Bristol JSNA Chapter 2017

Work and Health

Chapter information	
Chapter title	Work and Health
Chapter reference group	Employment and Skills sub-group (for West of England)
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Chapter endorsed by	West of England Directors of Public Health Partnership Board / July 2017
Chapter approved by	
Linked JSNA chapters	Mental health Substance misuse

Executive summary

Introduction

Employment is a major determinant of health and has a direct and indirect impact on individuals, their families and communities. Unemployment is associated with an increased risk of mortality and morbidity, for example, long term health conditions, cardiovascular disease, poor mental health and unhealthy lifestyles [1].

Nationally, 74% of adults are in employment and spend a third of their waking hours at work. As a result, workplaces provide an important setting for improving adult health and wellbeing which, in turn, contributes to business productivity. Evidence shows that good working conditions and a supportive work culture have a positive impact on health. By contrast, poor working conditions are associated with poor physical and mental health. Low levels of job control, lack of fairness, and a high imbalance between effort and reward are particularly detrimental.

Bristol has a good news story with regard to high employment rates, low numbers of benefit claimants and a good recovery from the 2008 recession, compared to other major cities in England. However, this masks some persistent inequalities: pockets of high unemployment which have not changed over time and demographic groups who are more likely to experience unemployment and, when in work, for this work to be precarious. Rates of long term health conditions, cardiovascular disease, poor mental health and unhealthy lifestyles vary demographically.

Bristol's employment rate (75.9%) remains higher than that for the UK (73.7%). In 2016, 79.4% (248,200) of Bristol's working age population (16-64 years) were economically active. Bristol has the lowest benefit claimant rate of the Core Cities, but this continues to be higher than the rest of the West of England[2].

Mental health conditions have a greater impact on people's ability to work than any other group of disorders[3]. In Bristol, poor mental health is the single largest cause of Employment and Support Allowance claims (54%), followed by musculoskeletal conditions (12%)[4] . Supporting employees with mental health conditions to stay in work is beneficial for employees, employers and the economy[5].

Disabled people and those living with long term conditions have much lower employment rates than the non-disabled working age population. In Bristol, there is a 27.7% gap between the employment rate for disabled people and non-disabled people which is higher than for other core cities but lower than for neighbouring authorities. For people with a learning disability, the

[1] Is work good for your health and well-being? An independent review , Waddell and Burton, 2006.https://www.gov.uk/government/publications/is-work-good-for-your-health-and-well-being
[2] Bristol Economic Briefing, March 2017
[3] Mental Health and Work, Royal College of Psychiatrists, 2016
[4] ONS statistics, via NOMIS, October 2016
[5] Webber, D et al, Mental health and employment transitions: a slippery slope, July 2017

employment gap in Bristol is 66.6% and for those in contact with secondary mental health services, the gap is 65.2%[6].

Evidence shows that 90% of people with common health conditions can be supported to remain in and helped back to work and, for many people, returning to work can be part of their recovery[7]. One of the challenges of the rising pension age is that employees will have a need to work for longer and this means that rates of employees suffering from long term conditions and co-morbidites in the workplace can be predicted to rise. As a result, there will be an increasing role for employers to play in recruiting, retaining and supporting employees to stay in work with health conditions.

In recent years, Government has supported the development of workplace health initiatives. The Government commissioned a major review of the health of the working age population which generated a wide-ranging series of proposals to improve access to work, provide in-work support to those who require it and encourage employers to promote workplace health[8]. The Marmot Review, published in 2010, included the creation of fair employment and good work for all as one of its policy objectives[9]. Improving staff health and wellbeing was included in the NHS Five Year Forward View[10] and support was provided for the Workplace Wellbeing Charter, a national standard, by Public Health England.

However, most workplace health schemes have been taken up by large organisations rather than small and medium sized businesses businesses and have mainly been limited to lifestyle health and individual focused stress management issues. This is equally true in Bristol[11]. There continues to be a question about how to promote workplace health in smaller organisations and how to address health inequalities through workplace health interventions[12]. There is a clear need to address vulnerability and poverty by providing routes to more secure and better paid work.

This chapter provides an overview of the relationship between health and unemployment, employment and the workplace. By necessity, it is not comprehensive but serves to provide context, to highlight some of the key issues, to identify where evidence is robust or lacking, to make connections to other chapters and to make recommendations for further work.

[6] Annual Population Survey – Labour Force Survey 2015-16, via NOMIS
[7] Work, health and disability Green Paper, October 2016
[8] Black, C. Working for a healthier tomorrow, 2008, Department of Work and Pensions. https://www.gov.uk/government/publications/working-for-a-healthier-tomorrow-work-and-health-in-britain
[9] Marmot, M. Fair society, healthy lives : the Marmot Review: strategic review of health inequalities in England post-2010. (2010) ISBN 9780956487001
[10] NHS Five year forward view, NHS England, October 2014
[11] Bristol Workplace Wellbeing Charter Annual Report 2015-16
[12] McEnhill, L and Steadman, K. Work Foundation, November 2015

Summary of key issues and gaps (see page 28 for full details)

- Addressing persistent unemployment and disadvantage across the city, particularly those who are furthest from employment
- Providing effective career pathways and fulfilling work opportunities for young people
- Responding to welfare reform
- Addressing the disability employment gap
- Tackling the two largest causes of health-related unemployment and sickness absence: musculoskeletal conditions and mental health (stress, anxiety and depression)
- Managing long term health conditions in the workplace as a result of the rise in the pension age
- Ensuring that the rise of self-employment and the gig[13] economy does not entrench disadvantage and inequality

Recommendations

- Work in partnership with West of England Combined Authority (WECA) and West of England Local Authorities to develop a common strategic framework for the commissioning of work and health programmes across the sub region.
- Ensure that the design and delivery of programmes with both health and employment outcomes are evidence based.
- Promote better coordination between agencies providing work and health advice and support at a community and citywide level.
- Target communities which are excluded and marginalised to overcome the cycle of unemployment and in work poverty.
- Provide local responses to welfare reform and changing government policy to ensure the best health and employment outcomes for local communities and individuals.
- Address the disability employment gap by working with employers to ensure fair recruitment and selection processes, to increase retention and to support employees with health conditions to stay in work.
- Explore opportunities to fill data gaps by working with academic partners on issues of common interest (for example, the growth of the local gig economy, how physical and mental health conditions affect different occupational sectors).

[13] The gig economy is defined as 'a labour market characterized by the prevalence of short-term contracts or freelance work as opposed to permanent jobs' (Oxford English Dictionary).

JSNA chapter report

A: What do we know?

1) What is the size of the issue in Bristol and who is affected?

Unemployment

Bristol has the lowest claimant rate of the Core Cities, but the rate has been consistently higher than the rest of the West of England. In 2016, the number of Bristol residents that were unemployed and claiming Universal Credit averaged 5,193[14].

Claimants by Gender

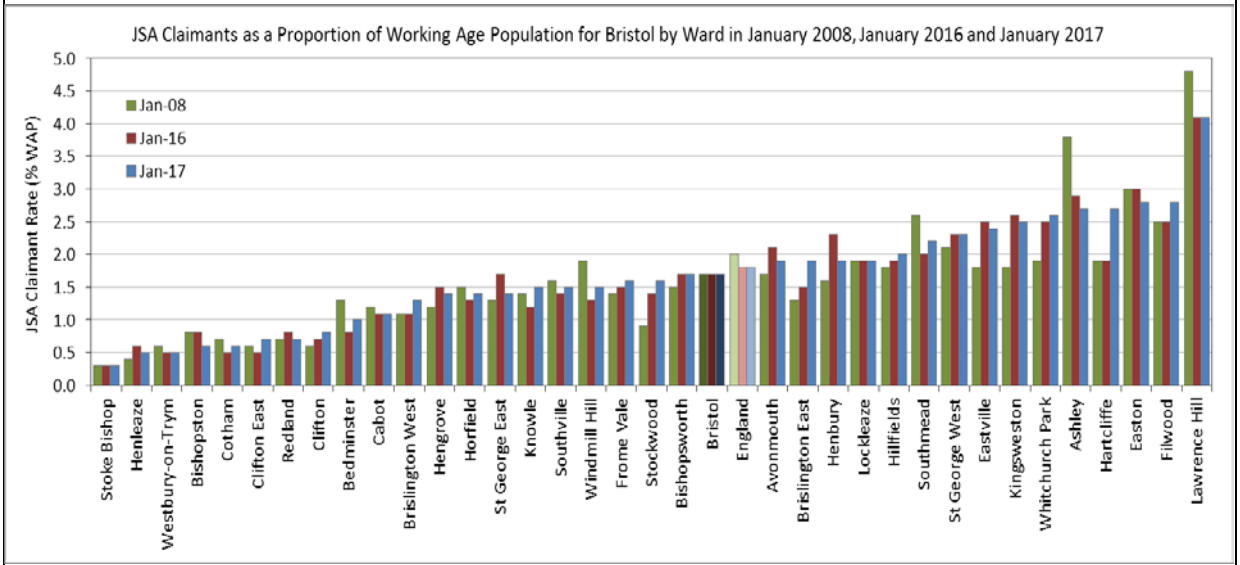
As of January 2017 there were 3,345 male and 1,875 female JSA/Universal Credit claimants resident in Bristol. Prior to the 2008 recession, there were about three times as many male as there were female claimants, compared to nearly twice (1.78) as many now. This means that the female population of Bristol has fared worse than males since the 2008 recession.

JSA Claimants by Duration

The numbers of long-term unemployed have been falling more or less steadily since 2012-13. However the numbers of very long term and extremely long term claimants are 2.2 and 6.0 times higher than those of the pre-recession levels.

Claimants by Ward for Bristol

Throughout the period 2008-17, Lawrence Hill had the highest number of Job Seekers Allowance claimants, followed by Ashley, Easton and Filwood. Other wards with high claimant rates during this period are Eastville, Hartcliffe, Whitchurch Park and Southmead. This demonstrates that, although unemployment rates have been falling city wide, residents in some wards of the city have been living with persistent long term unemployment.



[14] Bristol Economic Briefing, March 2017

Unemployment by Age

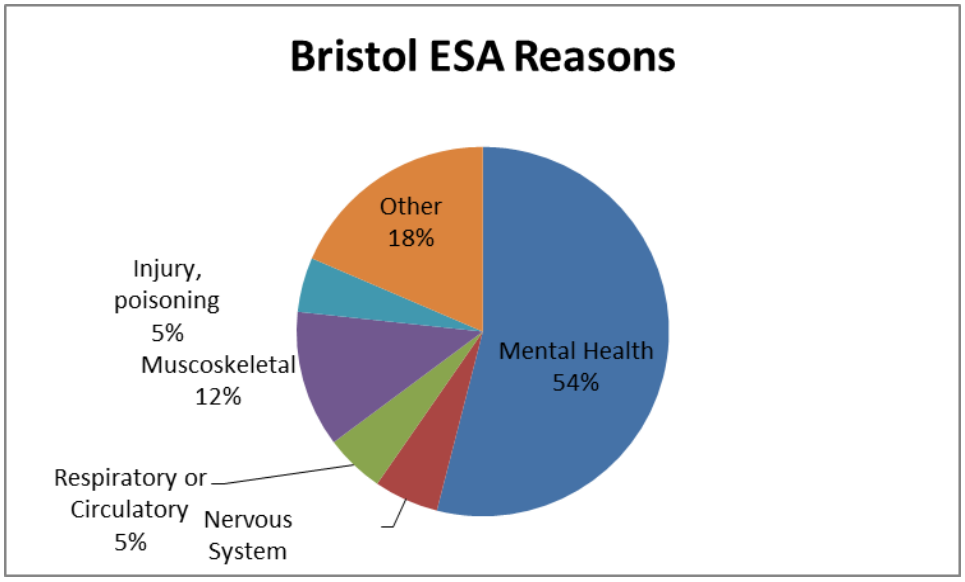
In February 2017, there were 5,515 claimants in Bristol, of whom 3,555 were men and 1,960 were women. Of these, the largest group were aged 25-49 (3,225), followed by the 50+ age group (1,305). 975 were aged 18-24. The number of young claimants resident in Bristol was 57% down on that for January 2014 and the lowest number on record. The proportion of claimants aged 18 to 24 years is also the lowest on record (17.5%). The number of claimants aged 50 to 64 years was up (16.4%) on that of January 2016; 93% above the pre-recession level of January 2008. The proportion (24.4%) of claimants who are aged 50 to 64 year continues to increase and remains at a historic high[15].

Worklessness

Claimant numbers have been falling steadily and, in August 2016, the total number of Bristol residents claiming DWP Out of Work Benefits was 28,240. Lawrence Hill, Filwood, Ashley, Whitchurch Park, Hartcliffe, Hillfields and Easton all had in excess of 1,000 residents claiming benefits and accounted for 35.6% of claimants in Bristol. The largest group of claimants were for Employment Support Allowance and Incapacity benefits – 20,300. 3,740 were claiming Job Seeker's Allowance (Working age benefit claimants (not seasonally adjusted, August 2016, DWP)).

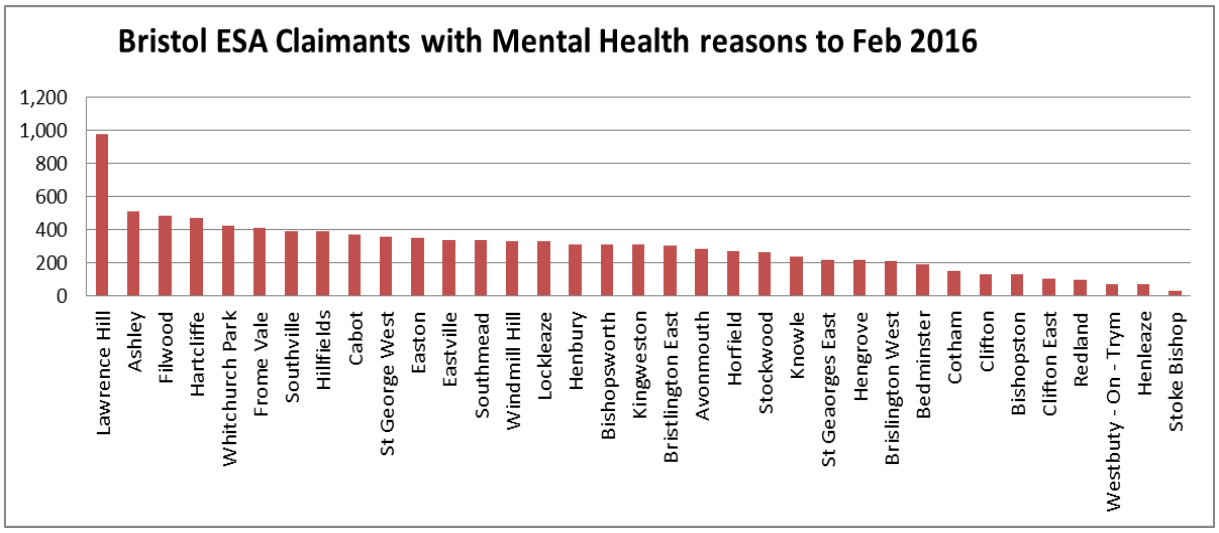
Reasons for claiming

In Bristol, poor mental health is the single largest cause of Employment and Support Allowance claims (54%). This is the second highest rate in the South West and the 6th in England. Musculoskeletal conditions are the second highest cause (12%)[16] .

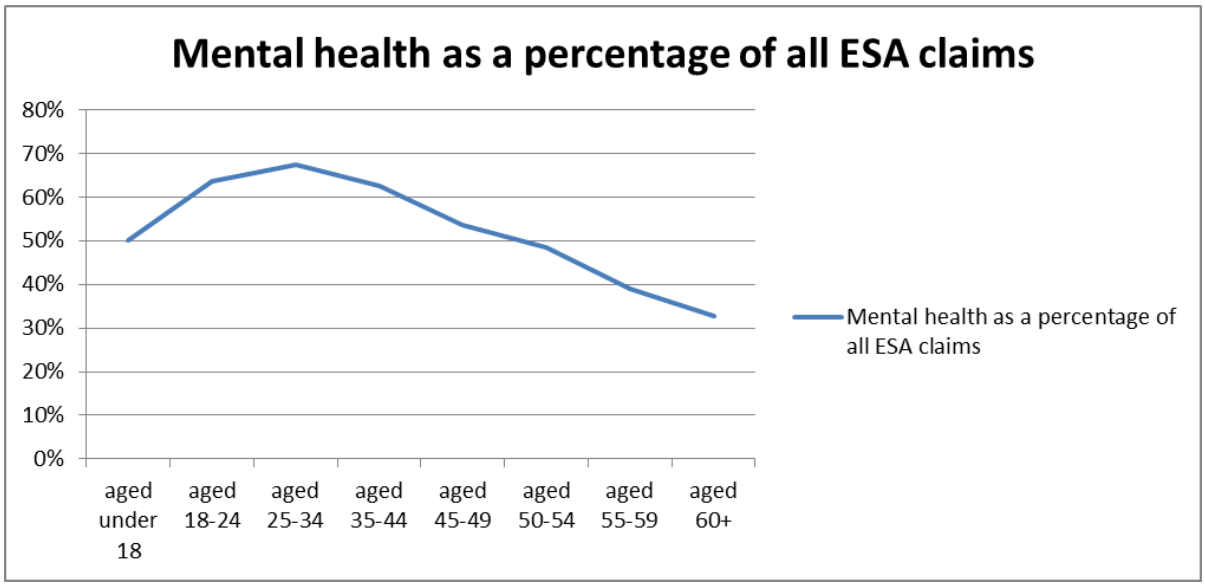


This table below shows the distribution of mental health claimants across Bristol by ward. Lawrence Hill has more than double the number of any other ward[17]. 55% of the population in Lawrence Hill belong to a black and minority ethnic group[18] .

[15] February 2017, ONS Annual Population Survey
[16] ONS statistics, October 2016
[17] ONS via Nomis, October 2016
[18] The Population of Bristol, July 2016



The table below shows the distribution of ESA claimants for mental health reasons by age. The largest number of claimants are in the 35-44 age group (25.2%) and 25-34 age group (21.4%). In the 25-34 age group, mental health reasons make up 68% of all ESA claims[19].



56% of ESA claimants for whom mental health was their reason for claiming are men and 44% are women[20].

[19] ONS via Nomis, accessed 22 June 2017
[20] ONS via Nomis, accessed 22 June 2017

Employment

Economy

Bristol is part of a buoyant West of England economy. 90% of all West of England businesses are small and medium sized enterprises. 50.6% of the West of England population are female and 9.1% of the population classify as being from minority ethnic backgrounds, rising to 16% in Bristol. Local research shows that black and minority ethnic and women-led businesses contribute an estimated average of £2bn to the regional economy[21].

Working age population (ages 16-64)

In 2015, the working age population in Bristol was 306,300 (men: 155,500 and women: 150,700)[22]. 15% of the working age population belong to a black and minority ethnic group[23].

Employment rate

The employment rate for Bristol (75.9%) remains higher than that for the UK (73.7%) and is the highest amongst the Core Cities Group[24]. Women's employment rates have risen rapidly since 2012-13 and hit an all time high in September 2015 since when they have fallen slightly (but not significantly).

Economic activity[25]

In 2016, 79.4% (248,200) of the population were economically active. 63.8% were employed, 11.4% were self-employed and 5% were unemployed. 20.6% (62,500) of the population were economically inactive. This includes those who are students, carers, retired and unable to work as a result of sickness. Between January and December 2015, 18,600 households in Bristol were workless – that is, there was no one aged 16-64 in the household who was working.

[21] Annual Equality and Diversity Report (April 2017), West of England Local Enterprise Partnership, http://www.westofenglandlep.co.uk/about-us/strategicplan
[22] ONS Annual Population Survey
[23] The Population of Bristol, July 2016
[24] Bristol Economic Briefing, March 2017
[25] Oct 2015 - Sept 2016, ONS Annual Population Survey

Employment by occupation[26]

In Bristol, more than half (53.7%) of those in employment are managers, in professional and technical occupations. This is well above the England average of 45.7%. 18.4% are in secretarial, administration and technical trades occupations (slightly below the England average of 20.9%). 13.8% are in caring, leisure and other service occupations (below the England average of 16.8%) 14.1% work in process plant and machine operations and elementary occupations (below the England average of 17.2%).

Jobs by sector[27]

The largest single category of employment in Bristol is health and social work with 40,000 jobs**.** This is followed by wholesale and retail trade, repair of motor vehicles and motorcycles with 38,000 jobs; professional, scientific and technical activities with 29,000 jobs; administrative and support services with 26,000 jobs and education with 23,000 jobs.

Number of businesses[28]

In 2016, there were 17,390 enterprises in total. Of these, 75 were large business (employing 250+ employees); 315 were medium sized businesses (employing 50-249); 1,724 were small businesses (employing 10-49) and 15,270 were micro businesses (employing 0-9).

Qualifications[29]

Bristol's workforce is very well qualified: 47.9% are qualified to NVQ4 and above (compared to 37.1% for England), 63.7% to NVQ3 and above (55.8% for England), 76% to NVQ2 and above (73.6% for England). 5.9% have no qualifications (compared to 8.6% for England).

Pay (by place of residence)[30]

Average gross weekly pay for full time workers in Bristol was £526.8 (compared to £541 for England). Male full time workers were paid £100 more per week than female full time workers. Average hourly pay for men was £14.22 compared to £12.77 for female full time workers.

Pay distribution[31]

Pay distribution can be seen as a measure of pay inequality. In Bristol, the minimum earnings of the top (10) percentile of those in work in 2015 was £875, compared to the maximum £138 for the lowest paid (10) percentile. This means the highest paid 10% earned at least 6.3 times as much every week as the bottom 10%. Between 2002 and 2015, this gap in Bristol's weekly earnings grew at an average rate of £16.80 each year, similar to the growth in the gap for England (£16 per year). Taking 2015 data as a starting point and assuming the top 10% earnings grow at 3% per year, even if the bottom 10% grew 3 times as quickly (9%), the gap between the two would take close to 20 years to start closing.

Housing costs[32]

House prices in Bristol are rapidly rising, faster than nationally and faster than average incomes. There is a serious shortage of affordable housing in the city and rising homelessness. There has also been a significant increase in private renting (and rental costs). The "affordability ratio" measures the relationship between the price of the cheapest homes and the lowest level earnings. In 1997

[26] Oct 2015 – September 2016, ONS Annual Population Survey
[27] 2015, ONS Business Register and Employment Survey
[28] 2016, ONS Interdepartmental Business Register
[29] Jan-Dec 2015, Annual Population Survey
[30] 2016, Annual Survey of Hours and Earnings
[31] Annual Survey of Hours and Earnings, 2015
[32] Bristol Joint Strategic Needs Assessment, 2016-2017

this ratio was 3.19 in Bristol, rising to a peak of 7.91 in 2007 before reducing. However, this ratio is again rising, and in 2015 set a new peak of 8.18 (i.e. the cost of the cheapest home in Bristol was over 8 times the annual earnings of lower income households)[33]. The England average in 2015 was 7 times. A similar ratio (7.80) applies when average (median) earnings are compared to median house prices for Bristol (7.63 nationally).

New ways of working

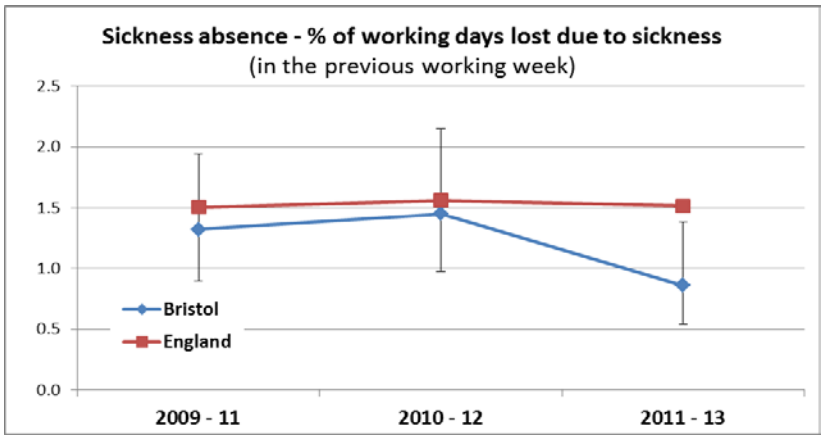
Nationally there has been a rise in the number of people who are self employed, involved in precarious employment and the gig economy[34]. This includes people who choose to freelance and work flexibly (for example, in the artistic, creative and digital industries) as well as those who are employed in jobs with variable working patterns (who often work in low paid occupations in service industries). About 7.1 million people have working conditions that are insecure and/or subject to short notice change. Some of these are designated as self-employed while others are designated as employed but may, for example, have zero-hours contracts or fluctuating working hours.

Bristol Citizens' Advice Bureau published a report in 2015, based on case work with clients, which found that irregular work and unpredictable incomes were making it difficult to budget for living expenses, or claim top-up welfare benefits. For many of these workers, there had been lack of clarity about the type of employment they were entering into and the difficulties of living with a fluctuating income over which they had little or no control[35].

Workplace

Sickness absence

Sickness absence rates in Bristol are below the England average[36].



Reasons for sickness absence

National data (2014) show that, after minor illnesses, the most common reasons for sickness absence was back, neck and muscle pain (accounting for 30.6 million working days lost), followed by stress, anxiety and depression (15 million working days lost). Furthermore, physical and mental health conditions often co-exist. Those with painful musculoskeletal conditions (MSK) will often experience anxiety and depression and a person with depression will often take longer to recover from MSK pain.

[33] Source DCLG, 2016 www.gov.uk/government/statistical-data-sets/live-tables-on-housing-market-and-house-prices

[34] See footnote1, p.3

[35] Works for you? Investigating the Impact of Insecure Employment in Bristol, Bristol Citizens' Advice Bureau, October 2015

[36] Labour Force Survey via Public Health Outcomes Framework 2016

Research into sickness absence in Bristol, carried out in 2013[37], highlighted the following:

- 10 million working hours were lost to sickness or injury in 2010 at a cost to the Bristol economy of £240 million.
- Mirroring national data, sickness absence rates were higher amongst public sector and older workers (50+)
- By occupation, rates were highest amongst those in lower managerial/professional positions and people employed in semi-routine and routine work.

Work-related stress and absence

Further local research in to work-related stress and absence[38] identified that:

- 1 in 4 days lost to sickness absence in Bristol were work- related, that is, the ill health symptoms/condition were considered to be a result of work or made worse by work.
- Stress, depression or anxiety accounted for 36% of work-related ill health.
- The average spell of sickness absence for stress, depression or anxiety in was 7.6 days compared to an average of 4.7 days for all sickness absence.
- Workload was the most frequent cause of job stress.
- Higher-level professionals, front-line supervisors, those working for a large organisation or dealing face to face with the public reported above average rates of stress-related sickness absence attributable to work.

Long term health conditions

It is estimated that by 2040, 40% of the working age population will have a long term health condition[39]. Nationally, 1 in 3 of the working age population in England report having at least one long-term health condition while 1 in 7 report more than one. 1 in 4 of report having a physical health condition: of those, 1 in 5 also report having a mental health condition. 1 in 10 have a musculoskeletal condition. In Bristol there is a 7.3% gap in the employment rate between those with a long term health condition and the overall employment rate.

With a rising pension age, there are likely to be more people within the workforce with disabilities and long term health conditions. Examples, using current data, include:

- Macmillan Cancer estimate that there are over 700,000 people of working age living with a cancer diagnosis[40].
- There are an estimated 4.5 million people with diabetes in the UK[41]. This includes 1 million people with Type 2 diabetes who do not know they have it. Based on current population trends, by 2035, 4.9 million people will have diabetes.
- British Heart Foundation estimates that there around 7 million people living with cardiovascular disease in the UK, 3.5 million men and 3.5 million women[42] .
- Chronic pain affects between one-third and one-half of the population of the UK, corresponding to just under 28 million adults[43] .

[37] Profiling Sickness Absence Within the City of Bristol, A. Weyman, A. Buckingham, University of Bath, Feb 2013 (2010 data)

[38] Profiling Work-Related Stress Sickness Absence Within the City of Bristol, A. Buckingham and A. Weyman, University of Bath, October 2013 (using 2010 data)

[39] Health and Wellbeing at Work: a survey of employees 2014, Department of Work and Pensions, June 2015

[40] King's College London, Macmillan Cancer Support, and National Cancer Intelligence Network. Cancer prevalence in the UK. 2008

[41] Using QOF figures with estimates from the Diabetes Prevalence Model 2016 (Public Health England) and 2012 APHO Diabetes Prevalence Model, Diabetes UK, November 2016

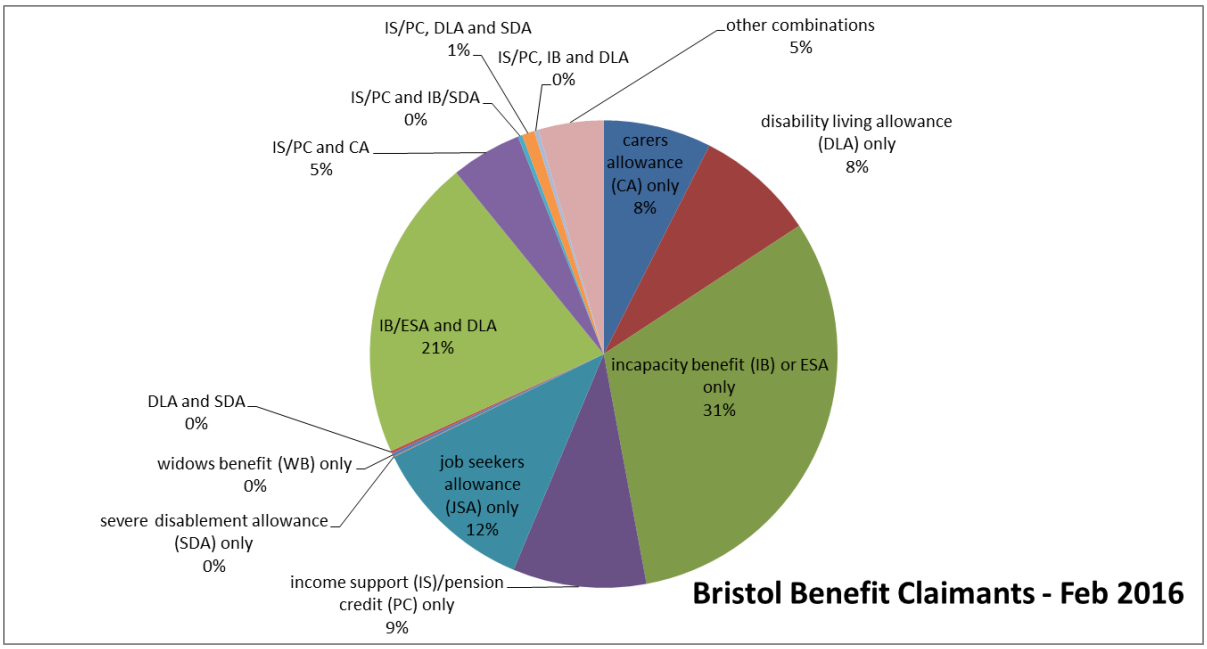
[42] BHF CVS Statistics Factsheet, updated March 2017

2) Who is affected?

Working age claimants in Bristol

In February 2016, the total number of working age (16-64) claimants was 36,810[44]. The largest number of claims was for Incapacity Benefit or Employment and Support Allowance (31%). The table and figure below provide a breakdown of the total number of claimants as follows:

Benefit	Total
Carers'allowance (CA) only	2,750
Disability living allowance (DLA) only	3,050
Incapacity benefit (IB) or ESA only	11,530
Income support (IS)/pension credit (PC) only	3,400
Job seekers allowance (JSA) only	4,210
Severe disablement allowance (SDA) only	20
Widows benefit (WB) only	80
DLA and SDA	70
IB/ESA and DLA	7,710
IS/PC and CA	1,800
IS/PC and IB/SDA	110
IS/PC, DLA and SDA	320
IS/PC, IB and DLA	110
Other combinations	1,660
Total	**36,810**



[43] Fayaz A, Croft P, Langford RM, *et al,* Prevalence of chronic pain in the UK: a systematic review and meta-analysis of population studies. BMJ Open 2016;6:e010364. doi: 10.1136/bmjopen-2015-010364

[44] Nomis, accessed June 2017

Social disadvantage and health conditions

The Marmot review[45] described the social gradient in health which results in reduced life expectancy, lower disability free life expectancy and poorer health outcomes for those who are disadvantaged and live in poverty. Patterns of employment both reflect and reinforce the social gradient and there are serious inequalities of access to labour market opportunities.

Rates of unemployment are highest among those with no or few qualifications and skills, people with disabilities and mental ill-health, those with caring responsibilities, lone parents, those from some ethnic minority groups, older workers and, in particular, young people.

A qualitative study, conducted in Bristol in 2013[46], explored the work experiences of people living in Knowle West. This research concluded that:

> *"The interviews conducted show that ill health can strike relatively early in Knowle West. The people interviewed here were keen to work and try to make a good living, but in the majority of experiences illness got in the way. For these people illness either caused poverty or prevented them from getting out of poverty."*

Disability free life expectancy[47]

Disability-free life expectancy is the average number of years an individual is expected to live free of disability if current patterns of mortality and disability continue to apply. For both women and men, average disability free life expectancy is lower in Bristol than for England as a whole (see Figures 1and 3 below). It is also below state retirement pension age for both women and men. This gap between the age at which disability and long term conditions may arise and state pension age will pose challenges for both individuals and employers.

Disability free life expectancy for women and men in Bristol
(Disability free life expectancy average for Bristol 2009-13, ONS 2015)

	Disability free average life expectancy		**Average life expectancy**	
	Bristol	England	Bristol	England
Women	63.9	65.0	82.7	
Men	62.3	64.1	78.0	

There is a significant gap between those parts of the city where disability free life expectancy is below the England average and those where it is above (see Figures 2 and 4 below).

Disability free life expectancy by Middle Layer Super Output Area[48]
(Disability free life expectancy average for Bristol 2009-13, ONS 2015)

	Disability free life expectancy below the England average	**Disability free life expectancy above the England average**
Women	Most of Hartcliffe and Withywood, Knowle West, Lawrence Hill, Redcliffe, Southmead, parts of Avonmouth and Lockleaze	Clifton, Redland, Cotham, Westbury on Trym, Stoke Bishop.
Men	Hartcliffe, Filwood, Lawrence Hill, Redcliffe, part of Avonmouth and Southville.	Clifton, Westbury on Trym, Henleaze, Stoke Bishop

[45] Marmot M, op cit
[46] Health and work local stories - a Knowle West perspective, Knowle West Health Park, 2013
[47] Average disability free life expectancy is 56-60 years for women and 53-58 years for men.
[48] A Middle Layer Super Output Area (MSOA) is a geographic area used for statistical purposes where the minimum population is 5000 and the mean is 7200.

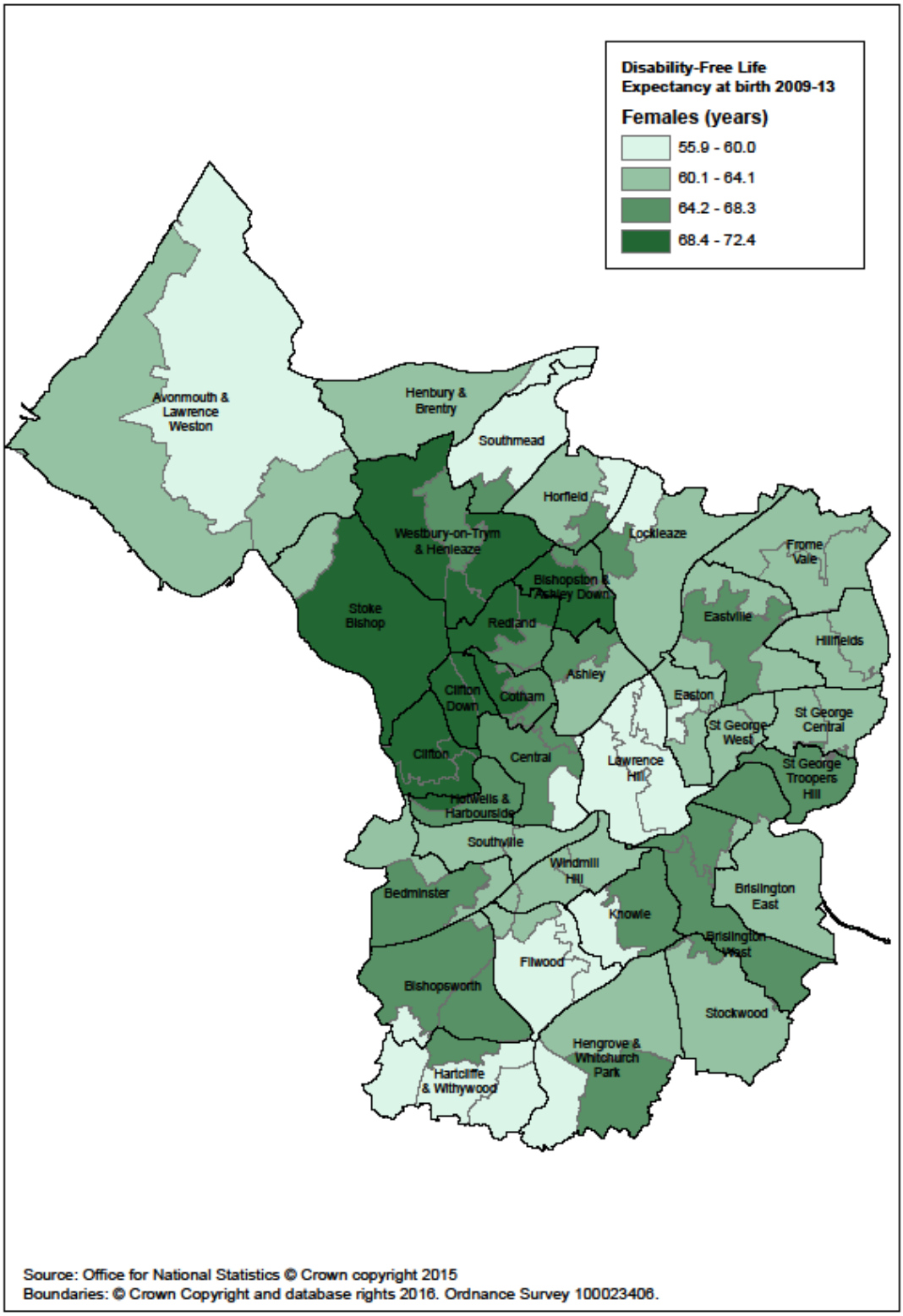


Figure 1. Female disability free life expectancy in Bristol

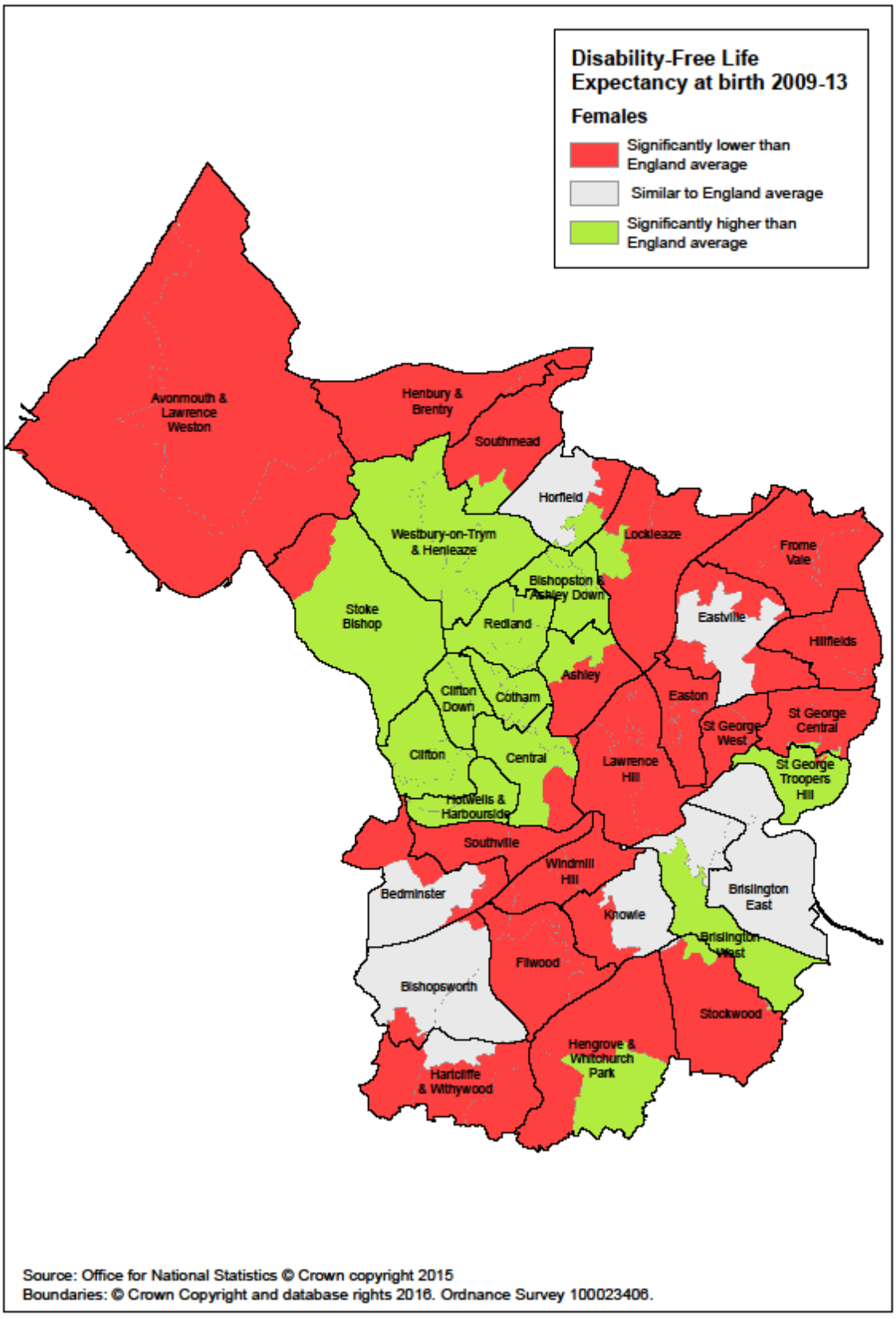


Figure 2: Disability free life expectancy for females comparing Bristol to the England average

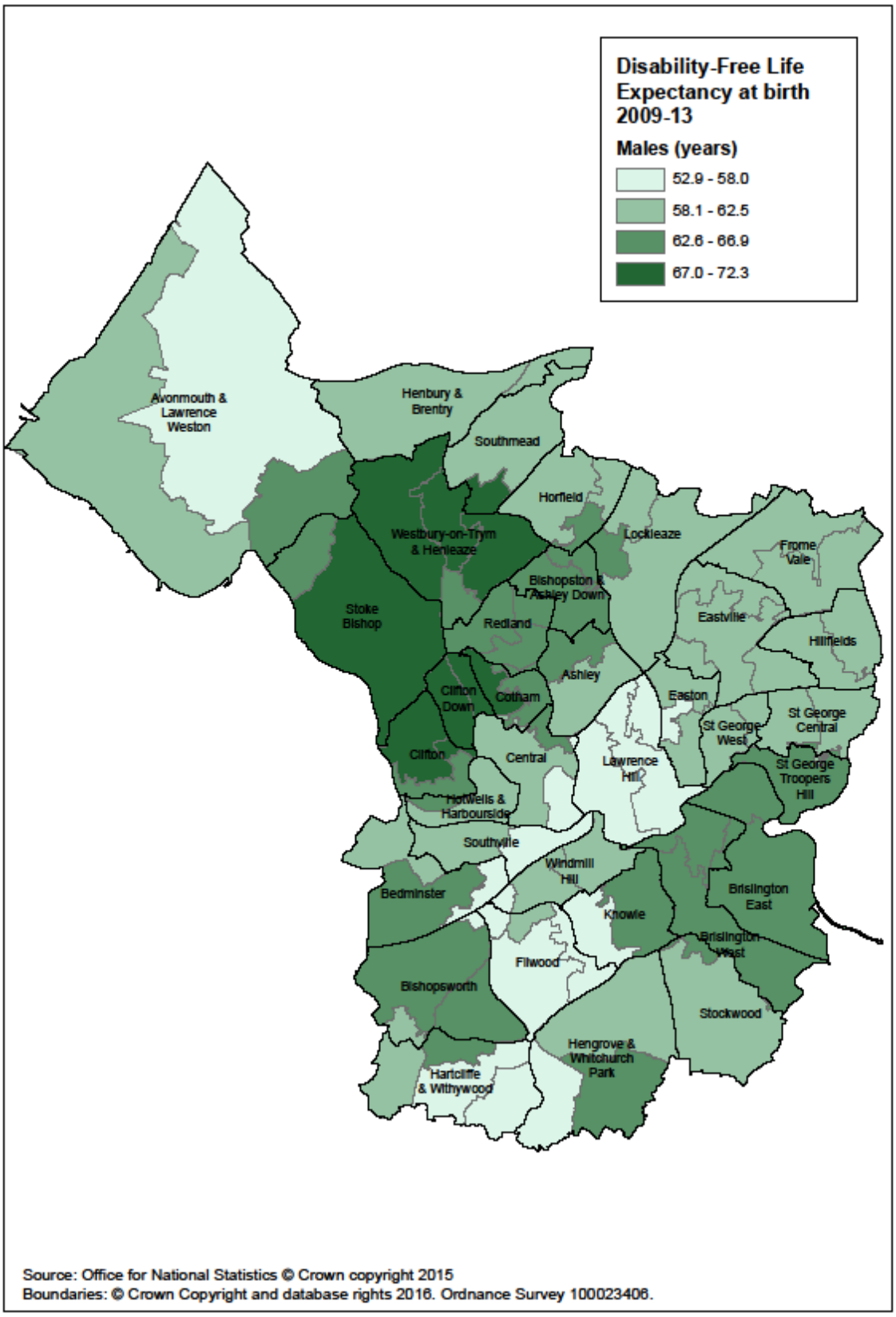


Figure 3: Male disability free life expectancy in Bristol

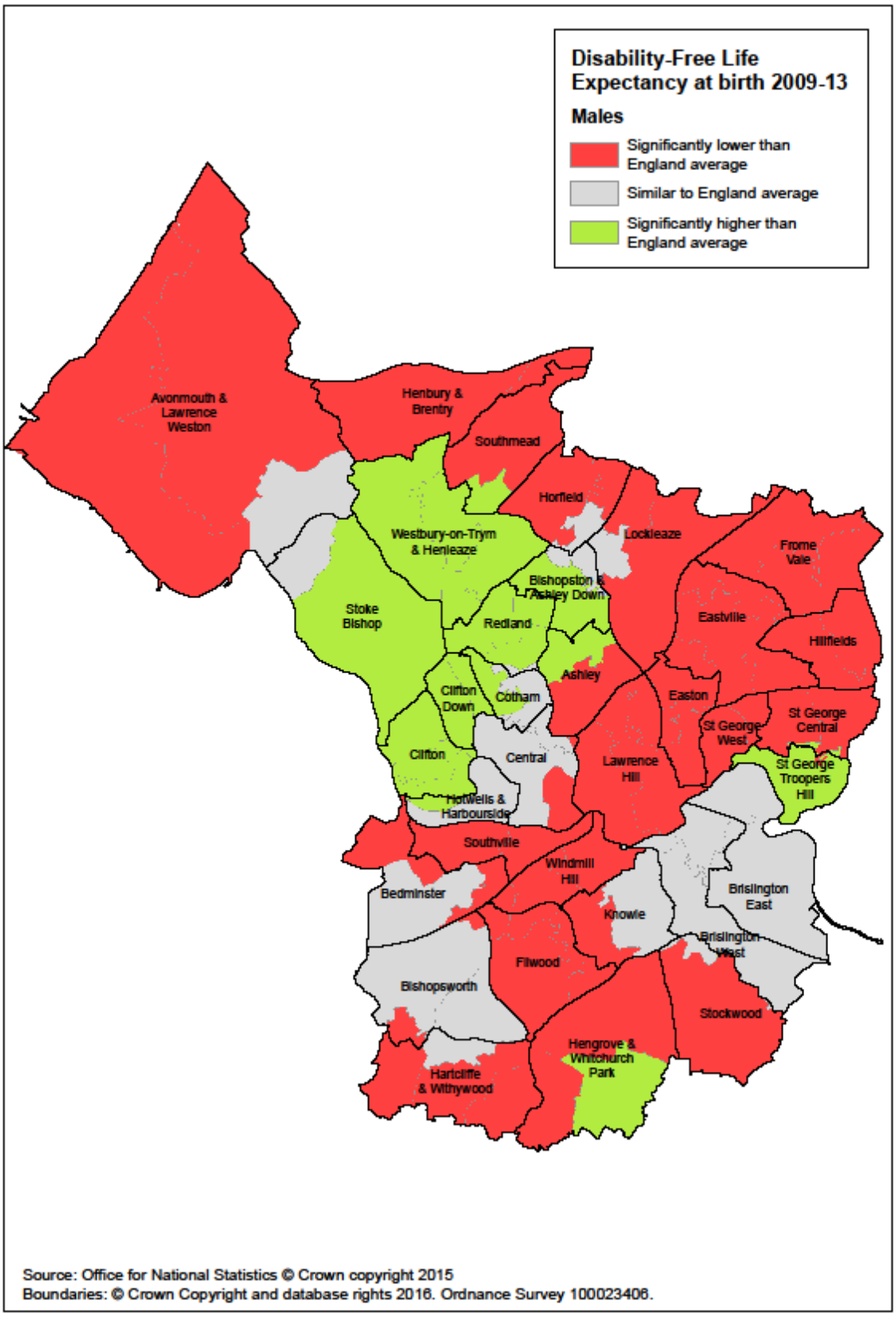


Figure 4: Disability free life expectancy for males comparing Bristol to the England average

Lone parents[49]

Nationally, children in lone-parent families were more likely to be living in workless households (36.3%) than couple households (4.5%) or other households (8.0%). Lone-parent families account for 65.3% of all children in workless households.The percentage of children in lone-parent families living in working households has risen to 52.2%. Figures for the numbers of working lone parents in Bristol, drawn from the 2011 Census, are provided below. In February 2016, there were 5,630 claimants for Income Support in Bristol. Of these, 66.42% were lone parents. Of these, 98% were women[50].

Lone parent households with dependent children - Bristol[51]

	All	Male	Female
All lone parent households with dependent children	14,842	1,576	13,266
Lone parent in part-time employment	4,779	292	4,487
Lone parent in full-time employment	2,953	666	2,287
Lone parent not in employment	7,110	618	6,492

Migrant communities

The majority of new migrants to Bristol live in inner city areas which are characterised by a high proportion of black and minority ethnic residents, a high proportion of rented accommodation, a high proportion of non-family households and higher than average levels of unemployment. Lawrence Hill ward has the highest proportion of people not born in the UK, at 39%, and Central ward has the second highest proportion, with 33% of all residents born outside the UK[52].

Bristol's largest recent migrant groups are people born in Poland, followed people who were born in Somalia. Qualitative research was conducted in 2013, in order to explore the work experiences of Bristol's Somali and Eastern European migrants. The findings were:

- Amongst Somali migrants, mental health conditions and work-related health conditions, many of which were the result of unemployment and low paid, insecure employment, were widespread. These were in addition to existing physical and mental health conditions.
- The report found that: **"***Somali migrants occupy some of the lowest rungs of the economic ladder. Their attempts to establish businesses show that there is plenty of skills, motivation and untapped potential in the community, but the confidence is fragile"*[53].
- Amongst Polish and Eastern European migrants, the research found that "*Due to the type of employment they typically undertake, that is low-skilled jobs with often unsecure contracts, migrant workers seem to be at increased risk of developing physical and mental health problems in the workplace.*" [54]

[49] The ONS definition of lone parent households is 'households that contain at least one dependent child under the age of 19. There may be other non-dependent children present, that is, those aged 18 or over'.
[50] Nomis, accessed June 2017
[51] Source: Table KS107EW. ONS Crown Copyright Reserved [from Nomis on 27 January 2017]
[52] JSNA, 2016-17
[53] Work and health of Somali speaking migrants in Bristol, Wellspring Healthy Living Centre, 2013
[54] Work and health of Polish migrants in Bristol, Wellspring Healthy Living Centre, 2013

Offenders

According to The House of Commons Work and Pensions Committee report on Support for Ex Offenders[55], individuals entering prison have a range of complex needs:

- 49% of prisoners suffer from anxiety and/or depression
- 32% of prisoners report having a learning difficulty and/or disability.
- 47% of prisoners are estimated to have no school qualifications, including GCSEs.
- 42% of adult prisoners report having been permanently excluded from school.
- 26.5% of prisoners enter employment on release

One of its conclusions was that:

> "*Employment significantly reduces the chances of reoffending. It can also lead to other positive outcomes that have been shown to reduce reoffending, such as financial security and finding a safe and permanent home."*

Despite this, 50% employers say that they would not employ someone with a criminal record.

Substance Misuse

An Independent Review[56]found that dependence on drugs and alcohol can have a damaging impact on employment status and can seriously affect people's chances of both taking up and remaining in employment. The Review suggested that as many as 1 in 15 working-age benefit claimants is dependent on drugs, such as heroin and crack cocaine, and 1 in 25 experience alcohol dependency.

There is a mutually-reinforcing relationship between employment and recovery. However, only around one in five people starting treatment are employed. Those who are employed tend to stay in work throughout treatment but few who enter treatment without work find it during or after treatment. The Review concludes that providing treatment alone, without additional support like employment, housing and skills, has limited and inconsistent effects on employment. Another factor is dual diagnosis and complex needs where treating/addressing only one of a number of health or social needs is likely to prove ineffective.

According to the Bristol Substance Misuse Needs Assessment[57], 24% of clients accessing Bristol Recovery Orientated Alcohol & Drugs Service (ROADS) were unemployed and 29% were recorded as 'long term sick or disabled'. Those in work are likely to be in part time, rather than full time, employment. The Needs Assessment concluded that:

- There are still key groups who are having difficulty accessing employment, such as those with a criminal history and a previous transient lifestyle.
- Those with recurrent health problems find access to employment very difficult, especially when these relate to their substance misuse.
- Training does not always address low educational attainment and skills.

[55] House of Commons Work and Pensions Committee, Support for ex-offenders, Fifth Report of Session 2016–17, 14 December 2016, https://www.publications.parliament.uk/pa/cm201617/cmselect/cmworpen/58/58.pdf

[56] Black, C (2015) An independent review into the impact on employment outcomes of drug or alcohol addition, and obesity, Department of Work and Pensions

[57] https://www.bristol.gov.uk/social-care-health/drug-and-alcohol-misuse-treatment

3) What are the relevant national outcome frameworks indicators and how do we perform?

Public Health Outcomes Framework indicators[58]	Bristol	England
1.05 % of 16-18 year olds not in education, employment or training	5.8	4.2
1.08i % point gap between those with a long term health condition and the overall employment rate	7.3	8.8
1.08ii % point gap in the employment rate between those with a learning disability and the overall employment rate (all)	67.6	68.1
1.08ii % point gap in the employment rate between those with a learning disability and the overall employment rate (males)	69.3	73.0
1.08ii % point gap in the employment rate between those with a learning disability and the overall employment rate (females)	66.6	63.6
1.08iii Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate (all)	68.4	67.2
1.08iii Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate (males)	73.8	73.7
1.08iii Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate (females)	62.6	60.8
1.08iv % of people aged 16-64 in employment (all)	74.9	73.9
1.08iv % of people aged 16-64 in employment (males)	78.3	79.2
1.08iv % of people aged 16-64 in employment (females)	71.5	68.8
1.09i Sickness absence – the percentage of employees who had at least one day off in the previous week	1.9	2.4
1.09ii Sickness absence – the percentage of working days lost due to sickness absence	1.3	1.5

4) What is the evidence of what works (including cost effectiveness)?

Supporting people with mental health conditions to enter or remain in employment

Research carried out in 2016[59] found that Individual Placement and Support (IPS), a vocational rehabilitation programme to improve employment outcomes for people with severe mental illness, was effective in many settings. IPS was more than twice as likely to lead to a return to employment than traditional rehabilitation. Another review[60] found that interventions with high fidelity to the IPS model resulted in increased numbers of people sustaining work or training in the short-medium term. A report on the economic evidence for supported employment[61] confirmed that Supported Employment for people with learning disabilites and IPS for people recovering from mental health conditions are the most effective route for supporting people into paid jobs. There is also more economic evidence for these approaches than for others. However,there is a shortage of evidence about the cost effectiveness of other, different types of interventions, particularly for low level

[58] http://www.phoutcomes.info/public-health-outcomes-framework#page/0/gid/1000041/pat/6/par/E12000009/ati/102/are/E06000023, accessed May 2017

[59] Modini, M. Tan, L. Brinchmann, B. et al (2016). Supported employment for people with severe mental illness: systematic review and meta-analysis of the international evidence. The British Journal of Psychiatry; DOI: 10.1192/bjp.bp.115.165092

[60] Heffernan, J. & Pilkington, P. (2011). Supported employment for persons with mental illness: Systematic review of the effectiveness of individual placement and support in the UK. Journal of Mental Health, 20:4.

[61] National Development Team for Inclusion. (2012). A Review of the Evidence Around Economic Support. Bath: National Development Team for inclusion.

mental health conditions.

Supporting people with Muskeloskeletal (MSK) conditions into employment
Best practice[62] suggests that health professionals need to take a careful occupational history in order to be able to assess those with MSK conditions as fit to work and advise on reasonable adjustments. It is not necessary for people to be symptom free (depending on their occupation and occupational risks). Their fitness to return to work will depend on issues such as working hours; shift work; exposure to physical, chemical, biological and psychosocial hazards; work relationships; physical work environment; and requirement to travel. However, there is a shortage of evidence about the most effective and cost effective interventions for different MSK conditions, occupational groups and sectors.

Supporting people with disabilities and long term health conditions
Department of Work and Pensions research[63]found that people with disabilities or long-term health conditions can best be supported in employment through:

- Delivery of individually tailored advice and guidance
- An understanding of which interventions work best for which groups
- Effective management of disabilities and long-term health conditions
- Adaptations to the workplace and working conditions
- Multidisciplinary interventions including workplace components
- Early engagement with workers to minimise absence
- Provision of financial incentives for job seekers and employers
- Additional robust research is needed on 'what works for whom'.

Supporting young and older people into employment
According to the 2013 DWP report[64], supported employment schemes can help young people lacking work experience. A Work Foundation report[65] found that the transition from education to work can be problematic for some young people, including those with chronic health conditions, who have an increased likelihood of being unemployed, earning less and obtaining fewer,and lower, qualifications than their healthy peers[66]. Older employees are more likely to benefit from initiatives focused on in-work retention and flexibility in the workplace[67].

Supporting ex-offenders into employment
The Centre for Mental Health worked with organisations that support offenders and ex-offenders into employment to analyse the elements of effective practice[68]. An estimated 90% of prisoners have a drug and/or alcohol issues, personality disorder or other mental health condition. Evidence suggests that additional support will be necessary in order to help ex-prisoners. Their recommendations include:

[62] Madan, I, Grime, P (2015). The management of musculoskeletal disorders in the workplace. Best Practice & Research Clinical Rheumatology, 29, pp.345–355.
McCall, (2016). World Report – Child Poverty continues to rise in the UK. The Lancet, 388, p.747.
[63] Department for Work and Pensions. (2013). What Works for Who in terms of Supporting People with Disabilities or Long-Term Health Conditions. London: DWP.
[64] Department for Work and Pensions 2013, op cit
[65] Don't Stop Me Now: Supporting young people with chronic conditions from education to employment, Bajorek Z, Donnaloja V, McEnhill L, Work Foundation, February 2016
[66] Maslow, Haydon, McRee, Ford, & Halpern, 2011; Sayce, 2011
[67] Living long, working well: Supporting older workers with health conditions to remain active at work, Tyna T, Shreeve V, Laghini M, Bevan S, Work Foundation, July 2015
[68] Centre for Mental Health, Briefing 42: Beyond the gate, Securing employment for offenders with mental health problems, Published November 2010

- Employers should play an instrumental role in creating and developing opportunities for paid work for offenders.
- Recruitment needs to be pragmatic: on the basis of attitude and 'character' rather than qualifications or health status.
- Support should be offered to employees and their managers for as long as they need it.
- Opportunities for 'pre-employment' and 'in work' skills development should be linked to realistic employment opportunities: not training for its own sake.
- Criminal justice and other statutory agencies should facilitate effective pathways and access to real work and appropriate skills development while offenders are in the criminal justice system.

What works in the workplace

A recent review[69] concluded that organisations as a whole, and individual stakeholders (directors, managers, workers), need to invest in workplace health in order for it to be successful. Interventions that are supported by organisational policy, focus their content on specific health issues and engage employees, have been shown to be effective. More research is required into the cost-effectiveness of different interventions in order to demonstrate which are most beneficial.

A review of workplace health interventions[70] concluded that psychosocial working conditions can be improved in a variety of ways, including through:

1. Greater employee control over their work
2. Greater employee participation in decision-making
3. Line management training
4. Effective leadership and good relationships between leaders and their employees
5. Engaging employees, ensuring employees are committed to the organisation's goals and motivated to contribute to its success
6. Providing employees with the in-work training and development they need to develop job satisfaction
7. Providing greater flexibility within a role to increase an employee's sense of control and allow them to improve their work-life balance
8. Reducing stress and improving mental health at work as these are leading causes of sickness absence
9. Addressing the effort-reward imbalance.

A report commissioned by British Heart Foundation [71] found a varied picture of effectiveness and cost-effectiveness for workplace health interventions. This review included initiatives to address mental wellbeing, physical activity, smoking, alcohol and healthy eating. One of its recommendations was that, in order to measure the return on investment, employers should track key metrics such as levels of sickness absence, including reasons for absence and the direct and indirect costs; productivity and employee satisfaction with work and management; ill-health, including health risk and lifestyle issues such as smoking and alcohol; and wellbeing. However, most employers do not measure these on a regular basis.

[69] Brunton G, Dickson K, Khatwa M, Caird J, Oliver S, Hinds K, Thomas J (2016) *Developing evidence informed, employer-led workplace health.* London: EPPI-Centre, Social Science Research Unit, UCL Institute of Education, University College London.

[70] Local action on health inequalities: Workplace interventions to improve health and wellbeing, Health equity briefing 5a: September 2014, Public Health England and University College of London Institute of Health Equity

[71] Health at Work: Economic Evidence Report 2016, ERS Consultancy, British Heart Foundation

A London School of Economics report looked at the economic case for mental health promotion which included some workplace based interventions[72]. The report concluded that some workplace wellbeing interventions can be significantly cost-saving in the short term, but some smaller companies may need public support to implement such schemes. This research is due to be updated in 2017.

Most research is based on the experience of large organisations. However, most people are employed in small and medium sized businesses[73]. However, most people are employed in small and medium sized businesses. Over 99 per cent of all UK businesses are SMEs and they employ about 75% of the entire UK workforce. A Work Foundation report[74] found widely varying practice amongst SMEs but identified some key needs, including more robust evidence for what works, support and training for employers about good practice, access to sources of good quality support. At a local level, SME employer knowledge of what is already available is often poor (awareness of the Fit for Work Service is very low).

National Institute of Health and Care Excellence Guidance and standards[75]:
NICE produce a range of evidence-based guidance and standards covering workplace health. Cost-effectiveness is included as part of the evidence review for each of these.
The main pieces of workplace health guidance provided by NICE are:

Topic	Link
Workplace health management practices NG13	https://www.nice.org.uk/guidance/ng13/resources/workplace-health-management-practices-1837269751237
Mental wellbeing at work PH22	https://www.nice.org.uk/guidance/ph22
Physical activity in the workplace PH13	https://www.nice.org.uk/guidance/ph13
Smoking: workplace interventions PH5	https://www.nice.org.uk/guidance/ph5
Workplace health: long term sickness absence and incapacity to work PH19	https://www.nice.org.uk/guidance/ph19
Healthy workplaces: improving employee mental and physical health and wellbeing QS147	https://www.nice.org.uk/guidance/qs147

5) What services / assets do we have to prevent and meet this need?

Employment Support
The Work Zone model [76] is providing system leadership and co-ordination in order to capitalise on provision already available in Bristol and localities within the city. It builds on the networks of providers of Employment Support and advice in order to reach hitherto unreached key communities

[72] Mental Health Promotion and Prevention: The Economic Case, Knapp M, McDaid D and Parsonage M (editors); Personal Social Services Research Unit, London School of Economics and Political Science, January 2011, Department of Health
[73] Definitions of SMEs: micro businesses have 1-9 employees; small businesses have 10-49 employees and medium businesses have 50-249 employees.
[74] This Won't Hurt a Bit: Supporting small business to be healthy, wealthy and wise, McEnhill L and Steadman, K. The Work Foundation, Lancaster University, November 2015
[75] NICE Guidance can be found here: https://www.nice.org.uk/guidance/settings/workplaces
[76] http://ways2work.org.uk/employment-support/work-zones/

in order to support/encourage/inspire people into secure employment and raise aspiration.

Young people and mental health pilot
The Mental Health Pilot commences in early June 2017 and is funded by the Council, Public Health and Public Health England. This project builds on the successful HYPE West model and is looking at new approaches to supporting young people with mental health barriers to entering the labour market into employment. It also looks at how it can develop and support employers in dealing with mental health issues in the workplace.

Migrant Project
Commencing September 2017, the Work Zone Migrant Project – providing a dedicated fund to support at least 70 migrants to obtain the personalised support they need into employment. This service will be targeted at people with ESOL language development needs, including both established community members who have experienced long term unemployment (for example people from local Pakistani and Bangladeshi communities) and also more recent migrants and refugees who are either unemployed or under-employed (i.e. not utilising their full qualifications and professional work experience).

Support for people with learning difficulties
Pathway provides a supported employment service that is accessible and appropriate to meeting the needs of people with learning difficulties. The service offers vocational counseling, job search and interview support and individual on-the-job training when someone starts work. Pathway also provides ongoing coaching support to people in paid work, within agreed timeframes, and offers job retention support if needed to keep people in their jobs.

Innovation Pilot
Commencing January 2018, the Innovation Pilot is a £4m, two year DWP funded programme which aims to reach a targeted 3000 adults aged 19+ who are in work, in receipt of Working Tax Credit or Universal Credit and social housing tenants:

- 3,000 people will engage in the process and approximately 1200 individuals (40%) will achieve a sustained reduction in their benefit claims for WTC, Universal Credit, Housing Benefit and Child Tax Credits;
- Reduced likelihood of a return to unemployment;
- Lower demand for services as a result of reduced levels of poverty and increased wellbeing – for example through reduced take up of advice, debt, housing support and health-related services;
- A possible reduction in financial debt and rent arrears by participants.

This is a West of England Combined Authority led partnership project. The 3,000 project beneficiaries will come from the Local Authority areas of Bath and North East Somerset, City of Bristol and South Gloucestershire with each area benefitting in proportion to the needs they are facing.

Community Learning
Bristol is the lead managing agent of a West of England Community Learning Consortium [77]. The local authorities have also formed a wider Community Learning and Skills Partnership. Through the Consortium, Bristol, South Gloucestershire and North Somerset Councils deliver and commission a range of work related community learning courses that are enabling people to develop skills and confidence to progress to further training, volunteering or employment opportunities. Funded through the Skills Funding Agency, the target group for courses includes adults without Level 2 qualifications, including people with low levels of literacy, numeracy and English language.

[77] https://www.lpw.org.uk/

Participants include people who face a range of barriers to employment, including people with mental health issues, refugees and asylum seekers, people who are risk of homelessness. The next step will be to work with WECA and the three West of England Local Authorities, to develop a local commissioning approach for the devolved Adult Education Budget to maximise the outcomes and benefits it generates for individuals residing with the WECA area.

Bristol Apprenticeship Service

Bristol City Council is establishing a new Apprenticeship Service with a strategic level Steering Group to oversee the development of apprenticeship, not just within the Council, but also across other employers and with partner training providers. To future proof and diversify the workforce, apprenticeships will be targeted at young people and adults from equalities groups, including Disabled people and those with health related barriers to work.

Bristol Learning City Partnership and WORKS

The Bristol Learning City Partnership, chaired by the Mayor, brings together lead education and training providers and employers to drive forward improvements in educational and employment outcomes across the City. The WORKS project is building an education, business and community partnership and virtual 'hub' to improve experience of work and career development opportunities for all young people in targeted schools serving the most disadvantaged communities.

Building Better Opportunities

West of England Works is a Big Lottery and ESF funded programme which provides support for those furthest from the labour market (BBO). This project aims to tackle multiple needs to improve employability. It will work with people who face multiple barriers and/or multiple disadvantages in the labour market, providing them with support to move towards and into employment.

- To improve the employability of long-term unemployed people, so that they can compete effectively in the labour market.
- To provide individuals from groups which face particular labour market disadvantage with additional support so that they can compete effectively in the labour market.
- To encourage inactive people to participate in the labour market and to improve their employability.
- To address the basic skills needs of unemployed and inactive people so that they can compete effectively in the labour market.

Support Services

Bristol Mental Health[78] is an umbrella for 18 Public and voluntary sector organisations that provide NHS funded services in the city. This includes the Mental health and Employment Service which is commissioned by Bristol Clinical Commissioning Group. People with direct experience of using mental health services have been involved in designing the services along with carers, voluntary organisations, community groups and health and social care professionals. The service supports adults who are experiencing mental health problems and need help with finding or staying in employment. The service also works with employers to raise their awareness of mental wellbeing in the workplace and what they can do to support their employees.

Recovery College

A poor education is often a contributing factor to homelessness, while unmet physical and mental health needs can seriously compromise a person's employability. Despite the challenges homeless people face, such as poor health or educational needs, the majority have a desire to work, either

[78] Bristol Mental Health - http://www.bristolmentalhealth.org/

now or in the future. The Recovery College offers a variety of free courses aimed at people who have experienced homelessness. The courses providing opportunities to learn new skills, make new friendships, build confidence and inspire others[79]. St Mungo's Pathways to Employment helps up to 125 people find employment every year. The programmes provides opportunities for education, skills training and work in a range of skills that will increase employability and help people stay off the streets. Bristol Together Community Interest Company[80] buys, refurbishes and sell empty properties with an ambition to create full-time jobs for people who have been in prison. Second Step[81] provide support, accommodation, rehabilitation and training for people experiencing addiction, mental health, physical, learning or housing difficulties.

Workplace health support

Bristol City Council offer the Workplace Wellbeing Charter, a good practice framework containing 8 standards, designed to help employers improve the health and wellbeing of staff. The programme evolved from the Black Review[82] which identified the potential of the workplace as a setting for health improvement. At present, more than 30,000 people working in the city are employed by organisations who are actively promoting workplace health[83].

Business in the Community[84] (BITC) provide access to employment schemes locally and nationally offer the Workwell Model. BITC[85] have produced a number of toolkits for employers in collaboration with Public Health England and other partners. These include mental health (May 2016), musculoskeletal, suicide prevention and suicide postvention toolkits (March 2017). A wide range of voluntary, community and private agencies provide training and support for local employers on workplace health issues.

6) What is on the horizon?

- The outcome of the 2017 General Election and the implement ion of the new government's proposals and priorities.
- An independent review of mental health and employment, commissioned by government, is due out in Autumn 2017.
- A mental health and wellbeing strategy for Bristol is currently under development and will have mental health and employment as a major component.
- The Taylor Review's recommendations on modern employment practices, including the gig economy (see section 2 above).
- Bristol City Council is reviewing its services and investment in relation to priority groups. Hot House processes are in progress in relation to: Education, Training and Employment Participation of 16-24 year olds; young people and adults with Learning Difficulties.
- West of England Combined Authority proposals are under development to address employment, skills, education and training.

[79] St Mungos - http://www.mungos.org/services/recovery_from_homelessness/our_skills_employment_services
[80] Bristol Together - http://www.bristoltogether.co.uk/
[81] Second Step - http://www.second-step.co.uk/our-services
[82] Black, C. op cit
[83] https://www.bristol.gov.uk/business-support-advice/bristol-workplace-wellbeing-charter
[84] Business in the Community Workwell Model - http://wellbeing.bitc.org.uk/issues/workwell-model
[85] http://wellbeing.bitc.org.uk/all-resources/toolkits

7) Local views

What do staff/users/carers think?

- A Mental Health Summit[86], carried out in November 2016 on behalf of Bristol Health and Wellbeing Board, was used to identify some of the most pressing mental health issues in the city – one of these was employment.
- A Work and Health Think Tank[87] was held in January 2017, attended by 100 representatives from government agencies, commissioners and service providers, academics, community and voluntary agencies and members of the public. This was convened by Bristol Health Partners and Bristol City Council with a view to starting a conversation about how to address local health inequalities arising from employment and unemployment. Key issues were: how to improve local data, the impact of welfare reform, developing better responses to mental health and musculoskeletal conditions, narrowing the disability employment gap, improving partnership working, the role of social prescribing, promoting access to work programmes, addressing financial exclusion and how to improve fit notes.
- Bristol Health and Wellbeing Board responded to the Work, Heath and Disability Green Paper[88]. While endorsing the ambition to reduce the disability employment gap, the Board raised a number of questions about the design and delivery of programmes, based on local experience, including the need to involve local people with lived experience of different conditions and services.
- A consultation with GPs, employers and managers on the future of fit notes was conducted in May 2017. Issues raised by GPs included: the volume of fit notes, the number of erroneous requests for fit notes (ie, within the period during which fit notes are not required), lack of understanding and knowledge about what different jobs involve in order to provide advice on what would constitute a reasonable adjustment. Issues raisesd by employers included insufficient information on fit notes for employers to know what adjustments to make.
- An Emotional Wellbeing in the Workplace event was convened by Bristol Anti Stigma Alliance in March 2017. This was attended by 100 local staff, employers (from the private, public and voluntary sectors), HR professionals, statutory and voluntary support agencies, commissioners. The event provided a forum for discussion about stigma, discrimination, the availability of workplace support, issues for managers and colleagues and what constitutes good practice.
- Feedback was collected during consultation events for the development of WorkZones and through pilot work currently being undertaken in different parts of the city[89]. A working group of agencies has developed an operating framework for the Bristol Work Zone model. Part of the remit is to create a shared and consistent customer journey for workless adults that will include new shared diagnostic tools, a common approach to client segmentation and referral as well as a clearly defined core offer.

[86] https://democracy.bristol.gov.uk/documents/s11704/6%20-%20Mental%20health%20and%20wellbeing%20in%20Bristol.pdf
[87] (http://www.bristolhealthpartners.org.uk/latest-news/2017/02/09/work-and-health-think-tank-improving-the-opportunities-for-people-with-long-term-conditions-and-disabilities/803
[88] https://democracy.bristol.gov.uk/ieListDocuments.aspx?MId=275
[89] http://ways2work.org.uk/employment-support/work-zones/

B: What does this tell us?

8) Key issues and gaps

- Some demographic groups are living with persistent unemployment and disadvantage. When in work, they are more likely to be on low pay in insecure jobs, with poor terms and conditions.
- Improved support is needed for priority groups, including young people aged 16-24 (including young people who face barriers to education, training and employment), people with learning difficulties and people with drug and alcohol addiction.
- There is a need to address the ageing workforce, the challenges that will emerge from the rising pension age, the health of older workers and the need to manage long term health conditions in the workplace.
- Support is needed for people who may have missed out on initial employment through childcare/caring repsonsibilities.
- Support is needed to enable people with convictions to be able to achieve employment. This will necessitate working with individuals around disclosure processes and requirements and with employers in order to increase awareness that a conviction may not necessarily be a barrier to hiring someone.
- There is a need to address the lack of ESOL /"English for Work" targeted specifically at employment within specific priority sectors such as construction and healthcare where migrant workers most often find work.
- Contact between between health and employment agencies is patchy. Many are unaware of the existence of the other and as a result cross-referring is limited. This means that effective signposting does not always take place and take up of available services is not maximised.
- Historically, work and health programmes have often been developed and operated in parallel. The establishment of the West of England Combined Authority will provide a frameworth for developing shared objectives which will bring these agendas together across a wider footprint.
- Mental health is a major challenge for unemployment (as the largest health reason), for access to employment (by contributing to the perpetuation of the disability employment gap) and in the workplace (as a growing cause of sickness absence). Increased awareness of mental health issues and how to manage mental health in the workplace is necessary. The role of employers in recruiting, retaining and supporting staff with mental health conditions will be essential to address this issue on a largescale. It will be important to ensure an evidence based approach is taken.
- Local knowledge of the DWP's Fit for Work Service is very poor amongst the public, employers and GPs. DWP data showed that between 1 January 2015 and 31 December 2017, fewer than 100 people in Bristol had contacted or been referred to the DWP's Fit for Work Service. This is a free service, primarily targeted at small to medium sized enterprises, to help support staff who have been or are expected to be off work sick for four weeks or more. Referrals can be made by GPs, employers or individuals.
- Some GP surgeries in the city receive more than 50 requests a day for fit notes. Many of these are generated by employers requesting that members of staff obtain a fit note during the self-certification period – this means that a note cannot be issued (fit notes can only be provided after the self-certification period ends). Improved employer knowledge of the fit notes scheme would help to reduce the number of requests.
- Musculoskeletal conditions are a major cause of sickness absence and the second highest reason for unemployment. Evidence shows that rapid referral for treatment advice and support is the most efficient way of limiting absence. At present, this is not available on a citywide basis.

9) Knowledge gaps

There is little information about :

- the gig economy in Bristol, the numbers involved and who is participating,which sectors are most involved and the implications for different demographic groups.
- The extent and implications of musculoskeletal conditions in the workplace and how different occupational sectors are affected in Bristol.
- What is most likely to achieve improved health outcomes for employers and employees in SMEs.
- The evidence base for achieving both health and employment outcomes in the design and delivery of programmes and services is not always being used. Additional work will be required to understand why this is the case and how to address it.
- Better understanding of the specific barriers that prevent Disabled people and people with health related conditions from achieving fulfilling employment and also securing better in-work progression.

C: What should we do next?

10) Recommendations for consideration

- Work in partnership with West of England Combined Authority (WECA) and West of England Local Authorities (Bristol, Bath and North East Somerset and South Gloucestershire) to develop a common strategic framework for the commissioning of work and health programmes across the sub region.
- Ensure that the design and delivery of programmes with both health and employment outcomes are evidence based.
- Promote better coordination between agencies providing work and health advice and support at a community and citywide level.
- Target communities which are excluded and marginalised to overcome the cycle of unemployment and in work poverty.
- Provide local responses to welfare reform and changing government policy to ensure the best health and employment outcomes for local communities and individuals.
- Address the disability employment gap by working with employers to ensure fair recruitment and selection processes.
- Explore opportunities to fill data gaps by working with academic partners on issues of common interest (for example, the growth of the local gig economy, how physical and mental health conditions affect different occupational sectors).

11) Key contacts (listed alphabetically)

Jane Abraham, Policy Fellow, Joint Work and Health Unit, Department for Work and Pensions and Department of Health
Victoria Bleazard, Programme Manager, Mental Health and Social Inclusion, Bristol City Council
Duncan Fleming, Senior Contracts and Commissioning Officer, Substance Misuse Team, Bristol City Council
Elaine Flint, Chief Executive Officer, Wellspring Healthy Living Centre
Paul Gaunt, Employment Support Team Manager, Bristol City Council
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References

Brunton G, Dickson K, Khatwa M, Caird J, Oliver S, Hinds K, Thomas J (2016) Developing evidence informed, employer-led workplace health. London: EPPI-Centre, Social Science Research Unit, UCL Institute of Education, University College London.

Marmot, M. Fair society, healthy lives : the Marmot Review : strategic review of health inequalities in England post-2010. (2010) ISBN 9780956487001

Black, C. Working for a healthier tomorrow. 2008. www.workingforhealth.gov.uk/documents/working-for-a-healthier-tomorrow-tagged.pdf

Work, health and disability green paper: improving lives. Ref: ISBN 9781474137805, ID 04101608 10/16 , Cm9342 PDF

Local action on health inequalities: Workplace interventions to improve health and wellbeing, Public Health England and Institute of Health Equity University College London, 2014

Local action on health inequalities: Increasing employment opportunities and improving workplace health, Public Health England and Institue of Health Equity university college London, September 2014

Local action on health inequalities: Reducing the number of young people not in employment, education or training (NEET), Health Equity Evidence Review No 5, September 2014

Local action on health inequalities: Working with local employers to promote good quality work, Health Equity briefing 5b, September 2014

Healthy, working economies: Improving the health and wellbeing of the working age population locally, Shreeve V, Steadman K, Bevan S, April 2015, Work Foundation
The Population of Bristol, July 2016, Bristol City Council, https://www.bristol.gov.uk/statistics-census-information/the-population-of-bristol

Work and health of Polish migrants in Bristol, Wellspring Healthy Living Centre, 2013

Work and health of Somali speaking migrants in Bristol, Wellspring Healthy Living Centre, 2013

Health and work local stories - a Knowle West perspective, Morris V, Knowle West Health Park, 2013

The impact of long term conditions on employment and the wider UK economy, February 2016, Work Foundation

This Won't Hurt a Bit: Supporting small business to be healthy, wealthy and wise, McEnhill L and Steadman, K, Work Foundation, November 2015.

Health at Work Evidence Report, 2016, ERS Research and Consultancy, British Heart Foundation

Workplace Wellbeing Charter Annual Report 2015-16, Bristol City Council