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NYE'S LOST LEGACY

TOWARDS A NATIONAL OCCUPATIONAL HEALTH SERVICE TO KEEP PEOPLE WELL IN WORK

Sasjkia Otto

September 2025

Acknowledgements

Thank you to Unison – the largest union for workers in public services – for supporting this editorially independent project. Special thanks to Joe Donnelly for championing this work; to Guy Collis, Josie Irwin and Sampson Low for feedback on the report; and to Gavin Edwards, Georgiou Stasoula, Joan McNulty, Nicholas Turnbull for supporting our workshop. The analysis, findings, and conclusions presented are solely those of the author and do not necessarily reflect the views of the funder.

Thanks also to other independent experts who helped inform the work through interviews, participation in our workshop, roundtable and interviews, and feeding back on drafts of the report. These include: Aish Moothan (Resolution Ventures), Alex Wilson and Kevin Brampton (British Occupational Hygiene Society), Alice Martin (Work Foundation), Amit Aggrawal (Association of the British Pharmaceutical Industry), Andrew Mackenzie and Tom Addison (Physiological Society), Andrew Phillips (Standard Life Centre for the Future of Retirement) Ash Singleton (Alcohol Change UK), Dr Belinda Steffan (University of Edinburgh), Ben Willmott and Rachel Suff (Chartered Institute of Personnel and Development), Ceri Finnegan (Institute of Occupational Safety and Health), Christopher Brooks (Age UK), Dan Lucy (Institute for Employment Studies), Dick Blackwell (Fabian Society member), Emily Wallace (Labour Business), Professor Emma Hughes (University of Leeds), Emily Andrews (Centre for Ageing Better), George Williams (Lancaster University), Joe Levenson (Versus Arthritis), Janel O'Neill (National School of Occupational Health), John Kamoto and Rebecca Ward (Association of British Insurers), Karen Blake (Powered by Diversity), Dr Kathryn McKinnon (British Medical Association), Lucy Kenyon (Association of Occupational Health and Wellbeing Professionals), Lucy Whing (British Retail Consortium), Luke McCullough (Aviva), Dame Marie Gabriel (NHS Confederation), Dr Mark Ferris (Cambridge Health at Work), Nick Pahl (Society of Occupational Medicine), Nicola Hamilton (Our Future Health), Quinn Roach (Trades Union Congress)), Sam Atwell (Health Foundation), Samantha Niblett MP (Women and Equalities Select Committee), Dr Shriti Pattani (NHS England), Simon Dixon (Royal Society for Public Health), Professor Stavroula Leka (University of Lancaster), Dr Willian Fleming (University of Oxford). This research is stronger because of their contributions; oversights are the author's own.

Thanks to Jennifer Trueland and Neil Hallows for lending this report its title, which first appeared in British Medical Association's The Doctor in July 2024.[1]

Finally, thanks to the team at the Fabian Society for support and challenge delivering this research – particularly Bradley Young, Iggy Wood, Joe Dromey and Luke Raikes.

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SUMMARY

Workforce health is a defining challenge for this government

Since Labour was last in power, the number of working-age people reporting a disabling condition has increased by 4.3 million.[2] And over 300,000 people leave work with health problems each year.[3] Healthy and inclusive work can help reduce the numbers leaving employment – and make it more feasible for others to return. But many are excluded from work because they cannot access the conditions or support they need.

People also reported 1.7m cases of work-related illness in 2023-24. This represents a 44 per cent increase since 2010-11 – driven in large part by a 93 per cent increase in work-related mental illness.[4]

This challenge can only be addressed if employers, workers and the state urgently step up to play their part. The biological, psychological and social drivers of health challenges at work are found in the workplace and beyond. And they are changing rapidly as our economy and society face new pressures.

A stronger occupational health system could support this partnership. Support for workers is currently left largely to market forces, with the government typically stepping in only once someone has left work. This results in inconsistent experiences – particularly at small and medium enterprises (SMEs). There are five key challenges:

- **Access to quality occupational health services is inconsistent.** Only 45 per cent of workers had access to occupational health through their work in 2023, and many of the employers who do invest are still underspending.[5] But access to occupational health cannot guarantee results either, since quality is inconsistent.
- **Poorly integrated services leave all parties disempowered to help.** Employers, the NHS and public services rarely coordinate support. But none of these has all the tools they need to support workers effectively alone, and public services face bottlenecks where workers have nowhere else to turn.
- **Intervention is not consistently preventative and proactive.** Access to healthy working conditions is unequal, and employers do not consistently gather the information they need to act early as challenges emerge.

- **Workers are not consistently supported.** Communication barriers, misunderstandings and gaps in entitlements mean that most workers who would benefit from personalised support do not receive it, while organisation-wide challenges remain unaddressed.
- **Incentives do not support recovery or continued employment.** Most employers provide only statutory sick pay. The low level, and restrictive eligibility criteria, make it difficult to take time off when needed and as recommended by medical professionals. Often neither workers nor employers are incentivised or supported to keep people in work.

The UK needs a National Occupational Health Service

This report proposes a model for a National Occupational Health Service to address these challenges and shift the UK's occupational health system to become universal, integrated, preventative, supportive and rehabilitative.

This service would rely on two pillars. First, improving **support** through better occupational health provision. Second, new **responsibilities** to ensure this support delivers for workers through incentives to engage with occupational health to keep people well in work.

Pillar 1: Occupational health support

The government should:

1. **Create a regulated occupational health market funded by a growth, skills and health levy.** Occupational health services should continue to be delivered through private providers contracted by employers. This builds on the UK's current capabilities and is in line with international norms, which assign primary responsibility for provision to employers. But these services must be set up to succeed, including in the following ways:

    - **Regulation.** Create a new Occupational Health Authority, sitting in the Health and Safety Executive (HSE), to set standards and enforce compliance.
    - **Funding.** Create a new growth, skills and health levy, funded by a small number of the largest employers, to incentivise and support employers of all sizes to invest in occupational health.

2. **Establish tiered public sector provision coordinated by WorkHealth caseworkers.** Integrated public services should step in where employers are unable to support workers, or where there is a public interest case for state involvement – for example, where someone is at significant risk of leaving work. This should include:

- **Vocational caseworkers.** Establish a new WorkHealth service, embedded in NHS neighbourhood health centres, to coordinate tailored, multi-agency support. This service would be accessed voluntarily via NHS pathways, self-referral and when someone has reached a specific sick leave threshold.
- **NHS occupational health referrals.** Update the fit note template to allow clinicians to recommend occupational health consultations.
- **Reform of the Access to Work programme.** Reform assessment and approval processes to clear the bottleneck. Any registered occupational health professional should be allowed to conduct standardised screenings, with automated approvals and self-service procurement from preselected services where appropriate.
- **HR support.** Pilot an HR support service available to SMEs investing in accredited occupational health services.

3. **Develop cross-cutting digital infrastructure.** Occupational health should form part of the government's plans to digitise the NHS and social care systems – reflecting its integral role in prevention and effective care. Infrastructure should include:

    - **Sick leave records.** Reinstate sick pay reporting via payroll to allow WorkHealth caseworkers and the HSE to contact consenting workers and employers with offers of voluntary support.
    - **A WorkHealth health record.** Ethically integrate occupational health with the NHS and social care single patient record to facilitate joined-up care. Let workers generate an adjustments passport with information selected from the record to support conversations with employers.
    - **A new digital front door.** Create an online portal to offer employers and workers practical routes to act early before turning to professional support, and to help them navigate and access available services and providers.

Pillar 2: Rights and responsibilities

The government should:

4. **Establish new rights and responsibilities to promote prevention, monitoring and support.** Employers should have clearer responsibilities to work with occupational health on:

    - **Prevention and monitoring.** Introduce incentives for employers to prevent, monitor and address emerging workplace challenges – including through a national 'good work standard', reporting requirements on work-related illness and greater parity between protections for physical and mental health and safety.
    - **Open dialogue.** Support early and constructive conversations between workers and employers, including by requiring employers to share a standardised

questionnaire with new starters, and introducing a new right to an accompanied "healthy work" conversation.

- **Reasonable adjustments and workplace improvements.** Improve access to support by introducing new duties: consult with occupational health before refusing requests for support; respond to and act on occupational health advice and requests for reasonable adjustments under the same terms as flexible work requests; and treat those with support in place fairly.

5. **Establish new rights and responsibilities for supportive sick pay and return-to-work processes.** Workers who have been off sick should have the best possible opportunity to stay in work that is good for them, through support including:

    - **Sick pay.** Increase statutory sick pay to at least the same level as out-of-work benefits, and ideally 20 per cent higher, to improve incentives to stay in work. This should happen immediately, pending a fuller review to tackle hardship and presenteeism. Also reform sick pay eligibility criteria to support workers to manage their health in accordance with professional advice, including by allowing time off for medical appointments and in half-day increments.
    - **Return-to-work processes.** Incentivise employers to rehabilitate workers who have been off sick, through two new requirements: to consult occupational health under specific circumstances; and to write to the government at least four weeks before dismissing a worker for health reasons.

INTRODUCTION

Exclusion from work is rightly a key focus for this government. The average number of people off sick long term in a year has not dropped below 2 million since 1994,[6] and working-age absence from work due to ill health costs the economy £216bn and the taxpayer £43bn in 2022.[7] In response, the government has committed £3.5bn towards employment programmes to help get people back into work.[8]

But we also need a plan to stop the flow out of work. Each year, 300,000 people leave work due to illness.[9] The longer they are away, the steeper their journey back, which limits the potential impact of programmes supporting them to return.[10]

Good work can help keep people well in work. But many are excluded because they can't access healthy conditions or support. And about 1.7m people in 2023-24 said they had an illness that has been caused or made worse by work – making occupational pressure among the leading contributors of years lived with disability.[11]

On their own, employers and healthcare professionals can't always help. It is true that some employers simply don't think it is worth their while to keep their workers healthy.[12] But many others do their best – and spend a lot of money without seeing results. They frequently have neither the information nor the appropriate tools, and cannot control what happens outside work. Similarly, healthcare professionals use the medical tools available to them – diagnosis, treatment and signing patients off work. But this does not always tackle the root causes of ill health, including how people are supported at work.

The government must find a better way to support and encourage partnership between employers, the state, workers and trade unions to keep people well in work. In many European countries, this is what a well-functioning occupational health system does. In the UK, William Beveridge hinted at such a vision when he published his report, Social Insurance and Allied Services, in 1942. And Aneurin 'Nye' Bevan's inspiration for the NHS came from an occupational health programme in his home community. But these were both false starts. There have been many more since.

Today, support for workers is left largely to market forces: an occupational health market operating with inconsistent oversight, and broad employer discretion as to how services are used. The result is significant variation in support – particularly from SMEs, who employ almost two-thirds of the workforce. And approaches known to be effective – prevention, context-appropriate support, and maintaining links with work when someone is unwell – are scarce.

The ongoing government review into healthy and inclusive work, led by Sir Charlie Mayfield, presents a generational opportunity to revive Nye Bevan's lost legacy. It is time to set and deliver an ambitious vision for a universal and integrated occupational health system, matched by rights and responsibilities. In other words, it is time to create a National Occupational Health Service.

This report will consider the health of the UK workforce, the limitations of the current occupational health system, and how a National Occupational Health Service could enlist employers, workers and the state in as key partners in keeping people well in work.

A PUBLIC HEALTH CHALLENGE

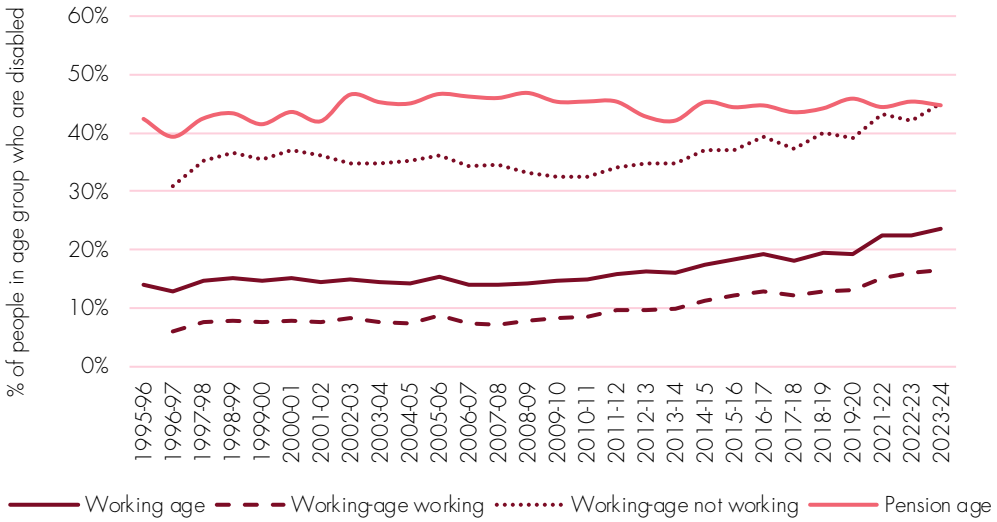
Workforce health is a growing challenge for policymakers

Working-age disability is on an alarming trajectory. Since Labour was last in government, the number of working-age adults reporting a disabling condition has risen by 4.3 million. In 2010-11, they accounted for 15 per cent of the working-age population. By 2023-24, this share had increased to 24 per cent (see figure 1 below). In contrast, disability prevalence among pension-age adults has remained flat – suggesting that the rise is driven by factors uniquely affecting working-age people.[13]

Many people in this group don't work. The UK has one of the widest employment gaps between people with health limitations and without, compared to other major European countries (the EU15).[14] Against this backdrop, 300,000 people leave work with health problems each year.[15] And out-of-work disability benefits claims have risen.[16]

While these problems have become more acute, they are part of a long-term trend. The average number of people who are economically inactive due to long-term sickness has not dropped below 2 million in any year since 1994. While recent data are affected by methodological challenges, the underlying trend is clear.[17]

FIGURE 1: REPORTED WORKING-AGE DISABILITY INCREASED WHILE PENSION-AGE DISABILITY REMAINED STABLE



Source: Fabian Society analysis of Family Resources Survey, 2023-24.

Keeping people well in work lies at the heart of tackling this challenge

The government has made tackling health-related inactivity a top priority. The spending review committed £3.5bn in this parliament to employment support to get people back to work.[18] The stated goal is to establish an integrated work, health and skills support offer for people with a health condition or disability, bringing together and building on existing support.[19]

But supporting workers before they have left should be a priority. It is far easier to keep people in work than to move them from inactivity into work.[20] And each day of absence carries rising personal, societal and economic costs, which can linger even after someone is working again.

Ensuring that work is healthy and inclusive can help reduce the number of people leaving employment – and make it more feasible for others to return. Many with long-term health conditions want to work but find themselves excluded because they cannot access the working conditions or support they need.[21] And while good-quality work can improve health outcomes, poor working conditions can lead to illness and injury. In 2023-24, workers reported 1.7m work-related illnesses and 600,000 injuries.[22]

This is underscored by disability benefits trends, which have risen due to mental health-related claims.[23] As shown in figure 2 below, work-related illness and disability benefit claims have risen in tandem since 2010 – highlighting how poor-quality work and inadequate support are key drivers of the UK's challenges with weak growth and rising benefits spend.

FIGURE 2:WORK-RELATED ILLNESS AND DISABILITY BENEFITS CLAIMANTS HAVE INCREASED IN TANDEM SINCE 2010

Source: Fabian Society analysis of HSE and DWP data.

Workforce health pressures are changing

The factors that shape people's ability to stay healthy at work are not just medical – they are also psychological and social. This 'biopsychosocial' model helps explain why some people struggle to stay in work while others, with the same condition, do not.

FIGURE 3: WORK-RELATED SUPPORT NEEDS ARE BIOLOGICAL, PSYCHOLOGICAL AND SOCIAL ("BIOPSYCHOSOCIAL")

Different health profiles present different support needs

Low support needs	Medium support needs	High support needs
Generally healthy	Health challenges but potentially not disabled (eg, menopause, short-term illness)	Disabled under Equality Act 2010 Multiple conditions

Factors specific to a role can increase support needs

At-work challenges
Precarious and hazardous work (zero hours contracts, shift work)
Structural discrimination (race, sex, disability)
Poor skills support

Factors specific to personal circumstances can increase support needs

Out-of-work challenges
Caring / parenting responsibilities
Life stressors / events (domestic abuse, bereavement)
Financial strain

Source: Fabian Society synthesis of research on biopsychosocial risk.

As illustrated in figure 3 above, people with multiple health problems or disabilities are at greater risk of falling out of work.[24] But others – including those managing menopause or short-term illness – may also need support. Poor job quality, lack of security, and discrimination can all intensify these challenges.[25] Wider social pressures, such as financial hardship or unpaid care responsibilities, further compound stress and health risks.[26]

These biopsychosocial pressures on workforce health have been changing. In the past, workplace risks were more straightforward: mostly physical hazards, often confined to a specific job or setting, and relatively static over time. Today's risks are more complex and interconnected. They are shaped by structural drivers, including:

1. **The nature of work.** Deindustrialisation, labour shortages, labour market liberalisation and digitisation have reshaped the structure and experience of work:

    - More people than ever – and especially women – now work in service sectors, where mental ill-health is more common than physical injury, as shown in figure 4 below.[27]
    - Key sectors such as childcare and social care face high demand and persistent shortages, which compound the impact of difficult working conditions.[28]
    - In 2024, one in five workers – disproportionately minoritised ethnic groups, women, and disabled people – were in severely insecure work. This includes low pay, irregular hours, weak protections, and limited progression.[29]
    - Automation and deindustrialisation mean change is now constant and unpredictable.[30]

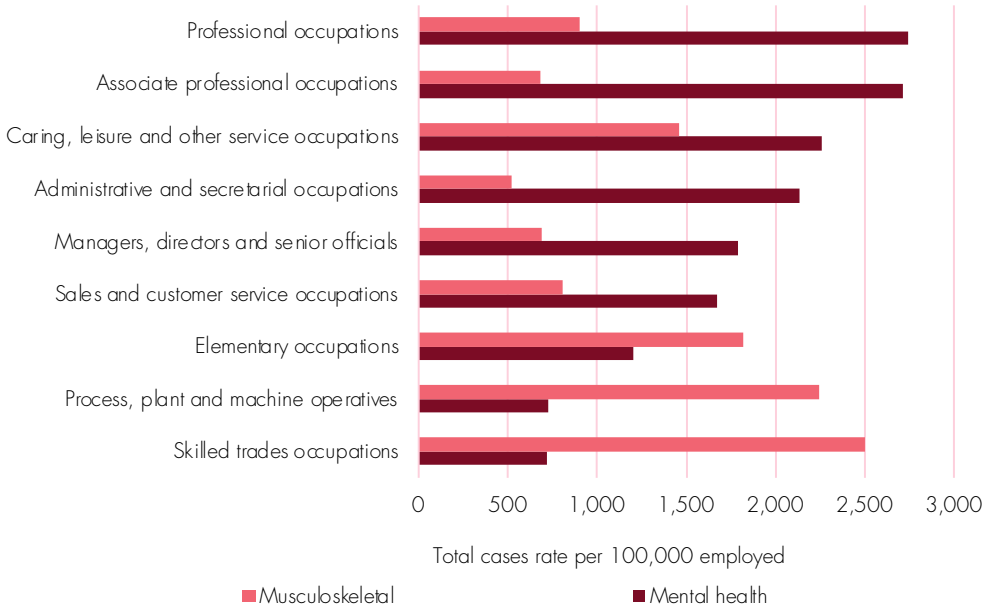
2. **Workforce characteristics.** Demographic and policy shifts have changed who is in the workforce and what pressures they face:

    - More disabled people are working than a decade ago. The reasons are complex and may reflect increased reporting. But health-related support needs at work are likely more prevalent.[31]
    - Healthy life expectancy is declining, yet the state pension age has continued to rise without an accompanying support package. This has created an older, sicker workforce with more complex health and care needs.[32]
    - Dual full-time working is now the norm for families with children, which is associated with stress for those – usually women – who shoulder more unpaid childcare and other work in the home.[33]

3. **The social contract.** Supports that once helped people stay well at work has eroded, at a time it is particularly needed:

    - Both employer and government investment in skills has dropped sharply in the past decade.[34] Training opportunities for young people have fallen, and older workers face long-term underinvestment. This has left many poorly equipped for changing pressures at work.[35]
    - Trade union membership is at its lowest point since the 1940s. thus limiting options to negotiate better conditions, and leaving many workers without the independent health support that many unions provide.[36]
    - Living standards and public services are under significant pressure, which contributes to stress and limits available resource to manage health problems.[37]

FIGURE 4: WORK-RELATED MENTAL ILLNESS IS MORE COMMON IN GROWING SERVICES SECTORS



Source: Fabian Society analysis of Labour Force Survey via HSE, 2021/22-2023/24.

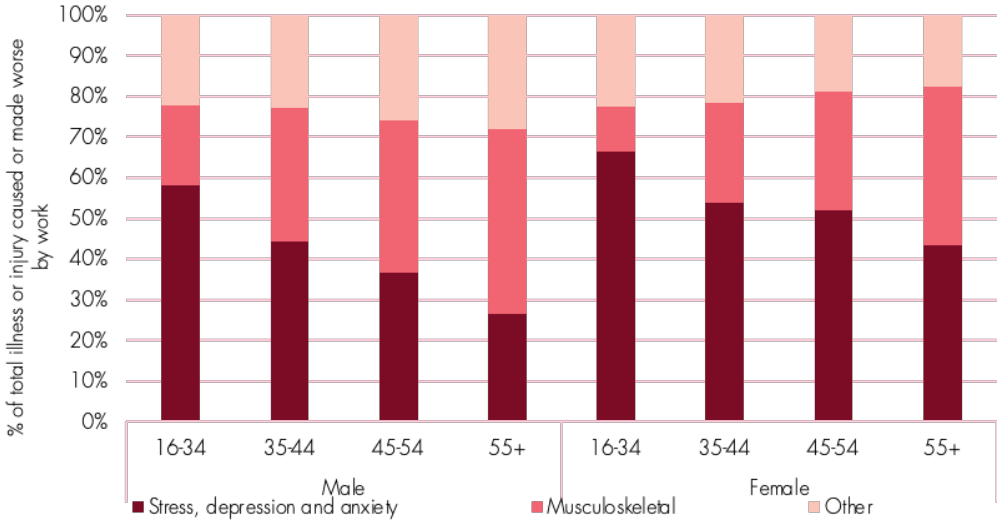
These changes demand comprehensive action. They affect a range of workers in different ways, and fall hardest on those already facing labour market exclusion. Figures 5-7 below show that the prevalence of work-related illness increased by 46 per cent between 2008/11 and 2021/24. But this rose to 100 per cent for 25-34 year olds, 60 per cent for over-55s, and 59 per cent for women. And psychosocial risks such as stress are more common among women and young people, while musculoskeletal issues remain prevalent for older workers and men.

But psychosocial risk has become a growing problem that demands particular attention. The rise of work-related illness has been driven largely by mental health (stress, depression and anxiety), which increased by 106 per cent. And it has continued even as work-related injuries and musculoskeletal illness decreased to an all-time low. This reflects that we have become better at managing physical hazards (biological risk) than psychosocial risk, even while the latter has become more common.

FIGURE 5: WORK-RELATED ILLNESS HAS INCREASED AMONG THE YOUNG BUT REMAINS HIGH AMONG OLDER WORKERS

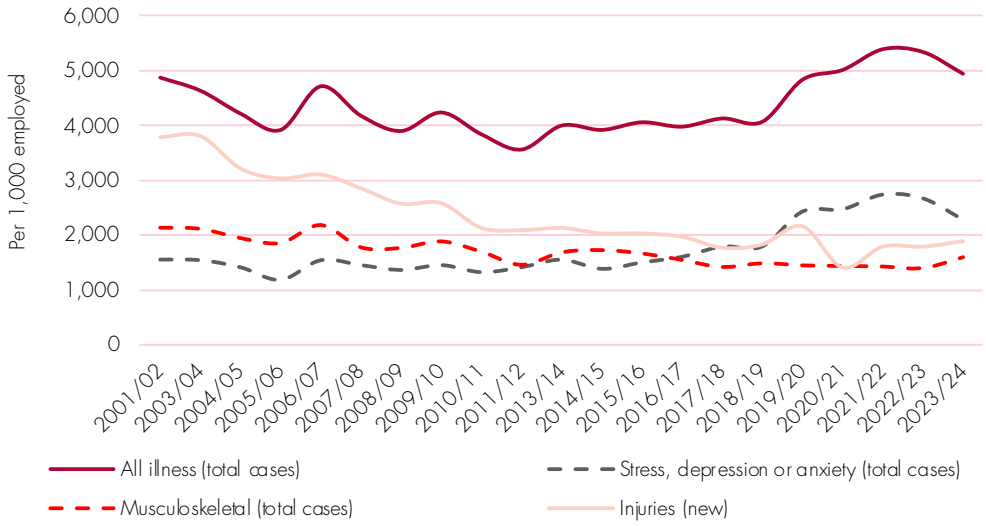
Source: Fabian Society analysis of Labour Force Survey via HSE, 2021/22-2023/24.

FIGURE 6: STRESS, DEPRESSION AND ANXIETY ARE DRIVING WORK-RELATED ILLNESS AMONG YOUNG PEOPLE AND WOMEN



Source: Fabian Society analysis of Labour Force Survey via HSE, 2021/22-2023/24.

FIGURE 7: MENTAL HEALTH PROBLEMS ARE DRIVING INCREASES IN WORK-RELATED ILLNESS



Source: Fabian Society analysis of HSE data, 2023-24.

This is a shared problem that must be addressed through partnership

These challenges place a heavy burden on workers, who have few options to address them alone. But they also cost employers and the state, meaning that everybody has a stake in finding solutions.

- Government estimates indicate that, in 2022, working-age ill health that prevented work caused lost output totalling £132bn from being out of work, £47bn from sickness absence, and £37bn from informal care provision. It also cost £41bn in benefits payments and £2bn in NHS spend.[38]
- The HSE estimates that in 2022-23, the total combined cost for work-related illness and injury was £12.6bn for individuals (lost quality-of-life, income and medical expenses), £4.1bn for employers (lost productivity, sick pay, liability and insurance), and £4.9bn for the government (NHS costs, tax losses and benefits payments).[39] Each work-related illness, on average, cost workers £12,300, employers £4,400, and the government £4,800.[40]
- Replacing staff lost to ill health can be a challenging process which contributes to labour shortages in key sectors. Recruiting a new nurse costs up to £10,000 and a bus driver around £8,500.[41]

Many employers want to play their part to address these problems. A 2024 Department for Work and Pensions (DWP) survey found that 87 per cent of employers agreed they had a responsibility to encourage and support employees to be physically and mentally healthy.[42]

But there are limits to what employers can do – particularly if factors outside the work environment or related to previous employers affect people's health. The public recognise these limits. A 2025 Institute for Public Policy Research (IPPR) survey found nearly all respondents saw individuals as having a "great deal" or "fair amount" of responsibility for staying healthy, while about four in five said the same about the NHS, three-quarters about national government, three in five local government, and half about employers.[43]

Public policy must help employers support workers and ensure public services step in where employers cannot do what is required on their own. The ongoing government review into healthy and inclusive work, led by Sir Charlie Mayfield, presents a generational opportunity to bring employers, workers and public services together around the shared goal to keep people well in work. The following chapters will discuss what needs to change, and how these changes can be achieved.

A FAILING OCCUPATIONAL HEALTH SYSTEM

Features of the UK's occupational health system leave some workers unsupported

An effective occupational health system could support a partnership between employers, public services and workers to keep people well in work. Indeed, in many European countries, these parties have clearly defined responsibilities to work with standardised occupational health services to prevent illness and departures due to ill health. And there are strong incentives to ensure they do everything they can to succeed.

The UK works very differently. Support for workers is left largely up to market forces, with the government typically stepping in only after someone has left work. The details of this system are described below.

Defining an occupational health system

This report uses the term "occupational health system" when referring to the framework or set of arrangements designed to promote and protect the health and safety of workers in the workplace. It involves the policies, actors, organisations, and financing of a range of activities aimed at preventing work-related ill health, managing existing health conditions, and supporting employee wellbeing. This includes assessing risks, providing advice and support, and implementing measures to improve working conditions and practices.

This definition is consistent with the International Labour Organisation's Promotional Framework for Occupational Safety and Health.[44]

The section below sets out the features of the UK's current occupational health system.

The current system leaves much to market forces

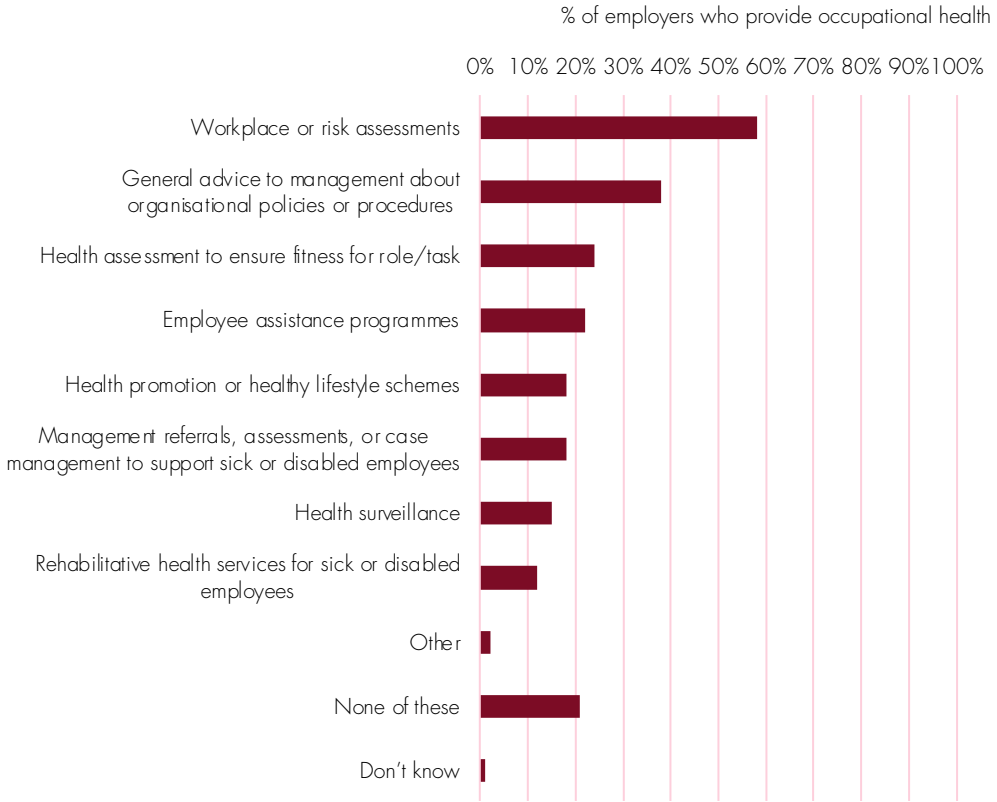
Occupational health provision

Employers have broad discretion over whether and how they provide occupational health support. Some have dedicated in-house occupational health staff. Others purchase external services. All support is optional, and substitutable with human resource (HR) functions.

Occupational health providers operate under a voluntary accreditation scheme known as Safe Effective Quality Occupational Health Service (SEQOHS). Providers supporting NHS staff must either have SEQOHS accreditation or be working towards it.[45] Clinical staff, if present, are regulated by the relevant professional registration bodies, including the General Medical Council, Nursing and Midwifery Council, and the Health and Care Professions Council.

Occupational health professionals can advise on a range of workplace health issues. As shown in figure 8 below, the most common is risk assessment. Other services include assessing fitness for work, advising on whether a worker may be disabled by law, and suggesting workplace adjustments.[46]

FIGURE 8: WORKPLACE RISK ASSESSMENT IS THE MOST COMMON FORM OF OCCUPATIONAL HEALTH INTERVENTION PROVIDED



Source: DWP, 2024.

Prevention, support and adjustments

Employers are responsible for deciding whether and how to seek and implement occupational health advice to meet their statutory duties.

They have general duties concerning workers' physical and mental health. These include protecting health and safety – also known as the "duty of care" – and conducting risk assessments to identify and control hazards. The HSE is responsible for enforcing these duties.

Employers also have specific duties towards workers who are disabled under the Equality Act 2010. They have a proactive duty to identify and take reasonable steps to remove barriers to employment where they know, or ought reasonably to have known, that an employee is disabled – also known as making "reasonable adjustments". This obligation applies regardless of what occupational health professionals have advised, or whether the employee has declared a disability.[47] The law protects disabled workers with reasonable adjustments in place from less favourable treatment.

Workers who are not disabled by law could access some working conditions suited to their needs through flexible work, which may better suit their needs. All workers can request flexible work, with refusal limited to specified circumstances. Part-time workers are legally protected from less favourable treatment; other flexible workers, however, are not.

Various statutory codes of practice and guidance specify how these duties should be operationalised and can be persuasive at an employment tribunal. These include the HSE Approved Codes of Practice and guidance including the Management Standards for Work-related Stress, which can also inform HSE enforcement; Advisory, Conciliation and Arbitration Service (ACAS) codes of practice and guidance on employment law; and, on disability, the Equality and the Human Rights Commission (EHRC) Employment Statutory Code of Practice.

Access to Work

Where a worker requires adjustments that would be unreasonably costly for the employer, they may apply for government-funded support of up to £69,260 per year over three years, through the centrally administered Access to Work scheme.

Anyone is eligible if they have a physical or mental health condition or disability that means they need support to work.

Monitoring and reporting

Under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR), employers must report workplace accidents to the HSE if they result in a worker being unable to do their normal duties for more than seven days, and record them in an 'accident book' if they result in a worker being unable to do their normal duties for more than three days.

Sick pay

Where someone becomes too ill to work, they are entitled to statutory sick pay from their employer. Under the employment rights bill currently before parliament, this is expected to cover 80 per cent of wages up to a maximum level (currently £118.75 per week), to be taken in full-day increments for up to 28 weeks over a three-year period, from the first day of illness. This is not reimbursed by the taxpayer. Any support above this level, known as contractual or occupational sick pay, is at the employer's discretion.[48]

Employers may dismiss workers on capability grounds if they can demonstrate there is no reasonably foreseeable return to work. They may have stronger grounds once contractual sick pay has run out.[49]

Fit notes

Workers can self-certify their absence for up to a week before they need a fit note from an authorised health professional. These professionals can sign them off or advise whether they may be fit for work with certain adjustments, such as a phased return to work.

Most fit notes are currently issued by doctors (90 per cent), followed by nurses (7 per cent), with the remaining 3 per cent issued by pharmacists, physiotherapists or occupational therapists.[50]

Social security

Means-tested benefits can top-up incomes for people living on statutory sick pay alone. Means-tested or contributory benefits can provide support where sick pay has run out or if the worker leaves or is dismissed.

The Pathways to Work green paper proposes reforming contributory benefits into a new "unemployment insurance." It envisions that people eligible for contributory benefits would receive a flat rate equals to the current higher rate of 'new-style' employment and support allowance (currently £140.55 per week), available to people assessed too sick to work. Others would receive means-tested universal credit, currently £98 per week,

plus an additional £50 per week health element if they are also receiving the daily living component of personal independence payment (a non-means-tested disability benefit).[51]

Employment support

Once receiving benefits, individuals may be expected to take steps to increase their earnings. Some may be offered structured support through employment programmes, which typically only step in if someone encounters the benefits system.

WorkWell – a new joint pilot programme by DWP and DHSC that will run until 2026 – aims to provide early, personalised support to people experiencing health-related barriers to work, regardless of their employment or benefit status.[52]

WorkWell participants receive personalised assistance from a work and health coach. This coach acts as a caseworker, helping them to navigate health-related barriers to employment through personalised work and health plans; access to services like physiotherapy, counselling, and occupational health; advice on workplace adjustments and flexible working arrangements; referrals to local community support services; and supporting conversations with employers. Referrals can be made by GPs, employers, community organisations, or self-referral.

These pilots are delivered through Local System Partnerships, jointly with other local services. NHS integrated care boards (ICBs) are the lead grant recipients, and collaborate with local authorities, jobcentre networks, and voluntary sector organisations.[53]

Worker experiences are inconsistent within this system

Given considerable room for discretion, employer practices vary. A 2024 DWP survey found that just 59 per cent of employers said that the financial benefits of spending money on employee health and wellbeing outweighed the costs.[54]

Against this backdrop, many do not prioritise action beyond what they believe is the legal minimum. The same survey found that employers providing occupational health support were twice as likely to be motivated by legal responsibilities or productivity considerations than they were by a duty of care or employee wellbeing.[55]

These attitudes partly reflect resource trade-offs. Of those who employ someone with a long-term health condition, 56 per cent said they faced barriers to providing support – the most common being a lack of capital to invest (46 per cent) and a lack of time or staff (39 per cent).[56]

This means support tends to be weakest in small and medium-sized enterprises (SMEs), who account for 60 per cent of the UK workforce.[57] Smaller firms often lack the resources and management capability to respond to health needs, are less likely to offer sick pay above the statutory minimum, and may encounter illness less frequently – thus making them less likely to develop formal processes to support staff wellbeing.[58] On the other hand, larger employers are better resourced, typically provide sick pay above the statutory minimum, and have higher rates of long-term sickness. As a result, they have stronger incentives to establish processes to manage staff wellbeing.[59]

Meanwhile the self-employed, who account for 13 per cent of employment, have few options to access support typically provided by employers.[60]

These variances are reflected in five connected challenges – related to occupational health provision on the one hand, and how workers are supported at critical points in the journey out of work on the other.

Occupational health provision is insufficient

1. Access to quality occupational health services is inconsistent

Many employers would benefit from occupational health advice: lack of expertise or specialist support is the most common reason employers struggle to support employees with long-term health conditions, after resource.[61] But neither the coverage nor quality of occupational health provision is placed to meet this need consistently. And some employers lack the capability to seek and act on advice.

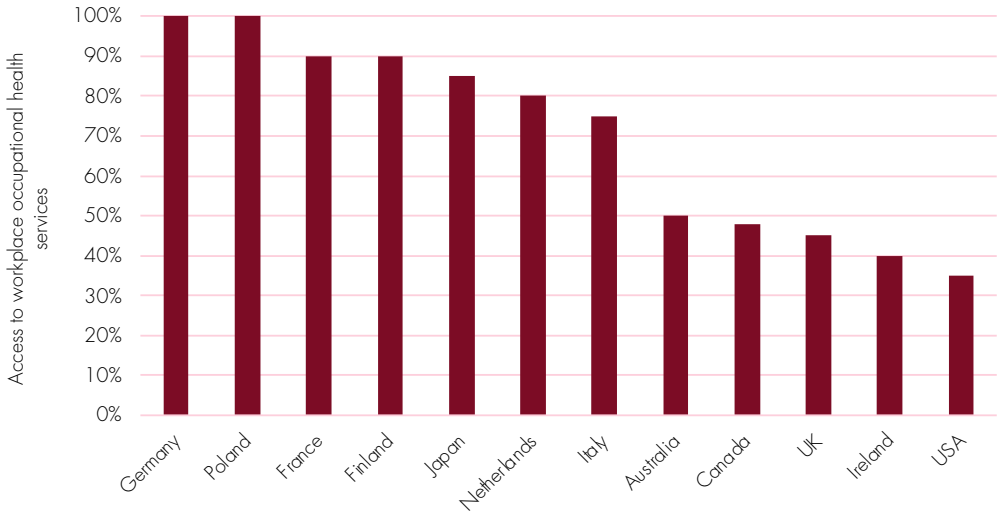
Occupational health access and investment are insufficient

Most workers do not have access to occupational health support. A 2024 DWP survey found that, while 90 per cent of large employers (those with 250+ staff) offered occupational health services to employees, just 23 per cent of SMEs did the same. [62] This means only around 45 per cent of British workers get this support (by a 2023 government estimate). [63]

This compares unfavourably to many advanced economies, where access to occupational health services is near-universal (see figure 9 below).[64]

And even existing provision is not always sufficiently funded. One in 10 large employers spend no more than £1,000 per year on occupational health – and so average, at most, £4 per employee (see figure 10 below). This level cannot support anything other than basic reactive intervention. Moreover, many employers, particularly SMEs, are turning to self-help resources online – suggesting they may lack access to effective and tailored support.[65]

FIGURE 9: UK OCCUPATIONAL COVERAGE COMPARES POORLY TO MANY OTHER COUNTRIES



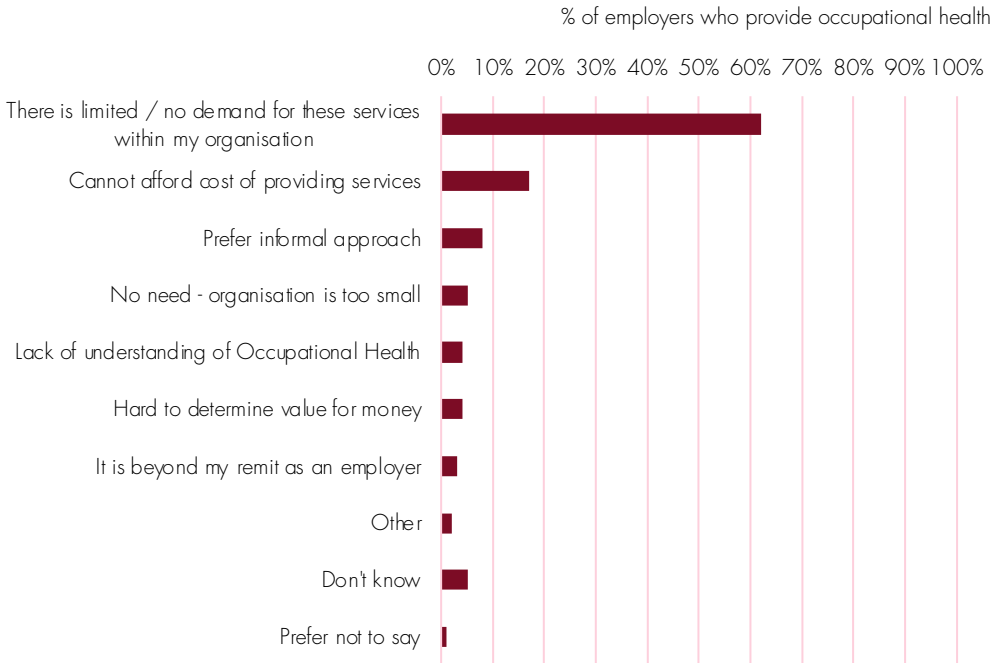
Source: Government estimates, based on data from a range of sources and years, 2021.

FIGURE 10: SOME EMPLOYERS ARE UNDERINVESTING IN OCCUPATIONAL HEALTH

Source: Department for Work and Pensions, 2024.

While resource constraints play a role, take-up is also low because employers do not see the value. The most common reason employers give for not providing occupational health services is limited demand, at 62 per cent, while those who say they cannot afford services account for just 17 per cent (see figure 11 below).[66]

FIGURE 11: LOW DEMAND, NOT AFFORDABILITY, IS THE BIGGEST CONSTRAINT ON OCCUPATIONAL HEALTH TAKEUP



Source: Department for Work and Pensions, 2024.

Not all occupational health service provision is high quality

Access to occupational health services cannot guarantee results either. Many employers invest significantly – spending an estimated £900m on occupational health, safety and wellbeing in 2022.[67] But reported worker experiences suggest return on this investment is inconsistent. A 2023 Business Disability Forum survey found that only 27 per cent of occupational health users with a long-term health condition felt it helped their manager understand how to support them. And just 22 per cent said occupational health services helped them manage their condition at work.[68]

These experiences partly reflect inconsistent market oversight. The voluntary SEQOHS accreditation scheme has helped raise the bar for occupational health provision, but does not sufficiently address these challenges – in part, because it is voluntary, and lacks enforcement mechanisms.[69] A 2024-2025 DWP survey found that just 32 per cent of providers were SEQOHS accredited and 17 per cent were working towards

accreditation – meaning most providers have not been assessed against this industry baseline for quality.[70]

This low take-up partly reflects mixed views on the standard. The same survey found that 65 per cent of occupational health providers have a favourable view of the scheme – most commonly because it ensures quality of service and provides assurance to customers. Twenty per cent had neither a favourable nor an unfavourable view. But 13 per cent had an unfavourable view – most commonly because they saw minimal benefit to their business, including in terms of clinical outcomes, and thought the process of gaining accreditation was too complicated and expensive.[71]

These views may not reflect recent updates to the standard, which have sought to remove unnecessary duplication and place a greater emphasis on outcomes. But the standard does not currently provide clarity on the purpose and scope of occupational health intervention or the use of multidisciplinary teams beyond requiring the use of a clinical occupational health professional. Multidisciplinary teams are used by only 60 per cent of occupational health providers, despite evidence on their efficacy.[72]

Some employers lack HR capabilities to support workforce health

Strong management and HR capabilities can be instrumental in creating a healthy work environment, supporting those who need it, and meeting statutory duties.[73]

But some employers lack these capabilities. The UK faces significant management skill gaps. And SMEs are less likely than larger organisations to have "good practice" HR systems in place – in part because they are less likely to have access to dedicated, professional HR support.[74]

These capability gaps interact with inconsistent occupational health quality to affect how employers use occupational health services. Many SMEs struggle to navigate the market and may prioritise cost over quality.[75] Others rely heavily on lighter-touch employee assistance programmes, which vary in quality and have limited evidence of impact.[76]

Quality and capability gaps also mean employee needs are not consistently met, and create legal risks for employers. A 2024 DWP survey found that among employers who received occupational health advice, 72 per cent implemented it fully, 22 per cent partially, and 3 per cent not at all. Of those who did not fully implement advice, 44 per cent reported the employee did not want it, and 42 per cent said it was not practicable.[77] Meanwhile, ACAS saw a 41 per cent increase in disability discrimination claims between 2023-24 and 2024-25 – largely from mental health related claims – as employers misunderstand their duties beyond protecting physical health.[78]

2. Poorly integrated services leave all parties disempowered

Even where employers and public services try their best to meet worker needs, poor integration of support means they often lack the right tools to help on their own. This can mean public services are overwhelmed by workers with nowhere else to turn, or who receive support too late.[79]

NHS professionals are forced to rely on medical tools to address complex biopsychosocial problems

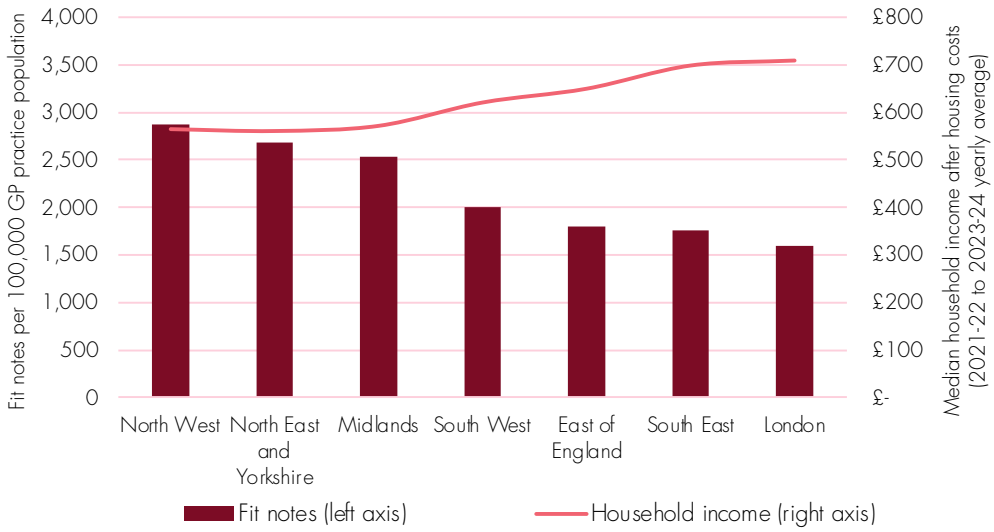
NHS clinicians lack the necessary information, tools and time to consider problems at work. This means work context does not always receive enough attention, despite being critical to understanding people's health: a 2023 Fabian Society survey of over-50s found that just 4 per cent had discussed their employment situation with a medical professional, despite well-documented health barriers to work among this demographic.[80]

Without these links, clinicians often fall back on the medical tools available to them: diagnosis, medical treatment or signing people off. Against this backdrop, mental health diagnoses have soared, waiting lists are at record highs, and just 7 per cent of fit notes include advice on how someone "may be fit for work."[81]

These medical interventions might offer respite and open the door to vital treatment and support – including reasonable adjustments at work – but experts are questioning whether they are always what workers need. Dr Annie Irvine, from the University of York, argues: "in an ever more complex and precarious social world, the administrative category of ill health is 'doing the work' for a much wider set of social, structural, relational and economic barriers to employment."[82]

Regional data hints at this dynamic. Fit note prevalence is higher in more deprived regions – likely reflecting a combination of factors, such as occupational and industrial composition, and inequalities in both health and support linked to socioeconomic disadvantage (see figure 12 below).

FIGURE 12: FIT NOTE PREVALENCE REFLECTS REGIONAL INEQUALITIES



Source: Fabian Society analysis of NHS and DWP data, 2024.

Public services lack reach and impact

Access to Work is the only national public scheme specifically designed to help people with health conditions stay in or return to work – yet it reaches just 1 per cent of working disabled people.[83]

This limited reach stems from both low awareness and low capacity. A 2024 DWP survey found that just one in five employers have heard about the scheme.[84] But even among those who apply, support often arrives too late: the current average waiting time for a needs assessment is six months, with reimbursement delays adding a further four months.[85] Some applicants leave work or lose job offers before receiving support.[86]

Several issues contribute to the scheme's underperformance.

First, a lack of referral pathways limits access. Access to Work relies primarily on self-initiated applications, with no routine mechanisms to access the scheme through public services or occupational health providers. As a result, only those already aware of the scheme are likely to apply – and awareness remains low due to minimal promotion.

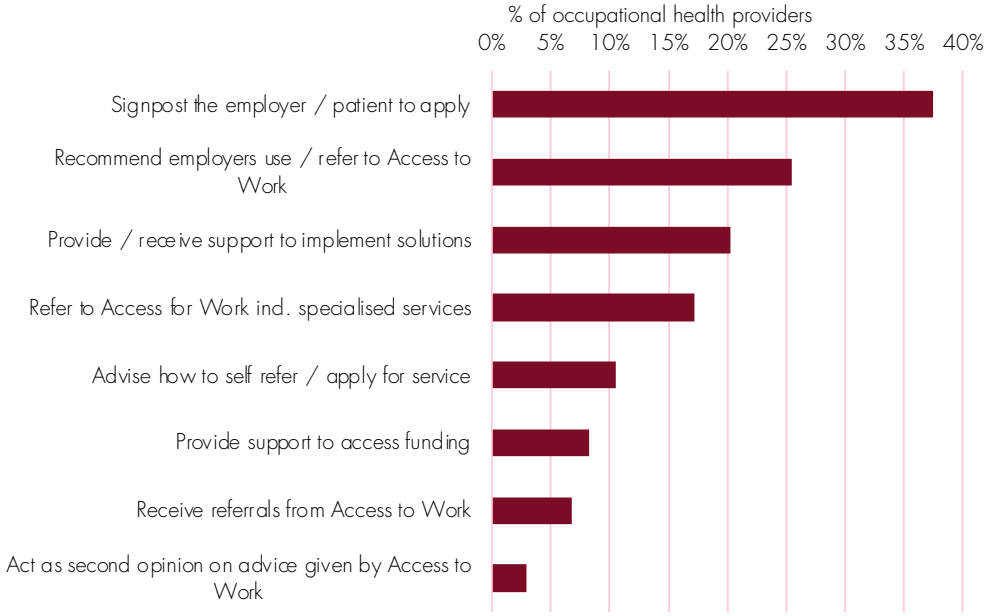
Second, assessment and approval processes are inefficient. Although the scheme has recently been digitised, centralised processing creates bottlenecks, and assessments may duplicate occupational health conversations. Meanwhile, workers with stable conditions require regular

reassessment, because their needs are not communicated between public services. This resource duplication needlessly slows the process.

Third, the scheme provides support that could be provided by employers. While employers are only required to fund adjustments if workers are disabled under employment law, Access to Work is open to anyone with a health condition affecting their ability to do their job, regardless of whether they are disabled. This places needless pressure on a scheme intended to step in where employers are unable to help.

Better integration with occupational health presents an opportunity to address these issues. Some occupational health providers already interact with government services such as Access to Work – for example, through signposting to services (see figure 13 below). While this is not done routinely, it demonstrates the willingness and capacity to engage. [87]

FIGURE 13: SOME OCCUPATIONAL HEALTH PROVIDERS INTERACT WITH PUBLIC SERVICES SUCH AS ACCESS TO WORK



Source: Joint Work and Health Directorate, DWP and DHSC

The journey out of work is paved with missed opportunities

1. Intervention is not consistently preventative and proactive

Most employers see the value of tackling workforce health problems before they emerge. This points to a readiness for reform. But good work and action to identify and address problems early are not universal.

Prevention works but is not consistently prioritised

Prevention and early intervention is often the more effective than waiting for problems to escalate. 60 per cent of people who leave work due to illness have been off sick for less than four weeks. This suggests that by the time someone becomes long-term absent, key opportunities for support may already have been missed.[88] On the other hand, most employers who have implemented preventative measures believe those actions were effective.

Yet prevention and early intervention are not consistently embedded. A 2024 DWP survey found that only 68 per cent of employers said they addressed health and wellbeing issues at the earliest opportunity. While this represents a majority, 29 per cent still said they only acted once problems had already emerged.[89]

Access to healthy working conditions is unequal

Healthy working conditions can help tackle health risks at their source. A substantial body of research outlines the features of work that are supportive of health. These include manageable workload and work-life balance, job autonomy aligned with capabilities, effective use of skills, supportive management and career development, positive organisational culture and relationships, and access to safe equipment and a well-designed physical environment.[90]

However, access to these conditions is unequal. A 2025 Work Foundation survey found that lower earners are significantly less likely to report having job autonomy and a manageable workload.[91]

Employers also vary in how seriously they consider and address risks. A 2023 Trades Union Congress (TUC) survey of workplace health and safety representatives revealed that 29 per cent had not seen any evidence of a legally required health and safety risk assessment in the previous two years. Among those who had, a third believed the assessment was inadequate.[92]

While poor risk management has consequences across the workforce, it also reinforces existing inequalities. As seen during the COVID-19 pandemic, people facing structural barriers to work – such as disabled people and those from minoritised ethnic backgrounds – are often the first affected.[93]

Psychosocial risk is poorly understood and managed

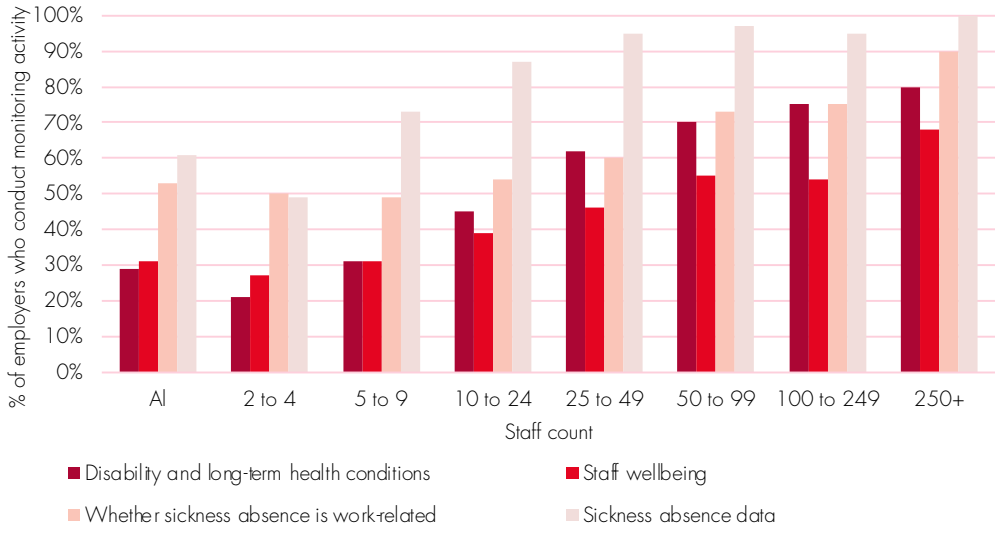
Despite the rising impact of psychosocial risk on worker health, there is currently lack of parity on action and enforcement to prevent psychosocial risk at work. An unpublished freedom of information request by the Chartered Institute of Personnel and Development (CIPD) showed that the HSE received 453 complaints regarding work-related stress but issued no enforcement notices on the matter.[94]

This partly reflects HSE capacity constraints. But legal gaps and ambiguity also expose workers to health risks and employers to legal risks.[95] For example, a 2023 TUC survey of health and safety representatives found that the most common workplace hazards were stress and bullying. The employer duty of care means they can be liable for these hazards. But work-related illness including mental health problems are not reportable in the same way as physical injuries under RIDDOR. And there is no specific legislation that defines and prohibits workplace bullying.[96]

Emerging issues are not identified and addressed early

Many employers take proactive steps to spot emerging issues and offer timely support if needed. Per figure 14 below, more than half with at least 50 employees assess and monitor wellbeing, and collect data on disability and sickness absence – including whether sickness absence is work-related.

FIGURE 14: MOST LARGER EMPLOYERS MONITOR STAFF HEALTH



Source: DWP, 2024.

These figures suggest that these activities are viable for most larger employers. But this is not done consistently, which reflects insufficient or inconsistent incentives and support.

2. Workers are not consistently supported

Communication barriers, misunderstandings and gaps in entitlements mean most workers who would benefit from personalised support do not receive it, and potentially harmful organisation-wide practices remain unaddressed, while employers face legal risk.

Personalised support is effective but inconsistently available

There is strong evidence that personalised support, including advocacy and workplace adjustments, are effective.[97] The same is true of organisation-wide policies that mean individual employees are empowered to manage their wellbeing. A 2025 Health Foundation survey found that 88 per cent of employers who funded adjustments for workers with health conditions (for example, ergonomic furniture, adaptive technology, flexible hours, or remote working options) believed the intervention had been effective.[98]

Most employers recognise these benefits and offer tailored support to their workers as a result.[99] However, this is not translating into consistent outcomes for workers. A 2023 Business Disability Forum survey found that only 45 per cent of employees with long-term health conditions had received all the adjustments they needed.[100] And a 2025 Work Foundation Survey found low earners were less likely to have access to flexible work.[101]

Conversations about health at work are challenging

Employers often lack the confidence, expertise, and support necessary to work with employees to address health challenges at work. A 2023 Business Disability Forum survey found that just 27 per cent of employers were 'very confident' about recognising when an employee has a disability or health condition.[102] Despite this, just 37 per cent felt 'very confident' about initiating discussions on adjustments.[103] Moreover, a 2022 DWP survey found that just 24 per cent of employers encouraged open conversations about health and disability.[104] Together, these challenges limit employers' ability to meet their proactive duty to make reasonable adjustments.

Workers also lack confidence and support to talk about health at work. A 2025 TUC survey found that 20 per cent of disabled employees had not told their employers they were disabled, with insecure workers less likely to do so. Of these, 56 per cent said they were worried about repercussions.[105]

People facing structural barriers to work are particularly affected. Timewise research found those from minoritised ethnic groups felt less comfortable than their white colleagues talking about their working arrangements.[106]

And overcoming these barriers does not guarantee indefinite support. Many who experience a change of employer or management face potentially duplicative discussions to negotiate adjustments they previously had in place, which can limit both access to support and job mobility.[107]

Many who ask for support do not get it

Most requests for support are either denied or excessively delayed. A 2025 TUC survey found that among those who asked for reasonable adjustments, 55 per cent had some or all of their request denied. And among those who had adjustments agreed, 82 per cent waited more than four months to receive them.[108] There are several reasons for this.

First, employers misunderstand their responsibilities. Some employers struggle to determine what adjustments are "reasonable".[109] Others mistakenly believe that the duty to make reasonable adjustments is only triggered by a formal medical diagnosis or request from the employee – but neither position is supported by employment law.[110]

Second, the law is ambiguous. Occupational health providers and health professionals issuing fit notes can make recommendations on adjustments. But this advice may not be enforceable unless the person is legally disabled, which is a matter for an employment tribunal to decide. This ambiguity is unhelpful for everyone. It creates risks for employers, who may inadvertently fall sort of their duties to protect worker health and safety.[111] It also introduces health risks for workers who are not yet legally disabled, but could deteriorate without support; do not identify as disabled (27 per cent with long-term health conditions); are not aware that they qualify for protection; or do not wish to share private medical details.[112]

Third, there are gaps in protections. Discrepancies between the law on flexible work and reasonable adjustments mean that the requirements for responding to flexible work requests are more stringent than for reasonable adjustments – even though the latter is aimed at workers with higher support needs. These discrepancies mean people requesting reasonable adjustments are not entitled to a response within a specific timeframe (which is two months for flexible work requests), consultation before a request is refused, or a written explanation of refusal.[113]

Flexible workers also risk detriment. Among them, only part-time workers are protected against less favourable treatment. This leaves workers without

support but could also create legal risk if employers fail to recognise where a flexible worker is disabled and so protected from discrimination.[114]

3. Incentives don't support recovery or continued employment

The UK's sick pay and social security systems, and rules governing sickness absence management, do too little to keep people connected to work if they fall ill. This creates significant challenges: once someone leaves employment due to ill health, they face a higher risk of low pay, underemployment, and skill loss – all of which make returning more difficult.[115]

Legal minimum requirements shape how employers support sick workers

Most employers do not offer sick pay beyond the legal minimum. A 2024 DWP survey found that 62 per cent of UK employers offered only statutory sick pay. This was especially common among SMEs. Based on a 2023 DWP and DHSC survey, this accounts for 26 per cent of the workforce.[116]

Moreover, most employers manage sickness on an ad-hoc basis, reflecting the limitations of current legal mandates. A 2021 DWP survey found only 29 per cent of employers had a dedicated sickness absence management policy – meaning most workers are supported at their line manager's discretion.[117]

Low statutory sick pay drives presenteeism and pushes people out of work

UK statutory sick pay is low by international standards. Even with the government's proposed increase, it would replace just 13 per cent of incomes during short-term sickness absence. This is well below the OECD average of 65 per cent.[118]

This presents a number of challenges. First, people living on statutory sick pay alone face significant financial hardship that can undermine their recovery.[119] Weekly support in 2023-24 fell £90 below the poverty line after housing costs, and more than £220 below Joseph Rowntree Foundation's minimum income standard, which is what the public think people need for a socially acceptable standard of living after housing costs.[120] Means-tested benefits could help, including with housing costs, but take-up among those an statutory sick pay is low.[121]

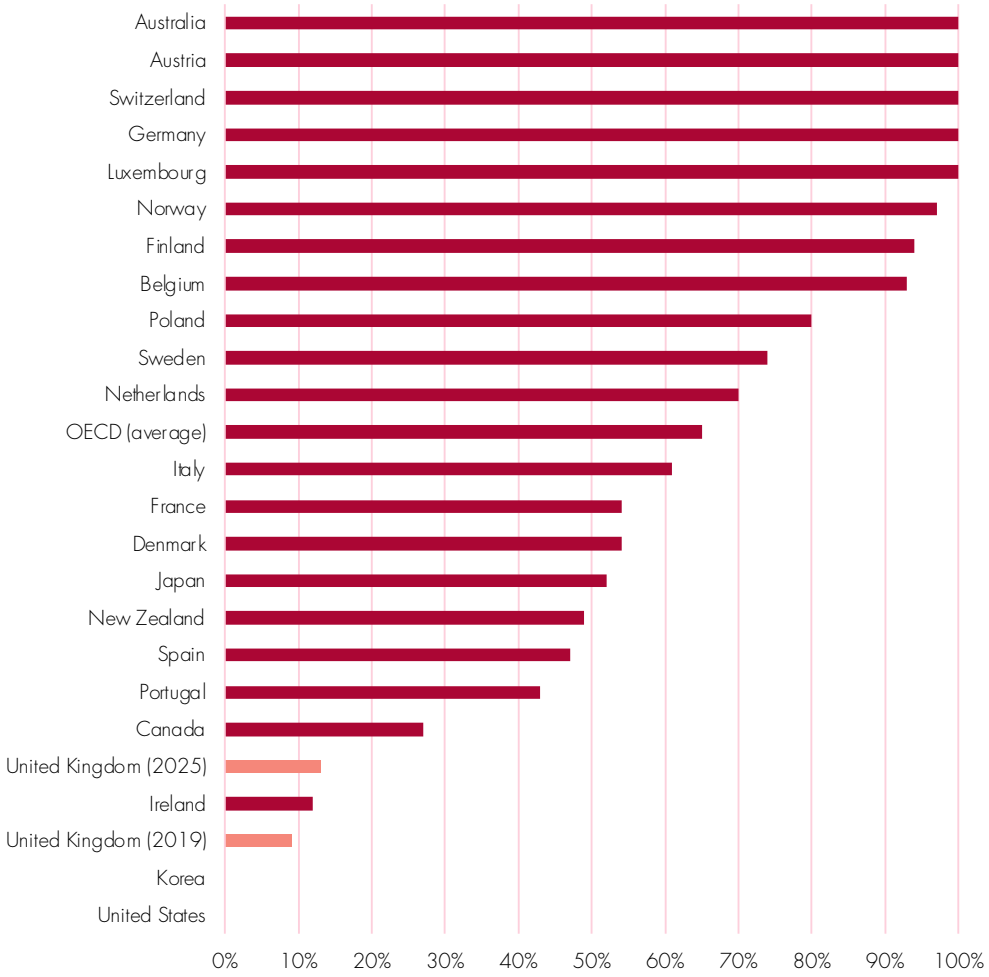
Second, a limited safety net means the UK has among the lowest rates of sickness absence in advanced economies. Rather than being a strength, and the sign of a healthy workforce, low levels of sickness absence reflect the large number of people who are unable to take time off and recover when they are sick – particularly if they are already financially vulnerable. A 2025 Work Foundation survey finds that just 46 per cent of low earners say they

feel confident taking sick days when they need them, compared with 58 of middle-income workers and 74 per cent of high earners.[122]

Third, sick pay is lower than means-tested benefits, creating perverse incentives that mean people are better off leaving work. People off sick today could get £21.80 per week – or 18 per cent – more through contributory benefits than through statutory sick pay.[123]

Fourth, employers lack financial incentives to support workers. A 2021 DWP survey found that employers who offer only statutory sick pay only are more likely than those offering higher occupational sick pay to wait until health becomes a problem before they offer support, rather doing so at the earliest possible opportunity.[124]

FIGURE 15: THE UK HAS AMONG THE LOWEST INCOME REPLACEMENT RATES FOR STATUTORY SICK PAY IN THE OECD



Statutory employer-provided sick pay and sickness benefits for a 2-week absence as a percentage of full-time employee earnings, selected countries (June 2019) and UK (2025 rates and proposals)

Source: Health Foundation, 2025.

Statutory sick pay eligibility rules are unhelpfully restrictive

The criteria for accessing statutory sick pay limits options for managing wellbeing in line with professional advice in two key ways.

First, it does not cover medical appointments. This means workers must attend appointments in their own time if they cannot be accommodated through flexible work or reasonable adjustments. Against this backdrop, there are more than 2m missed hospital appointments each year because of workplace commitments. This is a waste of public money. It also puts employees at risk of long-term sickness absence that could have been avoided with earlier intervention.[125]

The most vulnerable workers are the most likely to suffer. Just 51 per cent of workers reporting poor health say their employer allows them to attend medical appointments during working hours, compared with 67 per cent of those in good health. Similarly, just 53 per cent of low earners say the same, compared with 67 on middle incomes and 79 per cent of high earners.[126]

Second, it does not support certain forms of graded return, which occupational health professionals and fit notes sometimes recommend as a bridge back to work after illness.[127] In particular, statutory sick pay cannot be taken in part-day increments – meaning workers must return for full working days or not at all.

Current government action on work and health

The government is already stepping up to address many of the root causes of work-related ill health, which offers a solid foundation for future reform. Recent progress includes:

- **Work.** The government's plan to 'make work pay', which forms part of its broader mission to grow the economy and raise living standards, will address some of the barriers to thriving at work. Current and forthcoming legislation will ban exploitative zero-hours contracts, extend equal pay protections to disabled people, introduce stronger guarantees for access to flexible work, strengthen collective bargaining powers, and establish sectoral negotiating bodies for social care and education. The government has also committed to reviewing leave entitlements for new parents and carers.[128] And a new Jobs and Careers Service will support more people to succeed and adapt to the changing world of work.[129]
- **Health.** The government has a mission to improve population health by creating an NHS fit for the future. Its approach relies on shifting healthcare from treatment to prevention, from hospital to the community, and from analogue to digital. It has already delivered some results: in February 2025, it announced that it achieved its manifesto goal to reduce NHS waiting lists by delivering an extra 2m appointments – seven months ahead of schedule.[130] Ongoing reforms include joining up support across the health, work and skills systems, and making local NHS accountable for employment outcomes; trialling neighbourhood health centres with GPs and other services including employment advisors in one place; piloting NHS health checks at work for over-40s; and a single digital patient record for health and social care.[131]

A PLAN FOR REFORM

We need an ambitious new plan to keep people well in work

Improving worker health should be central to the government's ambitions to achieve a shift from treatment to prevention in the NHS and to raise growth and living standards through its plan to 'make work pay'.

It will require a new settlement: a comprehensive in-work health system where employers, workers, and public services are partners in enabling healthy and inclusive employment.

Visions for such a system date back to the genesis of the NHS, created in 1948 as the country recovered from the second world war. Sir William Beveridge's 1942 report, Social Insurance and Allied Services, provided the foundational blueprint for the welfare state. It envisioned healthcare "designed to be preventative as well as curative by establishment of a network of… factory… health centres."[132] And Aneurin 'Nye' Bevan, the architect of the NHS, was inspired by the Tredegar Workmen's Medical Aid Society, which provided free healthcare to workers in the mining community where he grew up.[133]

More than half a century later, Dame Carol Black's 2008 review, Working for a Healthier Tomorrow – which was commissioned by the last Labour government – revived this ambition. But progress stalled in the aftermath of the global financial crisis. Key recommendations – like universal access to occupational health integrated with the NHS – were not implemented. Those that were proved insufficient without systemic reform.[134]

Now – following unprecedented changes in the health pressures on workers – the case for transformation is more urgent than ever. We propose the creation of a National Occupational Health Service – comprising an integrated system of occupational health provision and clear responsibilities for employers, workers and the state.

A National Occupational Health Service should be guided by five objectives

This report has shown that the UK's occupational health system is failing. The government has an opportunity to learn from these failures – and shape more effective support – through five shifts.

TABLE 1: FIVE SHIFTS TOWARDS A NATIONAL OCCUPATIONAL HEALTH SERVICE

Now	After reform
Variable. Access to quality occupational health services is inconsistent.	**Universal.** Employers and workers are supported through universal and effective occupational health.
Disjointed. Poorly integrated services leave employers and public services disempowered to help.	**Integrated.** Employers, occupational health, the NHS and public services coordinate to deliver support.
Reactive. Intervention only steps in once a worker's health causes issues, which is often too late.	**Preventative.** Healthy and inclusive work, and proactive intervention, stop workers getting sick or sicker.
Unsupportive. Workers go without personalised support, and unaddressed problems spread.	**Supportive.** Workers get tailored support, and organisation-wide impacts on health are addressed.
Not restorative. Employer and worker incentives do not support recovery or continued employment.	**Rehabilitative.** Sick workers are actively supported to recover and maintain ties with work.

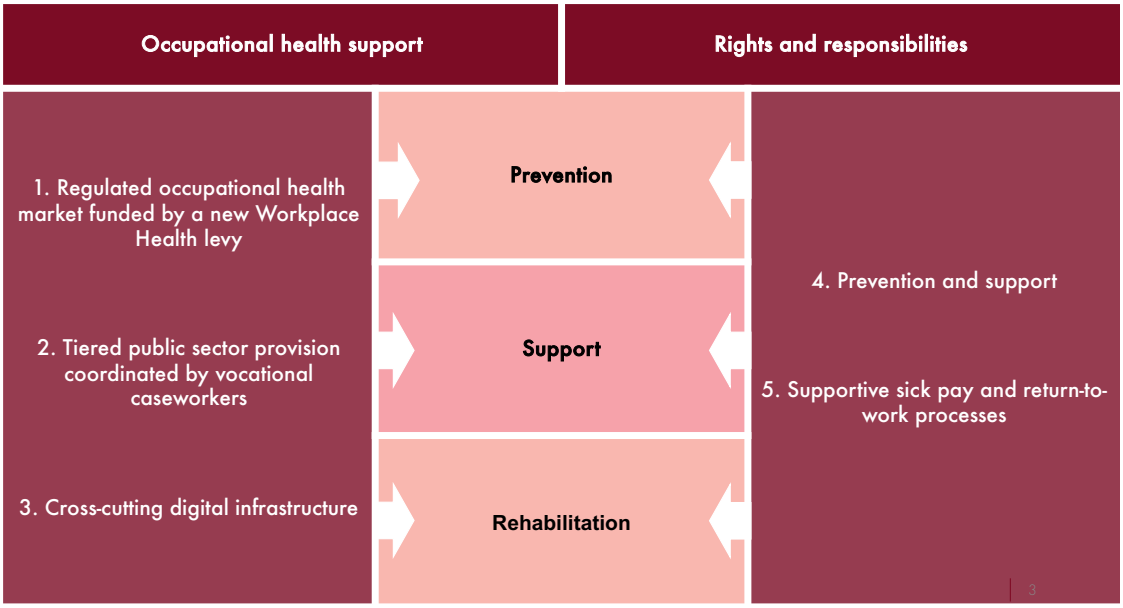
A National Occupational Health Service should match support with responsibility

Delivering these shifts will entail two pillars that support people at key moments when they become vulnerable to leaving work.

1. Improving **support** through better occupational health provision.
2. Strengthening **responsibilities** so this support delivers for workers.

Key components of these pillars are shown in figure 16 and described below.

FIGURE 16: A NATIONAL OCCUPATIONAL HEALTH SERVICE SHOULD MATCH SUPPORT WITH RESPONSIBILITY



Pillar 1: Occupational health support

This research has found that the current market-driven occupational health system results in inconsistent and fragmented support. To address this, we propose a model of public and private provision, supported by cross-cutting digital infrastructure, to increases take-up, guarantee appropriate quality, and improves integration between services.

The government should:

1. Create a regulated occupational health market funded by a new growth, skills and health levy

Occupational health services should continue to be delivered primarily through private providers contracted by employers. But a new system of regulation and levy funding should be implemented to improve value-for-money and incentivise take-up.

This aligns with international norms, which assign primary responsibility for occupational health to employers, and builds on the current market without requiring a full structural overhaul.

TABLE 2: REGULATED OCCUPATIONAL HEALTH SERVICE MARKET FUNDED BY A NEW HEALTH LEVY

Now	After reform
Some employers struggling to navigate an occupational health services market with no consistent quality guarantee may spend money on services that are not fit for purpose.	Regulated occupational health services provide standardised and quality support, giving employers confidence they will be appropriate and will deliver value for money.
Employers lack the incentives or resources to buy occupational health support, resulting in limited take-up – particularly among smaller employers.	Employers of all sizes are incentivised and supported to buy services through a growth, skills and health levy funded by the largest employers.

Regulation

Reform and regulate the occupational health market, to give employers confidence they will receive appropriate quality support. A new system of regulation should have the following features:

- **Oversight.** Create a new Occupational Health Authority, situated in an expanded HSE, to regulate the market. This body should:
    - Set standards based on best practice.
    - Monitor and enforce provider and employer compliance.
    - Undertake market stewardship, including capacity-building and innovation.
    - Be funded by occupational health registration fees.

- **Standards.** Task the Occupational Health Authority to establish standards for occupational health providers and employers, by:
    - Working with occupational health professional bodies to adopt and build on existing SEQOHS accreditation frameworks, in line with National Institute for Care Excellence guidance, by identifying and addressing gaps.
    - Convening employers from different sectors to identify best practice in their sector and updating guidance.

- **Registration and quality assurance.** Require all providers seeking access to levy funds to:
    - Register with the Occupational Health Authority.

- Meet a minimum standard to qualify for registration.
- Undergo inspections where indicated.

Funding

Create a new growth, skills and health levy. Contributions and withdrawals should be operationally integrated with the reformed growth and skills Levy, but with funds earmarked for occupational health provision. The system should be designed to:

- **Incentivise large employers to access occupational health advice**, by requiring them to pay into a pot that can only be used to fund registered occupational health provision.
- **Support SMEs to access occupational health**, by subsidising purchases with unused levy funds. Copayment could be from 50 per cent to 100 per cent, depending on employer size.[i]
- **Encourage take-up of preventative occupational health** services through higher subsidies, to complement new statutory duties on remedial occupational health services (as described below).

[i] DWP and DHSC piloting shows that shows that the employer response to subsidies above 50 per cent diminishes with employer size.

A growth, skills and health levy

The government has already committed to reforming the apprenticeship levy into a "growth and skills levy" to help increase and target employer investment in skills. Broadening this to into a growth, skills and health levy would be consistent with the government's ambitions to join up support across the health, work and skills systems, and reflect that these are shared responsibilities integral to employment at each life stage. It would also ensure that funding mechanisms do not introduce duplicative processes that unduly burden employers.

This model could prove both popular and effective. An expanded levy would help meet increasing employer demand for a healthier workforce. And employers are broadly supportive of this funding mechanism. Recent Fabian Society research on making the growth and skills levy work showed that 67 per cent of levy paying employers support the principle of a levy to raise investment.[135]

The benefits of a levy funding regulated services include higher standards, which can help improve value for money for most large employers who already invest in workforce health, while ensuring the remaining minority of large employers improve how they support workers and that SMEs have access to finance to invest.

Under the current Apprenticeship Levy:

- Employers with a payroll of at least £3 million contribute 0.5 per cent of their total payroll. This currently applies to the largest 2 per cent.
- Funds paid into the levy receive a 10 per cent top-up from the government and can be used for accredited apprenticeships or transferred to other organisations.
- Unused funds are clawed back by the government after two years, to subsidise 95 per cent of apprenticeship costs for non-levy payers.

Fabian Society research proposed reforms for the growth, skills and health levy which, after additional spend proposals, could increase the levy budget by £2.07 billion.[136] These include to:

- Increase payments from large employers to 0.7 per cent of payroll.
- Lower the threshold for contributing 0.5 per cent of payroll to £1m.

- Restrict the use of levy funds to non-graduates.

A new growth, skills and health levy could complement public investment to fund both private and public occupational health provision. Full costings are beyond the scope of this report. But the levy should:

- Raise at least enough to cover occupational health take-up for all large employers, on top of current spend. We estimate this is around £1bn, but regulation could help lower costs.[ii] This could be funded by the larger levy pot described above.
- Ideally reflect a share of target public and private occupational health spend commensurate with employers' stake in workplace health outcomes relative to the state, after accounting for copayments.

2. Establish tiered public sector provision coordinated by vocational caseworkers

Private occupational health provision should be complemented by integrated public services that step in where employers are unable to provide workers with the support they need. This would include where more holistic intervention is required, someone is at significant risk of leaving work due to ill health, the cost of support exceeds what is reasonable for an employer to shoulder, the employer is unaware that the worker needs support, or someone is self-employed.

This approach reflects the shared responsibility between employers and the state to keep people well in work, shifts the emphasis of public support to where it can achieve best impact – namely, before someone has left work – and ensures people receive a seamless support experience if transitioning in and out of work.

[ii] This assumes that large firms' occupational health spend increases proportional to the share of workers they employ, from 81 per cent to 100 per cent. This accounts for the 10 per cent of large employers who don't purchase occupational health and 9 per cent who spend less than £1,000 per year. Raising the quality of occupational health may lower the overall cost.

TABLE 3: TIERED PUBLIC SECTOR PROVISON COORDINATED BY WORKHEALTH CASEWORKERS

Now	After reform
Some employers and workers lack expertise and levers to find solutions to health barriers to work, with support often delayed until and if workers encounter the benefits system.	A caseworker service embedded in NHS neighbourhood health centres coordinates multi-agency support, so appropriate help steps in at the right time.
Primary care clinicians rarely engage with occupational health, leading to incomplete care and medicalisation of problems at work.	Fit notes have a "requires occupational health consultation" box, so clinicians can consider holistic evidence when signing people off.
Inefficient referral pathways and administrative bottlenecks result in poor take-up and delays in the Access to Work scheme.	Standardised Access to Work assessments are decentralised, with approvals prioritised and automated where appropriate.
Employers lack management and HR capability to support workers' health.	A dedicated HR service for SMEs helps employers meet their duties towards workers.

WorkHealth vocational caseworker service

Establish a national caseworker service, based on evidence-based evaluation of the WorkWell pilots, to coordinate tailored, multi-agency support for people facing health-related barriers to work. The service should have the following features:

- **Access.** The service should be:
    - Fully voluntary.
    - Embedded in neighbourhood health centres.
    - Accessible via self-referral through the NHS app or NHS pathways – including referrals resulting from NHS workplace health screenings currently being trialled.
    - Offered as standard when someone has reached a specific sick leave threshold – for example, six weeks within a 12-

month period – to workers who have provided explicit consent to be contacted in this way.

- **Services.** The service should be worker-focused, giving them the confidence to engage constructively with a caseworker who is on their side, seeking practical solutions to meet their health needs. Services could include:
    - Triage and collaborative action planning.
    - Advice and support on identifying reasonable adjustments and broader workplace improvements.
    - Escalation to clinical or intensive rehabilitation services where needed.
    - Links with multidisciplinary experts and other public services.
    - Advice on seeking private occupational support.

- **Governance and funding.** This service should:
    - Be a statutory NHS service.
    - Play a similar role and meet the same accreditation standards as private-sector occupational health provision.
    - Be part-funded by unused levy funds. The Health Foundation estimates that a tiered caseworker service taken up by everybody who has been off sick for four weeks (300,000), and disability benefits claimants who have been off sick for less than a year (70,000), would cost £624m per year.[137]
    - Form part of DHSC core funding. Some of the £3.5bn committed to return-to-work support could be repurposed toward this service.

Evidence on caseworker support

Coordinated vocational support provided by a dedicated caseworker is a proven, effective intervention. As such, it is routinely used by group income protection insurers, and as a public service in several other countries.[138]

This model has shown promise in Britain. A pilot across 21 primary care sites in England, Wales and Scotland demonstrated early success in integrating a tiered caseworker service into primary care that escalated support depending on need. Under the trial, GPs referred eligible patients to a health and work coordinator, within the GP surgery, for an initial conversation. These coordinators were trained on the biopsychosocial model, and could refer patients onto clinicians including occupational health specialists as appropriate.

An early evaluation suggests that such personalised tiered pathways could be both effective and resource-efficient. It found that 90 per cent of those who saw a clinician returned to work and only 5 per cent of patients needed support from a specialised occupational health physician. It also observed improvements in patient and clinician experience thanks to more joined-up care, reduced workload and the availability of a "safe space" to discuss work-related health challenges.[139]

Such a service would need to be designed in a way that maximises take-up to avoid the fate of the Fit for Work service. This service was rolled out after Dame Carol Black's review of health at work under the last Labour government, but closed due to low demand. The model proposed in this report seeks to address this through integration with the NHS and proactive offers of support.

NHS occupational health referrals

Embed occupational health referrals as standard within primary care so that clinicians are better equipped to support people experiencing work-related health problems. Reforms should:

- Update the fit note template to include a "requires occupational health consultation" tick box, which clinicians can select alongside "not fit for work" or "may be fit for work".
- Update guidance to clarify when referral to the caseworker service is appropriate.

A streamlined Access to Work service

Restructure the Access to Work scheme to ensure workers get timely support. Key reforms should include:

- Enabling standardised screenings to be conducted by any registered occupational health provider or WorkHealth caseworker to reduce the burden on a centralised team.
- Data-informed triage to fast-track high-priority cases.
- Automated approvals and self-service access for standard, low-cost interventions such as assistance software or ergonomic equipment, operating in parallel with more complex human-mediated processes.

Support for employers

Support employers to meet their duties towards workers, through channels separate to worker-focused occupational health provision, by piloting an HR support service for SMEs. This service could:

- Be available to any SME that has invested in accredited occupational health (or apprenticeships) in the preceding 12 months.
- Offer free online tools and resources, including signposting to occupational health resources and dedicated one-to-one support from a professional HR consultant.
- Be funded by the new growth, skills and health levy. Based on a 2015-2017 pilot by the Chartered Institute for Personnel and Development, rolling out support across the country would require funding of about £17.5m per year for an initial three years to support evaluation for future government policy (this figure takes account of inflation since the pilot evaluation). This would account for a relatively small share of the new growth, skills and health levy.

3. Develop cross-cutting digital infrastructure

Occupational health should form part of the government's plans to digitise the NHS and social care systems. This will enable joined-up care, early intervention, and effective conversations.

It is critical that this infrastructure serves to support and empower workers and public servants, and that workers retain full control over their data and how it is shared. To achieve these aims, the service must be codesigned with workers and health professionals, with appropriate technical safeguards and consent mechanisms in place from the outset.

TABLE 4: CROSS-CUTTING DIGITAL INFRASTRUCTURE

Now	After reform
The government does not know which workers or employers need support until problems arise, meaning public services step in when it is too late.	Payroll reporting with worker consent informs DHSC and HSE when workers reach sick leave thresholds to enable proactive support offers.
A lack of information and communication limits how healthcare professionals and employers can support workers.	A digital workplace health record and support passport enable joined-up conversations and holistic care.
Employers and workers struggle to navigate support and responsibilities through fragmented online sources.	A digital front door provides a one-stop-shop for self-help, signposting and triage for occupational health support.

Payroll-based early identification

Use sick pay data to target public service support towards those who need it. To do this, it should:

- Reinstate sick leave reporting via payroll.[iii]
- Implement a digital bridge from HMRC to HSE and DHSC, sharing sick pay data and contact details where workers have provided consent.
- Task DHSC with identifying workers who exceed defined sickness absence thresholds and proactively offer them support through WorkHealth where they have opted in.
- Task HSE with identifying employers with high rates of sickness absence and offer non-punitive support to reduce levels and associated losses.

[iii] This was discontinued in 2014 after the abolition of the percentage threshold scheme, which entitled employers to recover some statutory sick pay if this was greater than a set percentage of their national insurance contributions. Reinstating sick pay reporting through payroll could be justified, particularly if it helped target incentives for employers who hire and retain workers who have been off sick.

WorkHealth health record

Integrate WorkHealth digital systems with the NHS and social care single patient records. Such a system could include the following features:

- **A digital record.** This should:
  - Include notes from WorkHealth caseworkers and occupational health professionals.
  - Contain any recommendations on workplace adjustments and support.

- **An adjustments passport.** This should:
  - Allow workers to select and share relevant parts of their record with their employer or registered occupational health professionals if they wish.
  - Support discussions on workplace adjustments to promote continuity between employers and roles.

A digital front door

A central online platform, maintained by the HSE, should offer practical routes to act early and confidently when encountering common workplace health challenges before turning to professional support, and help employers and workers navigate professional support on offer – making use of AI technologies where reliable. Such a system should include:

- Self-help resources to address common workplace health challenges.
- A directory of registered occupational health providers.
- Signposting and triage for public services, such as WorkHealth or Access to Work.

High ethical standards

To give workers confidence in engaging with the system:

- The worker must provide consent before their data is shared. Workers sharing their data should enjoy a "no harm guarantee" – meaning their data won't be used against them, for example for the purpose of benefits administration.
- Existing protocols for occupational health professionals and employers to access medical information must remain unchanged.
- Only registered occupational health professionals may use workers' health records.

Pillar 2: Rights and responsibilities

This report highlights several missed opportunities at critical points in people's journey out of work. Occupational health services could give employers the tools to intervene, but only if employers and workers are incentivised and supported to engage with these services and implement their advice. To achieve this, we propose new rights and responsibilities to strengthen the role of occupational health to keep people well in work.

The government should:

4. Establish new rights and responsibilities to promote prevention and support

Employers should have new responsibilities to prevent and identify work-related health challenges and work with occupational health professionals to implement organisation-wide improvements and in-person support. Below, we set out measures to pilot and consult on.

TABLE 6: NEW RIGHTS AND RESPONSIBILITIES TO PROMOTE PREVENTION AND SUPPORT

Now	After reform
Prevention is limited by unequal access to healthy and inclusive work, inconsistent monitoring of evidence on potential work-related health problems, and insufficient action on psychosocial risk.	A national good work standard incentivises and rewards healthy working conditions, employers report work-related illness to the HSE in the same way as injuries, and physical and mental health enjoy parity by law.
Employers and workers struggle to have constructive conversations about health at work, meaning employers lack information to act and worker support needs are unmet.	All new joiners are invited to request flexible work and adjustments, and have the right to an accompanied "health at work" conversation to discuss their support needs.
Limited capabilities, alongside legal ambiguity and inconsistency, mean employers fail to act appropriately where employees raise health issues.	Employers have clear duties around consulting occupational health, implementing reasonable recommendations, responding in

This leave workers unsupported and exposes employers to legal risk.	line with flexible work processes, and treating workers who receive support fairly.

Prevention and monitoring

Act to prevent all work-related illness and facilitate early intervention where issues arise. Interventions should include:

- **A national good work standard.** Establish the governance for a national good work standard – aiming to incentivise and reward employers to create healthy working conditions, above and beyond the legal minimum. The standard should:
    - Be developed, implemented, and governed by a Good Work Council comprised of employers, the government, trade unions and occupational health professionals.
    - Provide a baseline for good practice, based on the biopsychosocial model, which all employers can seek accreditation against. This may include, for example, when and how to use occupational health services, training, disability employment, and performance under a workplace wellbeing survey.
    - Be linked to incentives to maximise take-up – for example, training budgets, or rebates on statutory sick pay or national insurance.
    - Carry specific mandatory reporting requirements for all employers with 250+ employees, regardless of whether they sign up to the standard.

- **HSE reporting.** Update Reporting of Injuries, Diseases and Dangerous Occurrences Regulations to include work-related illness, including mental health, to facilitate offers of support and enforcement action. Employers should be required to:
    - Ask workers who have been off sick for 3+ days whether their illness is work-related.
    - Record any reported work-related illnesses in their Accident Book, and report them to the HSE where they exceed seven days.
    - Work with the HSE, and trade union health and safety representatives where applicable, on an improvement plan where there are high rates of work-related illness.

- **Psychosocial risk.** Work with the HSE to review Health and Safety legislation, regulations and Approved Codes of Practice to

identify updates that could support parity between protections for physical and mental health at work.

Open dialogue

Introduce new rights and responsibilities to encourage early and open conversations about health needs at work. These should include:

- **A new joiner questionnaire.** Require all employers to issue a standardised questionnaire with employment contracts, inviting:
    - Voluntary disclosure of health needs.
    - Requests for flexible work and adjustments.
- **Supported "healthy work" conversations.** Support workers to initiate discussions with employers about health needs by guaranteeing the right to:
    - A "healthy work conversation".
    - Be accompanied to these conversations upon request – for example, by a trade union health and safety representative.

Reasonable adjustments and workplace improvements

Improve clarity on duties to fairly consider and implement reasonable support and broader workplace improvements, in accordance with occupational health advice, so that workers receive appropriate support and employers are protected against legal risk. An initial step could involve working with ACAS to update its guidance, while capacity constraints in the occupational health market are addressed. But the ultimate aim should be to end legal fragmentation and inconsistencies that mean some workers who need support slip through the net. New duties should include:

- **A duty to consult occupational health.** Require employers to consult with an occupational health professional before refusing requests for reasonable adjustments and flexible work, to help ensure all reasonable options have been explored.
- **A duty to act on reasonable occupational health advice.** Create a new duty to implement reasonable support recommended by registered occupational health professionals. It could include:
    - Personal support. This would apply unless the worker declines in writing or a valid reason for refusal applies.
    - Broader workplace improvements. This would help avoid individualising health and safety risks that affect the wider workforce.
    - Defined valid reasons for refusal aligned with those that currently apply to flexible work requests. Consistent with

the biopsychosocial model, this would apply regardless of whether someone is disabled under employment law.

- **Response duties.** Require employers to respond to occupational health recommendations and worker requests for reasonable adjustments in the same way as flexible work requests, so support steps in appropriately. This means they should:
    - Communicate a decision withing two months.
    - Consult with the worker before refusing an application.
    - Explaining reasons for refusal in writing, if applicable.
- **Equal treatment duties.** Give all workers the confidence to access support, by protecting those with adjustments and flexible work arrangements in place against less favourable treatment.

5. Establish new rights and responsibilities for supportive sick pay and return-to-work processes

Reformed statutory sick pay and employer rehabilitation responsibilities should improve support for workers to stay employed.

TABLE 7: NEW RIGHTS AND RESPONSIBILITIES FOR SUPPORTIVE SICK PAY AND RETURN-TO-WORK PROCESSES

Now	After reform
Low and restricted eligibility for statutory sick pay incentivises presenteeism, prevents workers from managing their health in line with professional medical advice, and pushes them out of work prematurely.	Statutory sick pay is set at a level that supports recovery, incentivises continued employment, and enables employees to use sick pay flexibly for medical appointments and phased returns to work.
Limited financial incentives, alongside the absence of formal sickness management requirements, results in unsupported exits from employment.	Formal health management responsibilities and financial incentives mean employers are appropriately incentivised to rehabilitate workers who have been off sick.

Sick pay

Reformed statutory sick pay levels and eligibility criteria should seek to remove the financial barriers workers face preventing and recovering from illness and perverse incentives that push people out of work.

- **Level.** The government should raise the maximum statutory sick pay. To do this, it should:
    - Immediately, raise it to at least the maximum potential value of out-of-work benefit – but ideally 20 per cent above this level – paying 80 per cent of total earnings up to the set level. This would help ensure more people are better off staying in their job on sick pay than claiming unemployment benefits. We estimate that raising statutory sick pay to from £118.75 to £140.55 per week would cost businesses around an extra £200m and to £168.66 around £460m.[iv]
    - Next, review sick pay to tackle hardship and presenteeism and to improve employer incentives to rehabilitate workers. This would require levels to increase significantly, which could be achieved via a range of funding options. Previous Fabian Society research has recommended that sick pay should seek to replace 80 per cent of normal earnings.[140] An interim measure could seek to protect people from income poverty after housing costs, alongside action to raise housing benefit take-up.[141] This would broadly track the state pension, which is currently £230.25 per week, which could be topped up by voluntary insurance through auto-enrolment.

- **Eligibility.** The government should update statutory sick pay eligibility criteria to allow employees to get support with their health when they need it and act on occupational health or fit note advice. Statutory sick pay should:
    - Cover time off for medical appointments where these cannot be accommodated through flexible work or reasonable adjustments. We calculate this would cost around £30m.[v]

[iv] The cost to employers of raising statutory sick is calculated based on a 20 per cent uplift on the government's estimate of the statutory sick pay bill under changes in the employment rights bill (ie, the statutory sick pay uplift under these additional changes). We do not assume a change in sick leave levels because the overall income replacement rate would remain low.

[v] The cost to employers assumes that a fifth of the 2m medical appointments missed for work reasons each year are now attended using a half day of statutory sick pay, at £70.28.

- Be available in half-day increments.[vi]

Rehabilitation responsibilities

Require employers to take simple low-cost steps to support sick employees to ensure they have exhausted reasonable options to retain them. As a minimum, they should:

- Offer workers an occupational health consultation under specified circumstances – for example, when a specific sick leave threshold has been breached (for example, three weeks in a six-month period).
- Write to DWP at least four weeks before dismissing an employee due to capability, if the employee consents, so WorkHealth can offer support.

Reforms should be implemented in stages

This is an ambitious project. It will take two parliaments to bring the UK up to international standards. But we must also seize opportunities to make work healthier for those at risk today. Figure 16 below summarises which reforms could deliver quick wins for workers, lay the foundations for broader reform, and achieve long-term transformative change.

- **Quick wins:** The quickest impact can be delivered by using ongoing government activity to strengthen rights and responsibilities, and broadening access to occupational health services as part of laying the foundations for a regulated occupational health service market. Near-term opportunities include legislation arising from the current Pathways to Work consultation, which is scheduled to be completed by 2027, and reforms to the apprenticeship levy that are currently under consideration.
- **Laying the foundations:** At the same time, the government should begin laying the foundations for more transformative reforms. This should entail using planned legislation to create governance for a regulated occupational health market, learning more about what works through current and new pilots, ensuring appropriate cocreation and consultation has taken place for digital systems handling sensitive information, and consulting on new rights and responsibilities.

[vi] We have not estimated cost. It may decrease if employees return to work for half days where they would otherwise have taken sick pay, or increase if employees take sick pay where they would otherwise have worked.

- **Transformative change:** Following piloting, and once foundations are in place, the final transformative changes should be delivered through a Healthy Work Act. This should include national rollout of occupational health service reforms, and new rights and responsibilities that will rely on this infrastructure.

TABLE 8: A STAGED APPROACH TO DELIVERING A NATIONAL OCCUPATIONAL HEALTH SERVICE

	Quick wins	**Laying the foundations**	**Transformative change**
1. Reform and regulate the occupational health market funded by a growth, skills and health levy	Establish an Occupational Health Authority in the HSE. Create a growth, skills and health levy, which can be used for any SEQOHS accredited providers.	Task the Occupational Health Authority with developing and overseeing a new regulated occupational health services market through standards, registration, inspection and ratings.	Bring together system of support and responsibilities through Healthy Work Act. Require all occupational health providers to meet minimum standards to qualify for levy.
2. Establish tiered public sector provision coordinated by WorkHealth caseworkers	Introduce a "requires occupational health consultation" box on fit notes.	Continue to trial and evaluate the WorkWell scheme. Pilot Access to Work reforms with qualified occupational health providers conducting workplace needs assessments. Develop standardised protocols for Access to Work assessments and approvals.	Legislate to make occupational health a statutory NHS service. Roll out support services based on pilot outcomes – including WorkHealth, SME HR services and reformed Access to Work.

		Pilot an HR service for SMEs investing in occupational health.	
3. Develop cross-cutting digital infrastructure	Develop a basic digital front door. Establish mechanisms to share and monitor sick leave data via payroll.	Work with patients to cocreate, test and consult on data sharing infrastructure – including a patient record integrated with health and social care and a workplace support passport.	Expand the digital front door to include a gateway to public services including Access to Work and WorkHealth. Legislate and fully roll out data sharing infrastructure.
4. Establish new rights and responsibilities to support prevention and adjustments	Establish a Good Work Council. Require employers to issue a standardised new joiner questionnaire. Create right to an accompanied healthy work conversation.	Develop and pilot a national good work standard. Consult on updated rights and responsibilities including RIDDOR reporting and workplace adjustments.	Roll out a national good work standard. Legislate on comprehensive employment rights reforms.
5. Establish new rights and responsibilities for supportive sick pay and	Raise statutory sick pay to at least the level of contributory benefits, and ideally 20 per cent above.	Review of the sick pay regime. Consult on requirements to engage with occupational health.	Implement a roadmap to better sick pay. Legislate on occupational health engagement.

return-to-work processes	Expand sick pay to medical appointments and half-days. Require employers to notify government four weeks before dismissal for health reasons.

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