

WORKING WITH ARTHRITIS



ARTHRITIS RESEARCH UK

Arthritis Research UK is the charity dedicated to stopping the devastating impact that arthritis has on people's lives. Everything we do is focused on taking the pain away and keeping people active. Our remit covers all conditions which affect the joints, bones and muscles including osteoarthritis, rheumatoid arthritis, back pain and osteoporosis. We fund research into the cause, treatment and cure of arthritis. We provide information on how to maintain healthy joints and bones and how to live well with arthritis. We also champion the cause, influence policy change and work in partnership with others to achieve our aims. We depend on public support and the generosity of donors to keep doing this vital work.

FOREWORD

Few among us have not at some time experienced problems with muscles and joints. Even when relatively mild, pain and stiffness can cause difficulties in moving, standing or walking, or lifting, carrying and holding things, or disturbing sleep. At worst the pain is persistent and relentless, often limiting the ordinary tasks of independent life.

Most often the problems ease; we recover, resuming daily life as before. But for many people, several million in fact, the problem is disabling, severely limiting and sometimes life-changing. Personal, family and social lives are undermined. People lose independence and the ability to do everyday activities that most of us take for granted. In the United Kingdom arthritis and other musculoskeletal conditions affect 10 million people. These conditions account for a third of all the years lived with disability.

To these private burdens and losses must be added the consequences for working life. Only 60% of working age people with persistent musculoskeletal conditions are in work. These conditions are now a leading cause of sickness absence. They account for a fifth of all working days lost through ill health in the UK.

Loss of work, even a reduction in the amount of work possible, brings further personal losses, financially and in social well being. And it brings economic costs to society.

Ensuring the most effective and timely health care and the practical support necessary for the best possible daily living are, of course, essential components of treatment and care and of rehabilitation, the journey to optimal recovery. But without regard to working life, occupation, and the conditions of work they are not at all sufficient. Entering, maintaining or returning to fulfilling and productive work calls for support and appropriate intervention beyond health care.

This report has been led by Arthritis Research UK, with input from the wider health and work sector. Its purpose is to help policy makers and people in supporting agencies: welfare, social services, voluntary bodies that play a vital part in representation and support, and – crucially – employers themselves, to better understand the needs and views of people whose working lives are significantly affected by arthritis and musculoskeletal conditions.

The evidence is clear that most people with these disabling conditions want to work. Indeed, with the right support and working arrangements, usually with modest adjustments, they can do so and be valued employees, often at high levels of achievement and fulfilment.

For those with persistent disabling conditions, whatever the cause, careful attention to the right type of work can contribute not only to successful and rewarding working life but also to good health and well-being generally.

We must enable these people to work in roles which are meaningful, fulfilling, flexible and adapted both to their skills and their capabilities. We must also give them confidence that there is a societal commitment to make this happen.

Reaching such a position must be a joint enterprise. Many agencies, several Government Departments, health and welfare agencies, and – crucially – employers must collaborate and from their different perspectives take a shared approach, in policy and in implementation, to answer the challenges. It means more than an agreed policy, it calls for a strengthened sense of purpose, better recognition of the proper needs of all people with long term conditions, not only musculoskeletal conditions although they are the most common.

We must encourage employers to take their full part in improving workplace health, making appropriate adjustments to working practices, and essentially to challenge a culture that underrates the skills, talents and drive and adaptability of so many people with long term conditions. They are a societal resource we must not neglect.

Employees too are not passive observers; they should be aware of rights that have been so determinedly earned, and to be willing to act constructively on them and confident they will be heard.

Professor Dame Carol Black DBE, MD, FRCP, MACP, FMedSci, Expert Adviser to the Government on Health and Work

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EXECUTIVE SUMMARY

Arthritis and other musculoskeletal conditions affect around 10 million people in the UK and are the most common diseases in our working population. These conditions include back pain, osteoarthritis and inflammatory conditions such as rheumatoid arthritis. The pain and fatigue they cause often makes working life hard. People who find standing and walking painful can have difficulty travelling to work and may have to stop doing physically demanding roles.

Having stiffness and pain in the arms or hands can make everyday tasks like keyboard work difficult and may slow people down. The unpredictable, fluctuating nature of musculoskeletal symptoms is a further challenge. People cannot plan their working week if they are not sure how far they will be able to walk the following day without pausing to relieve the pain, or whether they will be able to lift their tools. Ongoing pain can also lead to low mood and affect people's motivation to work.

Yet these are challenges that many people with arthritis and other musculoskeletal conditions overcome. Having the right type of job and appropriate support can be a really positive factor for people with a long-term condition. Julie has rheumatoid arthritis; she told us: *"I love my job. And, actually, that's one of the real helps even if I'm struggling, I get a lot of pleasure out of it. You don't want to give that up. You don't want the illness to take another thing from you."*

At a national level, the need to address musculoskeletal conditions in a work context is clear. Only two thirds of working-age people with a musculoskeletal condition are in work and these conditions are now the leading cause of sickness absence, resulting in a fifth of all absence – around 30.6 million working days lost each year. Back pain alone costs the economy an estimated £10 billion each year. Moreover, as the population ages and people are expected to lead longer working lives, a greater proportion of the working population will have musculoskeletal conditions.

People with musculoskeletal conditions often make adaptations so they can keep working. Some choose to change the type of work they do, reduce their hours, or become self-employed. A change in duties, flexible arrangements which allow people to work in comfortable settings and pace activity, and the ability to take emergency leave can help people with arthritis to stay in work. Some people are supported by special equipment, help with transport or improved workplace access. However, many people are reluctant to talk to their employer about their health and as a result too few have the help they need. A fear of being found unfit for work and being dismissed as well as a sense that colleagues and employers could not improve the situation prevent people from accessing support. People who have left work because of health issues may also need tailored support to start working again.

Closing the disability employment gap is a current focus of Government policy, and one that will only be met through a truly joint approach and a coordinated programme of interventions across the Departments of Health, Work and Pensions, and Business Innovation and Skills working together with Public Health England and the NHS. Employers of all sizes and sectors must also do more to improve awareness of musculoskeletal health, make appropriate adjustments and challenge stigma in the workplace. Individuals with musculoskeletal conditions must know their rights as employees and be willing to act on them.

Having a musculoskeletal condition can make work hard, but many people with arthritis want to work, and can do so with the right support. There must be greater awareness of the importance of musculoskeletal health in the workplace. Support to enable people with musculoskeletal conditions to remain in, or return to, work must be increased.

Recommendations

Supporting people with musculoskeletal conditions to stay in work

1. The **Access to Work** scheme should be supported by a greater than real terms increase in funding. The Department of Work and Pensions should undertake immediate and ongoing promotion of Access to Work to target people with musculoskeletal conditions.
2. HM Treasury should introduce fiscal incentives to encourage employers of all sizes to provide **workplace health and well-being initiatives targeting and promoting musculoskeletal health**, such as early referral and rehabilitation.
3. Public Health England should ensure that a musculoskeletal component is added to the **Workforce and Well-being Charter** within 2016–7, and should allocate resource to implement the Charter, to raise awareness among employers of their mandatory duties and of best practice.

Supporting people with musculoskeletal conditions to return to work

4. The future **Health and Work Programme** should provide services appropriate for people with musculoskeletal conditions and complex co-morbidities, and should be designed with input from professionals with expertise in these conditions. If Work Choice is not maintained as a separate specialist disability employment programme, the new Health and Work Programme should provide comparable, or better, support for people with additional needs arising from their health or disability.

Innovation and data

5. The Joint Health and Work Unit's **Health and Work Innovation Fund** should be used to pilot interventions to support people with musculoskeletal conditions to return to work, and to prevent work loss related to musculoskeletal conditions. This should include interventions targeted towards prevention, short-term absence (e.g. early-intervention clinics) and long-term absence (e.g. Individual Placement and Support (IPS)). All studies should include health-economic evaluation and scalability and should be robustly evaluated by a national expert panel and academic peer review.
6. **Work status should be systematically recorded in health records**, including for people with musculoskeletal conditions. Work should be routinely considered as a clinical outcome and systematically included as a health outcome measure for people with long-term conditions in all national and local outcomes frameworks.

Julie is self-employed and works despite the intense pain of rheumatoid arthritis

Julie is a self-employed photographer who specialises in portraits. She developed rheumatoid arthritis seven years ago. Having initially been intolerant to methotrexate (a drug often used to treat inflammatory arthritis which can have strong side-effects), she managed the condition for six years by using acupuncture and modifying her diet. However, her pain recently escalated and so she has started a different drug combination therapy. This will take around 12 weeks to work and has to be carefully monitored. While the drugs have yet to reduce the pain she experiences, Julie already has side-effects including migraine and continuous nausea. She feels the treatment suppressing her spirit, making her really low.

"It makes you feel quite isolated because it's invisible. To everyone else you look exactly the same but you're in a huge amount of pain every day. It's exhausting. You can't control it."

The pain of rheumatoid arthritis, and its unpredictable nature, are hard to deal with. Being self-employed means that turning down work just isn't an option. When the pain is really bad, Julie struggles with the equipment and has to use a tripod as she cannot lift her camera. She sometimes pays for an assistant.

"It is just really, really hard, you don't know when you are going to have a flare-up, you've got no idea what your joints will feel like the next morning. And if I'm doing a photography job I can't ring up the next morning and say I'm not turning up, my hands hurt. I just can't. So you have to do it no matter what you feel like. There's no sick pay, I'm self-employed ... It's really hard sometimes to hold the camera."

The costs of treatments and the time Julie spends being treated are a real issue. Julie has fortnightly visits to the hospital for blood tests, and queues to see both nurses and pharmacists. Even avoiding busy times, each visit means a half-day off work, and she cannot book work on days when she has appointments as it is so uncertain how long they will take.

Beyond work, the condition also has a massive impact on Julie's family. There are days when she cannot walk the children to school, even though it is only five minutes away, and she has to leave them with neighbours; her family worry about why she has to go to the hospital so much.

"At least I love my job. And, actually, that's one of the real helps at least even if I'm struggling, when I get to someone's house to photograph them, I get a lot of pleasure out of it... You don't want to give that up. You don't want the illness to take another thing from you."



1. INTRODUCTION

1.1 Working with musculoskeletal conditions

Musculoskeletal conditions affect around 10 million people in the UK. They can broadly be divided into three groups: inflammatory conditions such as rheumatoid arthritis and ankylosing spondylitis; conditions of musculoskeletal pain including osteoarthritis and back pain; and osteoporosis and fragility fractures (see Figure 1). These conditions affect people's ability to work in different ways, and whether someone with a musculoskeletal condition can work will depend on the individual, the job they do and the support they have. Many people with musculoskeletal conditions work full-time, some choose to adapt their working hours or the kind of job they do, some have periods of sickness absence, and others leave work altogether.

Overall, people with a musculoskeletal condition are less likely to be in a job than those without one, and for those in work, sickness absence is higher among people with a musculoskeletal condition.^{1,2} In addition, some musculoskeletal conditions are caused or made worse by work.³ However, while having a musculoskeletal condition can make working life challenging many people with a musculoskeletal condition want to work, and can do so with the right support.

1.2 Report overview

Arthritis Research UK held a symposium 'Working with musculoskeletal conditions' in June 2015 (see 8.1). Policy leads, healthcare professionals, academics and employers joined people with musculoskeletal conditions to discuss current initiatives around musculoskeletal health and work, and to identify opportunities for action. The discussion and outputs of the workshop informed this report alongside feedback from wider stakeholders. We are grateful to everybody who contributed.

This report describes the impact of musculoskeletal conditions on the UK workforce and gives the perspectives of people with musculoskeletal conditions about working life. It considers current health and work policy and programmes, the health and work research agenda and relevant employment legislation. It also highlights some examples of good practice by employers, and sets out a series of recommendations to address the needs of people with musculoskeletal conditions who want to work. The report is intended for policy makers, healthcare professionals, employers, academics and individuals with an interest in health and work.

Arthritis Research UK is committed to ensuring the views of people with musculoskeletal conditions inform our policy work. The experiences of people with musculoskeletal conditions about working life are told in their own words.

"I have degenerative osteoarthritis of the spine and have had two knee replacements due to osteoarthritis. My work has been fantastic. I do not have to hot desk, I have my own work station adapted to my needs. I do flexi hours so I do not have to drive in rush hour traffic. ... I am fully supported by all of my colleagues."

Linda has osteoarthritis and works flexi-time

Figure 1: Three groups of musculoskeletal conditions

Group	1: Inflammatory conditions	2: Conditions of musculoskeletal pain	3: Osteoporosis and fragility fractures
Example	Rheumatoid arthritis	Osteoarthritis	Fracture after a fall from a standing height ⁱ
Age	Any	More common with rising age	Mainly affects older people
Progression	Often rapid onset	Gradual onset	Osteoporosis is a gradual weakening of bone. Fragility fractures are sudden discrete events
Prevalence	Common (e.g. around 400,000 adults in the UK have rheumatoid arthritis ⁴)	Very common (e.g. 8.75 million people in the UK have sought treatment for osteoarthritis ⁵)	Common (e.g. around 89,000 hip fragility fractures occur each year in the UK ⁶)
Symptoms	Common musculoskeletal symptoms include pain, joint stiffness and limitation of movement. Symptoms often fluctuate in severity over time		Osteoporosis itself is painless. Fragility fractures are painful and disabling
Extent of disease	Can affect any part of the body including skin, eyes and internal organs	Affects the joints, spine and pain system	Hip, wrist and spinal bones are the most common sites of fractures
Main treatment location	Urgent specialist treatment is needed, and usually provided in hospital outpatient departments	Primary care for most people; joint replacement requires hospital admission	Primary care for prevention. Hospital for treatment of fractures
Interventions	A range of drugs and support	Physical activity, pain management. For severe cases joint replacement may be necessary	Bone strengthening drugs and fracture liaison services reduce future fracture risk. Fractures may require surgery
Modifiable risk factorsⁱⁱ	Smoking	Injury, obesity, physical inactivity	Smoking, alcohol intake, poor nutrition including insufficient vitamin D, physical inactivity

Back pain is very common: around 9 million people in England have back pain, and for 5.48 million the pain is severe.⁷ Low back pain (LBP) is a leading cause of years lived with disability worldwide.⁸ Back pain tends to be episodic, with the majority of episodes settling within 6 weeks.⁹ Around 9% of adults consult their GP for LBP each year.¹⁰ Treatment is usually in primary care and includes remaining active, doing appropriate exercise and taking painkillers. In more severe cases, physiotherapy, occupational therapy, additional medication or surgery may be helpful.

ⁱ Osteoporosis is a condition of bone weakening which is itself painless. Fragility fractures caused by osteoporosis happen when frail bones break, causing pain and disability. More generally, bone fractures can be due to trauma or injury.

ⁱⁱ Non-modifiable risk factors include age, sex and genetics

Sandra took redundancy because of osteoarthritis

Sandra had been in full-time work since she was 16, and was working as a bookseller when she began to get pain in her knees. The job was varied, but she spent most of the day on her feet, pushing trolleys of books and working in the packing area. Her job involved a lot of standing, bending and lifting. When the pain in her knees became really bad, Sandra took time away from work. Scans confirmed she had osteoarthritis in both knees.

Sandra knew that circumstances at her work were changing with some staff redundancy. She believed in the future the job would continue to involve working on the shop floor and she could not see a forward plan. She was in pain and thought redundancy was the right decision.

Sandra had physiotherapy and six treatments of acupuncture and now continues to do a series of exercises as well as taking painkillers to manage. Despite this, she is unable to stand for long periods, and walking even with two sticks has become very painful. She does not go out often, and is dependent on her husband to take her out in the car, as well as to help her around the home, for example getting her in and out of the bath. The pain and severity of the osteoarthritis varies; on good days she is able to do things around the house, on other days she cannot do anything.

Sandra would like to be working, but worries about how she would cope – how she would get there, whether she could access the toilet and locker room, and what could happen in a fire. The unpredictable nature of osteoarthritis is another barrier:

"I don't have the confidence to go back to work. Any employer wouldn't last long with me because my attendance would be appalling, even on one or two days a week. You can't tell in advance when you will have pain."

Sandra had a work capability assessment, which she described as "a very hard interview... there was no chance to explain, very closed questions ... they didn't ask about our circumstances at home". Sandra has been advised she is fit for work. Her appeal is pending.



2. IMPACT OF MUSCULOSKELETAL CONDITIONS ON THE UK WORKFORCE

Musculoskeletal disorders are the most prevalent diseases in the UK working population.¹¹ The impact they have on the UK workforce can be seen through lower employment rates, increased sickness absence and presenteeism.

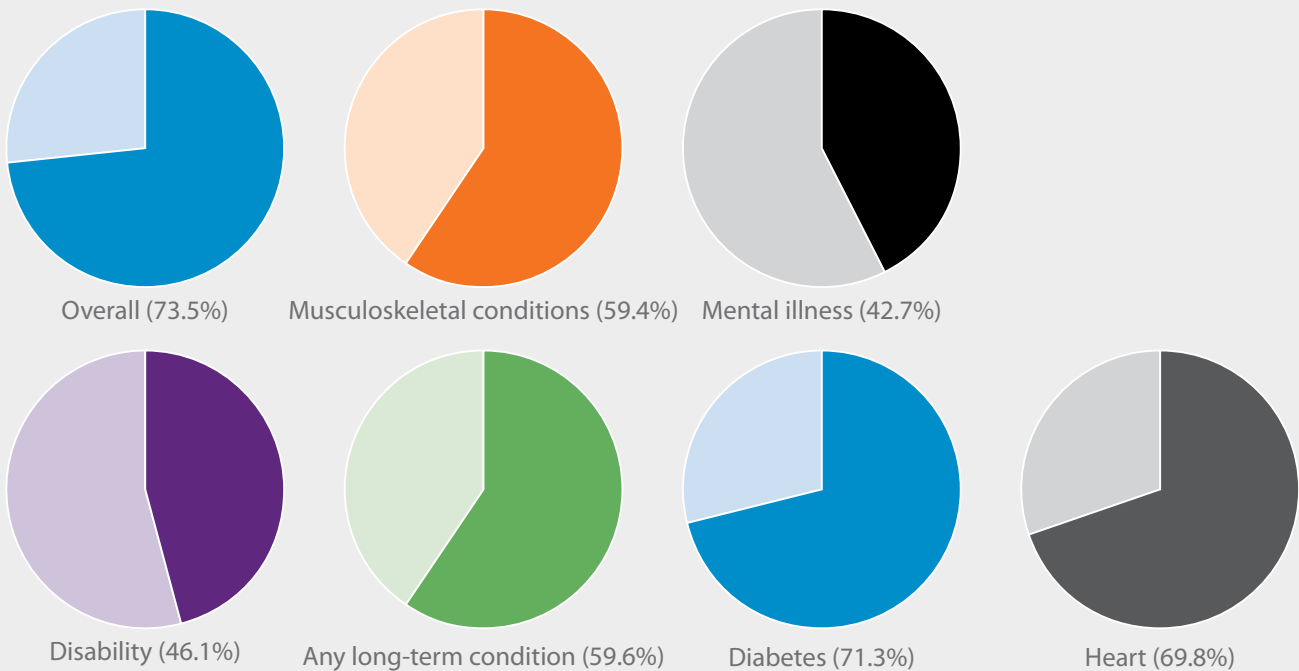
Only 59.4% of people of working age with a musculoskeletal condition are in work. ¹²	Musculoskeletal problems account for the greatest number of working days lost at 30.6 million days each year in the UK. ¹³
Musculoskeletal disorders are the most prevalent diseases in the UK working population. ¹⁴	35% of the days lost due to work-related ill health are due to musculoskeletal conditions. ¹⁵

2.1 Employment rates – people with musculoskeletal conditions who are out of work

Currently only 59.4% of people with a musculoskeletal condition of working age are in work.ⁱⁱⁱ This compares poorly with other chronic long-term conditions. For example, 71.3% of people with diabetes and 69.8% of people with heart disease are in employment, although the rate of employment among people with mental health problems is even lower (42.7%).

Overall, the employment rate among people of working age with a disability (46.1%) or a long-term health condition (59.6%) in the UK is substantially lower than for those without any health problem or disability (73.5%).¹⁶

Figure 2: Employment rates in people of working age¹⁷



Employment rates for people aged 16–64 in the UK, taken from the Labour Force Survey.

iii Defined in this dataset as problems with 'arms or hands', 'hands or feet' and 'neck or back'.

Inflammatory forms of arthritis such as rheumatoid arthritis and ankylosing spondylitis often affect people early in their working lives. Around three quarters of people with rheumatoid arthritis are of working age when they are first diagnosed.¹⁸ A third of people with the disease will have stopped working within two years of onset and half are unable to work within ten years.^{19,20} The average age of onset for ankylosing spondylitis (inflammatory arthritis of the spine) is 24 years. Around 15% of people with ankylosing spondylitis are unable to work and 25% retire early due to ill health.^{21,22,23}

“My former employers were very helpful and supportive. As a technical editor, my job was all screen/keyboard work. They provided me with a touchpad mouse, a chair with arms (so I could get up more easily) and voice-recognition software. I also used my own keyboard with programmable keys. All these things helped enormously with finger joint problems. I particularly recommend the touch pad mouse and keyboard for anyone with rheumatoid arthritis in their fingers whose work involves a lot of time on a computer.”

Angie, retired technical editor

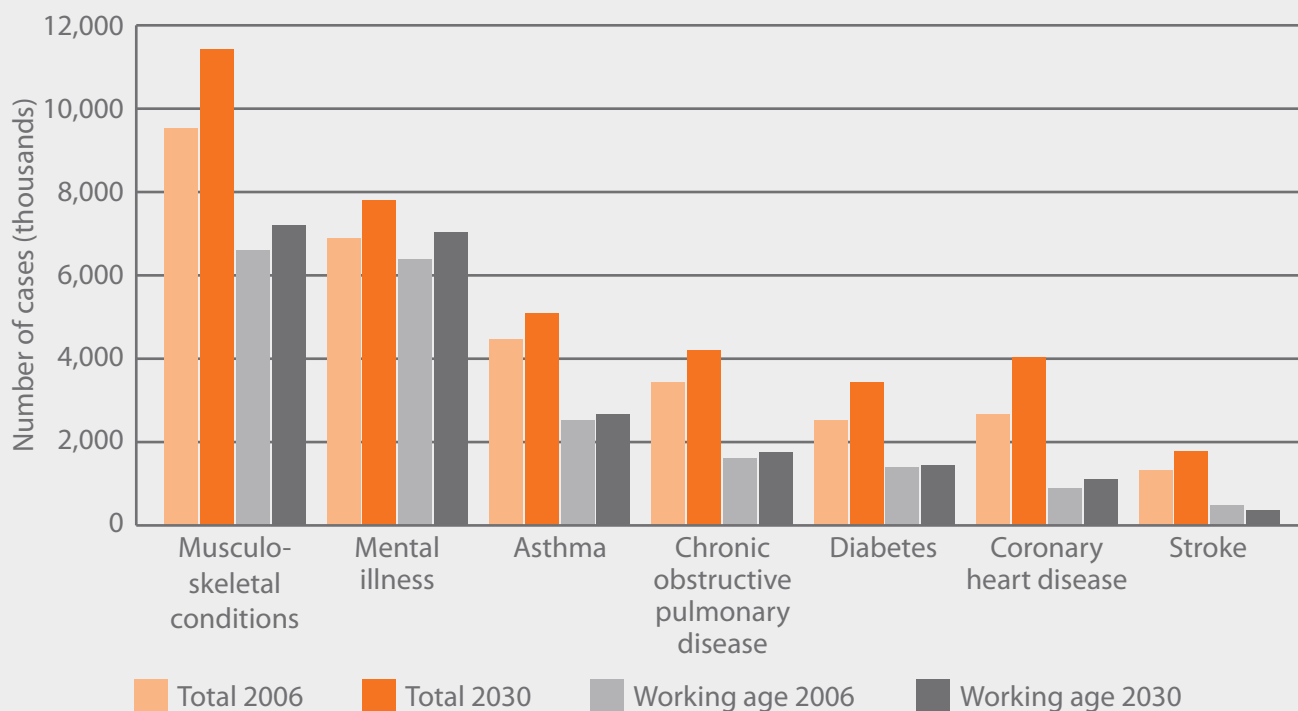
Osteoarthritis is the most common musculoskeletal condition in older people. Around a third of people aged 45 years and over in the UK have sought treatment for osteoarthritis.²⁴ Surveys suggest that a third of people with osteoarthritis retire early, give up work or reduce the hours they work because of their condition.²⁵

Back pain is a symptom rather than a disease and tends to be episodic, with the majority of episodes settling within 6 weeks.²⁶ Long-term absence from work is greatest among people with chronic back pain (where pain lasts for more than 12 weeks) or recurrent back pain (where people have several episodes of pain lasting less than six months within a year).²⁷ Across Europe, only around 41.9% of people with back problems are in employment.²⁸

2.2 Sickiness absence and musculoskeletal conditions

As well as causing people to give up work, musculoskeletal conditions also cause difficulties among working people. They are the most common diseases in the UK workforce and are increasing. Estimates suggest that by 2030 the UK working population will include 7 million people with a musculoskeletal condition.²⁹

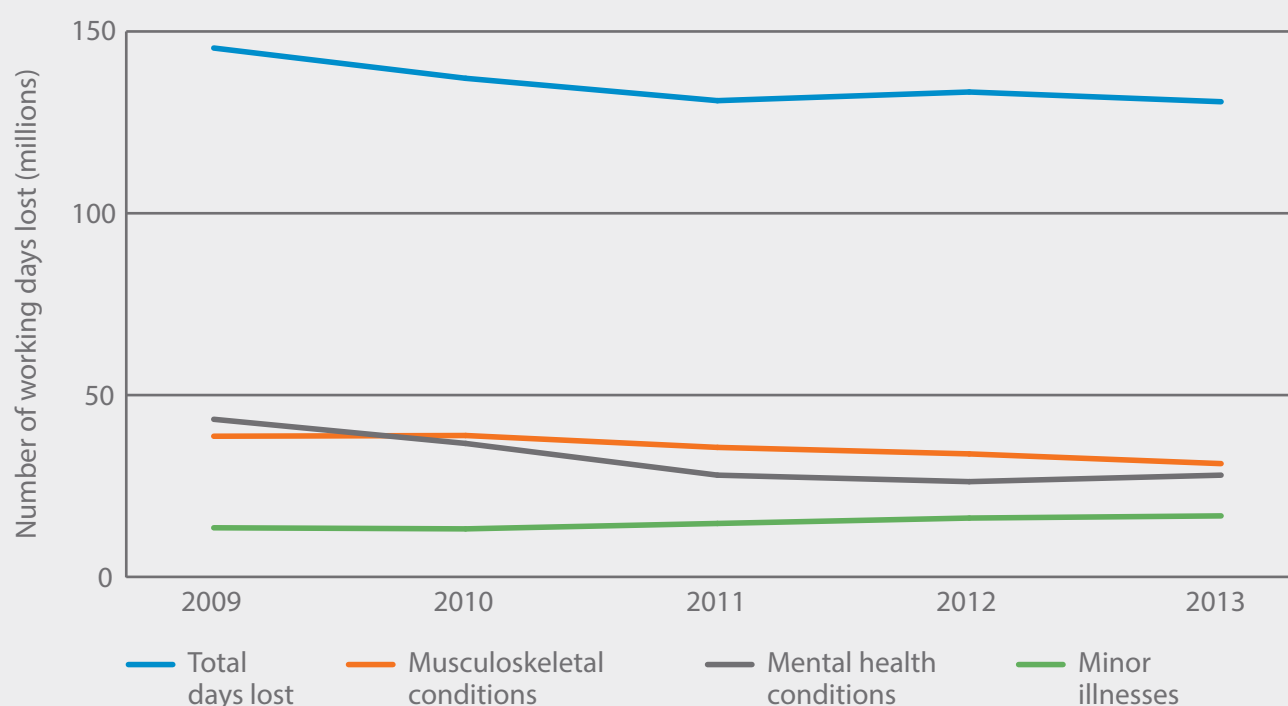
Figure 3: Projected cases of diseases in the UK population and working population 2006-30³⁰



Musculoskeletal conditions are a major cause of sickness absence. **In 2013, back pain, neck pain, upper limb problems and other musculoskeletal problems together accounted for the greatest number of working days lost in the UK at 30.6 million days.**³¹ They were the reason for sickness absence in 20% of cases. In the same year, mental health problems contributed to 15.2 million working days lost and were the reason for sickness absence in 9% of cases. In comparison, the most common reason for sickness absence, accounting for 30% of cases, was minor illnesses such as cough and colds. These illnesses tend to have a shorter duration and accounted for a total of 27.4 million days lost.

Although there has been a downward trend in working days lost due to ill health since 2009, in 2013 a total of 131 million days were lost to sickness in the UK, an average of 4.4 days per worker.^{32, iv} People with musculoskeletal conditions are above this average, with surveys across a range of musculoskeletal conditions finding that people take on average 7 days per year and people with rheumatoid arthritis as many as 40 days per year.^{33,34}

Figure 4: Sickness absence in the UK



Data taken from Office of National Statistics (2014).
Full Report: Sickness Absence in the Labour Market.

Sickness absence patterns

Surveys of employers have found that short-term and long-term sickness absences have different causes. Around 80% of absence spells are short-term, but fewer, longer spells of absence make up around half of working days lost.³⁶ Back pain is the second most common cause of short-term absences after minor illnesses (such as colds, flu and sickness).

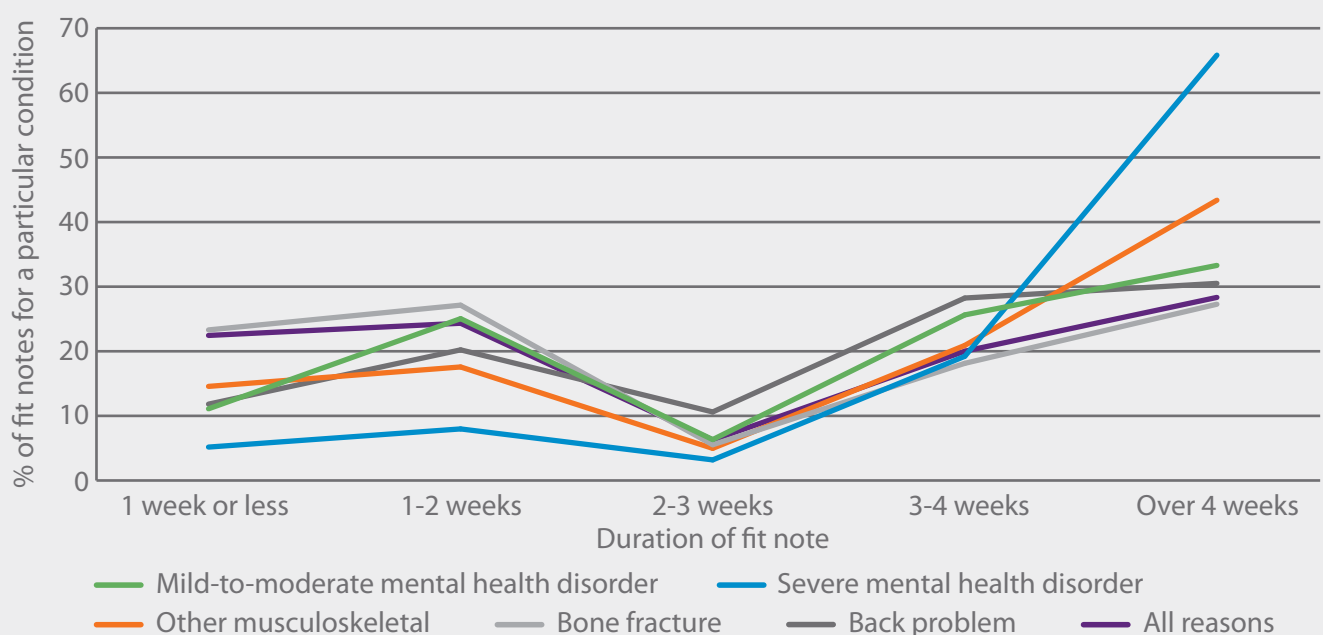
Medium-term absence has mixed causes including problems associated with joints or muscles and back pain as well as minor illness and mental health problems. Long-term absences are commonly caused by problems associated with joints or muscles, back pain, mental health problems and cancer-related illness.³⁷ There are also differences according to the nature of work involved. For both short- and long-term absence, back pain is a more common cause among manual workers than for those in non-manual work.³⁸

Figure 5: Causes of short-term and long-term sickness absence³⁹

	Short term (four weeks or less)		Long term (four weeks or more)	
Rank	Manual	Non-manual	Manual	Non manual
1	Minor illnesses	Minor illnesses	Acute medical conditions (e.g. stroke)	Stress
2	Back pain	Musculoskeletal injury	Musculoskeletal injury	Acute medical conditions (e.g. stroke)
3	Musculoskeletal injury	Stress	Stress	Mental ill health
4	Stress	Back pain	Mental ill health	Musculoskeletal injury
5	Home/family responsibilities	Recurring medical condition (e.g. asthma)	Back pain	Recurring medical condition (e.g. asthma)
6	Recurring medical condition (e.g. asthma)	Home/family responsibilities	Recurring medical condition (e.g. asthma)	Back pain
7	Mental ill health	Mental ill health	Injury/accidents not related to work	Injury/accidents not related to work

Since 2010, fit notes have been issued by GPs to employees to provide evidence of sickness to their employer for absences of over a week.⁴⁰ Between 2011 and 2013 around 9% of fit notes were issued due to back problems (including back pain and back injury) with a further 4.5% being for other musculoskeletal conditions (including osteoarthritis, arthritis and tennis elbow) and an additional 2.3% for bone fractures, a total of 15.8%. In comparison to other conditions, fit notes issued for back problems were often relatively short term, with half of fit notes for back problems being for two weeks or less. In contrast, the highest proportion (43%) of fit notes issued to people with a musculoskeletal disease *other than* a back problem were over four weeks in duration.

From February 2016, the Department of Work and Pensions (DWP) will analyse fit note data at general practice level to provide a better understanding of sick leave across the country.⁴¹

Figure 6: Length of fit notes issued for different health reasons

Data from Department of Work and Pensions (Jun 2013).

Evaluation of the Statement of Fitness for Work (fit note): quantitative survey of fit notes.

People with musculoskeletal conditions may be more likely to return to work after sickness absence than those with other illnesses. For example, survey data has found that people with musculoskeletal injuries or back pain were more likely to return to work after an absence of four weeks or longer than people with other reasons for absence. In a study by the Chartered Institute of Personnel and Development, 85% of people with musculoskeletal injuries and 82% of those with back pain returned to work. However, a significant group of 15–17% with these conditions did not.⁴²

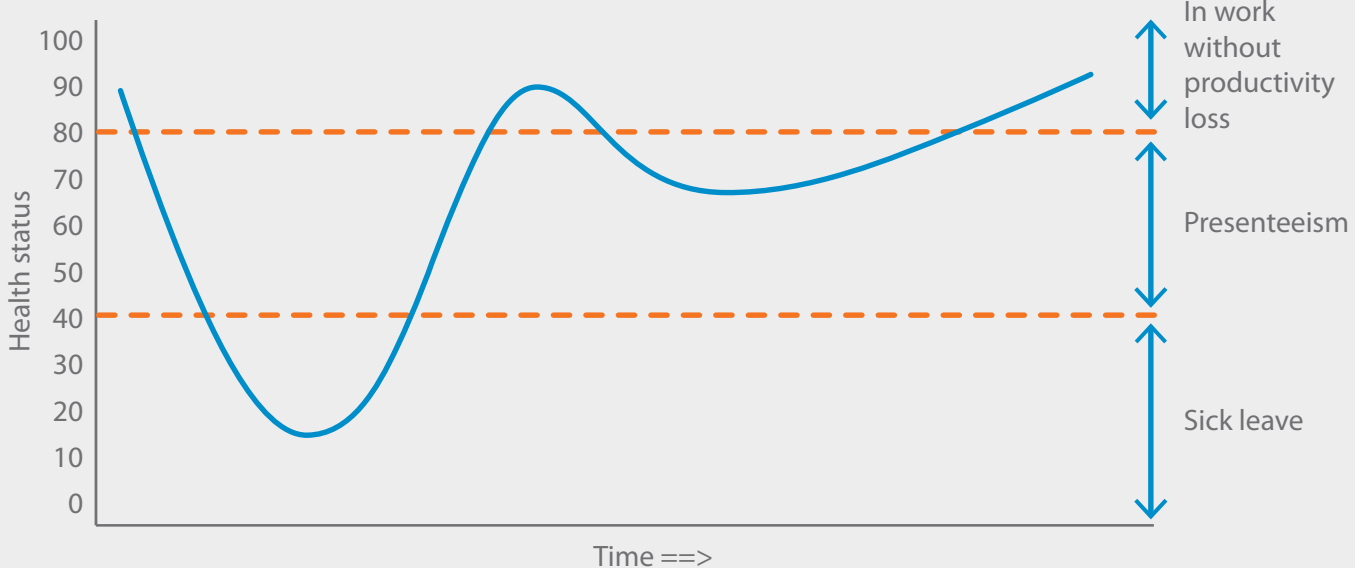
Figure 7: Return to work rates after absence of four weeks or longer⁴³

	Musculoskeletal injuries	Back pain	Stress	Mental ill health	Acute medical conditions	Other conditions
% return	85	82	80	75	66	78

2.3 Presenteeism – lost productivity within work

In addition to worklessness and sickness absence, long-term conditions result in presenteeism – people who are in work, but not working as effectively as they could. Although the true extent of presenteeism is hard to determine, it is significant – 40% of people with a long-term condition say that their condition affects their work, and in a 2009 survey, 57% of working adults said they had been to work in the last year when really they were too ill.^{44,45} Estimates suggest that the costs of presenteeism to UK businesses from mental illness are 1.5 times the cost of sickness absence.⁴⁶ Although research in people with arthritis has mainly focused on absenteeism, there is growing awareness of the socio-economic consequences of presenteeism. Current research aims to understand how people with inflammatory conditions move between periods of working, presenteeism and sick leave and the long-term consequences of going through these phases several times.⁴⁷

Figure 8: Fluctuating conditions, presenteeism and absenteeism



This graph shows the work status of a person with rheumatoid arthritis over time. Whether or not a person can work depends on their health (flare and remission), personal factors (age and financial situation) and environmental factors (job type and company size). If the pattern of 'in-work, presenteeism, sick leave' repeats over time, it may become harder for the individual, their employer and colleagues to maintain effective working life, and this may lead to work disability or to early retirement.⁴⁸

2.4 Work-related ill health and injury – musculoskeletal conditions caused or made worse by work

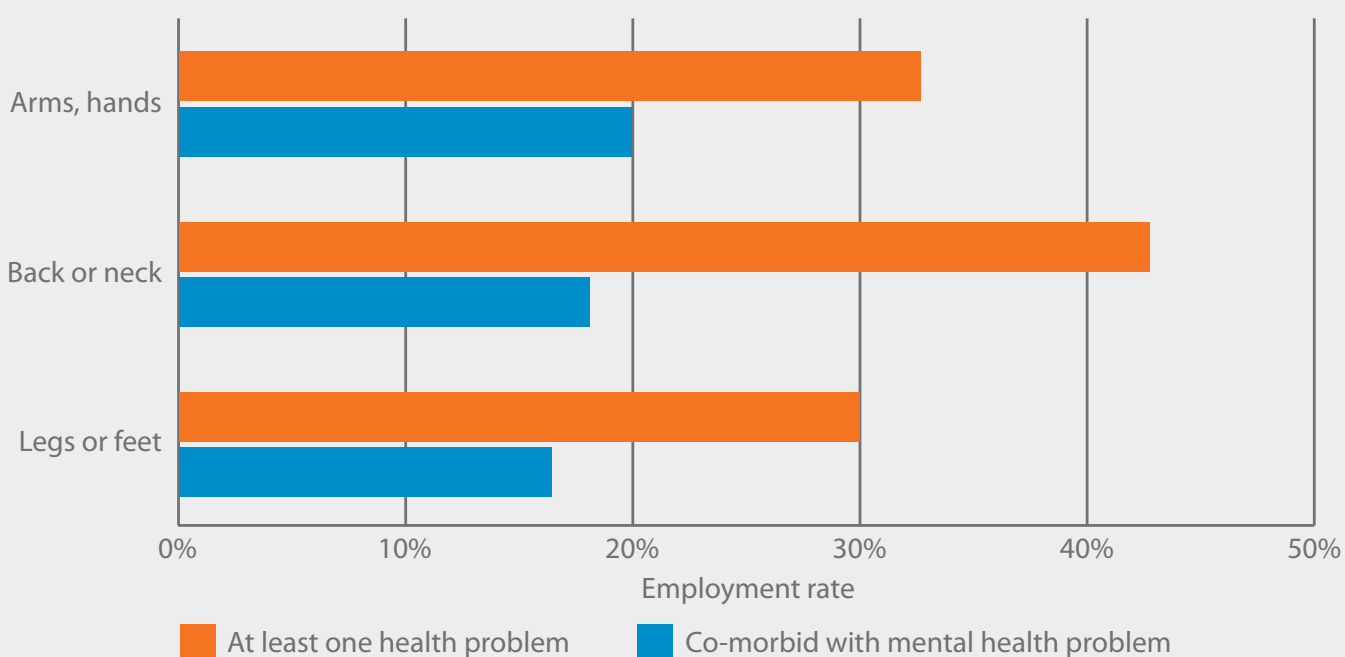
People often report that their musculoskeletal disorders (especially problems affecting the back, upper limbs and neck, or lower limbs) are caused or made worse by their work. The same is reported of common mental health problems such as stress, anxiety and depression. Overall, 1.24 million people in the UK reported a work-related illness in 2013–4, including 535,000 new cases; a total of 23.5 million working days were lost due to illness caused or made worse by work. In 2013–4, around 526,000 people, including 184,000 new cases, had a musculoskeletal disorder caused or made worse by work. This resulted in 8.3 million working days lost, 35% of the days lost due to work-related ill health.⁴⁹ In comparison, 487,000 people, including 244,000 new cases had a mental health problem caused or made worse by work, and 11.3 million working days were lost.

Those occupations most commonly associated with being caused or made worse by work involve manual handling, working in awkward or tiring positions, keyboard work or repetitive activities. Therefore, the highest burden of days lost due to work-related musculoskeletal conditions are in the construction, transport and storage and human health and social work industries. The specific occupations affected include skilled trade occupations, process, plant and machinery operatives and elementary occupations.^v

2.5 Musculoskeletal disease and mental health at work

Musculoskeletal and mental health are common co-morbidities. The relationship between physical and mental health is considered by many to be bi-directional – i.e. the two conditions influence each other.⁵⁰ Pain can be the linking factor, it is a common symptom of musculoskeletal conditions, and depression is four times more common for those people in persistent pain than in those without.^{51,52,53,54} Over 32% of working-age people with musculoskeletal disorders have co-morbid depression.⁵⁵ Among inflammatory arthritis patients, depression is a frequent co-morbid condition that predicts work disability.⁵⁶ Recent analyses indicate people with a mental health problem alongside a musculoskeletal problem are less likely to be in work.⁵⁷

Figure 9: Employment rates of people with musculoskeletal conditions with a co-morbid mental health problem⁵⁸



^v Occupations which require the knowledge and experience necessary to perform mostly routine tasks, often involving the use of simple hand held tools and, in some cases, requiring a degree of physical effort.

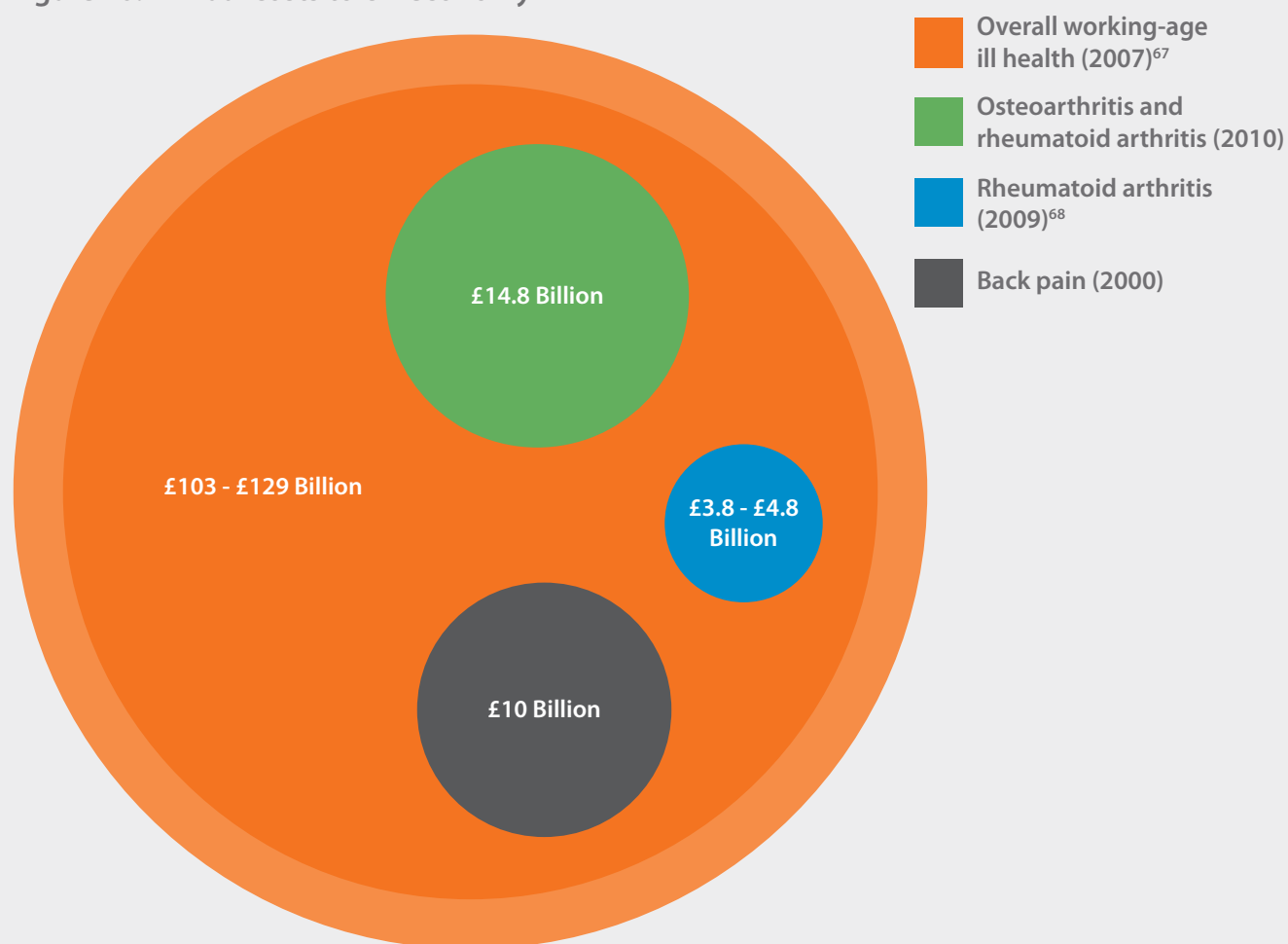
2.6 Musculoskeletal disease and the ageing workforce

In line with general population trends, the UK's working population is ageing. Estimates suggest that a third of the UK's labour force will be aged 50 or over by 2020.⁵⁹ Musculoskeletal conditions, along with circulatory problems, depression and diabetes are more common in older people. While most health problems are associated with lower employment, musculoskeletal issues and mental health problems are recognised as particular problems among older workers.⁶⁰ For example, older workers who report depressive symptoms or impaired physical mobility, especially with lower limb pain and shortness of breath, are more likely to retire early.⁶¹ There is a growing need for support to ensure the increasing number of older people with musculoskeletal conditions remain in employment.

2.7 Economic costs

The overall costs of working-age ill health fall on individuals, employers, the health service and the wider economy. Approaches to calculating costs vary. However, in 2007 the total annual costs to the UK economy of working-age ill health, including lost productivity, sickness absence, informal care and NHS healthcare costs were estimated to be £103–129 billion.⁶² This is more than the annual cost of the NHS. The cost of musculoskeletal ill health is a significant part of this overall cost. For example, the annual work-related costs of ankylosing spondylitis alone due to early retirement, absenteeism and presenteeism are estimated to be £11,943 per person.⁶³ Rheumatoid arthritis has been estimated to cost the UK economy between £3.8–4.8 billion per year, the combined costs of rheumatoid arthritis and osteoarthritis £14.8 billion and a further £10 billion of indirect costs are attributable to back pain.^{64,65,66}

Figure 10: Annual costs to UK economy



Arthritis limited Cathy's career choices and made travelling for work very difficult

Cathy is 62 and had a career in education, initially as a teacher and later as a consultant working on various projects including teachers' professional development, inspection and a content designer for an academy chain. She stopped working in 2015 and now volunteers on a weekly basis at a local primary school, acts as a lay member for her local hospital trust and as a lay reviewer of patient information leaflets, and cares for her parents.

Cathy was diagnosed with rheumatoid arthritis in 2008 and also has osteoarthritis. She currently manages her rheumatoid arthritis without drug treatment, as it is in a quiet period. Due to the osteoarthritis in her knee, Cathy finds standing difficult and can no longer cycle or go for long walks. As her hands are unaffected, she likes driving *"because it gives me movement that I don't get on my feet."*

Arthritis has affected Cathy's career at different stages. When her work contracts were coming to an end, Cathy's lack of mobility prevented her from returning to full-time teaching. She moved to working from home, which gave her more flexibility, but her arthritis continued to impact on her work.

"Being freelance, you're only as good as the work you do. So you do think about ways to get around it. Being paid on a daily rate, money was quite good and I was able to choose quieter trains and take taxis when I had to travel."

Travel, especially into or across London, was a particular challenge. Cathy found it difficult to walk from the train station and on and off the tube. She used a lot of taxis, but this was not always an option. If she had to walk she had a few strategies: *"I knew all the walls where I could sit and take a break."*

One of the biggest impacts of having arthritis which affected Cathy's working life, but also extends beyond it, is the extra time it takes to plan activities, especially travel.

"Before I had knee problems, I had time. I use to get to the station with a few minutes to spare and get to the train and off I'd go. Now I like to leave at least 20–25 minutes before the train. I have to make sure I get there in my own time and have time to park the car, walk to the station and get my ticket at my speed. Whereas before I just did my work, now all journeys have to be planned. I never used to do that before, I would have just gone."



3. WHAT DO PEOPLE WITH MUSCULOSKELETAL CONDITIONS TELL US ABOUT WORKING LIFE?

3.1 Working with musculoskeletal conditions

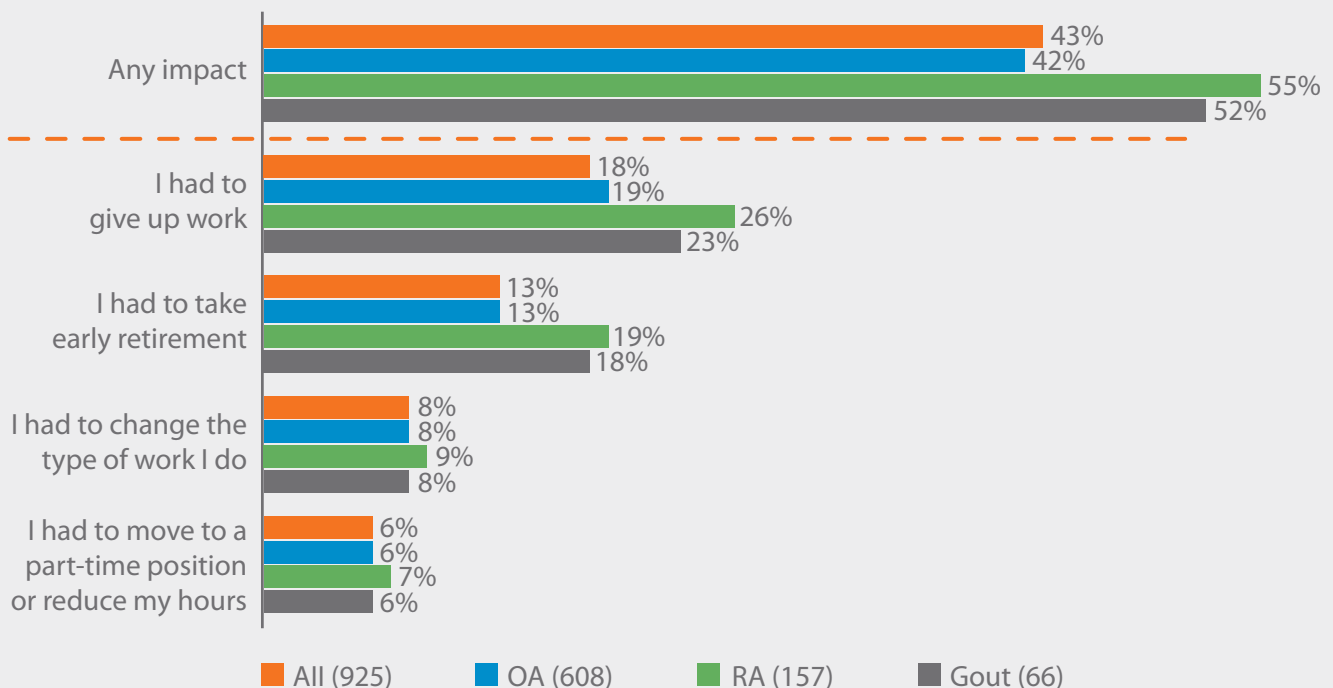
The challenges people with musculoskeletal conditions face in their working lives, and the value they place on being able to work, is clear. Surveys have captured the views of people with a particular condition (e.g. rheumatoid arthritis) or a broader range of musculoskeletal conditions, as well as the views of people both in and out of work (see 8.2).

3.2 Impact on working life: changing jobs, reducing hours and giving up work

A high proportion of people with musculoskeletal conditions say that their condition affects their ability to work. In the Arthritis Nation survey, 43% of working-age people diagnosed with arthritis (including osteoarthritis, rheumatoid arthritis or gout) said their condition impacted on their own working life, or on their partner's working life where their partner assumed a caring role for them.⁶⁹ In the Big Benefits Survey, 80% of people with a musculoskeletal condition reported that their impairment or health condition limited the hours they could work and 88% said that it limited the range of jobs they could do.⁷⁰ In a survey of people with rheumatoid arthritis, only 14% of working people felt that it had not affected their employment in some way.⁷¹

Fatigue, pain and the physical limits that musculoskeletal conditions cause (e.g. restricted dexterity or mobility) are aspects that people with arthritis often say limit their ability to work. Additional factors which can act as barriers to employment include the need to take sick leave, inability to travel to work, a lack of employer support, the need for adaptations to carry out a role, problems with colleagues and a lack of family support.^{72,73}

Figure 11: Impact of arthritis on working life⁷⁴



Responses from the Arthritis Nation survey (2014).

Participants were asked if their arthritis affected their working life, or their partner's life.

Some people with musculoskeletal conditions keep working by **changing their working hours, changing jobs** or by becoming self-employed to give themselves more control over their working patterns. In a study of people with a range of musculoskeletal conditions, 12% said they had reduced the number of hours they worked or changed jobs.⁷⁵ Among people with rheumatoid arthritis, 21% of people still working said they had changed job to allow for changes in their physical abilities.⁷⁶

A substantial proportion of people with musculoskeletal conditions, in particular people with inflammatory forms of arthritis, are unable to keep working. The proportion of people with arthritis that have given up work or taken early retirement may be as high as one in four.⁷⁷ The Arthritis Nation survey found that 26% of working-age people with rheumatoid arthritis had given up work, and 20% had taken early retirement.⁷⁸ The financial implications of giving up work or working reduced hours are a significant concern for people with musculoskeletal conditions.

3.3 Staying in work: stigma, support, awareness and the wider system

People with musculoskeletal conditions may **be reluctant to be open** about the nature of their condition with their managers or with co-workers. This can be because they fear losing their job or do not believe that managers or co-workers would help them manage their condition more effectively.⁷⁹ For example, in a recent study, 30% of people with ankylosing spondylitis were concerned about discrimination from employers or colleagues.⁸⁰ However, the ability of the employer to understand and adapt work to the needs of people with musculoskeletal conditions, and the support of co-workers, can be critical in enabling people to stay in work.

People with musculoskeletal conditions often need **additional support** to stay in work – in the Big Benefits Survey, 74% of people with musculoskeletal conditions in full- or part-time work said that they needed support to do their job.⁸¹ The types of support that people with musculoskeletal conditions say can help include special equipment, fewer hours or flexible working hours, a change in duties, working from home, help with transport, improved workplace access, ability to take emergency leave and other adjustments.^{82,83}

However, people feel that the current **awareness among employers** of the needs of people with musculoskeletal conditions is low, contributing to a lack of support. A study in 2014 found that 28% of working people with arthritis felt their employer was not fully aware of the rights of employees with arthritis.⁸⁴ In a survey of people with rheumatoid arthritis, almost a third of people (29.5%) felt their employer did not understand enough about their conditions or support needs, while a significant minority (15.4%) felt their employer had no idea about their needs.⁸⁵ A media campaign targeted at employers or workplaces to improve awareness of musculoskeletal conditions and to stress the need for preventative action may be beneficial.

Even when employers are supportive in principle, people may still not receive the support they need, and there is a need to improve many workplace environments so they better support musculoskeletal health and people with musculoskeletal problems. While 55% of people said that their employer was flexible and supportive, only 31% said they are receiving the support they need to stay in work.⁸⁶ Some surveys found even lower rates of support, with only 11% of working people with arthritis reporting they have had workplace support or training⁸⁷ and only 5% of people with ankylosing spondylitis saying they have received help to stay in work.⁸⁸

People with musculoskeletal conditions also say that **wider support** beyond that of their employer could enable them to stay in work for longer. Fifty percent of working people with arthritis are not aware of own their rights as an employee in relation to their condition.⁸⁹ Types of desired support are varied and include Government prioritisation of schemes to support people with long-term conditions to remain in work, improved urgent access to rheumatology services (for people with rheumatoid arthritis), guaranteed assistance from an occupational health advisor, better awareness of rights at work and of schemes to assist people with disabilities, easier access to the workplace, assistance travelling to work and family support.⁹⁰

People who keep working may also have concerns about the impact of having a musculoskeletal condition on their career prospects, feeling for example that they are offered less challenging jobs, or that they are more likely to be overlooked for promotion opportunities. In a Scottish survey, 32.8% of people believed that rheumatoid arthritis had been detrimental to their career progression.⁹¹

3.4 Support to find or return to work

People with musculoskeletal conditions who are seeking to return to work also need effective support. In the Big Benefits Survey, 48% of people with musculoskeletal conditions who were not working said that they needed support to help them find a job.⁹²

The work capability assessment (WCA) is currently the basis on which people's eligibility for some disability benefits, including Employment Support Allowance, are assessed. It also acts as an access route to Government programmes which support people in returning to work. However, in a recent survey, almost three quarters (73.3%) of people with musculoskeletal conditions who had a face-to-face WCA said that they did not feel that they had received sufficient support to help them get back to work.⁹³

"Far too much importance is put into the possibility of working, what you can or can't do and no interest in whether or not you could even get to work or home afterwards or even how working might impact your life outside of work."

Respondent to the Arthritis and Musculoskeletal Alliance (ARMA) benefits survey⁹⁴

3.5 Is the healthcare system helping?

Advice and support from healthcare professionals in relation to work, together with clear communication between the healthcare system and employers, can enable people to be informed of their choices about remaining in, or returning to work. However, work is not yet routinely considered as a clinical outcome, nor is work status routinely recorded in health records (see section 5.4).

There is some evidence that healthcare professionals do not routinely ask people with musculoskeletal conditions about their ability to work. For example, the National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis found that among respondents of working age (66 years or under) about one in eight (12.2%) people needed frequent time off work or were not working because of their arthritis. However, only a minority of respondents recalled being asked about their ability to work by a rheumatologist.⁹⁵ A solution may be to incorporate training about the need to discuss work, and approaches to such conversations, into healthcare professional training syllabuses.

An earlier survey of health professionals in rheumatology also concluded that access to support services such as rehabilitation and reablement which can help people return to work is still a major challenge, with seven out of ten respondents reporting that these elements were not well integrated into the care pathway.⁹⁶

"At first my employers thought I was taking the mick with the amount of time I had off work after I was diagnosed with rheumatoid arthritis. I got my consultant and nurse specialist to write to my employer explaining my condition. My employer was pretty good after that. I also contacted Access to Work and got equipment to help me including voice-activated software for the computer. My employer also reduced my hours at my request in order to help with fatigue and pain."

Beverley worked in data input

Wendy would like support so she can keep working despite osteoarthritis

Wendy, 63, is a local authority conservation planning officer. Her job involves a mixture of office work (meetings, research, report writing) and site visits to building projects, where she advises on the restoration of listed buildings and buildings in conservation areas.

Wendy has had osteoarthritis for several years which mainly affects her knees. She has had a thyroid condition for around 30 years and is also having further tests for rheumatoid arthritis and Sjögren's syndrome. These conditions often make her feel very tired.

Wendy finds the daily journey to work difficult, and a recent office move now means a slow and painful 15-minute walk on top of a train journey. Site visits are also hard, the costs of travel are no longer met by Wendy's employer, and it is a challenge to negotiate building sites, climbing up ladders and over materials. Often there is nowhere to sit to ease the pain.

Wendy has told her immediate boss about her health, but is wary at a time of local authority cuts of drawing too much attention to herself.

"I'm nervous about making my condition known to senior managers because I'm concerned that they may make a judgement that I can no longer do my job."

There are things that would make a real difference, including minor adjustments (e.g. a grab rail) in the staff toilets which would mean Wendy did not have to walk further to use the public disabled facilities. Paid transport costs within the city would also really help.

Wendy has bought herself a lightweight portable stool to take to sites so she can sit when she needs to, but a more durable one would help.



4. POLICY AND PROGRAMMES RELEVANT TO MUSCULOSKELETAL HEALTH AND WORK

4.1 Overview: musculoskeletal conditions within wider health and work policy

Policy, strategy and initiatives to support people, including those with long-term health conditions, to find and remain in work are well established in the UK.⁹⁷ Key reports which have informed policy in this area include Dame Carol Black's Review of the health of Britain's working age population; Fair society, healthy lives: The Marmot Review and Health at work – an independent review of sickness absence.^{98,99,100}

“Being in good employment is protective of health. Conversely, unemployment contributes to poor health.”

Fair society, healthy lives: The Marmot Review¹⁰¹

Increasing employment among people with disabilities and health conditions is a key part of the Government's current aim of achieving full employment.¹⁰² There is a particular emphasis on supporting people with disabilities to work: *“We will aim to halve the disability employment gap: we will transform policy, practice and public attitudes, so that hundreds of thousands more disabled people who can and want to be in work find employment.”* Alongside measures outlined in the Spending Review in November 2015 a Command Paper is expected in 2016. It will ‘set out reforms to improve support for people with health conditions and disabilities, including exploring the roles of employers, to further reduce the disability employment gap and promote integration across health and employment.’¹⁰³

A number of Government departments and bodies are involved in setting and implementing health and work policy, and in establishing the evidence base to inform it. These include the Department of Work and Pensions, the Department of Health, Public Health England, NHS England and the NHS, the Health and Safety Executive, and the National Institute for Health and Care Excellence. **The cross-Government nature of the health and work agenda means that coordination is essential.** In 2008, Dame Carol Black, in her role as the National Director for Health and Work recommended strengthening the “existing cross-Government structure to incorporate the relevant functions of those Departments whose policies influence the health of Britain's working age population”.¹⁰⁴ The UK Fit for Work coalition has more recently highlighted the need for a national health and work strategy and clear, forward-looking national leadership in this area.¹⁰⁵

Health and Work Unit

In summer 2015, the Government established the joint Health and Work Unit between the Department of Work and Pensions and the Department of Health.¹⁰⁶ The unit's remit is in development. However, the Spending Review confirmed it would receive over £115 million in funding, including at least £40 million for a health and work innovation fund to pilot new ways to join up across the health and employment systems.¹⁰⁷

4.2 Return to work support for the long-term unemployed

Welfare-to-work programmes have existed across Great Britain since the 1990s.^{vi} The programmes aim to support long-term unemployed people back into work, by providing job-searching, CV preparation and interview skills. The programmes are contracted out by the Government to private providers and operate alongside schemes targeted towards short-term unemployed (e.g. Jobcentre Plus) and locally commissioned schemes.^{108,vii} Alongside national programmes, a number of regional or local initiatives are underway, such as the Working Well pilot in Greater Manchester.¹⁰⁹

vi Responsibility for employment programmes is devolved to Northern Ireland. The Scotland Act 2016 contains provisions to devolve responsibility for welfare-to-work to the Scottish Government.

vii For a fuller description of the development of contracted employment programmes up to the introduction of the Work Programme, see House of Commons Library (Dec 2010), Welfare to work programmes: an overview, Standard Note SN/EP/5627.

Since its launch in June 2011, the Work Programme has been the main programme designed to support people on long-term benefits back into work. Over 1.7 million people took part in the programme between 2011 and 2015.¹¹⁰ People with musculoskeletal conditions may be referred into the Work Programme (this can be a condition of benefits payment) or more specialist schemes.

Data on the number and outcomes of participants in the Work Programme with musculoskeletal conditions is not readily available. However, there are concerns that it is 'not a success' for those with substantial health and disability-related needs.¹¹¹ The Government has announced that it will introduce a new Work and Health Programme after current Work Programme and Work Choice (see below) contracts end in April 2017. The new scheme, which may include aspects of both predecessor programmes as well as additional interventions, will provide 'specialist support for claimants with health conditions or disabilities and those unemployed for over two years.'¹¹²

4.3 Specialist return to work support for people with disabilities

Work Choice

Work Choice, launched in October 2010, is a specialist disability employment programme designed to support people who cannot be helped by mainstream programmes, or for whom reasonable adjustments made by their employer might not be sufficient to keep people in work. The programme was intended for people with more substantial barriers to employment arising from disabilities or long-term health conditions. It is voluntary and, since 2010, a total of 110,510 people have taken part.¹¹³

Around 11% of participants (12,540 people to date) in Work Choice have 'conditions restricting mobility or dexterity.'¹¹⁴ Reports indicate that it is considerably more effective than the mainstream programme for people with health conditions and disabilities. Of a six-month cohort of Work Choice participants who started on the programme between July and December 2014, 57.3% had entered a job by the end of June 2015.¹¹⁵ The contracts for Work Choice will expire in April 2017 and there is discussion on a new Work and Health Programme (see above).¹¹⁶

Figure 12: Participation in Work Choice¹¹⁷

Primary Disability	Total (>2010)	(as % of total)
Missing/Unknown	24,680	22.33
Conditions Restricting Mobility/Dexterity	12,540	11.34
Visual Impairment	2,830	2.56
Hearing and/or Speech Impediment	4,310	3.90
Long-term Medical Conditions	9,360	8.46
Moderate to Severe Learning Disability	8,230	7.44
Mild Learning Disability	15,110	13.67
Severe Mental Illness	1,010	0.91
Mild to Moderate Mental Health Condition	16,710	15.12
Neurological Conditions	4,330	3.91
Multiple Conditions	11,430	10.34
Total	110,510	

Fit for Work

Fit for Work is a relatively new programme to support people in work with health conditions and address sickness absence. Following a staged roll-out from December 2014, the scheme became available across England in July 2015. It has two key elements: free work-related health advice provided via a website and telephone line, and a referral to an occupational health professional for employees who have been, or are likely to be, off sick for four weeks or more. Occupational health professionals produce a Return to Work plan tailored to the employee's needs which is shared with the GP and employer. Referrals into the scheme are normally made by GPs but since 8 September 2015 employers have also been able to refer.

It is anticipated that the service will be of particular value to small- and medium-sized firms with limited or no employer occupational health support. It was expected that around one third of participants in the scheme will have musculoskeletal conditions, including back pain. The Government has indicated that it will expand the Fit for Work service in the future to support more people on long-term sickness absence with Return to Work plans.¹¹⁸

4.4 In-work support for people with disabilities

Access to Work

Access to Work (AtW) is a grant scheme designed to help disabled people to work.^{119, viii} It helps to pay for practical support for people with a disability or health condition so that they can start work, continue work or set up a business. Aspects covered by Access to Work that are relevant to people with musculoskeletal conditions include: adaptations to equipment, special equipment and the cost of moving equipment if people change location or job; transport fares for people unable to use public transport and disability awareness training for colleagues.

Around 35,560 people used Access to Work in 2013–4 and 24% of these (8,650 people) used the scheme due to problems with their 'arms and hands', 'legs or feet' or 'back and neck' – descriptions which are likely to relate to musculoskeletal conditions. Data for 2014–5 indicate a similar pattern (see figure 13).

Figure 13: Uptake of the Access to Work scheme by people with musculoskeletal problems ¹²⁰	
Total users of the scheme	32,400
Arms or hands	1,340
Legs or feet	2,310
Back or neck	3,570
Data are taken from Q1–Q3 2014–5	

The Sayce Review highlighted strong support for Access to Work among service users, employers, disabled people's organisations and charities, stating that the scheme was highly effective and well liked. However, it also suggested that low awareness of the scheme, particularly among smaller employers and particular groups of disabled people, meant that the scheme was helping far fewer people than might benefit.¹²¹ The 2015 Spending Review included a commitment to a real-terms increase in spending on AtW to help a further 25,000 people each year.¹²²

Disability Confident campaign

Launched in July 2013, the Government's Disability Confident campaign aims to encourage employers to become more confident about employing disabled people.¹²³ Alongside information portals and events, the campaign has led to development of the AtW scheme.

viii Access to Work is available in Scotland, Wales and England, but not Northern Ireland.

“I work for the police. I was frontline until I got ill. I was diagnosed with rheumatoid arthritis, and then developed Sjögren’s syndrome and fibromyalgia. Because of how the illness impacted on me and my role I had to change jobs and go part time. This meant going from a job I loved, based outside, to being in an office... I have to say that the support I received was amazing, through all of the medication trial and errors and the flare-ups...I wish this condition would go away but it won’t and so I just battle on every day and just do what I can. But going to work with the knowledge that I have support makes a great difference.”

Catherine works in the police force

4.5 Workplace health

Public Health England

Public Health England’s role is to ‘protect and improve the nation’s health and well-being, and reduce health inequalities.’¹²⁴ As part of this remit, the agency implements work and health policy set by the Department of Health. Health at work is important to Public Health England’s remit because:

- » the workplace is an important setting in which to promote health improvement – almost three quarters of working-age adults across the UK are in work, and spend on average a third of their waking hours in the workplace
- » good quality work has a beneficial impact on health and meaningful work has a positive impact on people’s health beyond its financial return – for example, work can provide a sense of identity, purpose and social connection.

Public Health England actions (2015–6) in relation to workplace health¹²⁵

- » **Improving the public’s health and well-being:** increase the number of local authorities running a Workplace Well-being Charter scheme using national standards, as well as the number of NHS and other organisations working for accreditation under this scheme.
- » **Improving population health through sustainable health:** help the NHS to provide a healthy environment for patients, staff and visitors, and establish itself as a leader in workplace health and well-being.
- » **Building the capacity and capability of the public health system:** review and make recommendations to Government on effective health interventions that can support people to return to work in order to inform wider programmes to tackle ill health and support people back into the workplace.

The **Workplace Well-being Charter** was launched by Public Health England in June 2014.¹²⁶ It is a voluntary scheme that can be used by organisations of all sizes and across sectors. The charter provides employers with a guide on how to make workplaces a supportive and productive environment for employees, and is intended to complement local initiatives and promote consistency by providing a national framework. Following self-assessment, employers are provided with advice and support to develop against eight standards prior to assessment. Public Health England is working to increase its uptake.

Although the charter includes a standard on physical activity, it does not specifically include a musculoskeletal health standard. This gap needs to be addressed. Work is currently underway with cross-sector input to develop an additional optional module on musculoskeletal health. This will consider best practice for small, medium and large employers to promote musculoskeletal health, to protect employees from known risks and to manage musculoskeletal disorders to reduce their impact on work loss. It will be supported by a topic guide on musculoskeletal health in the workplace. In addition there needs to be a staff survey tool to support this that better characterises musculoskeletal problems in the workplace.



THE WORKPLACE WELLBEING CHARTER NATIONAL AWARD for ENGLAND

STANDARDS

- 1 Leadership, culture and communication
- 2 Absence management
- 3 Health and safety
- 4 Mental health
- 5 Alcohol and substance misuse
- 6 Healthy eating
- 7 Physical activity
- 8 Smoking

COMMITMENT

Your organisation has a set of health, safety and well-being policies in place and has addressed each area, providing employees with the tools to help themselves to improve their health and well-being.

ACHIEVEMENT

Having put the building blocks in place, steps are being taken to actively encourage employees to improve their lifestyle and some basic interventions are in place to identify serious health issues.

EXCELLENCE

Not only is information easily accessible and well publicised, but the leadership of the organisation is fully engaged in well-being and employees have a range of intervention programmes and support mechanisms to help them prevent ill-health, stay in work or return to work as soon as possible.

Public health guidance in the workplace

Since 2007, the National Institute for Health and Care Excellence (NICE) has produced a suite of materials for the workplace setting including public health guidance, guidelines and a local government briefing. These provide an evidence base on how to address issues in the workplace, including physical activity, mental well-being and long-term sickness absence. Guidance on support for employees with disabilities and long-term conditions is due to be published in 2017. Although none of the existing NICE guidance is specific, there are references to musculoskeletal conditions (see 8.3).

In particular, the 2009 NICE public health guideline on long-term sickness absence includes three recommendations which are targeted 'particularly towards those with musculoskeletal disorders or mental health problems'.¹²⁷ In summary, these include:

1. Identify someone who is suitably trained and impartial to **undertake initial enquiries with the relevant employees**. This should occur within 12 weeks (ideally between 2 and 6 weeks) of a person starting sickness absence (or following recurring episodes of sickness absence).
2. If indicated, **arrange for a more detailed assessment** to be undertaken. The assessment could be coordinated by a suitably trained case worker.
3. **Coordinate and support the delivery of any planned health, occupational or rehabilitation interventions or services and any return-to-work plan** developed following initial enquiries or the detailed assessment. A graded approach should be taken with those people who are more likely to return to work offered less intensive interventions, and conversely more intensive interventions should be offered to those who are less likely to return to work.

Interventions or services may include:

- » referral to an appropriate health specialist or occupational health worker
- » workplace or work equipment modifications
- » a gradual return to the original job using staged increases in hours and days
- » a return to partial duties of the original job or temporary/permanent redeployment
- » individually tailored advice on how to manage daily activities at home and work
- » encouragement to be physically active, referral to a physiotherapist or psychological services.

More intensive interventions include:

- » small group cognitive behavioural therapy with telephone follow-up (for women with musculoskeletal pain).
- » small group cognitive behavioural therapy with sessions of behavioural-graded activity and liaison with the workplace (for people experiencing low back pain).
- » solution-focused group sessions using, for example, the Road Ahead course (for people with psychological or musculoskeletal problems).
- » a multi-disciplinary back management programme (for people with back problems/non-specific low back pain).

The guideline also recommended that the Department for Work and Pensions should develop 'an integrated programme to help claimants enter or return to work' targeted towards people with health problems who are unemployed and claiming some types of benefit.¹²⁸

Professional bodies and representative groups, including the Chartered Society for Physiotherapy and the Arthritis and Musculoskeletal Alliance (ARMA), have also produced guidance and materials for employers around musculoskeletal health in the workplace.^{129,130}

4.6 The NHS as an employer

The NHS is the UK's largest public sector employer, and employs over 1.4 million people.¹³¹ The Five Year Forward view set out a vision and action plan for the NHS to 2020 and included commitments around the health and work agenda.¹³² The NHS has a dual role in relation to work and health:

- » The NHS provides support to individuals to maintain their health and so avoid illness-related unemployment.
- » As an employer, the NHS seeks to set 'a national example as a major employer, supporting its own staff to stay healthy and to serve as health ambassadors in local communities'.¹³³

Supporting people to stay well and avoid illness-related unemployment

The Five Year Forward view included two specific objectives for the NHS in supporting people to stay well:

- » Firstly, the NHS will help develop and support new workplace incentives to promote employee health and cut sickness-related unemployment.
- » Secondly, the NHS will seek to test a win-win opportunity of improving access to NHS services for at-risk individuals (i.e. those at risk of unemployment due to ill health, particularly enduring mental health problems) while saving downstream costs at the Department for Work and Pensions, if money can be reinvested across programmes.

The NHS supporting its own staff to stay healthy

A major drive to improve and support the health and well-being of NHS staff was announced on 2 September 2015.¹³⁵ The first of three pillars of this work outlined a programme of actions which is now being taken forward by a group of leading NHS employers, in partnership with NHS Employers and Public Health England.

These include:

- » providing the NHS health check at work for NHS staff aged 40 or over
- » providing specific capacity for staff to access physiotherapy and weight management services
- » establishing and promoting a local physical activity offer to staff.

These interventions could benefit the musculoskeletal health of the NHS staff. Evaluation of this initiative within the NHS would strengthen the evidence base for wider adoption in other workplace settings.

Anna's experiences of a career in the NHS and osteoarthritis

Anna trained as a nurse in the 1970s and worked for the NHS for 38 years in a range of roles including as a midwife, a community nurse and sometimes in an office-based role. Anna retired due to ill health in 2013 and now does voluntary work.

Anna has osteoarthritis, which emerged as low back pain in her early 50s. It became extensive and led to a left hip replacement as well as surgery on her left thumb and on her right shoulder. She has osteoarthritis in both knees and her right hip as well as in her spine. Anna feels that, although she might have been prone to arthritis, the physical demands of her work – supporting women during labour and regular driving as a community nurse getting in and out of a car up to twenty times a day – played a part in making it worse.

Osteoarthritis made work difficult at different stages of Anna's career. Being a community nurse involved visiting people in their own homes. As her arthritis became worse, this became impossible: driving and gear changing became difficult, and Anna faced problems such as steps to people's houses and not being able to get up from chairs. Later, in her office-based role, she found it impossible to move heavy cabinets of medical records. She opted to avoid hot-desking, putting her name on the back of a chair and claiming a desk so she did not need to adjust it all the time.

When the pain of her arthritis became agonising, Anna had to take time away from work. Although she had received support, including an occupational health referral for physiotherapy, and a staged return to work after surgery, she also faced several dismissal hearings because of sickness absence. At one stage she had a work capability assessment to see if she would qualify for support. After a long delay, she was told that she had been assessed as being fit for work, although on the previous day she had been dismissed.

"As well as dealing with the pain and lack of mobility and function the added financial and emotional stress of attending various sickness and absence meetings, applying for ill health retirement and trying to claim benefits all adds to the trauma."



NHS England's pilots in Islington and Manchester

Islington: Although Islington has a healthy economy, there is a low employment rate. NHS England is working with councils, Clinical Commissioning Groups, health service providers and employers to understand how to make work a health outcome, and to include GPs in co-developing solutions. They are engaging with people out of work as well as those who have returned and they are evaluating system change.

Greater Manchester: NHS England is working with the Working Well programme. This programme includes focusing on the role of link worker navigators or care coordinators to help deliver the outcomes that people most want.¹³⁴

5. RESEARCH INTO MUSCULOSKELETAL HEALTH AND WORK

5.1 Research into musculoskeletal health and work

A robust evidence base is essential in informing the development and evaluation of interventions to support people with musculoskeletal conditions to remain in work, to avoid people transitioning from short-term work absence to longer periods of worklessness, and to support their return to work. Health economic evaluation of interventions is particularly important in making the case to employers and government to support wider uptake. This research field is well established in the UK, although there is an ongoing need to build academic capacity and expertise.

5.2 The Arthritis Research UK–MRC Centre for Musculoskeletal Health and Work¹³⁶

The National Centre of Excellence for Musculoskeletal Health and Work was established in October 2014, and is a multidisciplinary collaboration funded by Arthritis Research UK and the Medical Research Council. The overarching aim of the centre is to identify cost-effective ways to minimise the substantial adverse impacts of musculoskeletal disorders in the workplace. The centre is coordinated by the University of Southampton with collaboration from 14 other UK academic institutions. It is committed to:

- » preventing musculoskeletal ill health caused by work;
- » improving advice on fitness to work and return to work for those who have undergone musculoskeletal surgery;
- » identifying interventions to support the extended working lives of older workers, especially those with musculoskeletal disorders;
- » training a new generation of researchers with a broad range of skills.

The centre's programmes of work spans four broad themes:

1. Back, neck and upper limb pain
2. Osteoarthritis and knee injury
3. Inflammatory arthritis
4. Musculoskeletal health and work at older ages.

5.3 Examples of research on musculoskeletal health and work

The Health and Employment After Fifty (HEAF) study¹³⁷

By 2050, 30% of the European population will be more than 65 years old, and there is a trend and financial pressure for people to remain in work to older ages. Work at older ages may confer psychological and physical benefits. However, older people may struggle with the demands of work and their greater prevalence of co-morbidities and use of medication may increase their risk of injury at work.

The HEAF study is a cohort study of 8,000 adults aged 50–64 years recruited from general practices across England. The cohort completed questionnaires about their work and health, and determinants of these. This data will be linked to their anonymised general practice records providing information about diagnoses, consultations in primary and secondary care and prescribed medications. Data collection is ongoing and will run until at least 2017.

The study is seeking to address questions including:

- » What is the impact of common health problems (especially musculoskeletal disorders) on work capability and work participation at older ages?
- » What are the social, occupational, personal and medical co-factors which influence vocational outcomes among older people?
- » What is the impact of job loss (age-related or health-related) on subsequent physical and psychological health in people aged over 50 years?

Rheumatology rehabilitation research¹³⁸

The Rehabilitation Research Programme at the School of Health Sciences in Salford aims to improve outcomes and quality of life for people with long-term physical conditions by working across the research spectrum to:

- » develop measurement tools
- » identify the mechanisms underlying impairments
- » develop evidence-based interventions and
- » evaluate effectiveness of interventions and their impact on patients and clinical services.

The rheumatology rehabilitation research theme focuses on the rehabilitation of people with musculoskeletal and rheumatic diseases, with particular reference to the test and development of rheumatology patient reported outcome measures (R-PROMs), rheumatology occupational therapy interventions and patient education in self-management for people with rheumatic or musculoskeletal conditions.

An example of this research is a recent feasibility study to test the effect of vocational rehabilitation led by occupational therapists on employment and health status of people with inflammatory forms of arthritis.¹³⁹

Leeds early intervention clinic for musculoskeletal disorders¹⁴⁰

The UK's first early intervention clinic for people who have been signed off work with a musculoskeletal disorder is being established in Leeds. Referral of people with musculoskeletal conditions from primary care into a specialist care setting can currently take a long time and result in unnecessary discomfort and work absence. Delivered by Leeds Community Healthcare NHS Trust the clinic is designed to enable quick referral from primary care, reducing the time from being signed off work from weeks to just 5 days.

It is hoped that early intervention will reduce work disability and improve patient outcomes and satisfaction. It is anticipated that the clinic will provide a proof of concept for an intervention that reduces working days lost and absenteeism, addresses presenteeism, reduces hospital appointments and delivers savings to employers and the wider economy. More widely, the intervention may be transferable to other disease areas.

Opening in January 2016, the clinic will serve a population of 750,000 and will provide six dedicated sessions per week across two or three sites. Initial appointments will be 45 minutes long.

Promoting musculoskeletal health in the workplace: the training needs of line managers¹⁴¹

Musculoskeletal conditions are a leading cause of absenteeism and presenteeism in the workplace. However, the role of line managers in promoting and maintaining musculoskeletal health in the workplace is poorly understood. Using a focus group approach involving employees, employers and occupational health professionals from four large organisations in the health, local government, finance and food production sectors a recent qualitative study aimed to better understand the role of managers in promoting good musculoskeletal health in the workplace.

Barriers and facilitators to maintaining musculoskeletal health in the workplace cited by all participants included a lack of manager and employee awareness of the support and preventative measures for musculoskeletal conditions available in the workplace and the lack of a holistic approach to musculoskeletal health problems.

The study provided evidence that organisations and line managers are willing to engage in tackling issues of musculoskeletal health at work. It also suggested that, with improved training, managers could play a key role in the prevention of musculoskeletal conditions and the promotion and maintenance of musculoskeletal health in the workplace. This work will inform the development of:

- » a model musculoskeletal Health Management Policy that can be adopted by organisations to provide a formal structure for the prevention and management of musculoskeletal problems
- » an assessment tool to enable organisations to understand the impact of activities and policy on employee musculoskeletal health
- » a training programme in musculoskeletal health for managers to prevent and manage musculoskeletal conditions in the workplace.

5.4 Data needs for research

Research into the needs of people with musculoskeletal conditions in the workplace, and evaluation of interventions to support people with musculoskeletal conditions to remain in or return to work is dependent on data drawn from a range of sources, including health records, government collected surveys and data sets. The limited extent and accuracy of current data is a limiting factor, and there is a need for agreement of key metrics and improved data collection to enable the relationships between health and work to be better understood, and for progress and outcomes to be tracked at local and national level.

Progress could be made by:

- » improving the collection and analysis of the prevalence and incidence of musculoskeletal conditions in routine national health records
- » improving the consistency of the coding and capture of musculoskeletal conditions in national data sets and surveys, particularly those relating to work and benefits
- » systematically recording work status within health records.

Challenges in data capture about people with musculoskeletal conditions are not unique to the UK; a lack of consistent data capture across Europe and more widely hinders international research in this field.¹⁴²



Neil changed his role at work because of gout

Neil is 47 and has worked for the postal service for over 28 years. He first noticed a problem in his early 30s, when his foot and ankle would swell after football. He was diagnosed with gout in 2000, and tried to manage his condition for 10 years by modifying his diet to avoid high purine foods, and by using painkillers.

Gout attacks were hugely painful, and had impacts both in and out of work. The pain stopped him sleeping; even the weight of the bed covers would be too painful. To get around the three-and-a-half-hour postal deliveries, Neil would take painkillers which gave him a long enough window in which he could work. When the gout started in his hands and elbows, changing gears when driving became extremely painful too.

"My foot had swollen up. It was unbelievable, if you can imagine a joint of meat that's tied with string. It was horrible. It was really, really swollen and that was all my toes. It was my left foot. Of course, I'm a postman – my feet are my trade, basically."

Neil discussed his gout with his boss and with occupational health, and used information from the UK Gout Society to help people understand. But he was very conscious of taking time off, as a series of absences would have been a dismissible offence. Working six days a week, he made GP appointments in the afternoons (after deliveries) and sometimes took unpaid leave. Although it was not offered by his employer, Neil took opportunities as he gained seniority to change the type of work he did, moving from foot deliveries to driving deliveries, and finally to a specialist position which does not involve delivery but involves the accounts, ordering, computer work and answering calls.

"Occupational health had told me that I might have to accept this isn't the job for me. But it's all I have done since I left school. It's my job, my working life. So, I had to try everything I could to maintain that, really."

Around two years ago, Neil was referred to a specialist and started taking allopurinol. This drug has made a huge difference. But even after all this time, his condition is still seen as a bit of a joke by his colleagues at work.

"There's a stigma attached to having gout, you know, because of Georgian times ... that's all people know... to lots of my colleagues it was a big joke. They thought it was funny. All I can say is: if they had suffered the same pain that I had they would know differently."



6. EMPLOYMENT LEGISLATION AND EMPLOYERS' BEST PRACTICE

6.1 Employment legislation

Several pieces of legislation relate to people's rights as employees, and set out the duties of employers. This legislation is not specific to people with musculoskeletal conditions but also applies to broader groups.

The Equality Act (2010)

The Equality Act 2010 legally protects people from discrimination in the workplace and in wider society.¹⁴³ It protects specific groups of people with 'protected characteristics' including disability which is defined in the Equality Act as having 'a physical or mental impairment and the impairment has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities'. People with musculoskeletal conditions that substantially¹⁴⁴ affect their daily lives are likely to be protected. Guidance clarifies this definition and there are provisions for people with progressive conditions, including systemic lupus erythematosus (SLE), and recurring or fluctuating conditions such as rheumatoid arthritis (see 8.4).

The Equality Act prohibits direct discrimination, indirect discrimination, harassment or victimisation of people with any protected characteristic (see 8.4). It also specifically protects disabled people from discrimination arising from their disability and includes a duty on employers to make adjustments for disabled persons.

Discrimination can occur in many aspects of employment. The Equality Act states that an employer must not discriminate in areas including:

- » recruitment
- » terms of employment
- » promotion and training opportunities
- » dismissal and redundancy.

The Equality Act also sets specific requirements in recruitment, in that employers must not ask about the health of a job applicant (including whether or not a person has a disability) before offering them work, except in specific circumstances.^{ix}

To comply with the Equality Act employers must take reasonable steps to make adjustments for disabled people. The Act does not specify a list of adjustments, but these could include:

- » making physical adjustments to the premises (e.g. changing access to the building, providing a disabled parking space, altering the layout of furniture, providing appropriate washrooms)
- » supplying special equipment or services (e.g. an ergonomic chair, computer at home)
- » providing support (e.g. a support worker to accompany people on business out of the office, or a guide dog)
- » altering terms and conditions of employment or working arrangements (e.g. hours, shift patterns, flexible working, discounting disability-related leave for the purposes of absence management)
- » ensuring that information is provided in accessible formats
- » altering job duties, or allocating some of a disabled person's duties to another worker.¹⁴⁵

Employers are only required to make adjustments that are reasonable. The cost and practicability of making an adjustment and the resources available to the employer can be taken into account in deciding what is reasonable. Employment law is complex, and the nature of individual cases must be taken into account. Employers may treat disabled people less favourably if they have a sufficiently justifiable reason for doing so, and if the problem cannot

ix Exceptions include to determine whether an applicant can carry out a function essential to the role; to take 'positive action' to assist disabled people; for monitoring; to check that a candidate has a disability where this is a genuine requirement of the job.

be overcome by making reasonable adjustments. For example, an employer would be permitted not to appoint someone with severe back pain for a job as a carpet fitter if they could not carry out the essential requirements of the job.¹⁴⁶

"I was diagnosed with psoriatic arthritis 11 years ago... the nature of the job meant chairing large meetings, which means standing for long periods of time. They allowed me to stop doing these meetings and I had no time off for over a year, but now the service cannot manage it. I have been given time to try my new medication and see if I can get back up to speed. I don't imagine I will ever get back to chairing two-hour meetings so it looks like early retirement. I am 46. I have huge experience and skills yet my inability to stand means I could lose the job I love. It is soul destroying."

Stacey works for a local council

The Employment Rights Act (1996) and the Flexible Working Regulations (2014)

The Employment Rights Act (1996) provides an overarching framework for individual employee rights in the UK.¹⁴⁷ The Flexible Working Regulations (2014) amended this Act and came into force on 30 June 2014.¹⁴⁸ Flexible working is a way of working that suits an employee's needs. Different forms include job sharing, working from home, part-time working, working compressed hours, flexi-time, annualised hours, staggered hours and phased retirement.

The ability to work flexibly can be particularly important to people with fluctuating long-term conditions, including musculoskeletal conditions, as it can enable people to manage their time around unpredictable symptoms and work when, and where, they are able to.

Under the Flexible Working Regulations (2014), an employee who has worked for the same employer for 26 weeks in continuous employment has the right to request flexible working, and can make one statutory request in a 12-month period. Employers must deal with requests in a reasonable manner, for example by assessing the advantages and disadvantages of the application, holding a meeting to discuss the request with the employee and offering an appeal process if requests are declined.

Employers can reject an application for reasons including:

- » extra costs that would damage the business
- » the work cannot be reorganised among other staff
- » people cannot be recruited to do the work
- » flexible working will affect quality and performance
- » the business won't be able to meet customer demand
- » a lack of work to do during the proposed working times
- » the business is planning changes to the workforce.¹⁴⁹

Health and Safety legislation

Musculoskeletal disorders are the most common types of work-related illness. A number of pieces of legislation and sets of regulations are relevant to musculoskeletal health in the workplace, and place responsibilities on both employers and employees. The Health and Safety Executive (HSE) leads on providing and advice and guidance in this area.¹⁵⁰

Relevant legislation includes:¹⁵¹

- » The Health and Safety at Work etc. Act (1974).¹⁵² This Act requires employers to protect the health and safety of their employees and other people who might be affected.
- » Workplace (Health, Safety and Welfare) Regulations (1992). These Regulations cover a range of basic health, safety and welfare issues.

- » The Management of Health and Safety at Work Regulations (1999). These require employers to assess the risks to the health and safety of their employees while at work.
- » The Manual Handling Operations Regulations (MHOR) (1992 as amended). These regulations require employers to carry out a risk assessment on all manual handling tasks that pose an injury risk. Employers have to avoid manual handling if there is a possibility of injury, or if this is not reasonably practical, take steps to reduce injury risk.
- » The Health and Safety (Display Screen Equipment) Regulations (DSE Regulations) (1992 as amended). Regular users of DSEs can experience health problems including back pain. Under these regulations, DSE employers need to take steps for habitual users of DSEs including: analysing workstations to assess and reduce risks; ensuring workstations meet specified minimum requirements; planning work activities to include breaks or changes of activity; providing information and training.

A number of regulations are also relevant to reducing the risk of musculoskeletal injury at work. These include:

- » Control of Vibration at Work Regulations (2005). Regular long-term exposure to whole-body vibration (for example through driving industrial and agricultural vehicles) is associated with back pain. Employers are required to take action to protect people against risk arising from exposure to vibration at work.
- » Provision and Use of Work Equipment Regulations (PUWER) (1998) and Lifting Operations and Lifting Equipment Regulations (1998). Risks to health and safety from equipment at work must be assessed, prevented or controlled in line with these regulations.
- » Personal Protective Equipment (PPE) at Work Regulations (1992). Reflecting European Legislation (Directive 89/656/EEC), these regulations place a duty on employers to ensure that suitable PPE is provided to employees.

In addition to mandatory requirements, the Health and Safety Executive also provides advice to employers on non-statutory actions which can help to tackle musculoskeletal health problems in the workplace. Health monitoring enables employers to survey their workforce for symptoms of ill health, such as back pain. It can enable employers to be aware of health problems and intervene early to prevent problems being caused or made worse by work. Employers may also provide, or have access to, occupational health services to which workers could be referred for help and advice with their symptoms. Occupational health provision is valuable for advising on management of cases.

A summary of employees' rights is included at 8.5.

6.2 Incentives for employers

In March 2013, the Government announced new measures to support employers that help their employees return to work after periods of sickness.¹⁵³ These were introduced through the Finance Act (2014).¹⁵⁴ Previously, medical treatment arranged or paid for by an employer, or reimbursed to an employee, was viewed as a 'benefit in kind' and liable to income tax.

The new legislation introduced an exemption from income tax charge for any payment up to £500 per employee per year made by an employer to meet the costs of medical treatment for the purposes of assisting the employee to return to work after a period of absence (around 4 weeks) due to injury or ill health. The medical treatment must have been recommended by occupational health services, including the Government's Fit for Work service. The intention of this policy was to widen access to occupational health treatment and to encourage employers to engage with the well-being of their employees.¹⁵⁵

6.3 Best practice: examples of employer-led initiatives

A number of employers have recognised the impact of musculoskeletal conditions on their workforce and developed initiatives to address this challenge. Leading employers have moved beyond their legal duties to realise the benefits of promoting good musculoskeletal health to their employees, as well as introducing systems to rapidly identify musculoskeletal conditions in their staff and to offer prompt support. Leading employers are also introducing training for line managers to ensure they are aware of, and alert to, the musculoskeletal health needs of their staff, and can provide appropriate support. The Government's Responsibility Deal has a physical activity component which employers can pledge to support.¹⁵⁶

Display screen equipment – managing musculoskeletal risk in BP

BP is a multinational company with around 84,500 employees, including around 15,000 based in the UK. The global workforce includes employees in retail sites (garages), offshore installations, refineries, ships and office locations.

For BP's office-based staff, musculoskeletal conditions related to the use of display screen equipment (DSE) in office workstations are a recognised health risk. The company's programme to address these is part of their wider commitment to support both the physical and psychological health of their staff. Early identification of problems and provision of support are key features of BP's global DSE programme.

BP's programme has a number of elements:

- » **Remedy Office Ergonomic Software (OES) and Case Manager:** This programme and case management system is currently available in several countries including the UK and is being progressively rolled out to other BP staff. The Remedy dashboard provides an interactive hub with personal, real-time feedback, allowing users to take 'ownership' of their workstation set-up. Users complete an online assessment, and receive a risk/discomfort rating together with recommendations to modify their workstations if needed. For those at high/moderate risk or in frequent discomfort, cases are created within a case management system, which triggers more frequent follow ups, and includes referral to a healthcare professional if needed. Since its introduction in 2009, Remedy OES users have experienced a 69% reduction in high risk ratings, and there has been a significant reduction in users reporting constant or frequent discomfort. Users experiencing problems are able to access prompt support reducing the risk of long-term musculoskeletal issues.
- » **RSI Guard:** RSI Guard is an additional software programme which encourages breaks and movement within the workplace.

British Telecommunications plc: supporting musculoskeletal health

BT has a world-wide workforce of around 90,000, including 72,000 people based in the UK. Their Well-being Inclusion Safety and Health (WISH) mission is 'to promote the well-being of our people so they can make a better world through the power of communications.' There are mixed demands on the musculoskeletal health of the BT workforce which includes around 30,000 engineers as well as office-based staff. The ageing profile of the BT workforce is an important consideration for health and well-being initiatives.

The approach to management of musculoskeletal conditions within BT combines health and safety responsibilities with a public health approach. The programme includes primary engagement (ergonomics and health promotion), secondary intervention (early intervention for musculoskeletal conditions) and tertiary resolution (treatment of musculoskeletal conditions). Across this spectrum musculoskeletal health is supported through approaches including:

- » Health and well-being passports
- » Ergonomic risk management
- » Physical demand analysis of job roles
- » Early identification of work capability problems by line managers
- » Occupation Health service advice on adjustments and rehabilitation
- » The Enable service, providing specialised adjustments assessment and advice (delivered by AbilityNet in the UK)
- » Physiotherapy advice and treatment service
- » A 4–12 week functional restoration programme (delivered by ReHabWorks).

Two initiatives which are currently underway are:

- » A health-economic evaluation of the physiotherapy service
- » A controlled trial of Early Occupation Health Service intervention and case management for employees on long-term sickness absence. This trial will evaluate an intervention for employees with three weeks of absence. The intervention includes an assessment of needs, advice on accessing healthcare, and access to BT physiotherapy and cognitive behavioural therapy services.

Health promotion activities at BT are designed to encourage personal responsibility and focus on small but sustainable lifestyle changes. Activities include a 'WorkFit' intranet site to provide information and support. A specific initiative in 2015, the Fit for Life Challenge, took a stratified approach, targeting physical activities to employees in three groups depending on their initial activity level, with monthly challenges for each group.

National Grid: The Soft Tissue Injury Prevention Program (STIPP)

National Grid is a UK- and US-based utility company which provides infrastructure to deliver electricity and gas. Of its total of 10,000 employees, around 40% are operational and 60% are office-based. The company attributes around 30% of its sickness absence to musculoskeletal conditions.

The Soft Tissue Injury Prevention Program (STIPP) was originally a National Grid US initiative which was adapted to the UK. It is a work-focused intervention to address musculoskeletal injuries. The programme is multi-layered and includes both employee and supervisor training. The UK version of the programme includes work-focused physical rehabilitation services, provision of fast-track physiotherapy services and bespoke behaviour change manual handling training ('body mechanics').

Following an initial pilot in 2009–10 the programme was progressively extended throughout National Grid in the UK. By 2015, around 650 employees every year were accessing physiotherapy advice and support, with 94% returning to work on full duties, and 91% indicating that the physiotherapy treatment was beneficial to their return to work. Body mechanics training had been delivered to 45% of employees.

The programme has been evaluated using a Medical Disability Guidelines Predictive Tool. It continues to show a positive return on investment. Employee engagement scores for health and well-being have also been increased by 11%.

Future development of the programme will include a revision of the body mechanics training to provide a short version specifically for office-based workers, work to encourage absent employees to be referred early into physiotherapy and a work-focused cognitive behavioural therapy pilot.



7. RECOMMENDATIONS

Having a musculoskeletal condition can make working life difficult, but many people with a musculoskeletal condition want to work, and can do so with the right support. At present, only 59.7% of people with a musculoskeletal condition of working age in the UK are in work, and these conditions cause 20% of all sickness absence and 30.6 million working days to be lost every year. The need for greater awareness of musculoskeletal health in the workplace, and increased support to enable people with musculoskeletal conditions to remain in, or return to work, must now be met.

Supporting people with musculoskeletal conditions to stay in work

1. The **Access to Work** scheme should be supported by a greater than real terms increase in funding. The Department of Work and Pensions should undertake immediate and ongoing promotion of Access to Work to target people with musculoskeletal conditions.
2. HM Treasury should introduce fiscal incentives to encourage employers of all sizes to provide **workplace health and well-being initiatives targeting and promoting musculoskeletal health**, such as early referral and rehabilitation.
3. Public Health England should ensure that a musculoskeletal component is added to the **Workforce and Well-being Charter** within 2016–7, and should allocate resource to implement the Charter, to raise awareness among employers of their mandatory duties and of best practice.

Supporting people with musculoskeletal conditions to return to work

4. The future **Health and Work Programme** should provide services appropriate for people with musculoskeletal conditions and complex co-morbidities, and should be designed with input from professionals with expertise in these conditions. If Work Choice is not maintained as a separate specialist disability employment programme, the new Health and Work Programme should provide comparable, or better, support for people with additional needs arising from their health or disability.

Innovation and data

5. The Joint Health and Work Unit's **Health and Work Innovation Fund** should be used to pilot interventions to support people with musculoskeletal conditions to return to work, and to prevent work loss related to musculoskeletal conditions. This should include interventions targeted towards prevention, short-term absence (e.g. early-intervention clinics) and long-term absence (e.g. Individual Placement and Support (IPS)). All studies should include health-economic evaluation and scalability and should be robustly evaluated by a national expert panel and academic peer review.
6. **Work status should be systematically recorded in health records**, including for people with musculoskeletal conditions. Work should be routinely considered as a clinical outcome and systematically included as a health outcome measure for people with long-term conditions in all national and local outcomes frameworks.

8. ANNEXES

8.1 'Working with musculoskeletal conditions' event programme and participants

Tuesday 16 June 2015 Academy of Medical Sciences, 41 Portland Place, London, W1B 1QH

There is a clear association between musculoskeletal health and work, and the economic costs of musculoskeletal conditions within the UK workforce are significant. Around 30.6 million working days are lost in the UK each year due to sickness absence caused by a musculoskeletal condition and they are the most commonly reported cause of work-related illness. Sector-wide effort is needed to address this. This policy symposium will bring together people with musculoskeletal conditions, policy leads, members of the academic community and employers to discuss current initiatives and identify opportunities for action.

Welcome & introduction

Chair: Dr Karen Walker-Bone, Deputy Director, Arthritis Research UK/MRC Centre for Musculoskeletal Health and Work.

Olivia Belle, Director of External Affairs, Arthritis Research UK

1 – Experience and data

A personal experience of working with arthritis

Norman Webster

Musculoskeletal disorders and work – data from Health Survey for England

Stephen Bevan, Director, Centre for Workforce Effectiveness, Work Foundation

The impact of musculoskeletal conditions on work: research and surveys

Jill Hamilton, Development Manager, National Ankylosing Spondylitis Society

Discussion: Speakers with John Chisholm, Royal College of General Practitioners and Rosanna Singler, Disability Benefits Consortium/Leonard Cheshire Disability

2 – Policy initiatives

Working with musculoskeletal conditions: a Public Health England perspective

Sam Haskell, Healthy Adults Manager, Public Health England

NICE guidelines – using evidence to support productive and healthy working conditions

Simon Wilde, National Institute for Health and Care Excellence

NHS England Health and Work Programme

Amy Galea, Health and Work programme, NHS-England

Discussion: Speakers with Diana Kloss, Chair, Council for Health and Work

3 – Research studies

The Health and Employment After Fifty Study

Keith Palmer, MRC Lifecourse Epidemiology Unit, University of Southampton

Vocational rehabilitation in workers with inflammatory arthritis

Yeliz Prior, Research Fellow, University of Salford

Work and health: insights from the multidisciplinary rheumatology team

Miguel Souto, Head of Policy, British Society for Rheumatology

Discussion: Speakers with Peter Kay, National Clinical Director for musculoskeletal services

4 – Employers' programmes

Display screen equipment – managing musculoskeletal risk in BP

James Mackie, UK Health Manager & Medical Advisor, BP Shipping

Supporting musculoskeletal health

Alister Scott, Head of Health and Deputy CMO, Well-being Inclusion, Safety & Health, BT Group

STIPP

Sinead Furber, Health Specialist, National Grid

Discussion: Speakers with Stephen Bevan, Director, Centre for Workforce Effectiveness

5 – Closing remarks

Dr Gina Radford, Deputy Chief Medical Officer, Department of Health

Attendees

Margot Akeroyd, Director, Ergonomic consultant, Akeroyd Consulting

Dr Jessica Boname, Programme Manager, Population and Systems Medicine Board, Medical Research Council

Dr Laura Boothman, Policy Manager, Arthritis Research UK

Dr John Chisholm, Council Member and Lead for Health and Work, Royal College of General Practitioners (RCGP)

Dr Liz Davies, Medical Advisor, Strategic Health and Sciences, Department for Work and Pensions & GP

Tracy Elliott, Senior Research Programme Manager for Strategic Development, Clinical Studies & Experimental Medicine, Arthritis Research UK

Professor John Etherington, National Clinical Director Rehabilitation & Recovering in the Community

Amy Forbes, Policy Officer, Arthritis Research UK

Len Gooblar, Head of Strategic Health Initiatives, AbbVie UK

Laura Guest, Chief Executive Officer, British Society for Rheumatology

Dr Rob Hampton, Portfolio GP and Occupational Physician, RHH Medical Ltd

Nikki Hill, Director of Policy, Communications and Information, Arthritis Care

Matthew Holder, Head of campaigns and engagement, British Safety Council

Linda Horncastle, Fibromyalgia Association UK

Lindsey Hughes, Rehabilitation Programme Lead, Health & Work Programme, NHS England

Sylvie Jackson, Trustee, Arthritis Research UK

Professor Peter Kay, National Clinical Director Musculoskeletal Services, NHS England

Lucy Kenyon, Director for Communications, Association of Occupational Health Nurse Practitioners (AOHNP)

Mr Mike Kimmons, Chief Executive Officer, British Orthopaedic Association

Professor Diana Kloss, Chair, Council for Health and Work

Tracey Loftis, Head of Policy & Public Affairs, Arthritis Research UK

Sarah Marsh, Programme Manager, Clinical Policy and Strategy Team, Long Term Conditions, NHS England

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8.2 Surveys/studies on the employment experiences of people with musculoskeletal conditions

Title	Author	Date	Method
National clinical audit for inflammatory and early arthritis. ¹⁵⁷	Healthcare Quality Improvement Partnership & British Society of Rheumatology	2016	National Clinical Audit of all public and private organisations which provide NHS rheumatology services in England and Wales. A total of 748 audit participants under the age of 66 years returned a patient follow-up form which included questions on work status.
The state of play in UK rheumatology. ¹⁵⁸	British Society of Rheumatology	2015	Survey of over 2,000 BSR members (consultant rheumatologists, trainees, specialised nurses, physiotherapists, occupational therapists, psychologists and GPs with special interest in rheumatology) alongside focus groups with clinicians and patients.
ARMA benefits survey 2014-15. ¹⁵⁹	Arthritis and Musculoskeletal Alliance	2015	Online survey of voluntary participants 16 or over, including 490 people with a musculoskeletal condition. Around half of the respondents (54.24%, n = 265) were unable to work due to ill health.
OA nation ¹⁶⁰	Arthritis Care	2014	Online survey of 2,008 people with arthritis of any type, including a subset of 1,364 with osteoarthritis. Data were weighted to reflect the proportions of people with different types of arthritis in the overall population with the osteoarthritis component also weighted by age and gender.
Everyday life and arthritis. ¹⁶¹	Arthritis Research UK	TBC	Qualitative and quantitative study conducted in October 2015, including 2,504 people with musculoskeletal conditions.
Big benefits survey. ¹⁶²	Disability Benefits Consortium	2014	Online survey of voluntary participants, including 1,945 people of working age (14–64) with a majority (81%) unemployed. Included 537 respondents with musculoskeletal conditions.
National Osteoporosis Society (2014). ¹⁶³	National Osteoporosis Society	2014	Online survey of 3,228 people during June and July 2014. 27 people subsequently took part in in-depth face-to-face interviews and a further 25 people kept reflective diaries.
Musculoskeletal disorders and work. Results of a survey of individuals living with musculoskeletal disorders in six European countries. ¹⁶⁴	Work Foundation/ Fit for Work Europe	2013	Online questionnaire circulated to people with doctor diagnosed musculoskeletal disorders across Belgium, Bulgaria, Ireland, Portugal, Spain and the UK. Over 1,500 responses (including 800 from the UK) weighted by country.
Taking the strain: the impact of musculoskeletal disorders on work and home life. ¹⁶⁵	Work Foundation	2012	EU-wide survey of individuals with a range of musculoskeletal disorders using an online questionnaire including 809 valid responses in the UK. 47% were in employment.

RA and work: employment and rheumatoid arthritis in Scotland. A national picture. ¹⁶⁶	National Rheumatoid Arthritis Society	2010	Paper-based survey circulated through NHS outpatient clinics. 198 respondents – people of working age with a confirmed diagnosis of rheumatoid arthritis. 60.1% (119) of respondents were in employment.
Working with ankylosing spondylitis. ¹⁶⁷	National Ankylosing Spondylitis Society	2010	Postal and email survey; 324 responses from patients with current diagnosis of AS. 72% of respondents were in work.
I want to work. Employment and rheumatoid arthritis. A national picture. ¹⁶⁸	National Rheumatoid Arthritis Society	2007	UK wide online and postal survey with 782 respondents (people with rheumatoid arthritis and allied health professionals). 54.8% of respondents were in employment.

8.3 NICE Guidance on workplace well-being

Title	Date	Ref	Type	Content relevant to musculoskeletal conditions
Smoking: workplace interventions ¹⁶⁹	April 2007	PH5	Public Health Guidance	<ul style="list-style-type: none"> • N/A
Physical activity in the workplace ¹⁷⁰	May 2008	PH13	Public Health Guidance	<ul style="list-style-type: none"> • Notes that mental health problems and musculoskeletal disorders account for the majority of working days lost • Notes that the incidence of musculoskeletal disorders can be reduced by physical activity.
Workplace health: long-term sickness absence and incapacity to work ¹⁷¹	March 2009	PH19	Public Health Guidance	<ul style="list-style-type: none"> • Notes that the most common causes of long-term sickness absence among manual workers are acute medical conditions, followed by back pain, musculoskeletal injuries, stress and mental health problems. • Notes that among non-manual workers the most common causes are stress, acute medical conditions, mental health problems (such as depression and anxiety), musculoskeletal injuries and back pain. • Includes three recommendations targeted particularly towards those with musculoskeletal disorders or mental health problems.
Mental well-being at work ¹⁷²	November 2009	PH22	Public Health Guidance	<ul style="list-style-type: none"> • Notes that several diseases including musculoskeletal disorders are related to social and psychological conditions in the workplace.

Workplace health ¹⁷³	July 2012	LGB2	Local government briefing	<ul style="list-style-type: none"> • Notes that it is effective to offer help and advice, to improve employees' general health and well-being and to address specific, often work-related conditions. The latter typically include musculoskeletal disorders. • Suggests providing a range of options to help people get back to work. For example, for the many people on long- or short-term sickness absence who have musculoskeletal disorders or mental health problems, this could include multidisciplinary back management programmes, cognitive behavioural therapy in small groups (for low back pain or stress-related conditions).
Workplace health: management practices ¹⁷⁴	June 2015	NG13	NICE guideline	• N/A
<i>Workplace health: support for employees with disabilities and long term conditions</i>	<i>February 2017</i>	<i>TBC</i>	<i>NICE guideline</i>	<i>TBC</i>
<i>Workplace health – older employees</i>	<i>TBC</i>	<i>TBC</i>	<i>NICE guideline</i>	<i>TBC</i>

8.4 Definition of disability and discrimination in the Equality Act (2010)

Definition of disability in the Equality Act (2010)^{175,176}

A person has a disability for the purposes of the Equality Act (2010) if he or she has ‘a **physical or mental impairment** and the impairment has a **substantial** and **long-term adverse effect** on his or her ability to carry out **normal day-to-day activities**’.

Guidance clarifies:

- » There is no exhaustive list of conditions that qualify as impairments for the purposes of the Act. The term **physical or mental impairment** is given its ordinary meaning.
- » The term **substantial** means more than minor or trivial.
- » A long-term effect is one which has lasted at least 12 months, or where the total period for which it lasts, from the time of the first onset, is likely to be at least 12 months; or which is likely to last for the rest of the life of the person affected.
- » The Act does not define what is to be regarded as a **normal day-to-day activity**. ‘In general, day-to-day activities are things people do on a regular or daily basis, and examples include shopping, reading and writing, having a conversation or using the telephone, watching television, getting washed and dressed, preparing and eating food, carrying out household tasks, walking and travelling by various forms of transport, and taking part in social activities.’

Example: A man with osteoarthritis experiences significant pain in his hands undertaking tasks such as using a keyboard at home or work, peeling vegetables, opening jars and writing. The impairment substantially adversely affects the man's ability to carry out normal day-to-day activities.

There are additional specific provisions within the Act:

- » People with **cancer, HIV infection or multiple sclerosis (MS)** are classified as disabled and protected by the Act from the point of diagnosis.
- » A person who is certified as **blind, severely sight impaired, sight impaired or partially sighted** by a consultant ophthalmologist is deemed to have a disability.
- » People with **progressive conditions** that have ‘effects which increase in severity over time’, are regarded as having an impairment which has a substantial adverse effect on his or her ability to carry out normal day-to-day activities before it actually has that effect. There is no exhaustive list of conditions, but guidance includes systemic lupus erythematosus (SLE).
- » **Recurring or fluctuating effects:** The Act states that if an impairment has had a substantial adverse effect on a person's ability to carry out normal day-to-day activities but that effect ceases, the substantial effect *is treated as continuing* if it is likely to recur.

Definitions of discrimination under the Equality Act (2010) - continued from previous page

- » *Direct discrimination* occurs when a person is treated less favourably than another person because of a protected characteristic. It has three forms: 'ordinary direct discrimination', 'direct discrimination by association' and 'direct discrimination by perception'.¹⁷⁷
- » *Indirect discrimination* occurs when a provision, criterion or practice is applied which puts people with a protected characteristic at a disadvantage.
- » *Harassment* is defined as 'unwanted conduct' related to a protected characteristic which violates a person's dignity or creates an intimidating, hostile, degrading, humiliating or offensive environment for that person.
- » *Victimisation* is when someone experiences 'detriment' (i.e. damage, harm or loss) due to making an allegation of discrimination; supporting a complaint of discrimination; giving evidence relating to a complaint about discrimination; raising a grievance concerning equality or discrimination; and/or others activities for the purposes of (or in connection with) the Equality Act 2010.
- » *Discrimination arising from disability* occurs when someone with a disability is treated unfavourably because of something arising in consequence of their disability. A disabled person does not have to compare their treatment to how someone else is treated.
- » The duty to make *adjustments for disabled people* meets three requirements:
 - » where a provision, criterion or practice puts a disabled person at a substantial disadvantage in comparison to people who are not disabled, reasonable steps must be taken to avoid the disadvantage.
 - » where a physical feature (e.g. access to a building, or furniture) puts a disabled person at a substantial disadvantage in comparison to people who are not disabled, reasonable steps must be taken to avoid the disadvantage.
 - » where a disabled person not provided with an auxiliary aid would be put at a substantial disadvantage in comparison to people who are not disabled, reasonable steps must be taken to provide the auxiliary aid.

8.5 Arthritis: your rights at work

- » **You may be considered to have a disability in the context of your employment** if your arthritis or other musculoskeletal condition has a substantial and long term effect on your ability to carry out day to day activities.
- » **Your employer must treat you fairly and without discrimination** if you are disabled by arthritis or a musculoskeletal condition. This includes the way you are treated during recruitment, management of your attendance and any sick leave, your promotion and training opportunities and the way you are treated during any dismissal or redundancy processes. This right only applies when your employer knows, or could reasonably be expected to know, that you are disabled.
- » **Your employer must make reasonable adjustments to enable you to work** if you are disabled by arthritis or a musculoskeletal condition. There is no set definition of a 'reasonable adjustment' but it could include changing access to the workplace, providing equipment or support, or altering working arrangements (e.g. altering duties or working hours).
- » **You have the right to request flexible working** if you have worked continuously for the same employer for 26 weeks (whether or not you are disabled). You are only able to make one request in any 12 month period and your employer must act reasonably when considering this request.
- » **Your employer must assess and protect your health and safety** at work. This includes measures which protect your musculoskeletal health, for example:
 - » If your job involves manual handling, your employer must carry out a risk assessment.
 - » If you regularly use Display Screen Equipment, your employer must assess and reduce risk by ensuring: your workstation meets requirements; your work is planned to include breaks or changes of activity; you are provided with information and training.
 - » If you are exposed to whole-body vibration (for example by driving industrial and agricultural vehicles) your employer must take action to protect you against risk.
 - » If you use lifting equipment, your employer must assess, prevent or control the risks to your health and safety.
 - » Your employer must provide you with suitable personal protective equipment.
- » **Access to work** is a government grant scheme that can pay for practical support to help you start working, stay in work, move into self-employment or start a business if you have a disability or health condition. You may be eligible if your disability or health condition is likely to last at least a year and it either affects your ability to do a job or means you have to pay work-related costs (such as special computer equipment or travel costs).
- » **Further advice** may be available from the Advisory, Conciliation and Arbitration Service (ACAS), your local Citizens Advice Bureau or law centre. You should check your household insurance policy for Legal Expenses Insurance which may provide you with advice and further assistance. You should always seek legal advice from a qualified solicitor.

8.6 References

- Department of Work and Pensions (Feb 2015). Labour Force Survey analysis of disabled people by region and main health problem.
- Office of National Statistics (2014). Full Report: Sickness Absence in the Labour Market, February 2014.
- Labour Force Survey - Self-reported work-related ill health and workplace injuries on-line at <http://www.hse.gov.uk/Statistics/lfs/index.htm>
- Symmons D et al (2002). The prevalence of rheumatoid arthritis in the United Kingdom: new estimates for a new century. *Rheumatology* 41(7):793–800.
- Arthritis Research UK (2013). Osteoarthritis in general practice.
- National Osteoporosis Society (2011). A fragile future: 25th anniversary report.
- Arthritis Research UK (2015). The musculoskeletal calculator. Online at www.arthritisresearchuk.org/mskcalculator.
- Vos T et al (2015). Global, regional, and national incidence, prevalence, and years lived with disability for 301 acute and chronic diseases and injuries in 188 countries, 1990–2013: a systematic analysis for the Global Burden of Disease Study 2013. *The Lancet*, 386, 9995, 743–800.
- Arthritis Research UK and the University of Manchester (2011). A heavy burden. The occurrence and impact of musculoskeletal conditions in the United Kingdom today.
- Dunn et al (2006). Characterizing the course of low back pain: a latent class analysis. *Am J Epidemiol*.163(8):754-761.
- BUPA (2009). Healthy work challenges and opportunities to 2030.
- Department of Work and Pensions (Feb 2015). Labour Force Survey analysis of disabled people by region and main health problem.
- Office of National Statistics (2014). Full Report: Sickness Absence in the Labour Market, February 2014.
- BUPA (2009). Healthy work challenges and opportunities to 2030.
- Labour Force Survey (Oct 2015). Data on-line at <http://www.hse.gov.uk/Statistics/lfs/index.htm#allillinj>.
- Department of Work and Pensions (Feb 2015). Labour Force Survey analysis of disabled people by region and main health problem.
- Department of Work and Pensions (Feb 2015). Labour Force Survey analysis of disabled people by region and main health problem.
- National Audit Office (Jul 2009). Services for people with rheumatoid arthritis. Cites: National Audit Office analysis of Office for National Statistics population estimates (mid-2007) and age and gender specific incidence predicted from Wiles et al (1999) which is based on data from the Norfolk Arthritis Register.
- National Institute for Health and Clinical Excellence (2009). Rheumatoid arthritis: The management of rheumatoid arthritis in adults.
- Yelin E et al (1987). The work dynamics of the person with rheumatoid arthritis. *Arthritis and Rheumatism* 30: 507-12.
- Dean L et al (2001). The Impact of Ankylosing Spondylitis on Work Impairment. Data from the Scotland Registry for Ankylosing Spondylitis. Abstract on-line at <http://acrabstracts.org/abstract/the-impact-of-ankylosing-spondylitis-on-work-impairment-data-from-the-scotland-registry-for-ankylosing-spondylitis/>
- National Ankylosing Spondylitis Society (Jul 2010). Looking Ahead: Best practice for the care of people with ankylosing spondylitis.
- National Ankylosing Spondylitis Society (Jul 2013). Snapshot Patient Survey.
- Arthritis Research UK (2013).Osteoarthritis in general practice.
- Arthritis Care (2012). oanation2012.
- Arthritis Research UK and the University of Manchester (2011). A heavy burden. The occurrence and impact of musculoskeletal conditions in the United Kingdom today.
- Bevan S (2012). The Impact of Back Pain on Sickness Absence in Europe.
- Bevan S (2015). Data taken from the Work Foundation's analysis of the Health Survey for England, 2015. Presentation to the symposium.
- BUPA (2009). Healthy work challenges and opportunities to 2030.
- BUPA (2009). Healthy work challenges and opportunities to 2030.
- Office of National Statistics (2014). Full Report: Sickness Absence in the Labour Market, February 2014.
- Office of National Statistics (2014). Full Report: Sickness Absence in the Labour Market, February 2014.
- Arthritis Research UK/ESRO (TBC). Everyday life and arthritis.
- National Audit Office (Jul 2009). Services for people with rheumatoid arthritis.
- Office of National Statistics (2014). Full Report: Sickness Absence in the Labour Market, February 2014.
- Black C et al (2011). Health at work – an independent review of sickness absence.
- Young V et al. (2011). Health and well-being at work: a survey of employers.
- Chartered Institute for Professional Development (2014). Absence management. Annual survey report 2014.
- Chartered Institute for Professional Development (2014). Absence management. Annual survey report 2014.
- Department of work and Pensions (Jun 2013). Evaluation of the Statement of Fitness for Work (fit note): quantitative survey of fit notes.
- <http://www.telegraph.co.uk/journalists/laura-donnely/12120065/DWP-will-be-told-which-GPs-dole-out-the-most-sicknotes.html>
- Chartered Institute of Personnel and Development (2011). Absence management. Annual Survey Report 2011.
- Chartered Institute of Personnel and Development (2011). Absence management. Annual Survey Report 2011.
- Department of Health (Jan 2008). Raising the profile of long-term conditions care: a compendium of information.
- Trades Union Congress (Feb 2009). On-line at http://www.tuc.org.uk/h_and_s/tuc-15963-f0.cfm
- Sainsbury Centre for Mental Health (2008) 'Policy Paper 8 - Mental Health at Work: Developing the Business Case'. On-line at http://www.scmh.org.uk/pdfs/mental_health_at_work.pdf.
- Verstappen S (2015). Rheumatoid arthritis and work: The impact of rheumatoid arthritis on absenteeism and presenteeism. *Best Practice & Research Clinical Rheumatology* 29, 3, 495–511.
- Verstappen S (2015). Rheumatoid arthritis and work: The impact of rheumatoid arthritis on absenteeism and presenteeism. *Best Practice & Research Clinical Rheumatology* 29, 3, 495–511.
- Labour Force Survey - Self-reported work-related ill health and workplace injuries on-line at <http://www.hse.gov.uk/Statistics/lfs/index.htm>
- McGee R (Sep 2010). Exploring the connection between physical and mental health conditions.
- Gureje O et al. (1998). Persistent pain and wellbeing: a World Health Organization study in primary care. *JAMA*1998 290 (2): 147-1531998; 280(2): 147–151.
- Arnow B et al (2006). Comorbid depression, chronic pain, and disability in primary care. *Psychosomatic Medicine* 2006; 68(2): 262–268.
- Rosemann T et al. (2007). Predictors of depression in a sample of 1021 primary care patients with osteoarthritis. *Arthritis Rheum* 2007; 57(3): 415–422.
- Bair M et al (2003). Depression and pain comorbidity: a literature review. *Arch Intern Med* 2003; 163(20): 2433–2445.
- Bevan S (2015). Data taken from the Work Foundation's analysis of the Health Survey for England, 2015. Presentation to the symposium.
- Löwe B et al (2004). Psychiatric co-morbidity and work disability in patients with inflammatory rheumatic diseases. *Psychosomatic Medicine*, 66, 395-402.
- McGee R et al (Sep 2010). Exploring the connection between physical and mental health conditions.
- McGee R et al (Sep 2010). Exploring the connection between physical and mental health conditions.

59. Taylor P et al (2007). Employment and labour market policies for an ageing workforce and initiatives at the workplace. National overview report: United Kingdom. Dublin: EuroFound.
60. Department of Work and Pensions (Jun 2014). Fuller Working Lives – Background Evidence.
61. Rice N (2011). Common health predictors of early retirement: Findings from the English Longitudinal Study of Ageing. *Age Ageing* 2011, 40(1): 54–61.
62. Black C (Mar 2008). Working for a healthier tomorrow. Dame Carol Black's Review of the health of Britain's working age population.
63. Husain et al (Apr 2015). The work related costs of ankylosing spondylitis in a UK cohort. Abstract on-line at http://rheumatology.oxfordjournals.org/content/53/suppl_1/1140.2.full.pdf+html
64. National Audit Office (Jul 2009). Services for people with rheumatoid arthritis.
65. Oxford Economics (2010). The economic costs of arthritis for the UK economy.
66. Manladakis N et al (2000). The economic burden of back pain in the UK. *Pain* 84(1): 95–103.
67. Black C (Mar 2008). Working for a healthier tomorrow. Dame Carol Black's Review of the health of Britain's working age population.
68. National Audit Office (Jul 2009). Services for people with rheumatoid arthritis.
69. Arthritis Care (2014). Arthritis Nation 2014. A report from Arthritis Care on the pain of arthritis.
70. Disability Benefits Consortium (Jul 2014). Big Benefits Survey. On-line at <https://disabilitybenefitsconsortium.wordpress.com/your-experience-of-claiming-benefits/>
71. National Rheumatoid Arthritis Society (2014). I want to work ... Employment and rheumatoid arthritis. A national picture.
72. National Rheumatoid Arthritis Society (2014). I want to work ... Employment and rheumatoid arthritis. A national picture.
73. National Rheumatoid Arthritis Society (2014). RA and Work: Employment and Rheumatoid Arthritis in Scotland. A national picture.
74. Arthritis Care (2014). Arthritis Nation 2014. A report from Arthritis Care on the pain of arthritis.
75. Arthritis Research UK/ESRO (TBC). Everyday life and arthritis.
76. National Rheumatoid Arthritis Society (2014). I want to work ... Employment and rheumatoid arthritis. A national picture.
77. Arthritis Research UK/ESRO (TBC). Everyday life and arthritis.
78. Arthritis Care (2014). Arthritis Nation 2014. A report from Arthritis Care on the pain of arthritis.
79. Work Foundation (2013). Musculoskeletal Disorders and Work. Results of a survey of individuals living with Musculoskeletal Disorders in six European countries.
80. National Ankylosing Spondylitis Society (2010). Working with ankylosing spondylitis.
81. Disability Benefits Consortium (Jul 2014). Big Benefits Survey. On-line at <https://disabilitybenefitsconsortium.wordpress.com/your-experience-of-claiming-benefits/>
82. National Rheumatoid Arthritis Society (2014). I want to work ... Employment and rheumatoid arthritis. A national picture.
83. Work Foundation (2013). Musculoskeletal Disorders and Work. Results of a survey of individuals living with Musculoskeletal Disorders in six European countries.
84. Arthritis Research UK/ESRO (TBC). Everyday life and arthritis.
85. National Rheumatoid Arthritis Society (2014). I want to work ... Employment and rheumatoid arthritis. A national picture.
86. Disability Benefits Consortium (Jul 2014). Big Benefits Survey. On-line at <https://disabilitybenefitsconsortium.wordpress.com/your-experience-of-claiming-benefits/>
87. Arthritis Research UK/ESRO (TBC). Everyday life and arthritis.
88. National Ankylosing Spondylitis Society (2010). Working with ankylosing spondylitis.
89. Arthritis Research UK/ESRO (TBC). Everyday life and arthritis.
90. National Rheumatoid Arthritis Society (2014). I want to work ... Employment and rheumatoid arthritis. A national picture.
91. National Rheumatoid Arthritis Society (2014). RA and Work: Employment and Rheumatoid Arthritis in Scotland. A national picture.
92. Disability Benefits Consortium (Jul 2014). Big Benefits Survey. On-line at <https://disabilitybenefitsconsortium.wordpress.com/your-experience-of-claiming-benefits/>
93. Arthritis and Musculoskeletal Alliance (2015). ARMA Benefits Survey 2014-5. On-line at <http://arma.uk.net/musculoskeletal-disorders-msk/arma-benefits-survey-2014-2015/>
94. Arthritis and Musculoskeletal Alliance (2015). ARMA Benefits Survey 2014-5. On-line at <http://arma.uk.net/musculoskeletal-disorders-msk/arma-benefits-survey-2014-2015/>
95. Health Quality Improvement Partnership (2016). National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis 1st Annual Report 2015.
96. British Society of Rheumatology (2015). The State of Play in UK Rheumatology.
97. National Institute for Health and Care Excellence (2009). Workplace health: long-term sickness absence and incapacity to work. Public Health Guideline.
98. Black C (Mar 2008). Working for a healthier tomorrow. Dame Carol Black's Review of the health of Britain's working age population.
99. The Marmot Review (2010). Fair society, healthy lives: The Marmot Review. Strategic Review of Health Inequalities in England post-2010.
100. Black C and Frost D (2011). Health at work – an independent review of sickness absence.
101. The Marmot Review (2010). Fair society, healthy lives: The Marmot Review. Strategic Review of Health Inequalities in England post-2010
102. HM Treasury (2015). Spending Review and Autumn Statement 2015.
103. HM Treasury (2015). Spending Review and Autumn Statement 2015.
104. Black C (Mar 2008). Working for a healthier tomorrow. Dame Carol Black's Review of the health of Britain's working age population.
105. Fit for work UK coalition (2015). Is the UK Fit for Work? Confronting the challenge of UK workforce health.
106. House of Commons Work and Pensions Committee (Oct 2015). Welfare-to-work Second Report of Session 2015–16.
107. HM Treasury (2015). Spending Review and Autumn Statement 2015.
108. House of Commons Work and Pensions Committee (Oct 2015). Welfare-to-work Second Report of Session 2015–16.
109. Greater Manchester working well pilot (Nov 2014). On-line at <http://publicservicetransformation.org/resources/work-and- skills/523-greater-manchester-working-well-pilot>.
110. House of Commons Work and Pensions Committee (Oct 2015). Welfare-to-work Second Report of Session 2015–16.
111. House of Commons Work and Pensions Committee (Oct 2015). Welfare-to-work Second Report of Session 2015–16.
112. HM Treasury (2015). Spending Review and Autumn Statement 2015.
113. House of Commons Work and Pensions Committee (Oct 2015). Welfare-to-work Second Report of Session 2015–16.
114. Department of Work and Pensions (May 2015). Work Choice Official Statistics.
115. House of Commons Work and Pensions Committee (Oct 2015). Welfare-to-work Second Report of Session 2015–16. Cites Department of Work and Pensions, Work Choice Official Statistics, Aug 2015.
116. House of Commons Work and Pensions Committee (Oct 2015). Welfare-to-work Second Report of Session 2015–16.
117. Department of Work and Pensions (May 2015). Work Choice Official Statistics.
118. HM Treasury (2015). Spending Review and Autumn Statement 2015.
119. Access to work information on-line at <https://www.gov.uk/access-to-work/overview>
120. Department of Work and Pensions (Jan 2015). Access to Work Official Statistics. On-line at <https://www.gov.uk/government/collections/access-to-work-statistics-on-recipients--2>

121. House of Commons Work and Pensions Committee (Dec 2014). Improving Access to Work for disabled people. Second Report of Session 2014-5.
122. HM Treasury (2015). Spending Review and Autumn Statement 2015.
123. Department of Work and Pensions (2014). One year on - breaking down the barriers to employment. On-line at <https://www.gov.uk/government/collections/disability-confident-campaign>.
124. Public Health England (July 2015). Who we are and what we do: Annual Plan 2015/16.
125. Public Health England (July 2015). Who we are and what we do: Annual Plan 2015/16.
126. Workplace Wellbeing Charter website. On-line at <http://www.wellbeingcharter.org.uk/index.php>
127. National Institute for Health and Care Excellence (Mar 2009). Workplace health: long-term sickness absence and incapacity to work. Public health guideline.
128. National Institute for Health and Care Excellence (Mar 2009). Workplace health: long-term sickness absence and incapacity to work. Public health guideline.
129. <http://www.csp.org.uk/professional-union/practice/your-business/evidence-base/physiotherapy-works/fitness-for-work>
130. <http://arma.uk.net/resources/working-with-arthritis/#arma-work-charter>
131. Office for National Statistics. Public Sector Employment, September 2015. On-line at <http://www.ons.gov.uk/ons/rel/pse/public-sector-employment/q3-2015/stb-q3-2015.html>
132. NHS (Oct 2014). Five year forward view.
133. NHS (Oct 2014). Five year forward view.
134. Greater Manchester working well pilot (Nov 2014). On-line at <http://publicservicetransformation.org/resources/work-and-skills/523-greater-manchester-working-well-pilot>
135. NHS-England (Sep 2014). £5million plan to improve the health of NHS staff. On-line at <https://www.england.nhs.uk/2015/09/02/improving-staff-health/>
136. Arthritis Research UK, Medical Research Council, University of Southampton. Centre for Musculoskeletal Health & Work. On-line at <http://www.mrc.soton.ac.uk/cmhw/>
137. The HEAF Study. On-line at <http://www.mrc.soton.ac.uk/cmhw/southampton-hub/research-projects-led-by-the-southampton-hub/the-heaf-study>
138. University of Salford, Manchester. Rehabilitation research. On-line at <http://www.salford.ac.uk/health-sciences/research/research-programmes/rehabilitation-research>
139. See University of Salford, Manchester. Rehabilitation research. On-line at <http://www.salford.ac.uk/health-sciences/research/research-programmes/rehabilitation-research>
140. Roadmap for sustainable healthcare (2015). Sustainable healthcare pilot 3: Early intervention clinic for musculoskeletal disorders.
141. Erwin et al (2015). Promoting Musculoskeletal Health in the Workplace – the training needs of line managers. EULAR abstract.
142. Bevan S et al (2009). Fit For Work? Musculoskeletal Disorders in the European Workforce.
143. Government Equalities Office (2010). The Equality Act (2010).
144. <http://www.equalityhumanrights.com/publication/equality-act-2010-guidance-matters-be-taken-account-determining-questions-relating-definition>
145. Government Equalities Office (Feb 2013). Equality Act 2010: guidance. On-line at <https://www.gov.uk/guidance/equality-act-2010-guidance>
146. Citizen's Advice (2016). Equality Act 2010 - discrimination and your rights. On-line at <https://www.citizensadvice.org.uk/discrimination/about-discrimination/equality-act-2010-discrimination-and-your-rights/>
147. Department of Work and Pensions (1996). Employment Rights Act (1996).
148. Department of Work and Pensions (2014). The Flexible Working Regulations 2014.
149. Gov.uk (2014). Flexible working. On-line at <https://www.gov.uk/flexible-working/overview>
150. The Health and Safety Executive. On-line at <http://www.hse.gov.uk/>
151. The Health and Safety Executive. Legislation covering MSDs. On-line at <http://www.hse.gov.uk/msd/legislation.htm>
152. HM Government (1974). Health and Safety at Work etc. Act (1974).
153. HM Treasury (March 2013). Budget 2013.
154. Department of Work and Pensions (2014). Finance Act (2014).
155. HM Treasury (March 2014). Finance Bill 2014 Explanatory Notes. Clauses 1 to 67 (Volume 1 of 2).
156. <https://responsibilitydeal.dh.gov.uk/category/physicalactivity-network/>
157. Health Quality Improvement Partnership (2016). National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis 1st Annual Report 2015.
158. British Society of Rheumatology (2015). The State of Play in UK Rheumatology.
159. Arthritis and Musculoskeletal Alliance (2015). ARMA Benefits Survey 2014-5. On-line at <http://arma.uk.net/musculoskeletal-disorders-msk/arma-benefits-survey-2014-2015/>
160. Arthritis Care (2014). Arthritis Nation 2014. A report from Arthritis Care on the pain of arthritis.
161. Arthritis Research UK/ESRO (TBC), Everyday life and arthritis.
162. Disability Benefits Consortium (Jul 2014). Big Benefits Survey. On-line at <https://disabilitybenefitsconsortium.wordpress.com/your-experience-of-claiming-benefits/>
163. National Osteoporosis Society (2014). Life with Osteoporosis: the untold story.
164. Work Foundation (2013). Musculoskeletal Disorders and Work. Results of a survey of individuals living with Musculoskeletal Disorders in six European countries.
165. Work Foundation (2012). Taking the strain: The impact of musculoskeletal disorders on work and home life.
166. National Rheumatoid Arthritis Society (2014). RA and Work: Employment and Rheumatoid Arthritis in Scotland. A national picture.
167. National Ankylosing Spondylitis Society (2010). Working with ankylosing spondylitis.
168. National Rheumatoid Arthritis Society (2014). I want to work ... Employment and rheumatoid arthritis. A national picture.
169. National Institute for Health and Care Excellence (Apr 2007). Smoking: workplace interventions.
170. National Institute for Health and Care Excellence (May 2008). Physical activity in the workplace.
171. National Institute for Health and Care Excellence (Mar 2009). Workplace health: long-term sickness absence and incapacity to work.
172. National Institute for Health and Care Excellence (Nov 2009). Mental wellbeing at work.
173. National Institute for Health and Care Excellence (July 2012). Workplace health. Local government briefing.
174. National Institute for Health and Care Excellence (June 2015). Workplace health: management practices.
175. Government Equalities Office (2010). The Equality Act (2010).
176. Government Equalities Office (Feb 2013). Equality Act 2010: guidance. On-line at <https://www.gov.uk/guidance/equality-act-2010-guidance>
177. ACAS (Jan 2016). Disability discrimination: key points for the workplace.

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