September 2026

Keep Britain Working

A National Growth Opportunity

At a Glance

Keeping more people healthy and in work is one of Britain's largest and most attainable growth opportunities. It is good for employers and employees, it strengthens the public finances, and it does not require significant government investment.

Britain has an under-used economic asset hiding in plain sight: its working-age people.

Around 2.8 million people are economically inactive because of ill health or disability, while millions more are working with health conditions or facing barriers that limit what they can do.

The greatest opportunity is not to recover people after they have become detached from work; it is to prevent avoidable work loss in the first place.

Ten months of building and testing with employers, providers, places, unions and disabled people have made us clearer about what has to change, and more confident that it is attainable.

The Case	What it Means
The problem	Health-related economic inactivity costs Britain around £212 billion a year, close to 7% of GDP: £132 billion of lost output, £45 billion in health-related benefits, £37 billion in lost output from unpaid carers and £2 billion in additional NHS costs. [1]
Where the value is	Around 300,000 people with a health condition leave work each year. Someone absent for four to six weeks has a 96% chance of returning. After a year, fewer than half do. Once a person is inactive for health reasons, the chance of them working again within a year is 3.8%, against 47% for someone unemployed.[2] The same effort applied a year earlier can be worth more than ten times as much. If we could achieve a one percent increase in participation that would mean c.330,000 more people in work, which is equivalent to the productive capacity of a city the size of Cardiff, without building a single house or waiting for a generation to leave education.
Our estimate	Keep Britain Working (KBW) originally estimated annual benefits of £3bn–£8bn, rising to £9bn–£18bn as the system matures. The estimates include

[1] *The cost of working age ill-health and disability that prevents work - GOV.UK The cost of working age ill-health and disability that prevents work - GOV.UK*
[2] *Keep Britain Working Review: Discovery - GOV.UK Keep Britain Working Review: Discovery - GOV.UK*

	absence, productivity, retention and disability participation.[3] These were deliberately cautious estimates, drawn from relatively small-scale programmes, and the system change now proposed is broader.
The ceiling	Health Foundation analysis indicates £57bn of additional annual output and £72bn of public finance capacity were working age health to return to 2014 levels. A different question from ours and not additive to it, but it indicates the scale of what is at stake.
The model	Britain has a National Health Service. It has never had a Workplace Health System. Three components, held together by shared responsibility: better, more inclusive workplaces, accessible workplace health provision and trusted intelligence.
The engine	Intelligence. No employer in Britain can compare its retention of people with health conditions against a competitor's. Almost none are measuring whether the people they help back to work are still there six months later. No provider can compete reliably on outcomes, because comparable outcomes do not exist. There are 19,000 employers signed up to Disability Confident and not one can say reliably how it compares with its peers. And ministers cannot say for certain which government funded initiatives have actually changed participation. We must work together to improve intelligence and understanding of the system to drive accountability and change.
The cost	This is not a spending programme. The operational levers sit with employers and the returns land with employees, employers and the Exchequer. What government must supply is the framework, the intelligence, and access for the smallest firms.
What changes	Safer conversations replace fear; coordinated plans replace fragmented processes; emerging health issues and disability inclusion become visible and actionable.
The route to scale	Vanguards develop and test the model. Place and sector partnerships widen access. Evidence progressively supports incentives for adoption.

[3] *Keep Britain Working Final Review and Keep Britain Working Technical Note https://assets.publishing.service.gov.uk/media/6909fac488a98da87e292282/keep-britain-working-review-final-report.pdf and Keep Britain Working Technical Note*

Chapter One: A National Growth Opportunity

Growth hiding in plain sight

The UK's working-aged people are one of its most important economic assets and until 2020, a key driver of UK GDP growth was their rising participation in employment.

However, for the last six years, economic participation has gone into reverse, in large part due to the increase in the number of working-age people not working due to ill health: 2.8 million at the latest count, up around 800,000 since 2019.[4]

This naturally presents itself as a problem, one that we have repeatedly highlighted.

The estimated economic cost of health-related economic inactivity is colossal: £212 billion a year, or close to 7% of GDP.[5]

This is not government spending alone.

It is £132 billion of lost output, £45 billion in health-related benefits, £37 billion in lost output from unpaid carers and £2 billion in additional NHS costs, alongside the incalculable loss in life chances for those affected.[6]

The growth in health-related economic inactivity in the UK has been driven by a surge in reported work-limiting health conditions, and this has particularly been observed at each end of the age spectrum:

- Between 2015 and 2024 there was an increase of 1.2 million (77%) of 16–34-year-olds reporting work-limiting health conditions, 530,000 of which were related to mental health conditions.[7]
- In the same period, 0.9 million (32%) more 50–64-year-olds reported a work-limiting health condition of which 140,000 were related to musculoskeletal (MSK) issues.[8]

Neither factor is likely to improve on its own.

Mental health conditions amongst young people have been rising steadily since 2014, and we are ageing as a population.

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[4] *Keep Britain Working Review: Discovery - GOV.UK Keep Britain Working Review: Discovery - GOV.UK*
[5] *The cost of working age ill-health and disability that prevents work - GOV.UK The cost of working age ill-health and disability that prevents work - GOV.UK*
[6] *The cost of working age ill-health and disability that prevents work - GOV.UK The cost of working age ill-health and disability that prevents work - GOV.UK*
[7] *Department for Work and Pensions, "Get Britain Working White Paper," GOV.UK, November 26, 2024, https://www.gov.uk/government/publications/get-britain-working-white-paper*
[8] *Department for Work and Pensions, "Get Britain Working White Paper," GOV.UK, November 26, 2024, https://www.gov.uk/government/publications/get-britain-working-white-paper*

We are also experiencing a persistent disability employment gap (29.4%[9]), resulting in disabled people being excluded from the workforce and systematically disadvantaged.

We must do better at managing health and removing barriers in the workplace to help the millions of people who are in work to remain healthy, productive and included in work for longer, and to support those managing health conditions to keep working successfully.

The problem is urgent but so is the opportunity, and that opportunity is attainable.

For too long this has been framed mainly as a welfare problem.

Instead, it is one of the UK's largest and most attainable productivity and growth opportunities.

The opportunity is larger and more attainable than we thought

The modelling in our November 2025 report estimates £3 billion to £8 billion of annual benefit from an initial set of system changes, rising to £9 billion to £18 billion as adoption and impact mature.

These figures rest on deliberately cautious projections and are informed by relatively small-scale programmes.[10]

Given we are now proposing much broader system changes, we would hope to deliver greater benefits than those originally modelled.

These greater benefits may well be attainable.

Recent Health Foundation analysis estimates that returning working-age health to 2014 levels could generate £57 billion of additional annual output, around 2% of GDP, and unlock £72 billion of public finance capacity through higher receipts and lower spending on benefits and the NHS.[11]

To put the scale the other way round: if we could achieve a one percent increase in participation that would mean c.330,000 more people in work, which is equivalent to the productive capacity of a city the size of Cardiff, without building a single house or waiting for a generation to leave education.

Ten months on, having worked closely with Vanguard employers and regions, providers, disabled people, unions and the Devolved Governments, we are clearer about what must change and more confident about the attainability and impact of those changes.

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[9] *Source: Table A08: Labour market status of disabled people - Office for National Statistics (ons.gov.uk)*
[10] *Keep Britain Working Final Review and Keep Britain Working Technical Note https://assets.publishing.service.gov.uk/media/6909fac488a98da87e292282/keep-britain-working-review-final-report.pdf and Keep Britain Working Technical Note*
[11] *Health as an Economic Asset, The Health Foundation, July 2026*

We do not need to eliminate illness, “fix” disabled people or return all 2.8 million economically inactive people to work in order to create material economic value.

We need to better support people to be better in work, prevent a modest proportion of avoidable work loss, remove barriers, improve sustained return to work, and narrow the employment gap experienced by disabled people and people with health conditions.

The intervention window is key

Most people are still in work and more people with work-limiting health conditions and disabilities are employed, than are economically inactive because of them.

Around 300,000 people with a health condition nevertheless leave work each year, and the arithmetic of what happens to them is important.

Someone absent for four to six weeks has a 96% chance of returning to work.

Once absence extends beyond three months, the odds begin to fall in earnest. After a year, fewer than half return. And once somebody has become economically inactive for health reasons, the probability of moving into work within a year is just 3.8%, against 47% for someone who is unemployed.[12]

This is why we are concentrating on retention.

It is not indifference to the 2.8 million who are already economically inactive. It is the recognition that the same effort applied a year earlier has an impact worth more than ten times as much. Almost nothing else in economic policy has a payback curve this steep, or one this well understood.

The cheapest intervention is always the earliest one.

We have never been able to see this problem

We can say what health-related inactivity costs the country. What we cannot say is where and how employers can anticipate and respond to it.

No employer in Britain can compare its retention of people with health conditions against a competitor’s.

Almost no organisation measures whether the people it helps back to work are still there six months later. No provider of workplace health support competes reliably on outcomes, because no comparable outcomes exist. And no minister can say which of the things government funds actually changed participation.

If all we can measure is the cost of a problem but not the performance of the response, we are likely to go on paying for the problem, rather than solving it.

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[12] *Keep Britain Working Review: Discovery - GOV.UK* *Keep Britain Working Review: Discovery - GOV.UK*

This is essentially why decades of good intentions on work and health have not moved the national numbers.

This is fixable.

The gains are economic, social and regional

Longer, healthier working lives will protect earnings, pension wealth, confidence, connection and people's purpose.

They will also help employers retain experience and reduce the cost of absence and replacement whilst strengthening the tax base and reducing avoidable welfare and healthcare costs.

The gains will also be progressive.

Ill health is more prevalent in poorer communities, and place has always been critical to our approach.

The Health Foundation estimates that the number of working-age people living with major illness will grow by around 25% between 2019 and 2040 and that 80% of this increase falls in more deprived places.[13]

Recent Health Foundation modelling also suggests that restoring working-age health to 2014 levels would substantially raise median income in the poorest tenth of households and that the share of the income that is earned rather than received in benefits would nearly double.[14]

However, better health and seeing more disabled people retaining employment will not be enough on its own.

Health support, employment support and employer demand must be connected within the same place with Regional Mayors, Strategic Authorities and Devolved Governments uniquely placed to convene and deliver within their own labour markets.

We are also continuing to work with our regional Vanguards across rural areas, coastal communities, cities and towns to ensure we're capturing and understanding the challenges and what's working for employers and people across the four nations of the UK.

If we want this, we must engineer it

Countries that have achieved sustained improvements in participation have not done so through exhortation alone.

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[13] *Health inequalities in 2040 | The Health Foundation*

[14] *Health as an Economic Asset, The Health Foundation, July 2026*

The Netherlands created strong employer financial responsibility for sickness absence and reintegration. Denmark combined a more flexible labour market with a stronger safety net and active support.

Neither model can simply be transplanted to Britain, but the lesson is fundamental: better participation is the product of system design, not good intentions.

Leadership from Vanguard employers is essential, but national outcomes will not change simply because everyone else is asked to copy them.

Instead, what the UK needs is its own model, capable of working across large employers, small and medium-sized enterprises (SMEs), different sectors and different labour markets.

As such, Keep Britain Working (KBW) does not sit alongside growth, health, welfare reform and labour market policy.

It ***connects*** them.

The same people appear on the welfare bill, in the participation statistics, on NHS waiting lists and in the productivity numbers.

There are very few growth opportunities that are good for people, good for employers, good for growth, and good for public finances without requiring billions of pounds of upfront spending.

This is one of them.

Chapter Two: The System Britain Needs

A distinctly British model: the Workplace Health System

Britain has a National Health Service.

What it has not had, until now, is a Workplace Health System.

The Workplace Health System that we are proposing, and already working to build, has three practical components:

- Better, more inclusive workplaces,
- Better workplace health provision,
- Better intelligence on workplace health and inclusion.

They are held together by a concept of shared responsibility and, over time, by incentives increasingly aligned with measurable outcomes.

How the system will work

- Clear expectations will make responsibility visible.
- Accessible provision will make earlier action possible.
- Trusted intelligence will show what is happening early enough to act on, make performance comparable, and establish for the first time which interventions are worth paying for.

Who	Core Responsibility
Employers	Design healthier and more inclusive work, act early, make timely adjustments and support practical stay-in-work and return-to-work plans.
Employees	Where circumstances allow, participate in conversations about work and health, discuss barriers, maintain agreed contact and engage with support and agreed plans.
Providers	Offer accessible, coordinated and work-focused support, with clear accountability and measurable outcomes.
Places	Convene employers and providers, connect health and employment support, and organise shared access where useful.
Government	Set the framework, establish trusted intelligence, remove barriers to access and progressively align incentives.

Chapter Three: Better, More Inclusive Workplaces

A practical framework across the working lifecycle

Good work and good health can reinforce each other.

Employers have a unique role in creating healthy and inclusive workplaces, preventing ill health and absence, removing barriers and remaining involved throughout recovery and return.

But many employers do not currently have the confidence, capability or infrastructure to do this consistently.

Partnering with KBW, the British Standards Institution (BSI) has appointed an expert drafting panel to develop a new employer-facing standard, informed by insight and evidence, including from the Vanguard partners.

It is expected to set out clear, outcome-focused expectations, including the importance of stay-in-work and return-to-work plans, rather than prescribing a single operating model.

It should help employers understand where they are, what good looks like and what practical steps to take next.

Summary of principles and practice

Principle	What good practice means
Own workforce health	Treat health as a leadership, performance and work-design and environment issue, with clear accountability.
Act early to prevent issues	Make it safe to raise concerns, and to talk about health and work, equip managers to discuss impacts on work rather than make a diagnosis, and provide visible routes to help and support.
Keep people in work	Respond quickly, make adjustments and agree a stay-in-work plan focused on barriers that can be changed or removed.
Plan for sustained return	Maintain supportive contact during absence and coordinate recovery with a practical return-to-work plan.
Include everyone	Identify and work with employees to address issues with implementation of adjustments, retention and return to work approaches and disability participation.

Use the right support	Bring in impartial advice, treatment or coordinated case management when the employee and manager need it.

The commitments now being tested

The table above sets out a summary of the principles and high-level practices that are being developed as part of the BSI standard.

However, we recognise that there are areas where greater specificity or guidelines could be helpful for employers and employees to set clear expectations.

These will need to strike a balance between being supportive and helpful to employers and their employees while avoiding being overly prescriptive and risking excluding employers from the standard where it doesn't work for their context or workforce.

To that end, we have drafted some illustrative commitments below which add some specificity to the principles and summary we have set out above.

We will be testing these with Vanguard organisations of all sizes. The BSI drafting panel will also consider whether the timelines set out below should be reflected in the standard and the impact on accessibility for different types of employers.

The drafting panel will follow BSI's standards development process and reach consensus on what is included in the final standard, drawing on the balance of the Vanguard evidence, and the insight gained through the development process.

These should therefore be seen as early examples of where greater specificity might be valuable, as opposed to firm proposals.

Specific commitments to test with Vanguard employers

Principle	Commitment being tested
Act early to prevent issues	A work and health conversation offered within eight weeks of joining.
Keep people in work	A conversation within five working days of an issue being raised, and a stay-in-work plan with named actions, owners and review points.
Keep people in work	Adjustments agreed promptly and put in place as quickly as practicable.
Plan for sustained return	Contact on day one of absence where possible, and no later than day three.
Plan for sustained return	A return-to-work plan co-created for any absence and particularly those likely to pass four weeks or linked to underlying conditions, with provision engaged within ten working days where needed.

Plan for sustained return	Regular touchpoints established with agreement of the employee. Sustained return measured at six months, not day one.
Include everyone	Participation and retention measured annually, using common definitions.

Shared responsibility in practice

Shared responsibility is central to KBW.

Successful work and health outcomes depend on the interaction between employees, employers, worker representatives, support providers and the wider system, rather than the actions of any one party alone.

The KBW Review placed particular emphasis on the role employers can play in supporting people to stay in and return to work. Building on this, we are also exploring what meaningful employee participation looks like, and how that can be enabled and supported.

This is not about blame or creating a compliance focus.

It is about recognising employees as active participants who have important knowledge of their circumstances, needs and experiences and creating a system that collaboratively looks to develop support and solutions that benefit everyone.

It is also about recognising the role that worker voice, trade unions, employee networks, peer support and constructive workplace relationships can play in supporting healthier and more inclusive workplaces. This includes helping employers identify recurring barriers, workforce patterns and underlying workplace factors.

Where the right conditions are in place, employee participation can help shape workplace adjustments, support earlier conversations, improve rehabilitation and return-to-work planning, and contribute to safer and more sustainable outcomes.

Expectations must be proportionate and reflect individual circumstances. Employees can only exercise meaningful agency where employers, providers and government create the conditions that make engagement possible.

The following table translates this into indicative practical actions, aligned to the same core themes used for employers: own workforce health, act early to prevent issues, keep people in work, plan return from day one, and include everyone.

Core employer action	What this means for employees
Own workforce health **Treat health as a shared responsibility.**	Participate in conversations about health, available support and recovery where circumstances allow.
Act early to prevent issues **Raise issues early and engage with support.**	Raise concerns about health or work early and work with their employer to identify what work may be safely possible, and what support or adjustments may help make it sustainable.
Keep people in work **Work together on plans and adjustments.**	Collaboratively develop, monitor and review stay-in-work plans, considering adjustments, workload, hours, job design or other changes that may help sustain work.
Plan return from day one **Stay connected during absence where possible.**	Notify employer of absence from day one, and no later than day three, maintaining agreed contact with employer during absence and engaging with return-to-work planning and workplace, occupational health or clinical support that can help recovery and return.
Include everyone **Close participation gaps by developing robust insights to improve outcomes for all.**	Support data collection and reporting and share experience and feedback where this can improve workplace support, policies and practice, identifying barriers to participation and suitable adjustments to support inclusion.

This proposition is not settled. It now needs to be tested with employees, disabled people, trade unions and representative organisations. Expectations must allow for fluctuating conditions, acute illness, psychological safety and the fact that some people will not be able to engage at particular points.

Employees should not be expected to disclose unnecessary personal information, engage when doing so would be detrimental to their health, or take responsibility for matters that sit within the employer's or wider system's control.

None of this is a condition of sick pay, of employment or of access to support. Sick pay is not conditional on any of it.

Disability inclusion is an outcome, not a separate workstream

Increasing disability participation in the workplace is not a separate objective of KBW.

It is central to it.

Disabled people remain substantially less likely to be in work, and we have identified that there is poor visibility of inclusion and the participation of disabled people.

We understand that employers face a range of challenges in addressing these issues, however these go along with a genuine appetite to tackle them.

We know that progress depends on creating clearer accountability for outcomes which is why better measurement of the participation and the retention of disabled people in work continues to be a focus for us.

Above all, the system change that we are building towards is inclusive workplaces for **everyone.**

Creating a system with inclusivity at its heart will remove the burden of self-declaration as the trigger point of change and allow disabled people the opportunity to discuss their needs openly and safely.

The changed system must also build trust and ensure that disabled people's needs are taken into consideration in their workplaces from the outset and that there is both visible representation and accountability at management level.

An inclusive approach will also see employers respond to the needs of all employees by making any necessary adjustments faster and more portable – as well as working with them on identifying and removing barriers.

But we know that this, by itself, won't be enough.

There needs to be a much bigger change. We must tackle the stigma and exclusion.

Here, better intelligence is potentially a game changer. It will create accountability for delivering better outcomes, highlight good and bad performance and help drive changing attitudes in the system.

Retention and participation numbers of disabled people are important, but they are not the whole picture. It is the ability to compare these figures between organisations nationally and to identify patterns and gaps versus non-disabled employees that will motivate and enable employers to take action.

Our ongoing work will inform the future development of Disability Confident, Access to Work, and mandatory reporting, aligning national programmes with measurable participation outcomes.

And we remain committed to ensuring that the voices of disabled people continue to inform, support and challenge our work.

Chapter Four: Better Workplace Health Provision

From fragmented services to a coherent offer

Employees and employers taking greater shared responsibility can go a long way.

But even where excellent relationships exist, they cannot achieve our ambition without support – through impartial advice and coordination, early support or treatment, and ongoing learning on how to improve.

Many examples of such support services at work already exist, but today this support landscape is often fragmented across human resources, occupational health, employee assistance programmes, GPs, insurers, vocational rehabilitation or specialist treatment. Handovers between contacts are weak or non-existent, and employees and line managers, are frequently left to join the pieces together.

This means that good stay-in and return-to-work planning, monitoring and follow-up can be difficult, particularly for more complex cases. In addition, even employees with excellent line managers may be in situations where sharing their situation with their manager feels uncomfortable, or unsafe.

KBW has therefore developed a draft model of support at work – what we call 'Workplace Health Provision (WHP)' – that addresses this gap.

Its central proposition is that employees and line managers should be able to turn to a trusted, impartial coordinator when a work and health issue needs more than a straightforward managerial response.

Their role is to translate between them, coordinate and help monitor the stay-in-work or return-to-work plan and help point employees to the appropriate support. They do not replace clinical judgement, human resources or line management, but complement them when needed.

However, WHP consisting only of such a coordination and case management function is unlikely to change outcomes on its own.

It also needs to provide general advice and guidance to inform employees and employers, offer early support and treatment that can underpin stay-in or return-to-work plans, and use the insight from the issues employees face, and the support they seek, to help employers to continuously improve the workplace and support offer.

WHP built around coordination and case management, and combining these three additional functions, offers a more connected, coherent model that responds to employee and employer needs – and helps achieve the future BSI standard.

Overview of the KBW Workplace Health Provision model

Function	What it should provide at a minimum
Advice and guidance	A trusted route to impartial, practical advice and tools for employees and managers to resolve general questions, including on self-management, routes to further support, or inclusive and healthy workplaces.
Case management	An appropriately independent, non-clinical coordinator, or case manager for more complex cases, who helps agree and monitor stay-in and return-to-work plans, directs to and connects other support available, and escalates clinical needs.
Early support and treatment	Timely, evidence-based support for common work-limiting issues or conditions, focused on staying or returning to work, including early treatment for mental health and MSK needs, removal of barriers and early support for non-health issues such as finance, bereavement or caring responsibilities.
Employer insight	Collecting aggregate information on recurring employee needs and workplace barriers, and associated outcomes, to help employers improve workplace design and support.

Provision is also where the most valuable intelligence in the system is generated, because it sees the problem at the point a person seeks help, rather than at the point they go absent.

Defining WHP in this functional way gives employers and providers flexibility on how to evolve from what already exists today and deploy it tailored to their circumstances.

Large employers may want to build on their existing occupational health, early treatment and other capabilities to create a stronger coordination and case management function, connecting and learning from what they already offer.

SMEs and microbusinesses may want to procure a single, external provider to offer these functions for them.

Other employers may want to provide selected functions internally and procure others externally.

In some cases, and particularly while our envisaged Workplace Health System is evolving, public provision may be required for employees to access these functions, for example through WorkWell Centres.

The regions and nations all have strong convening and coordinating powers which could go a long way towards streamlining WHP for employers.

This in turn will improve the affordability and accessibility of WHP for SMEs.

Making the model affordable and accessible

This draft model of WHP has been developed through conversations and roundtables with employers, providers, occupational health and other employment support practitioners, GPs and insurers.

But the critical test is whether the model is affordable and accessible for all employers, including SMEs and microbusinesses.

Given what already exists in the market, and the interest we have received from providers, there is ground to believe that this test can be met. But it requires further exploration through two interdependent steps.

First, settling the minimum specification for the draft WHP model.

We are confident about the importance of coordination and case management at its centre and believe that for impact, it needs to be combined with advice, early support and treatment, and iterative improvement.

But we need to test this against feasibility and cost, drawing on existing products on the market, opportunities for innovative, digital delivery, and if a reduced functional model would retain the envisaged coherence and impact.

Second, exploring potential access routes for SMEs and microbusinesses.

From our conversations so far, we believe that there is opportunity to test the potential for pooled purchasing of WHP on behalf of small employers in a place, e.g. via Mayoral or Strategic Authorities, Devolved Administrations or through sector bodies.

WHP could also be pooled in this way through the supply chain of large employers, making services available to their partner companies.

This is already happening.

Hull's Resilience Hub, a partnership between the City Council and Vanguard provider, Latus, is testing whether a buyer's pool can give SMEs affordable access to workplace health support.

In Scotland, Working Health Services Scotland provides an established example of case-managed support for SME employees and the self-employed, focused on return-to-work planning.

South Yorkshire Mayoral Combined Authority is planning to trial independent, shared case managers sitting within businesses part-time to support employees with stay-in-work planning.

And West Midlands Combined Authority are working with large employers in key sectors to improve SME access to workplace health support through supply chain relationships, including exploring procurement mechanisms and the potential for pooled workforce wellbeing resources.

An alternative route for small businesses may be through insurance schemes that pool risks and support across small employers, so that premiums are priced lower across a larger group of employees.

This would draw on learning from approaches in some European countries and would build on insurance approaches that also already exist, such as group income protection, where workplace health support is already a prominent benefit.

However, it would need to address pricing, adverse risk selection, and appropriate brokerage.

Developing the minimum specification for WHP and exploring the routes for making it affordable and accessible for all employers therefore need to go hand in hand. Price depends on access, and vice versa.

We are keen to partner further, particularly regionally, to further test aspects of our draft WHP model, and approaches that enable affordable access for SMEs and microbusinesses, whether through the market or public provision like WorkWell centres.

Chapter Five: Better Intelligence on Workplace Health and Inclusion

Intelligence is the engine for transformation

Better workplace health intelligence will be vital to underpin the whole system, working alongside workplaces and provision and allowing both to continuously improve.

Currently, neither employers nor government can answer basic questions about workplace health and disability consistently.

Sickness absence is measured in different ways. Sustained return to work is rarely tracked. Disability participation within organisations is poorly understood. There is little robust, comparative evidence on which interventions work, for whom and at what cost. And we do not have consistent, robust insights about the health and work ability of employees, that would enable earlier, more targeted support.

We must create better data and intelligence to enable systematic improvement. Data is the key to unlocking the system to understand what works, benchmark performance, create accountability, and drive adoption and innovation.

The emerging model therefore is likely to require two complementary forms of intelligence: performance data from employers, and trusted insight from individuals while there is still time to act.

We are now exploring the case for both of these types of intelligence and how they could be generated.

How different could things be?

The gap between the system we have and the system better intelligence makes possible is not a marginal improvement.

Better intelligence could put employers and government on the front foot and allows proactivity and action.

Today, an employer discovers a health problem when a fit note arrives.

With better intelligence, in the Workplace Health System, they could see the incidence of emerging mental health and MSK challenges rising across a team earlier, alongside whether their own level was above or below the norm for their industry and their region. They could wait for the wave of absence to arrive with all its costs, or they could act. Most employers would act, because acting would benefit them, reducing absence, costing them less, and because for the first time they would have a reason to believe it would work.

Today, employers struggle to collect accurate disability data.

With better intelligence, in the Workplace Health System, an employer could know that their disability participation rate was half that of a direct competitor. There are 19,000 employers signed up to Disability Confident, every one of them signaling an ambition to be inclusive, and not one of them can currently say reliably how they compare with their peers. What would a Chief Executive do on being shown that number next to a rival? We have run this experiment in other fields. The National Joint Registry collects standardised outcomes from every unit, returns confidential comparisons to surgeons and publishes nationally, and it drove failing implants out of use without compelling anyone to stop using them. The wider evidence on audit and feedback points the same way and tells us how to design it: comparison works when it is against the best rather than the average, and when every number arrives with a recommended action.

Today, a provider sells a service based on claims of efficacy.

With better intelligence, in the Workplace Health System, providers could compete based on performance data, published in a common format. This creates accountability for delivering outcomes and demonstrating effectiveness.

Today, government sets policy for work and health with almost no line of sight between what it funds and what happens to participation.

With better intelligence, in the Workplace Health System, ministers could have reliable outcome measures for retention, sustained return and disability inclusion, disaggregated by sector, size and place, with visibility of what drives them. Those have direct consequences for growth, productivity and public expenditure. Only then can incentives be pointed at outcomes rather than at process, and only then can we know which incentives are worth paying for.

This isn't about data collection and reporting for their own sake. It's about making data comparable, and actionable, to incentivise change.

Comparison is confidential to the employer. What is published is national, sectoral and regional. An employer sees where it stands; the government sees where the region or country stands.

This is also why intelligence has to come first rather than last.

Incentives should align progressively with outcomes as evidence accumulates. You cannot pay for outcomes you cannot measure.

Without intelligence, there is no evidence, without evidence there are no incentives, and without incentives this stays a movement of willing employers rather than becoming a national system.

Start with information employers already hold

Employers can see their own absence data but have no way of reliably comparing their performance with others.

We have yet to find an organisation that consistently measures return-to-work rates. Among Vanguard employers and providers there is considerable interest in agreeing consistent measurement and in confidential pooling of data.

We have heard that issues with trust and self-reporting, differences in the definition of disability along with how the question is asked, if at all, mean that disability participation is something employers struggle to measure.

An employer data project will commence in Autumn 2026 with large and smaller employers across the private and public sectors. It will explore whether existing corporate-level data can be collected consistently and proportionately, how definitions differ, and what a useful confidential benchmark looks like in an employer's hands.

The project will start with information employers already hold. It will not require named or identifiable employee data, and employers will not initially be asked to redesign their reporting systems. Small-number results will be suppressed or combined where necessary. Participating employers will receive early insight into data quality, gaps and comparative performance.

This is a starting point, not the finished intelligence system.

It must lead towards the measures that matter: sustained returns to work, health-related exits, disability participation and the outcomes of support, rather than simply the volume of sickness absence or the number of disabled people employed.

Over time, insights and learning about workplace culture and from better workplace health provision should also improve how employers understand the needs of their staff, and target support.

Make work and health toolkits useful and trusted

Employers and support services often have opportunities to act before a condition, or a workplace barrier causes absence or work loss.

However, emerging needs frequently remain invisible until someone is already struggling.

We have recently completed a six-week sprint with Vanguard employers and providers to gather feedback on how more regular insights from employees could enable earlier support.

This has led to a draft proposition about the potential benefit of such an approach, principles for deployment, and an early prototype for a simple, employee-facing toolkit to develop further.

The proposition has three elements:

- **The individual is the first beneficiary.** A person completing the toolkit is helped immediately to understand their own health, wellbeing and work ability,

to identify unmet need, and to choose whether to seek support. They receive something useful rather than simply supplying data.

- **Responses are private by default.** Employers receive only protected, aggregated insight above a suppression threshold, never individual answers; an employee may choose to share a summary with a clinician, or their own summary with their employer, outside the toolkit.
- **Every question has legitimate use and a credible route to action.** Everything that is collected has the potential to better support employees.

Employers, and other public, regional services would benefit from resulting insights about trends about needs and barriers in the workforce, but would only receive aggregate, anonymised information.

We have partnered with the University of Liverpool's Civic Health Innovation Labs on the development of the Work and Health Toolkit and are working to run citizens' panels to establish the conditions for citizen trust in the Work and Health Toolkit – the social licence – alongside associated data and AI opportunities, and ahead of testing with selected Vanguards. https://liverpool.ac.uk/chil/keepbritainworking.

We will also continue to gather feedback on this approach from Vanguards, including on the benefit to small employers, and how it could be delivered. Depending on the results, this would be followed by further validation of methodology, user research, and testing with external partners to inform how such an approach could be scaled.

Two questions remain genuinely open.

The first is whether enough people will complete it, and in particular, whether the people most likely to need help are those who are the least likely to take part.

The second is whether the value it offers to someone is real enough to be worth their time.

Both are being tested and the findings will inform the system's development.

Give intelligence a permanent home

Establishing a Workplace Health Intelligence Unit (WHIU) was a key recommendation in the KBW Review, published in November 2025.

We are now able to define, based on what better intelligence requires, what this entity should be responsible for, and particularly the infrastructure and capabilities needed to deliver the vision set out above.

Function	Purpose
Common measures	Define nationally consistent, proportionate approaches to measuring work ability, absence, sustained return, retention and disability participation.
Secure collection	Receive aggregate employee, employer and provider data, with clear safeguards and no unnecessary collection of identifiable information.
Benchmarking	Return confidential comparisons that help employees, employers and providers understand performance and choose where to act.
Evaluation	Assess the effectiveness and value for money of interventions, including provision, digital and other innovation and workplace practice.
Public insight	Report regularly on national, sectoral and regional patterns so that the intelligence becomes a public good.
Policy and incentives	Translate evidence into practical recommendations for employers, places and government, including the design of outcome-based incentives.

Three things would make the unit credible rather than merely necessary.

It must be trusted as a steward of information rather than seen as a departmental data collection exercise.

It should report publicly at least annually, because an institution that reports only privately to those who fund it will not be trusted by those it asks for data.

And its governance should include employers, employees and their representatives, disabled people, providers, places, academia and government.

Chapter Six: What Changes on the Ground

The KBW Review identified three persistent issues and challenges inherent in the current system: fear, ineffective process and support, and the exclusion experienced by disabled people.

We also know that the current system too often discovers problems late and separates health from work.

The Workplace Health System would act earlier, keep people connected and make sustained participation the shared objective.

Fear gives way to safer conversations

An employee may not feel able to share a health problem because they fear losing opportunities or their job. A manager may avoid the conversation because they fear saying the wrong thing. Both wait, and the first formal exchange takes place after absence has begun.

In the Workplace Health System, managers would have a simple framework for discussing work and capability. Employees would have a route to impartial support and control over sharing personal information. The conversation would focus on what makes work difficult, what a good or bad day looks like, and which adjustments could help. Employees would see that raising a concern leads to concrete and positive action which builds trust.

Ineffective process and support give way to a practical plan

A fit note often becomes the main workplace document even though it cannot, on its own, resolve the demands of a particular job. Treatment, absence management and return are handled separately, and nobody consistently owns the whole journey.

In the Workplace Health System, clinical advice would inform a stay-in-work or return-to-work plan agreed around the employee and their job. The plan would identify actions, responsibilities, and a review point. Case management would become involved when needed, linking services and following through on workplace recommendations.

If absence is necessary, supportive contact would be agreed and the connection with work would be maintained. Where safe and appropriate, treatment and work would proceed together, with adjusted duties or a graduated return. Success would then become sustained participation and recovery, not simply attendance on the first day back.

Exclusion gives way to accountable inclusion

A stated commitment to inclusion is of little benefit if an adjustment takes months, a job cannot accommodate a fluctuating condition, or nobody notices that disabled colleagues are leaving disproportionately often.

In the Workplace Health System, employers would examine recruitment, adjustment, retention and progression outcomes alongside employee experience. Providers would help identify practical options, and places would connect employers to support. National programmes would then be assessed by the differences they make.

Four Changed Working Lives

The following examples, drawn from composites from our emerging findings, and Vanguard and provider feedback, illustrate the tangible difference that the Workplace Health System could make to people's working lives if introduced into the UK.

They are based on real-life experiences but do not relate to specific individuals or circumstances.

A 26-year-old woman: 4,000-person employer

Current Situation: She is six months into the job and has been sleeping badly for four months, dreading Sunday evenings. She says nothing, because the team is stretched and because she is still relatively new. She soon stops being able to get out of bed and is signed off. Her GP has ten minutes. The fit note says that she is not fit for work. Her manager, anxious about intruding, leaves her alone for three weeks. She is off for five months, returns to a role that has changed, and leaves the company within the year.

In the Workplace Health System: She is offered the Work and Health Toolkit eight weeks after joining and again at the two-year point. She completes the first stage check within seven minutes on her phone. Her wellbeing score comes back below the threshold, and her work ability score is low. The results page is hers alone. It tells her, in plain language and without a diagnostic label, that she may be finding work harder than she should be, and it signposts her to NHS Talking Therapies, which she can self-refer to without asking anyone at work. It also signposts her to her employer's provision. She refers herself to the NHS. After two weeks of thinking about it, she tells her manager she is struggling with workload rather than with her health, which is the part she is ready to say. Five working days later, she meets with her manager and a conversation takes place. Her hours are rebalanced within a fortnight. She is never absent. Her employer never sees her answers. What they do see, three months later, is that the wellbeing scores in her division are materially below the rest of the business and below the sector benchmark. It also reveals that 11 other people have experienced similar issues but have not said anything. The wellbeing scores are paired with suggestions on evidence-based action that the company should take to rectify the situation. The senior team looks at workload and shift design in the relevant division and makes changes.

A 58-year-old man: a 14-person building company

Current Situation: His back has been getting worse for a year. There is no occupational health, no human resources and no employee assistance programme

at work. He continues to work until he can no longer do so and must then wait for 14 weeks for an NHS physiotherapy appointment. Six weeks later, the company has replaced him and he never works again.

In the Workplace Health System: His employer buys affordable provision through a pooled arrangement organised by the Combined Authority. He raises the pain in a work and health conversation. Within five working days he speaks to a named case manager who knows him and the role he carries out. Two things then happen at once. He gets faster access to physiotherapy. His duties are adjusted within 20 working days, so that he keeps working while he recovers rather than waiting to be well before returning. He is absent for nine days rather than five months. At six months he is still at work, and the company keeps hold of 30 years' worth of irreplaceable experience. His case is one line in the aggregate return his provider sends to the WHIU: an MSK issue, resolved without significant absence, sustained at six months.

A 41-year-old woman: a 250-person employer

Current Situation: Diagnosed with Crohn's disease at the age of 38, she has told nobody at work. Over the course of two years, she is absent for 22 days in short spells. None is long enough to trigger any support except the attendance policy. Twice she asks for a later start on bad days and is told to make an HR request which she does not follow through on. Her absences continue and in the third year she is taken through a capability process. She leaves the role before it concludes. By this point she is 41, has 15 years of experience, and does not work again for two years. She appears nowhere in her employer's disability data, because she never disclosed that status.

In the Workplace Health System: Two years before her diagnosis, data revealed that the company's disability retention rate was around half that of the closest comparable business in its sector. The declaration rate was also low. They make concerted efforts to redress this, and employees feel more able to disclose diagnoses and to ask for support. She raises her diagnosis in a work and health conversation, which asks about work rather than diagnosis. The conversation happens within five working days. Adjustments are agreed within ten working days and operational within 20. She is given a flexible start, home working during a flare and a phased working which are written into an adjustment passport that travels with her when she changes manager the following year. Her case manager keeps the plan aligned with her NHS specialist nurse, so treatment and work run alongside each other rather than in sequence. Her absence falls to a few days a year. She is still there at six months, which is when the retention is measured, and two years later she is running the account she would once have been moved off.

A 23-year-old: 900-person employer

Current Situation: He has autism and was diagnosed at 19. He does not say so on the application form, or in his first week. His desk is on an open-plan floor, he goes into meetings without agendas, and his work expectations are not written down. At

six months he is rated below expectation on communication and collaboration. He resigns before the review that would have started managing him out. He is out of work for 11 months and takes a job well beneath what he can do. He was never absent for a single day, so nothing in his employer's sickness data records that anything happened at all.

In the Workplace Health System: Before he arrived, his employer had discovered that it was recruiting disabled people at roughly the rate its sector did but then losing them 18 months later and at twice the rate. Absence data hadn't revealed much because the people leaving were not going off sick. Only retention, measured against declared disability and compared with peers, made it visible. The company had assumed for years that its problem lay in recruitment. By the time he joins the company, a work and health conversation is offered eight weeks after joining, and it asks what helps him do the job well. Written agendas, a quiet space, one named point of contact and expectations set out explicitly are agreed within ten working days and in place within 20 days. None of which costs the employer. His manager has been equipped to have the conversation about work rather than about diagnosis. He stays. Three years later he is leading a team, and the adjustments have followed him into the role rather than being renegotiated for it. His employer's aggregate return to the WHIU shows a retention gap closing. What that return does across a sector is more useful still: it tells an industry that its disability problem is not where it had been looking for it.

Chapter Seven: The Next Phase

How we intend to work

Our approach in the next phase is the same approach that brought us here.

We develop with Vanguards rather than for them. We are no longer making recommendations and waiting for someone else to implement them. Everything is being built and tested with the employers, providers, places and institutions that control the practical levers. The response so far has exceeded expectations, and we want more organisations to join.

We are single-minded about outcomes. We want to see sickness absence down, returns to work up, participation and retention of disabled people up - all measured consistently, shared confidentially and benchmarked back.

We publish as we go. We will share progress, updates and emerging thinking. Partly because a programme asking employers for data has no business being opaque about its own. Mostly because publishing invites the challenge that makes the next iteration better.

Our role is to stimulate system change, not to prescribe it. We therefore keep recommendations on process as simple as we can, focus wherever possible on measurable outcomes, and create the conditions for scale and access. Then we leave the question of what is suitable and practical to the people better placed to answer it, above all to those running smaller businesses.

We build the evidence that makes stronger incentives possible. The prize is a government able to align incentives against measurable outcomes, with the confidence that comes from knowing which outcomes respond to what. That confidence does not exist yet. Building it is the main work of the next 12 months.

Five priorities for the next phase

Complete and test the workplace framework

Expectations for employers and employees should be simple, clear and not overly prescriptive. The acid test is the SME employer. To get there we will:

- **Continue to work with BSI** to develop a standard whose success is measured by adoption across a broad range of employers, and by size and sector rather than by headline count.
- **Test and refine the employer commitments** working in collaboration with Vanguard employers of all sizes.
- **Refine and confirm the role of employees within the shared responsibility model**, and test the proposition with employees, disabled people, trade unions and representative bodies.

- **Support Vanguard employers who are already adopting the framework to gather and share learning.**

Establish affordable and accessible Workplace Health Provision

To make our proposed model of Workplace Health Provision accessible and affordable to all employers, we will:

- **Settle the minimum WHP specification:** Further work with Vanguards and providers to specify what every employer should be able to buy (with coordination and case management at its core) and identify where digital delivery can lower costs and extend reach.
- **Test affordability and access:** Test the minimum specification against likely costs of provision and explore routes to access for small employers through pooled buyers or insurance arrangements.
- **Learn from regional and employer Vanguards:** Partner with interested employers, providers, insurers and regional authorities to test aspects of our proposed WHP approach, and the opportunities for affordable access by small businesses.

Make better intelligence a deliverable proposition

Intelligence is the engine of transformation and to make it real we will:

- **Aggregate employer performance data**: Develop the form and function needed to aggregate performance data, common definitions and a benchmarking that employers can act on.
- **Test the concept and prototype of a Work and Health Toolkit,** working with the Civic Health Innovation Labs at the University of Liverpool and selected Vanguards to establish the requirements for 'social licence' and how to safely generate actionable insight for employees and employers.
- **Establish the WHIU:** Develop the organisational model for a WHIU, with the governance, independence and public reporting that make it trustworthy.

Work with places to develop and scale the Workplace Health System

The places we work with, Mayoral Strategic Authorities, County Councils and the Devolved Administrations, are essential for the development and scaling of the Workplace Health System.

We will enable and encourage, not prescribe.

We will build on the ideas, challenges and good practice we have heard to date to:

- **Develop our place-based testing approach, starting by testing the return-to-work and stay-in-work elements of the Workplace Health System** with SMEs. We will continue working with places as they strengthen and scale their systems approaches to work and health to meet the needs of local residents and business communities.

- **Support regional Vanguards and Devolved Governments** to convene local employers and stakeholders to design, implement and evaluate affordable and accessible WHP offers.
- **Test emerging data and intelligence models**, starting by surveying SMEs in two of our regional Vanguards on how they currently collect and use absence data.
- **Establish an innovation and learning exchange** connecting practitioners across our place-based Vanguards, and curating lessons and experience to share the practical realities, challenges and successes of testing, learning and implementing change.

Examples of place-based work and testing are provided in Appendix B.

Prepare the route to scale and the Spending Review

Ahead of the Spending Review in 2027, we will develop a plan for a phased roll-out of the new Workplace Health System.

This will aim to set out:

- **Evidence of what works** and the initiatives and practice we propose to take forward into adoption.
- **A clear plan to drive adoption**. This should include how we move from simply working with the Vanguard organisations to encouraging employers and providers across the UK to adopt the changes. We will consider how incentives should be aligned progressively as evidence accumulates. The plan will set out the decision points rather than leaving sequencing open-ended.
- **A devolved approach.** The adoption plan should outline how delivery will work through place and sector, and what Mayoral and Strategic Authorities need in order to lead it. We envisage setting a clear national framework but working with local leadership to ensure delivery works in the local and sectoral context.
- **Opportunities for join-up.** We will clearly set out what the implications and opportunities are for a step change in disability inclusion as well as how better workplace health support will, over time, benefit young people who are not currently in education, employment or training linking to the Government's plans for disability and young people priorities.
- **Any requirements for Government investment or spending.** We will develop areas where the Government may be required to invest to support the new system. However, within the shared responsibility model, we expect these to be limited and the system to be deliverable without large amounts of government spending.

A national movement is building and there is tremendous momentum across all four nations of the UK.

The task now, for us all, is to harness that momentum into a Workplace Health System, capable of changing outcomes and improving lives – at national scale.

As KBW moves into its next phase, we are energised and clear-eyed about the size and the scale of the opportunity that awaits.

And we remain fully committed to seizing it.

Appendix A: sources and evidence status

This draft draws principally on the published Keep Britain Working Discovery Report and Final Report, the June 2026 Story So Far, Health Foundation analysis on health as an economic asset, the emerging Workplace Health Provision and Work and Health Check specifications, and contributions from Vanguard employers, providers and places.

Appendix B: Work underway across places to develop and scale the Workplace Health System

Liverpool City Region (LCR): Through a series of co-delivered workshops, LCR is bringing local employers, a mix of large employers and SMEs, who are accredited against the LCR Fair Employment Charter, together to test draft return-to-work plans developed with the Employers Vanguard. The plans have been designed as a flexible tool to guide open, supportive conversations between an individual and their employer about their health needs at work, resulting in a shared set of practical next steps. *

Northern Ireland: We have been working with the Department of Communities to integrate Keep Britain Working into their wider focus on work and health through the Pathways to Work and Wellbeing Transformation Project. Following co-design workshops with employers earlier in the year, we will soon be testing draft stay-in-work and return-to-work plans with SMEs in Northern Ireland to understand how they can be most effective in the workplace. *

**In both Liverpool and Northern Ireland, we are working with SMEs from a range of sectors, including construction and social care*.

East Midlands Combined County Authority (EMCCA): Given the fundamental importance of data to the changed system, it's essential that we understand existing workplace health intelligence practices. To do so, we are working with EMCCA to survey employers in the region about how they are currently capturing and using sickness absence data in their businesses.

West Midlands Combined Authority: We are working with the West Midlands Healthy Supply Chains project to explore how larger employers can improve SME access and uptake of workplace health support through, for example, procurement relationships. This will highlight how larger employers in key sectors, initially in construction and social care, can use their influence within supply chains to improve SME access to, and uptake of, preventative health interventions.

Worcestershire County Council (WCC): WCC convened an employer conference attended by over a hundred local employers at which WCC launched a practical guide introducing the Healthy Working Lifecycle with practical tips on how to integrate the approach into a business.

Greater London Authority (GLA): As part of its commitment to have a workforce that reflects London's diversity, the GLA ran a successful campaign to encourage more staff to share their diversity data. Through storytelling, role modelling and direct

engagement, sharing of disability information by employees increased by 23%. Working through the London Anchor Institutions' Network, the GLA has supported employers across the city to encourage more staff to share their data, in a collective commitment to inclusive employment.

South Yorkshire Mayoral Combined Authority: South Yorkshire Mayoral Combined Authority is planning to trial independent, shared case managers sitting within businesses part-time to support employees with stay-in-work planning.

Hull City Council (HCC): The Hull Resilience Hub is a partnership between HCC and our Vanguard provider Latus to make workplace health services more affordable and accessible for local SMEs. This test of creating a buyer's pool to enable SMEs to access occupational health services at the same prices as large corporates is something we are looking to replicate in different formats in other places across the country including West Yorkshire Combined Authority and the North East Mayoral Strategic Authority.