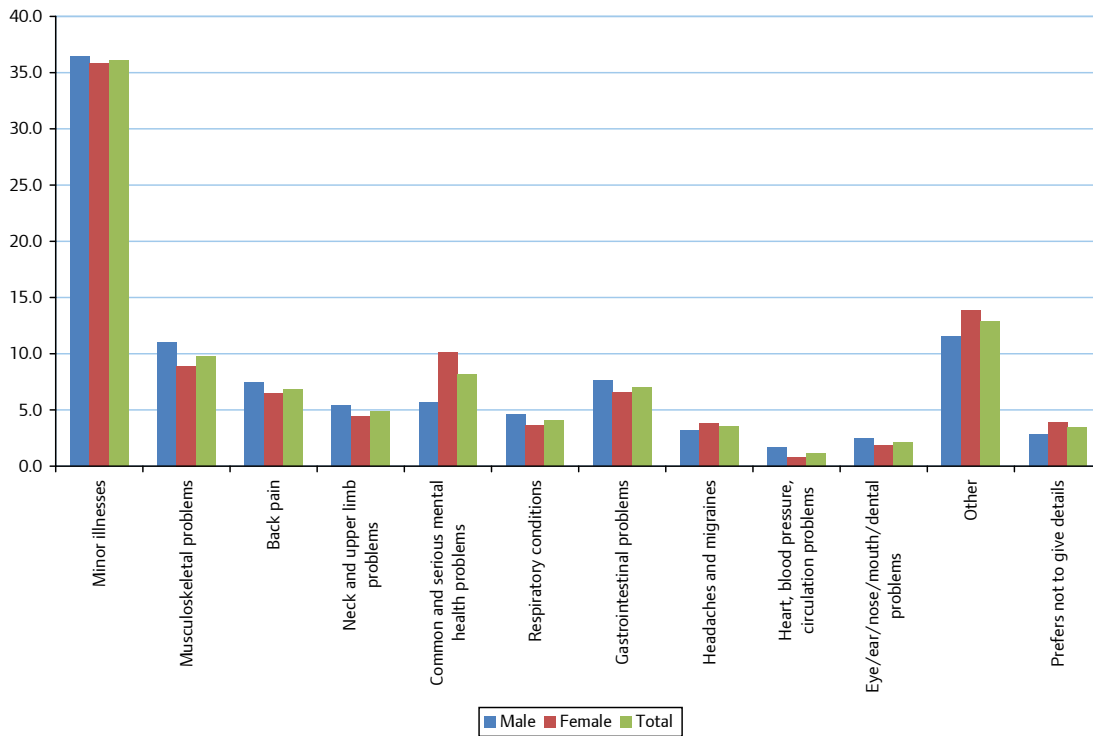
The top five causes of short-term absence for employees working manual and non-manual jobs are variable²³ (see Appendix A, Table A.1). However, musculoskeletal injuries, back pain and work related injuries are more prone to be reported as a cause for absence of manual workers compared to non-manual workers. Whilst stress is more prone to be reported as a top five most common cause of short-term absence in non-manual workers compared to manual workers.

However, as would be expected the most common causes of long-term absence are more variable with acute medical conditions generally being most often cited as a top five cause of long-term absence by those firms surveyed by the CIPD study (see Table A.2 in Appendix A). However, musculoskeletal injuries, stress, back pain and mental ill-health continue to be heavily cited as a cause of employee absence with these long-term absences also likely to be a significant driver of absence costs to the firm. In a separate survey by the CBI²⁴ which asked employers what the most common top three drivers of absence were, it was found that non-work related illness or injury, post operative recovery, work related illness or injury and paid sickness leave seen as an entitlement were all important drivers of employee absence.

Figure 14 shows data from the ONS and again highlights that the most common cause of absences to firms is minor illnesses. However, also emphasised by this data is the variety of causes of absence with musculoskeletal problems and mental health problems featuring as important causes of absence. Thus, as

noted, Table A.2 in Appendix A shows that musculoskeletal and mental health problems are significant causes of long-term ill health and are likely to have a large cost associated with the absences they cause. The multitude of issues faced by any wellness program indicates that a one size fits all approach is unlikely to be sufficient in minimising work place absences. Rather employers will need to tailor a wellness programme to their workforces’ needs²⁵ and their unique situations.

Figure 14: Percentage of employees absent from work due to sickness or injury by main reason in the UK, Jan-Dec 2010



Source: ONS Labour Force Survey

If we further examine workplace hazards²⁶ via TUC data,²⁷ stress and back pain are important causes of hazards in numerous sectors of the economy (see Table A.3 in Appendix A). The forms of hazards faced by firms also varied by firm size although stress was the most significant hazard irrespective of the firm’s size (see Table A.4 in Appendix A). Of the regions in the UK, London showed the most concern about stress as a workplace hazard with 70 per cent of London respondents to the TUC survey expressing their worry about it (see Table A.5 in Appendix A).

The cost of absenteeism/ ill-health

Employee ill-health has costs not only to the individuals concerned but to employers, who lose productive output from their workers, and also to society as a whole.

As well as the physical and mental 'cost' of ill-health to the employee there is also a potential loss of income and, where ill-health is prolonged, potential loss of employment. Costs to firms include sick pay, inefficiencies in the use of agency staff and recruitment costs for example. The costs to society include cost of healthcare, benefits incurred, taxes forgone and the negative impact to friends and family.

The multifaceted nature of sickness cost is highlighted in Table 1 which shows that the estimated cost of poor health in the working age population in 2007 stood at between £103-129 billion to the economy, with a cost of £62-76 billion to the Government.

Table 1: Cost of working age ill-health in 2007 (£ billions)

| Costs to Government | |
|--------------------------------|---------|
| Worklessness benefits | 29 |
| Healthcare | 5-11 |
| Foregone taxes | 28-36 |
| Total Government | 62-76 |
| Cost to the economy | |
| Worklessness – lost production | 63 |
| Sickness absence | 10 |
| Informal care | 25-45 |
| Healthcare | 5-11 |
| Total economy | 103-129 |

Source: Black Review²⁹

There exists however, many estimates of the costs of ill health depending on the type of illness, the methodology used, the period chosen, and exactly what type of costs (eg, individual, employer or societal) are included (see Box 1: The various estimates of the cost of ill-health). As an example, the CBI has estimated that the direct cost of employee absence (due to work days lost etc.) to the economy in the UK amounted to £17 billion in 2010.²⁹ However, this does not take account of the indirect costs to firms (due to inefficiencies with the use of agency staff, staff turnover costs, lost human capital etc.) or the impact on the worker or the wider impact on society as a whole. Appendix B gives a sample of the costs of ill health that have been calculated.

Nevertheless, the evidence shows that ill-health is costly and there is evidence that the cost of ill-health to the country is rising. For example it has been estimated that the cost of mental health problems in England (for people of all ages) in 2009/10 stood at £105.2 billion up from £77.4 billion in 2002/03.³⁰ In addition, hospital admissions due to alcohol misuse have doubled between 2002/03 and 2009/10.³¹

Box 1: The various estimates of the cost of ill-health

The cost of ill-health amongst the working-age population to the UK varies depending on the methodology used. For example if we compare the findings of different surveys we find that CIPD found from their survey that the median cost of absence to employers stood at £673 per employee per year,³² whilst the CBI survey found that the cost of absence to employers per employee per year stood at £760.³³ This difference can be explained by the different make up of the survey populations. Going into more detail, if we examine the effect of ill-health on the economy we see that the CBI calculated that the direct cost of absence to employers in the UK was £17.02 billion in 2010; this was based on their survey results showing an average absence rate of 6.5 days and then “based on average earnings of £453 a week in January 2011 and a UK workforce in employment of 29.2 million, according to the ONS”.³⁴ In contrast the Black Review gives a cost of absence to employers of £10 billion, with a total cost to the economy as a whole of working age ill-health (including worklessness, informal care and health care) coming to between £103-129 billion.³⁵ In this instance the CBI estimate (£17m) looks only at the cost of absence to employers. The ‘aggregate’ Black estimate (£103-129m) includes healthcare costs, informal care costs, costs to the government (by way of taxes foregone and benefits incurred) as well as the cost to employers. So depending on the assumptions used and what is examined then estimates of the cost of ill-health vary, making a definitive estimate of the total cost of ill-health to society difficult to pin point. However there is consistency in highlighting a considerable cost to the economy.

Appendix B of this report gives a wide variety of estimated costs of ill-health in order to provide an idea of the scale of costs involved and provide a context to the benefits of workplace interventions.

With the Black and Frost review of sickness absence noting “for employees, the costs of sickness absence fall on individuals, who often bear the personal and financial costs of absence, and employers, who are responsible for sick pay. For those who fall out of work due to ill health, the State bears much of the cost, and individuals and their families suffer through loss of income as well as the illness itself”.³⁶ Further CIPD observes that “the British Society for Rehabilitation Medicine (2001) has found that after six months’ absence there is only a 50 per cent likelihood of the employee returning to work. At 12 months this falls to 25 per cent and after two years, the chance of a return is practically nil”.³⁷ Thus by tackling sickness absence the employer can benefit from retaining human capital, reducing staff turnover costs, improved reputation and a more engaged and productive employee for example. Employees benefit from improved mental and physical well-being, as well as improved relationships with family and friends and society benefits from indirect social benefits as well as savings on healthcare costs for example. This many layered nature of the benefits from preventing or alleviating employee ill-health was highlighted by PricewaterhouseCoopers in their examination of the literature on ‘business wellness programmes’ which discovered numerous indirect as well as fiscal benefits to firms from these programmes (see Table 2).

Further numerous studies have concluded that being in work in itself is good for an employee’s physical and mental health,³⁸ whilst “work also reduces poverty and health inequalities for the family and the community”.³⁹ Whilst a systematic review of the evidence by Waddell and Burton concluded that “there is a strong evidence base showing 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. That is true for healthy people of working age, for many disabled people, for most people with common health problems and for social security beneficiaries. The provisos are that account must be taken of the nature and quality of work and its social context; jobs should be safe and accommodating. Overall, the beneficial effects of work outweigh the risks of work, and are greater than the harmful effects of long-term unemployment or prolonged sickness absence. Work is generally good for health and well-being”,⁴⁰ whilst the Marmot Review⁴¹ further highlighted that certain groups are more likely to experience poor quality jobs (such as disabled people, lone parents, those with caring responsibilities and from some ethnic groups). It also noted that having a good job is linked to positive health outcomes, and conversely jobs that are insecure, low-paid and fail to protect employees from stress and danger are more likely to make people ill.

Table 2: Business benefits associated with wellness programmes

| Intermediate benefits (non-financial) | Related bottom line benefits (financial) |
|---|---|
| Reduced sickness absence | Reduced overtime payments Reduced temporary recruitment Reduced permanent staff payroll ⁴² |
| Increased employee satisfaction Reduced staff turnover | Reduced recruitment costs |
| Reduced accidents and injuries | Reduced legal costs/claims Reduced insurance premiums Reduced healthcare costs |
| Increased productivity | Increased revenues Reduced overtime payments Reduced permanent staff payroll |
| Increased company profile | Reduced recruitment costs |
| Increased employee health and welfare | Reduced healthcare costs |
| Increased resource utilisation | Reduced management time costs |

Source: PricewaterhouseCoopers⁴³

The case for investing in employee health and well-being

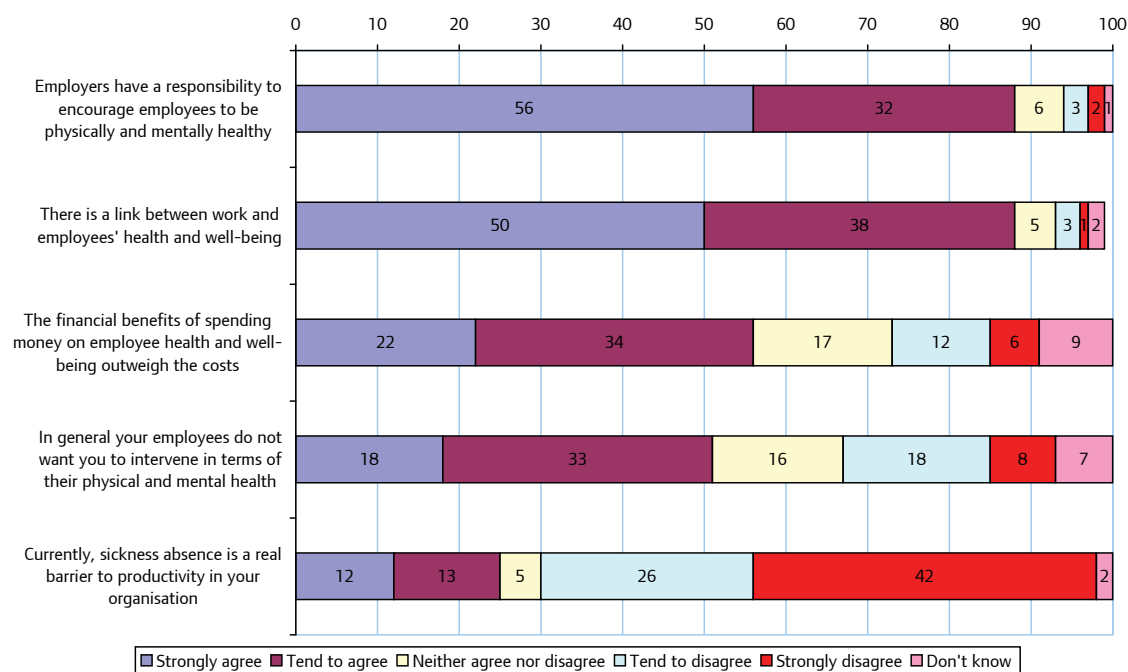
Workplace wellness programme

A workplace wellness program has been defined as “an organised, employer-sponsored program that is designed to support employees (and, sometimes, their families) as they adopt and sustain behaviours that reduce risks, improve quality of life, enhance personal effectiveness, and benefit the organisation’s bottom line”.⁴⁴ It has been remarked that with “nearly 80 per cent of people of working age economically active, spending on average around 37 per cent of their waking hours for around 40 years of their life at work ... the workplace offers the opportunity to influence the behaviour of large numbers of people”.⁴⁵

It should be noted however that work wellness programmes are not enough, with as shown in some examples in Appendix C, structural components such as flexible working, employee communication etc. being vital in order that a firm may get the best out of their workforce. Thus the Marmot Review has argued that “jobs need to be sustainable and offer a minimum level of quality, to include not only a decent living wage, but also opportunities for in-work development, the flexibility to enable people to balance work and family life, and protection from adverse working conditions that can damage health”.⁴⁶

Research undertaken by Ipsos MORI shows the importance that firms attach to wellness programmes with it being found that “all FTSE 100 firms include wellness and engagement themes in public reporting”⁴⁷ with talent management and wellness and working environment being the most common themes examined. However, even though the majority of employers agree that they have a responsibility to encourage employees to be physically and mentally healthy, research shows there is a mixed response to understanding the financial benefits, as shown by Figure 15. The report for the Department for Work and Pensions⁴⁸ also found that large employers were more likely than small employers to think that employees would not welcome interference in matters concerning their health. Moreover, with health and well-being placed fifth out of six priorities for the year ahead this indicates the vulnerability of these programmes to the current difficult economic times.

Figure 15: Employers attitudes to health and well-being amongst their employees in Great Britain

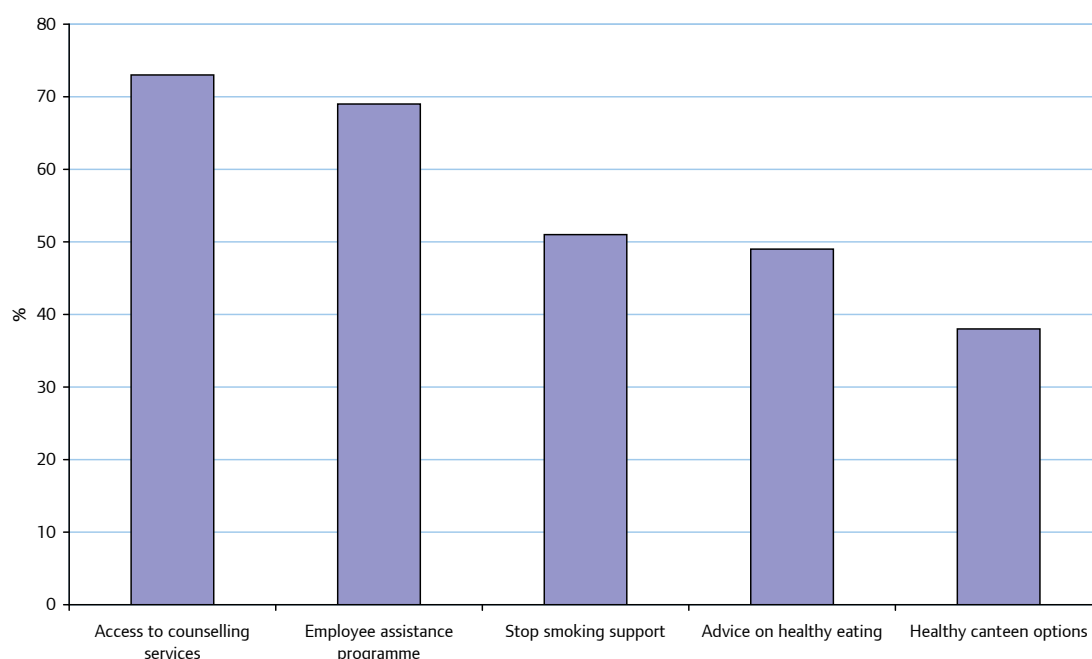


Source: *Health and well-being at work: A survey of employers*⁴⁹

However, as also seen from Figure 15, there is a perception in a number of firms that sickness absence is not detrimental to productivity in an organisation with 42 per cent of employers questioned strongly disagreeing that sickness absence is currently a barrier to productivity. Still it should be observed that an employee's health is also likely to impact on their performance and productivity whilst at work and that, as noted by Black and Frost, firms face significant costs due to sick pay and other costs associated with employee absence, whilst "a significant number of absences last longer than they need".⁵⁰ It would thus appear that firms would be ill advised to ignore employee well-being.

Additionally according to CIPD nearly half of employers have an employee well-being strategy (or similar) in place with large and public sector organisations more likely to have such a policy.⁵¹ Figure 16 summarises Table A.12 in Appendix A and shows the prevalence of the top 5 employee well-being benefits currently offered by employers of those firms surveyed by CIPD. As can be seen the most common form of programme is access to counselling with 73 per cent of all respondent's to the CIPD's survey providing it, with this hitting 87 per cent of public sector respondents. Similarly the CBI finds that counselling and occupational health support are widely offered by firms in order to manage stress. Although it should be noted that other surveys have shown less willingness of employers to offer well-being benefits.⁵² Further, as Table A.12 shows other policies were less popular with some such as private medical insurance being dependent on pay grade or seniority. Still, in further evidence of the usefulness of employer spending on employee health, CIPD notes "organisations that evaluate their well-being spend are twice as likely to have increased their spend this year (38 per cent compared with 19 per cent). They are also more likely to predict it would increase in 2012 (36 per cent compared with 21 per cent)".⁵³

Figure 16: The Top 5 employee well-being benefits by employers (% of employers surveyed in the UK that offered the benefit to all employees)



Source: CIPD⁵⁴

Absence Management

Most firms in the UK undertake some form of absence management with 95 per cent of firms surveyed by the CBI⁵⁵ and 94 per cent by CIPD⁵⁶ having an absence management policy. CIPD further found that “just under half of employers have a target in place for reducing employee absence”,⁵⁷ with the CBI finding that “more than a third of employers – and half of those in the public sector – have set an explicit target for reducing absence over the coming year”.⁵⁸ Surveys of the effectiveness of varying policies for managing absence, such as that shown in Table A.6 in Appendix A, indicate that a proactive approach by management to absence is most effective in supporting a reduction. The Black and Frost review noted that “sickness absence varies greatly among employees and between employments of different types. Analysis of the data indicates that this appears to be due to a combination of: employee characteristics and demographics; the presence and scope of occupational sick pay (OSP); management practice; and the degree of employee engagement”.⁵⁹ Whilst the long-term decline in sickness absence is largely due to better management practices Black and Frost also notes “even where absence records are kept, many organisations still have problems because of inaccuracy or inadequacy of the information collected”.⁶⁰ The wide variety of approaches and relative effectiveness of them in dealing with short and long-term absences is examined further in Tables A.7 to A.10 in Appendix A and indicates that although programs aimed at employee wellness can reduce absences other policies can also be instrumental in achieving this result.

Work undertaken by Hassan et. al.⁶¹ and shown in Table A.11 in Appendix A, gives evidence on the type of interventions that can be performed for different types of ill-health and the success of these types of intervention. Waddell et al. note “early intervention is central to vocational rehabilitation, because the longer anyone is off work, the greater the obstacles to return to work and the more difficult vocational rehabilitation becomes”.⁶²

The economic impact of employer initiatives on employee well-being

Beyond the case for corporate social responsibility economic factors strongly make the case for firms to run wellness programs, for example the cost of just sickness absence to the economy has been estimated at £17 billion in 2010.⁶³ Additionally, Bevan observes that research has indicated “that employers spend in the region of 9 to 10 per cent of their annual paybill managing the direct and indirect consequences of sickness absence”.⁶⁴ With consideration of a return on investment, Lee et al. argue, “that implementing wellness without financial backing is not effective. Nevertheless, it is possible for such a programme to become financially sustainable after an initial investment period”.⁶⁵

However, the benefits of policies to reduce absence will vary depending on the type of illness; it has been estimated that a firm of 1000 employees that implemented NICE public health guidance on promoting mental well-being at work would make a possible saving of £250,607.⁶⁶ Lee et al. also note that research in the US has indicated a return of \$2.5 per dollar spent on programmes; with other less tangible benefits accruing to the firm such as reduced presenteeism, improved moral, improved corporate image etc.⁶⁷ Whilst in a different study Baicker et al. found that for every dollar spent on US workplace disease prevention and wellness programmes saved \$3.27 in medical costs and the cost of absenteeism fell by \$2.73.⁶⁸ Again these results are supported by other research although the calculated returns are dependent on the firms used in the surveys sample, methodology issues etc.

The benefits to the individual and society of wellness programmes can be harder to quantify in monetary terms but still exist. For example, OECD research on tackling obesity by workplace interventions claims that fruit and vegetable consumption and physical activity would increase whilst fat intake would decrease with some benefits retained into retirement.⁶⁹ This workplace programme would include an introductory lecture to staff and “a series of 20-minute group sessions with a nutritionist every two weeks for twenty months” amongst other measures such as “walkers-clubs” at a cost of \$77 per target individual. Informal learning at work, which is often a part of workplace wellness programmes, can also improve both the employees and the wider community. Thus, a report by Business in the Community remarks that “the social relationships that develop as a result of this informal learning can provide networks of support and solidarity. For the low-skilled and under-confident, informal learning can be an important stepping stone to further learning and a more skilled future”.⁷⁰

In the case of mental ill-health, a number of studies have indicated that the atmosphere at work can significantly impact the outcome for the employee in terms of work and career progression.⁷¹ With research by Knapp et al. observing that for a firm of 500 employees it was possible that in the first year of running a mental well-being programme that “the initial costs of £40,000 for the programme are outweighed by gains arising from reduced presenteeism and absenteeism of £387,722. This represents a substantial annual return on investment of more than 9 to 1”.⁷²

As discovered by Hill et al. “interventions which included some form of employer/employee partnership and/or consultation, demonstrated improved results (compared to those which did not)”.⁷³ However, placing a value on employee wellness programmes is problematic in part because the benefits derive both to the firm, to the employees and to society in general. Further, the size of any benefits varies depending on the nature of the issue and the intervention. Thus as can be seen from Tables C.1 and C.2 in Appendix C the returns on employee wellness schemes are variable and are generally dependent on the type of intervention, how well designed these programmes are and how integrated they are into the running of the business.

Therefore it has been argued that if a firm is to implement a successful wellness programme, the following criteria should be met:⁷⁴

- 1) Employee needs.
- 2) Senior management buy-in.
- 3) Aligned with the business' overall aims and goals.
- 4) Allowed employees' views to drive ongoing change and influence the programmes and initiatives that are offered.
- 5) Measured the outcomes of these programmes.

A number of non-monetary benefits accrue to firms that promote wellness, with the World Economic Forum (WEF) finding that globally firms that actively promote wellness are 2.5 times more likely to be seen as a best performer by their employees, are three times more likely to be seen as productive and employees are eight times more likely to be engaged.⁷⁵

Financially the WEF⁷⁶ estimates that European firms could get €400 per employee per year in saved healthcare costs and improved productivity from targeting three major risk factors.⁷⁷ NICE has claimed that "an active workforce can reduce days off sick by 27 per cent and broader absenteeism by up to 20 per cent".⁷⁸ Additionally the WEF observes that the major cost of health risks to firms due to all forms of ill-health is from productivity lost with presenteeism being a significant contributing factor.⁷⁹ It has also been noted from a study from four large US firms that the cost to firms of different health conditions also varies (see Table A.13 in Appendix A). Thus although healthcare costs to the firm are likely to be significantly less in the UK than in the US, due to comprehensive public healthcare, these costs will still be borne by society and again indicates the varying burden of ill-health depending on the type of illness. That is in the US firms and employees generally cover the cost of healthcare directly whilst in the UK the cost is paid by them indirectly due to their tax contributions.

In an indication of the benefits of workplace wellness programmes to firms' research⁸⁰ has discovered that firms with workplace health and safety systems "outperformed the S&P/ASX 200 (the top 200 stock listed on the Australian Securities Exchange) by 38.4 per cent".⁸¹ Stewart argues that evidence exists of a link between employee engagement and business success.⁸²

In relation to the literature on the benefits of employee well-being programmes it is important to observe that a number of flaws in the methodologies of some of these reports have been highlighted by research conducted by the Work Foundation⁸³ as listed in Appendix D. Thus some care needs to be taken when examining the results of the literature. Still having noted this, in a survey of the available literature PricewaterhouseCoopers found seven case studies that gave costs and benefits that could allow the calculation of cost benefit analysis of wellness programmes (see Table 3). As can be seen the benefits varied widely, however most wellness programmes examined provided a positive return to the firm.

Table 3: Benefit/cost of selected wellness programmes that took place in the UK

| Company/Programme | Benefit : cost ratio ⁸⁴ |
|---|------------------------------------|
| Manufacturing company: ergonomic improvements | 4.17 (over 1 year) |
| Manufacturing company: physical well-being | 2.67 (over 1 year) |
| Call centre: physiotherapy | 34 (over 6 months) |
| Public sector health service provider: flu immunisation | 9.2 (over 2 years) |
| Manufacturing organisation: ergonomic support | 12 |
| Manufacturing company: health and safety awareness | 1 |
| Retail & distribution company: ergonomic support | 1 (over 2 years) |

Source: PricewaterhouseCoopers⁸⁵

PricewaterhouseCoopers also found from their literature survey the following benefit-cost ratios from certain types of wellness programmes:⁸⁶

- Programmes targeting medical costs alone found a return on investment of 2.3
- Programmes targeting absenteeism found returns on investment of 2.5, 4.9 and 10.1
- Programmes targeting absenteeism and presenteeism found returns on investment of 1.81, 3.24 and 8.81
- The benefit-cost ratio for programmes targeting musculoskeletal issues were as high as 15.4, 24.6 and 84.9

Whereas case studies presented in research for the Royal National Institute of Blind People (RNIB) found that the cost benefit ratios of programmes designed to retain employees that have become newly disabled “was never less than 2.5:1”.⁸⁷ As mentioned previously a summary of the results of various companies’ wellness programmes is provided in Appendix C Tables C.1 and C.2 and again highlights the varying results that are available from these programmes.

The economic impact of government initiatives on employee well-being

Employers are not the only agents that can influence workers well-being, the role of Government is also vital in providing positive social returns. Thus for instance it has been estimated that for every £1 spent on London's Improving Access to Psychological Therapies (IAPT) programme £2.79 of benefits were generated (£0.84 to the individual and £1.95 to the state).⁸⁸ The service offered interventions to gain or regain employment as well as interventions to aid in the retention of employment. This included:

- Basic advice and career guidance;
- Post-placement in-work support to maximise job retention;
- Vocational information and advice, including CV writing, job search and interviewing skills;
- Individual support for motivation, confidence building and assertiveness skills;
- Signposting to Job Centre Plus (JCP) support;
- Access to expert advice, benefits counselling and debt counselling;
- Management of employment and employer-related issues;
- Individual support for motivation, confidence building and assertiveness skills;
- Adjustments in the work place to help maintain attendance at work;
- Help to return to work after sick leave;
- Access to occupational health support;
- Careers guidance;
- Help to look for more suitable jobs whilst still employed;
- Sign-posting to legal advice and legal aid.⁸⁹

Tower Hamlets offers another example of a positive return by the Work It Out Programme in May 2008, which gave work experience in the PCT to people with significant health problems. In analysing the effectiveness of this policy it was found that it generated £17.07 of social return for every £1 spent in employment support, with the main returns coming from increased work volunteering, reduced demand on health services and increased taxation.⁹⁰

In examining the role of government policy in relation to the health of the working age population the Black review provided 10 recommendations, which are outlined in Appendix E. The Government responded to these recommendations with a number of policies one of which was the introduction of the 'fit note' in April 2010 aiming to encourage doctors to indicate where individuals could be supported to work. Other initiatives such as an occupational health helpline, regional health, work and well-being coordinators and piloting Fit for Work Services were also launched by the Government in response to the Black review.⁹¹ Recently an independent review into sickness absence has been launched⁹² which produced a number of recommendations which are reproduced in Appendix F. These included the setting up of an Independent Assessment Service to give an in-depth assessment of an individual's physical and/or mental health, that employer expenditure targeted at keeping sick employees in work should attract tax relief and that the state should provide free job-brokering for anyone with a sickness absence period of 20 weeks or more.

A further example of the government's attempts to promote workplace wellness programmes is the 'Promoting physical activity in the workplace Business Case'⁹³ in which employers can calculate the quantifiable benefits of reducing sickness absence and staff turnover. This is one of a number of NICE guidelines on workplace health including smoking cessation, mental well-being etc.

Government intervention beyond that which already occurs could also be useful for reducing health inequality due to social class. Thus the Marmot review observed that "health inequalities result from social inequalities. Action on health inequalities requires action across all the social determinants of health"⁹⁴ and that "action taken to reduce health inequalities will benefit society in many ways. It will have economic benefits in reducing losses from illness associated with health inequalities. These currently account for

productivity losses, reduced tax revenue, higher welfare payments and increased treatment costs".⁹⁵ Research by Piha et al.⁹⁶ found that a "high position by education, occupational class and individual income were all consistently associated with lower sickness absence rates among both women and men." Waddell and Burton observe that "work is generally good for health and well-being, not only for healthy people, but also for many disabled people, for many people with common health problems, and for many social security beneficiaries".⁹⁷

Thus when introducing different policy and programme interventions, consideration needs to be given in terms of reducing health inequalities. Areas of concern include the fact that it has been found that lower paid, lower skilled workers are more likely to take absences and to fall out of work altogether through ill health.⁹⁸ Further, a considerable degree of churn between employment and the benefits system for lower paid people coming from smaller and medium-sized firms has also been discovered.⁹⁹

In policies that led to a reduction in movements to long-term sickness, Hillage et al. found¹⁰⁰ that early interventions in sickness absence were more likely to lead to positive outcomes as was a multi-disciplinary approach and programmes that include a workplace component.¹⁰¹

Given that an average London firm of 250 employees loses around £4,800 per week (or around £250,000 a year) due to sickness absence,¹⁰² employers have a clear interest in reducing the ill-health of their employees. This is especially true given the declining likelihood of return to work the longer an employee is absent and thus the greater the likelihood of resources loss to a firm from their investment in an employee. Moreover, given that a significant proportion of an individual's life is spent at work, the workplace offers the opportunity to influence the behaviour of large numbers of people.

Despite research variations in terms of quality and design, evidence would indicate that well designed employee welfare programmes that are integrated into the core of the firm can more than cover the costs of such a programme to the firm. Further the benefits of these programmes accrue not only to the firms running them but to the employee and society as a whole. Thus given the demographic issues facing the UK and London, in addition to the rise of chronic health conditions (with up to three-quarters of the population not having a disability-free life expectancy as far as the age of 68¹⁰³) and the need to maximise economic output of the working age population, it would appear that London can ill afford to ignore the potential benefits of workplace wellness programmes.

Appendix A

Table A.1: Top five most common causes of short-term absence for employee by sector in the UK (% of respondents)¹⁰⁴

| Illness | All | | Manufacturing and production | | Private sector services | | Public services | | Non-profit organisations | |
|--|--------|------------|------------------------------|------------|-------------------------|------------|-----------------|------------|--------------------------|------------|
| | Manual | Non-manual | Manual | Non-manual | Manual | Non-manual | Manual | Non-manual | Manual | Non-manual |
| Minor illness | 97 | 98 | 97 | 94 | 95 | 99 | 99 | 98 | 98 | 100 |
| Musculoskeletal injuries | 62 | 50 | 61 | 28 | 57 | 46 | 72 | 65 | 72 | 55 |
| Back pain | 61 | 43 | 69 | 38 | 56 | 37 | 64 | 54 | 64 | 47 |
| Stress | 49 | 57 | 28 | 53 | 46 | 48 | 69 | 72 | 69 | 58 |
| Mental ill-health | 25 | 31 | 19 | 25 | 21 | 27 | 31 | 38 | 35 | 35 |
| Work related injuries/accidents | 15 | 3 | 20 | 0 | 10 | 2 | 20 | 7 | 14 | 3 |
| Injuries/accidents not related to work | 24 | 22 | 38 | 32 | 20 | 21 | 16 | 16 | 27 | 27 |
| Acute medical conditions | 17 | 18 | 19 | 25 | 19 | 16 | 16 | 23 | 14 | 22 |
| Recurring medical conditions | 37 | 40 | 41 | 32 | 40 | 42 | 32 | 37 | 33 | 45 |
| Drink or drug related conditions | 2 | 1 | 2 | 0 | 2 | 1 | 2 | 2 | 0 | 2 |
| Home/family responsibilities | 39 | 40 | 47 | 43 | 48 | 52 | 27 | 24 | 27 | 33 |
| Pregnancy-related absence | 9 | 14 | 3 | 9 | 13 | 18 | 20 | 13 | 6 | 13 |
| Other (not due to genuine ill-health) | 21 | 22 | 17 | 23 | 30 | 29 | 11 | 13 | 20 | 17 |

Source: CIPD¹⁰⁵

Table A.2: Top five most common causes of long-term absence for employee by sector in the UK (% of respondents)¹⁰⁶

| Illness | All | | Manufacturing and production | | Private sector services | | Public services | | Non-profit organisations | |
|--|--------|------------|------------------------------|------------|-------------------------|------------|-----------------|------------|--------------------------|------------|
| | Manual | Non-manual | Manual | Non-manual | Manual | Non-manual | Manual | Non-manual | Manual | Non-manual |
| Acute medical conditions | 57 | 62 | 61 | 64 | 56 | 57 | 59 | 67 | 51 | 64 |
| Musculoskeletal injuries | 57 | 46 | 61 | 38 | 44 | 36 | 73 | 65 | 55 | 43 |
| Stress | 58 | 68 | 38 | 54 | 55 | 63 | 70 | 80 | 69 | 70 |
| Back pain | 50 | 42 | 55 | 38 | 41 | 29 | 56 | 59 | 57 | 43 |
| Mental ill-health | 46 | 53 | 32 | 33 | 50 | 54 | 53 | 57 | 43 | 62 |
| Recurring medical conditions | 28 | 29 | 34 | 33 | 29 | 32 | 29 | 24 | 20 | 28 |
| Injuries/accidents not related to work | 30 | 32 | 30 | 33 | 32 | 30 | 25 | 23 | 31 | 49 |
| Work related injuries/accidents | 20 | 7 | 27 | 5 | 12 | 5 | 29 | 10 | 16 | 6 |
| Minor illness | 11 | 8 | 4 | 8 | 13 | 8 | 14 | 13 | 10 | 2 |
| Home/family responsibilities | 13 | 11 | 11 | 10 | 15 | 12 | 14 | 13 | 8 | 8 |
| Pregnancy-related absence | 10 | 12 | 5 | 8 | 15 | 20 | 10 | 8 | 6 | 6 |
| Other (not due to genuine ill-health) | 6 | 8 | 4 | 5 | 8 | 13 | 5 | 6 | 5 | 2 |
| Drink or drug related conditions | 1 | 2 | 0 | 0 | 0 | 0 | 3 | 0 | 3 | 2 |

Source: CIPD¹⁰⁷

Table A.3: The five main hazards of concern by sector in the UK (%¹⁰⁸)

| Sector | 1st concern | 2nd concern | 3rd concern | 4th concern | 5th concern |
|-------------------------------|--------------------|-----------------------------|-----------------------------|-----------------------------|---|
| Agricultural and fishing | Stress (34%) | Bullying / harassment (24%) | Slip level (19%) | Lone working (19%) | DSE ¹⁰⁹ and RSI ¹¹⁰ (17%) |
| Banking insurance and finance | Stress (100%) | DSE (73%) | Bullying / harassment (73%) | RSI (55%) | Overwork (46%) |
| Central government | Stress (82%) | DSE (56%) | RSI (44%) | Bullying / harassment (42%) | Overwork (37%) |
| Construction | Dusts (60%) | Back strains (49%) | Asbestos (46%) | Heavy loads (43%) | Slips height (43%) |
| Distribution and hotels | Back strains (66%) | Heavy loads (45%) | RSI (45%) | Stress (38%) | Slip level (35%) |
| Education | Stress (85%) | Overwork (60%) | Bullying / harassment (56%) | Long hours (30%) | Violence (24%) |
| Energy and water | Stress (67%) | Slip level (49%) | DSE (38%) | Bullying / harassment (33%) | Back strains (29%) |
| Health services | Stress (72%) | Back strains (55%) | Bullying / harassment (39%) | Overwork (33%) | Lone working (32%) |
| Leisure services | Stress (61%) | Back strains (33%) | Overwork (33%) | Noise (28%) | Spill level, dusts and cramped conditions all (22%) |
| Local government | Stress (70%) | Bullying / harassment (41%) | Back strains (34%) | Violence (34%) | Overwork (32%) |
| Manufacturing | Slip level (47%) | Noise (35%) | Stress (35%) | Back strains (34%) | Dusts (33%) |
| Transport and communications | Stress (59%) | Bullying / harassment (43%) | Slip level (40%) | Back strains (35%) | Long hours (31%) |
| Voluntary sector | Stress (86%) | Bullying / harassment (64%) | Overwork (50%) | Violence (43%) | RSI and lone working both (36%) |
| Other services | Stress (62%) | Slips level (42%) | Back strains (35%) | Bullying / harassment (34%) | DSE (27%) |

Source: TUC¹¹¹

Table A.4: Main hazards at work and workplace size in the UK (%¹¹²)

| Number of workers | 1st concern | 2nd concern | 3rd concern | 4th concern | 5th concern |
|-------------------|--------------|----------------------------|-----------------------------|----------------------------|-----------------------------|
| Under 50 | Stress (52%) | Back strains (31%) | Slips on level (31%) | Bullying / harassment -31% | DSE (27%) |
| 50-100 | Stress (63%) | Back strains (37%) | Bullying / harassment (33%) | Slips on level (28%) | DSE (27%) |
| Over 100 | Stress (62%) | Back strains (37%) | Slips on level (33%) | RSI (33%) | Bullying / harassment (29%) |
| Over 200 | Stress (63%) | Bullying / harassment -38% | Slips on level (36%) | RSI (33%) | Back strains (32%) |
| Over 1000 | Stress (71%) | Bullying / harassment -48% | Overwork (33%) | DSE (31%) | Back strains (31%) |

Source: TUC¹¹³

Table A.5: Main hazards by region/country

| Hazard | Worst area | 2nd worst area | % cited nationally in 2010 |
|--------------------------------------|--------------------|--------------------------------------|----------------------------|
| Stress | London 70% | South West 68% | 62% |
| Bullying and harassment | London 44% | Midlands/North West 40% | 37% |
| Back strains | Midlands 36% | Northern/South East and South 35% | 33% |
| Slips, trips and falls on the level | South West 38% | East Anglia/North West 37% | 32% |
| Overwork | London 40% | South East and South 36% | 29% |
| Display Screen Equipment | South West 38% | East Anglia/Midlands 30% | 28% |
| Repetitive Strain Injury | North West 32% | Northern 31% | 28% |
| Long hours of work | London 30% | South East and South 28% | 21% |
| Working alone | East Anglia 24% | South East and South 23% | 21% |
| High temperatures | London 22% | North West 22% | 19% |
| Handling heavy load | Northern 25% | Yorkshire and Humber 25% | 18% |
| Violence and threats | Midlands 22% | North West 22% | 18% |
| Slips, trips and falls from a height | North West 24% | Northern 13% | 11% |
| Low temperatures | Midlands 14% | Scotland 13% | 10% |
| Noise | North West 16% | Northern 13% | 10% |

| | | | |
|-------------------------------|-------------------|--|----|
| Asbestos | London 13% | Yorkshire and Humber 13% | 9% |
| Dusts | Northern 14% | Yorkshire and Humber 13% | 9% |
| Chemicals or solvents | Northern 14% | Yorkshire and Humber 13% | 8% |
| Cramped conditions | South West 10% | London 9% | 7% |
| Machinery hazards | Midlands 14% | Scotland 11% | 7% |
| Road traffic accidents | South West 14% | Wales 10% | 7% |
| Infections | Scotland 7% | North West 6% | 5% |
| Workplace transport accidents | Northern 7% | Yorkshire and Humber 7% | 5% |
| Dermatitis/skin rashes | Scotland 7% | North West 6% | 4% |
| Vibration | South West 6% | South East & South/ Yorkshire & Humber 3% | 3% |
| Asthma | Midlands 3% | South West 2% | 1% |
| Passive smoking | Northern 3% | Scotland 2% | 1% |

Source: TUC¹⁴

Table A.6: Rating of effectiveness of policies in private and public sector in the UK (% of respondents)

| | Private sector | Public sector |
|--|----------------|---------------|
| Return to work interviews | 71 | 89 |
| Line manager taking primary responsibility for managing absence | 54 | 63 |
| Rehabilitation plans | 46 | 50 |
| Support for line managers in managing absence | 36 | 66 |
| Employer-funded occupational health services | 27 | 43 |
| High levels of employee engagement | 31 | 27 |
| Disciplinary procedures | 30 | 23 |
| Flexible working | 27 | 27 |
| Health and well-being service | 22 | 36 |
| Centralised absence reporting with occupational health follow up | 18 | 23 |
| Private medical insurance | 21 | 0 |
| Waiting days before occupational sick pay is payable | 11 | 0 |
| Attendance bonus or similar | 9 | 5 |
| Absence record examined during redundancy selection | 7 | 0 |

Source: CBI¹⁵

Table A.7: Approaches used to manage short-term absence (% of respondents)

| | All | Manufacturing and production | Private sector services | Public services | Non-profit organisations |
|--|-----|------------------------------|-------------------------|-----------------|--------------------------|
| Return-to-work interviews | 87 | 89 | 81 | 94 | 86 |
| Trigger mechanisms to review attendance | 82 | 83 | 77 | 91 | 76 |
| Sickness absences information given to line managers | 79 | 82 | 75 | 88 | 73 |
| Disciplinary procedures for unacceptable absence | 75 | 84 | 75 | 76 | 70 |
| Line managers take primary responsibility for managing absence | 69 | 67 | 64 | 79 | 63 |
| Leave for family circumstances | 66 | 58 | 59 | 72 | 79 |
| Managers are trained in absence-handling | 62 | 61 | 51 | 80 | 60 |
| Flexible working | 54 | 28 | 48 | 70 | 64 |
| Occupational health involvement | 53 | 58 | 33 | 75 | 59 |
| Capability procedure | 48 | 42 | 36 | 64 | 55 |
| Changes to working patterns or environment | 48 | 29 | 46 | 58 | 50 |
| Restricting sick pay | 44 | 61 | 54 | 26 | 36 |
| Employee assistance programmes | 44 | 33 | 39 | 59 | 42 |
| Absence rate is a key performance indicator | 43 | 43 | 31 | 57 | 46 |
| Health promotion | 38 | 26 | 27 | 59 | 35 |
| Stress counselling | 38 | 24 | 25 | 60 | 41 |
| Tailored support for line managers | 33 | 18 | 29 | 48 | 28 |
| Well-being benefits | 32 | 29 | 30 | 35 | 33 |
| Risk assessment to aid return to work after long-term absence | 25 | 18 | 21 | 34 | 23 |
| Offering private medical insurance | 24 | 28 | 41 | 5 | 14 |
| Employees' absence records taken into account when considering promotion | 22 | 24 | 27 | 22 | 10 |
| Rehabilitation programme | 16 | 17 | 12 | 23 | 11 |
| Nominated absence case manager/management team | 15 | 9 | 14 | 23 | 9 |
| Attendance driven by board | 15 | 9 | 10 | 29 | 9 |
| Attendance bonuses or incentives | 12 | 18 | 18 | 5 | 8 |
| Attendance record is a recruitment criterion | 12 | 14 | 13 | 13 | 8 |
| Outsourced absence management process | 1 | 0 | 1 | 0 | 1 |

Source: CIPD¹¹⁶

Table A.8: Most effective approaches for managing short-term absence (% of respondents citing as one of the top three most effective methods)

| | All | Manufacturing and production | Private sector services | Public services | Non-profit organisations |
|--|-----|------------------------------|-------------------------|-----------------|--------------------------|
| Return-to-work interviews | 63 | 68 | 65 | 60 | 59 |
| Trigger mechanisms to review attendance | 57 | 54 | 47 | 70 | 64 |
| Disciplinary procedures for unacceptable absence | 28 | 39 | 31 | 28 | 11 |
| Restricting sick pay | 18 | 25 | 27 | 8 | 10 |
| Line managers take primary responsibility for managing absence | 17 | 17 | 18 | 16 | 16 |
| Managers are trained in absence-handling | 17 | 13 | 12 | 20 | 28 |
| Sickness absence information given to line managers | 16 | 25 | 14 | 16 | 15 |
| Occupational health involvement | 13 | 12 | 7 | 19 | 16 |
| Flexible working | 10 | 4 | 9 | 9 | 19 |
| Leave for family circumstances | 5 | 1 | 7 | 4 | 8 |
| Capability procedure | 5 | 3 | 4 | 6 | 5 |
| Attendance bonuses or incentives | 4 | 9 | 6 | 2 | 1 |
| Tailored support for line managers (for example online support, care conference with HR) | 3 | 1 | 4 | 5 | 1 |
| Employee assistance programmes | 3 | 0 | 4 | 1 | 8 |
| Nominated absence case manager/management team | 3 | 3 | 3 | 2 | 3 |
| Changes to working patterns or environment | 3 | 0 | 3 | 3 | 4 |
| Offering private medical insurance | 2 | 0 | 4 | 0 | 1 |
| Attendance driven by board | 1 | 1 | 1 | 3 | 0 |
| Stress counselling | 1 | 0 | 1 | 1 | 1 |
| Rehabilitation programme | 1 | 1 | 1 | 1 | 0 |
| Risk assessment to aid return to work after long-term absence | 1 | 0 | 2 | 0 | 0 |
| Risk assessment to aid return to work after long-term absence | 1 | 0 | 2 | 0 | 0 |
| Employees' absence records taken into account when considering promotion | 1 | 0 | 1 | 1 | 0 |
| Health promotion | 0 | 0 | 0 | 1 | 0 |
| Attendance record is a recruitment criterion | 0 | 0 | 0 | 0 | 1 |

Source: CIPD¹¹⁷

Table A.9: Approaches used to manage long-term absence (% of respondents)

| | All | Manufacturing and production | Private sector services | Public services | Non-profit organisations |
|--|-----|------------------------------|-------------------------|-----------------|--------------------------|
| Return-to-work interviews | 86 | 82 | 82 | 93 | 84 |
| Occupational health involvement | 74 | 77 | 61 | 89 | 75 |
| Sickness absence information given to line managers | 73 | 67 | 65 | 86 | 74 |
| Trigger mechanisms to review attendance | 71 | 64 | 67 | 82 | 66 |
| Risk assessment to aid return to work after long-term absence | 69 | 74 | 63 | 78 | 64 |
| Flexible working | 63 | 45 | 58 | 75 | 66 |
| Changes to working patterns or environment | 61 | 49 | 56 | 72 | 63 |
| Capability procedure | 60 | 58 | 54 | 68 | 61 |
| Disciplinary procedures for unacceptable absence | 57 | 63 | 52 | 61 | 57 |
| Managers are trained in absence-handling | 56 | 49 | 45 | 73 | 60 |
| Line managers take primary responsibility for managing absence | 55 | 45 | 47 | 73 | 51 |
| Employee assistance programmes | 47 | 36 | 43 | 58 | 45 |
| Restricting sick pay | 45 | 58 | 52 | 33 | 42 |
| Leave for family circumstances | 44 | 38 | 38 | 49 | 55 |
| Stress counselling | 43 | 29 | 31 | 64 | 47 |
| Rehabilitation programme | 40 | 52 | 36 | 47 | 25 |
| Absence rate is a key performance indicator | 40 | 38 | 28 | 56 | 45 |
| Tailored support for line managers (for example online support, care conference with HR) | 39 | 23 | 34 | 57 | 34 |
| Health promotion | 37 | 29 | 26 | 58 | 35 |
| Well-being benefits | 32 | 29 | 32 | 35 | 33 |
| Nominated absence case manager/management team | 26 | 21 | 24 | 35 | 16 |
| Offering private medical insurance | 25 | 30 | 43 | 4 | 15 |
| Employees' absence records taken into account when considering promotion | 19 | 21 | 22 | 20 | 10 |
| Attendance driven by board | 14 | 7 | 8 | 29 | 9 |
| Attendance record is a recruitment criterion | 11 | 14 | 11 | 11 | 7 |
| Attendance bonuses or incentives | 10 | 11 | 15 | 4 | 7 |
| Outsourced absence management process | 0 | 0 | 0 | 0 | 1 |

Source: CIPD¹¹⁸

Table A.10: Most effective approaches for managing long-term absence (% of respondents citing as one of the top three most effective methods)

| | All | Manufacturing and production | Private sector services | Public services | Non-profit organisations |
|--|-----|------------------------------|-------------------------|-----------------|--------------------------|
| Occupational health involvement | 49 | 51 | 36 | 62 | 55 |
| Return-to-work interviews | 29 | 31 | 32 | 21 | 37 |
| Trigger mechanisms to review attendance | 23 | 22 | 22 | 26 | 21 |
| Rehabilitation programme | 18 | 27 | 18 | 14 | 15 |
| Changes to working patterns or environment | 17 | 12 | 14 | 19 | 24 |
| Restricting sick pay | 16 | 19 | 21 | 11 | 15 |
| Flexible working | 14 | 9 | 15 | 12 | 20 |
| Risk assessment to aid return to work after long-term absence | 13 | 15 | 13 | 12 | 12 |
| Capability procedure | 12 | 10 | 12 | 14 | 11 |
| Managers are trained in absence-handling | 11 | 12 | 7 | 14 | 17 |
| Line managers take primary responsibility for managing absence | 10 | 9 | 10 | 11 | 9 |
| Disciplinary procedures for unacceptable absence | 10 | 9 | 10 | 11 | 7 |
| Sickness absences information given to line managers | 9 | 12 | 9 | 6 | 9 |
| Tailored support for line managers | 9 | 3 | 10 | 14 | 7 |
| Nominated absence case manager/management team | 8 | 8 | 8 | 9 | 7 |
| Employee assistance programmes | 7 | 5 | 10 | 4 | 7 |
| Offering private medical insurance | 7 | 6 | 15 | 0 | 1 |
| Stress counselling | 4 | 0 | 4 | 7 | 5 |
| Attendance bonuses or incentives | 2 | 5 | 3 | 2 | 0 |
| Leave for family circumstances | 1 | 0 | 3 | 0 | 3 |
| Employees' absence records taken into account when considering promotion | 1 | 2 | 1 | 1 | 0 |
| Attendance driven by board | 1 | 2 | 1 | 3 | 0 |
| Health promotion | 0 | 0 | 0 | 1 | 0 |

Source: CIPD¹¹⁹

Table A.11: Summary of the evidence of the effectiveness of health and well-being interventions in the UK¹²⁰

| Antecedent factors | Targets | Evidence on effectiveness in literature |
|--------------------|---|--|
| Work-related | Musculoskeletal disorders and lower back pain | <ul style="list-style-type: none"> • little evidence for preventive interventions such as back belt and lumbar supports • evidence of positive effects of education and training interventions • evidence that preventive exercise interventions have positive effects on leave due to lower back pain • evidence that preventive ergonomic interventions have positive impact on health and work outcomes • evidence of positive effects of supportive interventions targeted towards individuals still disabled and on sick leave after the acute stage • evidence of positive effects of physical conditioning programmes on work-related and health outcomes • evidence of positive effects of rehabilitation and return-to-work interventions after long-term absence due to musculoskeletal disorders |
| | Mental health | <ul style="list-style-type: none"> • evidence of positive effects of alterations to shift work patterns on health outcomes • evidence that preventive stress management interventions have positive effects on health outcomes • evidence of positive effects of supportive interventions focusing on personal support, training in individual coping skills on health and work outcomes • evidence that rehabilitative and return-to-work interventions such as cognitive behavioural training and cognitive behavioural therapy have positive effects on health outcomes • Limited available evidence on work outcomes eg, absenteeism, employee turnover and return to work, in the literature |
| Lifestyle | Alcohol | <ul style="list-style-type: none"> • evidence of positive effects of interventions linked to alcohol related problems on health outcomes • evidence that employee assistance programmes are the most effective interventions for achieving positive results on health outcomes • limited evidence on work outcomes |
| | Smoking | <ul style="list-style-type: none"> • evidence that material and financial incentives to reduce smoking do not always affect health outcomes • evidence of positive effects of interventions aimed at individual workers such as individual counselling on health outcomes • limited evidence on work outcomes |
| | Diet | <ul style="list-style-type: none"> • evidence that programmes aimed at improving nutrition behaviour to decrease weight are effective in promoting behaviour change • limited evidence on work outcomes |
| | Physical | <ul style="list-style-type: none"> • sufficient literature suggesting that physical activity is good for mental and physical health • limited evidence on work outcomes |
| | Multiple programme | <ul style="list-style-type: none"> • definition as well as the elements covered under these programmes varies tremendously • evidence that the outcomes of worksite health promotion programmes show positive effects on health risk factors, reduced sick days and absenteeism |

Source: *Health and well-being at work in the United Kingdom*¹²¹

Table A.12: Employee well-being benefits by employers (% of employers surveyed in the UK that offered the benefit)

| | All | Manufacturing and production | Private sector services | Public services | Non-profit organisations |
|--|-----|------------------------------|-------------------------|-----------------|--------------------------|
| Access to counselling services | | | | | |
| All employees | 73 | 68 | 54 | 87 | 79 |
| Depends on grade/seniority | 3 | 0 | 7 | 0 | 0 |
| Employee assistance programme | | | | | |
| All employees | 69 | 73 | 65 | 73 | 61 |
| Depends on grade/seniority | 1 | 0 | 4 | 0 | 0 |
| Stop smoking support | | | | | |
| All employees | 51 | 50 | 38 | 65 | 39 |
| Depends on grade/seniority | 1 | 0 | 1 | 1 | 0 |
| Advice on healthy eating | | | | | |
| All employees | 49 | 55 | 38 | 59 | 39 |
| Depends on grade/seniority | 0 | 0 | 1 | 0 | 0 |
| Healthy canteen options | | | | | |
| All employees | 38 | 68 | 37 | 40 | 9 |
| Depends on grade/seniority | 1 | 0 | 2 | 1 | 0 |
| Access to physiotherapy | | | | | |
| All employees | 37 | 41 | 27 | 48 | 21 |
| Depends on grade/seniority | 1 | 0 | 1 | 2 | 0 |
| Subsidised gym membership | | | | | |
| All employees | 36 | 36 | 35 | 37 | 33 |
| Depends on grade/seniority | 1 | 1 | 1 | 2 | 0 |
| Health screening | | | | | |
| All employees | 35 | 50 | 31 | 38 | 27 |
| Depends on grade/seniority | 10 | 18 | 17 | 4 | 6 |
| Healthcare cash plans | | | | | |
| All employees | 24 | 32 | 27 | 12 | 48 |
| Depends on grade/seniority | 3 | 5 | 6 | 0 | 0 |
| In-house gym | | | | | |
| All employees | 23 | 27 | 12 | 37 | 0 |
| Depends on grade/seniority | 1 | 0 | 4 | 0 | 0 |
| Private medical insurance | | | | | |
| All employees | 22 | 32 | 46 | 3 | 9 |
| Depends on grade/seniority | 21 | 59 | 33 | 4 | 15 |
| Walking/pedometer initiatives | | | | | |
| All employees | 22 | 9 | 14 | 28 | 27 |
| Depends on grade/seniority | 1 | 5 | 2 | 0 | 0 |
| Long-term Disability/permanent health insurance/income protection | | | | | |
| All employees | 21 | 36 | 33 | 9 | 15 |
| Depends on grade/seniority | 10 | 18 | 23 | 0 | 3 |
| Critical illness insurance | | | | | |
| All employees | 20 | 36 | 33 | 9 | 15 |
| Depends on grade/seniority | 10 | 18 | 23 | 0 | 3 |

| | All | Manufacturing and production | Private sector services | Public services | Non-profit organisations |
|---|-----|------------------------------|-------------------------|-----------------|--------------------------|
| Dental illness insurance | | | | | |
| All employees | 20 | 9 | 33 | 6 | 36 |
| Depends on grade/seniority | 5 | 9 | 12 | 0 | 0 |
| On-site massages | | | | | |
| All employees | 17 | 23 | 13 | 14 | 30 |
| Depends on grade/seniority | 1 | 0 | 2 | 0 | 0 |
| Self-funded health plans | | | | | |
| All employees | 15 | 27 | 17 | 12 | 12 |
| Depends on grade/seniority | 3 | 5 | 7 | 0 | 0 |
| Free fresh fruit | | | | | |
| All employees | 15 | 14 | 29 | 4 | 18 |
| Depends on grade/seniority | 1 | 0 | 1 | 0 | 3 |
| Personalised healthy living programmes for employees | | | | | |
| All employees | 13 | 14 | 15 | 15 | 0 |
| Depends on grade/seniority | 1 | 0 | 2 | 0 | 0 |
| Personal accident insurance | | | | | |
| All employees | 8 | 9 | 13 | 5 | 6 |
| Depends on grade/seniority | 4 | 5 | 10 | 0 | 0 |

Source: CIPD¹²²

Table A.13: The top 10 drivers of healthcare and productivity costs of 4 large US employers
 Source: 'Health and Productivity as a Business Strategy', by Ronald Loeppke et al. *Journal of Occupational & Environmental Medicine*, July 2007.

| Rank | Healthcare Cost | Productivity Cost | Total Cost |
|------|--|--------------------|--------------------|
| 1 | Other cancer | Fatigue | Back/neck pain |
| 2 | Back/neck pain | Depression | Depression |
| 3 | Coronary heart disease | Back/neck pain | Fatigue |
| 4 | Other chronic pain | Sleeping problem | Other chronic pain |
| 5 | High cholesterol | Other chronic pain | Sleeping problem |
| 6 | Gastroesophageal reflux disease (GERD) | Arthritis | High cholesterol |
| 7 | Diabetes | Hypertension | Arthritis |
| 8 | Sleeping problem | Obesity | Hypertension |
| 9 | Hypertension | High cholesterol | Obesity |
| 10 | Arthritis | Anxiety | Anxiety |

Source: 'Health and Productivity as a Business Strategy', by Ronald Loeppke et al. *Journal of Occupational & Environmental Medicine*, July 2007.¹²³

Appendix B

A number of measures of the cost of employee absence and ill-health have been calculated. Thus the median cost per year of an employee's absence to firms has been estimated at standing at £673¹²⁴ by CIPD and £760¹²⁵ by the CBI. However, this cost varies depending on the nature of the employer with CIPD finding the cost per year per employee of absence in manufacturing and production standing at £444, in private sector services at £446, in public services at £800 and in non-profit organisations at £743.¹²⁶ This variance in the cost of absence was also found by the CBI which estimated the median cost per year per employee of absence in the private sector at £710, whilst in the public sector it stood at £1,040.¹²⁷ The cost also varies depending on the size of the firms' workforce with those firms with a larger workforce generally finding the cost of employee absence per employee per year being higher (see Table B.1). The CBI remarked that "the higher costs for larger organisations are due in part to the higher rates of absence amongst their employees, combined with higher average levels of remuneration and wider availability of occupational sick pay".¹²⁸

Table B.1: Median absence cost per employee in the UK per year by workforce size

| Workforce size | Median cost per absent employee (£) |
|----------------|-------------------------------------|
| 1 to 49 | 684 |
| 50 to 199 | 648 |
| 200 to 499 | 672 |
| 500 to 4999 | 850 |
| 5000+ | 828 |

Source: CBI¹²⁹

It should further be noted that different types of illness lead to different sized costs, thus it has been estimated that for a firm of 1,000 employees the annual cost of absence due to sickness attributed to mental illness is £269,730.¹³⁰ The costs of presenteeism are also likely to vary over illness type as some forms of illness, due to social stigma, are likely to encourage more presenteeism than others and this will be hard to cost. Still it has been estimated that the number of working days lost because of presenteeism due to mental ill-health to a firm with 1,000 employees in the UK is 4,860,¹³¹ whilst the cost of staff turnover due to mental illness has been estimated at £79,625 for a firm of 1,000 employees.¹³² Further surveys indicate that mental ill-health affects nearly a quarter of the adult population at any given time¹³³ with it estimated to cost employers £26 billion every year,¹³⁴ which included a £2.4 billion staff turnover cost and £15.1 billion lost due to unproductive staff (a cost 1.5 times higher than the cost of absence), whilst the cost falling on tax payers was estimated at £35 billion in the UK in 2006/07.¹³⁵ Additionally, the ONS found that although 30 per cent of employed people took some time off work for health reasons over the previous year, this figure rose to 43 per cent for those suffering from mental ill-health and 48 per cent for those suffering from depression or anxiety.¹³⁶

Other examples of the types of costs due to wellness problems includes the cost of alcohol misuse which has been estimated at between 11 million to 17 million lost working days to the UK economy in 2001, with a total absence cost to the economy of between £1.2 billion and £1.8 billion.¹³⁷ Whilst as another example the total cost of obesity in England in 2002 was calculated at £3.34 - 3.724 billion, with the cost of treating obesity standing at £45.8 - 49 million, the cost of treating the consequences of obesity standing at £945 - 1,075 million with the total indirect costs due to mortality and sickness standing at £2,350 - 2,600 million.¹³⁸ Illness costs to firms due to musculoskeletal disorders are also high, with it estimated that nearly twice as many working days are lost due to them than due to stress, whilst it is estimated that in 1995/96 the cost to society of these disorders stood at £5.7 billion.¹³⁹ Thus it can be seen that numerous forms of illness have direct cost on firms and society. With the total cost to the UK economy of sickness absence and worklessness having been estimated at £100 billion, with it also calculated that ill-health gave a cost to the tax payer due to benefits etc. but not necessarily to the economy of over £60 billion.¹⁴⁰ Still what can be observed from this overview is that there exists a wide number of reasons for sickness absence that all have costs to employers, employees and society, and thus a wide variety of responses will be necessary to deal with them.

Appendix C

Table C.1: A selection of case studies where action has been taken to improve health at work, which provide results quantified in terms of benefit cost ratios

| Company | Policy | Outcome | Source |
|-------------------------------|--|---|--|
| British Gas Services | Back care workshop introduced in 2005 to reduce absence due to back pain | <ul style="list-style-type: none"> • Improvement in employee satisfaction, attendance management, occupational health referrals and work related injuries and conditions. • Back pain absence reduced by 43 per cent in the 2005 cohort one year after participation. • 73 per cent of intervention group had no absence in the year after participation. • 58 per cent improved attendance. • Return of £31 for £1 invested | Business in the Community ¹⁴¹ |
| Johnson & Johnson | Incentives for employee participation A comprehensive wellness programme that focuses on: Mental health and well-being Occupational health and benefit design Healthy lifestyle Health education and awareness | <ul style="list-style-type: none"> • Smoking declined from 12 per cent of employees in 1999 to 3.9 per cent in 2009 • High blood pressure reduced from 14 per cent to 6.3 per cent • High cholesterol reduced by 19 per cent to 5.3 per cent • Physical inactivity reduced from 39 per cent to 20.4 per cent • Estimate return of \$2.71 for every dollar spent¹⁴² | Harvard Business Review ¹⁴³ |
| Manufacturing, 1000 employees | Ergonomic improvements Redesigned manual handling training programme in 2006 New manual handling training produced Total cost £12,000 | Reduced: <ul style="list-style-type: none"> • Sickness absence, days lost per MSD incident by 5 days, soft tissue injuries by 60 per cent, overtime and temporary recruitment fees by £50,000 pa. • Gave a ROI of 1:4.17 | PWC ¹⁴⁴ |
| Manufacturing, 1000 employees | Physiotherapy & exercise Prevention talks, stretching programme Induction for new employees Cost: Physiotherapist time on programme £340, and operatives away from work for the programme costing £87.15 (half an hour at £4.15 per staff member for 21 staff members). | Reduced: <ul style="list-style-type: none"> • Sickness absence due to musculoskeletal issues by 137.2 hours in a year, absences related costs by £1,139 in one year • Gave a ROI of 1:2.67 | Ibid. |
| Utilities, 30000 employees | In-house and discounted physiotherapy scheme. Up to 90% utilisation of in house physiotherapy scheme. Cost: Physiotherapy treatments £75, physiotherapy assessments £35-50. | Reduced: <ul style="list-style-type: none"> • Absence rates. Increased: <ul style="list-style-type: none"> • Staff retention, health awareness & education amongst employees. • ROI (6 months for call centre staff) 1:34. | Ibid. |

London's business case for employee health and well-being

| Company | Policy | Outcome | Source |
|----------------------------------|--|---|--------|
| NHS organisation, 7000 employees | Voluntary flu immunisation for staff. Cost: Vaccine £8,000; time spent receiving jab £15,500 | Reduced: <ul style="list-style-type: none"> • Average number of days of sick leave among immunised group by 25% (cut absence by 540 staff days or over 2 staff years). • Absence related savings of £217,000 in 2001/2 (approx. £400/day, direct and indirect costs). • ROI of 1:9.2. | Ibid. |
| Manufacturing, 4000 employees | Rehabilitation of muscular skeletal disorder sufferers through expert support, prompt treatment of injuries and absence management to assist return to work. Cost: £16,000 in 2001 (around 400 treatments) | Reduced: <ul style="list-style-type: none"> • Average working days lost due to muscular skeletal disorders by over 80%, civil compensation claims. More positive health and safety culture (only 16% of referrals to physiotherapists had to take time off work). • Estimated benefits of £192,000 p.a. • ROI of 1:12 achieved. | Ibid. |
| Manufacturing, 300 employees | Wellness programme included safety levels target setting, training, observers, feedback, and empowering staff to identify and implement improvements. Cost: £238,000 p.a. average running costs, including training costs, time, salary of co-ordinators and observers, IT software | <ul style="list-style-type: none"> • Reduced: occupational Safety & Health administration time; injury rate to 0 in 2002/3 from 3 per 200,000 hours worked in 1997/8. • Improved awareness and proactive approach in safety management. • Reduced steam leaks, energy consumption and Climate Change Levy taxes savings at £250,000 p.a., reduced insurance premiums by 32% in 2003 (programme contributed), reduced operating costs as workers identify and rectify plant problems themselves. • ROI > 1 estimated. | Ibid. |
| Retail, 100 employees | Focused on manual handling, including written safe work systems, training and monitoring. Cost: Consultancy on training & developing safe practices £5,000. Staff time for training £19,500 (direct and indirect costs). | <ul style="list-style-type: none"> • Reduced: hours lost through manual handling injuries reduced to zero in 2003 from 521 in 2002, injuries to zero in 2003 from 6 in 2002, compensation claims, time spent on accident investigation and staff support. • £15,500 savings in one year from fewer lost hours (£30/hour direct and indirect costs). • ROI >1 expected in 1-2 years. | Ibid. |

| Company | Policy | Outcome | Source |
|------------------------------|---|---|-------------------------------------|
| Unlever | 12 month study at sites in the UK on implementing health risk reduction programmes. | <ul style="list-style-type: none"> • Average reduction of half a risk factor per individual and 8.5 per cent increase in work performance. • Estimated ROI of 3.73 to 1. | World Economic Forum ¹⁴⁵ |
| British Polythene Industries | Invested in a "Musculoskeletal Injury Management System", that treated injuries within 24 to 48 hours, oversaw absence and provided a company wide view on injuries. Cost of service £16,000. | <ul style="list-style-type: none"> • Three quarters of employees returned to work whilst undergoing treatment. • Estimated annual saving of £192,000. • ROI of 12:1. | RNIB ¹⁴⁶ |

Table C.2: A Selection of case studies where action has been taken to improve health at work, which did not provide results quantified in terms of benefit cost ratios

| Company | Policy | Outcome | Source |
|---------------|---|---|---|
| TfL | <p>Analysis of employee survey to identify stress 'hotspots'</p> <p>Stress reduction groups for employees, with some time given within the working day to attend</p> <p>Guidance for managers about how to spot common mental health problems, listen actively to staff and offer flexible support</p> <p>Culture change a successful manager is now one who refers to occupational health early</p> <p>A six year transformation plan to identify areas where stress levels will rise and develop mental resilience accordingly (station upgrades, upgrading trains to more computerised systems, preparing for the 2012 Olympics)</p> | A reduction in the number of staff off sick for mental health reasons year on year since 2003. | London Health Commission ¹⁴⁷ |
| Pizza Express | <p>Online staff updates - the daily and weekly "slice"</p> <p>Regular meetings between the board of directors and restaurant staff, held in the restaurants themselves</p> <p>Annual staff road shows</p> <p>The HR director personally reads every complaint and compliment made in every restaurant. If a member of staff has been complimented she emails them to congratulate them.</p> <p>A culture of promoting internal staff, demonstrating how much they're valued and energising and motivating them to achieve.</p> <p>A flexible training and development programme allows people to progress up the organisation at their own pace. This helps to reduce the uncertainty/stress associated with taking on significantly more responsibility at work.</p> | A level of staff loyalty which is unusual for the industry: it's not uncommon to meet a member of staff who has worked for PizzaExpress for 20 years. | Ibid. |

London's business case for employee health and well-being

| | | | |
|---------------------|---|--|-------|
| Alara Wholefoods | <p>Hold monthly team meetings where employees views are carefully listened to and acted upon</p> <p>Conduct regular staff appraisals</p> <p>Encourage staff to undertake skills training (NVQs) which gives them a chance to raise their ideas, work towards goals, and achieve nationally-recognised qualifications.</p> <p>Offer staff the opportunity to work in the community gardens instead of on the production line half a day in week, in order to understand more about organic food - which is what Alara is all about.</p> <p>Provide free breakfast and lunch for all staff Operate a bike purchasing scheme</p> | A loyal, committed workforce and a 10-20% increase in financial turnover year on year for the last five years. | Ibid. |
| London Fire Brigade | London Fire Brigade carried out a comprehensive stress audit and carefully analysed the results and what lay behind them. | Levels of stress, anxiety and depression have halved within the workforce since 2005. Stress-related absence has fallen from first to sixth place as the main reason for sickness absence. | Ibid. |
| Royal Mail Group | <p>Royal Mail Group introduced "Feeling First Class" - an innovative and comprehensive programme to promote employee well-being which included the following projects:</p> <p>Nutritional advice</p> <p>Emotional well-being</p> <p>Physical well-being</p> <p>Workplace design</p> <p>Employee support</p> <p>Health partnerships</p> | <p>Across Royal Mail Group:</p> <p>Sickness absence reduced by 25% between January 2004 and May 2007, resulting in direct cost savings of £227 million.</p> <p>In Parcellforce's London Central depot:</p> <p>£1m reduction in operating costs</p> <p>50% fewer injuries, 50% fewer days lost</p> <p>Reduced sickness absence (15.4% down to 1%)</p> <p>£0.5m increase in revenue</p> <p>Huge increase in morale</p> <p>Became most profitable depot</p> | Ibid. |

| | | | |
|------------------------|--|--|--------------|
| <p>Happy Ltd</p> | <p>Developed a workplace culture based on the following key principles:</p> <p>People are trusted to make the key decisions about their work. Instead of levels of approval, people are given the training and support to decide for themselves.</p> <p>The culture is blame free and new ideas and experiments are encouraged. If there are no mistakes, there isn't much learning going on. Information is shared. People get feedback on how they are doing now, not how their manager thinks they are doing three months later.</p> <p>People are trusted to work out how to balance their personal needs with their responsibilities at work. Happy assumes any proposals its people make for their working hours make sense, rather than forcing them to prove it.</p> | <p>Happy has been rated the best business in the UK for Health and Well-being in 2009 (Great Place to Work Institute) and listed in the UK's Best 20 Workplaces for the last four years.</p> | <p>ibid.</p> |
| <p>BT</p> | <p>BT actively encourages its employees to work flexibly from day one, believing that a healthy work-life balance helps to provide them with renewed energy and a new enthusiasm for their work.</p> <p>In particular BT is well known for its work to support carers in the workplace though some simple inexpensive changes in working hours and flexible arrangements.</p> | <p>The ability to:</p> <ul style="list-style-type: none"> Attract talented people from often overlooked parts of society Retain essential skills Increase productivity Cut costs Release the real potential of the business | <p>ibid.</p> |
| <p>Tate & Lyle</p> | <p>Introduced vocational rehabilitation as an alternative to sickness absence. Working with the employee, the manager, the GP and the human resources team, care pathways mapped out by Occupational Health to ensure that employees are returned to health, work and efficiency at the earliest date. The rehabilitation programmes might include:</p> <ul style="list-style-type: none"> Reduced working hours Amended shifts patterns Reduced or alternative duties Transportation to work | <ul style="list-style-type: none"> 64% reduction in sickness absence (particularly long-term) since 2000 75% reduction in the number of employees retiring early because of ill-health between 2001 and 2007 Reduction in workplace injuries - (back injuries reduced by 50%) 50% reduction in use of physiotherapy since 2002 - more time is now spent on education Employee opinion surveys show increased satisfaction | <p>ibid.</p> |

London's business case for employee health and well-being

| | | | |
|-------------------|---|--|--|
| NHS Tower Hamlets | <p>Taken action to address the linked problems of low rates of working and poor health through its 'Health and Work Strategy'. This includes:</p> <p>Work it Out - a scheme which offers work placements to service users with a history of poor health conditions (mainly mental health). Placements are office based and last for 6-13 weeks (2-3 days per week). Travel, lunch and childcare costs are covered.</p> <p>Mental health model employer project - staff and managers were interviewed to find out their knowledge of, and attitudes to mental health and provided with training. Mental health awareness is now imbedded in induction and management training, and a mental health policy has been introduced.</p> | <p>19 people participated in Work it Ibid. Out, of whom seven have gone on to get jobs</p> <p>Average of 50% increase in mental health awareness amongst staff and managers</p> <p>Mindful Employer status granted</p> <p>Reduced sickness absence amongst staff</p> | |
| Claridge's Hotel | <p>Amongst other initiatives an employee assistance programme:</p> <p>Emphasising preventative health measures</p> <p>Healthy and vegetarian food prepared</p> <p>Corporate gym and jogging club</p> <p>Flexible Working</p> <p>Lighter working for pregnant and new mothers</p> | <p>Low staff turnover (28 per cent vs. an industry norm of 60 per cent)</p> <p>Low long term sickness rates</p> <p>High staff satisfaction</p> | Business in the Community ¹⁴⁸ |
| Centrica | <p>Interventions in / treatment of existing conditions in musculoskeletal disorders comprising:</p> <p>Telephone based advice from physiotherapist</p> <p>Written health guidance</p> <p>Face-to-face physiotherapy</p> | <p>Reduced absence from musculoskeletal disorders from 37 days in 2008 to 24 days in 2009</p> | Business in the Community ¹⁴⁹ |
| Capita | <p>Formal 'day one' absence monitoring and case management</p> | <p>Training programme to support line managers reduced absence by 30 per cent over 2 years and saved £400 per employee</p> | ibid. |
| RBS | <p>Counselling service promoted.</p> <p>Quarterly statistics from counselling service analysed to identify issues and to shape health and well-being strategy and interventions.</p> | <p>In 2010 68 per cent of employees indicated that senior management are interested in their well-being.</p> | ibid. |
| Well@Work | <p>National programme, which implemented healthy lifestyle programmes with a focus on psychical activity, nutrition and quitting smoking.</p> | <p>Overall, employers participating in the programme viewed it as being worthwhile, whilst employees reported increased job satisfaction, commitment, involvement and performance.</p> | Business in the Community ¹⁵⁰ |

| | | | |
|--------------------------------|---|---|--|
| Ginsters Limited | Implemented integrated health and well-being programme encompassing physical activity as well as healthy eating, weight management, smoking cessation, chiropody, podiatry and reflexology treatments. | Improved employee health and morale, reduced short-term sickness and staff turnover. | Ibid. |
| AstraZeneca | A number of initiatives including: Health promotion Activities, Home-work balance initiatives, Ergonomic-designed working environments, Fitness opportunities, Healthy eating options in restaurants, Health assessments, Counselling and life management programme, Healthcare insurance, Rehabilitation programmes, Integrated occupational health/human resource interventions | Cost savings: £500-700k saved due to improved productivity after counselling, £80,000 saved on health insurance for psychological issues Improved health and safety: global accidents and occupational illness rates reduced 61 per cent, high employee favourability towards the programme Improved image: 84 per cent of employees proud of the company and 82 per cent would recommend the company as a good place to work, 80 per cent of employees say they have the flexibility to balance work and personal life | Business in the Community ¹⁵¹ |
| The British Library | As well as promoting health and safety at work also provided: Round-the-clock employee assistance Access to the Benenden Health Society BUPA discount Classes, massages, osteopathy and gyms Health events and flu vaccinations Nutritional advice and healthy catering Health and care benefits | Absence dropped from 10.2 to 7.5 days per annum Cost of absence dropped by £160K per annum (11 per cent) Staff turnover dropped to 6 per cent from 12 per cent Performance management results increased to 98 per cent from 86 per cent | Ibid. |
| Danone UK | Training on diet and Nutrition Free life management service Active Health Box for all new starters | Staff turnover reduced from 20 to 15 per cent 91 per cent of employees would recommend it as a good place to work Recognised as London's healthiest workplace by the BBC | Ibid. |
| Digital Outlook Communications | Flexible working Promotion of employee benefits system Mentoring and development scheme Improved ergonomic working environment Health and well-being as a KPI for all senior managers | Health and well-being survey score increased by 11 per cent Sickness absence improved 95 per cent from 4 days per person in 2006 to 0.22 days per person in 2008 Staff turnover reduced from 34 per cent in 2007 to 9 per cent in 2008 | Ibid. |
| EDF Energy | EDF Employee Support Programme was developed in consultation with a number of stakeholders. A cognitive behavioural therapy programme was developed and 100 managers were trained in recognising psychological ill-health. | Improved productivity saved £228,000 per year Staff morale increased from 36 to 68 per cent Retirements due to psychological ill-health reduced Awarded Beacon of Excellence status by the Health and Safety Executive | Ibid. |

London's business case for employee health and well-being

| | | | |
|------------------|---|---|-------|
| Ernst & Young | <p>Private health insurance Annual health screening Dedicated occupational professionals Workplace assessments Employee assistance programme Organisation wide campaigns Supported conversations about health and well-being issues with managers</p> | <p>Reduced staff turnover from 16 to 14 per cent Days lost to absence decreased by 3 per cent despite a 4 per cent increase in headcount 94 per cent of clients satisfied/very satisfied with the firm's service Recruitment and retention improved Improved health and well-being of employees surveyed Accident rates, personal injury and prolonged disability insurance claims all decreased</p> | Ibid. |
| First ScotRail | <p>Physiotherapy, at-work massage, chiropody and ergonomic improvements Employee Assistance Provider to reduce time off after traumatic events Well-being weeks Employee lifestyle diaries Hospital cash plan</p> | <p>Absence reduced from 6.2 to 4.2 per cent saving around £3 million per year 40 per cent of cases referred to physiotherapy return to work after 5 sessions</p> | Ibid. |
| Foyle Food Group | <p>Health and well-being programme, with initiatives including: Pre-employment health screening Translated health awareness leaflets for migrant employees</p> | <p>Absenteeism reduced by 15 per cent Short-term absence maintained below 3 per cent Health and Safety procedure adult score in factories improved by over 20 per cent Accidents reduced by 43 per cent Number of employees taking more than 7 days off reduced by 84 per cent Employee liability insurance premiums reduced 28.5 per cent Employee satisfaction increased from 80 to 84 per cent 97 per cent awareness of health and safety policies</p> | Ibid. |
| GlaxoSmith-Kline | <p>Company-wide personal and team resilience programme, with healthcare benefits focused on prevention and access to innovative and proven treatments.</p> | <p>Work-related ill-health levels dropped 60 per cent Lost working days fell 29 per cent Staff satisfaction increased 21 per cent with productivity increased by 7 – 13 per cent 53 per cent reported improvement in physical, emotional, mental and spiritual performance Employee strain at work reduced 3 per cent Days lost fell by 44 per cent and musculoskeletal cases fell by 33 per cent</p> | Ibid. |

| | | | |
|---|---|---|--------------------|
| Grimsby Institute of Further & Higher Education | Alignment of HR, staffing and health, safety and well-being policies Regular management training Extensive employee communication Proactive health and well-being team Speedy and supportive interventions | Increased staff engagement Improved Ofsted inspection marks Sickness absence reduced from 10000 lost days in 2001 (for 100 staff) to 3806 (for 1460 staff) in 2008 Days lost due to musculoskeletal disorders reduced by 48 per cent and for stress related absence by 57 per cent between 2004/5 and 2007/8 | ibid. |
| Metropolitan Police Service | Training to: Equip managers with emotional intelligence Provide practical tools and techniques for dealing with stress Raise awareness of stress and de-stigmatise it HR initiatives Regular mental health surveillance One-to-one psychological welfare and support In-house welfare counselling and cognitive behavioural psychology | Stress related absence down from 10.2 days per officer to less than one day per officer annually 90 per cent of those evaluated said they would change their response to stress following training | ibid. |
| Nationwide Building Society | Flexible working Workstation management 24 hour counselling service Free health screening Absence management support Lifestyle facilities including gyms etc. Healthy food services | Voluntary turnover reduced from 9.71 to 8.46 per cent Time lost due to absence dropped from 3.51 to 3.22 per cent Cost savings on reduced absence and improved retention rates | ibid. |
| Oaklands Care Home | General health and safety Promoting and raising awareness of the Welsh Backs Initiative Action on nutrition Physical activity promotion Alcohol awareness Smoking cessation | Staff turnover was low Absence reduced Team work improved | ibid. |
| Standard Life Healthcare | Healthier menu in staff restaurant Subsidised on-site massages Subsidised fitness classes Focus on nutrition Medical insurance Access to online health and well-being information | Sickness absence reduced by 26 per cent at headquarters Self reported improvement in job satisfaction Reduction in proportion of employees that smoke Health status of employees 7.1 per cent higher than similar business sectors | ibid. |
| Towry Law | Onsite gym Subsidised healthy restaurant Smoking cessation programmes Health screening | Reduced medical bills Reduced absenteeism Staff turnover down 25 per cent since 2007 High levels of engagement Accredited one of the "Best Companies to Work for 2008" by the Sunday Times | ibid. |
| E.ON UK | Proactive steps such as campaigns on cancer Providing appropriate support as quickly as possible Providing rehabilitation services | Reduction in absence rates equating to £8.9million per year | CBI ¹⁵² |

London's business case for employee health and well-being

| | | | |
|--|--|---|--|
| MD Anderson Cancer Center | Workers compensation and care unit staffed by a physician and nurse case manager | Within six years lost work days declined by 80 per cent and modified duty days by 64 per cent Cost savings calculated at \$1.5million Workers' comp insurance premiums declined by 50 per cent | Harvard Business Review ¹⁵³ |
| Retail, 60,000+ employees | Wellness pack, pedometer, healthy eating and smoking cessation. Information pack cost £100,000, joiner pack cost £250,000 | Decreased absenteeism, staff turnover, management time to health and safety, staff replacement costs Increased PR relations and reputation, increased profits | PWC ¹⁵⁴ |
| Public Sector Service Organisation, 100,000+ employees | Strategy boards for physical exercise, help line, musculoskeletal clinics, counselling and advisory service | Reduced sickness absence by 1.8 per cent between 2004-07, and reduced accidents by 30 per cent between 2004-07 | Ibid. |
| Manufacturing, 20,000 employees | Sickness absence management Early rehabilitation Policy development cost £7,800, management training cost £200,000 | Reduced absenteeism rates by 0.7 per cent between 1999-2002 and absence due to stress by 4 per cent between 1999-2002 Cost savings due to reduced absence between 1999-2002 £11,000,000 | Ibid. |
| Manufacturing, 150 employees | Holistic interventions for prevention Well-being policies Management training Smoking cessation Healthy eating Counselling | Absenteeism reduced by 1.53 per cent between 2006-2007 | Ibid. |
| Business services, 500 employees | Healthy eating Smoking cessation Counselling Healthcare cash plan & gym membership Well-being clinic services At annual cost of £35,000 in 2006-07 | Absenteeism reduced Staff turnover kept less than 5 per cent per annum since 1993 | Ibid. |
| Property management, 300 employees | Subsidised gym membership Health cash plans Personal health management plans & sickness management policy. Executive board introduced all wellness programmes | Absenteeism reduced with 18.3 per cent less days forecasted to be lost due to sickness for April 2007 compared with April 2006 | Ibid. |
| Manufacturing, 200 employees | Occupational health services and activities Counselling and annual health screenings External training costs of £7150 | Reduced: sickness absence by 97 per cent, disciplinary/grievance proceedings to 0, output reject rate, lost days from accidents, injury claims to zero, energy usage by 9.2 per cent, insurance premiums, overtime by 37 per cent, work week by 8 hours and stock by £1.3million Increased: Machine utilisation and productivity | Ibid. |

| | | | |
|--|---|--|-------|
| Employment support, 400 employees | Mental health awareness training Support line Well-being facilitators Total cost £2.5million | Reduced absenteeism and increased return to work rate with 90 per cent back within an average of 4 weeks | ibid. |
| Manufacturing, 2000 employees | Clinics at work and wellness weeks implemented Total cost £1million | Reduced: general absence / total no of days lost by 40 per cent between 2003-2006, long-term absence due to sickness by 40 per cent between 2003-2006 Improved health Outcomes smoking cessation increased with a 33 per cent success rate in 2006 | ibid. |
| Financial services, 800 employees | Attendance and well-being team Healthy eating Counselling Screening clinics | Reduced absenteeism rates by 1/3 | ibid. |
| Financial services, 400 employees | Smoking intervention classes and healthy living Physical activity week Wellness coordinator Cycle to work schemes. Total cost: £100,000 and 18 hours per week HR resources | Reduced: absenteeism by 0.2 per cent, staff turnover by 4 per cent Increased: Smoking cessation, health and welfare outcomes | ibid. |
| Utilities, 400 employees | On-site crèche, subsidised social club, private healthcare schemes, free on-site health checks, holiday buy-back scheme | Reduced: Absenteeism, staff turnover, recruitment fees, overtime and temp fees Company profile in local community as favoured employer improved | ibid. |
| Financial services, 150 employees | Free health assessments to all staff. Smoke cessation & physical health in workplace. Massage, onsite yoga & body conditioning. Counselling & advice onsite. | Reduced: absenteeism (155 days to 62 days) and staff turnover by 10.2%. Awarded accreditation in area of staff well-being. | ibid. |
| Education, 400 employees | Gyms and relaxation classes subsidised. Absenteeism policies implemented. Employee Assistance Programmes. | Reduced: absenteeism by 26% (3,430 to 2,544 days) between 2004-2006, staff turnover by 11%, and recruitment fees. Increased: employee satisfaction. | ibid. |
| Education, 6000 employees | Stress Management, Counselling & Advice. New sport centre. Transport plan implemented. Cost: Human Resources p.a. £371,083. Development & team costs p.a. £550,000. Sport centre £5,000,000. Employee health & wellness over 2 yrs £740,000. Hands on support to date £1,200,000. | Reduced: total sickness absence by 1744 work days, long term sick leave by 8% from 2002/3 - 2006, and absenteeism related costs by £165,680 (estimated at £95/day). Increased: staff productivity, employee satisfaction levels, and research grant income. | ibid. |
| Construction/ engineering, 800 employees | Health and Safety training. Cost: Induction & H&S costs p.a. £15,000. Assurance and supply chain management p.a. £120,000. | Reduced: accident rates by 69% 2001-2002 per 200,000 hours worked, management time spent investigating accidents. Improved competency in H&S. | ibid. |

London's business case for employee health and well-being

| | | | |
|--|--|---|-------|
| Manufacturing, 2000 employees | Behavioural safety programme – observation of employees' safe/unsafe behaviour at work. Cost: Training p.a. £145,000. | Reduced: work days lost by 45% (550 to 301 days lost) 1999-2003, accidents by 40% (45 to 27 accidents), lost time incident rate from 44 to 11.8 per 1,000,000 hours worked. Increased: productivity. Estimated savings 1999-2003 of £285,000 pa. | Ibid. |
| Public sector transport organisation, 400 employees | Sickness absence management. Support return to work interviews. Cost: Occupational health service £16,000 p.a. | Reduced: absenteeism by 7.66-8.66 per cent 1999-2003, staff absence by 70% 1999-2003, staff on long term absence (15-16 to 2-3 at any one time). | Ibid. |
| Business services (Legal & Professional), 1500 employees | Healthy living. Accident reporting processes. Policy monitoring staff sickness. Free gym and medical checks. Flu points set up during winter. | Reduced: staff turnover. Increased: profits four fold. | Ibid. |
| Utilities, 2500 employees | Stress interventions – stress ball fights, workplace competitions, employee assistance programme. Smoking cessation classes & fitness classes. | Reduced: absenteeism by 12%, staff turnover by 25%. Improved external reputation and PR. | Ibid. |
| Utilities, 20000 employees | 5 year H&S and environmental plan, stress management programmes. Lifestyle programmes. | - | Ibid. |
| Financial services, 1000 employees | Healthy lifestyle, fitness classes, relaxation classes. Cost: Occupational health adviser, project development £75,000 | Reduced: absenteeism by 0.47 per cent 2005-06 staff turnover by 10%. Increased: employee satisfaction (31.5% of staff recommended it good place to work). Absenteeism related cost savings £23,000, staff turnover related savings of £464,885.00 | Ibid. |
| Financial services, 17000 employees | Flexible working policy. Discounted gyms. Free phone counselling services, absence support management. Cost: Total 2005-2006 revenue Expenditure £8,000,000. | Increased: employee satisfaction (right work life balance achieved according to 78% employees responding to 2005/6 survey). | Ibid. |
| Local authority, 9000 employees | Diet & nutrition advice, Healthy breakfast campaign. Protection in the sun campaign. Exercise classes. Cost: Work site lifestyle clinics £13,000 in 12 months (£1.5 mil from non-cash savings) | Reduced: sickness absence equal to additional 141 full time employees 2001-2007. Increased: employee satisfaction from 26% surveyed in 2002 to 44% in 2006 (68% surveyed agreed good work life balance in 2006, up from 57% in 2002). Sickness absence related savings of £1.5m over three years. | Ibid. |
| Financial services, 50,000 employees | 24 hour Counselling face-to-face / over phone. Maternity coaching. Running & cycling challenges. Subsidised gyms & information on intranet. | Reduced: sickness absence days, new employees' absence rates cut by 1/3. 66% of employees believed counselling helped return to work rates. | Ibid. |

| | | | |
|---|---|---|-------|
| Criminal justice organisation, 400 employees | Counselling, physiotherapy, healthy living. Education on smoking cessation, alcohol & stress. Yoga classes & therapy sessions. Cost: £1,600,000 over 9 sites. | Reduced: sickness absence rates over duration of project. | Ibid. |
| Manufacturing, 1500 employees | Health & lifestyle screening. One-to-one sessions. Nutritional advice. Web based fitness programmes. 50% of employees used leisure centre, 90% registered with gyms on other sites. | Improved health outcomes within workforce. | Ibid. |
| Criminal justice organisation, 50,000 employees | IT infrastructure implemented to identify sick staff. Outsourced health service provided advice. New policy developments | Reduced: absence days by 25% 2002-2006. Increased: productivity Estimated cost savings from reduced absence days of £38m 2002-2006. | Ibid. |
| Government department, 90000 employees | Health & well-being site including advice & help on RTW and at work. | Reduced: absence days by 8% (8.5 days to 7.8 days) 2005 mid 2007. | Ibid. |
| Financial services, 60000 employees | Healthy living advice. On site flu jabs. Telephone and face-to-face assessment process. Cost: Start up costs £75,000 and on-going costs £1,250,000 p.a. | Reduced: sickness absence, injury claims, musculoskeletal absence by 3% in 1 year. Programme turnover increased leading to rapid case resolution. | Ibid. |
| Financial services, 60000 employees | | Reduced: absenteeism by 3.7 pct points, staff turnover by 9.2 per cent. Increased: employee satisfaction (96% staff happy with new services). Absence related cost savings of £561,000 when compared to industry staff recruitment cost savings of £1.6m when compared to industry. | Ibid. |
| Financial services, 3000 employees | Stress management, counselling, healthy living | Reduced: stress absence rate down by 80%, staff turnover by 20%. Increased: productivity estimated by 1% at no cost, employee satisfaction (72% Agree organisation has positive environment), health outcome (5% less smokers). Absence related cost savings of £250,000 in lost wages alone. | Ibid. |
| Manufacturing, 7000 employees. | Healthy lifestyle, smoking cessation. Weight management & back / stress management. | Health outcomes (18% staff improved diet, 14% staff improved lifestyle, 45% staff started exercise, 34% staff increased frequent activity, 82% more aware of health). | Ibid. |
| Business services, 100 employees | Workplace staff initiatives, gym discounts, healthy eating. Cost: Fruit £548 p.a., water £2,318 p.a., insurance £9.995 p.a., massage £3,320 p.a. | Reduced: absence rates. Increased: employee satisfaction (87% reported work environment as good). 1.73 sick days per employee per year | Ibid. |

London's business case for employee health and well-being

| | | | |
|--|---|---|-------|
| Utilities | All employees entitled to 45 minute health assessments with follow ups in company time. Lifestyle advice, health promotion. Discounted gyms and bike purchasing / memberships. | Increased: employee satisfaction (Staff survey reveals 45% improved opinion of workplace). Positive health outcomes (47% motivated to change lifestyle 87% more aware of their health). | Ibid. |
| Manufacturing, 20000 employees | Ergonomic improvements, absence management (recording system). Mental health team. Cost: Waste plant programme £26,000. Safety shoes programme £40 per person. | Reduced: absenteeism by 4.75 per cent (sick days down to 174 days p.a.). Improved personal resilience evaluation (reduced fatigue 15%, increased mental clarity 7%, increased self esteem 14%, increased ergonomic awareness 15%). Absence related cost saving of £196,320 (based on hourly staff rates). | Ibid. |
| Utilities, 15000 employees | Manual handling skills training by body mechanics experts. Cost: £53,000 in first year for specialist equipment, ergonomics support etc. mostly one-off. £2,000 p.a. estimated thereafter for occupational physiotherapy. | Reduced: annual rolling total of accidents by nearly 50% (79 to 41), proportion of total accidents caused by manual handling (70% to 25%) Savings of £19,000 p.a. anticipated in from halving days lost to manual handling injuries reduction in civil liabilities claims (currently £166,000 p.a.) Break even expected in first 2 years. | Ibid. |
| Manufacturing, 10000 employees | Home-work balance, physiotherapy, counselling, return to work and health promotion programmes including screening. Cost: both standalone and ongoing projects – difficult to quantify. | Reduced: absence levels (31% lower than CBI benchmark), ergonomic related cases per million hours) by 53% (Jan-Jun 2003), number of work-related stress cases (scores for depression 20% 30%). Increased: concentration and productivity reported by employees, company profile. Absenteeism related savings £5m (compared with CBI data), reduced health insurance premiums by £200,000 p.a. | Ibid. |
| Construction / engineering, 3000 employees | Health and Safety training for certification scheme for managers and supervisors. Cost: £2,000,000 approx. since 1997. | Reduced: Intermediate: time lost and time spent in accident investigation, staff turnover by 29 per cent, accident rate by 60%. Increased: competitiveness, staff morale. Supply chain management improved. Reduced staff turnover, recruitment, training and other associated costs estimated at £500,000 p.a. | Ibid. |

| | | | |
|---|--|---|-------|
| Manufacturing, 50 employees | Programme addressing manual handling injuries, including more suitable equipment, training in prevention and exercise, early treatment and annual checkups. Cost: Equipment £270,000. External osteopath £8,500 over 2 years. | Reduced: days lost through injury by 25%, injuries (from 10 to 3 per year), time managing short handed production teams, potential civil claims Increased: staff retention. Improved company profile. Production capacity saved by 1.5% previously lost through injury (increase in production £20,000 p.a.) | ibid. |
| Public sector administrative services and associated trade union, 70000 employees | Work-life balance project, including surveys and focus groups to identify staff needs, piloted new ways of working at work, trained staff in organising work flexibly and securely. | Reduced: unit costs due to greater efficiency. Increased: employee satisfaction company profile (improved relationships with union, workforce and prospective employees). | ibid. |
| Manufacturing, 450 employees | Programme addressed health and safety performance, including greater reporting and communication, and monitoring remedial actions. | Reduced: absenteeism by 7.5 per cent, injuries by 50 per cent compared to hours worked, insurance claims to zero in 2002 from over 50 in 1997, unit costs by 40 per cent. Increased: company profile in local community. | ibid. |
| Manufacturing, 2000 employees | Programme aimed at improving health and safety performance, including improving management systems and procedures and providing training. Cost: Consultancy to improve management systems £100,000. Manager training £75,000. | Reduced: days lost to injuries by 73%, reportable injuries by 61%, overall accident rate by 64%. £100,000 p.a. annualised savings from reduced days lost since 1997, reduced employee insurance claims by 73%, reduced rate of increase in Employers Liability Insurance premiums. | ibid. |
| Construction / engineering, 7000+ employees | Management of health and safety, including bonuses linked to safety targets, providing training and information, improving management systems and benchmarks. | Increased: company profile and reputation (seen as employer of choice). Claims, injuries and delays costs minimised | ibid. |
| Business services, 70 employees | General programme encompassing manual handling improvements, health management and smoking cessation. | Reduced absenteeism. Increased staff retention and morale, productivity, improved health and safety. Reduced overtime costs. | ibid. |
| Utilities, 12000 employees | Programme includes investigations and increased accountability and communications. Cost: Direct costs of safety training and management £600,000 | Reduced: lost time injuries by 80%. Increased staff morale. Improved reputation with key stakeholders, improved health and safety culture, incident investigations and reporting. £4.5m savings over four years from less lost time to injuries non-time lost injuries and civil claims cost savings. | ibid. |

London's business case for employee health and well-being

| | | | |
|--|---|--|---|
| Manufacturing, 5000 employees | Health and safety management programme. | Reduced: lost days through accident injury by 36% from 1999/2000 to 2002/2003, reportable incident rate by 18.1 pct points 1999/2000 - 2003/2004, civil claims per staff member by 45%+. £100,000+ savings from reduced days lost reduced employers' liability insurance premium. | Ibid. |
| Construction / engineering, 1000+ employees | Onsite medical room and nurse to provide first aid, medical advice and lifestyle checks. Cost: No additional cost – part of normal site overhead. | Reduced: lost time offsite seeking medical attention/advice, accidents and accident frequency rates. Increased: staff morale. Positive health outcomes. £145,000 over ten months saved from recovered lost time. | Ibid. |
| Johns Hopkins Workers' Compensation Program | Safety professionals, adjusters and medical and nursing providers work to prevent accidents, quickly assess and treat injured or ill workers, and return to work through jobs with restricted or modified duties. | Over 10 years lost-time claims decreased 73 per cent, medical only claims down 61 per cent, total days of temporary total disability benefits paid per 100 employees shrunk from 163 in 1992 to 37 in 2002, 54 per cent reduction in total workers compensation expenses per \$100 payroll | New York State Department of Labor ¹⁵⁵ |
| Principle Financial Group | Employed four staff members that met with injured workers soon after the onset of the disability to assess the worker's skills, abilities and restrictions. | Saved over \$1million in five years | Ibid. |
| Roto-Rooter Services Co. | Return to work programme. | Reduced workers compensation costs from between \$1.4 to 1.85 million to \$365,000 in 1993. | Ibid. |
| Gibson Greetings | Return to work programme. | Reduced workers compensation costs from \$400,000 in 1991 to under \$50,000 in 1992. | Ibid. |
| Port of London Authority | Improved occupational health services and trained line managers on the cause of absence and return to work plans | 70 per cent drop in staff sickness absence, equivalent to having an extra 30 staff working at any one time. | RNIB ¹⁵⁶ |
| Rolls Royce | Implemented sickness absence management system and early intervention of rehabilitation. Anyone off work for more than four weeks received a return-to-work action plan. Investment in IT monitoring system and staff and line manager training. In house physiotherapy provided. | A reduction in work days lost by 28,500, saving £11 million. | Ibid. |
| West Suffolk Hospital NHS Trust | Priority treatment referrals to a local physiotherapist for injured staff. Cost of £21,000 | Lost days due to sickness absence reduced by 40 per cent. Savings on direct costs of musculoskeletal injuries to the trust of £170,000. | Ibid |



Appendix D

Bevan found a number of problems with studies attempting to innumerate the returns of wellness programmes.¹⁵⁷ These include:

- 1) Questionable research design, such as a failure to include control groups, not specifying precise success criteria and undertaking the study for too short of a timeframe.
- 2) Relying on 'take-up' as a measure of success, with this often being used as the only measure of success for the study even though participation does not necessarily equate with changed employee behaviour.
- 3) Workplace-only causes and cures, in that the reports are often restricted to behaviour in the workplace whilst benefits could accrue from a change in out of workplace behaviour eg, quitting smoking at home as well as whilst at work.
- 4) Relying heavily on self reported measures of productivity and performance.
- 5) Restricting their focus to only a few explanatory factors ie, did a reduction in absence occur due to the wellness program or due to some other change in company policy.
- 6) Problems with dead weight effects ie, would the results have happened anyway?
- 7) Problems around long-run sustainability of the programmes.
- 8) Most are focused on large organisations.

Appendix E

The Black review recommendations were:¹⁵⁸

- 1) Government, healthcare professionals, employers, trades unions and all with an interest in the health of the working age population should adopt a new approach to health and work in Britain based on the foundations laid out in this Review.
- 2) Government should work with employers and representative bodies to develop a robust model for measuring and reporting on the benefits of employer investment in health and well-being. Employers should use this to report on health and well-being in the board room and company accounts. Safety and Health practitioners and, where present, trades union safety representatives, should play an expanded role in acting to promote the benefits of such investment.
- 3) Government should initiate a business-led health and well-being consultancy service, offering tailored advice and support and access to occupational health support at a market rate. This should be geared towards smaller organisations. It should aim to be self-sustaining in the medium-term, and be fully evaluated and tested against free-to-use services.
- 4) Government should launch a major drive to promote understanding of the positive relationship between health and work among employers, healthcare professionals and the general public. This should include encouraging young people to understand the benefits of a life in work and its impact on their families and communities.
- 5) Building on the commitment from the leaders of the healthcare profession in the recent consensus statement, GPs and other healthcare professionals should be supported to adapt the advice they provide, where appropriate doing all they can to help people enter, stay in or return to work.
- 6) The paper-based sick note should be replaced with an electronic fit note, switching the focus to what people can do and improving communication between employers, employees and GPs.
- 7) Government should pilot a new Fit for Work service based on case-managed, multidisciplinary support for patients in the early stages of sickness absence, with the aim of making access to work-related health support available to all – no longer the preserve of the few.
- 8) When appropriate models for the Fit for Work service are established, access to the service should be open to those on incapacity benefits and other out-of-work benefits. Government should fully integrate health support with employment and skills programmes, including mental health support where appropriate. Government should expand provision of Pathways to Work to cover all on incapacity benefits as soon as resources allow, and explore how to tailor better provision for those with mental health conditions.
- 9) An integrated approach to working-age health should be underpinned by: the inclusion of occupational health and vocational rehabilitation within mainstream healthcare; clear professional leadership; clear standards of practice and formal accreditation for all providers; a revitalised workforce; a sound academic base; systematic gathering and analysis of data; and a universal awareness and understanding of the latest evidence and most effective interventions.
- 10) The existing cross-Government structure should be strengthened to incorporate the relevant functions of those departments whose policies influence the health of Britain's working age population.

Appendix F

The Black and Frost review recommended:¹⁵⁹

- 1) Government should fund a new Independent Assessment Service (IAS). The IAS would provide an in-depth assessment of an individual's physical and/or mental function. It would also provide advice about how an individual on sickness absence could be supported to return to work. This service should usually be accessed when an individual's absence spell has lasted around four weeks.
- 2) Government should revise fit note guidance to ensure that judgements about fitness to work move away from only job-specific assessments.
- 3) Government should do more to improve knowledge and awareness among healthcare professionals, particularly those involved in certification, of the Work Capability Assessment (WCA) and the benefits system generally and the importance of work for health.
- 4) Expenditure by employers targeted at keeping sick employees in work (or speeding their return to work) such as medical treatments or vocational rehabilitation should attract tax relief. This should be targeted at basic-rate taxpayers.
- 5) Existing tax relief on employee assistance programmes (EAPs), which provide information, advice and counselling on a variety of issues causing absence and/or performance problems should be retained.
- 6) Government should abolish Percentage Threshold Scheme (PTS) which compensates mainly smaller employers for very high rates of sickness absence in their organisations, but reduces incentives to manage absence.
- 7) Record-keeping obligations under Statutory Sick Pay (SSP) should be abolished, thereby helping to reduce employer administrative burdens.
- 8) Government should update its Employers Charter to address misconceptions around sickness absence management, especially legal uncertainty.
- 9) Government should carry out further research into the reasons behind the significant number of people claiming ill health benefits who come straight from work, especially from smaller employers, but appear not to have been paid sick pay by their employer beforehand.
- 10) Public sector employers should take immediate action to bring the worst performing parts of the public sector up to the standards of the best. Government should also review occupational sick pay (OSP) in the public sector.
- 11) The introduction of a new job-brokering service to help long-term sick employees find new work (where appropriate) before they fall onto the benefits system. This service should be offered free by the State in cases of very long-term absence (at 20 weeks or sooner if the Government is convinced of the business case to do so), but should be available earlier for individuals and employers that are willing to pay for it. Government should consider delivering the service as an extension of the Work Programme.
- 12) The Government should end the Employment and Support Allowance (ESA) assessment phase altogether. People should go onto ESA only if they qualify after a WCA, or as at present, if they qualify to pass directly onto ESA without a face-to-face WCA.
- 13) The recommendation above should be supported by changes to Jobcentre Plus' claims policies and processes to prevent large numbers of people being inappropriately directed towards ESA.

Bibliography

- Alcohol Concern, 'Making alcohol a health priority: Opportunities to reduce alcohol harms and rising costs', January 2011
- Baicker, K., Cutler, D., & Song, Z., 'Workplace Wellness Programs Can Generate Savings', Health Affairs, 29:2, February 2010
- Berry, L. L., Mirabito, A. M., & Baun, W. B., 'What's the Hard Return on Employee Wellness Programs? The ROI data will surprise you, and the softer evidence may inspire you', Harvard Business Review, December 2010
- Bevan, S., 'The Business Case for Employee Health and Wellbeing', The Work Foundation, February 2010
- Bevan, S., Passmore, E., & Mahdon, M., 'Fit for Work? Musculoskeletal Disorders and Labour Market Participation', The Work Foundation, September 2007
- Black, C., & Frost, D., 'Health at work – an independent review of sickness absence', Department for Work and Pensions, November 2011
- Business Action on Health, 'Physical Activity Toolkit: Healthy People = Healthy Profits', May 2009
- Business in the Community, 'BITC Public Reporting Guidelines: Employee Wellness and Engagement', May 2011
- Business in the Community, 'Healthy People = Healthy Profits', February 2009
- Business in the Community, 'Physical Activity Toolkit: Healthy People = Healthy Profits', May 2009
- Business in the Community, 'Skills, Health and Wellbeing Toolkit: Healthy People – Healthy Profits', May 2009
- Butland, B., Jebb, S., Kopelman, P., McPherson, K., Thomas, S., Mardell, J., & Parry, V., 'Foresight – Tackling Obesities: Future Choices – Project report: 2nd Edition', Government Office for Science, October 2007.
- Cawley, J., & Berzins, K., 'SROI – Work It Out'. London South Bank University
- Clayton, S., Bambra, C., Gosling, R., Povall, S., Misso, K., & Whitehead, M., 'Assembling the evidence jigsaw: Insights from a systemic review of UK studies of individual-focused return to work initiatives for disabled and long-term ill people', BMC Public Health, 11:170, 2011
- CBI, 'Healthy returns? Absence and workplace health survey 2011', May 2011
- Centre for Mental Health, 'The economic and social costs of mental health problems in 2009/10', 2010
- CIPD, 'Absence Management: Annual survey report 2010', October 2010
- CIPD, 'Absence Management: Annual survey report 2011', October 2011
- CIPD, 'Recovery, rehabilitation and retention: Maintaining a productive workforce', 2004

Collingwood, S., 'Attitudes to health and work amongst the working-age population', Research Report No 763, Department for Work and Pensions, 2011

Dame Carol Black's Review of the health of Britain's working age population, 'Working for a healthier tomorrow', March 2008

Greater London Authority, 'The London Health Inequalities Strategy', April 2010

Greater London Authority, 'The London Health Inequalities Strategy: First Steps to Delivery to 2012', April 2010

Greater London Authority, 'Review of evidence for the Mayor's Health Inequalities Strategy', August 2009

The Government's Response to Dame Carol Black's Review of the health of Britain's working-age population, 'Improving health and work changing lives', November 2008

Hassan, E., Austin, C., Celia, C., Disley, E., Hunt, P., Marjanovic, S., Shehabi, A., Villalba-Van-Dijk, L., & Van Stolk, C., 'Health and Wellbeing at Work in the United Kingdom', The work foundation, Rand Europe, Aston Business School, Prepared for the Department of Health, August 2009

Health and Safety Executive, 'Interim update of the "Costs to Britain of Workplace Accidents and Work-Related Ill Health"', note by HSE's Economic Advisers Unit, June 2004

Health, Work and Well-being Strategy Unit, 'Health, work and well being baseline indicators report', December 2010

Hill, D., Lucy, D., Tyers, C., & James, L., "What works at work? Review of evidence assessing the effectiveness of workplace interventions to prevent and manage common health problems", Institute for Employment studies for Health Work and Wellbeing Executive, 2007

Hillage, J., Rick, J., Pilgrim, H., Jagger, N., Carroll, C., & Booth, A., 'Review of 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 return to work', NICE, Document 4, May 2008

Institute of Alcohol Studies, 'Alcohol and the Workplace', IAS Factsheet, June 2009

Ipsos MORI Reputation Centre, 'FTSE 100 Public Reporting on Employee Wellness & Engagement: Ipsos MORI Research Findings', Business in the Community, March 2011

Knapp, M., McDaid, D., & Parsonage, M. (eds.), Mental health promotion and mental illness prevention: The economic case, Department of Health, January 2011.

Lee, S., Blake, H., & Lloyd, S., 'The price is right: making workplace wellness financially sustainable', International Journal of Workplace Health Management, Vol. 3 No. 1, 2010

Leeser, R., 'English Indices of Deprivation 2010: A London Perspective', Intelligence Briefing 2011-06, Greater London Authority, June 2011

London Skills & Employment Observatory, 'Work Programme in London: Information for stakeholders as the Work Programme starts', April 2011

The Marmot Review, 'Fair Society, Healthy Life: Strategic Review of Health Inequalities in England post-2010', February 2010

McDaid, D., Zechmeister, I., Kilian, R., Medeiros, H., Knapp, M., Kennelly, B., & the MHEEN Group, 'Making the economic case for the promotion of mental well-being and the prevention of mental health problems', MHEEN II Policy Briefing, January 2008

Meadows, P., 'Worklessness in London: Explaining the difference between London and the UK', GLA Economics, Working Paper 15, January 2006

Mind/Federation of Small Businesses, 'Taking care of business'

New York State Department of Labor, 'Cost Benefit Analysis of Return to Work Incentive Programs – Industry Code Rule 60'

NICE, 'Promoting mental wellbeing at work: Business Case: Implementing NICE guidance', NICE public health guidance 22, November 2009

NICE, 'Promoting physical activity in the workplace Business case: Implementing NICE guidance in England', NICE public health guidance 13, May 2008

North West Public Health Observatory, 'Synthesis', Issue 88, June 2010

van Oostrom, S. H., Driessen, M. T., de Vet, H. C. W., Franche, R. L., Schonstein, E., Loisel, P., van Mechelen, W., & Anema, J. R., 'Workplace interventions for preventing work disability (Review)', The Cochrane Collaboration

PricewaterhouseCoopers, 'Building the case for wellness', February 2008

Piha, K., Laaksonen, M., Martikainen, P., Rahkonen, O., & Lahelma, E., 'Interrelationships between occupational class, income and sickness absence', European Journal of Public Health, Vol. 20, No. 3, October 2009

RNIB, Vocational rehabilitation: The business case for retaining newly disabled staff and those with a long-term health condition, September 2011

Royal College of Psychiatrists research and Training Unit, 'Mental Health and Work', Commissioned by the cross government Health Work and Well-being Programme, March 2008

The Sainsbury Centre for Mental Health, 'Mental Health at Work: Developing the business case', Policy Paper 8, December 2007

Sassi, F., Cecchini, M., Lauer, J., & Chisholm, D., 'Improving Lifestyles, Tackling Obesity: The Health and Economic Impact of Prevention Strategies', OECD Health Working Papers No. 48, 2009

Stewart, H., 'Do happy staff make for happy customers and profitable companies?', Journal of Direct, Data and Digital Marketing Practice, Vol. 11 No. 4, 2010

TUC, 'Focus on health and safety: TUC biennial survey of safety reps 2010', Trade Union Trends Survey, October 2010

Vaughan-Jones, H., & Barham, L., 'Health Work: Challenges and Opportunities to 2030', Bupa, 2009

Waddell, G., & Burton, A. K., 'Is work good for your health and well-being?', Department for Work and Pensions, 2006

Weldon, W. C., 'Fix the Health Care Crisis, One Employee at a time: The key to jump-starting health care reform is to invest in employee wellness programs that focus on prevention and yield steady returns', Harvard Business Review, January-February 2011

Working for Wellness, 'IAPT Employment Support Services: Assessment of the Economic Impact', Office for Public Management, January 2011

World Economic Forum, 'Working Towards Wellness: The Business Rationale', 2008

World Economic Forum/Boston Consulting Group, 'The New Discipline of Workforce Wellness: Enhancing Corporate Performance by Tackling Chronic Disease', 2010

World Economic Forum/Right Management, 'The Wellness Imperative: Creating More effective Organisations', 2010

World Health Organisation, 'Preventing Chronic Diseases: Designing and Implementing Effective Policy', Policy Brief

Ylikoski, M., Lamberg, M., Yrjänheikki, E., Ilmarinen, J., Partinen, R., Jokiluoma, H., & Vainio, H. (eds.), 'Health in the World of Work: Workplace Health Promotion as a Tool for Improving and Extending Work Life', Reports of the Ministry of social Affairs and Health 2006:62, 2006

Young, V., & Bhaumik, C., Health and well-being at work: a survey of employees, Research Report No 751, Department of Work and Pensions, 2001

Endnotes

- 1 This definition of workplace wellness is taken from PricewaterhouseCoopers, 'Building the case for wellness', February 2008.
- 2 GLA Economics calculation based on average working time lost in Q4 2010 in London from the ONS Labour Force Survey and median gross weekly pay for all full time workers in London in 2010 from the Annual Survey of Hours and Earnings.
- 3 Dame Carol Black's Review of the health of Britain's working age population, 'Working for a healthier tomorrow', March 2008.
- 4 Black, C., & Frost, D., 'Health at work – an independent review of sickness absence', Department for Work and Pensions, November 2011.
- 5 Meadows, P., 'Worklessness in London: Explaining the difference between London and the UK', GLA Economics, Working Paper 15, January 2006.
- 6 Office of National Statistics, Annual Population Survey, 2007.
- 7 London Skills & Employment Observatory, 'Work Programme in London: Information for stakeholders as the Work Programme starts', April 2011.
- 8 DWP (2011). IB ICD summary code by region. November 2010 time series.
- 9 Collingwood, S., 'Attitudes to health and work amongst the working-age population', Research Report No 763, Department for Work and Pensions, 2011.
- 10 Note that the number of respondents that provided data for all employee absence was higher than the respondents that provided data on manual and non-manual employees absence and explains the discrepancy in the results.
- 11 CIPD, 'Absence Management: Annual survey report 2011', October 2011.
- 12 CBI, 'Healthy returns? Absence and workplace health survey 2011', May 2011.
- 13 CIPD, 'Absence Management: Annual survey report 2011', October 2011.
- 14 The Marmot Review, 'Fair Society, Healthy Life: Strategic Review of Health Inequalities in England post-2010', February 2010.
- 15 Black, C., & Frost, D., 'Health at work – an independent review of sickness absence', Department for Work and Pensions, November 2011.
- 16 For instance it has been estimated that the cost to society of obesity by 2050 will reach £49.9 billion per year at 2007 prices.
- 17 Integrated Household Survey.
- 18 The Marmot Review, 'Fair Society, Healthy Life: Strategic Review of Health Inequalities in England post-2010', February 2010.

- 19 Leeser, R., 'English Indices of Deprivation 2010: A London Perspective', Intelligence Briefing 2011-06, Greater London Authority, June 2011.
- 20 Ibid.
- 21 CIPD, 'Absence Management: Annual survey report 2011', October 2011.
- 22 CBI, 'Healthy returns? Absence and workplace health survey 2011', May 2011.
- 23 That is in the CIPD survey each respondent was asked to list the top five most common cause of absence that they experienced, which produced a number of results and showed that on average minor illness is the most frequently reported cause of short-term absence.
- 24 CBI, 'Healthy returns? Absence and workplace health survey 2011', May 2011.
- 25 With the Black and Frost review of sickness absence finding that the lower paid, lower skilled the worker the more likely they are to take sickness absence or to fall out of work altogether. Whilst older workers, women, those with long-term health conditions, those in the public sector, those working for larger firms, those working in public administration and health/social work sectors, those that worked in workplaces that had union representation and part-time workers were also found to be more likely to experience sickness absence.
- 26 A workplace hazard was defined as a factor that caused a worker concern at their workplace and thus includes factors that cause employee ill-health such as stress, illness, back strains etc. as well as other factors such as bullying/harassment, handling chemicals and solvents, cramped conditions etc.
- 27 Of those safety representatives surveyed 1819 responded to the survey.
- 28 Dame Carol Black's Review of the health of Britain's working age population, 'Working for a healthier tomorrow', March 2008.
- 29 CBI, 'Healthy returns? Absence and workplace health survey 2011', May 2011.
- 30 Centre for Mental Health, 'The economic and social costs of mental health problems in 2009/10', 2010.
- 31 Alcohol Concern, 'Making alcohol a health priority: Opportunities to reduce alcohol harms and rising costs', January 2011.
- 32 CIPD, 'Absence Management: Annual survey report 2011', October 2011.
- 33 CBI, 'Healthy returns? Absence and workplace health survey 2011', May 2011.
- 34 Ibid.
- 35 Dame Carol Black's Review of the health of Britain's working age population, 'Working for a healthier tomorrow', March 2008.
- 36 Black, C., & Frost, D., 'Health at work – an independent review of sickness absence', Department for Work and Pensions, November 2011.

- 37 CIPD, 'Recovery, rehabilitation and retention: Maintaining a productive workforce', 2004.
- 38 Vaughan-Jones, H., & Barham, L., 'Health Work: Challenges and Opportunities to 2030', Bupa, 2009.
- 39 Greater London Authority, 'Review of evidence for the Mayor's Health Inequalities Strategy', August 2009.
- 40 Waddell, G. & Burton, A. K., 'Is work good for your health and well-being?', Department for Work and Pensions, 2006.
- 41 The Marmot Review, 'Fair Society, Healthy Life: Strategic Review of Health Inequalities in England post-2010', February 2010.
- 42 As with fewer absences from the firms the firms required fewer employees to perform the same task.
- 43 PricewaterhouseCoopers, 'Building the case for wellness', February 2008.
- 44 Berry, L. L., Mirabito, A. M., & Baun, W. B., 'What's the Hard Return on Employee Wellness Programs? The ROI data will surprise you, and the softer evidence may inspire you', Harvard Business Review, December 2010.
- 45 Vaughan-Jones, H., & Barham, L., 'Health Work: Challenges and Opportunities to 2030', Bupa, 2009.
- 46 The Marmot Review, 'Fair Society, Healthy Life: Strategic Review of Health Inequalities in England post-2010', February 2010.
- 47 Ipsos MORI Reputation Centre, 'FTSE 100 Public Reporting on Employee Wellness & Engagement: Ipsos MORI Research Findings', Business in the Community, March 2011.
- 48 Health, work and Well-being Strategy Unit, 'Health, work and well being baseline indicators report', December 2010.
- 49 Ibid.
- 50 Black, C., & Frost, D., 'Health at work – an independent review of sickness absence', Department for Work and Pensions, November 2011.
- 51 CIPD, 'Absence Management: Annual survey report 2011', October 2011.
- 52 Young, V., & Bhaumik, C., 'Health and well-being at work: a survey of employees', Research Report No 751, Department of Work and Pensions, 2001.
- 53 CIPD, 'Absence Management: Annual survey report 2011', October 2011.
- 54 Ibid.
- 55 CBI, 'Healthy returns? Absence and workplace health survey 2011', May 2011.
- 56 CIPD, 'Absence Management: Annual survey report 2011', October 2011.

57 Ibid.

58 CBI, 'Healthy returns? Absence and workplace health survey 2011', May 2011.

59 Black, C., & Frost, D., 'Health at work – an independent review of sickness absence', Department for Work and Pensions, November 2011.

60 Ibid.

61 Hassan, E., Austin, C., Celia, C., Disley, E., Hunt, P., Marjanovic, S., Shehabi, A., Villalba-Van-Dijk, L., & Van Stolk, C., 'Health and Wellbeing at Work in the United Kingdom', The work foundation, Rand Europe, Aston Business School, Prepared for the Department of Health, August 2009.

62 Waddell, G. & Burton, A. K., 'Is work good for your health and well-being?', Department for Work and Pensions, 2006.

63 CBI, 'Healthy returns? Absence and workplace health survey 2011', May 2011.

64 Bevan, S., 'The Business Case for Employee Health and Wellbeing', The Work Foundation, February 2010.

65 Lee, S., Blake, H., & Lloyd, S., 'The price is right: making workplace wellness financially sustainable', International Journal of Workplace Health Management, Vol. 3 No. 1, 2010.

66 NICE, 'Promoting mental wellbeing at work: Business Case: Implementing NICE guidance', NICE public health guidance 22, November 2009.

67 Lee, S., Blake, H., & Lloyd, S., 'The price is right: making workplace wellness financially sustainable', International Journal of Workplace Health Management, Vol. 3 No. 1, 2010.

68 Baicker, K., Cutler, D., & Song, Z., 'Workplace Wellness Programs Can Generate Savings', Health Affairs, 29:2, February 2010.

69 Sassi, F., Cecchini, M., Lauer, J., & Chisholm, D., 'Improving Lifestyles, Tackling Obesity: The Health and Economic Impact of Prevention Strategies', OECD Health Working Papers No. 48, 2009.

70 Business in the Community, 'Skills, Health and Wellbeing Toolkit: Healthy People – Healthy Profits', May 2009.

71 Royal College of Psychiatrists research and Training Unit, 'Mental Health and Work', Commissioned by the cross government Health Work and Well-being Programme, March 2008.

72 Knapp, M., McDaid, D., & Parsonage, M. (eds.), 'Mental Health Promotion and Mental Illness Prevention: The economic Case', Department of Health, April 2011.

73 Hill, D., Lucy, D., Tyers, C., & James, L., "What works at work? Review of evidence assessing the effectiveness of workplace interventions to prevent and manage common health problems", Institute for Employment studies for Health Work and Wellbeing Executive, 2007.

- 74 Dame Carol Black's Review of the health of Britain's working age population, 'Working for a healthier tomorrow', March 2008.
- 75 World Economic Forum/Right Management, 'The Wellness Imperative: Creating More effective Organisations', 2010.
- 76 World Economic Forum/Boston Consulting Group, 'The New Discipline of Workforce Wellness: Enhancing Corporate Performance by Tackling Chronic Disease', 2010.
- 77 The figure was calculated using a comprehensive simulation model developed by Healthways with an average company profile assumed that incorporated a comprehensive wellness programme with three sample interventions.
- 78 Business Action on Health, 'Physical Activity Toolkit: Healthy People = Healthy Profits', May 2009.
- 79 World Economic Forum, 'Working Towards Wellness: The Business Rationale', 2008.
- 80 By Regnan and Goldman Sachs JBWere.
- 81 Business in the Community, 'Skills, Health and Wellbeing Toolkit: Healthy People – Healthy Profits', May 2009.
- 82 Stewart, H., 'Do happy staff make for happy customers and profitable companies?', Journal of Direct, Data and Digital Marketing Practice, Vol. 11 No. 4, 2010.
- 83 Bevan, S., 'The Business Case for Employee Health and Wellbeing', The Work Foundation, February 2010.
- 84 The numbers in this column show the returns per pound invested.
- 85 PricewaterhouseCoopers, 'Building the case for wellness', February 2008.
- 86 Ibid.
- 87 RNIB, 'Vocational rehabilitation: The business case for retaining newly disabled staff and those with a long-term health condition', September 2011.
- 88 Working for Wellness, 'IAPT Employment Support Services: Assessment of the Economic Impact', Office for Public Management, January 2011.
- 89 Ibid.
- 90 Cawley, J., & Berzins, K., 'SROI – Work It Out'. London South Bank University.
- 91 The Government's Response to Dame Carol Black's Review of the health of Britain's working-age population, 'Improving health and work changing lives', November 2008.
- 92 Black, C., & Frost, D., 'Health at work – an independent review of sickness absence', Department for Work and Pensions, November 2011.

- 93 NICE, 'Promoting physical activity in the workplace Business case: Implementing NICE guidance in England', NICE public health guidance 13, May 2008.
- 94 The Marmot Review, 'Fair Society, Healthy Life: Strategic Review of Health Inequalities in England post-2010', February 2010.
- 95 Ibid.
- 96 Piha, K., Laaksonen, M., Martikainen, P., Rahkonen, O., & Lahelma, E., 'Interrelationships between occupational class, income and sickness absence', *European Journal of Public Health*, Vol. 20, No. 3, October 2009.
- 97 Waddell, G., & Burton, A. K., 'Is work good for your health and well-being?', Department for Work and Pensions, 2006.
- 98 Black, C., & Frost, D., 'Health at work – an independent review of sickness absence', Department for Work and Pensions, November 2011.
- 99 Ibid.
- 100 Hillage, J., Rick, J., Pilgrim, H., Jagger, N., Carroll, C., & Booth, A., 'Review of 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 return to work', NICE, Document 4, May 2008.
- 101 However, when examining observational and qualitative empirical studies of UK government interventions to help long-term sick or disabled workers back into work Clayton et al. found that "no randomised control trials were identified in our searches, and whilst those observational studies using comparison groups or areas provided reasonably robust evidence, most did not adequately control for or discuss the problems of selection bias in both the intervention and comparison groups". This makes examining the effectiveness of government policies difficult.
- 102 GLA Economics calculation based on average working time lost in Q4 2010 in London from the ONS Labour Force Survey and median gross weekly pay for all full-time workers in London in 2010 from the Annual Survey of Hours and Earnings.
- 103 The Marmot Review, 'Fair Society, Healthy Life: Strategic Review of Health Inequalities in England post-2010', February 2010.
- 104 The results in this table show the percentage of respondent firms that classed one of these illnesses as one of the top five causes of illness for their firm.
- 105 CIPD, 'Absence Management: Annual survey report 2011', October 2011.
- 106 The results in this table show the percentage of respondent firms that classed one of these illnesses as one of the top five causes of illness for their firm.
- 107 CIPD, 'Absence Management: Annual survey report 2011', October 2011.
- 108 Representing the percentage of respondents in each sector that listed the factor as a hazard.

- 109 Display Screen Equipment.
- 110 Repetitive Strain Injuries.
- 111 TUC, 'Focus on health and safety: TUC biennial survey of safety reps 2010', Trade Union Trends Survey, October 2010.
- 112 Representing the percentage of respondents in each sector that listed the factor as a hazard.
- 113 TUC, 'Focus on health and safety: TUC biennial survey of safety reps 2010', Trade Union Trends Survey, October 2010.
- 114 Ibid.
- 115 CBI, 'Healthy returns? Absence and workplace health survey 2011', May 2011.
- 116 CIPD, 'Absence Management: Annual survey report 2011', October 2011.
- 117 Ibid.
- 118 Ibid.
- 119 Ibid.
- 120 From a "review (of) the international peer review literature on the effectiveness of workplace interventions in terms of health and work outcomes. The review summarises evidence mainly from systematic and other quality evidence reviews" – Hassan et al.
- 121 Hassan, E., Austin, C., Celia, C., Disley, E., Hunt, P., Marjanovic, S., Shehabi, A., Villalba-Van-Dijk, L., & Van Stolk, C., 'Health and Wellbeing at Work in the United Kingdom', The work foundation, Rand Europe, Aston Business School, Prepared for the Department of Health, August 2009.
- 122 CIPD, 'Absence Management: Annual survey report 2011', October 2011.
- 123 World Economic Forum, 'Working Towards Wellness: The Business Rationale', 2008.
- 124 CIPD, 'Absence Management: Annual survey report 2011', October 2011.
- 125 CBI, 'Healthy returns? Absence and workplace health survey 2011', May 2011.
- 126 CIPD, 'Absence Management: Annual survey report 2011', October 2011.
- 127 CBI, 'Healthy returns? Absence and workplace health survey 2011', May 2011.
- 128 Ibid.
- 129 Ibid.
- 130 NICE, 'Promoting mental wellbeing at work: Business Case: Implementing NICE guidance', NICE public health guidance 22, November 2009.

131 Ibid.

132 Ibid.

133 The Sainsbury Centre for Mental Health, 'Mental Health at Work: Developing the business case', Policy Paper 8, December 2007.

134 Mind/Federation of Small Businesses, 'Taking care of business'.

135 The Sainsbury Centre for Mental Health, 'Mental Health at Work: Developing the business case', Policy Paper 8, December 2007.

136 Ibid.

137 Institute of Alcohol Studies, 'Alcohol and the Workplace', IAS Factsheet, June 2009.

138 Select Committee on Health, 'Annex 1: The economic costs of obesity', Scrutiny Unit, Clerk's Department, House of Commons, October 2004.

139 Bevan, S., Passmore, E., & Mahdon, M., 'Fit for Work? Musculoskeletal Disorders and Labour Market Participation', The Work Foundation, September 2007.

140 Dame Carol Black's Review of the health of Britain's working age population, 'Working for a healthier tomorrow', March 2008.

141 Business in the Community, 'Healthy People = Healthy Profits', February 2009.

142 Berry, L. L., Mirabito, A. M., and Baun, W. B., 'What's the Hard Return on Employee Wellness Programs? The ROI data will surprise you, and the softer evidence may inspire you', Harvard Business Review, December 2010.

143 Weldon, W. C., 'Fix the Health Care Crisis, One Employee at a time: The key to jump-starting health care reform is to invest in employee wellness programs that focus on prevention and yield steady returns', Harvard Business Review, January-February 2011.

144 PricewaterhouseCoopers, 'Building the case for wellness', February 2008.

145 World Economic Forum, 'Working Towards Wellness: The Business Rationale', 2008.

146 RNIB, 'Vocational rehabilitation: The business case for retaining newly disabled staff and those with a long-term health condition', September 2011.

147 <http://www.london.gov.uk/lhc/goodjobs/case-studies/index.jsp>

148 Business in the Community, 'Skills, Health and Wellbeing Toolkit: Healthy People – Healthy Profits', May 2009.

149 Business in the Community, 'BITC Public Reporting Guidelines: Employee Wellness and Engagement', May 2011.

- 150 Business in the Community, 'Physical Activity Toolkit: Healthy People = Healthy Profits', May 2009.
- 151 Business in the Community, 'Healthy People = Healthy Profits', February 2009.
- 152 CBI, 'Healthy returns? Absence and workplace health survey 2011', May 2011.
- 153 Berry, L. L., Mirabito, A. M., and Baun, W. B., 'What's the Hard Return on Employee Wellness Programs? The ROI data will surprise you, and the softer evidence may inspire you', Harvard Business Review, December 2010.
- 154 PricewaterhouseCoopers, 'Building the case for wellness', February 2008.
- 155 New York State Department of Labor, 'Cost Benefit Analysis of Return to Work Incentive Programs – Industry Code Rule 60'.
<http://www.labor.ny.gov/workerprotection/safetyhealth/PDFs/WSLP/Cost%20Benefit%20RTW.pdf>
- 156 RNIB, 'Vocational rehabilitation: The business case for retaining newly disabled staff and those with a long-term health condition', September 2011.
- 157 Bevan, S., 'The Business Case for Employee Health and Wellbeing', The Work Foundation, February 2010.
- 158 Dame Carol Black's Review of the health of Britain's working age population, 'Working for a healthier tomorrow', March 2008.
- 159 Black, C., & Frost, D., 'Health at work – an independent review of sickness absence', Department for Work and Pensions, November 2011.

For a large print, Braille, disc, sign language video or audio-tape version of this document, please contact us at the address below:

Public Liaison Unit

Greater London Authority
City Hall, The Queen's Walk
London SE1 2AA

Telephone 020 7983 4100
Minicom 020 7983 4458
www.london.gov.uk

You will need to supply your name, your postal address and state the format and title of the publication you require. If you would like a copy of this document in your language, please phone the number or contact us at the address above.

Chinese

如果需要您母語版本的此文件，
請致電以下號碼或與下列地址聯絡

Vietnamese

Nếu bạn muốn có văn bản tài liệu này bằng ngôn ngữ của mình, hãy liên hệ theo số điện thoại hoặc địa chỉ dưới đây.

Greek

Αν θέλετε να αποκτήσετε αντίγραφο του παρόντος εγγράφου στη δική σας γλώσσα, παρακαλείστε να επικοινωνήσετε τηλεφωνικά στον αριθμό αυτό ή ταχυδρομικά στην παρακάτω διεύθυνση.

Turkish

Bu belgenin kendi dilinizde hazırlanmış bir nüshasını edinmek için, lütfen aşağıdaki telefon numarasını arayınız veya adrese başvurunuz.

Punjabi

ਜੇ ਤੁਹਾਨੂੰ ਇਸ ਦਸਤਾਵੇਜ਼ ਦੀ ਕਾਪੀ ਤੁਹਾਡੀ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਚਾਹੀਦੀ ਹੈ, ਤਾਂ ਹੇਠ ਲਿਖੇ ਨੰਬਰ 'ਤੇ ਫ਼ੋਨ ਕਰੋ ਜਾਂ ਹੇਠ ਲਿਖੇ ਪਤੇ 'ਤੇ ਰਾਬਤਾ ਕਰੋ:

Hindi

यदि आप इस दस्तावेज की प्रति अपनी भाषा में चाहते हैं, तो कृपया निम्नलिखित नंबर पर फोन करें अथवा नीचे दिये गये पते पर संपर्क करें

Bengali

আপনি যদি আপনার ভাষায় এই দলিলের প্রতিলিপি (কপি) চান, তা হলে নীচের ফোন নম্বরে বা ঠিকানায় অনুগ্রহ করে যোগাযোগ করুন।

Urdu

اگر آپ اس دستاویز کی نقل اپنی زبان میں چاہتے ہیں، تو براہ کرم نیچے دئے گئے نمبر پر فون کریں یا دیئے گئے پتے پر رابطہ کریں

Arabic

إذا أردت نسخة من هذه الوثيقة بلغتك، يرجى الاتصال برقم الهاتف أو مراسلة العنوان أدناه

Gujarati

જો તમને આ દસ્તાવેજની નકલ તમારી ભાષામાં જોઈતી હોય તો, કૃપા કરી આપેલ નંબર ઉપર ફોન કરો અથવા નીચેના સરનામે સંપર્ક સાધો.

Other formats

GLAECONOMICS

Greater London Authority
City Hall
The Queen's Walk
London SE1 2AA

Tel: 020 7983 4922

Fax: 020 7983 4674

Minicom: 020 7983 4458

Email: glaeconomics@london.gov.uk

Web: www.london.gov.uk/gla-intelligence

MAYOR OF LONDON