The future of health and wellbeing in the workplace

Whilst physical health and safety in the workplace remains a paramount concern, more recently there has been a growing recognition of the importance of psychosocial issues, with a focus on both the psychological and social elements of work. An exploration of work and wellbeing touches on a vast array of employment relations issues from leadership to job design, organisational policy to workplace culture.

Emma Donaldson Feilder, Chartered Occupational Psychologist, Affinity Health at Work and Sarah Podro, Acas Senior Policy Adviser, review the broadening of the health at work agenda and the link to the concepts of good work and engagement.

The paper then goes on to highlight the future challenges to health and wellbeing such as the ageing workforce and economic austerity measures. It then turns to government policy in this area with a focus on the outcomes of the initiatives set in train by Dame Carol Black and her team in addressing absence and return to work strategies, and considers what future policy and workplace initiatives might best address wellbeing at work.
Introduction

Our perceptions and experience of work have changed considerably over the past 20 years. Work gives us the money we need to support ourselves and our families. It also provides us with purpose, status and friendship, all of which can have a profound effect on our sense of wellbeing. Yet as the pace and nature of work has altered – for example, through work intensification, greater flexibility, technological advances, and the blurring of what constitutes ‘work’ and ‘home’ life – so has our understanding of the impact that work has on our emotional and mental wellbeing.

Work may have become safer, with the introduction of health and safety legislation helping to reduce the number of injuries and deaths, but it has also become more complex, with rising levels of stress and mental health problems increasingly linked to working life. Whilst physical health and safety remains paramount in the debate on health at work, the emphasis has also shifted to take in the psychosocial aspects of our life at work.

Commentators increasingly link wellbeing at work with innovation, productivity, creativity, quality and reliability and ultimately to levels of growth at a national level, as well as our ability to compete on the global stage. A growing body of evidence also suggests that the key to making a positive connection between wellbeing, creativity and productivity is to recognise the value of ‘good work’ in people’s lives (Parker et al 2011). Black and MacLeod reviews have been instrumental in raising awareness at a public policy level of how the way we are treated at work and the nature of the work we do affects our wellbeing, and our levels of performance (Black 2008, MacLeod and Clarke 2009).

As we look ahead to the wellbeing agenda in 2020, this paper asks if good work alone is enough to ensure our wellbeing, or whether we also need a clearer vision of what makes a ‘good employer’ and, if so, how this can be supported by government initiatives.

From the physical to the psychosocial

Traditionally, measures of health and work-related risk to health were largely focussed on physical safety, for example, accidents, injury, slips, trips and hazardous chemicals; and interventions were mainly aimed at preventing harm. Over the last 20 years, however, there has been an increasing recognition of the importance of the psychosocial environment (i.e. the psychological and social elements of jobs and the workplace) and the risks presented for mental health, as well as the need to address the issues associated with physical and long term illness. Interventions have been geared towards enhancing positive wellbeing, rather than just preventing negative impact. These shifts have shed a ‘health and wellbeing’ light on aspects of work, such as people management, leadership, job design, organisational culture, autonomy and support at work, that were previously overlooked.

Why has the workplace health agenda changed so dramatically? With the shift from an industrial to a more knowledge-based and service economy, the significance and prevalence of physical hazards, whilst not eliminated, has certainly diminished. Meanwhile, the Management of Health and Safety at Work Act (1974) and subsequent regulations, together with the work of the Health and Safety Executive (HSE), and trade unions, resulted in considerable improvements in the safety of work. According to the HSE the number of fatal injuries to workers in 1974 was 651 compared to 171 in 2010/11, and the number of non fatal injuries fell by 38%
between 1974 and 2007. The recent Lofstedt Review of health and safety legislation, whilst acknowledging that the workplace is far safer, also emphasises the continued need for managing health and safety at work (Lofsdtedt 2011).

The overall decline of physical injury led to a recognition that the ‘health’ aspects of health and safety were lagging behind. By the 1990s, as work intensification increased and many organisations were ‘delayering’ or becoming ‘lean’, it became clear that a key aspect of health at work was mental health and stress-related health problems linked to long term absence and poor performance. As a result there emerged an increased focus on these issues from the HSE, for instance, with the introduction in 2004 of its Management Standards for Stress (HSE 2007).

At the same time, the prevalence of work-related mental health problems appears to have increased. The 2008/9 Labour Force Survey showed that 415,000 people in the UK reported suffering from stress, anxiety or depression that they believed was caused or made worse by their current or past work, second in prevalence to musculoskeletal disorders (HSE 2009). In 2011, CIPD and CBI surveys on absence reported that stress and mental health issues had become the number one reason for long term absence.

Whether a mental health condition is caused by work or non-work factors or, most likely, by a combination of the two, the impact of poor employee mental health on the organisation is significant. In 2007, the Sainsbury Centre for Mental Health estimated that the total cost to UK employers of mental health problems among their employees was nearly £26 billion each year: this included the cost of mental-health-related absenteeism, presenteeism and employee turnover (Sainsbury Centre for Mental Health 2007).

**Good work and the engagement agenda**

Alongside this shift in emphasis from the physical to the psychosocial there has been a parallel transformation in both people’s attitudes to work, and a corresponding change in workplace and government policies.

National and international evidence suggests that in post-industrialised countries such as the UK there has been a gradual shift in what motivates people to work from maximising income and job security towards a growing insistence on work that is meaningful, and has a purpose; with a greater emphasis on more collegial and participatory styles of management (Parker et al 2011). Moreover, whilst pay remains an important priority for employees, it is the level of discretion and level of effort (work intensification) that have most impact on job satisfaction (Green 2006). According to Green, “workplace autonomy is strongly and robustly associated with health and wellbeing, and its beneficial effect is found to be especially strong in jobs that require hard and intensive work.” (Green, in Gregg and Wadsworth 2011).

In recent years however, the concept of job satisfaction as the main driver for employee behaviour at work has been broadened to take on the broader concept of employee engagement. As well as re-enforcing the idea of ‘good work’, employee engagement introduces the idea of ‘good employers’ – employers with visionary leadership and empowering line managers who give employees a real voice in the way the business is run and whose behaviour re-enforces their stated organisational values.

A lack of engagement has been linked to increased absenteeism, presenteeism, lower
levels of performance and productivity. What then is necessary to deliver the different aspects of an engaged workforce? Research suggests that some of the factors that are most linked to positive commitment include employee trust in management, satisfaction with the work itself, satisfaction with involvement in decision-making at the workplace, the quality of relationships between management and employees, satisfaction with the amount of pay received, the degree of job challenge, and satisfaction with sense of achievement from the work performed (Purcell 2008).

**Good people management is vital**

Dame Carol Black in her report on the health of Britain’s working age population made the link between good line management and good health, wellbeing and improved performance. The MacLeod Review highlighted the line manager’s role in increasing levels of engagement to the same end. There is now a significant amount of research evidence that shows that poor management and lack of leadership skills is associated with lowered employee wellbeing and higher risk of stress-related health problems (Donaldson-Feilder et al 2009). And there is now much greater clarity about the behaviours managers need to prevent stress in their team and enhance engagement. These include the way in which managers express and manage their own emotions, manage conflict, are accessible and visible, and manage workload and resources. (see for example Yarker et al 2008; Lewis et al 2011a).

In the recently published Independent Review of Sickness Absence, Black and Frost note the wide variation in absence levels across the public sector and suggest that it is management buy-in on good practice and implementation that is critical in making a difference (Black 2011). And the recent CBI survey found that the long term decline in absence is largely due to better management practice: closer appropriate employer-employee contact during absence, return to work plans, and good records (CBI 2011).

**Organisational response**

How have organisations responded to this wider health and wellbeing agenda and recognised the need for good practice in the way they interact with their employees? There is certainly far greater flexibility in the workplace than there was, particularly for employees wishing to balance work and home life, childcare and eldercare, and the Government appears keen to extend this to everyone in the workforce. Policies on dealing with stress, if not ubiquitous, are far more widespread. In the latest absence and workplace health survey by the CBI, almost nine out of ten organisations taking part in the survey operated a formal or informal stress management policy for their employees (CBI 2011).

Trade unions also have an important role in promoting wellbeing. Negotiating against unsociable shift patterns has been a long term focus for union activity, as have issues around unfair performance management systems that put undue stress on staff. More recently union learning reps in particular have been involved in awareness raising activities with employers around healthy eating, smoking, stress and mental health. BAE systems, for example, worked with local reps from Unite and GMB, as part of the Better Health and Work Scheme promoted by the TUC and NHS. The employee led programme to promote health and wellbeing saved £1 million in absence costs at one plant in the North East (Wustemann 2011). Over recent years, the concept of resilience
has become popular in the workplace context. Resilience, or the ability to bounce back from adversity, is relevant at both individual and organisational level. Some employers appear to find it a more acceptable way to explore mental health issues and many of the interventions currently being used to develop resilience have their foundations in stress management and wellbeing models (Lewis et al 2011b).

However, both occupational health professionals and trade unions have expressed concerns about the use of this approach placing the onus for preventing and resolving issues that impact negatively on mental health or wellbeing onto the individual. If resilience is used as a means to pressurise individuals to ‘toughen up’ and ‘bounce back’ after a stressful encounter, or to put up with a greater workload and a faster pace, then the outcome is likely to be counterproductive and more likely to lead to greater levels of stress and burnout. Where the concept of resilience is embedded in genuinely supportive wellbeing programmes, however, the benefits can be significant.

The NHS Gloucestershire Primary Care Trust has for example, introduced the ‘Lighten-up programme’ aimed at improving overall wellbeing of staff both at home and at work. The programme helps employees to develop a range of strategies including how to manage work-life balance more effectively, deal with conflict, and identify and manage stress. As a result of the programme, NHS Gloucestershire has so far reported a 16% reduction in absence for those attending the Lighten up programme. And the total cost of absence has been reduced by 21%.

Despite examples of good practice, there is still room for improvement in management capability in the UK in relation to employee wellbeing. It remains the case, that many managers are promoted to management positions because they are good at their job and not for their people management skills. Many workplaces still do not measure absence levels or proactively manage absence, and still fewer have wellbeing initiatives. Of those that do, many do not measure or evaluate their effectiveness. Those organisations that do evaluate their wellbeing spending however are more likely to increase their spending on such initiatives for the next financial year compared to those who do not (CIPD 2011).

So how well are workplaces prepared for future challenges to workforce health? What is the Government doing to proactively address the issues? And what more could be done by employers?

**Future challenges**

There are a number of foreseeable factors that will impact on health, wellbeing and engagement in the workplace over the next 10 to 20 years – namely demographic change, in particular an ageing workforce, technological advances, globalisation and economic uncertainty.

**Responding to an ageing workforce**

Over the next ten to twenty years, the workforce will become, on average, older. While demographic change in the population as a whole will lead to an ageing population in general, the impact on the workforce will be even more marked due to the removal of the default retirement age and changes in pension provision that are likely to mean people will either retire later or feel that they are unable to retire at all (see Parry and Harris 2011).

Reviews of the research literature suggest that changes in health and wellbeing across
the life-course may be due more to exposure to lifestyle and environmental risk factors than to chronological age alone (Marcus and Harper 2006; Crawford et al 2009). This suggests that there is an important role for health promotion across all age groups to reduce the negative impact of factors such as lack of exercise, poor diet, smoking, drinking and environmental and psychosocial risks. There are generally higher levels of chronic health conditions such as musculoskeletal disorders, cardio-vascular disease and diabetes in older people, and cancer is also more prevalent in this age group. Statistics suggest that 90,000 people of working age are diagnosed with cancer every year (ONS 2011) and many of them stay in work during, or return to work following, treatment.

As people age, there may be changes to what they most value about work, from wanting to achieve promotion or pay the mortgage, to valuing the social support and structure provided by the workplace. Although changes in work capacity over the life-span can vary significantly, evidence suggests that ageing can bring with it declines in aerobic and cardiovascular fitness, musculoskeletal strength, cognitive functioning (for example, reaction times) and sensory acuity (for example, sight and hearing) (Kanowski 1994). This may affect certain aspects of performance, particularly in more physical jobs, but deficits can often be mitigated by good ergonomic design.

Evidence for different levels of mental health at different ages is mixed, with some studies showing higher levels of depression; others a decrease in depression with age. However, it does appear that older depressed people have higher chances of relapse and poor prognosis (Kanowski 1994).

In addition to the impact of ageing on employees themselves, there will also be implications for those caring for them. Responsibilities of the sandwich generation, those working and caring for both children and elderly parents are likely to increase. With increased longevity there may be more grandparents who are in work, while caring for their own elderly parents and also dealing with their own chronic conditions associated with ageing.

**Technological advance**

The onward march of technological change presents both opportunities and risks for workplace health and wellbeing. Communications technologies such as video conferencing, document sharing and virtual meeting systems can reduce time-pressures and stress levels by removing travelling. They can also help with inclusiveness for those who are unable to travel for health reasons, offering individuals recovering from ill health or with chronic health problems a way to be productive despite any limitations caused by their condition. Together with changes in regulation around flexible working and caring responsibilities, these technologically-enabled new ways of working can help improve work-life balance and achieve better fit between employees and jobs resulting in improved health, wellbeing and loyalty to the organisation.

From a people management perspective, a good workplace IT infrastructure can improve access to support and information for employees and managers. Standardised systems for processes such as performance management and absence/ attendance management can be rolled out through intranets and self-access database systems to help line managers, particularly as many no longer have direct access to HR support. Intranets and other communications technologies can also facilitate access to and distribution of health promotion information,
for example, providing online learning packages on health issues such as weight management, stress management and healthy shift-working.

At a national level, with the push to provide more public services online (see for example Martha Lane Fox 2010) health services are likely to be increasingly provided through portals such as NHS Direct. However, the efficacy of messages delivered through these technologies, in terms of helping people change behaviour, may not prove as great as those provided in a more personal and interactive way.

On the downside, a shift to more remote working and distanced employee relations brings with it significant risks. For example, there is a danger that home-workers will become isolated from their employer and colleagues: they may lose out on social support and feel distanced from organisational aims and culture. An increase in standardisation of roles and the ability to more closely monitor the performance of employees could also lead to a loss of autonomy, a decrease in engagement and greater experience of stress. Lower levels of face-to-face contact with their manager, colleagues and representatives may mean that if problems arise, for example stress and mental health problems, they are not picked up at an early stage and are more likely to escalate. It can be harder to recognise the human side of problems on line or over the phone, and easier for people to hide them, although conversely some employees may find having difficult conversations about sensitive issues easier without having to face their manager or employer in person.

Perhaps one of the big risks presented by new technology is that of information overload. The volume of emails and other communications received has increased exponentially and led to work intensification (Green 2009). Evidence suggests that this increases the pressures and demands on people, bringing risks of stress and mental health problems. The introduction of smart phones and hand-held devices has brought the ability to access emails wherever you are. The latest OfCom figures revealed that 27% of UK adults are now smart phone users. While this has the advantage of providing flexibility for individuals to work when and where they want to and keep on top of communications, it has also led to higher expectations in terms of speed of response. The risk is therefore that work extends into every waking hour of the day: not only does this mean that people work more hours, but also that they do not have a clear ‘recovery’ period when they are entirely switched off.

Engaging in times of austerity

Given that job satisfaction and engagement are reduced by work intensification, lack of task discretion, absence of voice, and pay disparities, the next decade may see serious challenges to workplace wellbeing unless prevailing trends can be checked. Globalisation, facilitated to a large extent by advances in technology, has fuelled a rapid growth in the standardisation and intensification of work processes in every corner of the economy (Huws 2012). The evidence currently points to an overall decline in task discretion with no sign of improvement (Gallie et al 2004; Felstead 2007). And it is now generally acknowledged that there is going to be a slow economic recovery from the global crisis. Income and wealth disparities are predicted to widen, as is the gap between skilled and unskilled workers (Wong et al 2010).

What seems certain is that many employees will experience significant organisational
change over the coming years in both private and public sectors. Such change can bring uncertainty about roles as the organisational structure changes and expectations shift. Relationships at work and networks of contacts may be disrupted due to redundancies, redeployments and organisational redesign. Support systems may become less available and people’s sense of autonomy and control may be reduced as changes seem to be forced on the workforce from above or by external factors.

The resulting situation for individuals may be one of high demand, low control, low support, poor relationships, lack of role clarity and on-going change: in other words, presenting potentially all the psychosocial hazards set out in the HSE Management Standards (HSE 2007). As these rise, the potential for stress-related problems is increased and there is a greater risk of health problems, particularly mental ill-health. While employer interventions to improve resilience are to be welcomed when they enable individuals to deal with difficult circumstances, there is also danger that some employers will use them as a way of justifying an unreasonable level of ongoing pressure on the workforce, resulting either in serious health problems or in disengagement from work, expressed through outcomes such as staff turnover or reduced performance.

Overall satisfaction with work itself and the hours worked rises during a recession. However greater unemployment is also associated with lower levels of wellbeing amongst those in employment, most likely because of feelings of both insecurity and empathy for those, often family members and friends, who have been made redundant (Clarke, in Gregg and Wadsworth 2011). The 2011 CIPD absence management survey also identified a link between job insecurity and mental health problems, with employers planning to make redundancies in the next six months significantly more likely to report an increase in mental health problems among their staff.

**Presenteeism**

In times of economic uncertainty, absence levels often drop in relative terms because employees are concerned about job security and employers may deal with absence earlier because they cannot afford the employee’s time away (Podro 2010). One area that has yet to receive the attention it deserves is the rise of presenteeism, where an individual goes to work despite suffering ill-health. According to the Sainsbury Centre for Mental Health there is evidence to suggest that this is a more costly problem for employers than absenteeism (Sainsbury Centre for Mental Health 2007), partly because it is more likely to happen amongst higher paid employees. It is by no means easy to identify or measure. However the recent CBI survey showed that almost three quarters of responding employers reported that presenteeism had an adverse impact on staff productivity levels, making this by far the most common problem in terms of poor performance.

Job insecurity may not be the only cause of presenteeism. The culture of the organisation and the nature of work – for example team working – may mean people attend work when not well so as not to let down their team members; a culture of presenteeism may mean that taking sickness absence is formally or informally frowned upon. It can also be exacerbated by absence management policies that penalise individuals who take sick leave. Moreover, individual factors – such as commitment to work (or even workaholism), personality factors and financial need – may influence whether or not someone comes into work when ill.
It is important to note that many people with a health problem can work perfectly well for much or all of the time and this is not in itself presenteeism. Work, after all, is generally good for health (Waddell et al 2006) and people do not need to be 100% fit in order to continue to/return to work. Indeed, returning to work following a period of sickness absence can contribute to the recovery process. It may be that a period of lowered productivity during an initial rehabilitation period or phased return to work is actually a price worth paying and therefore might be deemed ‘positive presenteeism’. Indeed this is very much what lies behind the introduction of the fit note.

If presenteeism increases over the next few years, however, the likelihood is that overall, it may lead to reduced productivity and disengagement. It may also lead to individuals suffering poorer longer-term health outcomes. For some conditions, a period of sickness absence may be beneficial to aid recovery and/or prevent exacerbation of symptoms. In addition, those who come to work despite suffering from an infectious disease risk infecting their colleagues and others in the workplace. While it might appear to be the opposite of absenteeism, research suggests that presenteeism is more prevalent in organisations where absenteeism is also high (Sainsbury Centre for Mental Health 2007), perhaps as a result of these latter effects.

**Government initiatives on health and wellbeing**

The ongoing work of the Government initiated by the Black report on the health of Britain’s working age population is aimed at improving the way health and wellbeing is managed for those who are in work, those who risk dropping out of employment and those who wish to return to the workplace.

The introduction of the fit note, which allows GPs to indicate that an individual ‘may be fit for work’ and suggest a phased return to work and/or job adaptations, in place of the sick note is still bedding down and it is becoming clear that more needs to be done to make it work effectively.

Fit notes have undoubtedly forced employers to look more seriously at how to help employees back to work more swiftly. There remain some significant hurdles however. Just 11% of employers in the CIPD’s absence management survey agreed that fit notes had helped reduce absence levels in their organisation, with an equally low proportion agreeing that fit notes were being used effectively by GPs (CIPD 2011). The DWP review of the fit note picked up a number of barriers including an unwillingness by GPs to damage their relationship with the patient if for example the relationship with the manager had broken down and the illness was partly triggered by stress, and the GP felt that it was not in the best interests of the patient to return to work (DWP 2011).

In 2010, the Government launched 11 Fit for Work Services (FFWS) pilots aimed in particular at employees for whom occupational health advice was not available, such as those working for small businesses. The services involve government-funded teams providing case-managed, multidisciplinary support for employees in the early stages of sickness absence who may be at risk of spending long periods away from work with health problems. They are under review: the interim findings published in March were not conclusive about whether the pilots had helped clients back to work more quickly, but stated that "the survey evidence suggests that most clients would not have received the interventions they had without the support of the FFWS and qualitative evidence from the panel"
interviews indicates that the service helped people get back to work quicker or easier than they would otherwise have done”. Forty percent of the users of the service suffered from a common mental health condition such as stress, depression or anxiety, and the pilots also found that health issues could be compounded by non-health issues which deterred employees from staying in or returning to work: “the most common barriers were work related and included lack of support at work, harassment and bullying, and a fear that they could not cope with work demands” (DWP 2012).

The Occupational Health Advice Line pilot, also aimed at small employers and closely linked to the aims of the FFWS, has been given two years additional funding and now provides both telephone and on line advice and support. With government policy actively seeking to increase the SME sector, be that in the private sector or the new breed of social enterprises and mutuals that are being promoted to take over some of the delivery of public services (Michie 2012), the question of how to improve access to occupational health advice and services needs to remain a priority area for policy makers.

The Workplace Wellbeing Charter Self Assessment Standards, supported by a regional network of health and wellbeing coordinators, provide guidance to employers of all sizes under key areas (leadership, attendance management, health and safety requirements, mental health and wellbeing, smoking and tobacco related ill health, physical activity, healthy eating, alcohol and substance abuse). The aim of the tool is to take a holistic look at health in the workplace, broadening out the agenda from a more narrow focus on absence management.

The latest major set of recommendations for further policy reform, the Independent Review of Sickness Absence by Dame Carol Black and David Frost, was published at the end of 2011. It set out to address some of the complex inter-relationships between sickness, absence and the benefit system and to explore ways to stem the flow of individuals falling out of work and onto health related benefits. Primarily motivated by the financial and social loss to those suffering ill health it also investigated potential savings for both employers and the state. Recommendations include a new government-funded Independent Assessment Service (IAS) to look at an individual’s physical or mental function once they have been absent for approximately four weeks, with the aim of helping them back to work more quickly. This would give access to occupational health advice to a far greater range of organisations than currently receive it, and might also be an opportunity to identify where sickness absence is related to poor employee relations and signpost users to support and advice services.

The Independent Review of Sickness Absence also recommends that the state should offer a free job brokering service for anyone with a sickness absence period of more than 20 weeks. This recommendation is in response to a situation where the employee needs, for example, to move from manual work to a job that is less physically demanding which might not be available with his or her employer, or where their stress-related health condition arose from an irreconcilable relationship with their current employer.
Conclusion: What more could be done?

While welfare reform and reductions in benefit costs are an understandable focus for the UK Government at the moment, there is a need to look at the complexity of issues that are associated with the health and work agenda. Just as the independent Review of Sickness Absence has found that there are no simple answers to reducing sickness absence and its associated costs, so the broader issue of getting governments, employers, healthcare providers, trade unions and employees to work together to achieve healthy, high performing workplaces cannot be solved with a single initiative. Regulation and legislation can only go so far in protecting employee health.

Awareness raising campaigns might focus on the business benefits of having a healthy workforce and the importance of good people management (particularly managers’ interpersonal skills) to employee health and sustainable performance. Increasingly there are arguments for greater transparency and reporting on wellbeing in the workplace. In 2003, the Government consulted on the inclusion of human capital management reporting as an indicator in Operating and Financial Reviews. Although there are companies that report on this area, there is no obligation on organisations to do so. Maybe now is the time to revisit this area. Business in the Community’s Workwell campaign has produced guidelines on public reporting on wellbeing and engagement and continues to progress this area. Government policy reviews of work should embrace the need to influence job quality. In times of austerity, this may need to start with a focus on job security, but improving job design, including increasing autonomy, might equally be part of policy focus to ensure long-term growth.

The reform of the NHS and the healthcare agenda for the future needs to consider the position of occupational health: for too long the ‘Cinderella’ service within the UK health system, occupational health now needs to be given more prominence. If employers are to meet the challenges set out in this paper, they will need to be able to call upon good occupational health and health promotion advice. This means that the distinct expertise of occupational health and others who work in this domain, such as Occupational Psychologists, needs to be recognised by mainstream healthcare and employers alike.

GP training needs to build understanding of occupational settings and return to work issues. If return to work is to become a recognised and valued clinical outcome, as Dame Carol Black is aiming it should, all healthcare practitioners need to understand better the interaction between health and work.

Employers have a vital role to play in managing health at work, particularly when it comes to promoting the policies and behaviours which support good work and engagement. Access to flexible working, channels for employee voice, job design that allows greater autonomy and control, and support and resourcing to improve leadership and management skills will all be fundamental to maintaining a healthy and productive workforce.
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