E R S
Research &
Consultancy

Health at Work: Economic Evidence Report 2016

ERS
Milburn House
Dean Street
Newcastle upon Tyne
NE1 1LE

T: 0191 244 6100
F: 0191 244 6101
E: newcastle@ers.org.uk
www.ers.org.uk

Contents Page

1. The Case for Action

About This Report

1.1 This report compiles evidence of the impact and effectiveness of workplace health initiatives, building upon our original report produced in 2014.

1.2 Over the last decade a number of research studies have identified the impact that ill health has had upon the economy. We present compelling evidence of the cost to employers of sickness absence, presenteeism and staff turnover and how these costs could be reduced through the introduction of up-front investment in workplace health initiatives. Alongside this report we have also prepared a 'cost calculator' tool accessed on The British Heart Foundation website: www.bhf.org.uk/health-at-work/get-started/cost-savings-calculator

Staff Absence

1.3 Staff absence is important to business – it is disruptive to operations requiring management resources to organise cover and can impact upon the need to pay staff overtime. Sickness absence costs UK businesses an estimated £29bn[1] each year, with the average worker taking 6.6 days off each year due to sickness[2]. In 2011, the government set up a review of the sickness absence system to help reduce the 140 million days lost to sickness absence every year. The review considered how the current system could be changed to help people stay in work, reduce costs and contribute to economic growth[3]. It has been estimated that an average London firm of 250 employees loses around £250,000 a year due to ill health[4]. The productivity loss as a direct cost of cardiovascular disease is £8 billion each per year[5].

1.4 The average level of employee absence in 2015 increased slightly compared with the 2014 rate, from 6.6 to 6.9 days per employee, although it remains lower than in 2013 (7.6 days). There is, however, considerable variation in absence levels across and within sectors. Average absence has increased most in the public sector where it is now 50% higher than in the private sector[6]. The level of absence across the UK also tends to be higher in larger organisations, regardless of sector, and on average manual workers have 1.5 more days absence per year than non-manual workers[7].

[1] PWC Research, The Rising Cost of Absence 2013
[2] CIPD - Absence Management: Annual Survey Report 2015
[3] Department of Work and Pensions and HM Treasury (2014) Helping people to find and stay in work
[4] GLA Economics: London's Business Case for employee health and well-being 2012
[5] European Cardiovascular Disease Statistics Nov 2012 www.bhf.org.uk/publications/statistics/european-cardiovascular-disease-statistics-2012
[6] CIPD - Annual Survey Report – Absence Management 2015
[7] CIPD - Annual Survey Report – Absence Management 2015

1.5 Indirect and hidden costs can cause employers to spend the equivalent of about 9% of their annual costs on absence[8]. Overall, the median cost of absence per employee was £554[9] in 2015, a reduction from £595[10] in 2013. The estimated cost remains considerably higher in the public than the private sector (£789 compared to £400)[11]. Over the previous two years the gap has widened considerably. By tackling sickness absence the employer can benefit from retaining human capital, reducing staff turnover costs, improved reputation and a more engaged and productive employee[12].

1.6 A review of UK case study examples of employer wellness programmes [13] found that:

- Reduced sickness absence was evident in 82% of programmes, making a positive contribute economically via reduced overtime payments, temporary recruitment and permanent staff payroll;
- Reduced staff turnover was evident in 33% of programmes, making a positive contribution economically via reduced recruitment costs;
- Reduced accidents and injuries was evident in 29% of programmes, making a positive contribution economically via reduced legal costs/claims, reduced insurance premiums and reduced healthcare costs;
- Increased employee satisfaction was evident in 25% of programmes, making a positive contribution economically via reduced recruitment costs;
- Reduced resource allocation was recorded in 16% of programmes, making a positive contribution economically though reduced management time;
- Increased company profile was reported by 15% of programmes, contributing economically via reduced recruitment costs;
- Increased productivity was reported in 15% of programmes, presenting a positive economic contribution via increased revenues, reduced overtime payments and reduced permanent staff payroll; and
- Increased health and welfare was evident in 15% of programmes, making a positive economic contribution via reduced healthcare costs.

[8] Bevan, S and Hayday S - Costing Sickness Absence in the UK. IES Report 382 for the Institute for Employment Studies 2001
[9] CIPD - CIPD - Annual Survey Report – Absence Management 2015
[10] CIPD - Annual Survey Report – Absence Management 2013
[11] CIPD - Annual Survey Report – Absence Management 2015
[12] CIPD - Recovery, rehabilitation and retention: Maintaining a productive workforce 2004
[13] PricewaterhouseCoopers - Building the Case for Wellness, 2008

1.7 Most firms in the UK undertake some form of absence management, with 95% of firms surveyed by the CBI[14] and 94% by CIPD[15] having an absence management policy. CIPD found that just under half of employers have a target in place for reducing employee absence with the CBI finding that more than a third of employers – and half of those in the public sector – have set an explicit target for reducing absence over the coming year.

1.8 In order to measure the return on investment, employers should track key metrics such as levels of sickness absence, including reasons for absence and the direct and indirect costs; productivity and employee satisfaction with work and management; ill-health, including health risk and lifestyle issues such as smoking and alcohol; and wellbeing.

1.9 Most employers do not currently measure all of these on a regular basis, but without a clear picture of 'before' and 'after', it can be difficult to assess what difference the initiative and investment has delivered. Some metrics can be harder to measure such as productivity but in this case it should be identifiable in terms of an improvement in financial measures such as: increased revenues (per employee), reduced over-time payment, reduce wage bill (i.e. less employers required for the same amount of work) and reduced penalties linked to extended deadlines.

1.10 Evidence shows that employers that invest in appropriate workplace health initiatives to support the health and wellbeing of their employees have the potential to see a significant return on investment[16]. A review of academic studies shows that the return on investment for some workplace health initiatives can range from £2 for every £1 spent (1:2) to £34 for every £1 spent (1:34)[17].

1.11 The evidence indicates that typically holistic wellness programmes can be expected to show a positive financial return over a period of 2 to 3 years, whereas more targeted interventions are more likely to show a pay-back earlier[18].

1.12 A selection of case studies reviewed report a return on investment, in terms of benefit-cost ratio (BCR), for their wellness programmes. This ratio highlights the nominal return for every unit of cost expenditure. The magnitude of the benefits can vary significantly and depend not only on what type of organisation and programme is involved, but also on the way the programme is planned and executed.

[14] CBI - Healthy returns? Absence and workplace health survey 2011
[15] CIPD - Annual Survey Report – Absence Management 2015
[16] BUPA, Workplace Health – A Worthwhile Investment, 2010
[17] Healthy Work – Evidence into Action 2010 page 46 Figure 9.
[18] PricewaterhouseCoopers - Building the Case for Wellness, 2008

1.13 There is a financial cost of delivering a wellness programme, generally spread over:

- Start-up costs: management time; external consultants; capital equipment; promotion and marketing; training, etc.
- Operating costs: management time; staff salaries; bought-in goods/services; training, etc.

1.14 Some employers have adopted specific initiatives in response to staff absence trends in their organisation, and such an approach has been proven to work.

British Gas introduced back care workshops for employees in physically demanding parts of the business. Almost 300 employees participated, and the company saw a reduction in back pain related absence of 43 percent, creating a business benefit of £1,660 per participating employee. In fact, for every £1 invested in the workshop, the company received a return of £31.

A ***manufacturer*** with 20,000 employees made cost savings of £11m over 3 years due to savings of 1% absenteeism reduction. For every £1 pound invested in health policy development and management training saved almost £53.

A ***manufacturer*** with 200 employees funded occupational health services and activities alongside counselling and annual health screenings at a total cost of £7,150. For every £1 invested £11 was saved on injury claims from employees.

A ***Public Sector*** transport organisation with approximately 400 employees introduced a sickness absence management plan alongside support and return to work interviews. The occupational health services provided cost £16,000 per annum and resulted in absenteeism falling by 70% between 1999 and 2003. Staff on long term sickness leave fell from 16 to 3 days at any one time.

1.15 Organisations use a combination of methods including[19]:

- Return to work interviews – 81%
- Occupational health involvement – 68%
- Sickness absence information given to line managers – 65%
- Risk assessment to aid return to work after long-term absence – 64%
- Trigger mechanisms to review attendance – 62%
- Flexible working – 62%
- Changes to working patters or environment – 57%
- Capability procedure – 55%

[19] CIPD - Annual Survey Report – Absence Management 2015

1.16 Less frequent mechanisms adopted by organisations include attendance bonuses or incentives, and the absence record taken into account when considering promotion.

Staff Turnover

1.17 The findings from a national study by Oxford Economics in 2014 found that, on average, each member of staff that leaves costs an employer £30,614 to replace. This figure is made up of two components: logistical costs, including agency fees and advertising, and the cost to the employers in wages paid to the new employee before they reach full productivity.

1.18 It estimates that it takes an average of 28 weeks for a new member of staff to get up to speed at a cost in wages of £25,182. According to the study, the full logistical cost of replacing an employee is as follows:

- Hiring temporary workers before the replacement starts: £3,618
- Management time spent interviewing candidates: £767
- Recruitment agency fees: £454
- Advertising the new role: £398
- HR time spent processing replacement: £196

1.19 Those working in the legal sector are most expensive to replace at £39,887, followed by accountancy staff at £39,230. Workers in the media and advertising cost their employers £25,787 to replace, taking just 20 weeks to reach optimum productivity. The cheapest employees to replace are retail workers, each costing their employers an average of £20,114 over 23 weeks.

1.20 The study found that it was cheaper for small to medium-sized employers (SMEs) with between 1 and 250 workers to replace staff as they take only 24 weeks to reach full productivity, compared to 28 for larger firms. However, the smallest businesses, those with between one and nine workers, take an even shorter amount of time to reach optimum productivity at just 12 weeks. The report calculates that the overall cost to employers of replacing staff in the UK is £4.1bn a year.

A ***professional services company*** invested £75,000 on a health advisor, who delivered healthy lifestyle advice, fitness classes and relaxation classes in an office environment. This reduced staff turnover by 10%, producing savings of £464,000 and absenteeism savings were calculated at £23,000 – a benefit-cost ratio of 1:6.5.

Presenteeism

1.21 Presenteeism is the act of attending work while sick. Presenteeism is associated with anxiety, particularly when job security is threatened, as well as high levels of workload and stress. Despite improvements in the employment market, over 3 in 10 organisations reported an increase in people coming to work ill in the last 12 months[20]. Those who had noticed an increase in 'presenteeism' are nearly twice as likely to report an increase in stress-related absence as those who hadn't (64% versus 35%) and more than twice as likely to report an increase in mental health problems, such as anxiety and depression (65% versus 28%)[21]. Some 89% of workers who turned up for work unwell admit they are less productive[22].

1.22 We have identified a number of further sources that identify the cost to business of presenteeism in comparison to the cost of absenteeism. These are summarised below.

The Sainsbury Centre for Mental Health[23] estimated that the cost to employers due to presenteeism because of mental health problems was 1.8 times that of absenteeism.

Research by Katherine Ashby and Michelle Mahdon[24] found that the 'sickness presence' (where an employee attends work but is unwell) may account for up to 50% more working time lost than absenteeism.

Research published by Birmingham's Aston University in 2010 revealed the cost of presenteeism amounted to twice the cost of absenteeism, according to figures from the Economic and Social Research Council.

The Houses of Parliament Parliamentary Office of Science and Technology[25] cited that there is little information on the extent of the problem in the UK but research from Australia and the USA suggests that the cost associated with presenteeism are 2.6 times greater than those of absenteeism.

1.23 We therefore have a range of different ratios representing the link between absenteeism and presenteeism, from 1:1.5 to 1:2.6. The research covers a range of geographies and was reported at various points between 2007 and 2012.

[20] CIPD - Annual Survey Report – Absence Management 2015
[21] CIPD - Annual Survey Report – Absence Management 2015
[22] BUPA - Workplace Health: A Worthwhile Investment 2010
[23] Sainsbury Centre for Mental Health. Mental health at work: developing the business case. 2007
[24] 'Why Do Employees Come to Work When Ill?: An Investigation into Sickness Presence in the Workplace', The Work Foundation and AXA PPP Healthcare, London, April 2010, p69.
[25] Postnote No. 422: Mental Health and the Workplace October 2012.

1.24 We sought to identify if there were any trends, as generally the research above indicated that the level of presenteeism was increasing with the more recent research. The level of presenteeism is still a key issue for employers[26].

1.25 Alongside this report, we have worked with the British Heart Foundation to develop the online cost calculator tool (see www.bhf.org.uk/health-at-work/get-started/cost-savings-calculator) that takes into account presenteeism. On the basis of the evidence gathered we are minded to adopt a ratio of 1:2.5 for the cost of absenteeism to presenteeism.

1.26 Therefore for every £1 cost to business of absenteeism there is estimated to be an additional cost of £2.50 due to presenteeism.

Investment in Workplace Health

1.27 Employers that invest in workplace health can expect to see improvements in productivity and employee performance. Furthermore, additional benefits could include staff retention, improved employee engagement, cost control and reduce absenteeism. Figure 1 below summarises a Comprehensive Workplace Health Promotion Scheme[27].

Figure 1: Summary of a Comprehensive Workplace Health Promotion Scheme

Health Education: Tobacco use; Alcohol/drug misuse; Physical inactivity; Overweight/obesity		
Minimum Steps	Moderate Steps	Comprehensive Steps
Annual health risk assessments; Information and resources for healthy life changes; Self-care health resources	Use targeted risk interventions based on readiness to change; Provide workshops on medical consumerism	Health coaching (person to person, telephone, online); On-site full-time wellness manager; Telephone nurse line
Supportive social and physical environments		
Minimum Steps	Moderate Steps	Comprehensive Steps
Open conference rooms and other spaces for after-hours physical activity classes; Negotiate health club discounts; Create tobacco-free workplaces	Provide showers, subsidise gym rates, walking trails, well-lit stairwells; Provide healthy selections in vending machines and cafeterias and at company functions	In-house health management centre in large locations; Allow for volunteer health teams, and budget discretionary programmes in all company locations

[26] CIPD - Annual Survey Report – Absence Management 2015

[27] Adapted from Partnerships for Prevention, Leading by Example: The Value of Worksite Health Promotion to Small and Medium Size Employers 2011

Programme integration		
Minimum Steps	Moderate Steps	Comprehensive Steps
Involve a diverse group of employees in a broad planning effort to create ownership of the programme	Match the goals of the programme with the mission statement of the organisation	With senior management support, develop and use a health scorecard integrated with business goals

Linkage to related programmes: Work related injury/death; Health insurance; Preventative services		
Minimum Steps	Moderate Steps	Comprehensive Steps
Create 'wellness champions'; Integrate lifestyle measures into safety meetings	Provide publications about benefits, job safety and preventative services	Create cross-functional team (e.g. wellness, benefits, employee assistance programme) for strategic planning of health promotion
Screening programmes		
Minimum Steps	Moderate Steps	Comprehensive Steps
Communicate importance of preventative screening through flyers and/or company communications	Sponsor or team up with other businesses to offer health fairs and screening NHS health checks	Through benefit plan, reduce cost and access barriers to preventative screening
Follow up interventions		
Minimum Steps	Moderate Steps	Comprehensive Steps
Locate and promote appropriate resources and support related to at-risk practices (being sensitive to privacy issues)	Create incentive based programmes to encourage maintenance of positive health changes	Benchmark health data to set short and long term objectives for reducing at-risk behaviour
Evaluation and improvement process		
Minimum Steps	Moderate Steps	Comprehensive Steps
Conduct periodic surveys of employee health promotion needs/interests; Measure employee participation rates; Use post-programme surveys to measure satisfaction	Stratify aggregate health risk assessment data by level of risk (e.g. % of population at low, medium and high risk); Measure and track disability, workers compensation and sick days	Evaluate return on investment on selected interventions; Integrate employee data; Measure presenteeism for selective health conditions

2. Mental Wellbeing

Scale and Benefits

2.1 In 2014/15 stress accounted for 35% of all work-related ill health cases and 43% of all working days lost due to ill health. The total number of cases of work-related stress, depression or anxiety in 2014/15 was 440,000 cases, a prevalence rate of 1,380 per 100,000 workers. The number of new cases was 234,000, an incidence rate of 740 per 100,000 workers. The estimated number and rate have remained broadly flat for more than a decade. The total number of working days lost due to this condition in 2014/15 was 9.9 million days. This equated to an average of 23 days lost per case[28].

2.2 The Centre for Mental Health calculated that presenteeism from mental ill health alone costs the UK economy £15.1bn per annum[29]. The financial cost of mental ill health to British business is an estimated £26bn per year, equivalent to £1,035 for every employee. The cost of mental health-related sick leave is £335 per employee per year[30].

2.3 A number of studies have assessed the economic impact of undertaking steps to promote mental wellbeing in the workplace. Whilst the variation in size, sector and workforce varies considerably the research suggests that positive steps to improve the management of mental wellbeing in the workplace should enable employers to save at least 30% of lost production and staff turnover. We have previously outlined the financial cost to business of staff turnover. It is interesting that stress of the role is cited by 19% of employees as a key reason for leaving the organisation[31].

Ideas and Options

2.4 There are a wide range of approaches to mental wellbeing promotion in the workplace. These include flexible working arrangements; career progression opportunities; ergonomics and environment; stress audits; and improved recognition of risk factors for poor mental health by line managers. Other measures targeted at general wellbeing can include access to gyms, exercise and sports opportunities and changes to the canteen food.

2.5 Included below are examples of two such approaches relating to enhanced depression care[32] and multi-component interventions.

---

[28] Labour Force Survey data 2014/15 www.hse.gov.uk/statistics/causdis/stress/index.htm

[29] McDaid, D, King, D and Parsonage, M - Mental Health Promotion and Mental Illness Prevention: The economic case. Department of Health, London 2011

[30] ENWHP - A guide to the business case for mental health 2009

[31] CIPD - Recruitment, Retention and Turnover Survey 2008

[32] Wang PS, Patrick A, Avorn J et al - The costs and benefits of enhanced depression care to employers 2006 and Wang PS, Simon GE, Avorn J et al - Telephone screening, outreach, and care management for depressed workers and impact on clinical and work productivity outcomes: a randomized controlled trial 2007

Workplace based ***enhanced depression care*** consists of completion by employees of a screening questionnaire, followed by care management for those found to be suffering from, or at risk of developing, depression and/or anxiety disorders. Those identified as being at risk of depression or anxiety disorders are offered a course of cognitive behavioural therapy (CBT) delivered in six sessions over 12 weeks. This intervention has been shown to be effective in tackling depression and reducing productivity losses in various workplaces. Productivity improvements outweigh the costs of the intervention.

It is estimated that £31 covers the costs of facilitating the completion of the screening questionnaire, a follow-up assessment to confirm depression and care management costs. For those identified as being at risk, the cost of six sessions of face to face CBT is £240. Computerised CBT courses are cheaper and may be less stigmatising to individual workers, but less is known about their longer-term effectiveness.

The cost savings impact is addressed from the perspective of the health system (including personal social services) and business, with the employer bearing the total costs of the intervention. It assumes that only two thirds of employees offered CBT as a result of screening will make use of this treatment. It is estimated that the reduction in presenteeism as a result of successful intervention is equivalent to an extra 2.6 hours of work per week. In year 1 it is assumed that this benefit is seen only in the 36 weeks after the completion of the CBT course. If depression and anxiety orders are averted, then 27.3 days of absenteeism per annum associated with these disorders will be avoided.

The results show that from a business perspective the intervention appears cost saving, despite the cost of screening all employees. Benefits are gained through both a reduction in the level of absenteeism and improved levels of workplace productivity through a reduction in presenteeism. However, the impact may differ across industries; the case may be less strong where staff turnover is high and skill requirements low. From a health and social services perspective that model is cost-saving, assuming the costs of the programme are indeed borne by the employer.

The cost of a ***multi-component intervention*** is estimated at £80 per employee per year. The model assesses the impact of a workplace based health promotion and wellbeing programme in a white collar organisation with 500 employees, all of whom are covered by the intervention. The costs savings are addressed from the perspective of the business, which is assumed to bear costs of the intervention.

Estimates of the effectiveness, uptake of the intervention (43% of all employees) and impact on absenteeism and presenteeism (lost productivity while at work) are taken from a study undertaken in the UK offices of a large multi-national company. From a business perspective the model appears cost saving compared to taking no action. In year 1, the initial costs of £40,000 for the programme are outweighed by gains arising from reduced presenteeism and absenteeism of £387,722. This represents a substantial annual return on investment of more than 9 to 1. In addition there are likely to be benefits to the health system from reduced physical and mental health problems as a result of the intervention, but these are not quantified here.

3. Healthy Eating

Scale and Benefits

3.1 Research has shown that workplace interventions can lead to improvement in diet[33]. There is a weight of evidence that demonstrates that employees who participate in programmes in a variety of workplace settings lose more weight, achieve lower BMI and reduce their percentage of body fat when compared to control groups that did not participate[34].

3.2 The scale and focus of workplace support to encourage and facilitate healthy eating amongst employees varies considerably across a range of broad activities covering:

- Health education;
- Providing supportive social and physical environments;
- Links to related programmes; and
- Screening programmes.

Ideas and Options

3.3 Our literature review has identified a range of health promotion activities utilised to encourage healthy eating. These include:

- Regular information on healthy eating, weight control and regular physical activity;
- Periodic communication on the links between diet and common health risks such as Type 2 diabetes and heart disease;
- Providing nutritional information on options at the workplace cafeteria;
- Pricing healthier food cheaper than less healthy options at the workplace cafeteria;
- Providing healthy options in vending machines;
- Providing healthy food options during company events;
- Promoting company-wide weight reduction contests with appropriate health education;
- Conducting periodic weigh-ins and BMI calculations for willing staff;
- Subsidising membership to approved weight loss programmes;
- Undertaking regular staff health assessments and triage individuals to health coaching where appropriate; and
- Providing advice on preparing healthy meals and eating on the road.

[33] Ni Mhurchu C et al: Effects of worksite health promotion interventions on employee diets 2010
[34] PricewaterhouseCoopers - Building the case for wellness 2008

3.4 The case study examples below outline approaches targeted upon improving the diet of employees alongside other measures, including physical activity based elements.

A large ***pharmaceutical company*** offered employees counselling and one-to-one support as part of a broader package of health and wellbeing activities, including healthy eating options in the canteen, access to sports facilities and advice on musculoskeletal disorders. The programme led to an 8.5% reduction in the absence rate and a saving of £1.2 million in absence costs.

Informed by an employee health survey, ***Arriva Buses Wales*** has introduced a wider variety of health and wellbeing activities for its staff, including: a weekly fruit and vegetable co-operative; cycle initiatives; football; and health awareness days. Arriva's senior managers acknowledge the business benefits that a focus on health and wellbeing can deliver e.g. improvement in attendance, reduced sickness absence, improved motivation and reduced driver stress levels of between 10-15%.

Scallywags Children's Play Ltd promoted a number of health and wellbeing activities. Previously, the centre had introduced gym discounts and healthy eating challenges. Most recently, around 20 staff members were invited for an individual health assessment, provided by the NHS. This included weight management, blood pressure monitoring and advice on health-related problems provided by a local nurse.

This resulted in the number of sick days per full-time equivalent member of staff decreasing from 38 to 31 from January 2012 to November 2013. Furthermore, all members of staff are committed to the Golden Apple and Healthy Teeth Awards, promoting healthy eating for children. This provides staff with important information on diet, nutrition and health benefits for children and staff alike. This type of training is free for applicants.

Blakelock Elderly Care Co-op, a day centre in Hartlepool, is keen to promote healthy lifestyle choices to its elderly service users and staff alike. They have an in-house weight management trainer who encourages and supports healthy eating, nutrition and dieting. A member of staff received the training from the local authority to fill this position, so there were no additional costs.

The Centre employs 11 on-site staff members, who are keen to set an example to its service users through healthy lifestyle choices such as smoking cessation, healthy eating and regular physical activity e.g. local walks for both users and staff. The centre encouraged health awareness campaigns such as breast cancer and blood pressure monitoring and as the centre is frequented by occupational therapist and district nurses, access to this information and support on raising awareness is free.

4. Physical Activity

Scale and Benefits

4.1 Physical inactivity has major health consequences and is estimated to cost the UK economy about £8.2 billion per year[35]. Workplace physical activity interventions can have a positive effect on physical activity behaviour, overall fitness, body measurements, work attendance and job stress. Physical activity programmes at work have been found to reduce absenteeism by up to 20% and physically active workers take 27% fewer sick days[36].

4.2 There is strong evidence that workplace counselling influences physical activity behaviour amongst employees[37]. Key practices identified that promote employee weight loss include enhanced opportunities for physical activity combined with health education.

4.3 A physical activity programme would also help to mitigate some of the problems associated with an ageing workforce. The possibility of losing skilled workers to ill-health retirement is a serious risk to many organisations, particularly small and medium sized enterprises. Encouraging older employees to adopt a healthier lifestyle may help to reduce the impact of age-related chronic diseases[38].

Staff from **Redcar & Cleveland Borough Council** 'climbed' Mount Everest as part of the Better Health at Work Bronze Award – but they didn't have to leave the office to complete the challenge. Instead, the Everest challengers trekked up and down the council's staircases until they eventually hiked the equivalent height of the famous mountain – a full 29,035ft. The council has addressed other health issues and implemented initiatives such as stress awareness sessions, No Smoking Day, mental health and alcohol awareness training. This has resulted in the average number of sick days declining from 11.2 to 8.3 days. Using figures provided by CIPD (i.e. that an absence day costs £726 per public sector employee) an average reduction in absenteeism of 2.9 days for each of the 6,000 employees can be said to save the council £8.4million per annum.

A ***manufacturing company*** with approximately 1000 employees introduced a new physiotherapy and exercise programme which included prevention talks and stretching programmes. The physiotherapist time on the programme cost £340. The cost of sending operatives away from work for the programme was £4.15 for 21 members of staff, a total of £87.15. The programme reduced absence related costs by £1,139 per year (average operative wage £8.30/hour). The return on investment was positive with £2.67 of benefit for every £1 spent.

[35] Faculty of Public Health and Faculty of Occupational Medicine - Creating a Healthy Workplace 2006
[36] Health, Work and Wellbeing Programme - Working for a healthier tomorrow 2008
[37] Dugdill L et al - Workplace Physical Activity Interventions, A Systematic Review 2008
[38] EEF - An ageing workforce: how are manufacturers preparing? 2008

Durham Tees Valley Probation Trust focused upon three health topics: weight management including diet and exercise, women's health and stress and work life balance as part of their Better Health at Work Award. Activities were promoted to address these topics such as weight management gym discounts, healthy eating workshops and fresh fruit delivery. Other types of activities included breast cancer awareness, discounted aquatic sessions, free massages and stress management workshops. There were no costs associated with the running of these activities as delivery providers, such as gyms, were contacted directly to arrange company discounts and local council health departments organised discounts for swimming pool use. All office staff took part, and certain discounts were distributed across other offices within the Trust.

A company working within ***utilities industry*** with 30,000 employees implemented an in-house discounted physiotherapy scheme, in which treatments cost £75 and physio assessments cost £35 to £50. This resulted in a reduction in absence rates as well as an increase in staff retention rates and health awareness. For every £1 invested, savings of £34 were generated.

Cumbria County Council initiated a health and wellbeing campaign in May 2008 called 'Well-being for Life'. Initiatives are varied and included fitness tests, Wii Fit Challenge, a pedometer challenge and guided health walks, and a cycle to work scheme.

Ideas and Options

4.4 NICE guidance[39] recommends that employers develop a physical activity policy or plan, based on consultation with staff, and implement an organisation-wide physical activity programme. Employees should be encouraged to be more physically active at work and while travelling to work through information, support and advice including the offer of a confidential physical activity health check. Physical activity programmes at work have been found to reduce absenteeism by up to 20% and physically active workers take 27% fewer sick days[40].

4.5 Work-based approaches to increasing physical activity that could be adopted include the following:

- Delivering health risk assessments on an annual basis;
- Providing information and advice resources;
- Providing health coaching;
- Providing space on site for after hours exercise classes;

[39] NICE - Promoting Physical Activity at the Workplace: How to Encourage Employees to be Physically Active, 2008

[40] Health, Work and Wellbeing Programme (2008) Working for a healthier tomorrow. London: The Stationery Office.

- Organising gym discounts for staff;
- Organising step and walking challenges;
- Involving employees in the planning of activities;
- Providing financial incentives relating to the achievement of agreed fitness goals;
- Providing physical fitness assessments;
- Sponsoring workplace sports/leisure teams;
- Providing showers and changing areas, alongside space of parking bicycles;
- Providing flexible working hours to enable exercise; and
- Providing healthy options at workplace vending machines.

5. Smoking

Scale and Benefits

5.1 Smoking is one of the most significant risk factors to health. Research undertaken on the cost of smoking to the UK economy[41] identified that:

- Over a working week smoking breaks cost businesses around £26 per smoker in lost time that otherwise could have been used productively. Smoking breaks cost £1,815 each year for a full-time employee and £447 for a typical part-time employee;
- The average smoker takes 0.7 days more sick leave per annum than their non-smoking colleagues. This equates to an additional cost of £50 per year per employee. Across the economy as a whole this additional sick leave represents a cost to business of £288 million per year; and
- Smokers' sick leave and smoking breaks therefore cost UK businesses £8.7 billion per year.

5.2 Research from a range of studies[42] concluded that group programmes, individual counselling and nicotine replacement therapy increased smoking cessation in comparison to no treatment or minimal intervention controls. Self-help materials were less effective. Interventions need to be tailored to the specific workforce sector and individual smoking patterns.

Ideas and Options

5.3 The evidence indicates that the most effective smoking cessation programmes have multiple components, including group counselling, individual's therapy, pharmaceutical interventions and incentive schemes tailored to the individual workplace setting. Adopting a one-size-fits-all approach or a single smoking cessation tool is likely to bring fewer benefits.

5.4 NICE guidance[43] recommends that employers inform employees about the possibilities, different types of help and local stop smoking services. Workplaces are encouraged to provide on-site stop smoking services of to allow staff to attend smoking cessation services during working hours. In addition, workplaces are asked to incorporate a smoking cessation policy into an overall smoke-free workplace policy. These measures will support workplaces to adhere to smoke-free legislation and will show additional benefit in reducing sickness absence and increasing productivity.

[41] CEBR - The Cost Of Smoking to UK Businesses, Analysis for the British Heart Foundation 2014
[42] Cahill K - Workplace Interventions for Smoking Cessation 2008 and Bell K et al - NICE Rapid Review: Workplace Interventions to Promote Smoking Cessation 2007
[43] NICE - Workplace Health Promotion: How to Help Employees to Stop Smoking, 2007

5.5 The scale and focus of workplace stop-smoking support varies considerably across a range of broad activities covering:

- Health education;
- Providing supportive social and physical environments;
- Links to related programmes; and
- Screening programmes.

5.6 Across these broad activities specific actions could include:

- Providing health/behaviour coaching either on a face-to-face basis, via telephone or online;
- Provision of full pharmaceutical options;
- Providing space for and foster creation of after-hours employee support groups;
- Creating a programme of incentives for potential quitters;
- Providing healthy eating options to support quitters' potential urges to eat;
- Highlighting success stories across the business;
- Undertaking a survey to monitor smoking amongst staff;
- Prohibiting tobacco use within company vehicles;
- Establishing and publicising smoke free policies; and
- Identifying and publicising community support groups.

6. Alcohol

Scale and Benefits

6.1 The UK government's Alcohol Harm Reduction Strategy identifies that alcohol misuse results in a number of factors which are detrimental to the employee, employer and workforce. This includes loss of productivity, cessation of employment, increased accidents in the workplace, greater absenteeism/presenteeism and premature death among others[44].

6.2 As of 2012, alcohol misuse led to £7.3 billion per year in lost productivity in the UK. The Institute of Alcohol Studies (IAS) concluded that 17 million working days are lost in the UK each year due to alcohol related sickness, with a cost of £1.7 billion relating to these absences[45]. Alcohol misuse affects employee concentration, and increases mistakes and accidents[46].

6.3 The work environment and managerial style of an organisation can have a positive or detrimental impact upon alcohol misuse. Organisations which prioritise rewards, reduced stress and a supportive rather than punitive environment can help to reduce alcohol misuse amongst staff and increase effectiveness of interventions.

6.4 Work environments and management styles can also increase risky behaviour in specific ways, such as a promotion of drinking culture, alcohol-centred work functions, raffle prizes and so on. Particular sectors, occupational settings, job responsibilities and organisational styles can lead to increased risk of misuse, for example, effort-reward imbalances increase rates of alcoholism in men[47].

Ideas and Options

6.5 The workplace is an ideal environment for targeted intervention. A significant proportion of adults who are at risk for problems with alcohol use are employed, and individuals in employment are more likely to drink during the week than those who are unemployed.

[44] NICE Factsheet www.nice.org.uk/nicemedia/documents/CHB19-alcohol_diet-14-7.pdf
[45] Institute of Alcohol Studies: Alcohol in the Workplace Factsheet 2014 www.ias.org.uk/uploads/pdf/Factsheets/Alcohol%20in%20the%20workplace%20factsheet%20March%202014.pdf
[46] Data gathered from IAS, International Labour Organisation, Psychiatry Online and the World Health Organisation www.journals.psychiatryonline.org/article.aspx?articleid=98512
[47] The Psychosocial Work Environment and Alcohol Dependence: A Prospective Study by J Head, S Stansfeld, and J Siegrist 2004 www.ncbi.nlm.nih.gov/pmc/articles/PMC1740737/

6.6 The workplace provides good opportunities for public health interventions due to the potential for high exposure to the message, increased likelihood of noticing change in employees' health and opportunity to intervene as well as the advantage of leverage with regard to retaining employment[48].

6.7 Types of workplace interventions on alcohol misuse are varied and typically include primary (preventative) and secondary (early identification and treatment) interventions. A number of options are available which can be employed alone or in synergy.

6.8 Self-assessment tools, e.g. Alcohol Use Disorders Identification Test (AUDIT), aim to identify problem behaviours and allow self-assessment and referral. These can be delivered via paper, online questionnaire or website, which aids privacy and access and allows integration within wider health promotion. A UK study of workplace health found 92% of staff were happy to be asked about their health, including questions on drinking as part of a survey from their Occupational Health team[49].

6.9 Screening is typically followed by a brief intervention strategy (as detailed later in this section) or provision of advice and referral to services. Evidence shows this approach to be successful and there is a growing evidence base for the success of online self-assessment[50].

6.10 In terms of impact, a study of employees in an intervention group reported reductions in terms of:

- The average maximum number of units consumed in one 24-hour period;
- The number of drinking days per week;
- The average number of units consumed in one week; and
- Fewer days use of hospital services and primary care.

6.11 The total costs of the screening (£3.60 per individual) and intervention (£12.48 per intervention) resulted in an overall net saving of resources valued at £332[51].

[48] BMA note on alcohol, drugs and the workplace www.bma.org.uk/practical-support-at-work/occupational-health/alcohol-drugs-and-the-workplace

[49] NICE Public Health Guidance Note www.nice.org.uk/guidance/ng13/documents/workplace-policy-and-management-practices-to-improve-the-health-of-employees-draft-scope-stakeholder-comments-and-responses2

[50] Alcohol Health Network Case Study www.ias.org.uk/uploads/pdf/Factsheets/Alcohol%20in%20the%20workplace%20factsheet%20March%202014.pdf

[51] Alcohol Health Network research www.alcoholresearchuk.org/alcohol-insights/reducing-alcohol-related-harm-in-the-workplace-a-feasibility-study-of-screening-and-brief-interventions-for-hazardous-drinkers/

6.12 Employee assistance programmes generally involve the provision of screening, counselling and referral services in order to deal with personal issues which may impact adversely on work and/or health and wellbeing. Brief intervention (normally preceded by initial screening) is a low-intensity strategy which aims for early identification and treatment.

6.13 Screening, usually through a self-report questionnaire, is followed by personalised feedback of health risks. This may be online, over the phone or in person and aims to inform and to motivate individuals to examine their drinking pattern and to initiate changes. The advantage of this method is it allows privacy and self-assessment. Research has shown that for every £1 spent on screening and brief interventions/referral, companies saved £4 over a four year period in sickness absence costs, absenteeism, 'presenteeism' and recruitment[52].

6.14 Workplace alcohol policies frame acceptable/unacceptable behaviours such as drinking in the workplace, workplace discipline, and point to recognition, help and education. Policies are also of assistance in framing alcohol misuse as a health, rather than disciplinary, issue and in preventing problems and, in turn, liability for problems.

6.15 Wider activities could include:

- Psychosocial or skills training for staff and/or supervisors increases knowledge and skills on recognising and dealing with individuals suffering alcohol misuse. This aims to aid peer support, peer referral and intervention as well as positive attitudes;
- Education programmes can provide information on impacts of alcohol misuse, available services and ways to identify symptoms or problem behaviours. This should include providing information and resources on responsible alcohol use;
- Promotion of services and programmes that provide information, advice, counselling and referral to treatment services for staff who may be concerned about their alcohol use, or that of family or friends;
- Offer education and training to employees about safe consumption of alcohol;
- Organise social and other team building functions that do not include alcohol;
- Develop and implement a workplace policy that encourages responsible alcohol use at work related events. Make sure to provide non-alcoholic drink options; and
- Offer workplace Employee Assistance Programmes to help employees reduce their alcohol intake.

[52] NICE Public Health Guidance Note www.nice.org.uk/guidance/ng13/documents/workplace-policy-and-management-practices-to-improve-the-health-of-employees-draft-scope-stakeholder-comments-and-responses2

Glossary

Absenteeism – the time an employee spends away from work. Absences can be scheduled (e.g. vacation) or unscheduled (e.g. due to illness or injury).

Alcohol Misuse – describes alcohol consumption that puts individuals at increased risk for adverse health and social consequences. The Chief Medical Officer's Guidelines development group recommend that for men and women who drink regularly or frequently i.e. most weeks, the guideline should be that 'you are safest not to drink regularly more than 14 units of alcohol per week'. The group also recommended that it is best for people who do drink as much as 14 units per week to 'spread this evenly over 3 days or more. If you have one or two heavy drinking sessions, you increase your risks of death from long term illnesses and from accidents and injuries'.

Body Mass Index (BMI) – a number calculated from a person's weight and height. BMI provides a reliable indicator of excess body weight for most adults and is used to screen for weight categories that may lead to health problems.

Cardiovascular Disease (CVD) – the collective term for all disease affecting the circulatory system (heart, arteries, blood vessels).

Cognitive Behavioural Therapy – a type of psychotherapy in which negative patterns of thought about self and the world are challenged in order to alter unwanted behavioural patterns or treat mood disorders such as depression.

Depression – a complex condition characterised by changes in thinking, mood, or behaviour that can affect anyone.

Employee Health Survey – a means to gain input from an employee on health related issues. Survey items may include questions relating to health behaviour (physical activity, dietary habits), use of preventive health services, and measures of health status (blood pressure and cholesterol levels). Additional items could include employees and management health promotion needs and interests as well as opportunities and barriers to participating in workplace health programmes.

Health Education/Coaching – learning opportunities designed to encourage or promote the adoption of healthy behaviour.

Holistic Interventions – workplace health and wellbeing interventions that include multiple components in order to address a wide range of health issues such as mental health, physical activity, stress management, healthy eating and smoking cessation.

Intervention – a generic term used in public health to describe a programme or policy designed to have any impact on a health problem.

Job (Work-related/ Occupational) Stress – the harmful physical and emotional responses that occur when the requirements of the job do not match the capabilities, resources, or needs of the worker that can lead to illness or injury.

Lifestyle practices – one of three aspects of comprehensive workplace health promotion, which generally refers to efforts to change the employees' behaviour. Examples of issues to encourage employees to act upon may include tobacco use, alcohol use, nutrition and physical activity.

Needs assessment – a situational assessment tool that collects the self-reported needs of individual employees. Individual employees fill out the needs assessment and assess areas they would like to focus on. A needs assessment asks for employee opinion and usually results in individualised results and an aggregate report for the workplace.

Occupational Health - the physical, mental and social wellbeing of workers in the workplace.

Occupational Health Guidance - the advice, guidance and signposting to other services to help employees promote and maintain the highest degree of physical, mental and social wellbeing of workers by preventing departures due to ill health, controlling risks and the adaptation of work to people and people to their jobs.

Presenteeism – the measurable extent to which health symptoms, conditions and diseases adversely affect the work productivity of individuals who choose to remain at work.

Productivity – a measure of worker output impacted by the worker's health status.

Return on Investment (ROI) – analysis used to compare the investment costs to the magnitude and timing of expected gains. For workplace health programmes this usually refers to the medial savings or productivity gains associated with the employer's investment in employee health programmes.

Small and Medium-sized employers – employers with fewer than 250 employees.

Smoking Cessation – stopping or quitting using tobacco (e.g. cigarettes, cigars, smokeless tobacco). Tobacco users may often require multiple quit attempts and use cessation methods such as counselling or medications to aid them in stopping tobacco use.

Specific Interventions – a workplace health programme that aims to address a particular employee health related concern or workplace issue such as high absenteeism and lower rates of productivity.

Workplace Health Assessment – a process of gathering information about the factors that support and/or hinder the health of employees at a particular workplace and identifying potential opportunities to improve or address them.

Workplace Health (Wellness) Manager – an individual who is responsible for the administration and coordination of the workplace health promotion programme.

Workplace Health programmes – refer to a coordinated and comprehensive set of strategies which include programmes, policies, benefits, environmental supports, and links to the surrounding community designed to meet the health and safety needs of all employees.

Work-related Musculoskeletal Disorders – are musculoskeletal disorders (injuries or disorders of the muscles, nerves, tendons, joints, cartilage, and spinal discs) in which the work environment and performance of work contribute significantly to the condition; and/or the condition is made worse or persists longer due to work conditions.