Working for Health:

Supporting the Work & Health Domain in the South East

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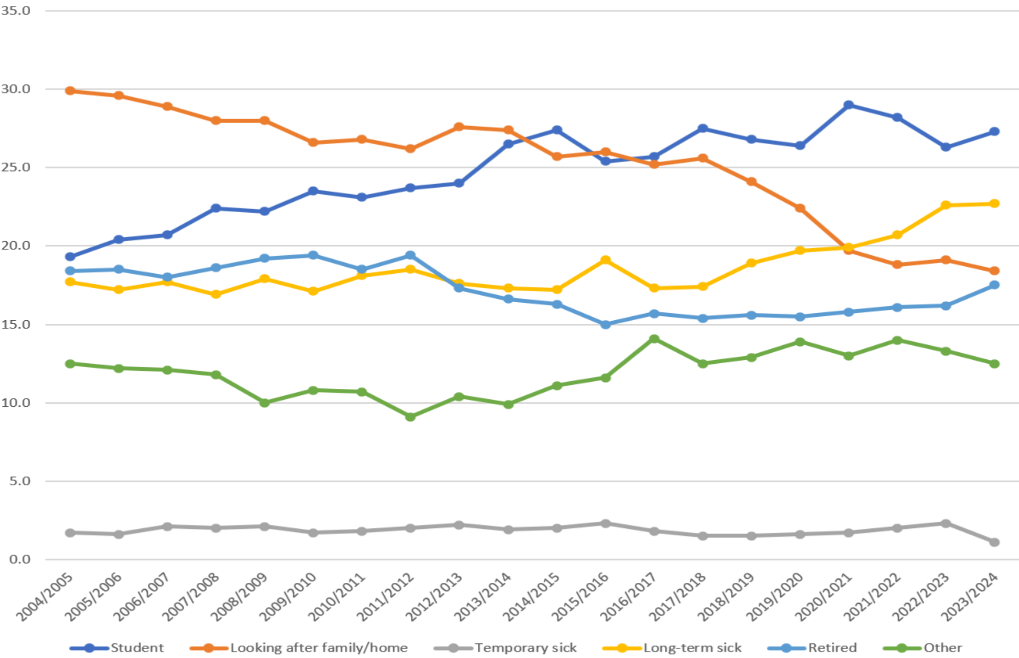
Introduction

Economic inactivity is a major, rapidly growing and extremely politically and socially sensitive issue in the UK. In Jan-Mar 2024 there were 9.4 million economically inactive working age (16 to 64 year-old) adults in the country *[ONS, 2024]*. The South East region fares better than the English average, but rates are still high and increasing.

Area	Recent Trend	Count	Value
England	→	7,486,800	21.4
South East region (statistical)	→	1,080,900	19.3
Isle of Wight	→	23,300	30.2
East Sussex	→	72,400	22.6
Slough	→	21,700	22.5
Brighton and Hove	→	44,200	21.3
Kent	→	197,000	20.7
Portsmouth	→	28,800	20.1
Oxfordshire	→	84,400	20.0
Southampton	→	34,500	19.9
West Sussex	→	98,500	19.4
Bracknell Forest	↑	14,600	18.6
Surrey	→	132,100	18.2
Medway	→	32,500	18.1
Hampshire	→	148,600	18.0
West Berkshire	→	16,700	17.4
Milton Keynes	→	29,700	17.2
Buckinghamshire UA	→	55,500	16.9
Wokingham	→	16,300	16.0
Windsor and Maidenhead	→	13,900	15.1
Reading	→	16,200	14.7

The proportion (%) of economic inactivity 2022/23 in England, the South East region and county and unitary authorities in the South East (benchmark all in South East) *[Fingertips, 2024]*.

Long-term sickness and/or disability is now the biggest driver of economic inactivity nationally, with 30.1% of those not at work giving ill-health as the main reason.



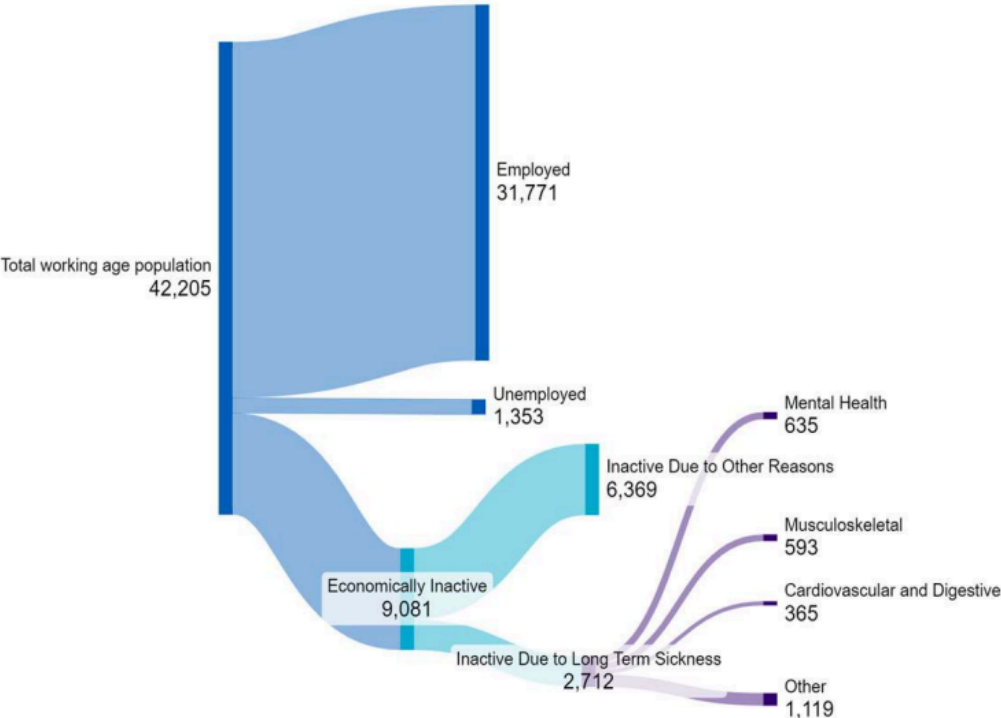
Percentage of economically inactive by main reason, 16 to 64, South East, 2005 to 2024 *[Labour Force Survey, 2024]*

This is avoidable: from 2015 to 2019 economic inactivity due to long term sickness was falling in England across most conditions, but began to rise again shortly before the pandemic, increasing by 27% (540,000 people) between 2019 and 2023 *[Employment of Disabled People, 2023]*. While most who fall in that group are aged 50-64 (1.4 million), the proportion aged between 25 and 34 has increased markedly, accounting for more than 370,000 people *[Employment of Disabled People, 2023]*. In the South East, just under half of working-age adults who have a long-term health condition (LTC) lasting one year or more, are economically inactive *[ONS, 2024]*.

The nature of ill-health has changed as well. Between 2013 and 2023, for workers in England aged 16-34, the proportion reporting work-limiting mental health conditions has nearly quadrupled *[Health Foundation, 2023]*. Increased awareness of and changing attitudes towards mental health may play a role in this shift, though evidence from diagnostic questionnaires also indicate a rise in mental ill-health over the past decade.

For 50-64-year-olds nationally, MSK conditions are more common, making up 22% of the total rise in health-related inactivity in this age group *[Employment of Disabled People, 2023]*.

For cardio-vascular disease, from 2013 until the pandemic there was a 43% decline in the number of people in England who couldn't work because of it. However, over the period from 2020 to 2022, there was a rapid reversal, with a 40% increase in the numbers of working age people inactive primarily due to heart problems. Analysis shows that cardiovascular disease is the condition that increases the risk of exit from employment most sharply, especially in older adults *[IPPR, 2024]*.



Breakdown of Uk's working age population labour market activity, January to March 2023 (thousands) *[OHID Economic Inactivity in Young People Presentation, 2024]*

The majority (89%) of working-age people who were economically inactive in England because of long-term sickness in April-June 2023 had not worked in the last two years (65%) or had never worked (24%) *[Employment of Disabled People, 2023].* Data shows the longer an employee's sickness absence lasts, the less likely they are to return to work at all, and once an individual falls out, they are likely to stay out for a long time.

The proportion of 16-34 year olds in the UK who have never had a paid job because of long-term sickness, has seen a similar increase. Interestingly, most 18 to 24 year-olds who are workless due to ill health are non-graduates, and are therefore less likely to have received career advice and guidance, perhaps limiting their own assessment of their options *[Resolution Foundation and Health Foundation, 2024]*

It is universally acknowledged that work, *good work* in particular, must be a key pillar of any attempt to address the wider social determinants of health *[Marmot Review, 2010]*. Good work means not only having a work environment that is nominally safe, but also one that enables everyone to be as productive as possible and retain a sense of autonomy and security, regardless of any disability or long-term condition they might be living with. This is not only just, it makes economic sense: it has been estimated that, on average, preventing a single job loss can save employers £8,000 in recruitment costs and business output. Having one extra disabled person in full-time work, rather than being out of work and fully reliant on benefits, would mean the Government could save an estimated £18,000 a year, up to £28,000 per year of societal savings when considering increases in output, reductions in healthcare costs and increased travel *[Occupational Health: Working Better, 2023]*.

In the UK, there are currently an estimated 3.7 million employed people who live with a work-limiting health condition *[The Health Foundation, 2024].*

Area	Value
England	65.3
South East region (statistical)	68.6
Wokingham	80.1
Windsor and Maidenhead	78.7
West Berkshire	76.0
West Sussex	74.3
Surrey	73.6
Reading	72.0
Buckinghamshire UA	71.7
Hampshire	70.9
Bracknell Forest	70.3
Slough	70.1
Portsmouth	69.4
Medway	68.7
Oxfordshire	68.0
Southampton	66.5
Brighton and Hove	66.2
Milton Keynes	65.7
Kent	63.3
East Sussex	56.5
Isle of Wight	50.8

The percentage of the population with a physical or mental long term health condition in employment (aged 16 to 64) 2022/23 in England, the South East and county and unitary authorities in the South East (benchmark all in South East)

The aim of this project is to help OHID build effective relationships with local system partners leading, involved in or impacted by Work and Health initiatives, in order to better assist them in implementing national programmes and policies, with the ultimate goal of reducing economic inactivity by empowering and making it possible for more people with disabilities or long-term conditions (LTCs) to enter, stay in and come back to work.

Methodology

Building on previous work conducted by OHID North West, we reviewed existing evidence, particularly focusing on mental health, musculoskeletal conditions, and interventions that have proven successful in getting and keeping people into work. We also used local, national and healthcare data, including the Labour Force Survey and Fingertips, to identify inequalities and/or gaps in either provision or knowledge, that we could then bring to local partners to address.

Stakeholder engagement was a key component, involving qualitative interviews to gather insights into current practices, challenges, opportunities, and support needs (interview prompts in Appendix A). The findings were thematically analysed to inform the development of recommendations. Over the course of the project, we spoke to agencies on the national (DWP/ DHSC Joint Work and Health Unit), regional (ORD, OHID, NHSE, DWP) and local levels (4 out of the 6 ICBs, either directly or through updates at network meetings; 9 Local Authority PH teams, via semi-structured interviews).

Finally, recommendations for regional action were formulated based on the gathered data. Logic modelling techniques were employed to ensure that they align with and effectively contribute to our desired outcome of reducing economic inactivity due to poor health across the South East.

This report provides a summary of the findings from the stakeholder interviews and introduces our vision for OHID's role in supporting Work & Health in the region.

Summary of Stakeholder Feedback

The below is a summary of the feedback we received from stakeholders.

Role of Public Health

Views on the role of Public Health teams in the Work & Health domain varied greatly across our conversations, which may explain some of the diversity of ways in which colleagues have chosen to engage with it. Nevertheless, certain themes recurred:

1) To provide the evidence base, framing and intelligence for public health interventions. This includes clinical and disease prevalence data, but also best practice, policy rationale and health communication tools and resources to engage both stakeholders and the general population.

2) To advocate for vulnerable, underserved and/or at-risk groups and communities, and to guide resource-allocation towards tackling health and social inequalities.

3) To use existing partnerships and convening power to facilitate a whole-system approach and collaborative working. From healthcare providers (primary and secondary), through councils' economic development teams and jobcentres, to employers and community groups - the value of Public Health teams is in their networks and influencing ability. Encouraging partners to make every contact count (MECC) in terms of identifying barriers to work, was also mentioned as part of this point.

4) To provide a 'people and places' perspective to all levels of strategic thinking across the council and the wider system. To get disparate stakeholders to understand and support work on the wider determinants of health, as well as adopt a Health in All Policies approach, and to influence service design and commissioning.

5) To commission its own evidence-based services where possible, particularly around tackling inequalities.

6) To participate and guide internal recruitment and health at work processes and initiatives, modelling healthy settings from within the council.

Recommendations:

- Local Public Health teams should have a clear mission statement in regards to their role in the Work & Health domain. This should include an overview of the outcomes they are trying to achieve, what aspects of the work they are choosing to prioritise (given their limited capacity) and who are their key partners.

- Having member(s) of staff who lead on Work & Health within the team and champion it in relation to other projects and at stakeholder meetings, is necessary to retain momentum and encourage accountability.

Inequalities

Existing work tends to focus on specific geographical areas, particularly those with higher levels of deprivation. Research indicates that deprived communities often do not see themselves as eligible for support, instead accepting living with long-term conditions and their impacts as a norm. Conversely, there is debate over whether long-term conditions (LTCs) are the primary reason people are unable to work, or if there are more significant social determinants at play.

Some areas are targeted due to a higher concentration of employers that the council wants to engage, including larger employers (as part of establishing anchor networks), or small and medium-sized enterprises (SMEs) that lack workplace health provisions and/or are located in places with relatively poorer health outcomes.

Specific industries are also afforded greater attention: those that are male-dominated and labour-intensive, such as construction, manufacturing, and other routine or manual jobs, particularly around smoking rates.

Other groups mentioned as vulnerable and in need of employment support include those with mental health issues, informal carers, certain migrant populations, and people experiencing homelessness. Concerns have also been raised about insufficient support for young people to enter and remain in the workforce, particularly in high-need areas.

Some councils collaborate with their local Integrated Care Boards (ICBs) to identify inclusion groups based on the Core20+5 framework, and to incorporate considerations of inequalities into all policies and processes at the systems level.

Recommendations:

- Deprivation, unemployment and disease prevalence data should be cross-referenced with local and national employers registries (such as the Interdepartmental Business Register (IDBR)). This should be supplemented with qualitative research with residents and employers, to understand what is preventing people from working, and what they feel could be done to address it.

- Local authorities should develop targeted outreach, communication and support programmes to address the needs of deprived and/or vulnerable communities and groups, focusing on raising awareness about eligibility for support and providing resources on how to manage long-term conditions.

- A whole-system approach is necessary: a common understanding of vulnerable/targeted groups (based on Core20+5 or an alternative) between local

authorities, ICBs and other health leaders, jobcentres and the DWP, and employers, will allow for a more coordinated, holistic approach across the patch.

Work Within Councils

The majority of Work & Health-related initiatives mentioned in the interviews concerned the local council itself as a workplace. The idea, it seems, is to 'get the house in order' first, before moving on to support the wider community. Multiple partners admitted that there does not seem to be a great deal of momentum on the subject, but expressed enthusiasm for the upcoming rollout of national programmes.

Two similar, but distinct, tenets to the work were identified - supporting the council's workforce with their health, and using it as a site for existing community interventions. Examples of the first included commissioning a report on staff burnout, promoting cycling to work and other physical activity, employing mental health advisors, and convening a whole-council wellbeing working group. The second comprised smoking cessation and vaping support, NHS health checks, and using internal communications to propagate health messages.

In addition, a significant focus appears to be including health in councils' own strategy, decision-making and administrative processes, making them 'health-promoting'. From workplace health position statements with concrete deliverables, to HR wellbeing charters, to corporate parents/targeted recruitment schemes, public health teams are influencing systems to take health and its wider determinants into consideration. A common challenge appeared to be extending this into commissioned/contracted-out services, as it still does not, on the whole, play a role in provider selection.

Finally, some public health teams are keenly aware of the council's responsibility as an anchor institution, and eager to link with other large employers, share best practice, and amplify their influence. Conversely, there is a sense that public health is sometimes the only team within the local authority that recognizes this role, and that they face indifference and lack of understanding from other departments.

Recommendations:

- Include health and wellbeing and social impact in the selection criteria for commissioned and contracted-out services.

- Increase collaboration with other anchor institutions via communities of practice, local, regional and national networks. Consider common standards and joined-up working.

- Work with occupational health, HR and councils' corporate teams to better support the existing workforce and increase recruitment from vulnerable groups.

Work with Employers

While positive, productive relationships with individual companies were mentioned by most participants (largely to do with workplace-based health outreach by existing community programmes, or through collaboration with economic development teams), examples of systematic engagement of employers were relatively scarce: an accreditation scheme (Wellbeing at Work, in East Sussex), an online training module (still at the testing stage), a Future of Work event (almost two years ago, inspired by the IFW Good Work Charter) and sporadic involvement in a network of wellbeing leads, were the only interventions relevant to the Work & Health domain.

Recommendations:

- Employer uptake and participation are key for any Work & Health programme to be successful. Establishing a network of trusted partners, spanning large companies, public sector bodies and local SMEs should therefore be a priority. There are different ways to achieve that - through incentives such as communities of practice, free or subsidised occupational health services, micro-payments, or accreditation; or through regulation e.g. factoring social impact in procurement decisions, or through licensing restrictions.

Work with Residents

As with employer engagement, the extent to which different PH teams have harnessed Work & Health for their residents varies widely. Many areas have no structured programmes to support people with work, while others only rely on generic health interventions with a workplace remit, rather than anything specifically about employment. These include CVD health checks, mid-life MOTs, promoting physical activity and postural stability, mental health and wellbeing, smoking cessation, financial advice, and social prescribing. Some also encourage employers to actively refer people to health services.

Where Work & Health programmes do exist, they tend to focus on stakeholder leadership and data collection on the one hand (convening steering groups, Hampshire's Middle Years Data project), and providing skills training to keep people well, on the other (e.g. Link Up Leigh Park, training job centre staff to deliver brief interventions around smoking). One particular area of emerging interest appears to be Mental Health, with two local authorities already operating in the space, and another two preparing to invest in as of yet undetermined workplace support services.

Work with Stakeholders

Among the PH professionals we spoke to, there was a clear recognition that partnership working is key to successfully addressing unemployment and economic inactivity. A bottom-up, whole system approach, linking with employers, the DWP (particularly around addressing inequalities in their provision), Chambers of Commerce, voluntary sector organisations, job centre networks, other LA departments and, of course, with residents themselves, was repeatedly mentioned as the only way for Work & Health interventions to have a sustained impact.

Examples given of collaborative practice included:

- regular informal sharing between topic leads of best practice and data to facilitate strategic coordination.

- anchor institutions network to model health behaviours to one another and to smaller employers

- engagement with (and funding) WHISPAs*, providing information, advice, activities and/or accreditation around workplace health and wellbeing, such as guidance on flexible working policies, mental health support, fitness classes, etc.

- working closely with ICSs and ICBs to support funding bids, roll out national programmes such as WorkWell, and help coordinate actions in line with their fourth purpose. ICBs in particular complained about 'ad hoc' calls for applications and how the lack of advance warning or a consistent, accessible funding stream distracts from their strategic direction and eats into already limited resources. A robust peer network with a functioning 'alert system' could moderate some of the worst impacts of that.

- identifying aspects of the work that would benefit from being rolled out 'at scale' and being able to coordinate such action on the regional level.

- coordinating with councils' economic development teams and utilising their existing network of employers and stakeholders to promote a different kind of engagement with Work & Health. Also applies to local enterprise partnerships (LEPs).

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*WHISPAs - workplace health and wellbeing initiatives that are free at the point of use to workplaces

Strategic Work

The extent to which Work & Health concerns are integrated within the strategic priorities of systems varies across the region, as well as by the context to which they're deemed relevant. Overall, there appear to be several ways for a public body to put employment on the agenda:

- as part of needs assessments (be it of a specific population, or of residents in general; topic-based or as part of a JSNA)
- taken into account in strategic documents of other local government departments, such as economic development or planning, or in the council's corporate strategy
- featured in councils' local Health and Wellbeing strategy produced by their Health and Wellbeing Boards
- by including it in the area's ICB and ICS strategies
- focus of annual DPH reports
- considered by Health in All Policies working groups
- embedding health within all economic growth programmes and ensuring people with health conditions' needs are taken into account

Needs assessments that feature Work & Health usually approach the subject from an inequalities standpoint, with certain vulnerable populations (young people, people with disabilities or long-term conditions, those with mental ill-health or high levels of deprivation) finding it difficult to find and stay in work. Some may also focus on the wider determinants, or on the economic development of places or communities. Needs assessments are particularly useful in bringing a data- and evidence-driven dimension to the conversation, and highlighting the scale of the issue on a local level.

Council plans/strategies tend to be less explicitly health-focused and concentrate instead on the council's role in encouraging and enabling economic growth and wealth creation/retention, as well as meeting statutory social care duties. The former is often achieved through skills training, partnerships and incentives for employers, addressing infrastructure challenges and modelling behaviours as an anchor institution, while the latter focuses on expanding the social care workforce and early intervention for vulnerable populations (e.g. LAC and SEND support).

Health & Wellbeing and ICB/ICS strategies are, on the whole, mainly concerned with employment as a determinant of health. They recognise the need for a joint, whole-system approach to training, housing and healthcare, among others, in order to address inequalities and impact on outcomes, but do not always set out how to deliver it. Where strategies are outlined, they include going beyond traditional partnerships and engaging with businesses (as employers) and other institutions (schools, universities, central government) to create more routes into work (e.g. by situating employment advisors in primary care), supporting those in occupations with higher level of risk and/or deprivation, enabling older adults to stay economically active, providing carers with opportunities for employment, and making it feasible for people with LTC to stay in work.

Recommendations:

- Consider how strategic integration is replicated across systems. Critical mass is important - the more mention of an issue/domain, the more influence that has with ‘big hitters’. Strategies don’t work in isolation and, in the absence of an overarching set of outcomes, consistency is key. How can Work & Health be tied to other national priorities (e.g. MSK and MH)?

- Consider partner capacity and the funding that is available to support them. How can limited resources be maximised within a network? What are the actions needed to put strategy into practice, and who is best placed to carry out each task? What is the role of peer learning, especially in real time? What are lessons learned from the two WorkWell pilot areas?

Future Work & Support

Multiple colleagues identified further engagement with other anchor institutions (in line with the work of the Joseph Rowntree Foundation) as important, defining their role and maximising their influence. Working with both large employers and SMEs, and enhancing collaboration with workplace health leads to share best practice, was also seen as crucial.

Similarly, building relationships with integrated neighbourhood teams, PCNs, and social prescribers was considered a good way to gather insight into individuals who are ‘barely holding on to work’ but wouldn’t seek employment support on their own. In general, in-person rapport-building was considered the best way to identify inequalities and gaps that initiatives like skills boot camps could address.

Working with youth centres is important in order to bridge the gap between finishing education and entering the workforce. Leveraging existing youth provision helps engage target populations, especially young men, but, by itself, may mean they miss out on the comprehensive support over their first year of work that dedicated employment services offer. Thus, place-based targeted programmes are necessary, such as the Health Foundation’s Economies for Healthier Lives project.

Gathering and utilising data at all levels (ICBs, upper-tier and lower-tier local authorities, wards) is needed to properly design, integrate, and evaluate Work & Health services. This helps better identify and understand inequalities, particularly in overall affluent areas, and evaluate the success of interventions that are harder to quantify, such as social prescribers.

Overall, there is a need for better information sharing among partners across the system. Public health is often seen as secondary in employment-related discussions, leading to late awareness of opportunities and lower prioritisation when resources are allocated.

Recommendations:

- Develop a platform, such as a newsletter or forum, to proactively disseminate information about Work and Health, particularly upcoming policies and programmes. It should provide guidance on integrating these elements within the existing service framework and highlight the role of public health, including examples of good practice.

- Establish, agree and adopt a consistent, region-wide position on the role of anchor institutions, particularly those part of the NHS. It should emphasise the relevance of the Work & Health domain to the ICBs' fourth purpose and their responsibility in amplifying local concerns within the larger NHS system.

- Create data resource packs for each area, including local and regional maps of unemployment rates, proportion of people in the gig economy, benefits recipients, qualification levels, what a 'fair wage' is in the region, long-term sickness prevalence, and more. If capacity is limited, that at least a blueprint of data sources would be useful. This resource should also include evidence of effective interventions for different groups, potential inequalities, and a mapping of local partners and significant employers to help identify opportunities for engagement.

- Develop a self-assessment checklist for Work & Health to guide areas, especially those new to resident-facing work, on what aspects to focus on and how to begin integrating relevant practices into their operations.

Summary of Recommendations for OHID

Identifying, Using and Developing Tools

- Facilitate a stakeholder mapping exercise to identify what additional agencies can be invited to existing networks e.g. locally-operating carer support charities.
- Develop a platform, such as a newsletter or forum, to proactively disseminate information about Work and Health, particularly upcoming policies and programmes. It should provide guidance on integrating these elements within the existing service framework and highlight the role of public health, including examples of good practice.
- Identify or develop a self-assessment checklist for Work & Health to guide areas on how to integrate new programmes into their operations.
- Work with anchors to identify or produce a self-assessment checklist of good health-related employment practices to model, including agreeing on minimum standards to be adopted across the region.

Using Evidence to Define Parameters of Work

- Support areas in agreeing and adopting a coherent, region-wide position on the role of Public Health teams in engaging with the Work & Health domain.
- Identify a member of staff within each Public Health team who leads on Work & Health and use them to amplify messages from central government and/or partners, and ensure accountability in terms of participation in networks, key regional stakeholder meetings and communities of practice.
- Facilitate pan-regional approach to supporting inclusion groups with Work and Health, based on the latest evidence and best practice
- Conduct or commission more research into the specific local causes of economic inactivity in different areas. For instance, the most common reason for people being out of work on the Isle of Wight and in East Sussex is long term sickness, while in Slough, it is looking after family. Those differences are crucial in terms of the support services needed, but get lost when looking at the region as a whole.

Partnership Working

- Be a voice for W&H in all fora OHID is a part of e.g. ICS and PCN meetings, anchors network, etc.
- Facilitate system wide partnership working with DWP across the region and work with them to roll out national programmes.
- Support local areas with establishing and implementing new ‘Work, Health and Skills’ plans as per the government’s Back to Work plan and other related policies.

Appendix A: Interview Prompts for Meetings with Stakeholders

1. **What are you currently doing? / What is your PH team's role in work and health?**

- Role – What is your role? What are your priorities?
- Strategy – Do you have a Work and Health strategy? Is Work and Health included in other strategies e.g. Health and Wellbeing Strategy, ICB Plan, Council Plan
- Data – what data analysis/intel do you have on work and health? Is work and health included in your JSNA?
- Interventions – Workplace health programmes, Universal Support, Disability Confident Employers, WorkWell, Additional Work Coach time, Individual Placement and Support in Primary Care
- Engagement – who and how engages with: Job Centres, Economic Growth team, Functional Economic Area leads, ICB, employers, networks, facilitation, co-production
- Inequalities – target populations? People with health conditions/ disabled people/ People with Mental Health or Musculoskeletal conditions / People in areas of high deprivation/ People on low incomes/ Specific gender/age, etc.
- Evaluation/Outcomes

2. **What more would you like to do?**
- Opportunities
- Challenges
- Gaps

3. **What support do you need?**
- National
- Regional – data/networks/sharing best practice/evidence
- Local

4. **What is the public health role in work and health?**

5. **Is there anyone else we should be speaking to at this stage?**

Appendix B: Full Logic Model Showing Interdependencies and Complexity

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