AUTUMN 2025

Keep Britain Working

Final Report

Pat McFadden
Secretary of State
Department for Work and Pensions

Peter Kyle
Secretary of State
Department for Business and Trade

Dear Secretaries of State,

Thank you for asking me to lead the *Keep Britain Working* Review. Over the past nine months I have had the privilege of engaging deeply with the issues surrounding ill-health and disability in the workplace. What I've seen is both concerning and encouraging. Concerning, because ill-health has now become one of the biggest drivers of economic inactivity in the UK. Encouraging, because so many employers, providers and local leaders are ready to help change that.

There is broad recognition that Britain is facing a quiet but urgent crisis. Over one in five working-age adults are out of the workforce, substantially because of health problems. Mental ill-health among young people is rising sharply. Older workers are leaving too early. Disabled people remain locked out of work at twice the rate of non-disabled people.

The impact touches everyone. For individuals, leaving work can mean a lifetime of lost income, poorer health, and missed opportunities. For employers, sickness and staff turnover bring disruption, cost and lost experience.

For the country, it means weaker growth, higher welfare spending and greater pressure on the NHS.

But this is far from inevitable. Other countries do much better. We can too. With the right approach, many more people could stay in work, recover faster, and live healthier, more secure lives. Employers would retain experienced staff and see higher productivity. Government would save billions and be able to focus resources on those who need them most. Everyone gains if we can keep Britain working.

Achieving that will require a new deal – one where employers, employees and government each play their part.

Employers must be in the lead. Some may resist that message amid tight margins and slow growth. But many already recognise they are carrying the cost of ill-health every day. I have yet to meet an employer unconcerned about mental health in their workforce. Employers are uniquely placed to ‘do’ prevention – by encouraging safe and early conversations about emerging health issues, making reasonable adjustments, supporting people swiftly, and offering flexibility for treatment and phased returns. They can act on prevention in ways the NHS can never do alone. Many already try, spending significantly but too often against a system that feels fragmented and unsupportive.

Employees also have responsibilities. Someone leaving the workforce in their 20s can lose out on over £1 million in lifetime earnings – with the state incurring a similar

cost. Work and health are not always easy partners, but they are mutually reinforcing. Supportive employment practices are vital, but so too is personal responsibility: frustration with work, still less ‘I hate my boss’ syndrome, are not health conditions. Disengaging from work and potential support, or relying on welfare as an alternative to work, can set people on a path towards detachment and dependency, rather than recovery and participation.

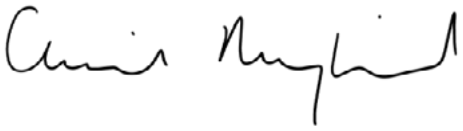
Government is critical to resetting the system. There is no viable scenario where more public spending alone can solve this. Instead, government must enable and incentivise employers and employees to act. That begins with better data: today it is weak; by the end of this Spending Review, it must be strong. Robust evidence will show that shared responsibility delivers the best outcomes – keeping people in work, improving health, increasing inclusion and saving the state billions. With that evidence, government must deploy a full range of targeted incentives – from procurement, rebates and the tax system, through to reforms to welfare and dispute resolution – to drive and sustain change.

The report I am submitting today sets out how to achieve this. The Prime Minister has rightly emphasised the dignity, purpose and contribution that good work brings. Our proposals align directly with that vision – helping more people to stay and thrive in work throughout their working lives, whatever health conditions or disabilities they may face.

The good news is that the groundwork is already laid. Across the country, employers, local leaders and providers are stepping forward to act as vanguards of change. With their energy, and with government backing, we can build a healthier, more inclusive working life for millions.

This review shows how. Its message is simple and urgent: **keeping Britain working is good for people, good for employers, and good for the country.**

Yours sincerely,



Sir Charlie Mayfield

Lead reviewer, Keep Britain Working

Executive Summary

1. The UK has been sliding into an economic inactivity crisis driven in large part by ill-health and by barriers to work faced by disabled people. This is holding back growth, damaging people's life chances, and costing the UK billions in lost output and welfare payments. It need not be this way. This is a serious but fixable problem. However, it can't be solved by government or employers acting alone.

2. Over **1 in 5 working-age people** are now out of work and not looking for work, higher than many comparator countries such as Netherlands (14.5%), Sweden (15.9%) and Denmark (17.7%).[1] Increasing the UK employment rate to 80%, bringing it in line with leading OECD countries, would add 2 million people to the workforce,[2] boost the economy and save taxpayers billions.[3]

3. Instead, we have been going in the wrong direction with 800,000 more people out of work now than in 2019 due to health problems. Without decisive action to address this trend, projections show we

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1 OECD Data Explorer • Infra-annual labour statistics

2 Get Britain Working White Paper: Analytical Annex – GOV.UK

3 Get Britain Working: The path to an 80% employment rate

are on track to add another 600,000 by 2030.[4] The trends are against us – '*our society is getting older and living longer but becoming sicker sooner*'.[5]

4. We've ended up in a situation that no one wants, that is neither sustainable nor necessary. Everyone caught up in this loses:

   - **Individuals** face life-changing financial and social costs. A 22-year-old who falls out of work for health reasons could be more than £1 million worse off over the course of their lifetime than if they had been sustained in employment[6]; and the impact on wellbeing of being out of work is immense – greater than the loss of a partner.[7]
   - **Employers** lose on average £120 per day in profit from sickness absences, which are at a 15-year high,[8] and face costs to replace staff

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4 Keep Britain Working Review: Discovery – GOV.UK

5 NHS Performance: Darzi Investigation – Hansard – UK Parliament

6 See technical Annex at: https://www.gov.uk/government/publications/keep-britain-working-review-final-report

7 Why Workplace Wellbeing Matters, The Science behind Employee Happiness and organizational performance – Jan-Emmanuel De Neve, George Ward

8 Health and wellbeing at work | CIPD

which stretch into the tens of thousands each time. This causes disruption, lost capacity and unplanned costs.

- **The state** faces an unsustainable cost from economic inactivity due to ill-health of £212bn per year[9], equivalent to 7% of GDP or nearly 70% of the income tax we pay[10], through lost output, increased welfare payments and additional burdens on the NHS.

5. If we do nothing, the costs will mount, and we will be stuck with weaker growth, higher taxes, and reduced opportunities for individuals and employers alike. **Everyone wins if we can 'Keep Britain Working'.**

6. The case for change could not be stronger.

What must change?

7. In relation to health and disability within the workplace, throughout this review we have found three persistent problems:

- a **culture of fear**, that is felt by employees and, differently, by employers, especially line managers. This creates distance between

9 The cost of working age ill-health and disability that prevents work – GOV.UK

10 HMRC tax receipts and National Insurance contributions for the UK – GOV.UK

people and discourages safe and early disclosure, constructive conversations and support just when they are needed most.

- a **lack of an effective or consistent support system** for employers and their employees in managing health and tackling barriers faced by disabled people. This lack of support is sometimes compounded by a ‘fit note’ system that is not working as intended.
- **structural challenges** for disabled people, creating barriers to starting and staying in work. Compared to international comparators, the UK lacks systemic levers to support disabled people in work, leaving them disproportionately excluded and talent wasted.

8. These problems are not inevitable. Across the country we have seen examples of employers, unions and providers delivering real progress despite the system’s flaws. The will to act exists, as do significant resources. What is missing is coordination, focus, and a coherent framework for change.

9. To achieve that change, we must recognise that the workplace is a community of millions of people. Their motivation and discretionary effort are the real engines of transformation. There is no credible scenario in which public spending alone can solve this. Lasting change depends on leadership by

employers, responsibility from employees, and smart enabling policy from government.

10. **We are therefore proposing a fundamental shift from a model where health at work is largely left to the individual and the NHS, to one where it becomes a shared responsibility between employers, employees and health services.**

11. **Employers** will need to do more. They are uniquely placed to act on prevention, to support rehabilitation, and to remove barriers for disabled people. They also stand to gain most from higher productivity and lower costs. Much of what's required is not additional expenditure: employers already invest billions in health and wellbeing but need greater clarity on what works. The priority now is to get them off the sidelines and onto the pitch.

12. **Employees**, too, have responsibilities. Work can be demanding. Setbacks are part of life. Health and work are not always easy partners, but they are mutually reinforcing. Supportive workplaces matter and so does personal responsibility. Disengaging from work and potential support leads to detachment and dependency; staying connected to work supports recovery and resilience.

13. **Government's role** is to reset the system – to enable and incentivise employers and employees to act. That means tackling barriers such as the fit note system, rewiring incentives, and building

a strong evidence base. Today, the data and evidence for what works are weak; by the end of this Spending Review, they must be strong. With robust evidence, government can use procurement, tax, welfare and regulatory levers to embed shared responsibility and sustain change – keeping people in work, improving health, promoting inclusion, boosting growth and saving billions.

14. We cannot reach that end state overnight. A phased approach is required – working with willing employers and providers to develop and prove what works, before embedding and extending it across the wider economy over the next 3-7 years.

15. **Hundreds of employers, large and small – including some of the UK's best – plus mayoral authorities and providers are ready to act now as vanguards.** The government should build quickly on this engagement, immediately launching a three year 'vanguard phase' to deliver three major changes, that together will constitute the framework for general adoption.

The Vanguard Phase – three deliverables:

1. A Healthy Working Lifecycle

- Establish, with employers and providers, a Healthy Working Lifecycle which defines the practices that drive the best outcomes in reduced sickness absence, improved return to work rates and better participation and inclusion of disabled people. Develop the Healthy Working Lifecycle as a certified standard, which becomes the basis for general adoption of a common, outcome-based philosophy around work, health and disability across the UK.

2. Better Workplace Health Provision (WHP)

- Build, with existing providers and practitioners, the support employers and employees need to deliver the Healthy Working Lifecycle, focusing initially on new ‘stay in work’ and ‘return to work’ plans within the lifecycle, and on improving faster access to support. Work with providers and practitioners to ensure this provision is affordable and effective, and establish certified standards for a multi-provider marketplace that expands access to high-quality support for all employers.

3. **Evidence of what works to underpin incentives for adoption**

   - Create a **Workplace Health Intelligence Unit (WHIU)** to aggregate and analyse data, guide continuous improvement and provide leadership, as a movement HQ, across the new system. Develop the WHIU into a high-value data asset to guide certification and provide the evidence base to support targeted incentives – financial, operational, legal, and cultural – to accelerate adoption.

Employer and system engagement

16. We have been particularly encouraged by the strength of response from employers, mayoral authorities and regional leadership, providers, and sector groups across all four nations of the UK. Hundreds of employers – along with several of the UK's leading providers, both private and NHS – have expressed clear interest in participating in the vanguard phase.

17. Momentum now matters. Interest is high, but it must be channelled into delivery. Employers and providers alike are ready to collaborate on developing solutions based on robust evaluation. Many see value in convening around shared priorities and generating practical insight into what

works. Early discussions have identified potential areas for focus, including:

- Undertaking deep dives into challenges faced by particular workforce cohorts (such as disabled people) and conditions (such as mental health or musculoskeletal conditions).
- Creating safer, more trusted mechanisms for sharing information about health and disability, enabling better prevention and support.
- Encouraging more active management of sickness absence by both employers and employees.
- Testing alternative approaches to the fit note, working with GPs and health services to explore improvements and replacements.

Leadership and governance

18. Delivering these reforms – and sustaining progress – will require clear, credible, and enduring leadership. Governance must bridge a complex policy landscape that spans government departments and the devolved administrations. There will need to be accountability both for day-to-day direction and for long-term strategic decision-making.

19. The Workplace Health Intelligence Unit (WHIU) should provide the central driving force for the

vanguards: a ‘movement HQ’ that convenes partners, aggregates and analyses data, builds the evidence base, and drives performance. For transparency, the WHIU should report annually to vanguards and to ministers on progress. As evidence accumulates, it should also advise on scaling adoption and introducing targeted incentives.

20. Senior political sponsorship will be essential. Embedding shared responsibility for workplace health and inclusion will intersect with adjacent policy areas as well as devolved powers – welfare reform, the NHS Long Term Plan, growth, and the industrial strategy. System issues such as fit note reform, dispute resolution, and links with programmes like Pathways to Work will also demand coordination. Strategic leadership should therefore sit with the UK Government, under the joint sponsorship of the Secretaries of State for Department for Work and Pensions (DWP), Department for Business and Trade (DBT), and Department of Health and Social Care (DHSC).

Turning the tide on ill-health and disability in work

21. For too long, we have been moving in the wrong direction when it comes to preventing ill-health in work, supporting disabled people and helping people with health conditions to stay in work.

The changes we recommend aim to reverse that trend, transforming how the UK tackles the rising incidence of health-related economic inactivity.

22. The value at stake is enormous. Employers face an estimated £85 billion a year in lost output and costs linked to ill-health. For government, the additional burden in welfare payments and NHS demand is around £47 billion annually. On top of this lies the wider cost to the economy of lower participation, and the human and social costs of lost opportunity, stalled careers, and reduced life chances.

23. The potential benefits of change are therefore substantial – financially, socially, and in terms of opportunity. Quantifying them precisely is difficult, not least because of poor and inconsistent data – one of the issues our recommendations seek to address. For now, our modelling focuses mainly on the reduction in employer losses, with a modest estimate of benefits from reducing sickness absence and flows into inactivity. Drawing on available evidence, we estimate direct benefits of £3-8 billion per year.

24. Over time, as reforms take hold and adoption broadens, the benefits could rise significantly. Once the system reaches general maturity – with lower flows into inactivity and higher employment

among disabled people – the total potential benefit could reach £9-18 billion annually.[11]

25. These figures are indicative, not precise. They contain inevitable uncertainty, but they also exclude the cumulative and compounding effects that would build over time. Taken together, they point clearly to one conclusion: the scale of the opportunity is vast, and the case for urgent action is overwhelming.

Why are these impacts believable and achievable?

26. A 'do nothing' scenario means continued decline. More people will leave work because of health conditions and disability. On current trajectories, the numbers will keep rising. The system is already under strain; without reform, outcomes will worsen as demand grows and capacity buckles.

27. Our recommendations go to the root causes of this loss. They tackle the main drivers we have identified – fear, lack of effective support, and the structural disadvantages faced by disabled people. The aim is to **re-humanise the workplace**, raise standards, improve access to support, and transform the visibility of data. By enabling

11 See technical Annex at: https://www.gov.uk/government/publications/keep-britain-working-review-final-report

employers to act earlier and more effectively on prevention and rehabilitation, we will unlock resources that far exceed anything government could deploy alone.

28. The evidence is clear. Case studies show that when employers adopt similar approaches, returns on investment and improvements in outcomes are often **many times higher** than the assumptions used in our modelling. Wider adoption will naturally temper some of the highest returns, but the system-wide gains from prevention, retention and productivity will be profound and cumulative.

29. For government, these proposals turn what currently feels intractable into something that can be led, measured and improved. The upfront costs are modest. The potential benefits are enormous. This approach simply puts the players in the right positions on the pitch: employers lead, employees play their part, and government sets the rules and incentivises successful outcomes.

30. In short, these reforms will deliver for everyone:

    - For employers: they will lift an existing burden, reduce risk, improve resilience, and generate measurable returns.
    - For employees: they will create safer, more supportive, inclusive workplaces with earlier and fairer access to help to ensure they are able to thrive in work.

- For government: they will ease NHS and welfare pressures while supporting growth and opportunity through higher participation and social cohesion.

31. Everyone wins if we keep Britain working. The case for change is compelling.

Asks of Government

32. The opportunity is now. Government must play its part – resetting workplace health and inclusion as a proactive, shared responsibility between the state, the employer and the employee.

33. We ask government to take three decisive steps:

1. **Launch a three-year scaling of the Vanguard** – Create the pathway for employer-led solutions to develop a Healthy Working Standard and Workplace Health Provision by 2029 – a framework of evidence-based practices that deliver:
   - Better retention of people with physical or mental health conditions, and those who are neurodivergent
   - Longer, healthier working lives for older workers
   - Stronger support for disabled people

2. **Establish the Workplace Health Intelligence Unit** – Quickly stand up and provide initial funding for the unit as an independent 'movement HQ' to support vanguards, build the evidence base and drive innovation. By 2029, it will deliver:
    - Outcome measures and data to underpin the Healthy Working Standard
    - Development of sustainable Workplace Health Provision with innovation and accessibility at its core
    - Recommendations to drive general adoption in the next Spending Review
3. **Rewire the incentive system in time for the next Spending Review** – The Secretaries of State for DWP, DBT and DHSC to act as joint sponsors, aligning levers across government to remove barriers and accelerate change, including:
    - Employer incentives, grounded in evidence, to accelerate adoption
    - Adjacent reforms – e.g. welfare, fit note, Access to Work, dispute resolution – that amplify impact
    - NHS and occupational health partnerships, including regional and pooled-risk models, to make provision more affordable for SMEs

- Integration of workplace health into neighbourhood health strategies, making sustained employment a core health outcome

Contents

The Case for Change

34. The UK is sliding into an **economic inactivity crisis**. Our Keep Britain Working Discovery Report set out the scale of the challenge:

    - Over **1 in 5 working-age people** are now out of work and not looking for work, higher than many comparator countries – Netherlands (14.5%), Denmark (17.7%).[12]
    - Ill-health is now the most significant driver: **2.8 million working-age people** are now economically inactive due to health conditions – **800,000 more than in 2019** (a 40% rise).[13]
    - More people are in work with work limiting health conditions or disability than ever before.
    - Without action, projections suggest **another 600,000 could leave work by 2030**.[14]

35. We are growing older and living longer but getting sicker sooner, and the interaction between work and health is not keeping pace. In addition, many disabled people are shut out of the labour market. Unless addressed, this will deepen the gap between those who can work and those who cannot.

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12 OECD Data Explorer • Infra-annual labour statistics

13 Keep Britain Working Review: Discovery – GOV.UK

14 Keep Britain Working Review: Discovery – GOV.UK

36. Economic inactivity is not just a labour market problem. It undermines **individual lives, business resilience, and public finances**. If we can "Keep Britain Working," the benefits will be immense: higher productivity, stronger economic growth, and better social cohesion and life chances for millions.

37. However, right now, when someone leaves work due to ill-health, or is unable to work due to the barriers faced by disabled people, **everyone loses**: the individual, the employer, and the state. It need not be this way; this is a serious but fixable problem.

Impact on Individuals

38. It is a serious concern when anyone is faced with leaving work for health reasons or due to barriers faced by disabled people. The evidence set out in our Discovery report highlighted that the challenge of managing health conditions or disabilities and remaining in work spans all age groups. However, certain groups are particularly at risk:

    - Young adults are being hit hard: the growth in 16-34 year-olds with a mental health condition who are economically inactive due to long-term sickness is particularly concerning, **having risen by 190,000 (76%) between 2019 and 2024.**[15]

15 The employment of disabled people 2024 – GOV.UK

- Older workers are primarily leaving because of musculoskeletal conditions, often compounded by multiple health issues.

39. For disabled people, the barriers are particularly stark. While many employers may want to employ disabled people – the reality looks more like exclusion for many:

    - Only **53%** are in work[16], and disabled people are more likely to be self-employed (often because it feels like the only option).
    - While getting into work is more challenging for disabled people, staying in work is too. The lack of appropriate, timely adjustments and wider barriers mean disabled people are more than twice as likely to be unemployed and nearly three times as likely to be economically inactive than non-disabled people.[17]
    - The impact is also not uniform. Certain groups fare even worse. For those with learning disabilities in England registered with their local

16 A08: Labour market status of disabled people – Office for National Statistics

17 A08: Labour market status of disabled people – Office for National Statistics

authority, employment is vanishingly rare – only **4.8%** are in paid work.[18]

40. The nature of health conditions and disabilities and their impact on an individual's confidence can become pernicious, creating greater distance from work and quickly reducing the likelihood of return. For employees who are off sick, the longer they are out of work on sickness absence, the harder return becomes:[19]

    - Absent employees had a **96%** chance of return after absences of 4-6 weeks.
    - **This fell to less than a 50%** chance of a successful return once they had been absent for more than one year.

41. This trend continues once individuals have left the workforce. An individual who has been out of work for less than a year is **8 times more likely** to return to work compared with someone who has been out of work for more than two years.[20]

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18 Measures from the Adult Social Care Outcomes Framework, England, 2022-23 – NHS England Digital

19 Keep Britain Working Review: Discovery – GOV.UK

20 Keep Britain Working Review: Discovery – GOV.UK

42. The financial impacts of leaving work are huge and life-changing:

    - A 22-year-old with a health condition sustained in work could be **over £1m better off over their lifetime** compared with leaving work early.
    - The impact remains significant later in life as well. For someone aged 50–59, falling out of work reduces lifetime earnings by over **£200,000**.[21]
    - Disabled employees also face a persistent **12.7% pay gap** compared with non-disabled colleagues.[22]

43. The wellbeing effects on individuals are equally profound. Good work provides purpose, connection, and identity. Oxford University's Wellbeing Research Centre reports that being out of work results in a loss in wellbeing unmatched in any other domain of life – greater even than the loss of a partner.[23]

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21 See technical Annex at: https://www.gov.uk/government/publications/keep-britain-working-review-final-report

22 Disability pay gaps in the UK: 2014 to 2023

23 Why Workplace Wellbeing Matters, The Science behind Employee Happiness and organizational performance – Jan-Emmanuel De Neve, George Ward

Impact on Employers

44. The annual cost to employers of poor workplace health is enormous – around **£85bn.** However, these huge figures can mask the real-world, practical pressures:

- On average each sickness absence day costs **£120 in lost profit**. With **150 million days lost annually**, this means huge disruption, lost capacity, and unplanned costs.
- The CIPD reports sickness absence is getting worse – now at its highest rate for 15 years and **50% higher than in 2019**.[24]
- Replacing an employee lost to ill-health costs employers over **£11,000** including recruitment and onboarding costs.
- In addition to sickness and absence, **presenteeism** – employees working while unwell – costs employers the equivalent of **4-9 lost productive days per person per year**, through poor decision-making, extended recovery times, and contagion.[25]

45. Appropriate and effective management of health and disability is so important to support employees to work when they can, and also to recover and

24 Health and wellbeing at work | CIPD

25 Health-Happiness-Productivity.pdf

rehabilitate when required, so that situations do not escalate and lead to worse outcomes.

46. Conflict management in handling health and disability is another challenge faced by employers:

- Employers reported rising costs from disputes and tribunals.
- A forthcoming Employment Lawyers Association (ELA) sponsored review on employment dispute resolution found grievance processes are rarely effective, often escalate conflict, and usually end with the employee losing their job.[26]
- Research in Wales highlights the heavy **emotional and health toll** on all sides of a dispute – employees, managers, HR staff.[27]

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26 S. Fraser Butlin, C. Barnard and M. Menashe, *Reimagining Employment Dispute Resolution and Enforcement*, Hart 2026 (forthcoming)

27 Cooper, A. J., Behrens, D. A., Jones, S. E., Neal, A., Jones, A., & Hyll, W., *Understanding the Impact of Employee Investigations on Those Who Lead Them: A Case Study from NHS Wales* (2025) 15(6) Administrative Sciences 2. See also Neal A, Cooper A, Waites B et al, *The impact of poorly applied human resources policies on individuals and organisations*, (2023) British Journal of Healthcare Management 112.

47. As one employer put it:

"The burden is already there, it's heavy and unsustainable. Change is needed to help manage it."

Employer participant, KBW Roundtable

Summary of current cost of ill-health for employers:[28]

£10bn – Direct costs from Statutory & Occupational Sick Pay.

£47bn – Lost output when employees cannot work.

£21bn – Lost productivity from presenteeism

£7bn – Conflict resolution, litigation, and recruitment

Impact on Society

48. The wider impact and burden on society is equally unsustainable. Economic inactivity caused by ill-health that prevents work is currently estimated to be costing the UK £212bn a year[29] and rising,

28 See technical Annex at: https://www.gov.uk/government/publications/keep-britain-working-review-final-report

29 The cost of working age ill-health and disability that prevents work – GOV.UK

equivalent to around 7% of GDP, or nearly 70% of the total income tax we pay in the UK.[30]

Summary of the current cost of ill-health for society:

£132bn – Lost output due to working-age ill-health that prevents work.

£37bn – Lost output from unpaid carers looking after the sick.

£2bn – Additional NHS costs of someone becoming economically inactive.

£45bn – Health-related benefits, forecast to rise another £20bn by 2030.[31]

49. These costs create substantial pressures across the system:

    - The **NHS is forced into a reactive role** – treating illness rather than supporting prevention. The OBR estimates inactivity adds measurable extra burden per person to NHS costs.

30 HMRC tax receipts and National Insurance contributions for the UK – GOV.UK

31 Benefit expenditure and caseload tables 2025 – GOV.UK

- Rising benefit spend risks making the UK one of the **highest spenders on health-related benefits** among advanced economies.[32]
- Unpaid carers – many of working age – add hidden costs in lost productivity and foregone earnings through stopping work to care for those with health conditions.[33]

The case for change is overwhelming

50. We have, in short, **arrived at a place no one wants**. We have a system that is neither sustainable nor necessary. If we do nothing, the costs will mount, and we will be stuck with weaker growth, higher taxes, and reduced opportunities for individuals and businesses alike.

32 "Health-Related Benefit Claims Post-Pandemic: UK Trends and Global Context | Institute for Fiscal Studies," Institute for Fiscal Studies, September 19, 2024, https://ifs.org.uk/publications/health-related-benefit-claims-post-pandemic-uk-trends-and-global-context.

33 The cost of working age ill-health and disability that prevents work – GOV.UK

51. If we act, we can **keep people in work longer**, with benefits for:

    - **Individuals** – through higher and more secure income, better health, greater purpose, and more security.
    - **Employers** – through better resilience, more successful retention, improved productivity, and reduced conflict.
    - **Society** – through lower costs, stronger communities, and higher growth.

We need change now.

| What Issues Must We Tackle?

52. Over the past nine months, we have examined the underlying causes in depth. We have spoken directly with employers, employees (including line managers), people with lived experience, and representative organisations.

- **150+ in-person and virtual meetings** across England, Wales, Scotland, and Northern Ireland.
- **525+ written submissions** from individuals and organisations.
- **International study visits**, including to Denmark and the Netherlands.

53. The engagement has been excellent. It has strengthened our conviction that change is possible because alongside problems and barriers, we found many examples of excellence. But these are too rare. For solutions to spread, we must first address three major challenges.

A Culture of Fear

54. Fear pervades this landscape – for both individuals and employers – and it creates distance at the very moments when dialogue is most needed.

- **Employees** told us they fear disclosing health conditions or disabilities, and are worried about

stigma, discrimination, or damage to career prospects.

- **Employers and line managers** admitted fearing doing the wrong thing and that raising health issues or disabilities might cause offence, trigger grievances, or escalate into a tribunal.

55. Employees off sick for months reported little or no contact with their employer. Our view is that this is not because employers or line managers are uninterested or uncaring. Instead, it reflects risk aversion. This mutual risk aversion and fear often leads to a lack of contact when communication and connection is key.

"My employer didn't know what to do. I didn't hear from them for six months while I was off sick."

Employee, retail sector, KBW Workshop

56. These reactions may be understandable, but they are deeply problematic. A lack of communication and dialogue can mean that opportunities are missed to support employees early. Developing conditions or barriers to work may go unnoticed by employers until they become more acute and start to spiral out of control.

57. By contrast, in the **Netherlands**, frequent and early contact is required by law. Employers must stay in touch with absent employees and work with them on a reintegration plan within weeks, not months.

This proactive approach reduces fear on both sides and keeps employees connected to work.

Lack of Support

58. Fear is compounded by the lack of effective support for employees and employers or line managers. We found that there is a great disparity when it comes to the support available. Some employers offer excellent occupational health (OH) support or well-designed Employee Assistance Programmes (EAPs). This was, however, heavily skewed towards large employers (86% of large employers offer some form of OH provision while only 30% of SMEs do).[34]

59. Additionally, the common feedback on OH we heard was that it lacks independence and that OH advice misunderstands the working environment, resulting in reasonable adjustments that are generic or ill-suited to the context of the work.

60. Other employers have little or no support at all and many describe a confusing patchwork of wellbeing initiatives like "*a random set of explosions*" with no clarity on what works.

61. Most of the time, health remains a personal matter between the employee and the NHS, only surfacing when someone goes to their GP. At this

34 DWP Employer Survey 2024 – GOV.UK

point the **fit note** becomes central and is often problematic.

- **GPs and other healthcare professionals** are asked to assess both treatment needs and work capacity, despite most lacking occupational health training and time to get into sufficient detail.
- **93% of fit notes** in England deem the patient "not fit for work,"[35] and we heard these fit notes are often extended without further consultation.
- This can be exacerbated by **long waiting lists and delays** in getting support, adjustments or treatment**.**
- To employers, the fit notes often become a **barrier to contact**, further embedding distance between employer and employee.

35 Fit Notes Issued by GP Practices, England, December 2024 – NHS England Digital

62. As one employee explained:

> *"I asked for a phased return fit note, but it just said, 'not fit for work.' HR asked me to get another note specifying a phased return, which took some doing, but I did eventually manage it"*
>
> **Female, 35–49, learning disability (quote edited for conciseness)**[36]

63. This system is not serving employees either. Disabled people and people with health conditions are left isolated and facing complex processes that they do not know how to navigate. Schemes such as Disability Confident and Access to Work have several positive features and good intent, but we heard regularly across the review that they were not delivering effectively in practice, with Disability Confident lacking accountability and 'teeth' and Access to Work facing long delays and delivery challenges. For both schemes there is also a lack of evidence on outcomes.

64. Workplace health and disability are sensitive and personal challenges to navigate, and decisions are often left to be agreed by employees and line managers, without the independent support needed to reach an agreed outcome quickly.

65. In **Denmark**, by contrast, municipalities take on responsibility for case management when employees are off sick for more than thirty days.

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36 DWP Forthcoming publication

Employers, health services, and job centres coordinate early interventions, focusing on what people *can* do rather than what they cannot. This structured support makes phased returns and appropriate adjustments more common.

Structural Exclusion

66. The effects of fear and weak support are felt most acutely by disabled people.

    - The employment rate for disabled people in the UK remains at **53%**[37] – below many other OECD countries.
    - Disabled people are more likely to be self-employed than non-disabled people, often because they see it as their only viable option.

67. Disabled people describe repeatedly having to **self-advocate for workplace adjustments**, often with anxiety about whether support will be given or withdrawn in future. As many conditions are dynamic and fluctuating, this becomes a recurring burden. It also makes changing roles or employers much harder.

68. They also told us we "**have a system that pitches rights against reality**". Employers may view adjustments as unrealistic, or fear disputes. Too

37 A08: Labour market status of disabled people – Office for National Statistics

often, instead of constructive dialogue, cases become adversarial:

“We are having to constantly self-advocate. We are fighting against the system.”

Disability workshop participant

69. By contrast, **Denmark’s use of reserved contracts** and the **Netherlands’ reintegration obligations** both show how structural levers can shift employer behaviour. In Denmark, public procurement rules are used to create job opportunities for vulnerable groups, including disabled people. In the Netherlands, employers are legally obliged to fund up to two years of sickness absence and demonstrate active reintegration efforts – giving them a direct stake in supporting employees back to work.

70. The UK lacks comparable systemic levers, leaving disabled people disproportionately excluded and talent wasted.

Change Is Possible

71. Despite the challenges outlined above, we know things do not need to be this way. Throughout this review, it has been clear that employers and employees alike care deeply about workplace health and the inclusion of disabled people. The level of discussion, engagement, and enthusiasm for reform has been striking – and across the country we have seen promising examples of what a better system could look like. There are reasons to be hopeful.

72. We are advocating a **step-change** in how the UK approaches health, disability and work. This requires a fundamental shift: lasting change depends on leadership by employers, responsibility from employees, and smart enabling policy from government, to create supportive, inclusive workplaces that celebrate strengths, build trust and transparency, and embrace flexibility. Done well, work can fulfil its potential to improve the quality of life for UK citizens.

73. For change to succeed, health and disability can no longer be seen as solely the responsibility of the individual or the NHS. Instead, it must become a **true partnership, a shared responsibility,** between employees, employers, and the health system.

74. Critically, **employers must be "on the pitch."** Employers see their people every day. They are uniquely placed to spot problems early, prevent conditions from escalating, remove barriers and make adjustments, and support recovery. They can create safe, inclusive environments where people can thrive, and when ill-health does occur, rehabilitate and return to work, reducing burdens on the NHS and improving long-term outcomes. They also stand to gain most from higher productivity and lower costs. Much of what's required is not additional expenditure: employers already invest billions in health and wellbeing, we need to direct that better.

75. **Employees, too, have responsibilities**. Work can be demanding. Setbacks are part of life. Health and work are not always easy partners, but they are mutually reinforcing. Supportive workplaces matter and so does personal responsibility. Disengaging from work and potential support leads to detachment and dependency; staying connected to work supports recovery and resilience.

76. **Government's role is to reset the system** – to enable and incentivise employers and employees to act. That means tackling barriers such as the fit note system, rewiring incentives, and building a strong evidence base. Today, the data and evidence for what works are weak; they must be strengthened. With robust evidence, government can use procurement, tax, welfare and regulatory

levers to embed shared responsibility and sustain change – keeping people in work, improving health and inclusion, boosting growth and saving billions.

77. We have already seen many examples of employers and providers showing what is possible. The challenge now is to build a system that consistently works with employers and employees to manage health and disability more effectively. To do that, three principles must guide action.

Three Principles for Change

1. **Rehumanise the workplace –** Over time, workplaces have become increasingly procedural and risk-averse. Too often, employees are treated as risks rather than as people to invest in. We need to rebalance this by reducing perceived risks, fostering constructive dialogue, and taking a person-centred approach that considers what is right for both the individual, and the employer, in their specific circumstances.
2. **Systematic change, not piecemeal fixes –** Human health is complex. The scale and variety of ill-health and disability mean we cannot tackle issues one condition at a time. We need a people-focused, needs-led system that is adaptable and flexible. Piecemeal fixes – such as changing the fit note in isolation – will not deliver the outcomes we need.

3. **Encourage a race to the top –** In the visits we have made across the UK we have found a wealth of good practice already in place. We must aim to build from this and increase its prevalence. We want to push the boundaries of good practice and create a race to the top, supporting those already delivering to keep improving and creating a movement that brings people with us. Change is urgently needed, and we will get further, faster, by mobilising existing resources and amplifying their impacts.

A New Way Forward: How We Deliver Change

78. The scale of ill-health and disability in the workplace – and the likelihood that it will grow – demands a fundamental response. We are advocating **system-wide change** that improves outcomes for individuals, employers, and the state, while boosting economic participation on which growth depends.

79. The scope of the review is broad and covers workplace health but also the inclusion of disabled people. We recognise that these are not the same. At times we will talk about healthy workplaces. In doing so we are considering this in the broadest sense where employers are supporting the health of their workforce, but also acting to promote the inclusion of disabled people, creating safe, supportive, and inclusive working environments where everyone feels supported and able to thrive.

80. Over the next 3-7 years, we believe it is possible to **radically improve results** in managing health and disability in work. To do so, we recommend **three major changes**, delivered across **three distinct phases**.

The Healthy Working Lifecycle

81. At the heart of our recommendations is the **Healthy Working Lifecycle**: a simple but powerful framework that reflects the different stages of a person's health journey during employment. We propose an approach that works with employers to develop best practice and improve outcomes at each stage of the lifecycle to help keep employees healthy, productive and in work.

Exhibit 1: The Healthy Working Lifecycle

Stage	Recruitment & Onboarding	Healthy in Work	Unwell in Work	Absence & Return to work	Exit and Re-employment
This is when…	An employer advertises and hires, and an individual joins the organisation.	The employee is broadly healthy, with adjustments in place to enable effective working.	The employee experiences health issues that affect their performance but continues working.	The employee is signed off but is expected to return.	The employee may no longer be able to perform their role, requiring redeployment or transition out of the organisation.

82. This model resonates with both employers and employees. Many high-performing organisations already deliver positive outcomes, supporting employees across each stage of the lifecycle, but for many, opportunities are also missed to support employees better. The strength of the lifecycle lies in **framing the opportunities** for prevention, inclusion, early intervention, rehabilitation, and sustainable return to work – showing clearly how good provision can drive better outcomes.

Our Three Major Changes

83. With the lifecycle as the organising theme, we propose three major changes:

1. **Establish a Healthy Working Lifecycle**
   - Establish, with employers and providers, a Healthy Working Lifecycle which defines the practices that drive the best outcomes in reduced sickness absence, improved return to work rates and better participation of disabled people. Develop the Healthy Working Lifecycle as a certified standard, which becomes the basis for general adoption of a common, outcome-based philosophy around work, health and disability across the UK.
2. **Develop Better Workplace Health Provision (WHP)**
   - Build, with existing providers and practitioners, the support employers and employees need to deliver the Healthy Working Lifecycle, focusing initially on new ‘stay in work’ and ‘return to work’ plans within the lifecycle, and on improving faster access to support. Work with providers and practitioners to ensure this provision is affordable and effective and establish certified standards for a multi-provider marketplace that expands access to quality support for all employers.

3. Drive adoption with evidence and incentives

   - Create a **Workplace Health Intelligence Unit (WHIU)** to aggregate and analyse data, guiding continuous improvement and leadership across the new system. Develop this into a high value data asset to guide certification and provide the evidence base to support targeted incentives – financial, operational, legal, and cultural – to accelerate adoption.

How Change Will Be Delivered

84. Transformation cannot happen overnight. It requires new systems, new capabilities, and new attitudes, developed through **partnership working** between employers, providers, trade unions, and government.

85. Experience from countries such as the Netherlands shows this takes time, but momentum and consensus building are critical. A phased approach is required – working with willing employers and providers to develop and prove what works, before embedding and extending it across the wider economy over the next 3-7 years. We propose three overlapping phases of delivery:

1. **The Vanguard Phase (Years 1-3),** focused on action and learning to build momentum and consensus with vanguard employers, providers and regional leadership groups (such as local employment charters and other local initiatives) and supported by the Workplace Health Intelligence Unit. This phase would include deep dives into key issues such as how to address mental health at work, retention of older people in work and improving participation and retention of disabled people in work.
2. **An Expansion of uptake (Years 2-5),** which would see the roll-out of certified standards for the lifecycle and WHP and the start of fit note reform based on lessons and evidence from the vanguard phase. These standards would be expected to integrate or replace existing guidance. Incentives would start to be deployed to encourage adoption based on the strength of the evidence from the WHIU.
3. **General adoption (Years 4-7),** which would include a normalisation of healthy and inclusive working standards, workplace health provision, and integration with NHS patient records. Wider adoption would be driven through targeted incentives based on the growing strength and breadth of data across the UK employment market.

86. Hundreds of employers, large and small – including some of the UK's best – plus mayoral authorities and providers are ready to act now as vanguards. The government should build quickly on this engagement and momentum, immediately launching a three year 'vanguard phase' to begin to develop and deliver the three major changes, that together will constitute the framework for expansion and general adoption.

A Partnership for Change

87. This is a **significant transformation**, but one that can deliver **lasting impact**: healthier, more inclusive workplaces and greater economic participation. Fundamentally shifting the UK labour market to deliver better outcomes:

- **For employers: moving from** feeling powerless and confused, navigating complexity and incurring a substantial burden, **to** a system with greater clarity and support where employers feel confident and empowered to act to support their employees to deliver greater productivity.
- **For Individuals: moving from** a situation plagued with fear, which requires constant self-advocacy and often results in isolation **to** an approach where support is expected not the exception, is collaborative and preventative building trust and connection, and is tailored to

ensure it is effective in supporting them to thrive in work

- **For the state: moving from** a world with rising welfare costs and NHS burden, where employers feel change is imposed upon them, **to** delivering an agenda with employers where growth and fairness clearly come together to drive greater participation in a dynamic, resilient labour market.

88. The following chapters set out in more detail how this change can be achieved; through collaboration, evidence, and shared commitment to building a healthier, more inclusive, working future.

Embracing a Healthy Working Lifecycle

We recommend the development and adoption of an outcome-focused Healthy Working Lifecycle. This framework promotes positive practices where employers and employees can work together to deliver inclusion, prevention, early intervention, rehabilitation, and sustainable return to work.

The lifecycle aims to deliver three core outcomes:

- **Reduced sickness absence**
- **Improved return to work**
- **Greater participation and representation of disabled people**

Over time the best practice lifecycle should be developed into a formalised accreditation and standard that is designed to reset the expectations of the workplace, support a partnership between employers and employees and drive a race to the top.

A Simple, Outcome-Focused Framework

89. The lifecycle is designed to be **clear, simple, and adaptable**, setting out the territory over which

employers, employees, and health services can collaborate to deliver better outcomes. Its purpose is to promote health, support inclusion, act quickly to prevent issues deteriorating, and support rehabilitation and reintegration.

90. The lifecycle breaks employment into five broad phases:

Exhibit 2: The Healthy Working Lifecycle

91. The lifecycle is **not linear**. Employees will move between phases throughout their working lives. While simplified, this model has resonated with both employers and employees.

Why Employers Need the Healthy Working Lifecycle

92. Employers consistently tell us they want to do the right thing: **87% agree they have a responsibility to support employees' mental and physical health.**[38] This is both the ethical and the commercial choice – helping retain staff, sustain productivity, and reduce the costs of absence or turnover.

93. However, the current system makes this harder than it should be. Employers face:

- At least **seven pieces of complex legislation** which impact on health and disability and work.
- **Multiple enforcement bodies** with inconsistent approaches.
- A tribunal process that is often adversarial.[39]

38 DWP Employer Survey 2024 – GOV.UK

39 S. Fraser Butlin, C. Barnard and M. Menashe, *Reimagining Employment Dispute Resolution and Enforcement*, Hart 2026 (forthcoming).

- Guidance that is fragmented, inconsistent, and often behind a paywall.

94. This legislation is important for employee protections, however the lack of support and guidance, and the level of complexity results in a system that **disempowers employers**, pushing them into a compliance culture rather than focusing on partnership and support for their employees. The lifecycle aims to reverse this – **empowering employers to act proactively, with their employees,** preventing issues occurring and better managing health and disability.

Outcomes That Drive Better Practice

95. The lifecycle focuses initially on three simple outcome measures:

1. **Reducing absence rates** – keeping people in work and shortening absences where possible.
2. **Improving return-to-work rates** – enabling faster, more sustainable reintegration.
3. **Increasing participation of disabled people** – boosting both employment and retention of disabled people.

96. These outcomes are deliberately high-level and straightforward, setting clear goals. Evidence from our review shows that focusing on them drives

good practice: many employers naturally think about inclusion, prevention, early intervention, maintaining contact during absence, and adapting work on return.

97. The **Vanguard Phase** would test and refine these outcomes with employers, co-creating and standardising measurement and ensuring they are effective in driving desired behaviours and do not create unintended consequences.

Four Themes of Best Practice

98. Through engagement with employers, employees, and providers, we identified four recurring themes that underpin successful delivery of these outcomes. These form the principles of the lifecycle:

1. Encouraging supportive relationships

- Open, honest conversations enable early disclosure and safe sharing. They help prevent health issues, or impairments from escalating and ensure early support.

2. **Clear signposting to support**

    - Early and easy access to appropriate support is critical. Some organisations provide services directly; others work with third-party providers. The Workplace Health Provision (see next chapter) will play a key role in strengthening pathways to help access support before problems become critical.

3. **Clear policies and contractual arrangements**

    - Setting expectations early ensures employers and employees understand their roles. Policies should encourage shared responsibility: employees receive support, but employers also expect engagement. Occupational sick pay is one area where conditionality can reinforce this partnership.

4. **Making the workplace as inclusive as possible**

    - Disabled employees told us that constantly self-advocating for adjustments is exhausting and alienating. Inclusivity should be proactive – bringing universal design principles into the workplace, focusing on enabling excellence rather than managing limitations in line with the social model of disability.

From Framework to Standard

99. By the end of the Vanguard Phase, the lifecycle should evolve into a **formal accreditation and standard**. This would:

    - Reset expectations of what a supportive, inclusive workplace looks like.
    - Strengthen partnerships between employers and employees.
    - Drive a “race to the top” where positive practices are recognised and rewarded.

100. The lifecycle is deliberately **outcome-focused and flexible**. The aim is that employers can adapt it to their own contexts, but within a consistent framework that encourages better outcomes for all.

Supporting Employers and Employees: Workplace Health Provision

We recommend the widespread adoption of a **Workplace Health Provision (WHP)**: a non-clinical case management service that supports employees and line managers across the Healthy Working Lifecycle.

Funded by employers and building initially from existing resources, the WHP will offer support and advice, early intervention, good case management, and targeted early-stage treatment pathways.

Over time, we envisage the provision becoming certified, being integrated with the NHS app and reducing – or even replacing – the need for the current fit note.

Core Functions

101. To deliver improved outcomes across the Healthy Working Lifecycle, there needs to be greater support for both employees and line managers. We want to see a greater focus on inclusive, supportive workplaces that encourage early intervention and prevention, removal of barriers,

more proactive support and planning for return to work when absence occurs.

102. The WHP would provide three core services to help address these gaps we have found across the review:

1. **Case management** – Guidance and support for employees and line managers from the first signs of difficulty through to return to work or redeployment support.
2. **Stay-in-Work and Return-to-Work Plans** – Early dialogue and agreed plans that enable employees to remain in work (with appropriate adjustments), or, where absence is necessary, to return successfully.
3. **Targeted early support** – Rapid access to help for common conditions such as early-stage mental health or musculoskeletal problems, bridging the gap between clinical care and workplace support.

103. Over time, we would envisage these services will become certified, integrated with the NHS app and should, in time, substantially reduce reliance on fit notes.

Why the WHP Matters

104. Current systems often leave employees disconnected and employers unsupported. We want to see:

- **More prevention** – anticipating and tackling issues earlier, including support and guidance around reasonable adjustments.
- **Better intervention** – clear, proactive support when difficulties arise.
- **Stronger planning** – structured return-to-work processes.

105. The WHP would initially build from existing provision already available through social prescribers, NHS work initiatives, occupational health, income protection, and private insurers. Initially, the focus would be on developing new **Stay-in-Work** and **Return-to-Work Plans**, with services expanding as the system matures. We want to create a system that works with the wider landscape and integrates with schemes such as Access to Work for adjustments, as well as the NHS and Neighbourhood Health Systems as they develop and grow, looking forward and complementing the vision set out in the 10 Year Health Plan.

Stay-in-Work and Return-to-Work Plans

106. For employees with health conditions or disabled employees, WHP would work with them and their employer to agree tailored *Stay-in-Work Plans*. These would include agreeing and implementing reasonable adjustments and flexibility to help people remain as productive as possible. Importantly, third-party involvement should foster **safer sharing and earlier conversations**, through facilitation and mediation, encouraging quicker responses to emerging needs. The WHP could also provide support and advice in navigating and accessing wider services such as Access to Work.

107. Where absence is unavoidable, WHP would support the creation of *Return-to-Work Plans*. These should be agreed between the employee and employer, supported by the WHP from two weeks and no later than six weeks after the commencement of absence. These arrangements would include plans to maintain contact during longer periods of leave – similar to “keeping in touch” days during parental leave.

108. Together, these plans bridge the gap between employee and employer, ensuring better conversations about reasonable adjustments, and bringing together health and work. These plans align closely with the NHS 10 Year Health Plan and

its commitments around work forming a key part of people's care plans, recognising the positive impact good work can have on health.

Relationship with GPs and primary care

109. The **WHP would not replace the GP's, or other healthcare professionals' role in primary care.** Instead, it would focus on how best to support a disabled employee, or employee with a health condition, to thrive in work, as well as considering an individual's ability to work while ill or recovering, in partnership with the employer. Nothing here undermines the principle of universal healthcare, free at the point of use.

110. GPs themselves, in our engagement with them, have highlighted that the current fit note system is ineffective:

- They often lack detailed knowledge of workplace environments.
- Most do not have occupational health training.
- Long-term certification drains GP capacity.

111. As one GP representative put it:

"GPs should only supply facts about a patient's condition, whereas what is needed is a detailed assessment of function and capacity."

GP roundtable participant

112. Employers echo this concern:

"Once you have a fit note, they [the employee] are lost to us."

Employer roundtable participant

113. The WHP would help resolve this. Fit notes would remain at least initially, but dependency on them should diminish as *Stay-in-Work* and *Return-to-Work* Plans mature. GPs and neighbourhood health services should retain overall clinical responsibility and should remain a referral point where clinical support is required. Information-sharing should be enabled, including exploring options to do so in the Vanguard Phase and through the NHS app.

114. Our ambition is that the WHP would take the pressure off our GPs and healthcare professionals, freeing up their valuable time to be spent on diagnosing and treating patients. To do this in the right way, the Vanguard Phase should work closely with GP representatives and the NHS on fit note reform, and we are grateful for the support

we have already received from the British Medical Association and Royal College of GPs.

115. To avoid risk of duplication between the Neighbourhood Health Service and WHP services, part of the role of the WHP should be to work with the NHS to have a single plan so that *Stay-in-Work* and *Return-to-Work* Plans and treatment plans are coordinated and complimentary.

116. During the Vanguard Phase it is vital that GPs and healthcare professionals are closely involved in the development of the WHP, to test different approaches to developing *stay-in-work* and *return-to-work* plans, to understand the impacts on the fit note, and to trial clinical oversight mechanisms which include options for second opinions. A robust appeals and dispute resolution process will also be essential, including oversight by a national enforcement body (for instance the Fair Work Agency or Health and Safety Executive) to ensure consistency, enforceability, and legal robustness. There will also be a need for national oversight of training and development, and a professional home for the workforce.

Accessibility and Innovation

117. For WHP to succeed, services must be **accessible to employers of all sizes**. This requires:

- Effective market competition.

- Innovation in digital and remote service provision.
- Economies of scale for smaller employers.

118. Our initial analysis suggests likely costs of **£5–£15 per employee per month**. However, this is based on current service provision, and advances in digital case management, guidance systems, remote support as well as developing economies of scale should reduce costs further over time.

119. To ensure small employers are not left behind, pooled funding models should be explored during the Vanguard Phase (by sector or region). In the Expansion Phase, these would be formalised to lower unit costs, broaden access, and build momentum toward general adoption, supported by appropriate incentivisation.

Implications

120. We believe that the WHP will provide much needed support to employers across the lifecycle and in doing so will:

- Foster collaboration between employees and employers in managing health and disability.
- Encourage earlier disclosure and proactive support.
- Provide advice and support in making reasonable adjustments

- Reduce reliance on fit notes while preserving the GP's and other healthcare professionals' role in primary care.
- Make workplace health support more consistent, accessible, and cost-effective.

121. Ultimately, the WHP represents a shift from a reactive, fragmented system to one that is **proactive, collaborative, and focused on keeping people in work wherever possible**.

Driving Adoption: Data, Intelligence and Incentives

122. We are confident that widespread adoption of the Healthy Working Lifecycle and improved workplace health provision (WHP) will deliver better outcomes for employers, employees, and the state. But to achieve real and lasting impact, adoption must **become the norm**.

123. A two-tier system, where some employers adopt standards while others do not, would undermine effectiveness. It would complicate provision, weaken incentives, and allow non-adopters to undercut those making investments. By contrast, **general adoption** will enable the essential partnership between employers, employees, and health services needed to address rising ill-health and support the disabled in the workplace.

124. Achieving this requires two things:

    - **Data and intelligence** to build consensus and a robust business case.
    - **Incentives** that flow from this evidence and strengthen over time.

Momentum will be key.

Data and Intelligence

125. Return on investment (RoI) is a powerful driver of adoption. Evidence already shows that managing health and disability at work delivers strong returns.

1. **Employee Assistance Programmes (EAPs)**: An EAP association report (2022) found an average **£8 return for every £1 invested**, based on data covering 7 million UK employees across different sectors, regions and workforce sizes.[40]
2. **Mental Health and Wellbeing investments**: Deloitte (2024) reported an average **£4.70 return per £1 spent**, based on 26 studies since 2011.[41]
3. **MSK interventions**: Public Health England found returns ranging from **£11 to £99 for every £1 invested**, depending on intervention type, with even higher societal returns.[42]

40 22-0022-EAPA-ROI-Report-January-2022-V3-Web.pdf

41 Deloitte, Mental Health and employers, May 2024

42 Public Health England, Return on Investment of Interventions for the Prevention and Treatment of Musculoskeletal Conditions, Final Report, October 2017

4. **Case evidence**: Employers we engaged with reported RoIs ranging from £7 to £24 per £1, depending on sector and approach.

126. Beyond financial metrics, employers also cite benefits that are harder to quantify but commercially important: improved morale and engagement, better relationships, stronger cultures, reduced absence, better staff retention, and enhanced customer service and brand.

127. Despite this evidence, adoption is hampered by **poor understanding of the impact workplace health and inclusion initiatives can have**. This is largely due to a lack of data. Some providers and large employers hold deep datasets, but most do not.

128. We need to shift from today's patchwork to a system with **clear, credible, and widely shared data** – both to demonstrate impact and to identify which interventions deliver the greatest returns.

Workplace Health Intelligence Unit (WHIU)

129. To achieve this, we propose creating a **Workplace Health Intelligence Unit (WHIU)**: an agile, employer-focused body to collect, analyse, and share data, providing the backbone for adoption.

130. The WHIU would:

1. **Act as a data trust** – coordinating secure collection, aggregation, and analysis of data from employers and providers as reforms are tested and scaled.
2. **Provide confidential benchmarking** – offering vanguard employers, regions, sectors, and providers insight into their own performance, while publishing anonymised best practice.
3. **Conduct deep dives** – analysing what works best across conditions, sectors, and cohorts, and exploring the impacts of different implementation models.
4. **Fuel innovation** – creating a national data asset that allows predictive analytics, AI and new service platforms to emerge and drives innovation in supporting earlier intervention and prevention.

131. The WHIU will be central during the Vanguard Phase, providing strategic leadership and building the evidence needed for expansion and general adoption, including developing robust benefits that could be scored with the Office for Budget Responsibility. We envisage the WHIU as a **joint government–industry enterprise**, working with independence, pace and agility, while ensuring both credibility and sustainability.

Incentives

132. Compelling evidence of return on investment and best practice will drive adoption of the changes we are proposing. However, evidence alone will not be enough. As the changes move from vanguard into wider expansion and general adoption, **incentives will be critical** – for both employers and employees.

133. A key principle we have in mind when looking at incentives for both employer and employees is that they "**should not get something for nothing**". Incentives should encourage and reward positive behaviours and employment practices that deliver better health and employment outcomes. They must be dynamic, building over time, giving government the chance to test uptake, monitor evidence, and adapt. They would also need clear definitions and certification standards so that employers and employees know what is expected.

134. The sections below set out **potential incentive areas**. These are not exhaustive, but outline options the government would have open to it in helping to drive adoption. Findings from the WHIU should help identify where (and which) incentives would have the greatest impact.

Employer Incentives

135. While a positive return on investment is the most powerful incentive, additional levers will be needed to secure widespread adoption (particularly for smaller employers). These must be tied to evidence of impact and designed to endure. We see two broad categories:

    i. **Financial incentives** – ranging from procurement through to tax benefits.

    ii. **Risk reduction incentives** – addressing the fear of disputes and litigation.

Financial Incentives

136. We believe there is a strong case for considering financial support for employers where they are embracing good practice. These incentives could evolve over time as the evidence base strengthens, and range from more straightforward to deliver, to more challenging – requiring more evidence to support:

    - **Public procurement –** Adoption of the certified healthy working lifecycle could be recognised in government procurement scoring, and in projects where the public sector is a stakeholder or investor (e.g. Industrial Strategy sectors).

- **Reserved contracts –** Reserved contracts can be targeted at employers supporting vulnerable or underrepresented groups. Successful models already exist in the UK (e.g. USEL in Northern Ireland) and Denmark, where they have created sustainable jobs while proving commercially viable.
- **Access to pooled funding or risk pooling –** Pooled funding or risk pooling could make high-quality WHP services more affordable, especially for smaller employers – similar to auto-enrolment in pensions. Adoption of the certified lifecycle could be a condition for access to the economies of scale or built into pricing.
- **Tax relief on benefits in kind –** Employers certified as adopters could receive tax relief on investments in workplace health and adjustments that enable people to stay in work.
- **Sick pay rebates –** Certified adopters could qualify for partial rebates, especially if they use evidence-based practices such as phased returns. This could be applied to either statutory or occupational sick pay to encourage greater support to employees.
- **National Insurance adjustments –** Over time, rebates (and/or surcharges) could reflect whether employers' actions are reducing – or

increasing public benefit including the flow of people out of work and onto welfare.

Risk Reduction Incentives

137. Many employers told us they fear disputes when managing health issues, especially when employees can no longer perform their original role. This fear often leads to distance, adversarial processes, and reliance on tribunals – outcomes that rarely benefit either side.

138. With the expected introduction of day-one employment rights, these fears may grow. We therefore recommend fast-tracking alternative dispute resolution (ADR) approaches alongside the reforms.

139. Sarah Fraser Butlin KC and Professor Catherine Barnard have shared draft recommendations (from a review on employment dispute resolution with the Employment Lawyers Association) to reduce conflict through ADR.[43] We endorse these proposals and believe that they offer an opportunity to reduce the adversarial nature of the current system and thus the fear we have found throughout the review. We would suggest integrating WHP certification into ADR frameworks,

43 S. Fraser Butlin, C. Barnard and M. Menashe, *Reimagining Employment Dispute Resolution and Enforcement*, Hart 2026 (forthcoming).

so that employers doing the right thing face a lower risk of tribunal action.

Employee Incentives

140. Employer incentives alone will not be enough. Employees must also be encouraged to stay engaged, disclose early, and take up support.

141. Too often, employees who develop health conditions quickly detach from their workplace, exacerbated by fear and the disconnection that comes from long periods signed off with fit notes. Instead, we want policies that **maintain contact and build trust**, improving return-to-work outcomes.

Financial and Contractual Incentives

142. Where employees have a health condition or disability which requires an absence from work, we want them to be supported to enable a return to work as soon as possible. The Statutory Sick Pay (SSP) rate in the UK is much lower than in many advanced economies,[44] and we have noted that many recent reviews have recommended increasing it. While we are sympathetic to that, simply increasing SSP is unlikely to drive the level of change needed.

44 Keep Britain Working Review: Discovery – GOV.UK

143. We have seen across the review that a higher rate of **Occupational Sick Pay** (OSP) will often be an important part of supporting employees, providing the employee with the financial security to rehabilitate properly. However, employers tell us that they struggle with a one-size-fits-all policy, and that the incentives are not always well aligned between employers and employees. The data on outcomes is fragmented, and we do not currently have sufficient data to know whether absence and return rates are any better when there is higher OSP. Understanding this better should form part of the focus of the vanguard phase and work of the WHIU. We need to look at ways to build engagement in rehabilitation and return to work alongside the financial support offered.

144. We therefore want to encourage employers to offer occupational sick pay, but also to include **reasonable conditionality** for accessing it, including a requirement to engage with support where that is provided. Mutual obligations like this already exist in many other countries in particular Netherlands, Norway and Denmark, and during the review we have come across employers, both large and small, who are already experimenting here and seeing promising results. Work should be carried out with employers during the Vanguard Phase to establish which approaches strike the right balance and generate the best outcomes.

Cultural Incentives

145. Early disclosure and open, honest communication are critical to successful management of health and disability in the workplace. It allows early intervention and support to be put in place which in turn prevents problems from arising or escalating. However, early disclosure depends on trust and feeling safe to share information. Fear is an enormous barrier here as it undermines trust. Overcoming this fear is therefore vital.

146. Humanising support is in part about creating a cultural shift that changes how we talk about health and disability, breaking the stigma, encouraging a dialogue around what is possible and adopting impactful interventions that enable someone to undertake their role successfully. The Vanguard should explore how to incentivise better approaches that can encourage earlier disclosure, embed a preventative approach and enable better support. These will in turn build trust and engagement. Policies and processes can be designed to encourage this and embed a more supportive culture, for example:

    - Allowing protected time off for treatment and rehabilitation.
    - Supporting flexible approaches to managing fluctuations in long-term health conditions and disabilities.

- Linking the *Stay-in-Work* Plan to eligibility for OSP.
- Developing and embedding clear pathways for safe disclosure and support.
- Developing specific policies to support the inclusion of disabled people removing barriers that prevent success in work.

147. The Vanguard Phase should work with employers to understand what works to build an inclusive workplace where employees feel safe and supported to share information about their health condition or disability, identifying which approaches generate the best outcomes.

Delivering the Change: A Phased Approach

148. The changes we propose represent a **system shift** in how workplace health and disability are managed. They will take time to develop and embed – but momentum must start now. Engagement throughout the review has been excellent. Employers, employees, providers, unions, and representative bodies all care deeply about this issue, and there is real appetite to embrace reform.

149. Our focus is not only on ***what*** needs to change, but also ***how*** to start the movement and build consensus and momentum. A phased approach is required – working with willing employers and providers to develop and prove what works, before embedding and extending it across the wider economy over the next 3-7 years. We propose three overlapping phases to take the UK from early action to widespread adoption.

Three Phases of Change

1. **The Vanguard Phase (Years 1-3),** focused on action and learning to build momentum and consensus with vanguard employers, providers and regional leadership groups (such as local employment charters and other local initiatives) and supported by the Workplace Health Intelligence Unit. This phase would include deep dives into key issues such as how to address mental health at work, retention of older people in work and improving participation and retention of disabled people in work.
2. **An Expansion of uptake (Years 2-5),** which would see the roll-out of certified standards for the lifecycle and WHP and the start of fit note reform based on lessons and evidence from the vanguard phase. These standards would be expected to integrate or replace existing guidance. Incentives would start to be deployed to encourage adoption based on the strength of the evidence from the WHIU.
3. **General adoption (Years 4-7),** which would include a normalisation of healthy and inclusive working standards, workplace health provision, and integration with NHS patient records. Wider adoption would be driven through targeted incentives based on the growing strength and breadth of data across the UK employment market.

150. These timelines should not be seen as set in stone. We had initially assumed these changes could take around 10 years to deliver the systemic shifts required and it is possible that it will take this long. This would be consistent with reforms in the Netherlands. However, we have been challenged by stakeholders to go faster and maintain the momentum. The phasing needs to be dynamic and build as evidence and insight is developed to support expansion and adoption.

The Vanguard Phase: Starting the Movement

151. The Vanguard Phase is about **action and learning**. We want to engage diverse employers and providers to test approaches, generate evidence, and build momentum. Change should be developed ***with*** **employers, their employees, and providers**, not imposed on them – making this a real opportunity for employers to lead.

152. We have already had positive responses from a wide range of UK employers and providers keen to participate, as well as from local and national leaders keen to build the proposed approaches into their employment charters and local employment initiatives, ensuring representation across sectors, regions, geographies and employer size.

153. Momentum now matters. Interest is high, but it must be channelled into delivery. Employers and providers alike are ready to collaborate on developing solutions based on robust evaluation. The government should build quickly on this engagement, immediately launching a three year ‘vanguard phase’ to develop and deliver the three major changes, that together will constitute the framework for expansion and general adoption.

154. Many see value in convening around shared priorities and generating practical insight into what works. Early discussions have identified potential areas for focus, including:

- Undertaking deep dives into challenges faced by particular workforce cohorts (such as disabled people) and conditions (such as mental health or musculoskeletal conditions).
- Creating safer, more trusted mechanisms for sharing information about health and disability, enabling better prevention and support.
- Encouraging more active management of sickness absence by both employers and employees.
- Testing alternative approaches to the fit note, working with GPs and health services to explore improvements and replacements.

What Will Come from the Vanguard Phase?

155. By the end of the Vanguard Phase, we expect:

- **Healthy Working Lifecycle** – developed and formalised into a certified standard, with agreed outcome measures, consistent reporting, and consolidation of overlapping schemes into one clear framework.
- **Workplace Health Provision (WHP)** – tested across delivery models, with outcome data informing service design, market standards, quality assurance, and pooled funding arrangements.
- **Fit Note Reform** – practical pilots on how lifecycle and WHP can supplement or replace aspects of the fit note, integrating with NHS care and establishing protocols for transitions, escalation, and dispute resolution.
- **Evidence of impact and benefits** – established data collection and agreed measurement approaches which can be used to build the evidence base and the case for developing well targeted and effective incentives to drive uptake and positive behaviours.

What does it mean to be a vanguard?

What We Ask of Vanguards

- **Adopt the Healthy Working Lifecycle** and help to develop the outcome measures and good practices within it.
- **Provide WHP support** for employees and line managers (directly or via vanguard providers, especially to support SMEs).
- **Measure and share data** on absence, return-to-work, and participation and retention of disabled employees, through the WHIU's data trust.

Participation in the vanguard is voluntary and self-funded.

What Vanguards Will Receive

- **National leadership profile** – shaping reform and being seen as early leaders.
- **Confidential benchmarking and insights** – access to WHIU analysis, early evidence of what works, and peer learning.

- **Opportunities for focused innovation** – piloting new approaches in prevention, pooled funding models, interventions for key cohorts (e.g. young people with physical and mental health conditions or who are neurodivergent, older workers with MSK), and integrated NHS solutions (including fit note reform).

156. The WHIU will play a central role – coordinating activity, gathering and analysing data, and publishing regular insights.

Who will lead the Vanguard?

157. Delivering these reforms – and sustaining progress through each phase – will require clear, credible, and enduring leadership. Governance must bridge a complex policy landscape that spans departments and the devolved administrations. There will need to be accountability both for day-to-day direction and for long-term strategic decision-making.

158. The Workplace Health Intelligence Unit (WHIU) should provide the central driving force for the vanguards: a ‘movement HQ’ that convenes partners, aggregates and analyses data, builds the evidence base, and drives performance. For transparency, the WHIU should report annually to vanguards and to ministers on progress. As evidence accumulates, it should also advise

on scaling adoption and introducing targeted incentives.

159. Senior political sponsorship will be essential. Embedding shared responsibility for workplace health and inclusion will intersect with adjacent policy areas – welfare reform, the NHS Long-Term Plan, growth, and the industrial strategy. System issues such as fit note reform, dispute resolution, and links with programmes like Pathways to Work will also demand coordination. Strategic leadership should therefore sit with the UK Government, under the joint sponsorship of the Secretaries of State for Department for Work and Pensions (DWP), Department for Business and Trade (DBT), and Department of Health and Social Care (DHSC).

Expansion Phase: Scaling Up

160. The expansion phase would scale adoption, guided by lessons from the Vanguard. Evidence would underpin the development of certified standards, clearer expectations for employers, and stronger incentives.

161. The WHIU would remain crucial – refining datasets, identifying high-impact interventions, and supporting innovation (e.g. predictive analytics to spot risks earlier). This phase would look to grow market capacity, supported by clear guardrails but with room for providers to innovate. Incentives

should be introduced to help drive uptake and encourage positive behaviours from employers and their employees.

General Adoption Phase: Embedding Change

162. By the general adoption phase, the lifecycle and WHP should be **mainstream practice**, adopted by most employers. Government would then have options, based on WHIU evidence, to:

- Target interventions in sectors or regions with low adoption.
- Apply stronger incentives or reporting requirements where needed.
- Drive continuous improvement through legal, financial, and cultural levers.

Summary

163. Change will not happen overnight, but through a phased approach – **starting small, learning fast, and scaling effectively** – we can transform the UK workplace.

- The **Vanguard Phase** develops the changes, builds momentum, consensus and evidence.
- The **Expansion Phase** turns proven practice into certified standards and incentives.

- The **General Adoption** phase embeds a new normal where good health, inclusion, and good work go hand in hand.

Why will these reforms make a big difference?

164. The Keep Britain Working Review proposes a substantial shift in how health and disability are managed in the workplace. The changes are ambitious but achievable, with the potential for **lasting impact** on the UK economy and society.

165. There will be benefits for employers, employees and the state from the changes, addressing challenges we have encountered throughout our engagement, which will deliver healthier, more inclusive workplaces that drive greater economic participation and productivity.

Benefits for employers

166. **Clarity and confidence:** employers today are often fearful of doing the wrong thing and ending up in tribunals, exacerbated by having to navigate complex legislation, frequently with little to no support or guidance. Our recommendations simplify responsibilities, reduce risk, and provide structured, independent support.

167. **Practical guidance:** a certified Healthy Working Lifecycle, supported by WHP services, will embed clear standards around good practice, and provide proactive support in delivering these.

168. **Productivity gains:** moving from reactive to preventative approaches reduces absence rates and turnover, ultimately delivering a more productive workforce. Early estimates suggest potential benefits of **£3-8bn annually**, with potential for these to rise further with general adoption. These are indicative estimates that will be refined further during the Vanguard Phase.

169. **Empowered leadership:** Clear guidance and structured, independent input will leave employers confident to act early, manage health and disability well and support staff to thrive and succeed in work.

170. **Competitive advantage:** Employers who fully adopt the changes proposed through the review are likely to create lasting competitive advantage for themselves by creating inclusive, supportive organisations which can attract and retain the most diverse pool of talent (including disabled people).

Benefits for Employees

171. **Timely and fair support:** Employees all too often report facing stigma, isolation and interventions that are too late or poorly targeted. Our reforms will shift the system towards proactive and preventative action.

172. **Stronger workplace culture:** Through our proposed new system, we will create a new deal

around work and health. With the adoption of the Healthy Working Lifecycle and the WHP services, employees will begin to experience workplaces where successfully managing health and disability is a priority and as a result more discussed openly, reasonable adjustments are timely, and wellbeing is prioritised. Support will become expected, not exceptional.

173. **Better outcomes through intervention:** Early support and targeted intervention will set employees on the path to success:

- ***Stay-in-Work* Plans** secure workplace adjustments and flexible work arrangements.
- **Early access to treatment** for common conditions (e.g. mental health, MSK) ensures support is provided early to prevent escalation.
- ***Return-to-work* plans** to ensure ongoing support and successful reintegration.

174. **A fairer deal:** The development of the partnership and shared responsibility around health and disability may encourage more employers to offer **enhanced sick pay**, knowing it is tied to engagement with support and rehabilitation. Through this, employees gain security and employers gain assurance.

Cohort Benefits

175. These changes will support employees across all ages and demographics, however there are some key cohorts that have come up in the review:

- **Young People/Not in Education, Employment, or Training (NEETs)** – are facing challenges around rising mental health issues and cycling through poor quality employment experiences which entrenches them out of work. The changes proposed in the review are intended to provide a more supportive environment with quicker access to mental health support, all with the goal of preventing issues from escalating.
- **Disabled People** – face structural barriers to work and challenges getting the support they need. The introduction of the lifecycle and WHP services will provide clarity around employers' responsibilities in supporting disabled people but also reduce the fear of getting things wrong. The WHP will be key in working with the employer and disabled employee to develop plans collaboratively and implement reasonable adjustments that support productive work and help them remain in work.
- **Women's Health** – is an area of growing priority in workplaces but one where employers lack confidence and support to act. The lifecycle and WHP, particularly support via *stay-in-work*

plans and *return-to-work plans,* are expected to be valuable in creating a better environment and improved outcomes across a range of women's health concerns.

- **Older Workers** – often reach a position where health challenges (particularly MSK conditions) lead to early retirement and withdrawal from the workforce. The early access to support for MSK issues provided by the WHP service and flexible arrangements that arise from *stay-in-work plans* and the lifecycle allow longer positive working lives and skills and experience to be retained in work.

Benefits for Government

176. The NHS is currently under enormous pressure with long waiting lists and rising costs from an older and sicker population. Welfare costs are rising with working-age health and disability benefits costing £45bn in 2024 and forecast to rise to £65bn by 2030.[45] And overall, ill-health costs the UK economy around £212bn a year in lost output**.**

177. **Reduced pressure on the NHS:** Our changes recognise that employers are better placed than the NHS to intervene and manage health conditions and disability early. Through their

45 Benefit expenditure and caseload tables 2025 – GOV.UK

interventions, they can prevent conditions worsening and needing NHS intervention, and support rehabilitation. It is also only employers who can make the adjustments required to support disabled people. Having employers more actively engaged will release pressure on the NHS to focus on diagnosis, treatment, and delivery of the 10 Year Health Plan.

178. **Lower welfare costs:** Supporting people to stay in work will **stem the flow onto out-of-work benefits**, reducing costs and freeing up resources for other priorities. And by keeping people in work, we **boost productivity** and output of our economy, reducing inactivity and driving economic growth.

179. **Delivering the Government missions:** Taken together, these changes offer an important way in which Government priorities around **growth, fairness and opportunity** can come together delivering better outcomes across all three.

Starting the Movement: Asks of Government

180. Britain is sliding into an economic inactivity crisis that threatens growth, prosperity and the future of public services. Ill-health is now the main driver, particularly mental health conditions among young people. It risks hardening into a permanent divide between those who work and those who do not. Without urgent action, this divide will weaken growth, drive up welfare costs, and deepen pressure on the NHS. In that scenario everyone loses: workers, employers and the state.

181. The *Keep Britain Working Review* comes at a critical moment. Economic growth is weak, with severe consequences for social cohesion and public finances. Rising economic inactivity is driving up welfare costs and stifling growth.

    i. Over one in five working-age adults are neither working nor looking to do so.

    ii. Ill-health is the main driver, with a 76% rise in young people reporting mental health conditions becoming inactive since 2019.

    iii. A person in their 20s who leaves the workforce can lose over £1m in lifetime earnings and pensions.

iv. Around 300,000 people with a health condition leave work each year[46] with the state bearing costs in welfare and healthcare that can run into tens of thousands per individual.

182. However, while the debate usually focuses only on costs – lost output for employers, extra demand on the NHS, rising welfare bills for government – to fix it we must shift the focus to people and impact. For employees: earlier access to support, greater security, and fair chances to stay in work. For employers: reduced absence, lower churn and higher productivity. For the economy: fewer people leaving the workforce.

A New Deal on Workplace Health

183. Economic inactivity cannot be left to government alone. Only employers can deliver prevention in the workplace. What is needed is a new deal between employers, government and employees.

184. Employers must lead. Employees have a responsibility to remain engaged and connected to work. Government must enable, incentivise and drive this shift. Only then can we unlock the prevention, workplace support, and cultural change needed to reverse the tide of inactivity. Engaging employers in the way we propose will:

46 Towards a healthier workforce | The Health Foundation

- Expand the supply of sustained employment, boosting productivity and growth.
- Unlock workplace-based prevention and early intervention, reducing ill-health, supporting the inclusion of disabled people, and mobilising resources far beyond the reach of the state.
- Reduce demand for welfare and free up fiscal headroom for those most in need.
- Ease pressure on the NHS, especially through early intervention and better mental health, enabling it to focus on acute care and its 10 Year Health Plan.

185. The potential benefits of change are therefore significant – financially, socially and in terms of opportunity. Quantifying them precisely is difficult, not least because of poor and inconsistent data – one of the issues our recommendations seek to address. Drawing on available evidence, we estimate direct benefits of £3-8 billion per year.

186. Over time, as reforms take hold and adoption broadens, the benefits could rise significantly. Once the system reaches general maturity – with lower flows into inactivity and higher employment among disabled people – the total potential benefit could reach £9-18 billion annually.[47]

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47 See technical Annex at: https://www.gov.uk/government/publications/keep-britain-working-review-final-report

187. These figures are indicative, not precise. They contain inevitable uncertainty, but they also exclude the cumulative and compounding effects that would build over time. Taken together, they point clearly to one conclusion: the scale of the opportunity is vast, and the case for urgent action is overwhelming.

188. Achieving this requires a new deal between business, government and citizens – commensurate with the scale of the challenge and sustainable over time.

189. The groundwork is already laid. Hundreds of employers, large and small, plus mayoral authorities and providers are ready to act as vanguards. Now government must play its decisive part by resetting workplace health as a proactive, shared responsibility between the state, the employee and the employer.

Three Asks of Government

1. **Launch a three-year scaling of the Vanguard** – Create the pathway for employer-led solutions to develop a Healthy Working Standard and Workplace Health provision by 2029 – a framework of evidence-based practices that deliver:

    - Better retention of people with physical or mental health conditions, and those who are neurodivergent

- Longer, healthier working lives for older workers
- Stronger support for disabled people

2. **Establish the Workplace Health Intelligence Unit** – Quickly stand up and provide the initial funding for the unit as an independent 'movement HQ' to support vanguards, build the evidence base and drive innovation. By 2029, it will deliver:
   - Outcome measures and data to underpin the Healthy Working Standard
   - Development of sustainable Workplace Health Provision with innovation and accessibility at its core
   - Recommendations for general adoption in the next Spending Review
3. **Rewire the incentive system in time for the next Spending Review** – The Secretaries of State for DWP, DBT and DHSC to act as joint sponsors, aligning levers across government to remove barriers and accelerate change, including:
   - Employer incentives, grounded in evidence, to accelerate adoption
   - Adjacent reforms – e.g. welfare, fit note, Access to Work, dispute resolution – that amplify impact
   - NHS and occupational health partnerships, including regional and pooled-risk models, to make provision more affordable for SMEs

- Integration of workplace health into neighbourhood health strategies, making sustained employment a core health outcome

Appendix A: Workplace Health Provision

190. There is a gap in the support available to employers and employees in managing health and disability in the workplace. Some employers across the UK have attempted to address this gap by providing health and wellbeing offers to their employees such as occupational health or employee assistance programmes – but the quality can be varied, and coverage is inconsistent, especially for smaller employers.

191. We are recommending the development of a Workplace Health Provision (WHP) which is built from the range of existing provision but looks to amplify, expand and improve the availability of it.

The current workplace health services landscape

The CIPD's *Health and wellbeing report at work* (2025) found that that only 25% of all surveyed respondents ha*ve* **private medical insurance** for all employees – as high as 40% for large private sector employers, 20% for SMEs, and 7-11% for the public and non-profit sectors respectively.

Occupational Health (OH) services are also unevenly distributed. In 2024 only 45% of workers had access to OH support, and access varies sharply by employer size: while 92% of large employers offer some form of OH, this falls to just 18% among small employers.[48]

Vocational rehabilitation typically involves assessments and personalised support (rehabilitation programmes, advice on adjustments, health management strategies) to overcome barriers to work due to illness or injury.

Group Income Protection (GIP) covers employees unable to work due to illness or injury and may include rehabilitation and wellbeing services to support employees back to work.

Employee Assistance Programmes (EAPs) are now more widely available, with analysis conducted by the Employee Assistance Programme Association (EAPA) finding that 75% of UK employees have access to an EAP.[49]

48 Occupational Health: Working Better – GOV.UK

49 EAPA – Holding it Together Report – 2023

Alongside these market-based solutions, there is also publicly funded support for work and health issues. Programmes such as WorkWell in England and Working Health Services Scotland provide support to support individuals with health conditions and disabled people to start, stay in or return to work. In 2024 there were 3,400 Social Prescribers in the UK and the NHS Long Term Workforce Plan targets this to grow by 9,000 in 2036/37.[50]

192. We have seen a range of examples over the course of the review where employers or local areas are already delivering a version of the sorts of services we envisage the WHP offering and, in some cases, going beyond this. We know that good, practical solutions exist, they just need to be more prevalent.

What is the WHP?

193. We want to develop a service that builds from existing provision and works with employers and employees to better manage workplace health issues in a balanced way, acting objectively and independently on behalf of both parties. To do this we have developed the concept of a Workplace Health Provision.

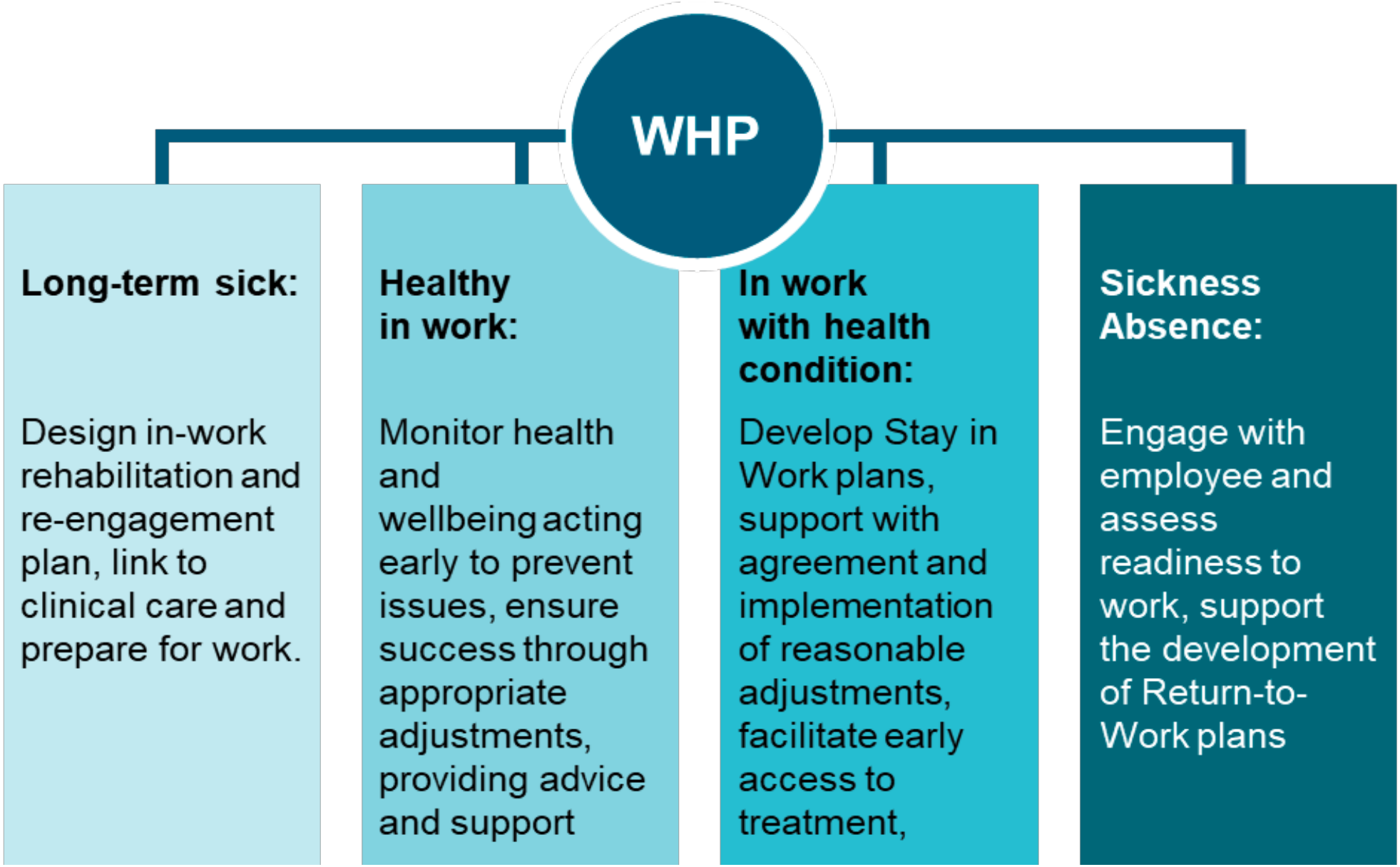
50 NHS Long Term Workforce Plan, June 2023

194. We envisage that the WHP would be a largely non-clinical service providing triage, support, advice and signposting into options for early intervention. The WHP would also have access to pathways for further support for employees for certain common health conditions in the workplace (talking therapies and counselling for mental health conditions or physiotherapy for musculoskeletal conditions). Over time, advanced digital triage systems are expected to develop to guide employees to the right level of support, improve coordination between stakeholders, and reduce delay in a cost-effective way.

195. The services offered by the WHP would not necessarily all be performed by a single individual, but probably by a multidisciplinary team. We expect that there will be a new practitioner role that provides the core coordination and support functions.

Core WHP services

196. Our view of the key WHP functions is set out below. This will be tested and refined through development in the Vanguard phase. The WHP would focus on how best to support a disabled employee, or employee with a health condition, to thrive in work, as well as considering an individual's ability to work while ill or recovering, in partnership with the employer.


WHP
Long-term sick:
Design in-work rehabilitation and re-engagement plan, link to clinical care and prepare for work.
Healthy in work:
Monitor health and wellbeing acting early to prevent issues, ensure success through appropriate adjustments, providing advice and support
In work with health condition:
Develop Stay in Work plans, support with agreement and implementation of reasonable adjustments, facilitate early access to treatment,
Sickness Absence:
Engage with employee and assess readiness to work, support the development of Return-to-Work plans

How will the WHP link to the NHS?

197. The WHP would not replace the role of the National Health Service in primary care: nothing here undermines the principle of universal healthcare, free at the point of use. Through early intervention the WHP services should help mitigate the risk of needing specialised treatment in the first place and reroute cases that do not need medical attention at all. In doing so the WHP should help to reduce the burden on the NHS.

198. Over the longer term, this joining up and cohesion could be achieved through the NHS App. We would envisage embedding the WHP into the neighbourhood health system to ensure communication is effective between the employer, WHP and the NHS.

199. If employers and employees are holding facilitated and mediated discussions involving the WHP around the impact of their health conditions or disability on work and their ability to carry out their role, we expect that over time the role of the WHP-facilitated *Stay in Work* and *Return-to-Work* plan offers a functional alternative to, and could negate the need for, the fit note. To do this in the right way, we are committed to working closely with GP representatives and the NHS on fit note reform.

200. A robust appeals and dispute resolution process will be essential. In addition, oversight by a national

enforcement body such as the Fair Work Agency or Health and Safety Executive would likely be required to ensure consistency, enforceability, and legal robustness in tribunal settings.

Who will deliver it?

201. Delivery should build on existing ecosystems available through social prescribers, NHS work initiatives, occupational health, vocational rehabilitation, income protection, and private insurers, while avoiding duplication. We envisage the development of a minimum service specification, which could be added to or enhanced by different providers to differentiate their offering – employers can go further if they choose. This should allow space and scope for innovation to improve quality, and to develop this with businesses and the provider landscape based on needs of employers and their workforce. Over time we would expect that this provision would be formalised and certified, and there will be a need for national oversight of training and development, and a professional home for the workforce.

202. There is already some evidence of stretched capacity for occupational health qualifications – with more than 60% of providers reporting difficulty in recruiting registered nurses, and nearly 50%

struggling to recruit physiotherapists and specialist doctors.[51]

203. The capacity challenge underlines the importance of a phased, long-term strategy that works within the context of the current system while building a sustainable market for the future.

How will it be funded?

204. We think the WHP needs to be a flexible, market-led solution, with employers funding the provision and choosing certified providers that meet their needs. Providers will be assessed against national standards – possibly stewarded by government – giving employers access to a wide range of trusted options. This model ensures both quality and choice, while setting a clear bar for entry.

205. It is our view that employers need to be responsible for funding the WHP. Direct public delivery or funding risks both inefficiency and crowding out, particularly where employers already invest in health and wellbeing support. Employers benefit from healthier, more inclusive workforces and a broader range of talent (including disabled people), and funding aligns with their duty of care, but strategic support will be needed to ensure SMEs and the self-employed can access provision

51 Understanding Occupational Health Provision 2023-24, 2025, GOV.UK

fairly. For this to be feasible the model must be affordable and scalable.

206. Many employers, particularly SMEs, struggle with the capital, time, and knowledge needed to invest in workplace health. Costs are frequently higher for smaller employers, arising from the relatively larger administrative burden to providers, reduced risk pooling opportunity, and limited negotiating power.

207. In the Vanguard Phase, we propose the exploration of pooling mechanisms to reduce costs and create economies of scale, particularly for SMEs.

Appendix B: Workplace Health Intelligence Unit

208. The Workplace Health Intelligence Unit (WHIU) will be an independent and innovation-focused body at the heart of transforming workplace health management across the UK. It will bring together employers, providers and government to test and scale interventions, collect and generate robust real-world data and inform future policy, driving inclusion, productivity and growth.

209. Previous attempts at workplace health and disability reform have lacked robust evidence which means it is hard to understand effectiveness of initiatives and benchmark performance. This lack of insight prevents further adoption and reduces employer buy-in, meaning it is difficult to get sufficient scale to achieve the systemic shift required to reduce sickness absence, increase return to work rates and improve participation of disabled people.

210. The WHIU is different, focused on bringing value and ensuring that future policy change is designed in partnership. During the Vanguard Phase, the WHIU will take the lead and accelerate adoption of the KBW recommendations. Over time, the WHIU will develop into a strategic asset which will leverage data to drive value, a public-private

asset jointly funded and executed by industry and government.

Agile set up and rapid scaling

211. The WHIU will be the hub for the Vanguard Phase. It will support business, regions and providers in developing the WHP offer and adopting the lifecycle. It will also develop measurement and data collection protocols to gather data to establish a reliable baseline for tracking return on investment, and drive for further transparency against the KBW outcome measures.

212. The WHIU will scale through an agile delivery model, ensuring that data collection is secure and trusted by Vanguard organisations from day one while minimising transactional or reporting costs. In parallel, the unit will build the data infrastructure and capacity to drive real insight, leveraging AI and predictive analysis to strengthen insight, refine the recommendations and model, and show real-world return on investment before scaling. This reduces risk, builds momentum, and strengthens credibility.

213. The WHIU will therefore:

- **Work with vanguards to test change:** Support early adopter employers and regions in the implementation of the KBW recommendations, ensuring focus on outcomes and innovation to

develop workplace health management and disability inclusion

- **Drive adoption:** Generate momentum by sharing insight, showcasing success and encourage wider take-up across sectors, regions and industries.
- **Collect and analyse outcomes:** Aggregate unstructured data from vanguards on absence, return-to-work and inclusion, turning it into insights on what works and what doesn't. Over time, this will be broadened to aggregate more standardised datasets, ideally through integration with providers or more automated live data sharing.
- **Develop excellence:** Share anonymised benchmarks and insights with providers, industry sectors, and small and medium sized employers to foster innovation. During the Vanguard Phase, the WHIU will oversee the crystallisation of the lifecycle into a Workplace Health Standard. In the longer term, it is envisaged that oversight of the Standard will be transferred to the appropriate institute.
- **Liaise with health sector and government:** Identify priority areas for policy change, such as fit note reform or changes to incentives, and support evidence collection and co-design future policy.

214. The Keep Britain Working Review has worked with employers across the UK, raising awareness and urgency among businesses, and leading to a commitment to change. The WHIU needs to build on this momentum and keep those organisations that have already committed to being vanguards engaged and supported to start making changes.

215. We suggest an WHIU interim period that utilises existing infrastructures and governance to build capacity and capability. However, the WHIU will require independence as a neutral broker between industry, individuals and government. This can be most effectively achieved if all parties come together to commit to building a sustainable asset which is sufficiently flexible to meet emerging needs – we envisage this taking the form of a data trust.

216. This approach will allow the WHIU to mobilise quickly while scaling in both reach and maturity, continuing to develop towards an enterprise-grade platform and design the right construct for the WHIU's long-term delivery.

Generating evidence: Deep dives

217. The review has identified several areas where current understanding of what works is weaker than it needs to be. The WHIU will enable contextual deep dives into specific categories and characteristics, supported by a secure research

environment. While data sharing on the core elements and outcomes described above will be asked of all vanguards, deep dives will accelerate innovation with leading organisations. We have identified three initial priority areas for deep dives. These will be developed further working with vanguards to understand priority questions for building evidence:

1. **Mental health in Young People** – Despite the rapidly rising prevalence of mental health issues among young people, understanding of what specific actions employers can take to protect young people's mental health and wellbeing is weak. The aim of the deep dive will be to understand the problem in greater detail and explore whether there are changes which could be deployed at scale to make a systemic difference. It will also identify specific practices which work in certain environments or industries, which could be shared more widely.

2. **Reasonable adjustments and disability** – We envisage the WHP would take an active role in advising businesses on reasonable adjustments. However, opinions on what is reasonable often differ between employers and employees. Many people told us that current advice often doesn't work in practice. The deep dive will explore whether it is possible to move towards a set of standard adaptations which should be considered by all employers to facilitate participation of those living with a disability in the workplace. This would clarify and simplify early discussions about disability.
3. **WHP support for micro and small businesses** – The review has shown that although return on investment of many workplace health prevention initiatives is clear for large employers, smaller employers struggle. This is due to higher costs, and inability to fund even low additional cost in a cash-constrained environment. The deep dive will test appropriate strategies and incentives which would allow micro and small businesses to benefit in a cost-effective way, either on a regional or sector-led approach.

Appendix C: Analytical Calculations

Summary

218. The specifics of how WHP will be delivered to and implemented in workplaces will be determined through testing during the Vanguard Phase, including how much of the service will build on or replace existing provision. Modelling the benefits of WHP at this stage therefore relies on benchmarks and assumptions of comparators, with take-up profile another key uncertainty.

219. On this basis we have not taken a full Green-Book type appraisal approach. We consider what benefits could look like at full adoption, with the fit note phased out. At this stage, we expect benefits to reach up to £8bn a year due to reducing overall sickness absence, presenteeism days and flows to inactivity.

220. As adoption increases, and the WHP aims to drive further improvements in the employment landscape, there is potential for possible further benefits including reducing flows into long-term sickness or inactivity and increasing the number of disabled people in employment, which could increase overall to up to £18bn per year.

221. These estimates provide an indicative view and remain uncertain. The annual view may not fully incorporate some sustained impacts that may further increase the potential benefit. These evidence gaps will be filled, and analysis strengthened, through the Vanguard Phase.

222. These benefits are split between employers, government and employees, with the greatest benefit to employers:

Annual Benefits	Lower Estimate	Central Estimate	Higher Estimate
Direct			
Employers	£2.8bn	£3.9bn	£7.4bn
Government	£0.14bn	£0.2bn	£0.3bn
Employees	£0.3bn	£0.5bn	£0.9bn
Total	£3.2bn	£4.6bn	£8.6bn
Potential additional benefits from further improving the system			
Employers	£3.8bn	£3.8bn	£5.2bn
Government	£0.8bn	£0.8bn	£1.5bn
Employees	£1.5bn	£1.5bn	£2.6bn
Total	£5.8bn	£5.8bn	£9.3bn
Total Benefits	£9.0bn	£10.3bn	£17.9bn

*Totals may not sum due to rounding

Summary of key assumptions

223. To calculate the benefits, we consider a range of different cohorts within the employee population which correspond to the Healthy Working Lifecycle (figures are annual):

- Healthy at Work – c.19 million employees
- Managing a health condition or disability in work – c.11 million employees
- Absent from work – c.4.4 million employees
- Leaving work due to poor health – c.120,000 employees

224. We then consider how the changes proposed through the review (particularly the WHP) could improve their position. These estimates are based on evidence we have from current provision and case study evidence with some stretch applied to the further benefit calculations. More detail is provided in the technical annex published alongside this report[52]

Sickness Absence

225. For the direct benefits in the table above we assume that sickness absence is reduced by:

- Healthy at work – 0%
- Managing a health condition or disability in work – 8-16%
- Absent from work – 8-32%

52 See technical Annex at: https://www.gov.uk/government/publications/keep-britain-working-review-final-report

226. When considering the potential future improvements these figures increase to

- Healthy at work – 0.5 day reduction reflecting prevention work

Presenteeism

227. For the direct benefits in the table, we assume that presenteeism days are reduced by:

- Healthy at work – 1 day reduction
- Managing a health condition or disability in work – 4-to-9-day reduction
- Short term absent from work – 1 to 4-day reduction

Flows into Inactivity

228. For the direct benefits in the table above we assume that the flow into economic inactivity reduced by 3-7% per year or the group who are leaving work due to long-term sickness.

229. For the potential further improvements, we assume this rises to 10% per year.

Disability participation

230. In the direct benefits we do not assume an uplift in disability participation. However, the Healthy Working Lifecycle specifically targets disability participation as an outcome measure and therefore in our further improvement estimate, we assume

that the lifecycle combined with the improvements delivered by the WHP could increase participation by 0.5% to 1%.

Monetising these benefits and splitting them between Employer, Employee and Government

231. To monetise these benefits, we use:

- DWP Internal Social Cost Benefit Analysis Model to estimate benefits to employers, employees and government of retaining an employee in work
- Average salary estimates for full- and part-time workers in combination with Gross Value Add estimates to estimate the benefit to employers and employees of reducing sickness absences
- Average salary estimates for full- and part-time workers and productivity estimates to estimate benefit to employers of reducing presenteeism days
- Prevented recruitment costs to employers of retaining an employee in work of around £11,000 per employee
- Prevented litigation costs based on ACAS figures for proportion of tribunals that are disability related

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We want to extend our thanks to everyone who has been involved. We have heard from a diverse range of stakeholders from across employers (large and small, public and private sectors), unions, representative bodies, healthcare providers, insurance providers, think tanks, academia, the NHS (including GPs), deaf and disabled people's organisations, and health and disability charities. The input and insight have been invaluable.

Many individuals also gave up their time to share their personal experiences of managing health conditions or disabilities in work.

Their candour and openness were greatly appreciated, and we have carried their experiences and insights with us as reference points throughout the review.

Our Advisory Board

Name	Company
Sara Weller CBE	BT; Lloyds Banking Group plc; United Utilities; Money and Pensions Service
Joe Rafferty CBE	NHS Provider Trust
Dr Steve Iley	BP
Dr Natalie-Jane Macdonald	Nuffield Health
David Rogers	AA Insurance Services; Liverpool Victoria Financial Services; McKinsey
Joanne Cairns	Union of Shop, Distributive and Allied Workers (Usdaw)
Valarie Todd CBE	Digital Catapult; Leonard Cheshire; Great British Energy

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Buckland, Blake Morgan LLP, Blind Ambition, Boots UK Ltd, Boston Consulting Group, BP Plc, British Airways Plc, British Beer and Pub Association, British Chambers of Commerce, British Retail Consortium, Brompton Bikes, BT Group Plc, BUPA, Burger King, Business Disability Forum, Business Services Association, Business in the Community, Camilleri Group, Capita Plc, Care Tech, Cartrefi Cymru, CMI, CIPD, Centre for Ageing Better, Centrica, Cerebral Palsy Scotland, Chambers Wales (South East, South West and Mid), Coca-Cola Europacific Partners, Confederation of British Industry (CBI), Cornwall Council, Cosy, Costain, Council for Work & Health, Daisy Comms, Deloitte, DFN Project Search, Disabled Peoples Organisation Denmark, Disabled Workers Committee, Disability Action (Northern Ireland), Disability Charities Consortium, Disability Positive, Disability Rights UK, Disability Wales, Disabled People's Organisation Forum England, Dunsters Farm, Dutch Ministry of Social Affairs and Employment, Dutch Employee Insurance Agency (UWV), DWP Labour Market Advisory Board, EDF, EmployAble, Employment Related Services Association (ERSA), Equality and Human Rights Commission, Evenbreak, EY, Fabian Society, Faculty of Occupational Medicine, Fedcap, Federation of Small Businesses, Five Guys, Food and Drink Federation, Good Growth Foundation, Google UK Ltd, Greater Manchester Combined Authority, Greater Manchester Good Work Charter, Greater Manchester NHS ICB, Group Risk Development (GRiD), Growth Incorporated, GSK Plc, Haleon, Headland Hotel, Health and Safety Executive (HSE), Health Partners Group

Ltd, Healthy Working Wales, Heeley City Farm, Hilton, Hospitality & Skills Board, Hospitality Sector Council, IHG Hotels & Resorts, Inclusion Barnett, Inclusion London, Inclusion Scotland, Independent Healthcare Practitioners Network, Industry Chief Medical Officer group, Industrial Strategy Advisory Council, Institute of Grocery Distribution (IGD), J Sainsbury's Plc, Jaguar Land Rover, John Lewis Partnership Plc, Kingfisher Plc, Kings College London, Kraftværket, Lancaster University, Latus Health, Learning and Work Foundation, Lloyds Banking Group Plc, Local Government Association, LSN Diffusion, Make UK, Make a Difference Events & Media, Maximus UK, McGinley, McKinsey, Mental Health First Aid England, Mental Health Leaders Group, Mental Health at Work Leadership Council, Mercer, Mind, Ministry for Employment (Denmark), Motionspot, MS Society, Mutual Ventures, Netcompany, Neurodiversity Together, NHS Confederation, NHS England, North-East Combined Mayoral Authority, Northern Ireland Government, Nuffield Health, OECD (Organisation for Economic Co-operation and Development), Office Cleaning Services Group, Onward, Our Future Health, PA Consulting, PeoplePlus, Premier Foods, Prosper, PwC UK, Rail Safety & Standards Board, Rail Safety and Standards Board, RCS Wales, Reed in Partnership, Resolution Foundation, Retail Sector Council, Retail Trust, Rio Tinto Plc, Rockwool Foundation, Rolls Royce, Royal College of GPs, Royal College of Occupational Therapists, Royal National Institute of Blind People (RNIB), Scope, Scottish Action for Mental Health, Scottish Government, Selling Group, Serco, Shell Plc, SIC Official, Simply Health, Sky

UK Ltd, Small Business Britain, Society of Occupation Medicine, Solar Energy, Sopra Steria, South Yorkshire Combined Mayoral Authority, Spire Healthcare, Sport for Confidence CIC, SwissRe, Tesco Plc, The Business Services Association, The Busy Group, The Gym Group Plc, The Health Foundation, The Health and Safety Committee, The Institution of Occupational Safety and Health (IOSH), The King's Fund, There Is Something More, Thrive at Work, Timewise, Tony Blair Institute, Trades Union Congress, Trades Union Congress Cymru, Truro College, UK Active, UK Hospitality, UK Hospitality, Ulster Supported Employment Ltd, UNISON, Unum, University College London, UWV, Versus Arthritis, VIVE, Vocational Rehabilitation Association, Warwick University – Institute for Employment research, Well Adapt, Wellcome Trust, Wellics, Welsh Government, Wellbeing Research Centre, Saïd Business School, University of Oxford, West London Alliance, West Midlands Combined Mayoral Authority, Westminster Employment Forum, Whitehall & Industry Group, Wincanton Group Ltd, Work Foundation, Work and Pensions Select Committee, Working Health Services Scotland, Working Well Trust, Working to Wellbeing, Working with Cancer, WPI Economics, Xeinadin, Youth Employment UK, Youth Futures Foundation, Zurich Insurance UK