European Agency for Safety and Health at Work

Safer and healthier work at any age

Country Inventory: United Kingdom

European Agency for Safety and Health at Work

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EU-OSHA would like to thank members of its focal point network for their valuable input.

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Abbreviations

AAA:	Age Action Alliance
Acas:	Advisory, Conciliation and Arbitration Service
CBI:	Confederation of British Industry
CIPD:	Chartered Institute of Personnel and Development
DRA:	Default Retirement Age
DWP:	Department for Work and Pensions
EHRC:	Equality and Human Rights Commission
ENWHP:	European Network for Workplace Health Promotion
EU:	European Union
Eurofound:	European Foundation for the Improvement of and Living and Working Conditions
EU-OSHA:	European Agency for Health and Safety at Work
FSB:	Federation of Small Businesses
GP:	General Practitioner
HR:	Human resources
HSE:	Health and Safety Executive
HSL:	Health and Safety Laboratory
HSENI:	Health and Safety Executive for Northern Ireland
IIDB:	Industrial Injuries Disablement Benefit
IEHF:	Institute of Ergonomics and Human factors
ILC-UK:	International Longevity Centre-United Kingdom
ILO:	International Labour Organization
IOSH:	Institution of Occupational Safety and Health
MSD	Musculoskeletal disorder
NGO:	Non-governmental organisation
NHS:	National Health Service
OECD:	Organisation of Economic Cooperation and Development
OSH:	Occupational Safety and Health
P.p.:	Percentage points
RTW:	Return to work
SCHWL:	Scottish Centre for Healthy Working Lives
SPA:	State Pension Age
TAEN:	Age and Employment Network
TUC:	Trades Union Congress
WHO:	World Health Organisation

Introduction

This report is part of the project 'Safer and healthier work at any age', initiated and financed by the European Parliament[1][2]. The objective of the European Parliament was to further investigate possible ways of improving the health and safety of older people at work.

The project, which started in 2013,

- reviewed state of the art knowledge on ageing and work;
- investigated EU and Member States policies, strategies, and programmes addressing the challenges of an ageing workforce in the field of occupational safety and health (OSH) and policy areas that affect OSH, such as employment and social affairs, public health, and education;
- investigated EU and Member States policies, strategies, and programmes in relation to rehabilitation/return-to-work;
- and collected information on related workplace-level practices.

To review policy developments and initiatives taken in Europe to tackle the demographic change, country reports were prepared, with a specific focus on initiatives to improve the health and safety of an ageing workforce and on those aiming at promoting rehabilitation/return to work.

Methodology

The country reports were prepared in each of the 28 European Member States and EFTA countries (Iceland, Switzerland, Lichtenstein and Norway). In eight countries (Austria, Belgium, Denmark, Finland, France, Germany, the Netherlands and the United Kingdom), the research was carried out at a more in-depth level including additional resources and the consultation of relevant stakeholders via the organisation of expert workshops.

The **information** used to prepare the reports was collected between September 2013 and June 2014 and comes from international, European and national sources, referenced in the report's bibliography.

The **indicators** presented in the first section of the reports have been selected taking into account:

- *Relevance to the topic:* In addition to data on working conditions and health, indicators related to general contextual factors such as the demographic development, labour market and employment have also been included.
- *Availability of data by age groups:* As the focus of this work is to investigate activities in the context of an ageing workforce, it is central to the project to collect data by age groups.
- *Geographical coverage:* In order to be able to compare results across the Member States, it is important to use the same indicators in all country reports. For this reason, European and international sources were favoured.

National expert workshops took place in the eight countries subject to in-depth review as well as in two additional countries, Poland and Greece between March and June 2014.

The objectives of the workshops were to:

- Confirm the findings and interpret the results of the desk research;
- Stimulate discussions between intermediaries and experts in the field of occupational health and safety and rehabilitation/return-to-work, in order to collect additional information and examples of good practices;
- Exchange views and ideas on what works well, what could be improved, and what are the drivers, needs and obstacles to address the challenges of an ageing workforce.

[1] Official Journal of the European Union, '04 04 16 – Pilot project - Health and safety at work of older workers', Chapter 0404— Employment, Social Solidarity and Gender Equality, 29.02.2012, pp. II/230 - II/231. Available at: http://bookshop.europa.eu/en/officialjournal-of-the-european-union-l-56-29.02.2012-pbFXAL12056/ (Accessed December 2014

[2] The activities carried out for the European Parliament's pilot project are coordinated by the European Agency for Safety and Health at Work (EU-OSHA) and implemented by a consortium led by Milieu Ltd (other consortium partners include: COWI, IOM, IDEWE, FORBA, GfK, NIOM).

In the United Kingdom, the national expert seminar and workshop “Safer and Healthier Work at Any Age” (including rehabilitation and return-to-work) took place on 15-16 May 2014 at the premises of the Work Foundation in London, with around 46 participants over two days. The Health and Safety Executive (HSE), EU-OSHA’s focal point, provided extensive support for the organisation and execution of the workshop. On 15 May, a full day seminar took place on the topic of OSH and older workers, during which experts and policy makers came together to discuss the implementation and effectiveness of policies and strategies that play a role on safer work at any age. In addition to considering the overall context of the ageing workforce in the United Kingdom, the seminar examined specific issues relating to rehabilitation and return-to-work. A half a day workshop was organised on Friday 16 May, which with a smaller group of experts was able to consider the main issues raised during the seminar in more depth, and identify lessons for United Kingdom and EU policy and practice.

Representatives from the European Agency for Safety and Health at Work (EU-OSHA), the Department for Work and Pensions (DWP), the Health and Safety Executive (HSE), the trade union UNISON, and representatives from NGOs, networks, charities and businesses gave presentations to introduce the topics for discussion. Participation in the United Kingdom was quite diverse and represented well the different groups. A summary of the stakeholders’ views is provided in the conclusions of this report.

The present report describes policies and strategies in United Kingdom, addressing the ageing of workforce. Specifically, it focuses on initiatives to improve the health and safety of an ageing workforce and on those aiming at promoting the rehabilitation/return to work of workers following a health problem.

Structure of the report

The first section of the report provides background information on demographic developments, the labour market, working conditions and the health status of the older working population. The institutional and legal framework for occupational health and safety in the United Kingdom, as of June 2014, is also described.

The second section of the report describes strategies, policies, programmes and activities initiated by the government or government-affiliated organisations, social partners and non-governmental organisations to tackle the challenges related to demographic change, and more specifically to the ageing of the workforce. These initiatives were identified primarily in the area of occupational health and safety but also in the areas of employment and public health and any other relevant policy areas.

The third section of the report focuses on the issue of the rehabilitation and return to work of workers following a health problem (accident or disease). The section starts by introducing the national system for the rehabilitation of workers following a long-term sick leave or work incapacity and considers the legal and policy framework, the actors involved and the main steps of the rehabilitation process. The second part of the section describes specific activities, programmes or strategies implemented by the government or government-affiliated organisations, social partners and non-governmental organisations for the rehabilitation of workers.

The position on a number of the issues dealt with in this report is very fluid and, as much of the report was prepared in 2014, further updates may be necessary.

1 General context

Section I of this report starts with an overview of the most relevant facts and figures on the current situation in the UNITED KINGDOM with regard to demographics, the labour market, working conditions and the health status of the older working population. It then provides background information on the institutional and legal frameworks in the United Kingdom that pertain to safe and healthy work in the context of an ageing workforce. Finally, it provides a brief overview of the pension system, looking specifically at legal and actual retirement ages, early retirement opportunities and ongoing or upcoming reforms that would affect older workers.

1.1 Facts and figures

In this sub-section on facts and figures, a number of indicators introduce the current situation in the United Kingdom with regard to demographic factors, the labour market, working conditions and health status of the older working population.

The following definitions aim to provide clarity on a number of terms used frequently in this section:[3]

- "Median age" is the age that divides a population into two groups that are numerically equivalent.
- The "old age dependency ratio" is the ratio of the number of elderly people at an age when they are generally economically inactive (i.e. aged 65 and over), compared to the number of people of working age (i.e. 15-64 years old)
- "Old age pension" is payment to maintain the income of a person after retirement from employment at the standard age or payment made to support the income of elderly persons.[4]
- "Anticipated old age pensions" are periodic payments intended to maintain the income of beneficiaries who retire before the legal/standard age as established in the relevant scheme.[5]
- "Survivors' pension" is payment to a person whose entitlement derives from their relationship with a deceased person protected by the scheme (widows, widowers, orphans and similar).[6]
- "Healthy life years", also called disability-free life expectancy (DFLE), is defined as the number of years that a person is expected to continue to live in a healthy condition.[7]

Table 1 provides a quick snapshot of selected indicators, some of which are further described in the rest of the section.

Table 1, Overview table of main indicators

	United Kingdom	EU-28
Median age 2013 (2060)	39.8 (42.6)	41.9 (46.3)
Share of population aged 55 to 64 years (2013)	11%	13%
Share of population aged 65+ (2013)	17%	18%
Old age dependency ratio (65+/15-64) 2013 (2060)	26.4% (42.7%)	27.5% (50.2%)
Employment rate of 55 to 64-year-olds (2013) (Δ since 2003)	59.8% (+4.4 p.p.)	50.2% (+10.3 p.p.)
Official Retirement age[8]	65 (m) / 62* (f)	

[3] Definitions extracted from the Eurostat glossary (unless stated otherwise): http://epp.eurostat.ec.europa.eu/statistics_explained/index.php/Thematic_glossaries (Accessed December 2014)
[4] Eurostat, Methodologies and Working Papers, *The European System of integrated Social PROtection Statistics (ESSPROS), ESSPROS Manual and user guidelines*, 2012, p. 58. Available at: http://ec.europa.eu/eurostat/documents/3859598/5922833/KS-RA-12-014-EN.PDF/6da3b2bf-85ba-4665-b318-a41d6a2df37f?version=1.0 (Accessed December 2014)
[5] Definition according to Eurostat Methodology Paper on ESSPROS, p. 51
[6] Ibid, p62.
[7] This indicator is compiled separately for men and women, both at birth and at age 65. It is based on age-specific prevalence (proportions) of the population in healthy and unhealthy condition and age-specific mortality information. A healthy condition is defined as one without limitation in functioning and without disability.
[8] See 1.4: Pension system

	United Kingdom	EU-28
Effective retirement age[9] (2012)	63.7 (m)/ 63.2 (f)	62.3(m)**/60.9(f)**[10]
Share of pensioners (50-69) who quit working for health or disability reason (2012)	20.6%	20.9%
Pension expenditures (% of GDP) (2011*)		
All pensions	11.8%	13.0%
Old-age pensions	10.4%	9.5%
Disability	1.3%	0.9%
Life expectancy at 65 years, in years (2011)	19.9	19.7
Women	21.1	21.3
Men	18.5	17.8
Healthy life years at the age of 65 (and 50)		
Women	11.9 (21.8)	8.6 (17.9)
Men	11 (20.8)	8.6 (17.5)
Employed persons aged 55 to 64 years reporting one or more work-related health problems in the past 12 months in 2007 (% from all employed aged 55 to 64 years)	6.9%	11.4%[11]
Share of employed people aged 55-64 yrs who perceive their health as in being in a bad or very bad status (and 45-54 yrs), 2012	5.1% (3.3)	5.7% (3.8%)
Share of employed people aged 55-64 yrs who have a long-standing illness or health problem (and 45-54 yrs), 2012	33.8% (25.6%)	33.3%** (24.2%**)
Share of people aged 55-64 yrs reporting MSDs as their most serious work-related health problem during the past 12 months (2007)	58.5%	59.9%[12]
Women	64.7%	64.4%
Men	53.7%	56%
Share of workers above the age of 50 who think they could do their current job at the age of 60[13] (2010)	84.9%	71.4[14]%
Share of employed people with working experience who report that measures to adapt the workplace for older people have been put in place at their workplace[15] (2013)	52%	31%

Sources: All figures are as published by Eurostat, unless mentioned otherwise. Sources used by Eurostat include: Eurostat population statistics, Eurostat population projections, the European Labour Force Survey (EU-LFS), the European Survey on Income and Living Conditions (EU-SILC), the European System of Integration Social Protection Statistics (ESSPROS)
* For women, moving gradually to 65 by 2018
** figure refers to 2011

[9] OECD estimates on the "average effective age of retirement versus the official age, 2007-2012". Available at: http://www.oecd.org/els/emp/ageingandemploymentpolicies-statisticsonaverageeffectiveageofretirement.htm (Accessed December 2014)
[10] These figures refer to the EU-27
[11] This figure is for the EU-26 without France. Due to different wording in the French version of the questionnaire, the results were very different in France and Eurostat recommends using the aggregate figures without France.
[12] This figure is for the EU-26 without France. Due to different wording in the French version of the questionnaire, the results were very different in France and Eurostat recommends using the aggregate figures without France.
[13] European Working Conditions Survey 2010
[14] This Figure refers to the EU-27
[15] European Commission, Flash Eurobarometer on Working Conditions – Fact sheet for the UK, 2014. Available at: http://ec.europa.eu/public_opinion/flash/fl_398_fact_uk_en.pdf (Accessed December 2014)

1.1.1 Demographic developments

In the United Kingdom, the population's median age actually decreased between 1960 and 1980 (table 2). However, there has been an increase since then. From 34 years in 1980, the median age rose to 36 years in 1990 and further to 40 years in 2013. The increase in the median age between 1990 and 2013 has however not been as large as the EU average (increase United Kingdom: 4 years, EU-27: 7 years). In 2013, the median age of the United Kingdom's population was two years less than the EU average.

Table 2, Median age (actual and projections) of population in the United Kingdom and for EU, 1960-2060 (in years)

	1960	1980	1990	2000	2012	2013	2020	2040	2060
United Kingdom	36	34	36	38	40	40	40	42	43
EU-27	:	:	35	38	42*	42**	44**	46**	46**

Source: Eurostat population statistics: Population on 1 January: Structure indicators [demo_pjanind];
*figure for EU-27 for this year is flagged "estimated"
** figures from 2013 onwards are for the EU-28 aggregate

The ageing of the population is also reflected in the **distribution of the population across the different age groups** and their development since 1990: The share of the oldest age group (65 years and above) increased between 1990 and 2013 from 16% to 17%. The share of the age group of 55 to 64-year-olds increased as well, from 10% in 1990 to 11% in 2013. In the United Kingdom, the increase in the share of older people between 1990 and 2013 was not as pronounced as across the EU, and in 2013, the shares of older people were slightly less in the United Kingdom (17% of 65-year-olds and above and 11% of 55 to 64-year-olds) than across the EU (18% and 13%, respectively).

Figure 1, Total population by age group and gender, 2010 and projection for 2050

Source: International Conference on Population and Development Beyond 2014, United Kingdom Country Implementation Profile[16]

[16] International Conference on Population and Development Beyond 2014, UK Country Implementation Profile. Available at: http://icpdbeyond2014.org/about/view/19-country-implementation-profiles (Accessed December 2014)

The ageing of the population is predicted to continue. The age group of "65+" is predicted to increase to 25% until 2060. The age pyramids above (figure 2) also show that the age group of 35 to 50-year-olds is predicted to decrease between 2010 and 2050, while the age group of "50+" will grow in that time span.

The **old age dependency (OAD) ratio** (ratio of 'dependants' – aged 65 and above – and working-age population) is also predicted to increase until 2080 (table 3). The increase will be most pronounced between 2020 and 2040. This means that while in 1990 and in 2010 there were still four people of working age per old person (65 years and above), in 2040 there will be fewer than three people and in 2080 around two people of working age per old person.

Table 3, Old-age dependency ratio, (65+ year olds/15-64 year olds) (actual and projections), 1990-2060

	1990	2000	2010	2015	2020	2040	2060
OADR	24%	24%	25%	27%	30%	39%	43%

Source: Eurostat, Old dependency ratio 1st variant (population 65 and over to population 15 to 64 years), population on 1 January: Structure indicators [demo_pjanind], 1990-2010; the same ratio was calculated for 2015-2060 with figures from Eurostat population projections, [proj_10c2150p]

The population ageing in the United Kingdom is reflected in the change of the total numbers of **pension beneficiaries** (table 4). Between 2007 and 2011, the number of beneficiaries of all old age pensions actually increased by around 893,000[17].

Table 4, Number of beneficiaries of old-age pensions in the United Kingdom, 2006-2011, in thousands

	2007	2008	2009	2010	2011	2012
Total old-age pension beneficiaries	12,251	12,478	12,742*	12,882*	12,996*	13,145**
As % of total population	20.1%	20.3%	20.5%	20.6%	20.6%	20.7%

Source: Eurostat ESSPROS Pensions beneficiaries at 31st December [spr_pns_ben], figures include beneficiaries of means-tested and non-means-tested pensions.
* Figures are estimated; ** Figures are provisional; Figure for 2006 is not available.

For **pension expenditure**, it is possible to analyse figures over a longer time span: as table 6 shows, pensions increased between 1990 and 2000, then slightly decreased in 2005 and then increased again to the same or a higher level than in 2000 (except survivors' pension). The expenditure on all pensions increased from 9.9%/GDP in 1990 to 11.8%/GDP in 2000, then decreased slightly and was again 11.8%/GDP in 2011. This was lower than the EU average (13.0%). The expenditure on old age pensions, however, rose compared to 2000 (9.5%/GDP) to 10.1%/GDP. This was slightly higher than the EU average (9.4%/GDP).

[17] Source: Eurostat ESSPROS Pensions beneficiaries at 31st December [spr_pns_ben], figures include beneficiaries of means-tested and non-means-tested pensions.

Table 5, Expenditures on all pensions and old-age pensions, United Kingdom and EU, as % of GDP, 1990, 1995, 2000, 2005 and 2011*

Type of expenditure		1990	1995	2000	2005	2011*
Total	**United Kingdom**	9.9	11.4	11.8	10.6	11.8
	EU-27**				12.1	13.0
Old-age pension	**United Kingdom**	7.9	8.8	9.5	8.8	10.4
	EU-27**				8,5	9.4
Anticipated old-age pension***	**United Kingdom**	0.0	0.0	0.0	0.0	0.0
	EU-27**				0.7	0.7
Disability pension	**United Kingdom**	1.3	1.8	1.3	1.0	1.3
	EU-27**				0.9	0.9
Survivors pension	**United Kingdom**	0.7	0.9	1.0	0.8	0.1
	EU-27**				1.7	1.9

Source: Eurostat ESSPROS Expenditures on pensions [spr_exp_pens], 1990-2011.
* figures for 2011 are provisional; ** figures for 2011 are for EU-28; *** 'anticipated old age pension' are periodic payments intended to maintain the income of beneficiaries who retire before the legal/standard age as established in the relevant scheme.[18]

Early retirement benefits (both due to reduced capacity to work and for labour market reasons) made 0% of the GDP according to Eurostat figures throughout the time since 1990. According to a qualitative description by Eurostat, no early retirement benefit schemes are provided by the state in the United Kingdom[19].

1.1.2 Labour market participation

Retirement age

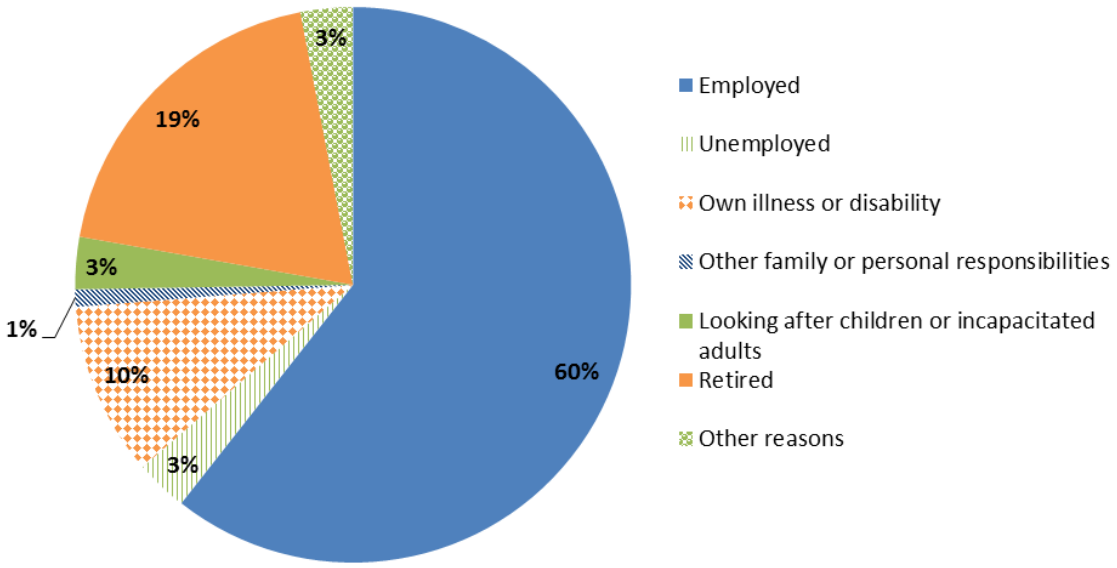
There is no official **retirement age** in the United Kingdom. Up until 2010, the state pension age was 65 years for men and 60 years for women. Legislation introduced in 2011confirmed that the state pension age for women would rise gradually to 65 by 2018. The state pension age for both men and women will then increase to 66 by October 2020 and after that to at least 68. The average **effective retirement age** was around 64 years for men and around 63 years for women in 2012 according to OECD estimates[20]. This means that people in the United Kingdom stay in the labour market for around two years longer than the population across the whole EU. The United Kingdom's national statistical office (ONS) indicated a similar figure using a 'duration of working-life based approach'[21] indicating the average age of withdrawal from the labour market as around 64.6 for men and around 62.3 for women in 2010. This shows that estimates only show the order of magnitude, but are not fully reliable[22].

The effective retirement age in the United Kingdom has increased by around one year for men and by around two years for women since 1990[23]. This is also reflected in the increasing employment rate for people aged 65 years and above (see below). According to the ONS, the increase in effective retirement age for women may partly be due to the changing State Pension Age. However, ONS warns of attributing this change to one single factor only[24] and indicates that other factors such as changes in the economic climate could also be responsible[25].

[18] Definition according to Eurostat Methodology Paper on ESSPROS, p. 51
[19] Eurostat, social protection meta data, qualitative information by scheme and by detailed benefit, last updated in 2011.
[20] Source: OECD estimates on the "average effective age of retirement versus the official age, 2007-2012", as above.
[21] Explanations on the different approaches of OECD and the ONS can be found in 'Pension Trends, chapter 4: the labour market and retirement', p. 8.
[22] Office for National Statistics (2012), 'Pension Trends, chapter 4: the labour market and retirement', table 4.8, p. 9.
[23] Source: OECD average effective age of retirement, OECD estimates based on the results of national labour force surveys, the European Union Labour Force Survey and, for earlier years in some countries, national censuses.
[24] Office for National Statistics (2012) 'Pension Trends, Chapter 4: The labour market and retirement', p. 11.
[25] Ibid., p. 6.

In 2013, around 60% of 55 to 64-year-olds were still in employment, compared to only 50% on average in the EU. The proportion of retired persons was only around 20%. However, the proportion of unemployed people (and thus who were still looking for a job at that age), was also very small (3%) in the United Kingdom (fig.2). Ten percent of the population of this age group was inactive due to illness or disability.

Figure 2, Population of 55 to 64-year-olds in the United Kingdom, by labour status (employed, unemployed or inactive) and reason for inactivity (not seeking employment), 2013 (in %)



Source: EU-LFS, Eurostat "Population by sex, age, nationality and labour status (1 000) [lfsa_pganws]" and "Inactive population - Main reason for not seeking employment - Distributions by sex and age (%) [lfsa_igar]"; all green shades show the share of the inactive population

Similar to the EU average, the two **main reasons** for people aged 50 to 69 who receive a pension **to stop working** were that "they had reached eligibility for a pension" (20.2%) and "own health or disability" (20.6%) (table 6). "Eligibility for a pension" is not as strong a reason in the United Kingdom as on average in the EU. However, an important reason in the United Kingdom is favourable financial arrangements to leave (17%) (against 7.2% in the EU), which may also be related to pensions.

Table 6, Main reason for pensioners to quit working, as shares from all persons receiving a pension aged 50 to 69 (%), 2012

Main reason	United Kingdom	EU-28
Favourable financial arrangements to leave	17.2	7.2
Lost job and/or could not find a job	7.5	7.5
Had reached the maximum retirement age	7.2	9.8
Had reached eligibility for a pension	20.2	37.0
Other job-related reasons[26]	6.0	4.0

[26] Other job-related reasons not included above: inconvenient working hours, tasks, health and safety at the job site, job stress, job too demanding, and skills not adequate or not valued, employer's attitude.

Main reason	United Kingdom	EU-28
Own health or disability	20.6	20.9
Family or care-related reasons	8.8	3.9
Other reasons	12.5	5.3
No answer	:	4.3

Source: Main reason for economically inactive persons who receive a pension to quit working (%) [lfso_12reasnot], 2012

When looking at the reasons why people aged 50 to 69 who receive a pension continue working, there are again notable differences between the United Kingdom and the EU average (table 7): While a higher share of persons in the United Kingdom say that they continue working mainly due to non-financial reasons (41% compared to 29% on EU average), a slightly lower share reports to do so to provide sufficient income (33% compared to 37% on EU average). However, the majority of respondents state that the main reason to continue working is for financial reasons in general (54% which is even slightly above the EU average of 52%). It has to be noted that the non-response rate for the EU average was very high (12%), so comparisons have to be interpreted with caution.

However, the share of pensioners who work in order to ensure sufficient income is still one third (while, for example, in Austria, this share is only a quarter). Figures from 2008 from the Department for Work and Pensions showed that 63% of people who wanted to stay in employment past retirement age said that money was the major cause, while 57% said it was for non-financial reasons (they enjoyed their job) and 38% said that working helped keep their mind active[27].

Table 7, Main reason for persons who receive a pension (50-69 years) to continue working (%), 2012

Main reason	United Kingdom	EU-28
To establish or increase future retirement pension entitlements	4.0	6.8
To provide sufficient personal/household income	33.2	37.3
To establish/increase future retirement pension entitlements and to provide sufficient personal/household income	21.0	14.5
Non-financial reasons*, e.g. work satisfaction	40.7	29.1
No answer	1.1	12.3

Source: Main reason for persons who receive a pension to continue working (%) [lfso_12staywork], 2012
*e.g. work satisfaction, flexible working arrangements, good opportunities to update (labour) skills, healthy and safe workplace, appreciation at work, social contacts; see Eurostat Explanatory Notes on ad-hoc module 2012

Employment rate

Employment among older people has been constantly increasing, particularly since 2000. According to the Office for National Statistics, the number of workers who worked beyond the State Pension Age (SPA) has almost doubled from 753,000 in 1993 to 1.4 million in 2011, with a particularly big increase between 2000 and 2010[28].

Employment among 55 to 64-year-olds was already a lot higher than the EU average in 2002 (around 12 p.p. higher). It has since increased at a slightly slower pace than the EU average but was still around 10 p.p. higher in 2013 (60% in the United Kingdom and 50% on EU average). As within other age groups, the employment rate for women was lower than that for men, especially for the population between 60 and 64 years (gender gap was 9 p.p. while for age group 55 to 64 years was around 20

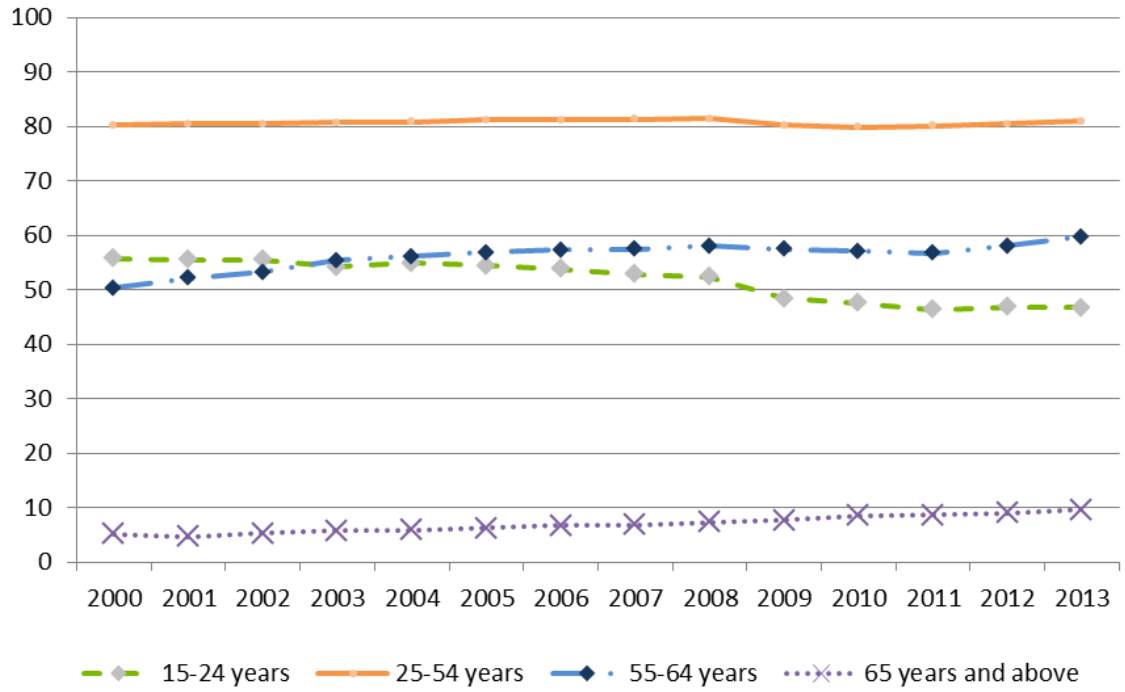
[27] Source: Department of Work and Pensions quoted on: Employers Forum on Age, section 'Later life working-UK'. Available at: http://www.efa.org.uk/pages/later-life-working-uk-.html (Accessed December 2014)
[28] Office for National Statistics, Source: Labour Force Survey, 'Older Workers in the Labour Market, 2012.

p.p.[29]). Furthermore, national figures show that there is a transition to part-time employment over a worker's life time: in Q1 2012, 14% of men aged 60 and above worked part-time, compared to 9% of men aged 55 to 59 years and 7% in the group aged 50 to 54. For women, there is less change in the proportion working part-time as they approach retirement[30].

There was also an increase in the employment rate of people aged 65 years and above: from around 5% in 2002 to around 10% in 2013 which was thus almost twice as high as the EU average in 2013.

The **employment rates** of the population above 55 have thus increased, while the main employment rate (25 to 54-year-olds) slightly decreased between 2008 and 2013 and the youth employment rate decreased quite markedly between 2008 and 2011.

Figure 3, Employment rates per broad age groups, trend 2000-2013, residents in the United Kingdom (in %)



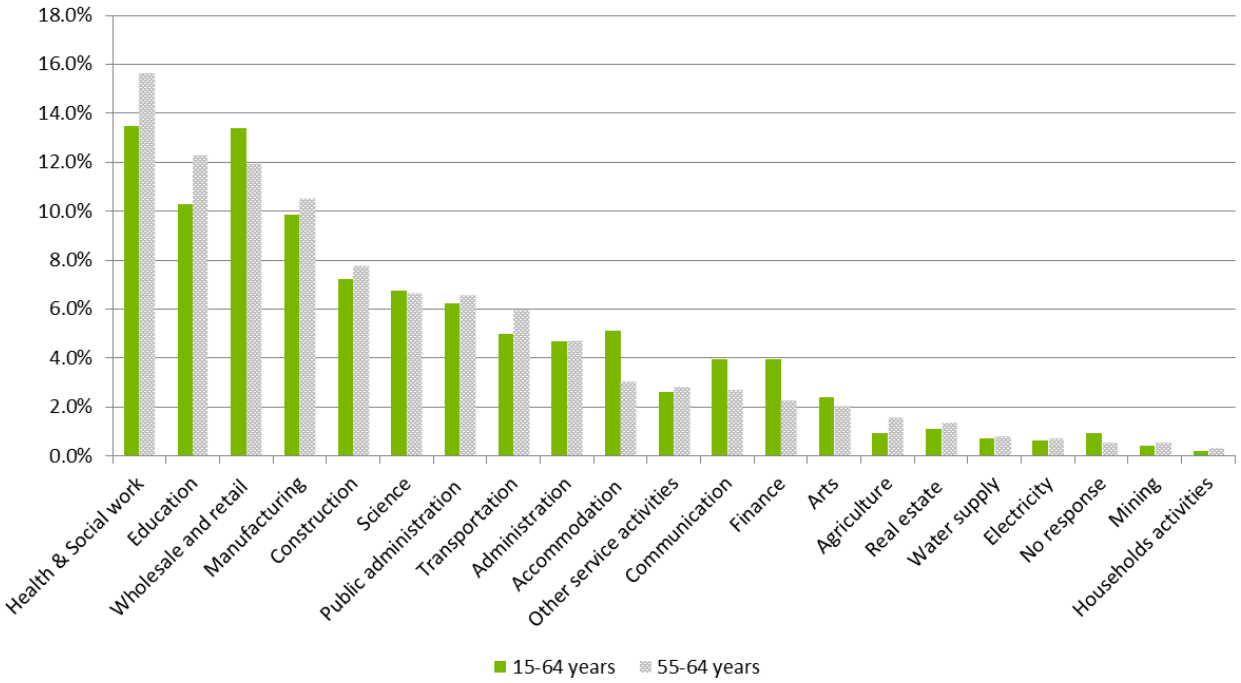
Source: Eurostat 2013, EU-LFS, annual detailed survey results, Employment rates by sex, age and nationality (%) [lfsa_ergan]

As can be seen in the graph below (fig.4), around 50% of workers in the United Kingdom of both age groups are working in four **sectors**: health & social work, education, wholesale and retail, and manufacturing (at least 10% of workers working in one of these sectors). Further important sectors are construction, science, public administration, transport and accommodation (between 5% and 10% of workers work in each, apart from accommodation, where the share of older workers is only 3%). Older workers are over-represented in health and social work, education, manufacturing, construction, and transport (to a lesser extent for the last three). They are under- represented in wholesale and retail, accommodation, communication, and finance.

[29] Office for National Statistics (2013) 'Pension Trends – Chapter 4: The Labour Market and Retirement, 2013 Edition', p.8.
[30] Ibid., p.12.

Furthermore, a literature review from 2005 found that "older individuals tend to be employed in occupations that vary substantially by gender and reflect traditional trends. In that, males are proportionally over-represented in managerial, professional, skilled trades, machine operative and elementary occupations and women are represented in administrative and elementary occupations with relatively few employed in skilled trades or machine operator occupations"[31].

Figure 4, Shares of workers employed in different sectors, by age groups "15 and above" and "55 to 64 years", 2012 (in %)

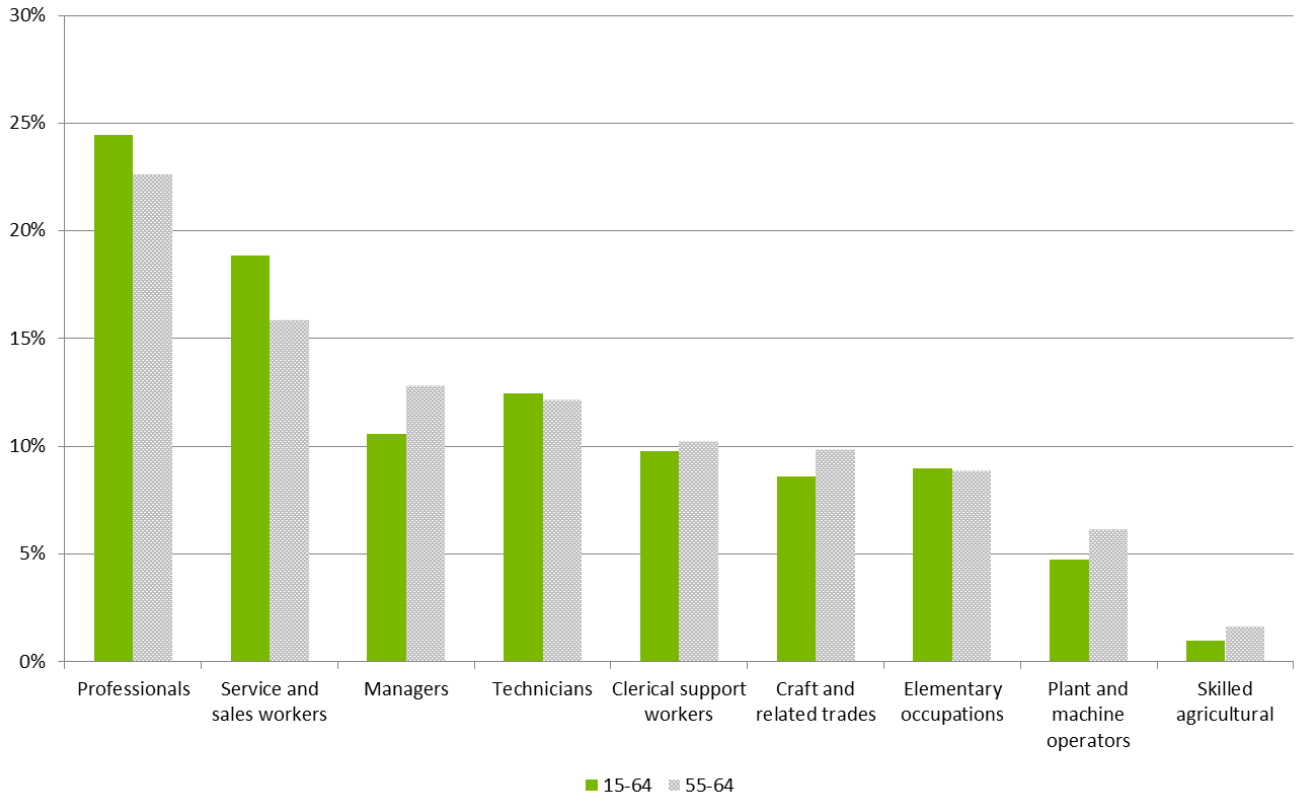


Source: EU-LFS, Employment by sex, age and economic activity (from 2008 onwards, NACE Rev. 2) - [lfsa_egan2]; shares refer to total number of workers in above-mentioned sectors; * figures for the age group 55 to 64 years are unreliable; sector labels were abbreviated for presentation purposes.

As shown in fig.5, **professional occupations** and employments service and sales are most important among United Kingdom employees. However, older workers are slightly under-represented in both occupations. They are, on the contrary, over-represented among managers and among craft and related trade workers.

[31] Health and Safety Laboratory (2010) 'Ageing and work-related musculoskeletal disorders. A review of the recent literature', p. 5.

Figure 5, Distribution of employed persons across different occupations, by age groups "15 and above" and "55 to 64 years"; shares from total employed persons per age group, 2013 (in %)



Source: Eurostat, EU-LFS, Employment by sex, age, professional status and occupation (1 000) [lfsa_egais]
* no data available (for both or one age group)

Gender gap

Women are less likely to be employed than men in the United Kingdom. This gender gap in employment rates can be seen in all age groups although it has been reducing continuously for the past decade. In 2003, the gender gap for the 55-64 year-olds age group was 18.5 p.p., while in 2012 it was 14 p.p. among the 25-54 year-olds age group the gender gap dropped from 14p.p in 2002 to 11.5 p.p. in 2013[32].

1.1.3 Working conditions

Based on the Fifth European Working Conditions Survey (5th EWCS), carried out by the European Foundation for the Improvement of Living and Working Conditions (Eurofound) in 2010,[33] the following conclusions can be drawn with regard to the working conditions of older workers[34] in the United Kingdom::

- In the United Kingdom, the share of workers having to *carry heavy loads* for at least a quarter of the time decreases with age: from 42% among younger workers[35], to 36% among workers aged 30 to 49 to 31% of older workers (EU-27: 32% among older workers).
- The share of workers who report having to work in *tiring or painful positions* for at least ¼ of the time increases with age, mainly after the age of 30 (19% among young workers, 22%

[32] Eurostat 2013, EU-LFS, annual detailed survey results, Employment rates by sex, age and nationality (%) [lfsa_ergan]
[33] Unless otherwise mentioned, all of the following figures come from the European Working Conditions Survey, 2010, http://eurofound.europa.eu/surveys/ewcs (Accessed December 2014)
[34] The term "older workers" in this section refers to workers aged 50 years and above, the term "young workers" refers to workers below 30 years.
[35]The term "older workers" in this section refers to workers aged 50 years and above, the term "young workers" refers to workers below 30 years.

among 30-49 year olds and 27% among older workers). However, for older workers, it is lower in the United Kingdom than across the EU-27 (27% and 32%, respectively).

- The share of United Kingdom older workers who are exposed to *night work* is slightly higher than the EU average (20% in the United Kingdom, 16% across the EU-27). The share of workers having to *work shifts* decreases with age, although mainly after the age of 30. The share of older workers having to work shifts is similar in the United Kingdom than across the EU-27 (13% and 14%, respectively).
- The share of United Kingdom workers who think their *working hours fit well or very well with their private life* increases slightly after the age of 50 (86% of 30-49 year olds think this, and 91% of older workers). This share among older workers is higher than the EU-average (84.5%).
- As in most other EU Member States, the share of people reporting three or more *external constraints on their work pace* (such as demands from people or production/performance targets) decreases with age in the United Kingdom: 51% of young workers report that at least three external factors determine their work pace against only 36% of older workers (however, this share is considerably higher than the EU-27 average of 27% of older workers) [36].
- The share of workers receiving *on-the-job training* decreases considerably after the age of 50 (48% of 30-49 year olds against 34% of older workers). However, for older workers, it is considerably higher in the United Kingdom than across the EU (34% and 26%, respectively).
- The share of older workers who think their *work negatively affects their health* is much lower than the EU average (15% and 27%, respectively).
- The share of older workers in the United Kingdom who are *satisfied or very satisfied with their working conditions* increased between 2000 and 2010 by 6 p.p. to 94% and is a lot higher than the EU average (84%).
- In addition, the share of older workers who think they will be *able to do the same job at the age of 60* is a lot higher than the EU average (85% and 71%, respectively).
- Finally, in the United Kingdom, 52% of employed people and people with working experience indicated that *measures to adapt the workplace for older people* had been put in place at their workplace (compared to 31% at EU-28 average) while only 38% responded that such measures had not been put in place (compared to 62% EU-28 average)[37].

1.1.4 Health

In 2011, **life expectancy** in the United Kingdom at the age of 50 was 31.2 years for men (EU-28: 29.7), 34.4 for women (EU-28: 34.5) and at the age of 65 it was 18.5 years for men (EU-28: 17.8) and 21.1 for women (EU-28: 21.3)[38]. Since 2005, life expectancy has increased by 1.5 years on average for both ages and gender groups.

In the United Kingdom, men at the age of 50 can expect around 21 more **healthy life years** and women at the same age around 22 more healthy life years (17 for men and 18 for women on EU-average). At the age of 65, men in the United Kingdom can expect around 11 more healthy life years and women 12 (9 years on EU-average). The amount of healthy life years at both ages has not increased a lot (by less than one year) for both genders between 2005 and 2011.

General health status

The **general health status** of the population in the United Kingdom and across the EU is summarised in Table 8. Self-perceived health status deteriorates with age: while among 45 to 54-year-old employed workers the share of those who report a very bad or bad health status is only 3.3%, it increases to 5.1% among 55 to 64-year-old and to 11% after 65. The health status among the population in the United

[36] The index measures if any of the following factors determine the worker's pace of work: work done by colleagues, demands from people, production or performance targets, speed of a machine, direct control of a boss; shares refer to workers reporting that their work is determined by three or more of these factors.
[37] European Commission, Flash Eurobarometer on Working Conditions, fact sheet for UK, as above.
[38] Source: Eurostat 2013'Life expectancy by age and sex' [demo_mlexpec].

Kingdom is very similar to the EU averages, except for people aged 65 years and above: for this age group, among the employed, the health status is slightly worse than EU average (11% reporting "bad" or "very bad" health status).

Table 8, Self-perceived health among employed in different age groups, 2012; shares of age group reporting "very bad" or "bad" health status (in %)

	16-44 years	45-54 years	55-64 years	65 years and above
Employed	1.6%	3.3%	5.1%	11%

Source: EU-SILC Self-perceived health by sex, age and labour status (%) [hlth_silc_01]
* the figure for "very bad" is missing due to unreliability; thus, this only represents respondents under "bad" health status

The prevalence of **long-standing illnesses** (according to self-reported information) shows the same pattern as the general health status: the unemployed report higher rates than employed people and long-standing illnesses increase with age. The prevalence of long-standing illnesses among the employed is at a very similar level to the EU average. However, a larger share of employed 65-year-olds and above report long-standing illnesses in the United Kingdom than the EU average (51% and 43%, respectively).

Table 9, Long-standing illness by age group, 2012 (in %)

	25-34 years	35-34 years	45-54 years	55-64 years	65 years and above
Employed	12.8%	18.5%	25.6%	33.8%	50.9%

Source: EU-SILC, People having a long-standing illness or health problem, by sex, age and labour status (%) [hlth_silc_04], 2012.

Work-related health

Although **work-related health problems** increase with age in the United Kingdom, the share of workers aged 55 to 64 years who report that they suffered from one or more work-related health problem in the past 12 months was a lot lower in the United Kingdom (around 7%) than across the EU (16%) in 2007 (table 10). This somewhat corresponds to the results from the EWCS mentioned above, that a lower share of older workers think that their work negatively affects their health (see page 15).

The increase in illnesses with age is also reflected in sickness absence rates: "For workers aged between 16 and 34 around 1.5 per cent of hours were lost to sickness in 2011 compared with around 2.5 per cent of hours lost for workers aged 50 to 64. Workers aged 65+ lose a lower percentage of hours to sickness because those with health problems are more likely to have left the labour market" (ONS, 2012)[39].

Table 10, Self-reported work-related health problems by workers in the United Kingdom and EU-27, by age group

Age group	Share
United Kingdom 25-34 yrs	3.1%
United Kingdom 35-44 yrs	4.5%
United Kingdom 45-54 yrs	**5.7%**
United Kingdom 55-64 yrs	**6.9%**

[39] Office for National Statistics (April 2012) 'Sickness Absence in the Labour Market', p.2.

Age group	Share
United Kingdom 55-64 yrs men	***7.8%***
United Kingdom 55-64 yrs women	***6%***
EU-27* 55-64 yrs	**11.4%**

Source: EU LFS ad-hoc module 2007 on accidents at work and work-related health problems, Persons reporting one or more work-related health problems in the past 12 months, by age - % [hsw_pb1]
*the EU-27 average is calculated without France, as, due to different question wording, their results are not comparable to other countries

Like in many other EU Member States, musculoskeletal disorders was the **most serious work-related health problem** reported by the largest share of workers, among all age groups, in the United Kingdom in 2007 (table 11). This is followed by psychological illnesses (stress, depression, anxiety), pulmonary disorders and then cardiovascular disorders, the latter two however being reported much less often. This order does not change with age, although musculoskeletal disorders become more frequently reported and psychological disorders become less frequently reported with age.

Table 11, Most serious work-related health problem during the past 12 months, % of all employees who reported a work-related health problem during the past 12 months; by gender and by most prevalent types of diseases[40], 2007

		Cardiovascular disorders	Musculoskeletal disorders	Stress, depression, anxiety	Pulmonary disorders
35-44 yrs.	**Total (EU-27*)**	1.2% (2.9%)	48.8% (60.9%)	33.3% (16.4%)	3.2% (4.9%)
	Women	0.9%	45.4%	38.8%	2.3%
	Men	1.5%	51.7%%	28.5%	4.1%
45-54 yrs.	**Total (EU-27*)**	2% (6.2%)	51.7% (61.3%)	31.2% (13.5%)	3.5% (4.7%)
	Women	0.9%	49.1%	36.4%	3.1%
	Men	3.1%	54.3%	26%	3.9%
55-64 yrs.	**Total (EU-27*)**	4.1% (11.3%)	58.5% (59.9%)	19.5% (9.2%)	6.8% (5.8%)
	Women	2.5%	64.7%	22.1%	2.3%
	Men	5.4%	53.7%	17.4%	10.3%

Source: EU LFS ad-hoc module 2007 on accidents at work and work-related health problems, Persons reporting their most serious work-related health problem work in the past 12 months, by type of problem - % [hsw_pb5] the module distinguishes 8 different problems in total.
*this figure is for the EU-26 without France. Due to different wording in the French version of the questionnaire, the results were very different in France and Eurostat recommends to useusing the aggregate figures without France

Mental health

Psychological illnesses are reported much more often in the United Kingdom than the EU average: in 2007, 31% of 45 to 54-year-old workers reported that their most serious work-related health problem was a psychological disease in the United Kingdom (19% for the EU population), for the older workers (55 to 64 years), the shares were 20% in the United Kingdom and 12% in the EU.

[40] More recent figures are available (EU-LFS ad-hoc module 2013); however, several countries have not delivered data for 2013, which is why no EU aggregates for this variable could be calculated. Due to these limitations, the 2007 data was used in this report. Data for 2013 can be obtained from Eurostat, available at: http://ec.europa.eu/eurostat/web/lfs/data/database

Furthermore, psychological illnesses reported as the most serious health problem are more prevalent among women than among men (for all ages), while musculoskeletal, cardiovascular and pulmonary disorders are more prevalent among men.

1.1.5 Definition of an older workers

"Older workers" are not defined formally in the United Kingdom, although most documents, research studies and publications take 50 and over as the definition (although often it is not clear whether the term is "over 50" or "50 and over").

1.2 Institutional structure for health and safety at work

The following section presents the overall institutional structure related to occupational health and safety in the United Kingdom.

Overall structure

A schematic overview of the main stakeholders for health and safety at work in the United Kingdom can be found on page 25.

Regulation/enforcement

The **Health and Safety Executive (HSE)**[41]**,** the lead regulator in Great Britain (England, Scotland, Wales), is concerned almost exclusively with OSH, and, unlike in other member states, has virtually no involvement in issues to do with general conditions of work, such as salaries, hours of work, or illegal employment, although it liaises when necessary with other government or public sector organisations who have these responsibilities. It is classed as a Non-Departmental Public Body (NDPB) sponsored by the Department for Work and Pensions (DWP).

The HSE has an oversight of OSH in relation to almost all work activities and direct responsibility in all conventional areas including onshore industry, such as manufacturing, construction, mining and agriculture; the offshore industry; major hazards onshore; and the public sector, including the emergency services. There are ongoing activities to streamline OSH legislation in the United Kingdom, and debates on the OSH system have extended to discussing the role and function of HSE.

While Northern Ireland has separate laws from mainland United Kingdom, for health and safety they are usually similar and the **Health and Safety Executive for Northern Ireland (HSENI)**[42] has similar responsibilities and works closely with the HSE.

Every three years the government commissions an independent review of NDPBs, and the most recent Triennial Review Report on HSE was published in January 2014[43]. The leader of the review, Martin Temple, concluded "my report necessarily sets HSE in a very positive context, reflecting the nearly universal praise from those who responded to this Review. My view is that this support for HSE is a reflection of the impartiality and independence it maintains in its regulatory and other work, in addition to the professionalism and technical competence of its staff." But he recognises that improvements are necessary in certain areas and goes on to make a number of recommendations for improvement in the way HSE performs its functions. The Government's response[44] is also relevant.

Throughout the United Kingdom, responsibility for **enforcement** of OSH legislation is shared between HSE and local authorities (municipal governments).

[41] HSE web site: http://www.hse.gov.uk/ (Accessed December 2014).
[42] HSENI web page: http://www.hseni.gov.uk/ (Accessed December 2014).
[43] Triennial Review Report on HSE: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/275233/hse-function-form-governance-triennial-review.pdf (Accessed December 2014).
[44] Triennial Review Report on HSE, Government response: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/323221/govt-resp-triennial-review-hse.pdf (Accessed December 2014).

Work-accident insurance

Compensation for the recognised list of occupational accidents and diseases is dealt with in the United Kingdom through **Industrial Injuries Disablement Benefit (IIDB)**. The United Kingdom has no equivalent to the major accident insurance associations which play a significant role in OSH and prevention in other Member States. Under the provisions of the Employers' Liability (Compulsory Insurance) Act 1969, employers are required to insure against liability for injury or disease to their employees arising out of their employment. Further details are given in Section 3.1.

General employment conditions and labour relations

The **Department for Work and Pensions** (DWP) is responsible for everything related to employment and labour relations, pensions and welfare. The ageing society in general is a key topic of concern to the DWP, for example in relation to the changes in the pension system.

More specifically, for the past 10 years, the DWP has been coordinating the cross-governmental "Health, Work and Wellbeing" initiative, which aims to improve the general health and wellbeing of the working-age population as a whole, and to support more people with health conditions to stay in work or enter employment[45]. HSE's relationship with "health work and wellbeing" was also considered in the Triennial Review of HSE and the Report expressed the view that "HSE should be prepared to actively engage with other public bodies that are developing wellbeing programmes. HSE's role should be supportive of wellbeing and wider public health programmes, where it is able. But promotion of those agendas is not its core responsibility. It may have to challenge other public bodies if they inadvertently misrepresent what health and safety law does and doesn't require.".

Even more specifically to this project, on 13 June 2014, DWP published "Fuller Working Lives – a Framework for Action" which outlines the business case for fuller working lives, along with important background papers. This Framework will constitute an important signpost for future Government action on this topic, although it has not yet been possible to analyse the Framework and supporting papers in any detail. Further information is given in Section 2.1.1.

There are two United Kingdom advisory bodies on ageing which have formal links to the DWP: the **Age Action Alliance**[46] (AAA) and the **United Kingdom Advisory Forum on Ageing**[47]. The difference between the two organisations can be summarised as follows[48]: "The Age Action Alliance is an independent alliance of organisations, which has adopted a new approach to the problems of ageing, focussed very clearly on finding practical means to establish social justice for older people. The United Kingdom Advisory Forum on Ageing is a strategic forum with a broad remit, providing a unique and wide ranging advisory function to the Government on all aspects of the ageing agenda". It comprises representatives from organisations that work with and for older people, regional representatives from older people groups, devolved nations and government offices, and older people themselves.

The **Advisory, Conciliation and Arbitration Service** (Acas) is a Non-Departmental Public Body largely funded by the Department for Business, Innovation and Skills, (BIS) which aims to improve organisations and working life through better employment relations by supplying up-to-date information, independent advice and high quality training, and working with employers and employees to solve problems and improve performance.

Public Health

General health policy, including health promotion, is devolved to **Health Departments** in the four countries of the United Kingdom and the **National Health Service.**

[45] More information about the policy "Helping people to find and stay in work" on the website of the UK government: https://www.gov.uk/government/policies/helping-people-to-find-and-stay-in-work/supporting-pages/co-ordinating-the-health-work-and-wellbeing-initiative (Accessed December 2014).
[46] Age Action Alliance, home page: http://ageactionalliance.org/ (Accessed December 2014).
[47] UK Advisory Forum on Ageing, DWP: https://www.gov.uk/government/policy-advisory-groups/uk-advisory-forum-on-ageing (Accessed December 2014).
[48] Yorkshire and Humber Regional forum on ageing, Age Action Alliance: http://www.futureyears.org.uk/age_action_alliance/clarification_between_aaa_and_ukafa/ (Accessed December 2014).

OSH research

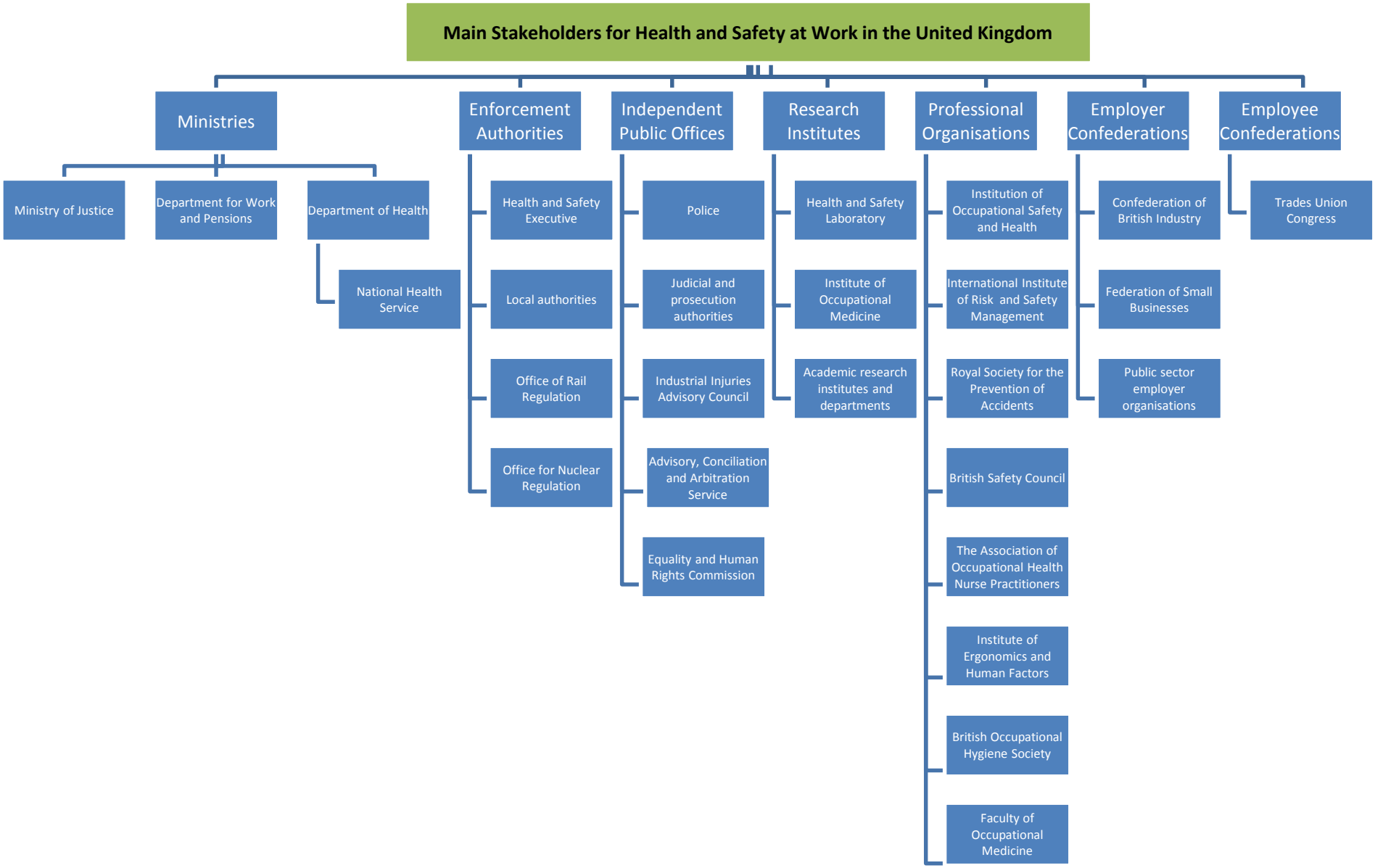
The **Health and Safety Laboratory (HSL)**[49], which is an independent agency of the HSE, is the principal OSH research and testing laboratory in the United Kingdom. HSL employs over 350 scientific, medical and technical specialists engaged in health and safety research, expert advice and consultancy, specialist training and incident investigation. Universities and research organisations, such as the Institute of Occupational Medicine IOM), also carry out a wide range of OSH research, including projects for HSE, the European Commission, the World Health Organisation and other international organisations. The United Kingdom does not have the range of semi-state research institutions nor the range of OSH consultancies which seem to be relatively common in other Member States.

Other players

A wide range of other players are active in the United Kingdom OSH environment. There are a number of **professional organisations** such as the Institution of Occupational Safety and Health (IOSH), the International Institute of Risk and Safety Management (IIRSM), the Faculty of Occupational Medicine, the Association of Occupational Health Nurse Practitioners. **Charities** (NGOs) active in a wide range of campaigning and training include The Royal Society for the Prevention of Accidents (RoSPA), and the British Safety Council (BSC); the National Examination Board for Occupational Safety and Health (NEBOSH) which sets the standards for OSH training; and the British Standards Institution (BSI).

[49] HSL web site: http://www.hsl.gov.uk/about-hsl (Accessed December 2014).

Figure 6, Main stakeholders for OSH in the United Kingdom - *Source: diagram prepared by the authors of this report*[50]



[50] Certain areas of activity, such as health and justice are devolved in the four nations of the UK, but for simplicity, the diagram only illustrates the England position in those areas of activity.

Social dialogue

Both HSE and HSENI are governed by Boards drawn from the social partners and independent interests.

The main **employer groups** are the Confederation of British Industry (CBI), which tends to represent the larger employers, and the Federation of Small Businesses (FSB), which tends, as its name suggests, to represent SMEs.

The **umbrella group for workers** is the Trades Union Congress (TUC) which represents trade unions. It should be noted that, according to the OECD, trade union density[51] has decreased in the United Kingdom – as it has in all OECD countries, from 36.4% of all employees in 1993 to 25.4% in 2013, but still remains above the OECD average (16.9% in 2013).[52]

HSE has a non-executive Board which at present consists of the Chair plus employer, trade union and municipal government representatives and an independent academic. The HSENI Board consists of the Chair plus eight members, most of whom have a high-level employer background.

1.3 Labour, OSH and anti-discrimination legislation

The following section provides a brief overview of the main pieces of legislation in the fields of occupational health and safety, labour and employment and anti-discrimination and whether they contain any provisions in relation to older workers.

Occupational health and safety

Compared with most MS, the law on OSH in the United Kingdom is more widely drawn. The enabling law, the Health and Safety at Work Act 1974, applies to employers, the self-employed and others, as well as to risk to members of the public from work activities. The legislation relating to health and safety at work is common across Great Britain. Northern Ireland has separate legislation which closely matches the Great Britain legislation. In each jurisdiction, there is a wide range of supporting law implementing relevant EU Directives, and other OSH topics.

Labour law

There is a wide range of law in the United Kingdom on issues such as the National Minimum Wage; employment contracts and working hours; holidays and time off; redundancies, disciplinary action and dismissal; and joining a trade union[53].

Anti-discrimination

The Equality Act 2010[54] legally protects people from discrimination in the workplace and in wider society (including on the basis of age or disability). It replaced previous anti-discrimination laws (including the Employment Equality (Age) Regulations of 2006) with a single Act, making the law easier to understand and strengthening protection in some situations. It includes provisions that ban age discrimination against adults in the provision of services and public functions. The ban came into force on 1 October 2012 and it is now unlawful to discriminate on the basis of age although it does not outlaw the many instances of different treatment that are justifiable or beneficial. Amongst other provisions, the Act includes a public sector Equality Duty which means that public

[51] Trade union density corresponds to the ratio of wage and salary earners that are trade union members, divided by the total number of wage and salary earners (OECD *Labour Force Statistics).*Density is calculated using survey data, wherever possible, and administrative data adjusted for non-active and self-employed members otherwise (OECD)

[52] OECD (Online OECD Employment database: http://www.oecd.org/els/emp/onlineoecdemploymentdatabase.htm#union (Accessed December 2014).

[53] See guidance on "Working, jobs and pensions" on Government website: https://www.gov.uk/browse/working (Accessed December 2014).

[54] The Equality Act 2010, Department of Culture Media and Sport webpage: https://www.gov.uk/equality-act-2010-guidance (Accessed December 2014).

bodies, including HSE, have to consider all individuals when carrying out their day-to-day work – in shaping policy, in delivering services and in relation to their own employees. The Equality Act does not apply in Northern Ireland, but consideration is being given there to urgent legislative reform.

1.4 The pension system

The State Pension arrangements in the United Kingdom are the responsibility of the United Kingdom Central Government through the Department for Work and Pensions (DWP). A lot of changes are happening in this area and getting an overview of the current position can be difficult; this DWP web page[55] "Pensions and ageing society" is a good starting point.

There are three general approaches to pensions in the United Kingdom:

- the state pension scheme
- workplace pension schemes (for employees)
- self-organised pensions (for the self-employed or those not eligible for workplace schemes).

State pension

The State Pension Age (SPA) is currently 65 for men and, for women, it is moving gradually to 65 by 2018. It will move to 66 for both men and women by 6 October 2020, to 67 by 6 April 2036 and to 68 by 6 April 2046, although the government has made proposals for this timetable to be accelerated. The basic state pension of £110.15 (2013/14) is paid if the pensioner has made the equivalent of 30 years national insurance contributions or credits; a proportional pension is paid to those who have fewer than 30 years of contributions. An Additional State Pension (ASP) may also be paid, which relates to contributions made under previous supplementary pension arrangements or under current State Second Pension (S2P) arrangements; the pension paid under this element is based upon earnings/contributions.

There is no provision to take the State Pension early, before SPA. The changes to the State Pension, and the associated changes to private pension schemes, have prompted a Trade Union-led campaign against the changes "68 is too late"[56].

Workplace pension

Workplace pension schemes have up until now been provided by many employers; however, that provision has not been compulsory, but will be by 2018. Workplace schemes are generally either "defined benefit" or "defined contribution" although the last ten years has seen a shift away from the "final salary" defined benefit schemes, amidst substantial controversy. Some workplace schemes may be "contract-based"; i.e. the employer arranges for an outside provider to make the pension arrangements. Those who are enrolled in workplace or private pension schemes may also be able to take advantage of pension-related benefits such as early retirement, ill-health retirement, life insurance, income protection and dependants' benefits. Before 2006, certain professions such as the police, the armed forces or the fire service could receive their pension at age 50 (or after 30 years of contributions), but since then, the retirement age under such schemes has generally risen to 60.

Self-organised pension

Contract-based systems are also the basis on which self-employed people and individuals can self-organise their pension arrangements, through a number of different types of pension scheme.

[55] DWP, "Pensions and ageing society": https://www.gov.uk/government/topics/pensions-and-ageing-society (Accessed December 2014).
[56] Pensions campaign: http://www.68istoolate.org.uk/pages/too-long-to-work (Accessed December 2014).

2 Overview of policies, strategies and programmes in relation to the occupational health and safety of older workers

As life expectancy rises, it is important to create working conditions that enable healthy and active ageing and ensure that workers reach pension age in good health. The following chapter provides an overview of the various policies, programmes and initiatives put in place by governmental and non-governmental organisations in the United Kingdom to address the issue of work sustainability and healthier working lives.

2.1 Initiatives from government/ government-affiliated organisations

2.1.1 National level

Diversity (including disability and older workers)

The Health and Safety Executive (HSE)'s activities on older workers and workers with disabilities are grouped together with activities on all vulnerable workers (defined as workers who are at risk of having their workplace entitlements denied, and who lack the capacity or means to secure them). The HSE developed what can be termed a single framework policy on equality and diversity which has been used to steer its specific activities on vulnerable workers, including older workers and disability.

The Equality Act 2010 and prior legislation on equalities has underpinned the HSE's policy development and activities on vulnerable workers (see Section 1.3). The HSE's general approach is to ensure that consideration of diversity issues, including age and disability, is embedded into working practice and that employers assess such impacts during decision-making. It should be noted, however, that following a statement from the Prime Minister in December 2012, formal Equality Impact Assessments are no longer carried out, though equality impacts are still considered when policies and initiatives are under development. An important part of the HSE's approach on diversity is developing and expanding external working relationships and cooperation. The HSE works on an ongoing basis with the Department for Work and Pension (DWP)'s Age Positive campaign (see section below on "employment policies"), and other stakeholders which includes promoting key messages and guidance on OSH and ageing to a wide number of stakeholders.

The HSE previously developed a single framework, its **Single Equality Scheme**, to address the areas covered by the Equality Act, which includes age and disability The Scheme included a number of actions related to **disability** and the management of disability in the workplace, e.g. through raising awareness of risk assessment for disabled employees and signposting employers to guidance on reasonable adjustments in the workplace. However, the Single Equality Scheme has now been superseded by the HSE's "**Diversity action plan – 2012 onwards"**[57], which includes internal staff action commitments and external objectives, some focussing on younger workers, and one on improving the access to health advice of older workers in the agricultural sector. This resulted in a discussion with the Department for Environment Food & Rural Affairs (Defra) on the provision of occupational health services in rural areas and the creation of a new Farm Safety Partnership ill-health working group, which, it is hoped, will look at this issue.

Health and safety at work

Previous HSE **National OSH strategies** highlighted diversity and recognised that care should be taken to acknowledge differences within populations. The latest strategy "The Health and Safety of

[57] HSE Diversity action plan - 2012 onwards: http://www.hse.gov.uk/equality-duty/diversity-action-plan/index.htm (Accessed December 2014).

Great Britain\\Be part of the solution"[58] (BPoS) which was published in June 2009 sets very broad, high-level goals. It does not include any reference to the ageing working population, to age or to the concepts of work ability and workplace health promotion, although it acknowledges that "the practice of health and safety must continually evolve to accommodate diversity within the population". Nor does it discuss specific health issues such as musculoskeletal disorders or stress. With respect to setting health priorities and establishing the most effective delivery mechanisms, it states that collaboration is required to establish who should deal with specific issues, and that key among those issues is how best to manage the interface between work and the other factors that may be impacting on a person's health. This point could be relevant to older workers.

A number of "**Sector strategies**" lie under the main OSH strategy. The sector strategy of the **offshore oil and gas industry**[59] expresses concern about the challenges in attracting and keeping experienced people in the industry (where the average age is said to be 41). A lot of emphasis is placed on the need for technical and managerial competence, but without any concrete proposals on how more experienced workers could be kept in the industry. The **agricultural sector** strategy acknowledges that many people work or are involved in the industry past the age of 65 and that workers over that age are killed and injured on farms each year. The answer to this challenge is seen as a competency issue, to be dealt with through improved training and competence, particularly in the middle-aged and older sections of the farming community. The sector strategies for beauty (where there is a high proportion of younger workers), construction, and manufacturing do not refer to the age issue or to any age-related measures. The HSE "Diversity action plan – 2012 onwards" refers to action in relation to vulnerable workers in agriculture, and in meat and poultry processing.

The HSE website section devoted to vulnerable workers, includes managing questions of race and migrant workers, disabled people, gender issues, older workers, and workers new to the job. The more detailed guidance on the "Health and safety for older workers" page[60] identifies some of the evidence about ageing and gives relatively succinct guidance on what employers should look for when **employing older workers**. It also summarises some of the evidence and research and gives links to other sources of information, but it makes only limited reference to the available age management guidance. In particular, it suggests to employers to "think about the activities older workers do" as part of the overall risk assessment and to "consider whether any changes are needed. This might include:

- allowing older workers more time to absorb health and safety information or training, for example by introducing self-paced training.
- introducing opportunities for older workers to choose to move to other types of work.
- designing tasks that contain an element of manual handling in such a way that they eliminate or minimise the risk."

OSH in employment policies

Many of the other mainstream governmental activities/initiatives described below are mainly concerned with the employment of older workers rather than their health and safety, although they may touch upon the subject.

On 11 March 2015, the Department for Work and Pensions (DWP) published the review "**A new vision for older workers: retain, retrain and recruit**" produced by Dr Ros Altman CBE, appointed in July 2014 "Business Champion for Older Workers" by the United Kingdom government. Dr Altman's role in this position is to work with employers to understand the significant benefits of retaining and recruiting older workers. The review focuses on various employment-related issues that constitute barriers to people working longer, such as discrimination and stereotypes in recruitment and training. The report makes only limited mention of issues related to working conditions and health and safety at work. The only health issue that is explored in more details is

[58] HSE strategy, "Be part of the solution" and "One year on" review: http://www.hse.gov.uk/strategy/index.htm (Accessed December 2014).
[59] Offshore sector strategy, HSE: http://www.hse.gov.uk/aboutus/strategiesandplans/sector-strategies/offshore-oil-and-gas.htm (Accessed December 2014).
[60] "HSE Website: Health and safety for older workers: http://www.hse.gov.uk/vulnerable-workers/older-workers.htm (Accessed December 2014).

that of menopause. Several recommendations refer to the need to make age and skills audits in companies but are more related to skills management than to OSH and working conditions. One of the recommendations relates to the management of ill health and disabilities, encouraging the promotion of the "Fit for Work" services launched at the end of 2014. Finally, several references are made in the recommendations to the need for flexible working conditions to ensure better work-life balance.[61]

On 13 June 2014, DWP published "**Fuller Working Lives – a Framework for Action**"[62] which outlines the business case for fuller working lives, which means "working as long as is necessary to create the future you want". The Framework examines:

- Health conditions and disability
- Carers
- Back-to-work support
- Skills and workplace factors
- Financial security and incentives.

It looks at the wide range of actions which the Government is already taking and those that the Government will be taking forward. According to the document, the Government intends to set up a governance structure "to review and direct progress of the implementation of actions outlined in the Framework and identify further priority actions." This structure will include representatives from the relevant Government Departments, representatives of employers and employees, and employers themselves. It will also consider the involvement of the United Kingdom Advisory Forum on Ageing in the development of policies on fuller working lives. The Framework is supported by three other background papers (also accessible through reference 53), the first summarising the background evidence; the second providing the statistical reference tables and charts relating to the background evidence; and the third is a single sheet "infographic" setting out the main points in graphical form. The first two of these papers constitute the most up-to-date source of demographical and social information relating to older workers, and constitute an important resource for this Project. It has also not yet been possible to study these in detail.

The DWP approaches the theme of the **employment of older workers** from the policy perspective of "Helping people to find and stay in work" and has a dedicated extensive webpage[63] which presents the issue in the following terms:

"Long-term unemployment is damaging to individuals and communities, it affects mental and physical health, and holds back economic growth. We want to help people into work and make sure that work pays. In return, people on out-of-work benefits need to take the opportunities available to them to move off benefits and into work. Out of work older people can find it more difficult to get a job and they are more likely than younger people to remain unemployed for longer."

This webpage summarises the range of actions which the government is taking including managing the "**Work programme**" (which "provides personalised support for people of all ages who need more help to find and stay in work"), supporting young people and the disabled, coordinating the "Health, work and well-being" initiative (see Section 1.2), and helping older people who want to find and stay in work. It explains measures such as the ending of the default retirement age and the benefits in pension terms of working beyond state pension age. Also included are 17 case studies, all drawn from experience of the Work Programme, four of which relate to jobseekers aged 50 and over. All four illustrate the value of individual support in getting people back into work but, although many of the case studies appear to involve an element of mental health support, the kind of support described does not have any other OSH focus.

[61] Altmann, R., A new vision for older workers: retain, retrain and recruit, Report to the Government, Department for Work and Pensions, 11 March 2015. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/411420/a-new-vision-for-older-workers.pdf (Accessed May 2015)

[62] DWP, "Fuller Working Lives: a framework for action", available at: https://www.gov.uk/government/publications/fuller-working-lives-a-framework-for-action (Accessed December 2014).

[63] "Helping people to find and stay in work" webpages, DWP: https://www.gov.uk/government/policies/helping-people-to-find-and-stay-in-work (Accessed December 2014).

The DWP **Age Positive** initiative[64] "brings together research and information from employers on effectively managing an ageing workforce of all generations". The objective of the Age Positive Campaign is to increase awareness of employers on health and safety issues related to age and provide them with guidance and support regarding the type of measures and actions that can be put in place to retain older workers. It is complemented by two DWP publications "Employing older workers – An employer's guide to today's multi-generational workforce"[65] and "Employer case studies – Employing older workers for an effective multi-generational workforce"[66]. The employer's guide concentrates more on the *process aspects of employing older workers*, and although it mentions the needs for adjustments, it does not go into the practicalities in any detail. The case studies document provides *32 case studies from a wide range of industry sectors* (including details of McDonalds and South Wales Forgemasters cases – see below). The cases are all relatively new (from 2011 onwards) and form a substantial resource of actual experience of managing older workers.

- The McDonalds case study describes its positive policy to recruit older staff members and its "Family and Friends Contract". This is said to be a United Kingdom first, ground-breaking scheme, which allows family and friends working in the same restaurant to share and cover each other's shifts (with no prior notice required). It is designed to help McDonalds' diverse range of employees to juggle their work and personal lives, and benefits all ages, including its older workers.
- The South Wales Forgemasters case study describes how the company decided to deliver more flexible training to make older workers feel more comfortable, as there was a certain reluctance from these workers to undertake training.

The DWP is leading on a number of reforms at present, which will have an impact upon the employment of older workers, including "Fuller Working Lives – A Framework for Action", and as part of that reform, DWP is seeking to draw together relevant governmental policies, such as the Disability and Health Employment Strategy, the refreshed Carers Strategy (both due to be published in 2014), the extended right to request flexible working from June 2014, the new Fit for Work Service from December 2014, and the current Mid-Life Career Review pilots.

Research

The HSE takes an evidence-based approach to its activity development and another thread of the HSE's OSH and diversity work is its **research programme,** managed through the Health and Safety Laboratory and other research organisations. The first HSL research report on older workers concerning facts and misconceptions, published in 2006, was jointly commissioned by the HSE and the DWP and used by the DWP to prepare employers for the 2006 Employment Equality (Age) Regulation.

More recent HSL research includes a report from 2010, entitled "**Ageing and work-related musculoskeletal disorders**"[67], an update report from 2011, entitled "**An update of the literature on age and employment**"[68] and a report from 2012, which deals with "**Age related changes and safety critical work – Identification of tools and a review of the literature**"[69]. Although this last report deals mainly with safety critical work and major/high hazard industries, it is also of general

[64] "Age positive" guidance, DWP: https://www.gov.uk/government/collections/age-positive (Accessed December 2014).
[65] "Employing older workers - An employer's guide to today's multi-generational workforce", DWP: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/142751/employing-older-workers.pdf. (Accessed December 2014).
[66] DWP, *Employer case studies - Employing older workers for an effective multi-generational workforce*, 2013. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/142752/employing-older-workers-case-studies.pdf (Accessed December 2014).
[67] HSL/HSE, *Ageing and work-related musculoskeletal disorders – A review of the recent literature* (RR799), 2010. Available at: http://www.hse.gov.uk/research/rrhtm/rr799.htm (Accessed December 2014).
[68] HSL/HSE, *An update of the literature on age and employment* (RR832), 2011. Available at: http://www.hse.gov.uk/research/rrhtm/rr832.htm (Accessed December 2014).
[69] HSL/HSE, *Age related changes and safety critical work - Identification of tools and a review of the literature* (RR946), 2012. Available at: http://www.hse.gov.uk/research/rrhtm/rr946.htm (Accessed December 2014).

relevance in judging whether workers have the functional capacity to work to the required level of safety performance.

Initiatives from other government-affiliated organisations

The **Age Action Alliance** (AAA – see Section 1.2) has a specific "*Healthy workplaces*" group, which meets two or three times a year on a self-financing basis. Amongst other materials, the group has produced a "Healthy and Productive Workers" leaflet[70] which gives ten tips for action, and guidance on measuring success. It has also produced an *online toolkit* "Managing the health & productivity of an ageing workforce: solutions to employer questions"[71]. The toolkit contains numerous links to existing guidance under some principal themes such as "Good health and well-being", "Health and safety" and "Work adaptions" which is under review.

The **United Kingdom Advisory Forum on Ageing** (UKAFA) comprises representatives from organisations that work with and for older people, regional representatives from older people groups, devolved nations and government offices, and older people themselves. It has a broad remit to address the opportunities and challenges of an ageing society and give advice and support to the Government and comment on policy ideas, for example, concerning the implementation and development of the Government's strategy for *older people and an ageing society*, "including helping people to live well in later life – (by) continuing to work, through volunteering or remaining active in their community or within their family". The UKAFA has considered issues such as unemployment and employment opportunities for people over 50 but its main focus appears to be on older people in society at large.

The **Advisory, Conciliation and Arbitration Service** (Acas – see Section 1.2) has published a comprehensive guide to the implications of the *Equality Act for age-related management issues*: "Age and the workplace – Putting the Equality Act 2010 and the removal of the default retirement age (DRA) 2011 into practice"[72]. Although this is quite a legally-focussed management guide, it emphasises many of the practical organisational changes that can be made to *help older people stay in work*, and alerts employers to the pitfalls that can occur if age-related issues are not managed in a holistic manner.

The **Equality and Human Rights Commission** (EHRC – see Section 3) maintains a website with many useful guidance documents on diversity for decision-makers and the general public as well as guidance on how to approach diversity (including age-related diversity) in the workplace for employers and workers. In the second phase of its campaign "Working Better", it developed a specific initiative in 2010 targeting +50 workers. In addition to its publication "Working Better – The over 50s, the new work generation"[73], the EHRC published a number of documents:

- The research report 'Older workers: employment preferences, barriers and solutions', which includes a review, stakeholder and employer interviews and survey findings of 1,500 people aged 50-75 years.
- The policy briefing 'Working Better - The over 50s, the new work generation', which contains findings, recommendations and practical solutions for government and employers.

[70] "Healthy and Productive Workers" leaflet, AAA: http://ageactionalliance.org/wordpress/wp-content/uploads/2013/04/AAA-Healthy-Workplaces-leaflet-final-2013-05-01.pdf (Accessed December 2014).
[71] "Managing the health & productivity of an ageing workforce: solutions to employer questions", AAA: http://ageactionalliance.org/wordpress/wp-content/uploads/2013/11/Employers-Toolkit2.pdf (Accessed December 2014).
[72] Acas, *Age and the workplace*, 2011. Available at: http://www.acas.org.uk/media/pdf/i/1/Age-and-the-Workplace-a-guide-accessible-version-July-2011.pdf (Accessed December 2014).
[73] "Working Better - The over 50s, the new work generation", EHRC: http://www.equalityhumanrights.com/advice-and-guidance/working-better/the-over-50s/ (Accessed December 2014).

2.1.2 Devolved administrations/regional initiatives

Northern Ireland

The **HSENI strategy** "Health and safety at work: protecting lives, not stopping them"[74], has, as its fifth goal, to "Assist in highlighting the needs of *vulnerable groups* to ensure that their needs are recognised and managed within the workplace". This theme is also picked up in the "Corporate Plan 2011-2015"[75], where it states that "we will ensure that the recognition of vulnerable workers' needs will form an intrinsic part of intervention strategies aimed at achieving wider compliance with workplace health and safety laws". The most recent Annual Report for 2012-13[76] carries this theme through, by summarising the action taken in relation to vulnerable workers in its review of performance over the year. There is a clear strategic thread through the core documents of concern relating to vulnerable (including older) workers. However, all of the actions recorded in the Annual Report relate to young people. The 2012-13 Report confirms the seriousness of the *older worker challenge in the agriculture* industry: seven of the 11 fatal agriculture accidents in that year happened to workers aged 50 and over (five of the seven were over 60). The Annual Report for 2010-11 referred to the launch of the "Stay Farm Safe" campaign aimed at older workers, but the status and outcomes of the campaign are uncertain. In general however the HSENI documents over the last few years have had a clear emphasis on *younger workers*; the relevant website page[77] gives access to a lot of guidance material.

Other devolved administrations

Apart from the position in Northern Ireland and local authority involvement in OHS inspection throughout the United Kingdom, there is little that can be said on regional/local activity. Northern Ireland, Scotland and Wales have for several years run **SME OHS advisory services**, and these are closely linked in the case of Scotland and Wales to the "Health, Work and Well-being" initiatives, and will be covered in more detail in Section III.

Both the Age Action Alliance and the United Kingdom Advisory Forum on Ageing have regional/devolved government structures, but it has not been possible to identify regional activity in relation to OHS and ageing, although there has been broader regional activity on employability. A project on "Valuing Older Workers"[78] managed by the South East England Forum on Ageing was identified. It focuses on six companies in the voluntary sector and provides bullet point summaries of "implications for practice".

2.2 Initiatives from social partners

Employers

The **Confederation of British Industry** (CBI) has responded to the concerns of its members by publishing on 15 May 2014, a report "Getting better: workplace health as a business issue"[79]. The report sets out the case for a long-term commitment from both business and government to investing in positive health management. It details a number of case studies (or "exhibits" as the report refers to them) supporting different aspects of the new agenda. Early in the report it flags up the importance of demographic changes and sets out measures to support the health and wellbeing of an ageing workforce. In examining the need for a proactive approach, the report concentrates on three stages; primary prevention, early intervention, and tertiary rehabilitation. In the context of

[74] HSENI, *Health and safety at work: protecting lives, not stopping them - A HSENI and District Council Strategy for the better regulation of health and safety at work in Northern Ireland*, 2011. Available at: http://www.hseni.gov.uk/joint_strategy.pdf (Accessed December 2014).
[75] HSENI, *Corporate Plan 2011-2015*, 2011. Available at: http://www.hseni.gov.uk/hseni_corporate_plan_2011_2015.pdf (Accessed December 2014).
[76] HSENI, *Annual Report and Statement of Accounts - 1 April 2012 – 31 March 2013*,2013. Available at: http://www.hseni.gov.uk/hseni-annual-report-2013.pdf (Accessed December 2014).
[77] Young people, HSENI: http://www.hseni.gov.uk/..guidance/topics/youngpeople.htm (Accessed December 2014).
[78] Valuing Older Workers", South East England Forum on Ageing: http://ageactionalliance.org/wordpress/wp-content/uploads/2013/05/SEEFA-Valuing-Older-Workers-report-nick-wilson-2013-04-16.pdf (Accessed December 2014).
[79] CBI, *Getting better: workplace health as a business issue*, 2014. Available at: http://www.cbi.org.uk/media/2724238/getting-better.pdf (Accessed December 2014).

mainstream OSH and older workers, the Report mentions examples of tackling workplace risks, but in dealing with primary prevention the report concentrates on general ill-health prevention issues. In developing the new CBI agenda it would be helpful if the opportunities for workplace prevention could be examined further. A number of individual sectoral employers' organisations have also carried out work in this area. The **Engineering Employers Federation** (EEF) endorses the Acas guidance referred to above and has published a review entitled "An Ageing Workforce – How are manufacturers preparing?"[80]

The **Federation of Small Businesses (FSB)** has had limited involvement in older worker OSH issues so far. Their members have been concerned mainly with maintaining their businesses in the recession. They recognise that the owners of many small businesses may themselves be older workers, and that staff in smaller businesses may have long service with the employer; they therefore value older workers and understand the contribution they make. Small businesses do not have the same flexibility as larger employers in making workplace adjustments, and they feel that there is insufficient guidance to help them understand what they can and cannot do.

The **Employers Network for Equality and Inclusion** is an employer network covering all aspects of equality and inclusion issues in the workplace. It now incorporates the Employers Forum on Age[81]. It offers training and consultancy to employers on workplace diversity, strategy development etc. It also seeks to influence Government, business and trade unions and campaigns against discrimination. Guides on managing ageing in the workplace are available for members and topics covered by case studies include ageing, retirement and health and wellbeing.

Employees

The **Trades Union Congress (TUC)** is the umbrella body for all the United Kingdom's trade unions, and its website contains relatively clear links to its OHS and equality guidance. The TUC, in conjunction with the Chartered Institute of Personnel and Development (CIPD), has produced a guide entitled "Managing age"[82] revised in 2011 to take into account the latest good practice developments and the phasing out of the Default Retirement Age (DRA) from 6 April 2011. This guide "supports Acas guidance on managing without a retirement age and reflects the business case for extending working life and employing people of all ages. It gives guidance on good age management practices to support and sustain business success". It includes a specific section on health and safety (section 6) and emphasises the importance of taking the longer view of the ageing workforce by introducing *changes to support older workers before they reach that stage*. It also explains the advantages of following the Finnish Workability Index Model.

In April 2014, the TUC published a paper on "**The health and safety of older workers**"[83] which emphasises that age "*is not about decline but change*" and builds upon the HSE guidance on older workers. It also suggests a number of actions that employers can take and gives a checklist for health and safety representatives.

The TUC has also published a guide to "**Supporting women through the menopause**"[84], which deals with a subject little discussed in other guidance; it recognises that "unfortunately there is often very little understanding of the issues and very little support for women who are going through the menopause." It explores women's experience of working through the menopause and describes some of the adjustments and changes that can be made to make the transition easier.

Individual trade unions also produce information on older workers. For example, **Unison**, one of the main public sector unions, published in April 2013 "**The ageing workforce – health and safety**

[80] EEF, *An Ageing Workforce – How are manufacturers preparing?* The guidance document is no longer publicly available.
[81] Employers Forum on Age, homepage: http://www.efa.org.uk/ (Accessed December 2014).
[82] TUC/CIPD, Managing age, New edition 2011, 2011. Available at: http://www.tuc.org.uk/sites/default/files/extras/managingageguide.pdf (Accessed December 2014).
[83] TUC, The health and safety of older workers – A guide for workplace representatives, 2014. Available at: http://www.tuc.org.uk/equality-issues/age-equality/workplace-issues/health-and-safety/health-and-safety-older-workers (Accessed December 2014)
[84] TUC, *Supporting women through the menopause – Guidance for union representatives*, 2013. Available at: http://www.tuc.org.uk/sites/default/files/Supporting_Women_Through_the_Menopause.pdf (Accessed December 2014).

implications"[85], which summarises the legal background, including the need to *make reasonable adjustments under the Equality Act*. Its main content builds upon the HSE guidance and examines how age affects the work people can carry out, covering sickness absence, stress, accidents at work, physical strength and stamina, cognitive performance, sight and hearing, shift work, and gender. Under each of these headings the guide gives suggestions for the precautions that should be taken and the adjustments that can be made to keep workers, and especially older workers, safe and healthy.

Sectoral joint initiatives

The **NHS "Working Longer Review"** is a tripartite partnership review group between the NHS Trade Unions, NHS employers and health department representatives. The Working Longer Review derives from the changes to the NHS Pension Scheme, and the implications that all staff would have to work longer in future, but is broad in its scope. It covers a very large employer (the NHS), with diverse groups of workers, and is proceeding on a tripartite basis. The "Preliminary findings and recommendations" report[86] was submitted to the health departments on 3 March 2014. The four main themes are: the data challenge; pension options, retirement decision making and their impact on working longer; the importance of appropriate working arrangements and the work; and good practice occupational health, safety and wellbeing. The report is mainly focussed on broader management challenges. The recommendation on occupational health, safety and wellbeing builds on existing reviews and says that it is vital that these recommendations continue to be fully implemented and that they "should be taken forward in the context of an ageing workforce". The health departments have not yet responded to the report, although it is understood that Government feedback has been positive. It is understood that a similar kind of review is being considered for the education sector.

The **"Constructing Better Health" (CBH**) initiative is the national scheme for the management of occupational health in the construction industry. It builds upon consultation with Government, the Construction Industry and Unions. CBH is an independent, not-for-profit organisation bringing together those who work in construction and those providing OSH services by the setting of industry-wide standards and its board includes employer and trade union representatives. As companies join CBH, their employees benefit from the occupational health services provided by the scheme. The aim is to improve the health of the industry workforce. The scheme focusses on five key areas:

- Setting industry standards for both work-related health issues and competency of occupational health provision
- Building a construction specific knowledge portal, giving consistent advice, guidance and support in the management of health related risks
- Centralising the collection of work related health data to ensure the future improvement of workforce health based on valid and reliable data and the provision of a 'benchmark' for industry
- The transmission of data to enable employers to manage work-related health risks at site level
- A referral route through to specialists in the field of return-to-work and rehabilitation.

In June 2014 the scheme was formally re-launched in Scotland, concentrating initially on the fact that in Scotland all new apprentices have to be registered, therefore allowing health improvement and health monitoring to be built into their working life from the beginning.

[85] Unison, The ageing workforce – health and safety implications, 2013. Available at: https://www.unison.org.uk/upload/sharepoint/On%20line%20Catalogue/21474.pdf (Accessed December 2014).
[86] NHS, *Preliminary findings and recommendations report for the Health Departments*, 2014. Available at: http://www.nhsemployers.org/your-workforce/need-to-know/working-longer-group/preliminary-findings-and-recommendations-report-for-the-health-departments (Accessed December 2014).

2.3 Initiatives from other organisations

The **Institute for Employment Studies** undertook a review "**An Ageing Workforce: the Employer's Perspective**"[87] published in 2009. The review brought together both qualitative and quantitative research, and *gives a voice to employers' views and concerns*. It covers "health" at work, but much of the discussion extends to what is normally categorised as OSH. Based on its qualitative analysis, it highlights the impact or otherwise which a wide range of factors appear to have on health at work outcomes. The report contains a section on "managing health" and the actions that employers have taken, or would consider taking to make accommodations.

The **Age and Employment Network (TAEN)** is an "independent not-for-profit organisation whose goal is to help remove age barriers to employment. It works to promote an effective labour market that serves the needs of people in mid and later life, employers and the economy". TAEN is supported by the General Federation of Trade Unions (GFTU) Educational Trust and publishes a wide range of *tools and guidance to help 50+ people into work* and how to *manage the 50+ workforce* to keep them there. TAEN also offers an age management consultancy service to employers. The support offered by the consultancy service covers workforce assessments, surveys, age strategy and policy development, disability and older workers, and health and well-being among others. TAEN has produced a United Kingdom version of the AARP (formerly the American Association of Retired Persons) **Workforce Assessment Tool**[88] which can help "create a work environment that attracts qualified workers of all ages".

Earlier this year TAEN published its **third survey of jobseekers aged 50+**[89]. Although its main focus is related to getting people into work, it also contains information on "factors contributing to difficulties in getting work", which raises awareness of where adjustments can be made. It also includes many real jobseeker comments, and therefore provides a counterpoint to the IES study referred to above.

The **Institution of Occupational Safety and Health** (IOSH)[90] has consistently promoted the need for a professional and managed approach to the OSH needs of vulnerable workers, in particular, older workers – for example, in its response[91] in 2007 to Dame Carol Black's review of the health of Britain's working age population, and its response[92] of 26 August 2013 to the European Commission's consultation on the EU Occupational Safety and Health Policy Framework.

In 2009, IOSH commissioned the **Institute of Occupational Medicine** (IOM) to carry out a review of the *health, safety and health promotion needs of older workers*[93]. The report reviews the evidence, and in a "good practice in action" section sets out a number of factors that should be taken into account as people age. It includes information on the kind of accommodations and changes which can be made to help older people stay in work.

The **Royal Society for the Prevention of Accidents** (RoSPA) and the **British Safety Council** (BSC) are both broadly based charities that amongst other activities, campaign, raise awareness, encourage leadership, and run training courses. RoSPA has had limited involvement in this area of interest so far, but is aware from its membership that interest is increasing. **Safety Groups United Kingdom** is a body which coordinates the activities of around 70 health and safety groups

[87] IES, *An Ageing Workforce: the Employer's Perspective*, 2009. Available at: http://www.employment-studies.co.uk/pdflibrary/468.pdf (Accessed December 2014).
[88] AARP/TAEN, Workforce Assessment Tool. Available at: http://www.aarpworkforceassessment.org/uk/. (Accessed December 2014).
[89] TAEN, *Survey of Jobseekers Aged 50+*,2014. Available at: http://taen.org.uk/uploads/resources/JobseekerSurveyReport_Final_0313.pdf (Accessed December 2014).
[90] IOSH homepage: http://www.iosh.co.uk/ (Accessed December 2014).
[91] IOSH, *Dame Carol Black's call for evidence – IOSH response to Dame Carol Black's review of the health of Britain's working age population*, 2007. Available at: http://www.iosh.co.uk/~/media/Documents/Books%20and%20resources/Policy%20and%20Consultation/Dame%20Carol%20Blacks%20call%20for%20evidence.ashx (Accessed December 2014).
[92] IOSH, *EU Occupational Safety and Health Policy Framework – IOSH comments on the European Commission public consultation*, 2013. Available at: http://www.iosh.co.uk/~/media/Documents/News/IOSH_response_to_the_public_consultation_on_the_new_EU_OSH_policy_Aug_13.ashx (Accessed December 2014)
[93] IOSH, *The health, safety and health promotion needs of older workers – Building an evidence base for a diverse workforce*,2009. Available at: http://www.iosh.co.uk/books_and_resources/published_research.aspx (Accessed December 2014).

across the United Kingdom, and is supported by RoSPA and other OSH organisations. In 2009 the Groups initiated the production by HSE and the Scottish Centre for Healthy Working Lives (SCHWL) of a set of ready-reference cards in book form "Health risks at work – do you know yours"[94] which gives practical guidance on prevention; it is unusual in guidance terms in that it derives directly from a *partnership involving health, health promotion and OSH professionals*. The BSC is currently campaigning to "Push health up the workplace agenda", and their Annual Conference in October 2014 will have this as its theme, and one of the main conference sessions will explore "Occupational health in an ageing workforce".

The **International Longevity Centre-United Kingdom** (ILC-United Kingdom)[95] is "an independent non-partisan think-tank dedicated to addressing issues of longevity, ageing and population change". It publishes a wide range of age-related research, including a *fact pack of United Kingdom statistics on ageing, longevity and demographic change*; a study of the cost of our ageing society; and a compilation of EU Member States profiles under the title of "Working Longer: An EU perspective"[96]. The latter document provides summaries of the position in each EU Member State, including the United Kingdom.

The **Institute of Ergonomics and Human factors (IEHF)** is a professional organisation in the United Kingdom for ergonomists and human factors' practitioners. Its website provides links to guidance on how *ergonomics can help older workers*, and it has an "Ageing and Work" Special Interest Group.

[94] Health Risks at Work-Toolkit (2011) available on SCHWL website: http://www.healthyworkinglives.com/document?PublicationID=5356 (Accessed December 2014).
[95] International Longevity Centre-UK (ILC-UK), home page: http://www.ilcuk.org.uk/ (Accessed December 2014).
[96] ILC-UK, *EU Member State Profiles – Working Longer: An EU perspective*, 2013. Available at: http://www.ilcuk.org.uk/images/uploads/publication-pdfs/EU_Member_State_profiles_Working_Longer_An_EU_Persepctive.pdf (Accessed December 2014).

3 Overview of policies, strategies, and programmes in relation to the rehabilitation/return to work of workers

Extending working lives in healthy, safe and sustainable working conditions also means ensuring that people who suffer from an illness or an accident that leads to prolonged sick leave have the necessary support to return to work in safe and adapted conditions. By promoting the return to work of those who are suffering from a health problem, and specifically in the older age group, a number of people who may otherwise have chosen early retirement or needed a disability pension will remain employed.

The effectiveness of the rehabilitation process is therefore another important factor related to prolonging healthy working lives. Although the issue of rehabilitation and return-to-work is particularly relevant for older workers, as they are more likely to suffer from work-related health problems than younger age groups, the chapter looks at rehabilitation for all workers.

In the United Kingdom, this is a particularly dynamic area of government policy and practice, although it is difficult to describe the overall strategic and operational approach. What might be described as “medical rehabilitation, ,that is in simple terms, the provision of surgery or drugs to repair or cure an illness or injury, is clearly the responsibility of the NHS or private healthcare providers. “Workplace rehabilitation” including the range of management tools such as flexible working, and practical tools such as the provision of powered handling equipment, and which can be used to help someone suffering ill health or injury back into work, falls at the other end of the rehabilitation/return-to-work spectrum. Linking both ends of the spectrum is Vocational Rehabilitation (VR); VR was defined as “whatever helps someone with a health problem to stay at, return to, or remain in work” in an independent review of the scientific evidence “Vocational Rehabilitation: What works, for whom, and when?” [97]. The review, published in 2008, was commissioned by the Vocational Rehabilitation Task Group (which seems no longer to exist) and the Industrial Injuries Advisory Council and is an important background paper for this topic.

Vocational Rehabilitation can clearly include medical treatment at one end and management adjustments at the other. Responsibilities for the different stages of the process span a number of government departments and many professions, as well of course as the employers and employees involved. The Vocational Rehabilitation Association (VRA) brings together many of the professions and other organisations involved in rehabilitation, but at present there is no clear strategic lead on vocational rehabilitation across the United Kingdom as a whole, nor within the individual NHS’s (as far as can be determined) – but this may be about to change and the available details are given below.

The main United Kingdom government departments involved in this theme are the **Department for Work and Pensions (DWP)**, which has the lead on jobs, pensions and benefits, health work and wellbeing, and the **Departments of Health**, which have the lead on rehabilitation, health promotion and health improvement generally.

The following chapter first describes the institutional system in the United Kingdom for the rehabilitation/return to work of workers suffering from a health problem and then looks at specific initiatives from governmental and non-governmental organisations to promote rehabilitation and return-to-work.

[97] Waddell, G., et al., *Vocational Rehabilitation: What works, for whom, and when?*, 2008. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/209474/hwwb-vocational-rehabilitation.pdf (Accessed December 2014).

3.1 The national system for the rehabilitation/return to work of sick or injured workers

Legal and policy framework

The **Equality Act 2010** (see Section 1.3) protects older people and disabled people from discrimination in the workplace and employers are required to accommodate employees with disabilities. The employer has to make 'reasonable adjustments' for a disabled person where a provision, criteria or practice; a physical feature; or the absence of an auxiliary aid, place the disabled person at a substantial disadvantage. The employer must take reasonable steps to avoid the disadvantage. Practicability and cost can be taken into account when determining what is reasonable.

The **Health and Safety at Work Act 1974** (see Section 1.3) requires employers to protect their employees after they return to work if they have become more vulnerable to risk because of illness, injury or disability.

The **Employers' Liability (Compulsory Insurance) Act 1969** (see Section 1.2) requires employers to insure against liability for injury or disease to their employees arising out of their employment.

Employers considering taking disciplinary action or dismissing employees for ill health reasons have responsibilities under the **Employment Rights Act 1996** to adopt fair procedures before dismissing employees on grounds of sickness absence.

On 30 June 2014, the **Flexible Working Regulations** were amended. This will mean that the right to request flexible working will be extended to cover all employees after 26 weeks' service, rather than only those with children, and certain carers. Employers will have a duty to consider all requests in a reasonable manner but they will have the flexibility to refuse requests on business grounds.

The "**Health, Work and Well-being**" initiative is a cross-government initiative coordinated by the Department for Work and Pensions (DWP), which was launched in 2005. It aims to improve the general health and wellbeing of the working-age population, support more people with health conditions to stay in work or enter employment, and reduce the number of days lost to sickness absence. The government works with employers, trades unions and healthcare professionals to create healthier workplaces, improve occupational health services and rehabilitation support and increase employment opportunities for people who are not in work due to ill health or disability. This is done through a range of measures and initiatives, including awareness-raising activities, provision of practical support to employers, in particular small businesses[98].

Main actors and steps in the rehabilitation process

As mentioned in Section 1.2, the United Kingdom does not have the type of approach to occupational health that is found in many continental Member States, organised through the state insurance associations, where rehabilitation is an integral part of the insurance associations' role. Occupational health care in the United Kingdom is part of the **National Health Service (NHS)**, which is managed in governmental terms through the Health Departments in each of the devolved administrations (England, Scotland, Wales and Northern Ireland). While certain responsibilities remain United Kingdom-centred, such as the governance of the health professions, in recent years the systems in the four countries have been drawing apart, with the approach in England being noticeably different from the systems in the other three countries. The NHS Choices website is focussed on the system in England but also has direct links to the approach in Northern Ireland, Scotland and Wales.[99]

If a worker is injured or becomes ill, whether it is related to work or not, the **National Health Service** provides the necessary treatment free of charge, without the involvement of an insurance system.

[98] "Helping people to find and stay in work/Coordinating the health, work and well-being initiative – supporting detail" DWP: https://www.gov.uk/government/policies/helping-people-to-find-and-stay-in-work/supporting-pages/co-ordinating-the-health-work-and-wellbeing-initiative (Accessed December 2014).

[99] NHS Choices: http://www.nhs.uk/NHSEngland/Pages/NHSEngland.aspx (Accessed December 2014).

The normal first "port of call" within the NHS will be the person's **General Practitioner** (GP), who will deal with the majority of illnesses or injuries. If the GP cannot deal with a particular illness or injury, the patient will normally be referred to secondary care in a hospital, either as an out-patient or an in-patient to be reviewed by a specialist in their injury or illness.

The NHS also takes the lead in relation to vocational rehabilitation, getting the patient back to full health, or restoring the greatest degree of workability, and does this through a number of **specialist support mechanisms**, such as physiotherapy, cardiac exercises, and physical and sensory equipment. Many NHS bodies also provide an occupational health service. The NHS should liaise as necessary with **employers** in relation to workplace management and adjustments, although the main responsibility in this respect falls to employers themselves. A great deal of guidance to employers on how to deal with these situations has been produced in the last ten years.

It is recognised that the rehabilitation system may have a number of problems and challenges to overcome, and the NHS began a major review of the overall approach to rehabilitation in England in Spring 2014, led by the Director of the Defence Medical Rehabilitation Centre who has been seconded into the NHS to carry out this review. Further details are given below in section 3.2.1 under the NHS.

The NHS is also assisted in many of these functions by the **voluntary sector** through the wide range of health charities (NGOs) that provide guidance and support to patients. There are active charities for all the main health groupings, and many of these deal, not only with acute problems, but also chronic disease and how it can best be managed. Many of the main charities provide guidance for patients and employers on sustainability in work, and return-to-work issues.

In addition to the state-run NHS, there is also an active **private health sector** in the United Kingdom and private providers of health care facilities. Companies may arrange **Private Medical Insurance** (PMI) for their employees which, on a referral by a GP, will give access to specialist medical services outside the NHS (such as physiotherapy and musculoskeletal expert support). However, insurance does not usually cover existing chronic conditions. In addition, it is difficult to judge the extent to which these insurances cover vocational rehabilitation and workplace adjustments[100].

For workers recognised as disabled following an accident or a disease, the **Equality and Human Rights Commission** also offers guidance and advice to workers and employers on how to make workplace adjustments, as required by the Equality Act, and ease the return-to-work process.

The review of sickness absence and the creation of the Fit for Work Service

One of the main elements of the several "Health, Work and Well-being" initiatives, which have taken place across the United Kingdom over the last ten years (see section on "legal and policy framework" above), has been to provide a more *integrated support mechanism to help employees get back to work* more quickly after an accident or illness. This is based on the notion that the longer an individual is absent from work, the more difficult it is to get back into work, and treating many conditions promptly can minimise their impact on workability.

In March 2008, Dame Carol Black then the National Director for Health and Work within DWP, published her review of the health of Britain's working age population "**Working for a healthier tomorrow**"[101]. In her foreword she stated: "To date, occupational health has been largely restricted to helping those in employment. But supporting working age health today requires us to reach much further. It remains critically important to improve health at work and to enable workers with health problems to stay at work, but occupational health must also become concerned with helping people who have not yet found work, or have become workless, to enter or return to work."

[100] "Which?", the magazine of the Consumers Association, summarises the place of PMI in the overall health landscape on one of its web pages (http://www.which.co.uk/money/insurance/guides/choosing-private-medical-insurance/how-private-medical-insurance-works/ (Accessed December 2014).

[101] Dame Carol Black, *Working for a healthier tomorrow – Dame Carol Black's Review of the health of Britain's working age population*, 2008. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/209782/hwwb-working-for-a-healthier-tomorrow.pdf (Accessed December 2014).

The government's response to the review included a number of "fit for work" pilot services which provided case-managed, multidisciplinary support for employees in the early stages of sickness absence who may be at risk of spending long periods away from work with health problems. Services coordinated help with health and treatment, employability, and wider support services – for example debt, relationship or housing problems.

Dame Carol Black and David Frost CBE, former Director-General of the British Chambers of Commerce, later also carried out a review of sickness absence. Their report "**Health at work – an independent review of sickness absence**"[102] was published in 2011. The government published its response to the review's recommendations on 17 January 2013. The response "outlines a strategy to support the health and wellbeing of the working age population" and examines:

- setting up a health and work assessment and advisory service *(now called the "Fit for Work Service" – see below)*
- improving sickness absence management
- supporting healthcare professionals
- reforming the benefits system

The government-funded **Fit for Work Service**[103] recommended by the sickness absence review was launched in December 2014. Its objective is to help people who have been on sick leave for at least four weeks (or who are considered by their GP to be likely to be absent for four weeks) to get back to work by providing a *return-to-work plan*. Reference to the Service is mainly by the GP, although the employer can also refer an employee to the service, if the GP does not. Through the service, support (in the form of guidance) for GPs, employers and employees should be available at any time during the sickness absence and additional help should be available for more complex cases. More generally, the service also aims to provide occupational health and workplace health promotion advice to workers and employers. At the time of writing this report, the Fit for Work service has been launched in four areas in England and Wales (Sheffield, South Yorkshire and Bassetlaw, Betsi Cadwaladr and Abertawe Bro Morannwg). It is planned to be launched in an additional 13 areas but no specific date is provided.

Financial incentives

The government intends to introduce a tax exemption for amounts of up to £500 a year per employee for medical treatments recommended by the Fit for Work service. The tax exemption will also apply to medical treatments recommended by employer-arranged occupational health services in addition to those recommended by the Service. It is also possible that incentives exist within the private insurance arrangements of employers to encourage the provision of services to get employees back to work quickly.

Compensation system

Compensation system for sickness absence

Compensation for the recognised list of occupational accidents and diseases is dealt with in the United Kingdom through **Industrial Injuries Disablement Benefit** (IIDB)[104], and is administered by the **Department for Work and Pensions**, advised by the **Industrial Injuries Advisory Council**. This is a "no fault" state system and operates in parallel with "tort", that is the worker's right to sue the employer for damages in the civil courts, and such a claim can be based on a much broader concept of loss than IIDB. Benefits paid through the state system can later be recovered from any damages awarded as a result of a tort action. Trade unions normally support such legal action by their members. As mentioned above (section on "legal and policy framework"), to ensure that employers have the resources to pay any damages awarded for injury or illness, all employers are required to hold Employers' Liability Compulsory Insurance (compliance with this legal requirement

[102] *Dame Carol Black and David Frost CBE,* Health at work – an independent review of sickness absence, DWP, 2011. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/181060/health-at-work.pdf (Accessed December 2014).
[103] Fit for Work website: http://fitforwork.org/ (Accessed May 2015)
[104] DWP Guidance on IIDB: https://www.gov.uk/industrial-injuries-disablement-benefit (Accessed December 2014).

is enforced by HSE). Unlike many other EU MS where a form of work insurance association exists, compensation in the United Kingdom is not linked directly to rehabilitation.

For non-work related accidents or diseases, **Statutory Sick Pay** (SSP) is paid once a number of criteria are met (including being off work for four or more days)[105]. This amounts to £87.55 a week (approx. €107) for 28 weeks, paid by the employer. However, many employers, particularly larger companies and public sector organisations, have their own sick pay arrangements, which offer significantly better terms – for example, six months at full pay, then six months at half pay.

Compensation system for disability or reduced work ability

After 28 weeks, other benefits may be provided for workers who are still on sickness absence, such as the **Employment and Support Allowance** (ESA). In order to get the ESA, the person must undergo a Work Capability Assessment to assess to what extent their illness or disability affects their ability to work. On this basis, the person can be placed in a work-related activity group where he/she may have regular meetings with an adviser.

In parallel to receiving ESA, the person is allowed to do "permitted work", which means having a job in which they could:

- work and earn up to £20 a week
- work and earn up to £101 a week doing work as part of a treatment programme, or supervised by someone from a local council or voluntary organisation
- work fewer than 16 hours a week, and earn up to £101 a week for up to 52 weeks

For people with an illness or disability that severely limits their ability to work, they can also do "supported permitted work" and earn up to £101 a week for an indefinite period of time under the supervision of the local council or a voluntary organization.

3.2 Initiatives from government/government affiliated organisations

3.2.1 National level

The Department for Work and Pensions (DWP)

In the framework of the "**Health, Work and Wellbeing**" initiative, a number of case studies have been carried out by DWP showing practical examples of organisations (covering a range of sectors and issues) that have introduced successful health and wellbeing initiatives mostly through health promotion campaigns[106]. The case study on Sandwell Homes describes a *comprehensive approach to reducing sickness absence* through a quite strongly-focussed set of medically or managerially focussed interventions, with a few OSH-related initiatives such as specific 'on-the-job' manual handling training and instruction along with specific risk assessments for musculoskeletal problem areas. The Airbus case study focusses mainly on the *mental health of the workforce* through an integrated approach involving the local NHS. Although the case study mentions advice in terms of 'reasonable adjustment', allowing people experiencing mental health issues to remain in work, it does not detail what these adjustments are.

On 17 December 2013, the government, through the DWP, published "**The disability and health employment strategy: the discussion so far**"[107], which is a consultation paper in advance of the publication of a further "delivery paper" in 2014. The paper sets out a number of proposed reforms which should improve *the ability of everyone with a disability or ill-health to stay in work, or get into work*. The press release accompanying the strategy sets out some high-level proposals about:

[105] DWP information on Statutory Sick Pay (SSP): https://www.gov.uk/statutory-sick-pay/overview (Accessed December 2014).

[106] DWP page on the Health, Work and Well-being initiative: https://www.gov.uk/government/policies/helping-people-to-find-and-stay-in-work/supporting-pages/co-ordinating-the-health-work-and-wellbeing-initiative(Accessed December 2014).

[107] DWP, The disability and health employment strategy: the discussion so far, 2013. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/266373/disability-and-health-employment-strategy.pdf (Accessed December 2014).

- supporting employers to recruit, retain and develop disabled people and people with health conditions, through a new offer including a 'One Stop Shop' and a revamped Disability Symbol
- enabling more young disabled people and people with health conditions to make a successful transition from education to employment,
- developing a new gateway to the employment services, to ensure that disabled people and people with health conditions get the right support at the right time to enable them to get into or get back into work
- improving the specialist employment support offer for disabled people and people with health conditions by ensuring that it includes a number of key features, including greater personalisation, better integration of local services, better use of local providers and a greater focus on supported employment
- improving the mainstream employment support offered by developing the evidence base about what is most effective
- developing more effective approaches for supporting people with mental health problems to get into work.

The full paper also highlights the introduction of the new Fit for Work Service (see Section 3.1 "The review of sickness absence"), which should support employers to retain greater numbers of people in work when they become sick or develop an impairment by providing more direct access to expert advice on occupational health matters.

National Health Service (NHS)

Section 3.1 summarised the overall involvement of the NHS in rehabilitation. One of the earlier actions was the replacement in 2010 of the "sick note" (issued by the GP to say how long someone needed to be off work) by the "fit note" which allowed GPs to indicate how best the patient might be able to return to work. The "**Healthy Working United Kingdom**" initiative supports the role of GPs and other primary care health professionals by providing information and decision aids to support the management of health at work.

In 2007 the NHS in Scotland published a comprehensive review "**Co-ordinated, integrated and fit for purpose: A Delivery Framework for Adult Rehabilitation in Scotland**"[108], which set out many of the challenges facing rehabilitation in Scotland and the ways in which these would be addressed. Although Scotland-focussed, it is also of broader relevance to the United Kingdom position as a whole.

One of the most interesting approaches to rehabilitation in the United Kingdom is that undertaken on behalf of military personnel, through the **Defence Medical Rehabilitation Centre** (DMRC) at Headley Court in Surrey. Defence rehabilitation operates through primary health care centres and 15 more specialist regional centres, while the most demanding cases are treated at Headley Court. The DMRC approach identifies rehabilitation needs as soon as possible, and provides more intensive therapy and support than is usually the case in the mainstream NHS. Most significantly, the vocational element – getting military personnel back to their units as quickly as possible – is a dominant element in the approach. The approach overall seems to provide a template for how mainstream rehabilitation might be better focussed, and it understood that the Director of DMRC has been asked to lead a review of rehabilitation in the NHS, which will build upon earlier analyses, including the NHS Scotland report. Details of the review "**Transforming Rehabilitation**" are not yet available, but the Director gave a presentation[109] to the Annual Conference of the VRA in May 2014 in which he set out the vision for the review and many of the issues which are to be tackled. It forms a valuable summary of the current position and the current challenges.

[108] NHS Scotland, *Co-ordinated, integrated and fit for purpose – A Delivery Framework for Adult Rehabilitation in Scotland*, 2007. Available at: http://www.scotland.gov.uk/Resource/Doc/166617/0045435.pdf (Accessed December 2014).
[109] VRA Conference , "Transforming Rehabilitation", John Etherington, May 2014. Available at: http://www.vra-uk.org/sites/default/files/TransformingRehabilitation-JohnEtherington.pdf (Accessed December 2014).

A section of the NHS website "**NHS Choices**" provides *a list of rehabilitation case studies*[110]. Most are medically-focussed, but they also give insight into the barriers to rehabilitation and the adjustments that may need to be made. Examples are provided below:

1. One example is a video presentation of an exercise package to aid the control of chronic **obstructive pulmonary disease** (COPD) (most of the participants seem to be over 50). The presentation mixes specialist comment from NHS staff, with patient views. As shown in Section 1.1, in the United Kingdom 7% of people reporting a work-related health problem report pulmonary disorders as their most serious health problem. In comparison to an EU-average of 4.7%, it shows that pulmonary disorders are a serious issue for British workers.
2. Another related site is that of the British Heart Foundation, the leading United Kingdom charity in this field. It describes some of the barriers to returning to work after a **heart attack,** for example, whether or not it is still safe for the person to drive or to carry out heavy manual work or the possibility that medication may affect a person's ability to operate certain machinery safely. The guidance takes a positive view and encourages people in this position to talk through the problems both with their medical specialists and their work management and work out the most suitable regime for a return to work.
3. A number of the links are to specialist **military rehabilitation facilities**, referred to above, and these, along with sports rehabilitation facilities, probably represent the high-level end of rehabilitation techniques and facilities. Headley Court, near Leatherhead in Surrey, is the armed forces' dedicated rehabilitation centre. Many of the military personnel who attend the centre have suffered complex and severe injuries involving limb loss, brain and spine injury or a combination of both. Treatments focus on getting service personnel fit for operational duty, and a **multi-disciplinary approach** has been adopted which includes specialist medical officers, nurses, fitness instructors, physiotherapists, occupational therapists, speech and language therapists, cognitive therapists and social workers. While still restricted to a small share of the workforce, these innovative approaches to rehabilitation are relevant to all workers suffering from complex and severe injuries.
4. The Priory is a private health group which works in partnership with the NHS and specialises inter alia in **neuro-rehabilitation and mental healthcare**. One example given in its web pages is its approach to acquired brain injury (ABI). Whether the brain injury is traumatic or non-traumatic, the physical, cognitive and behavioural consequences can be complex and difficult to manage. Treatment recognises that everyone's situation is different, and needs a unique treatment plan tailored to their needs. These services are usually on an inpatient basis, and use a brain injury care pathway which coordinates specialist input to the treatment which aims to address the consequences of the disability as well as maximising quality of life, functional potential and independence via brain injury rehabilitation.

The Health and Safety Executive

While the Health and Safety Executive does not have a role in providing return-to-work services, the previous national OSH strategy, '**Strategy for workplace health and safety in Great Britain to 2010 and beyond**', published in 2004, recognised the need to *strengthen the role of health and safety in getting people back to work* through a much greater emphasis on rehabilitation as a contribution to the wider government employment agenda. One element in this area was to develop closer partnerships in health and rehabilitation by contributing to the nation's health and well-being and dealing with health inequalities. Under the general theme of improving access to advice, it included the commitment to *press for the provision of nationally available advice and support*

[110] NHS Choices, Webpage on rehabilitation case studies. Available at: http://www.nhs.uk/Search/Pages/Results.aspx?___JSSniffer=true&q=Rehabilitation (Accessed December 2014).

focussed primarily on occupational health which should be active in preventing ill health, promoting rehabilitation and getting people back to work more quickly.

HSE worked in partnership with the Department for Work and Pensions (DWP) and other stakeholders, e.g. trade unions, employers, insurers and health professionals, to take forward this agenda. Part of its work in this area has included commissioning research, for example, to *examine issues faced by employers, workplace practice and tools*. The HSE has developed its website to provide a variety of resources on sickness absence and return-to-work, including guidance on policy development, legal aspects, workplace adjustments, MSDS and return-to-work and case studies. Arising out of its policy on equality, the HSE also provides advice and cases studies on disability in the workplace.

However, the **Triennial Review of HSE** (see Section 1.2) recommended that "HSE's role should be supportive of wellbeing and wider public health programmes, where it is able. But promotion of those agendas is not its core responsibility." The Government's response has supported this recommendation saying that "the Government has asked HSE to use these and other forums to encourage others to recognise the distinction between occupational ill-health conditions and more general public health issues." It remains to be seen how this change in emphasis will impact upon the HSE's overall approach.

3.2.2 Devolved administrations/ regional initiatives

OSH Advisory Services

OSH advisory services for SMEs in various forms were set up in all four countries of the United Kingdom in the period 2000-2010. In 2009-10, the United Kingdom government as part of the health, work and well-being initiative funded the formal establishment of pilot schemes in England, Scotland and Wales. These pilots are worth noting, even though they did not focus particularly on vulnerable workers, because they were formally evaluated, and the evaluations published[111]. Since the pilot exercises ended, the advisory services have continued in different forms. The "health, work and well-being – supporting detail" webpage on the website of the DWP has links to the England, Scotland and Wales advice lines, which are embedded within the National Health Services of each country (the SME advisory service in Northern Ireland is managed through HSENI.). The NI, Scotland and Wales services are quite broadly based OSH advisory services, whereas the England service tends to focus on health matters.

The England service[112] contains a lot of summary advice on health at work, and getting people back to work. There are links to other useful services including to the over 100 occupational health providers operating locally in the NHS in England. An example of one of these is the **Sheffield Occupational Health Advisory Service**[113] (SOHAS) whose advisers work in GP surgeries and take referrals from GPs and other professionals. The service gives confidential advice and support to people with work-related ill health, including

- advice on health and safety rights.
- raising awareness of work-related health problems.
- carrying out health checks for deafness, lung disease and vibration damage. The service includes advice on job retention and rehabilitation case management.

This allows workplace ill-health problems to be identified and advice given on how to rectify them. The advice is designed to help improve conditions at work, and past work has helped to gain recognition for problems such as stress at work, repetitive strain injuries, lung problems caused by work in the steel and engineering industry and problems of workers with chronic health problems. In 2009, SOHAS, in cooperation with Improving Access to Psychological Therapies (IAPT) Sheffield,

[111] DWP, *Occupational Health Advice Lines evaluation: Final report*, 2012. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214580/rrep793.pdf (Accessed December 2014).
[112] England health for work advice line, NHS: http://www.health4work.nhs.uk/ (Accessed December 2014).
[113] Sheffield Occupational Health Advisory Service, "About us" page: http://www.sohas.co.uk/about_whig.php (Accessed December 2014)

developed a methodology for the return to work of people with mental health problems, using the Wellness Recovery Action Plan (WRAP) method.[114]

The Scotland service is run through the **Scottish Centre for Healthy Working Lives** (SCHWL)[115] which in its current and previous guises, has been operating since the mid-1990s. It offers a more broadly-based system than the other advice lines and in recent years its role has changed to become a more central part of the Scottish government's equality agenda (health inequalities being one of the most important strategic challenges). It also has strong links to the European Network for Workplace Health Promotion. Partly because of its interest in equality issues, the SCHWL has had an interest in vulnerable workers, including older workers, and rehabilitation. It commissioned the Chartered Institute for Personnel Development (CIPD) to prepare a guide for employers "Managing a healthy ageing workforce – a national business imperative"[116]. This guide discusses three basic steps – building the business case; addressing the myths; and talent management. It contains a range of tips and recommendations backed up by focus group *and case study material* (including a summary of the approach of B&Q, the DIY retailer, who are recognised as being one of the pioneers of the employment of older workers). The SCHWL and CIPD are preparing a further report, due for publication in 2015, on "Managing a Healthy Ageing Workforce: A Small Business Imperative". Each of the Scottish Health Boards (the main subdivisions of the NHS) also offers "Working Health Services"[117] aimed at workers in SMEs, which provide tailor-made interventions to suit individual needs. The website has four employee case studies; all four are stress management-related.

The Wales system is known as "**Healthy Working Wales**"[118] and is a similar model to the Scottish approach, although the Welsh system is perhaps more medically focussed and not as wide in its scope.

3.3 Initiatives from other organisations

In November 2008, Professor Sir Michael Marmot of the **University College London (UCL) Institute of Health Equity** was asked by the then Secretary of State for Health to chair an independent review to propose the most effective evidence-based strategies for *reducing health inequalities* in England. The final report, **'Fair Society Healthy Lives**'[119], was published in February 2010, and concluded that reducing health inequalities would require action on six policy objectives:

1. Give every child the best start in life
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of ill-health prevention.

The programme has developed a suite of social indicators (which includes work-related illness), the most recent review of which has just been published. This initiative seems mainly health-based, but in examining issues such as fairness, maximising capability and sustainability, it also has one foot in the health, work and wellbeing camp.

The age and health-related charities have a range of information available on work and health. For example, the main **Age United Kingdom** website has a lot of helpful information and the charity

[114] For more information about the work of SOHAS and the IAPT Sheffield, see the detailed case study carried out in the framework of the project "Safer and Healthier Work at Any Age".
[115] Scottish Centre for Healthy Working Lives, home page: http://www.healthyworkinglives.com/ (Accessed December 2014).
[116] SCHWL/CIPD, Managing a healthy ageing workforce – a national business imperative, 2012. Available at: http://www.cipd.co.uk/publicpolicy/policy-reports/managing-healthy-ageing-workforce.aspx (Accessed December 2014).
[117] "Working Health Services", NHS Scotland: http://www.healthyworkinglives.com/working-health-services-scotland/about.aspx (Accessed December 2014).
[118] "Healthy Working Wales", NHS Wales: http://www.healthyworkingwales.com/ (Accessed December 2014).
[119] UCL, *Fair Society Healthy Lives (the Marmot Review)*, 2010. Available at: http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review (Accessed December 2014)

publishes a useful information guide "Working over 50 – Your options for staying in work"[120]. Although not specifically directed at older workers, a number of the charities which deal with health conditions which are more common in older workers, have useful guidance on work and health.

The Work Foundation is part of Lancaster University. Its health and wellbeing programme[121] "seeks to promote a systemic approach to creating healthy workplaces." One of its main research strands is "Fit for work" which has demonstrated that improvements in early intervention, treatment and return-to-work practices could help people of working age with even severe musculoskeletal disorders (MSDs) stay in work. **Fit for Work Europe** is a project led by The Work Foundation which aims to build on the research findings to stimulate debate, develop policy and practice in Europe and beyond and to ensure that the early diagnosis and treatment of workers with MSDs takes into account the positive health impact of high-quality employment on rehabilitation, and in some cases recovery.

Another aspect of the Work Foundation's research is its links with **Macmillan Cancer Support** (see below). In March 2013, Macmillan Cancer Support and The Work Foundation launched two complementary reports on *work and cancer*. The reports recognised the benefits of supporting people with cancer to stay in or return to work for those who want it. They also highlighted the importance of specialist vocational rehabilitation services for people who have more complex problems and called for better availability and access to these services. The Work Foundations report looks at the recent development of return-to-work support services in the United Kingdom, and at what issues need to be addressed to help people with cancer remain in work.

Macmillan Cancer Support is a national charity which provides practical, medical and financial support, and which pushes for better *cancer care*. Its web site has a comprehensive section devoted to "Work and cancer"[122]; the guidance explains that "tests and treatments usually mean spending some time in hospital and away from work. The symptoms of cancer or the side effects of treatment may also make it more difficult to work. […] Many people find they're unable to work while having treatment. This can lead to financial difficulties, but financial help is available in these situations."

The web pages describe the advantages of a return-to-work plan. An essential part of such a plan is the adjustments that can be made, such as:

- allowing a phased return to work after extended sick leave
- changing your job description to remove tasks that cause particular difficulty
- allowing time off to attend medical appointments
- allowing some flexibility in working hours
- temporarily allowing you to be restricted to 'light duties'
- adjusting performance targets to take into account the effect of sick leave and side effects such as fatigue
- moving you to a post with more suitable duties (with your agreement)
- moving your work base – for example, transferring you to a ground-floor office if breathlessness makes it difficult to climb stairs
- allowing working from home

The questions of benefits and financial matters are also covered in detail in addition to guidance for those not directly affected by cancer, but have a relationship with, or who are at work with cancer patients, – such as carers, or fellow-workers.

The **British Heart Foundation (BHF)** gives advice on many aspects of *living with a heart condition*[123]. It explains in easy to understand terms how patients can improve their mood through

[120] Age UK ,*Working over 50 - Your options for staying in work*, 2013. Available at: http://www.ageuk.org.uk/Documents/EN-GB/Information-guides/AgeUKIG34_Working_Past_Retirement_inf.pdf.pdf?dtrk=true (Accessed December 2014).
[121] The Work Foundation, Health and well-being programme. Available at: http://www.theworkfoundation.com/Research/Workforce-Effectiveness/Health-Wellbeing (Accessed December 2014).
[122] Macmillan Cancer Support, "Work and cancer". Available at: http://www.macmillan.org.uk/Cancerinformation/Livingwithandaftercancer/Workandcancer/Workandcancer.aspx (Accessed December 2014).
[123] BHF, "Living with a heart condition". Available at: http://www.bhf.org.uk/heart-health/recovery.aspx (Accessed December 2014).

self-help techniques and explains that anxiety and depression are not unusual reactions to trauma or illness. There are also a number of sub-guides dealing with work matters, such as "Telling work" and "Returning to work", which recognise that both employer and employee may have worries about a heart patient returning to work; about possible restrictions on driving; protecting against the cold in winter because of the effect cold temperatures can have on the heart; about making sure that flu vaccinations are up to date; and many other factors. The BHF also produces a booklet with a lot more detailed guidance on "Returning to work with a heart condition"[124], which refers to a number of factors, including the risks that might arise if someone has a pacemaker or Implantable Cardioverter Defibrillator (ICD) fitted, and they work where strong magnetic fields are present.

Arthritis Care emphasises the importance of self-management for *arthritis* sufferers – this means taking control of living with the condition, and is crucial for emotional and physical wellbeing. Self-management can be life-changing. Arthritis Care devotes a substantial section of its website to "Working with arthritis"[125] with guidance for people with arthritis, for employers and for healthcare professionals. The healthcare professional guidance explains that "clinical management of most musculoskeletal conditions emphasises the importance of staying active and participating in society as fully as possible. This includes enabling and supporting people with arthritis to work, where appropriate. Advising patients inappropriately to stay off work could have significant and long-term consequences". It gives guidance on adaptations that may be helpful in the workplace, such as:

- a phased return to work
- making sure premises are accessible
- help with transport to and from work
- flexible working – to avoid the rush hour or when starting late and finishing late might help overcome a painful start to the day
- home working
- provision of special equipment to enable the person to do their job effectively
- offering time off for rehabilitation, assessment or treatment.

Arthritis Care is a member of the **Arthritis and Musculoskeletal Alliance** (ARMA)[126] which is "the umbrella body providing a collective voice for the arthritis and musculoskeletal (MSK) community in the United Kingdom". ARMA emphasises that as the United Kingdom population ages and the number of people living with multiple long-term conditions grow, the burden of MSK conditions is set to increase. It is organising a "World Summit" in October 2014 on the theme of "Keep people moving" which will include sessions on MSKs in the workplace, and prevention and treatment.

Mind, the England and Wales charity for better mental health, (the Scottish "equivalent" is the Scottish Association for Mental Health) has guidance on its website[127] on *managing stress* both in and outside work, which is useful for all ages of worker. The web site summarises the wide range of mental health problems, with further links to more detailed guidance on each. One of the issues covered in detail under "tips for everyday living" is "How to manage stress". This section defines stress, explains what causes it and explains the hormonal response and how stress can be both positive and harmful. Most of the "How to manage stress" section deals with the topic in a general manner but there is a separate section under "tips for everyday living" on "work and mental health". This section also covers work and stress, workplace bullying, getting support, rights at work and useful contacts; all of these subsections give practical advice on dealing with mental health problems at work. Guidance is available through Mind for employer and employee alike, dealing with mental health.

Disability Rights United Kingdom is a leading charity which works to create a society "where everyone with lived experience of disability or health conditions can participate equally as full citizens". It is an organisation of disabled people leading change to:

- "Mobilise disabled people's leadership and control – in our own lives, our organisations and society

[124] BHF, "Returning to work with a heart condition". Available at: http://www.bhf.org.uk/publications/view-publication.aspx?ps=1000876 (Accessed December 2014).
[125] Arthritis Care, "Working with arthritis". Available at: http://www.arthritiscare.org.uk/LivingwithArthritis/Workingwitharthritis (Accessed December 2014).
[126] ARMA home page: http://arma.uk.net/ (Accessed December 2014).
[127] Mind, "How to manage stress". Available at: http://www.mind.org.uk/information-support/tips-for-everyday-living/how-to-manage-stress/about/?o=10133 (Accessed December 2014).

- Achieve independent living in practice
- Break the link between disability and poverty
- Put disability, equality and human rights into practice across society"

The charity has published '**Doing Work Differently'**[128], a guide to getting and keeping a job while *managing ill-health, injury or disability*. The guide contains information on adjustments and case studies.

[128] Disability Rights UK, *Doing work differently - Getting and keeping a job while managing ill-health, injury or disability (IID),* 2007, Available at: http://disabilityrightsuk.org/sites/default/files/pdf/DWD%202007.pdf (Accessed December 2014).

4 Conclusions

General context

Facts and figures

- *The population in the United Kingdom is ageing, although at a slower speed than the EU average:* the proportion of the two oldest age groups in the United Kingdom increased from 26% in 1990 to 28% in 2013, which was, however, slightly less than the EU average (31%). Furthermore, the median age in the United Kingdom has risen by four years since 1990, while across the EU it has risen by seven years. The proportion of older people is predicted to continue increasing, with the fastest increase between now and 2040.
- *On average, people in the United Kingdom stay in the labour market for around two years longer than across the EU:* while in other EU Member States the effective retirement age is well below the official one, this is not the case in the United Kingdom. The state pension age for men is 65, and in 2012 the effective retirement age was at around 64.5, while for women the state pension age is between 60 and 65 and the effective retirement age was 62.3 in 2012.
- *Health and disability, eligibility for a pension and favourable financial agreements main reasons to quit work:* in the United Kingdom, a much higher share of pensioners stated that they had quit work due to favourable financial arrangements than the EU average. However, their own health or disability and eligibility for a pension were still the two most important reasons.
- *Non-financial reasons and providing sufficient income important reasons for pensioners to continue working:* pensioners in the United Kingdom stated non-financial reasons as reasons to continue working to a larger extent than EU pensioners, e.g. work satisfaction, as the reason why they continued working (41%).
- *Many working conditions for older people in the United Kingdom are a lot better than on EU average:* in the United Kingdom, job sustainability among older workers is a lot higher than the EU average (85% and 71%, respectively). The share of older workers who think their work negatively affects their health is much lower than the EU average (15% and 27%, respectively) while the share of United Kingdom older workers who are satisfied with their working conditions is a lot higher than the EU average (94% and 84%, respectively).
- *Measures to adapt the workplace for older people reported more often in place than the EU average:* in the United Kingdom, 52% of employed people and people with working experience indicated that measures to adapt the workplace for older people had been put in place at their workplace (compared to 31% at EU-28 average).
- *Work-related health problems among older workers less frequent than across the EU:* self-reported work-related health problems among workers in the United Kingdom increase with age; however, the share of older workers who reported work-related health problems in 2007 was considerably lower in the United Kingdom than the EU average (7% compared to 16%, respectively).
- *Musculoskeletal disorders and psychological illnesses by far the most serious work-related health problems:* the share of workers who reported that psychological illnesses were their most serious work-related health problem was considerably higher in the United Kingdom than across the EU for all age groups. This is the second most reported work-related health problem after musculoskeletal disorders.

The context of older workers in the United Kingdom

There is no official retirement age in the United Kingdom, and the concept of a “default” retirement age has been removed. The state pension age for both men and women will be rising in stages over the next 30 years. There have been major changes in both state and private pension arrangements over a very short period – approximately a quarter of what has been a normal working life – and there are still substantial uncertainties about the impact of the changes and how individuals and employers should react to these. *In discussing pension matters with many of the*

sources for this report, it was clear that better advice on pension matters was seen as particularly important.

The determining factors for a long, satisfying and productive life were seen by most sources as health and wealth. Choice and flexibility of employment, voluntary work and leisure pursuits are affected (and often determined) by how much income a person had, and their fitness. Ensuring a reasonable income in retirement or semi-retirement is very important; the poorer parts of society have poorer choices. The Government believes that the revised pension arrangements will lead to a "sustainable and decent retirement" whereas others believe there will still be significant financial uncertainty. Many private pension payments are relatively small, but there has been much media and political criticism of what are portrayed as "gold-plated" pension arrangements and it was argued that this critical climate has had the effect of turning younger people off the consideration of their pension arrangements.

There are a number of age groups of workers affected by these changes, and while younger workers are still far enough away from retirement for the position to be recoverable if not understood at present, and while older workers were sufficiently close to retirement to have to take an interest in the changes, the group which seemed most at risk of missing out, or ending up in an unsatisfactory financial position, were the *middle-aged.* It is important that the information needs of different age groups are considered when financial planning guidance is being prepared.

There is widespread recognition of and interest in the demographic challenge – the increasing proportion of older people supported by a smaller proportion of younger workers. There is also recognition of the increase in life expectancy but against that, uncertainty about the change in healthy life expectancy. A TU-led campaign "68 is too late" reflects concerns in education and many other areas of work about the physical and psychological demands of a longer working life. This is linked to the workability and expectations of the current older generation, but there was also widespread recognition that answering the demographic challenge necessitated *starting now with the younger generation of workers*, and adopting a "*healthy working lives*" approach which aimed at maximising functional capacity through the working years. (In the broader public health environment of course a healthy working life must be preceded by a healthy childhood.)

The ten years up to 2015 have been a very active period for *health, work and wellbeing initiatives* and policy development. There have been significant initiatives which have advanced knowledge, developed a better understanding of good practice, and inspired action, and many of these are mentioned in the body of this report. A great deal of useful *guidance* has been prepared on occupational health and safety and its relationship with sickness absence management and the wider public health agenda, although it is difficult to always get a sense of coordination or cooperation in the activities that have taken place (this is also a problem at times across the four NHS's). Older workers as a specific issue has also emerged in the second half of this period as awareness of the demographic challenge and pension pressures has grown.

The first half of 2014 has been a particularly active period, with the launch of important policy documents and initiatives on health and work, and older workers, by the Department for Work and Pensions (DWP), employers' confederation (CBI) and the national trade union organisation (TUC), along with the issue of revised older workers guidance by the Health and Safety Executive (HSE). In addition it is understood that a major review of rehabilitation has been launched. A number of other guidance documents or initiatives are taking place and should emerge in 2015. It is difficult to form a clear overview of all this action, even though a few organisations appear to have a role in drawing together or monitoring health work and wellbeing and workability in general, and older workers in particular. The multi-disciplinary nature of the broad topics make this particularly challenging, but there are suggestions that developments still sometimes happen in silos, or in the metaphor borrowed from the intelligence community, in stovepipes. It was said at the national expert seminar[129] of May 2014 that a very useful website which gathered together a number of information sources had been taken down, and that it had not been possible to find out what had happened to it. *There is a need for an organisation to take a lead at least in monitoring the whole field and raising awareness of what different organisations are doing.*

[129] Views expressed during the national expert seminar and workshops on "Safer and Healthier Work at Any Age", which took place on 15-16 May 2014 (more details provided in the introduction to this report).

OSH and older workers

The HSE published updated older workers guidance on its website in May 2014. The guidance is part of a larger suite of guidance on "vulnerable workers", and it would be worthwhile considering whether there are *synergies and commonalities between the different groups of vulnerable workers.* The guidance also links in to further guidance on discrimination, disability and the requirements of the Equality Act. HSE considers that the current legislative framework for this topic is robust and this view has not been challenged. The HSE's view is that "a separate risk assessment for older workers is not required, although a review of existing assessment may focus on a particular group where there is evidence of a problem, and that any assessment which concentrates on individual capability at the expense of task or workplace design is likely to be misleading". However this view is not accepted by everyone, and the need for individual risk assessments in particular cases has been highlighted. The HSE view is clearly related to the General Principles of Prevention (GPP) in the Framework Directive, and further debate is needed about how the needs of older workers in general, or the *specific needs of individual workers* in particular, can be integrated into risk assessment in a practical way which supports the GPP.

The current HSE guidance on risk assessment also suggests that "you do not need to include risks from everyday life unless your work activities increase the risk" but in many cases the boundaries between work risks and everyday risks will be unclear – for example in relation to arthritis and musculoskeletal stresses at work, and between cancer recovery and fatigue while at work. The recommendations of the recent Triennial Review on HSE's involvement with health, work and wellbeing encourages active engagement by HSE with other public bodies but still emphasises the need for a clear separation of functions. This seems to thrust the different aspects of the issue into silos. It is a complex issue, but if *multiple-cause ill health* is to be tackled effectively, the first emphasis should be on *working together* and in practice collaborative work between the different bodies continues on the wider health and work issue.

The updated HSE guidance is helpful, but is deliberately quite high level. As thinking on the issue of older workers develops it could usefully include *more detailed information on the practical issues* which affect older people and some of the adjustments which can help them stay in work, as well as signposting more of the guidance on this topic (although this is complicated by the boundary issues described above).

The HSE Strategy and supporting high-level documents contain only indirect references to the ageing workforce although *HSE's Diversity Action Plan* does contain references to some initiatives being taken in relation to older workers. The sector plans for the agriculture and offshore sectors refer to the need to keep experienced workers and the reality that many agriculture workers keep an involvement in the farm well into old age, but the answer in both industries is seen as a question of increasing competence and skills; it would be useful if the sector plans could consider also some of the practical issues that influence older workers staying in work and the changes that can be made to accommodate them. This also applies to sectors at the other end of the spectrum (for example the Beauty sector), where many young workers are employed. A *sectoral analysis of age factors and risk* would be a valuable element in developing a better approach.

The HSE itself and many of the other organisations mentioned in this report produce excellent OSH guidance material, including material aimed specifically at older workers, at SMEs, and at the management of health at work.

The *Health and Safety Laboratory* has taken a leading role in examining the issue of the demographic challenge in general and of older workers in particular. Other research institutions have also been active in this area and HSL is currently undertaking a further major review of where better understanding of the demographics is needed, as well as modelling work of the variables which can affect a healthy working life. There is now a need to *identify the priorities* from the research which can have most impact on improving healthy working lives and move to *implementation*.

Health, work and wellbeing

The DWP takes the lead on this topic generally and specifically on the position of older workers; all the guidance and policy recognises the need to take a long-term approach, and tackle *the health of the working age population*. The DWP is active on a large number of fronts, and this is reflected in the extensive and useful website information, but it is difficult to get a clear strategic sense of what are considered the priorities in terms of policy and action. It is understood that the Government prefers to see *more commitments to action than strategies*, hence the publication in June 2014 of the "Fuller Working Lives – Framework for Action". This is a broadly based framework, examining many aspects of "working as long as is necessary to create the future you want". However it contains an array of actions in hand and actions planned which are difficult to place in context and to understand the linkages between them. Nevertheless, there is also a commitment to establishing a *governance structure* to review and direct progress of the actions outlined in the framework. This could have a major impact if it becomes a real *multi-departmental, multi-disciplinary body* with the ability to *break down silos*, and establish clarity of direction.

Rehabilitation and return to work

Return to work

Although the issue of ill health absence from work is usually portrayed as a matter of improving support for the return to work, this minimises the importance in the longer term of "turning off the tap", that is helping employees to *stay at work* and not go absent. This is directly linked to effective prevention and management procedures which anticipate problems before they arise, and good guidance has been produced on these issues. Direct help for employers and employees is available through the occupational health services or through the NHS-run services, which are available in many parts of the country and particularly in the devolved NHS's.

The Government has launched the *Fit for Work Service* in December 2014*,* which aims to provide a more integrated support mechanism to help employees get back to work. The introduction of the Service has been broadly welcomed by the social partners as providing additional support to help people stay in work, and there is also considered to be a good evidence base for the telephone advice approach and the assessment process. Five particular areas of concern have been raised:

1. The trade unions wish to make sure that the confidentiality of the General Medical Practitioner (GP)/patient relationship and the consent of the employee to sharing information with the employer is respected.
2. The involvement of the employer in developing the return-to-work plan is regarded as essential by many; at present the guidance is not clear on this, indicating only that if an occupational health service is in place it may be consulted. Clearly there is a balance to be struck between confidentiality and the acceptance of the return-to-work plan; possibly there will have to be differences in the approach adopted between conditions which are work-related and those which are not. But it is difficult to see in most cases how an effective return-to-work plan could be developed without the agreement of the employer.
3. There are concerns about GP awareness of work-related issues and GP capacity, although the available guidance suggests that raising GP awareness will be a major element in the role of the appointed contractor.
4. The role of vocational rehabilitation is not well understood, and capacity in the professions contributing to vocational rehabilitation will not be available; raising awareness in those professions does not appear to be part of the contract.
5. There is a lack of clarity about how the whole approach to rehabilitation within the NHS will contribute to a return to work, particularly as it does not appear at present that "return-to-work" will be one of the measured GP or wider NHS outcomes (and see below).

This kind of multidisciplinary service is an important step forward, however the new service will have a number of delicate balances to make, and the development of positive relations between everyone involved will be very important. It will be essential to *raise the awareness of GPs* and allied health professionals; gain the *commitment of employer and employee* to the return-to-work

plan; establish return-to-work as the agreed outcome; and *review the rehabilitation process* within the NHS and private providers.

The tax exemption in the plans is a particularly interesting change of emphasis from the approach in the past (which taxed such expenditure). *Further development of this measure might encourage more investment in occupational health* and indirectly, or directly through the Fit for Work Service, might lead to the development of a form of national occupational health service.

Rehabilitation

It has been very difficult to find information on how rehabilitation is supposed to work. Most of the sources consulted are of the view that despite the undoubted expertise and resources put into rehabilitation on an individual basis, there is little sense of direction about the overall objectives of rehabilitation or broad knowledge of best practice. It has also not been possible to identify whether demographic factors are considered in rehabilitation policy, particularly issues such as increased demand because of an ageing population and the management of multiple conditions, which becomes a more likely challenge in older people. The military experience (which in its primary, regional and specialist stages mirrors the basic NHS organisation) is undoubtedly relevant to the mainstream NHS. The Director of the Defence Medical Rehabilitation Centre, who also has a role in conducting a major *Review of Rehabilitation within the NHS* summarised the strengths of the military approach in a presentation to the Vocational Rehabilitation Association in April 2014 as: *Early assessment and intervention; Accurate diagnosis; Multi-disciplinary team working; Rapid access to onward referral for further opinion; Close relationships between teams; Active Case management; Exercise-based rehabilitation; and Group therapy*. He also discussed the several obstacles to change within the NHS, which his review will have to tackle.

It is important for the general achievement of healthy working lives, and for the effectiveness of the Fit for Work Service, that the review of rehabilitation within the NHS is successful in bringing about *a change in the approach to rehabilitation*, when a return to work is seen as the *desired outcome*. In the absence of detailed information on the review it can only be said that it is important that it is not simply a medical review, but involves all the organisations who can support vocational rehabilitation and ties in with the new "Fuller working Lives" framework.

Other significant issues

There are a number of other significant initiatives related to businesses and industries in development. The "Working Longer Review" in the NHS (and any related review in the education sector) because of its size and scope, is bound to have implications for other employers. The "Constructing Better Health" initiative has the potential to develop into the sort of unified, industry-based approach to healthy working lives which many continental Member States enjoy through their accident insurance associations. The "Managing a healthy ageing workforce" guide being prepared by the Scottish Centre for Healthy Working Lives (SCHWL) and the Chartered Institute of Personnel and Development (CIPD), and aimed at SMEs should be available in 2015.

The contribution made by many of the *health-related charities* to advice and guidance on working with a condition should be highlighted. Most charities give good advice on their websites about continuing to work and returning to work with particular diseases or conditions and often have a more practical approach which draws on real life experience. They are also active in campaigning and research and they are perhaps an underestimated source of expertise on rehabilitation. It is important that as new initiatives, such as the *Fuller Working lives Framework* and the *Fit for Work Service* develop that they draw upon the experience of the health charities.

General Conclusions

Safe and healthy working at any age is a topic of substantial interest in the United Kingdom, and there has been a great deal of useful activity over the past ten years, in developing evidence-based policy, research, and advice on good practice; then implementing this in the workplace and for workers of all ages. The period has also seen rapid change in the area of pensions, the implications

of which remain uncertain. HSE has recently revised its *guidance on OSH and older workers*, which it sees as part of the spectrum of diversity and vulnerable workers.

DWP as the governmental lead on health, work and wellbeing has also been very active in trying to bring departments and non-government interests together to develop a more integrated approach, and through the new *Fit for Work service* aims to create a multidisciplinary system to helping individuals stay in work, and get back to work after an absence. Although the principles of the approach have been welcomed, doubts have been raised about how the service will work in practice, and as it is closely linked to controls on benefits, it is politically controversial.

Rehabilitation in the United Kingdom has a different approach compared with many continental states, as the medical and many vocational aspects are largely organised through the National Health Service. Many individual aspects of rehabilitation work well, but there is concerned that more needs to be done to *create a better, more integrated approach*, and a major review is under way. While there is a considerable value and learning experience in the current United Kingdom approach, the level of activity is such that there is a sense of initiative overload and the whole field would benefit from *better coordination and a stronger lead*.

5 References and further information

The documents and webpages referenced in the text and detailed below provide useful guidance on the employment and health and safety of older workers. There is also useful guidance (particularly available through the HSE/HSENI websites, and the DWP "health, work and well-being" website), which applies to all workers, of all ages.

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