**Expert Workshop**

**What good health can contribute to productivity**

Held on 11 October 2016 at the Health Foundation

**Introduction**

UK productivity – or lack of it – continues to rise up political, business and public-sector agendas. A report published in October 2016 by the Office for National Statistics (ONS 2016) estimated that output per hour worked in the United Kingdom in 2015 was 18 percentage points below the average for the rest of the G7 advanced economies (a productivity gap that is unchanged compared with the previous year), despite the publication in July 2015 of a government plan to increase productivity (HM Government 2015). Productivity is also a particularly pressing concern in the NHS, as calls continue for ever greater efficiency savings.

And yet the role of employee health everywhere is often not front-and-centre in discussions on how to improve productivity, despite its impact on sickness absence and presenteeism – so *What good health can contribute to productivity* was a clear choice for the subject of the Expert Workshop that rounded off C3’s ‘Improving the health and wellbeing of the NHS workforce’ project.* The Workshop brought together 21 people – from the NHS and the private sector, academics, influencers and some ‘unusual suspects’ – to share experiences on workplace health across sectors and disciplines, addressing the barriers to workplace health and the opportunities to embed it.

The Expert Workshop included two keynote talks, from Professor Kevin Daniels (Norwich Business School and the What Works Centre for Wellbeing) and Dr Steven Boorman (Empactis, and the author of the influential 2009 ‘Boorman Review’ of wellbeing in the NHS) – these are described in detail in the Annex to this report. The rest of the discussion – which included eight brief ‘lightning talk’ presentations (four minutes each) – was held under the Chatham House Rule, so the reporting is by theme and no individual participant is identified.

**Themes of discussion**

**Making the case**

The impact of good health – both physical and mental wellbeing – on productivity is not a new concern: in the 19th century, George Cadbury recognised that improving the working conditions of his workers would improve both productivity and quality of output. The case is, broadly, accepted: a survey of 400 people, undertaken by the What Works Centre for Wellbeing, found that people do connect wellbeing with productivity (both absenteeism and presenteeism). There is a business case for action (improving the bottom line), a moral case (the ‘right thing to do’) and also a taxation case (lost productivity and long-term...
sickness absence have implications for lower corporate tax returns and higher spend on long-term health-care and disability benefits).

And yet, too often ‘health’ is seen as a cost, rather than an essential investment for the future, seemingly occupying a different mindset from decisions into, for example, investing in up-to-date IT or facilities. There is a tension between the long-term investment in wellbeing and the financial squeeze affecting so many parts of the economy – notably the NHS (where there are serious challenges to making long-term investment decisions), and sectors in which zero-hours contracts and a lack of training are increasingly commonplace. Investing in a health-promoting workplace may be part of genuine corporate social responsibility, but the non-believers need to be engaged, too – by making clear the difference that good health can make (for example on patient outcomes in the NHS).

Evidence
An important question is: how much (and how detailed) evidence do we need to make the case?

‘Lack of evidence’ may be cited as an excuse for failing to invest in a healthy workplace – but in fact there is significant evidence to support the link between wellbeing at work and productivity. There is a consistent relationship between job satisfaction and performance indicators, with around 12 per cent of the variation in organisations’ overall productivity being shared with average levels of job satisfaction. There is clear evidence that ‘good work’ (jobs that are skilled, autonomous, well supported, secure, with good work–life balance, good income, progression and clarity of role) is associated with better physical and mental health – and less absenteeism. Studies have been carried out by Professor Cary Cooper and by the Sainsbury Centre for Mental Health that link wellbeing and mental health with reduced presenteeism and increased productivity.

The evidence of the impact of tackling risk factors such as smoking, physical activity and obesity is also clear – both outside and within workplaces. A survey of 25,000 health workers found that those who smoked are twice as likely to take time off work, and twice as likely to take longer time off, and a study of Transport for London found workers with obesity (BMI of over 30) take an average of three days more in sickness absence each year than those with a normal BMI (under 25), and those with severe obesity (BMI over 35) take six days more. There are interventions – for example in smoking – that are recognised by NICE as effective, and yet workers are often not given access to these, despite the impact that it could have on the bottom line as well as on health.

Investment in occupational health has been shown to make a significant different. Using data from Royal Mail, the London School of Economics analysed data from the Royal Mail, where an investment of £45 million led to a £225 million return on investment over the period 2004 to 2007. The study concluded that, were the 13 worst-performing sectors to follow suit, the impact on the economy could be £1.45 billion.

The CQUIN (Commissioning for Quality and Innovation) system – a system that makes proportion of health-care providers’ income conditional on demonstrating improvements in quality and innovation – was cited several times, having recently been expanded to include requirements on areas around employee health. This provides an incentive for NHS Trusts to begin to take action on areas such as physical activity – and be able to demonstrate their impact.

Being smart with the way that evidence is gathered (being sure to build in measurement from the start, and factoring in the impact of external context, such as a recession) is key. There should also be greater flexibility in ‘what counts’ – for example, through making better use of case studies and other grey literature. There are plenty of examples out there, but identifying them can be challenging. Requiring too high a standard of proof makes us ‘our own worst enemies’. And, because organisations may not want to share their data, there is much that remains unpublished and un-peer-reviewed – but internal data can be effective in persuading a board to take action.

Leadership and engagement
It was clear throughout the discussion that leadership plays an essential part in embedding health within an organisation – through the involvement of the Board, trade unions, senior management, line managers and peer leaders (role models): ‘It makes a difference if you think your employer cares.’
The benefit that engaging the workforce as a whole has on the NHS has been investigated by Aston University, which found a clear reduction in the likelihood of a patient dying in an acute Trust in which staff are more engaged. Engagement is an important aspect of the annual NHS Staff Survey, and so can be measured over time.

Role modelling can also play a key role – both within an organisation (such as the use of health ambassadors to spread the word about health) and as an example to clients (such as trialling aspects of a health programme internally before recommending to others).

Careful discussion with employees throughout the organisation will also enable employers better to ascertain the requirements of the workforce – this may not always be what you want to hear (the employees of one organisation said that they wanted more chocolate), but it is essential if the right programmes and priorities are to be delivered. The best ideas may not come from the top; the real change may be driven from those who will be most affected.

‘Bringing people with you’ can make changes run much more smoothly and effectively, as well as identifying what those changes should be in the first place. Society beyond the workplace is changing (differing patterns of transportation and child care, for example), and the workplace should appreciate and adapt to these realities.

Discussion with the workforce can also help to identify the influencers within an organisation – who could perhaps act as ambassadors. And appreciation of their work – particularly when they are donating their time – was also singled out as being essential, as volunteers may be fundamental to the success of health or engagement initiatives.

There was a word of caution voiced that high engagement does not necessarily equate to high wellbeing – where individuals are very highly engaged, they may work too many hours, fail to take breaks or time off, which can impact both on their wellbeing and, ultimately, on their productivity if they reach burnout.

Successful engagement with employees may also facilitate a better understanding of the role of health within the organisation. For example, bringing sickness absence down to zero (coming into work even when ill) is good neither for the employee nor the organisation, and this is particularly true in the NHS, where infection could be spread to patients, but where staff may feel under obligation to come into work to support overstretched colleagues.

The workplace as a community

This sense of being socially embedded within the workplace was highlighted many times as being fundamental to good work, to health and to productivity (and will be the focus of future research by the What Works Centre for Wellbeing). Where there is a sense of belonging, people are more likely to give extra effort and there will be less conflict – and if there are shared values around health then employees are more likely also to engage in health-promoting activities. Together, leadership, engagement and social belonging create a culture of health, which underpins productivity. This can also engender a greater sense of trust between employee and employer, facilitating better relationships within which to discuss personal health issues and a belief that privacy will be respected.

What works for all and what works for some?

There is clear evidence that good working practices – such as autonomy, good management and work–life balance – are fundamental to both wellbeing and productivity in the workplace, and what is good for wellbeing can also be good for creativity, innovation and on-the-job learning. For health to be successfully embedded, it should be integrated into business practice (not just see as an add-on), and with a sense of ownership among the workforce. However, beyond these ground rules, different challenges are faced by different categories of employee, dependent on factors such as type of work, sector, gender, geography and age.

To be effective, tailored initiatives may be required – for example, the case for health may need to be made differently in male- or female-dominated workplaces, requiring different messaging and a focus on different health behaviour – although it is clear that it is possible to engage everyone, if the nature of the workforce is sufficiently understood. There were also some interesting parallels between public and private
sector – for example, shift workers in the NHS and in manufacturing, who face challenges around access to healthy food or physical activity.

Nurses were cited as one example of a workforce requiring specific interventions. There are 360,000 nurses in England, of whom 25 per cent are obese, with consequent increased risk of type 2 diabetes, hypertension and pressure on joints. Nurses are also now expected to work longer, often face 12 hour (irregular) shifts, and may not have the time even to have a drink of water or go to the toilet. They can also play a role of motivator for lifestyle change, as well as being a caregiver – and empowering them to take control of their own health is an important step. Designing an initiative with nurses to tackle obesity is essential, and even finding the time to come to focus groups to discuss it can be challenging – but we have to make a start.

Large and small organisations, too, face very different challenges and have different solutions. Among the examples given by representatives of large organisations at the Workshop were establishing a series of themes around healthy mind and body (each theme being supported by a director (with a personal interest) and a peer ambassador), themed roadshows (on, for example, healthy eating) and running specific training for shift workers on how best to manage fatigue and nutrition. For small- and medium-sized enterprises (SMEs) the challenges are around scale and time – the Workshop included some examples of what can be done, including taking small steps towards health, encouraging cycling, flexible start- and finish-times to the day, and making good use of existing free resources.

Education and behaviour change

Education and training are important steps in creating a more health-promoting workplace – for example, enhanced management training to include awareness of mental-health issues, educating health-care workers on the link between their own health and the health and safety of patients, or providing screening for employees so that they are aware of their own health issues. Examples of education initiatives given at the Workshop included health screening and education for employees at a large food company (taken up by over 90 per cent of the workforce) and the Healthy Living Week for NHS organisations in London, now reaching 45 organisations from CCGs to acute Trusts, and with initiatives ranging from hospital-wide events to small groups of nurses bringing in healthy food for themselves and colleagues.

However, education is not sufficient for sustainable behaviour change: the challenge is to bridge the gap between knowing and doing. This is likely to take time – but taking small steps (for example, encouraging physical activity such as using the stairs) can be effective. In one organisation the instigation of Email-Free Fridays cut down on emails in the rest of the week (reducing once source of overload). Competitions and challenges can create enthusiasm and temporary change – but habit-formation will not happen overnight, so a longer-term commitment is needed. And this commitment must be to initiatives that employees really want and that are fully supported – they need to have the capability and the confidence to change.

Future discussion

The Expert Workshop identified a number of areas for potential future discussion:

- **What hasn’t worked?** Some examples were given during the Workshop of things that have not been successful – and more sharing of these challenges would be particularly welcomed. Too often, meetings and conferences focus only on the positives, when everyone working in this space knows that improving health and productivity is often about trial and error.

- **Better definition of terms:** Terms such as ‘wellbeing’, ‘health’ and ‘presenteeism’ are often discussed but without a clear definition of what they mean in the context of the workplace.

- **Evidence:** How much evidence (and for whom) is needed on the impact of initiatives and need for investment? How can we make better use of existing case studies and ‘grey’ literature?

- **The workplace as a hub:** What are the opportunities to spread health messages and initiatives beyond the workplace – to families, local communities and suppliers?

- **What makes some initiatives snowball?** What are the characteristics of really successful health initiatives?
• **Sustainability**: What makes initiatives to improve health and productivity sustainable over the long term – both in terms of behaviour change and of investment by the organisation?

**Annex**

This annex consists of a summary of the two keynote talks given at the Expert Workshop – by Professor Kevin Daniels and Dr Steven Boorman.

**Wellbeing and productivity are mutually compatible, not mutually exclusive**

*Professor Kevin Daniels (Norwich Business School and the What Works Centre for Wellbeing)*

There is an occasional misconception among some managers and some management students that ‘if people are “too well”, they’ll be too comfortable and won’t work well!’ This is absolutely not the case, as the presentation made clear. Kevin’s focus is on wellbeing in its broad sense, including the impact of employment practices, and he drew on information derived from an evidence review for the Work and Learning Programme of the What Works Centre for Wellbeing, which is part of the What Works network. The aim of the Centre is to improve the wellbeing of the nation, particularly psychological and subjective wellbeing (such as happiness). Funding for the Centre is from a variety of sources and is organised by the Economic and Social Research Council. The Centre involves contributions from many universities.

One of the first tasks of the Work and Learning Programme was to consult with over 400 stakeholders across the four countries of the UK on their attitudes and priorities for wellbeing at work and in adult learning. These included adult learners, workers, managers, union representatives, and experts in employment relations and occupational health. In relation to work, people cited happiness and mental and physical health as being important, but also that productive economic activity – including low absence and presenteeism rates – is closely linked to wellbeing. In other words, many people believe that if you are well then you will be productive.

A key message is that being a happy, productive worker is also about a sense of belonging to a community, being socially embedded and connected.

There are clear business and moral cases for improving wellbeing at work – and now there is a taxation case too: lost productivity and long-term sickness absence have implications for lower corporate tax returns and higher taxation spend on long-term healthcare and disability benefits.

The evidence:

- There is a consistent relationship between job satisfaction and performance indicators, with around 12 per cent of the variation in organisations’ overall productivity being shared with average levels of job satisfaction in organisations. (The studies showing this are not longitudinal, and are therefore not predictive, and have not included interventions – but they have been consistent across numerous studies (Whitman et al. 2010).)

Possible explanations for the link between job satisfaction and productivity:

- When people are happy at work they are more likely to give extra effort – for example, to help others or take on work beyond their job description. (The inverse is working to rule, which is the first step on the road to strike action and which reduces organisational effectiveness.)

- Workplaces in which everyone is happier have better social relations and fewer politics and conflictual relationships.

The link between high-quality work and wellbeing:

- Where good working practices are in place then wellbeing can be increased by improving indicators of performance. For example, work demands do not have to be detrimental to wellbeing if individuals have autonomy over how they work and are well supported by colleagues. We are natural self-regulators – and good employment practices help people to manage their own wellbeing. Often, what is good for wellbeing is also good for creativity, innovation and on-the-job learning.
The stakeholders consulted by the Work and Learning Programme were asked about what they felt were the most important factors in improving wellbeing at work. A consistent answer across all stakeholders was the provision of high-quality jobs (i.e. jobs characterised as skilled, autonomous, well supported, secure and with good work–life balance, good income, progression and clarity of role). The epidemiological evidence here is ‘absolutely overwhelming’ (such as the Whitehall II study on cardiovascular disease): high-quality jobs are associated with less absenteeism and better physical and mental health. However, intervention studies are more ambiguous. We need to identify what is happening differently in organisations that are successful in improving job quality and wellbeing versus those that try to improve job quality but do not improve wellbeing.

To address this issue, the Work and Learning Programme conducted a systematic review of 31 relevant studies, plus two that focused on how to implement changes. The review found that successful interventions were accompanied by management commitment (although this is not sufficient on its own), integration of changes into other business systems, involvement of those affected by the changes (ownership), and sensitivity to local contexts.

The review looked at different forms of intervention and their impact (if any) on wellbeing and productivity. Although showing some positive effects on wellbeing, there were no clear and consistent effects of training workers to improve their own job quality or training line managers to improve the job quality of those they manage. Participatory interventions – those that allow groups of workers to make changes to their own jobs – were found to have mixed effects on wellbeing, with some even having negative effects. One promising form of intervention for improving wellbeing was to introduce improvements in job design alongside training. However, more extensive interventions appeared to be promising for improving both wellbeing and organisational performance. These more extensive interventions involve redesigning jobs alongside enhancements to training and changes to other employment practices (such as the introduction of different reward packages).

In an example of the latter kind of intervention, Kevin gave the case study of an organisation that changed its focus on skills and abilities (e.g. training on safety and communication), motivation (e.g. a shift to reward-based management) and job design, with strong backing from both the CEO and the trade unions. This led to a small improvement in job satisfaction of around 8 per cent, but had a bigger impact on productivity (up by 14 per cent) – after the intervention, there was also a 24 per cent reduction in time delays, a 33 per cent reduction in accidents and a 77 per cent reduction in lost-time incidents (Tregaskis et al. 2013).

What good health can contribute to productivity: a view based on working with Royal Mail, the NHS ... and others!
Dr Steven Boorman (Empactis)

Steve is a member of the NHS England advisory board on workplace health, and was the primary author of the 2009 Boorman Review into health and wellbeing in the NHS. While Kevin is an academic, Steve spoke from the perspective of having spent years working in business in occupational health – which was often being squeezed financially, as it can be hard to make the case to invest in something that tends to be seen as a cost (i.e. health) versus something practical (such as buying a new sorting machine).

Managers think very differently about health than they do about IT, vehicles, complex machinery or facilities; if these are not maintained, you will be sacked – but this is not the case in health. For a car to be high-performance, money needs to be invested upfront in maintenance/prevention and – to extend the analogy – the track conditions are getting tougher. We are asking people to race harder – and yet the whole approach seems to be based on trying to put the car back on the track once it’s gone wrong (reactive approach), rather than maintaining it in the first place.

The business case is not new. Cadbury is thought of as a great philanthropist – but his business had been in trouble (half the workforce had been laid off due to overseas competition) and he realised that productivity and quality would improve if working conditions were improved. And the first chief medical officer at Royal Mail was appointed to reduce sickness absence because delivery was becoming so unreliable.
Steve highlighted the demographic issues facing modern workforces and used the example of rising obesity rates. He gave as an example a major utility company whose front line engineers were showing year on year rises in obesity with potentially higher costs of sickness absence. A study undertaken within Transport for London showed that obese workers take three days more off sick each year than people with a BMI under 25, and those with severe obesity take six days more (Harvey et al. 2010).

Steve shared the example of Royal Mail in the early 2000s at a time when it was losing £1 million a day. Industrial action was high (accounting for 70 per cent of UK strike days) and the workforce felt that the company’s leaders did not care. The accident rate was three times that of the construction industry, and it failed 14 out of 15 regulatory targets (for which it faced enormous fines). Despite having a monopoly of the market, it was losing market share as customers tried to find other ways to send messages, as they did not trust the post. A forward-thinking management team recognised the opportunity to invest in staff health as an engagement tool.

The turnaround was remarkable in 18 months: profits rose to £1.5 million a day, absence fell to 3.5–4.5 per cent, the accident rate halved, and the target for first class post was reached for the first time in 10 years with fewer staff.

David Marsden of the London School of Economics (Marsden and Moriconi 2010) analysed the data and concluded that the £45 million invested in occupational health (broadly defined) led to a £225 million return on investment over the study period (2004–7). In addition, an average of nine extra parcels a day were delivered from each Parcelforce depot, which could make a significant difference in terms of staying in business. The study concluded that, were the 13 worse-performing sectors to follow suit, the impact on the economy could be £1.45 billion.

One of the stark findings of the Boorman Review into health in the NHS was that 80 per cent of NHS staff felt that their health and wellbeing impacted on the care they give to patients, but only 40 per cent felt that managers cared.

A survey of 25,000 health-care workers found that those who smoked were twice as likely to take time off work, and nearly twice as likely to take longer time off. Steve commented that when NICE says that smoking interventions are effective, everyone in the NHS should be given access to them. The evidence on physical activity is also a clear business case – while 65 per cent of non-exercisers take sickness absence in a year, this falls to 57 per cent among people who do regular exercise (supporting data to Boorman Review 2009).

The final conclusion of the 2009 Review still stands: NHS Trusts in which staff scored highly on the health and wellbeing index have better performance across a range of measures, including financial, agency spend, patient satisfaction and fewer acute infections.

Since the review, a three-year study on the impact of good engagement with staff has been carried out by Michael West at Aston University, which showed a clear reduction in the likelihood of dying in an acute Trust in which staff are more engaged (unpublished data submitted to NHS Innovation and Strategy Group).

While Steve accepts that there is a need for academic rigour in studies of wellbeing intervention, he urged some caution and practicality: we do not do control studies on parachutes! We may not always be sure what aspect of an intervention is effective, but it does make a difference if you think your employer cares.

Much data is unpublished and un-peer-reviewed, often because it is seen as not ‘rigorous’ enough and kept internal to business – but it can be effective in persuading a board to take action.

Also – rehab works! At Royal Mail a £350,000 investment was made in a high-end rehab unit at a sorting office. There was an analysis of the cost of the reduction in space for sorting mail, the cost of the rehab staff and kit – but it had a big impact. One patient had been on 50 per cent productivity for a decade because of a bad back, and came back to full duties. The estimated return on investment was 5:1 in the first year, and 3.2:1 once the programme had stabilised.

There are many sources of evidence (see References section), and yet we keep coming back to ‘where is the business case?’ We are our own worst enemy!
It is often small pieces of information that persuade clients and boards to continue interventions – for example:

- during an engagement programme at a large retail company, employee turnover fell to 0.5 per cent, sickness absence fell 7 per cent in one month, 10,500 employees took wellbeing pledges (such as to drink more water), and employees lost a total of 4 tonnes of weight;
- another large retailer that implemented a telephone support and self-treatment (video-based) physiotherapy programme, rather than a face-to-face programme, saved 23,000 days’ productivity through fast-tracking, with a 50 per cent reduction in pain and 21 per cent increase in movement and increased productivity of 1.1 days per week per person; and
- a utilities company that offered a cognitive behavioural therapy service for specific cases identified through the OH team repeatedly demonstrated over 400 per cent return on investment.

One challenge is that occupational health often does not collect adequate data. When working with a large utility company, Steve took information from an insurance database to compare the amount of time off that would be expected with a particular ICD code (e.g. sedentary/light/medium/heavy work) and compared this to the actual time off and the cost of each OH intervention (such as physiotherapy) – and found a consistent return on investment of between 2.4 and 4. This persuaded the customer that the programme should not be cut.

Steve also presented further data from the NHS. There have been some interventions into musculoskeletal disorders and, although they have been widespread and disparate, they have been broadly costed, and are not expensive to introduce. One peer-reviewed study from Southampton (Smedley et al. 2012) reduced sickness to the level of the private sector.

In conclusion: when people allege that the evidence is not available, he agrees that not all studies reported are academically robust – but there are many case studies upon which we can draw in clever ways. [See, for example, the set of case studies produced with this report.]
References

Reference was made to the following publications during the course of the Expert Workshop (not all are mentioned in the report précis, but are provided here for completeness).


Business in the Community. The Workwell Model (http://wellbeing.bitc.org.uk/issues/workwell-model) and Mental Health at Work Reports (http://wellbeing.bitc.org.uk/all-resources/research-articles/mental-health-work-report-2016)


CIPD (Chartered Institute of Personnel and Development) 2016. Growing the Health and Wellbeing Agenda: From First Steps to Full Potential: https://www.cipd.co.uk/publicpolicy/policy-reports/health-well-being-agenda.aspx


Time to Change (including materials on mental health in the workplace): http://www.time-to-change.org.uk/


Whitehall II (the Stress and Health Study): https://www.ucl.ac.uk/whitehallII