Ageing Well in Work:
A call to action

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Foreword – Ageing Well in Work: A Call to Action

The landscape of our society is changing. More people are living longer and to older ages. Recent data from the Global Burden of Disease Study shows that between 1990 and 2013, life expectancy in the United Kingdom has increased by over five years – one of the biggest jumps across Europe. This is a fantastic achievement, and something that should be celebrated. The benefits are felt across the whole system; by individuals, their families and the communities that they live in.

One of the consequences is that long-term health conditions are becoming a reality for many people in middle and older ages. The question becomes: how can we support people to maintain a good quality of life throughout this period, both at work and home? We know that work is a critical aspect of health, and can support healthy active ageing by contributing to personal wellbeing and resilience. It should come as no surprise that these issues are also being played out in the workplace.

Like most other European countries, more and more people are working longer into later life, with increasingly varied career histories in both paid work and unpaid work that extend well beyond the current and projected age of formal retirement. Older workers are becoming a key part of our workforce, in businesses of all sizes and sectors. Making use of their skills and experience is a top priority and will help boost the economy both nationally and within local communities.

Whilst there have already been a number of government initiatives around supporting an ageing workforce – and pockets of good practice across the country – we are still only just getting to grips with this new reality.

This report takes stock of progress to-date and, drawing on the experience of 'what works' across Europe, sets out a framework for positive action. The exact actions to take will depend on who you are – employee, employer, commissioner or policy-maker – and the local circumstances. What follows is not an instruction manual, but a set of guiding principles to help us along this journey towards a longer and healthier working life. It is only when we work together, across the whole system, that we will see true transformation. We conclude with a call to action with suggestions as to how we may go forward, learning from the many examples of success so far and unlock the considerable assets and talents of older people for the benefit of everyone.

This work has been jointly led by colleagues at the Greater Manchester Public Health Network (GMPHN) and Public Health England (PHE), ably supported by a wide range of partners from across the system who contributed through the project steering group. Special thanks go to our international partners: the Finnish Institute of Occupational Health, the Department of Sociology and Work Science at the University of Göteborg, and the EMGO+ Institute for Health and Care Research in the Netherlands, who have been so generous in contributing to the project, and sharing their experiences and insight around this important issue.

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2. Project background

2.1 Project rationale

Ageing Well in Work's (AWiW) clear focus is on the actions needed to help individuals delay retirement or remain active in their local communities, or a combination of both.

> This project adopts a holistic definition of work, recognising that individuals engage in a range of meaningful activities that include volunteering, caring, life-long learning and civic roles, as well as paid employment

From the outset, a key strength of the project has been the examination and application of relevant international research via a series of learning exchange visits and policy development sessions.

Evidence in the UK has revealed significant trend data. Between 2001-2009, around 1.25% of the working age population left employment on health grounds (ONS, 2015) and a disproportionate number of these were aged over 50. The NHS Health Check programme has revealed that a high number of adults become aware of a new chronic condition around the age of 50. This diagnosis is frequently coupled with periods of absence from work and has a causal link to early retirement due to ill-health (Waddell, Burton, & Kendall, 2008) (Rice et al., 2011). Poor health and limited social engagement, both with family and the wider community, have been identified as key factors in increased mortality and social isolation for older people living in England (Age UK, 2014) (Lloyd J, 2014).

AWiW identifies several themes of interest in response to this evidence:

- **reducing the flow of older people falling out of work as a result of ill-health**
- **working with individuals, PHE, local authorities and employers to reduce early retirements and to identify appropriate community interventions for those who retire on the grounds of ill-health, to help them continue to participate in social or community activities**
- **extension of age-friendly workplaces – working with employers to identify key actions and activities**
- **health promotion and disease – promoting opportunities to help older people manage long-term conditions in order to stay in work and remain independent**

This project is innovative and offers added value by examining the role of work as an early intervention and preventative public health tool. Using work as a means of preventing future ill-health amongst the population has not previously been included in national frameworks. One of the key elements of this project, therefore, is a study of the Active Ageing Index (AAI) and an assessment of the feasibility of aligning England's national framework for public health to AAI domains.

This presented an opportunity to review to what extent the outcomes that most effectively influence older people's ability to stay independent with good mental and physical wellbeing are reflected within the current performance framework, the Public Health Outcomes Framework (PHOF).

When this project first began, there was limited means to benchmark older worker participation rates in England to countries with high participation such as Sweden. It was anticipated that this strand of work would provoke a long-term conversation about the use of national measures and the extent to which these reflect the effectiveness of our approach to ageing well.

2.2 Forerunner projects

AWiW is founded on the findings of a number of forerunner projects, summarised below.

Young Foundation – Wellbeing Programme NEETs (2006-2008)

- assumption by medical and teaching staff that children with special educational needs (SENs) would not progress into employment
- some vulnerable young people needed to be protected from employment. However this was subject to much local variation
- young people with SENs wanted good jobs, a good home and good friends
- poor mental wellbeing and poorer physical health resulted when young people were excluded from work

Sheffield Family Centred Poverty Reduction Strategy (ESF) (2007-2010)/All Together Better Programme (Yorkshire and Humber) 2006-2012

- poor health is associated with a cycle of low pay, no pay
- many health issues emerge after the age of 45
- high numbers had undergone a health crisis, after which they never returned to secure, permanent work that offered career progression
- social isolation, lack of daily structure and low income all impact upon mental and physical health
- sense that health professionals were keen to help people get better but that there is minimal support to help people stay in work
- the cohort typically lacked confidence about managing their own conditions and were nervous about talking to employers (for fear of being stigmatised)

EU Progress Mental Health and Employment Tool Kits (2010-2012)

- most recovery plans did not emphasise return to paid work or volunteering
- support from health professionals is very important – this instils more confidence when speaking with employers
- employers' attitudes were often outdated
- some older workers had a physical and mental health condition, but preferred to talk about physical issues
- older participants felt they were not expected to return to work

Work for Health (2013-present)

- individuals expect the health professional to tell them it is acceptable to return to work
- healthcare professionals (HCPs) and patients are uncomfortable opening this conversation, although they know it is important
- some HCPs believe that these conversations are the preserve of occupational health specialists

2.3 Why Greater Manchester?

Greater Manchester (GM) is an excellent location for testing recommendations that could be scaled up and applied to other parts of the country. GM is a large conurbation with a population of 2.7 million. It is diverse in terms of age profile, health outcomes, individual wellbeing and other social characteristics, e.g. Black and Minority Ethnic population. It is also diverse in terms of the lower proportion of the population that is in work, compared with the England average.

Since the start of the project, the GM context has shifted considerably. The Health and Social Care Devolution Memorandum of Understanding signed in February 2015 gives the Greater Manchester Combined Authority (GMCA) and local NHS services much more control of the region's £6 billion health and social care budget. Reform priorities are aligned to opportunities for growth, and this includes getting people into, and keeping them in, good quality employment and reducing dependency amongst working age populations.

There is a clear articulated relationship between being in good quality employment, life chances and health and wellbeing that begins in very early life. This provides a firm basis for local authorities and other stakeholders to take action. Furthermore, the Due North report (University of Liverpool and CLES, 2014) recommends that local authorities and other stakeholders use the duties vested in them, including the Social Value Act, to address and reduce the burden of worklessness, whilst also increasing the provision of high quality work.

Across GM, around 227,000 people are claiming out-of-work benefits. The cost of worklessness and low pay has now reached over £2 billion. Local authorities are active commissioners of services that can influence individual life course journeys and, through targeted approaches, help the long-term unemployed return to work.

For example, GM's Working Well programme adopts a key worker model, which uses simple sequential steps to tackle issues holistically that hamper re-engagement, such as morbidity and a lack of skills and experience. The Working Well cohort includes a sizeable number of over 40s, many of whom are single adult households. The programme will be scaled up as part of the agreed priorities of Devolution and will include a pilot to help individuals with long-term conditions back into work (GMCA, 2015).

A further Memorandum of Understanding (MOU) is creating a single unified public health system in GM. This outlines major programmes of work that acknowledge the inter-relationship between health, work and growth; ways to help people have more knowledge and control about their health; the importance of good early years and staying well and connected to friends as people age. This is an innovative approach that sets out to rebalance the health and care system and focus it towards prevention and early intervention, particularly amongst working age populations.

The MOU includes proposals to:

- **extend a GM training programme to educate health professionals on how to open conversations with individuals about work and ensure work is embedded as a core element of treatment plans**
- **offer a reinvigorated approach to helping businesses secure accreditation to the Workplace Wellbeing Charter and**
- **expand the behaviour change programme (piloted in 2013-2014) to normalise and strengthen back-to-work support for people with long-term conditions (LTC)**

Being in good employment not only supports positive emotional wellbeing, opportunities to socialise and financial resilience, but can also support independence in later life

The MOU has originated the GM Ageing Hub, which will develop an evidence base to test new and innovative solutions to the challenges and opportunities associated with ageing populations. It looks to develop understanding and to respond to the implications of an ageing population in GM, to enhance the significant opportunities for this demographic to boost economic growth and for older people to live longer, happier and healthier lives (Manchester City Council, 2015).

2.4 National context

The over 50s currently form a quarter of all people in work in Great Britain (Altmann R, 2015) (DWP, 2013). By 2020, this proportion is set to rise to a third (Altmann R, 2015). Between 1990 and 2013, life expectancy in England increased by 5.4 years, one of the biggest increases compared with the other EU15+ countries (Newton et al., 2015). The fact that people are living longer is a public health success story. However, recent evidence (Altmann R, 2015) suggests that these extra years are not always being spent in good health. In fact, many individuals work with a long-term health condition or disability during the later stages of their careers.

Much has already been written about the challenges and opportunities of an ageing workforce. In terms of the policy response, a range of different interventions and programmes have been put in place. For example, DWP has published a Fuller Working Lives framework (2014) which sets out a number of areas for action (DWP, 2014). This was followed in 2015 by A New Vision for Older Workers (Altmann R, 2015). The introduction of an older workers champion scheme in 2014, together with the roll-out of the disability confident mark, indicate the government's intentions in this important area.

Formal guidance will be available for businesses in March 2016 when National Institute for Health and Care Excellence (NICE) publish official guidelines on older workers. In the meantime, a number of useful guides are available to organisations, some specific to certain sectors – for example, the NHS Working Longer Review for health – and others aimed at organisations of all sizes and across all sectors (DWP, 2013).

AWiW aims to bring together these different strands into a single narrative. This will move the issue of older workers higher up the agenda, both nationally and locally, and set out some of the opportunities for action through a summary of key principles which, if followed, can help improve people's ability to age well in work.

2.5 Transnational element

Many European countries recognise the need to increase work participation in the 50-64 age range and above. The involvement of EU partners has been fundamental to AWiW. This widens the evidence base and brings a range of different conceptual and applied solutions in relation to extended work life, health and the workplace for older workers, and the management of chronic disease.

AWiW's transnational activities involved fact finding missions to three European institutions with specialist knowledge about choices in retirement (University of Göteburg), managing chronic disease in the workplace (EMGO+ in the Netherlands), and workplace adaptations (Finnish Institute of Occupational Health). Reciprocal visits were hosted in the UK with a view to building upon the international relationships and fostering opportunities to share learning.

As in the UK, the workforce in the Netherlands is ageing. As a consequence, mitigating the impacts of an ageing population has been recognised as a nationally important topic for government policy and system reform. Despite increased life expectancy, improved living conditions and better health status, the average time period spent in paid work during a person's lifetime has decreased.

The Netherlands' social security and taxation system (including early retirement schemes) has allowed and encouraged workers to retire with a pension and leave the labour market before the official retirement age of 65. Individuals also leave the labour market due to the development of chronic conditions. The Dutch government and advisors have prioritised and put in place measures to extend working lives. AWiW has sought to learn about the Netherlands' approach to chronic disease management.

Finland has an increasingly ageing workforce. By 2010 there were more people leaving the workforce than joining it and 31% of full time employees will reach retirement by the end of 2016. Like the UK, this trend is tied in with their cohort of 'baby boomers' (the wealthiest, most active, and most physically fit generation up to that time). An added complication is the flexible retirement age which is between 63-68.

As a result, Finland has started to put in place measures to support its ageing workforce (Ilmarinen J, 2005). This document presents some of the Finnish best practice around workplace adaptations.

Recent demographic change and, in particular, an ageing workforce have not been as striking in Sweden as other Western European countries. Around 18% of the population is over 65, with this set to rise to 30% in 2030 due to the high number of Swedes born in the 1940s. In western Sweden the age pyramid does not indicate a rapidly ageing population. However, in some areas, depopulation has led to an ageing population and a range of issues affecting both the economy and communities. AWiW has sought to learn from Sweden's experience of age management and the factors that influence retirement.

3. Aims, objectives, outputs and outcomes

AWiW seeks to inform actions and approaches around supporting older people to remain active in work and use work to prevent future ill-health.

3.1 Aims

- to bridge the gap between health and work by emphasising the role and importance that work plays in recovery and managing health conditions
- to explore ways of helping people to remain active in work as they age (even if they have chosen to retire) so they can gain the health benefits of remaining in work
- to provide advice on the benefits of work in managing chronic conditions and the role of the employer in supporting workers to remain healthy
- to consider how best to maximise the number of healthy years an individual has after retirement and reduce the numbers of people who leave work due to ill-health after the age of 50

3.2 Objectives

- to explore why older people stop working, with a focus on the relationship between health and employment
- to work with national government, regional commissioners, charities and a sample of older people from GM
- to develop outcome measures to gauge the future resilience of older people
- to identify specific challenges and the potential for promoting active ageing

3.3 Expected outcomes

- influencing national policy development to reposition work as a key indicator of the future health of older people
- changes to policy and practice: widening the position of work (including voluntary and civic participation) as a tool to keep people healthy in later years
- clear evidence-based recommendations on changes to national policy
- a new set of international relationships to test new policies, share information and encourage a wider use of good work to improve health and condition management

3.4 Expected outputs

- a baseline report and a summary of UK evidence of active ageing in the workplace
- international evidence summaries
- e-platform for sharing policy and good practice identified through the project
- tools for employers and health and social care staff to help them actively support older people with chronic disease in the workplace
- adaptation of the NHS Health Check (NHS HC) to prepare people to make decisions about work as they become older
- development of PHOF measures to further reflect AAI measures and outcomes

4. Methodology

Four distinct methodologies have been employed in AWiW.

4.1 In-depth reviews

Three in-depth reviews were undertaken covering themes chosen to complement the evidence provided through transnational activities:

- **impact of social isolation on health and health on social isolation**
- **mental health and work**
- **influences on retirement**

Insights were drawn from academic papers, government documents, NICE guidance and tools from stakeholders including unions, ACAS, charities such as Age UK. and other stakeholders including the Work Foundation and the RenEWL collaboration led by University College London.

4.2 . Analysis of Public Health Outcomes Framework (PHOF)

The PHOF is a compendium of indicators of key determinants of public health improvement and of corresponding desired health outcomes, presented through a readily accessible on-line access tool, and calculated for local authority populations. The current version consists of 66 key improvement indicators (several having additional sub-indicators) that have been selected as known contributors to differential life expectancy and differential healthy life expectancy.

The PHOF includes only one specific indicator of employment: Employment rate for those with a long-term health condition. It also has relatively few indicators specific to health improvements in middle-aged and older populations.

The Active Ageing Index (AAI) 2012 is also a compendium of indicators that draws on a survey of ageing populations across the countries of the European Union. It includes specific indicators of employment in older age at national level. Closely corresponding indicators of employment by age for local authority populations within England can be extracted from the National Online Manpower Information Systems (NOMIS) statistical resource. For the purpose of analysis, four employment rates were tested: at ages 16-24, 25-49, 50-64 and 65 plus.

The first stage of analysis employed Multiple Linear Regression (MLR) techniques to construct stable and consistent predictive models for the observed locality distributions of three definitions of health expectancy: healthy life expectancy, disability-free life expectancy at birth, and disability free life expectancy at 65. In each case male and female expectancies were separately modelled, with the explanatory terms confined to indicators within the current PHOF set. Units for analysis were 150 upper-tier authorities in England; the City of London and Isles of Scilly being excluded.

The second stage analysis explored whether adding any of four employment rate indicators to the set of potential explanatory terms could be shown to significantly enhance the explanatory power and consistency of these models. Further work explored whether significant associations could be inferred as demonstrating a causal dependence of health expectancy on older age employment, through applying the technique of Two-stage Least Squares Regression.

4.3 Learning exchange with EU partners

The AWiW project team visited specific institutions, active on the national, regional and international stages, in the Netherlands, Finland and Sweden. Themed programmes for each visit were supplemented by literature provided by European partners. Reciprocal learning was promoted as an opportunity to share insight from the UK.

Case Study 1: The Netherlands

A two-day study visit was undertaken from 24-25 April 2014 to the EMGO+ Institute for Health and Care Research in the Netherlands to learn about the Dutch approach to managing chronic conditions in the workplace.

Case Study 2: Finland

The Finnish visit took place at the Finnish Institute of Occupational Health in Helsinki from 20-21 May 2014. Finland is internationally recognised for its expertise in active ageing, particularly around workplace adaptations and changes to employer practice for older workers.

Case Study 3: Sweden

The visit to the Department of Sociology and Work Science and the Business School at the University of Göteborg took place from 13-14 October 2014. This explored a theme around retirement choices and Sweden's experience of an ageing population.

Case Study 4: Manchester

A two-day reciprocal learning visit was organised in December 2014 for a senior researcher from the EMGO+ Institute for Health and Care Research in the Netherlands. The itinerary for this included an update on AWiW, sharing good practice from Greater Manchester and an academic session at the University of Salford.

Case Study 5: Manchester

A two-day reciprocal learning visit was organised in March 2015. This was an opportunity to test out thinking from the AWiW project with experts from Sweden and Finland and to share good practice from the UK. The visit included a seminar session delivered at the University of Manchester.

4.4 Additional engagement

Engagement with a wide range of stakeholders took place to foster networks that would endure for the life of the project, and beyond into longer-term conversations. These stakeholders included:

- **Department for Work and Pensions (DWP)**
- **Age Action Alliance**
- **Centre for Economic and Social Inclusion (CESI) and National Institute for Adult Continuing Education (NIACE)**
- **National Institute for Health and Care Excellence (NICE)**
- **Age UK**
- **Business in the Community (BITC)**
- **International Longevity Centre (ILC)**
- **University of Manchester**
- **University of Salford**
- **Lancaster University**
- **University College London**
- **Work Foundation**

A policy round-table event was staged in April 2015. Various Greater Manchester stakeholders attended including New Economy (the organisation leading on the development of the GM Ageing Hub), as well as stakeholders from across the UK including the Employers Network for Equality and Inclusion (ENEI) and representatives from the NHS Working Longer Group.

4.5 Insight work: NHS Health Checks and Health Trainers

Qualitative insight was obtained to understand the views of GM leads for NHS HC and to scope out an extended role for the Health Check programme to be a baseline and an opportunity to assess and influence work ability.

Further insight was captured from GM Health Trainer leads to devise an extended role for this professional workforce, particularly around primary prevention in the context of work life.

AWiW project personnel attended two fora to capture the perspective of both Health Check and Health Trainer leads. A semi-structured focus group schedule was drafted and used to capture views. Responses were categorised thematically to inform thinking around the development of methods to deliver healthy work conversations.

5. Findings

5.1 Labour market participation

Comparison of variations in labour market participation in each GM local authority reveals that the percentage of working people aged 50-64 years in Trafford (69%) and Stockport (69%) are higher than the England figure (67%), with Manchester (56%), Salford (59%) and Rochdale (61%) much lower.

Nine per cent of residents in Manchester aged 50-64 years have never worked and 5% of the GM workforce has not worked for around 20 years, which suggests some have not worked from mid-life onwards or even earlier (Table 1).

There is a significant fall in the percentage of individuals who are categorised as economically active in the 65-74 age group. Only Trafford (15%), Stockport (16%) and Bury (16%) have percentages above the figure for England (Table 2).

	Bolton	Bury	Mcr	Oldham	Rochdale	Salford	Stockport	Tameside	Trafford	Wigan	Greater MCR	England
In employment	63%	65%	56%	63%	61%	59%	69%	64%	69%	63%	63%	67%
Last worked in 2011	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%
Last worked in 2010	4%	5%	4%	5%	4%	4%	4%	4%	4%	4%	4%	4%
Last worked in 2008 or 2009	6%	7%	6%	7%	7%	6%	7%	5%	6%	7%	6%	6%
Last worked in 2006 or 2007	4%	5%	4%	4%	5%	4%	4%	4%	4%	5%	4%	4%
Last worked in 2004 or 2005	4%	2%	2%	2%	2%	3%	3%	3%	3%	3%	3%	3%
Last worked in 2002 or 2003	2%	1%	2%	2%	3%	3%	2%	2%	2%	2%	2%	2%
Last worked in 2000 or 2001	3%	2%	2%	2%	2%	3%	2%	2%	2%	2%	2%	2%
Last worked in 1996 or 1999	3%	3%	3%	3%	3%	4%	3%	3%	2%	3%	3%	3%
Last worked in 1991 or 1995	3%	2%	3%	3%	3%	4%	2%	4%	2%	4%	3%	2%
Last worked before 1991	5%	4%	8%	5%	6%	7%	3%	5%	4%	5%	5%	4%
Never worked	3%	2%	9%	4%	4%	3%	2%	3%	2%	2%	3%	3%

Table 1: Last year worked by those aged 50-64[1]

	Bolton	Bury	Mcr	Oldham	Rochdale	Salford	Stockport	Tameside	Trafford	Wigan	Greater MCR
50 -64 in work now	63%	65%	56%	63%	61%	59%	69%	64%	69%	63%	63%
previously worked	34%	33%	36%	34%	35%	37%	29%	34%	30%	35%	34%
never worked	3%	2%	9%	4%	4%	3%	2%	3%	2%	2%	3%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
65 -74 in work now	12%	16%	12%	11%	12%	11%	16%	12%	15%	11%	13%
previously worked	85%	80%	78%	85%	82%	84%	81%	84%	81%	86%	83%
never worked	3%	3%	10%	4%	6%	5%	3%	3%	4%	3%	5%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
75+ in work now	3%	3%	3%	2%	2%	3%	3%	2%	3%	2%	3%
previously worked	90%	88%	83%	90%	90%	90%	90%	91%	92%	90%	89%
never worked	7%	9%	13%	8%	8%	7%	6%	7%	5%	7%	8%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Total in work now	57%	60%	53%	56%	55%	56%	60%	58%	61%	59%	57%
previously worked	34%	32%	31%	33%	34%	35%	34%	34%	32%	35%	33%
never worked	9%	8%	16%	11%	11%	9%	6%	8%	7%	7%	10%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Table 2: Percentage aged 50-64, 65-74 and 75+ who are economically active [2]

[1 and 2] https://census.ukdataservice.ac.uk/use-data/guides/microdataOffice for National Statistics, 2011 Census: Aggregate data (England and Wales) [computer file]. UK Data Service Census Support. Downloaded from: http://infuse.mimas.ac.uk. This information is licensed under the terms of the Open Government Licence [http://www.nationalarchives.gov.uk/doc/open-government-licence/version/2].

Headline national figures provide a macro picture of economic engagement. Currently, those aged over 50 account for around a third of the workforce. The size of this group will increase significantly by 2025.

In employment

- The 50+ age group accounts for 30% of total people employed in the UK. There are 8.1 million people aged 50-64 employed in the UK and an additional 1.1 million aged 65+
- By 2025 there will be 3.3 million more workers aged between 50 and state pension age

Separating out the economically inactive population is significant as people aged 50-64 account for 40% of the total economically inactive population aged 18-64.

Economically Inactive (not looking for employment)

- 3.4 million people aged 50-64 are economically inactive. This accounts for 41.5% of the total number of economically inactive people aged 18-64

National trend data does show that, since the abolition of the state retirement age in 2011, participation by people over the age of 65 has increased by one million (DWP, 2014). However, this is still lower than equivalent rates in Sweden (Eurostat, 2010). Abolition of the state retirement age alone will not facilitate participation since the most disadvantaged in our society are more likely to have more lost years due to factors such as ill-health and so changes in work life must be made simultaneously with pension and retirement reforms (Kadefors R, 2013).

People aged 50-64 are disproportionately more likely to be unemployed for 12 months or longer. Although the situation has improved for some older people (mainly those in secure work and high-status occupations), losing a job in later life makes them much more vulnerable to long-term unemployment and the effects on their wellbeing and financial situation may be significant and long lasting (Cory G, 2013).

Unemployed (looking for employment)

- 47.2% of people aged 50+ and unemployed have been out of work for 12 months or more. This is in contrast to 34.3% of all UK adults

Almost two million older people have become entrepreneurs. However, there is insufficient evidence to show whether this is through choice or as a consequence of decreasing job security and more work is needed to understand whether push or pull factors are driving this growth. Business in the Community and the International Longevity Society report that more than one million older workers may have been forced to leave the labour market (BITC and ILC, 2015). On the other hand, the success rate of start-up businesses is much higher for older people, feeding into a narrative around older people being active agents of wealth creation and it may be helpful to extend this to a narrative of socio-economic wealth creation.

Self-employed

- 42.9% of all those self-employed in the UK are aged 50+
- 14.3% of the entire workforce
- 19.4% of the workers aged 50-64
- 40.9% of workers aged 65

5.2 Summary of in-depth reviews

Contribution of older workers/citizens

Extending working lives is imperative to help individuals and organisations develop and to support economic growth (DWP, 2014). Contrary to the view that people become passive, less visible, poorer and more dependent as they age, older citizens, living fuller working lives, make a valuable contribution to their workplaces and communities through their individual strengths. This in turn fosters independence, activity and engagement (WHO, 2007).

Work is a contributing factor to health and wellbeing (Waddell & Burton, 2006). The relationship between work and health is complex. Poor working conditions and job insecurity may be at the root of poorer health and wellbeing and a trigger for early departure from the labour market (Waddell & Burton, 2006). Conversely, good quality work (good work) can be a route to reducing poverty and the economic and health inequalities experienced by individuals, families and communities (University of Liverpool and CLES, 2014).

Being in good work provides financial reward, social identity, purpose and daily routine

Good work, as defined through empirical research, delivers psychosocial benefits such as improved staff support, sense of worth, autonomy and job control, through characteristics including (Bloomer E, 2014):

- **promoting worker involvement**
- **encouraging staff support**
- **promoting autonomy and employee job control**
- **minimising work pressure**
- **having clear expectations**
- **providing ongoing access to support, particularly natural supports, in the workplace**

Volunteering

Volunteering is a good stepping-stone into paid work, boosting an individual's self-esteem, learning experiences and skills whilst also preserving the time to deal with health and social issues that prevent people from working (Jenkinson et al., 2013), although rates of volunteering are lower amongst more deprived communities and those with long-term conditions (McMunn et al., 2009).

Evidence suggests that volunteering for altruistic reasons is more effective at generating secondary impacts related to wellbeing than volunteering for a purpose of self-interest, e.g. employment, status, etc. (Jenkinson et al., 2013). Many employers support altruistic volunteering as a means of connecting with communities and in providing job satisfaction for staff (Department of Communities and Local Government, 2009). As such, volunteering and serving the community could be a routine part of a paid worker's professional development (Corporate Citizenship, 2010), or a transition stage e.g. from paid work to retirement.

Jenkinson et al (2013) concludes that most people volunteer for altruistic reasons, although it is recognised that volunteering brings many benefits to individuals, employers and society alike, producing goods and services of value.

It benefits not only the recipient, but also the volunteer, provided they feel valued for their volunteering activity. Systematic reviews have captured evidence, which suggests volunteering offers a range of benefits to the volunteer.

Overall, there are health and wellbeing benefits to volunteering, but the effect depends on a range of variables including age of the volunteer. There may be a dose effect and factors such as training of volunteers may impact on experience and outcomes (Jenkinson et al., 2013) (Casiday et al., 2008). The Citizenship Survey 2009-10 found that 30% of people aged 65-74, and around 20% of over 75s, undertake some formal volunteering (Department for Communities and Local Government, 2010).

Although volunteering is essentially a social exchange, it is important to give it a monetary value. Calculating its precise economic value is challenging and usually proxy measures are used to produce an estimate. For example, the ONS estimated the value of regular formal volunteering to be £23.9 billion. Volunteering England calculated formal and informal volunteering at £45.1 billion (Institute for Volunteering Research, 2009).

Caring

Caring touches most families in the UK. It is an expression of human care, respect and affection. Caring responsibilities are rewarding but have significant impacts on carers. One in five people gives up work to care. They are more likely to suffer ill-health and to be worse off financially (Buckner & Yeandle, 2011). The RCGP Carers Hub commits the NHS to find new ways to support carers, a vision that clearly must be replicated across the system.

The contribution carers make to the economy is significant and has been estimated at £119 billion per year, more than the entire NHS budget, by the University of Leeds and Carers Trust. The cost of providing alternative care equates to £14.50 per hour. Unpaid carers save the UK economy £87 million per year (Buckner & Yeandle, 2011).

The annual economic value of grandparents providing childcare to grandchildren is estimated to be £7.3bn. In the UK, grandparents plug the gap due to the cost of childcare. Often it is women that are carers, which will affect participation by women in the labour market (Grandparentsplus, 2013). In contrast, Sweden has one the highest proportions of working mothers with children under the age of 6 years (76.8%).

There is a highly developed system of flexible parental leave and paid leave which supports women to stay working (European Union, 2015). Fifty to sixty per cent of grandparents in Sweden and the Netherlands provide some form of care on an informal basis, but only 2 per cent of grandparents in the latter provide almost daily care for grandchildren (Grandparentsplus, 2013).

There is a gender gap between male and female employment across most European countries. Sweden has a very narrow gap between males and females in employment. Part-time working is common in many countries including the Netherlands and UK.

Whilst part-time working may reflect a preference, there is a need to be clear how much is choice and how much is constraint via a lack of alternative care arrangements (European Union, 2013). Kadefors (2013) notes that Sweden and Norway addressed the issue of access to quality child care provision several decades ago to improve work participation amongst older females.

Finland has identical municipal child care programmes in place as in Sweden and Norway. Furthermore, each child under the age of 3 yrs has the right to have daycare services from the municipality. This has been an effective way of engaging women in the labour market.

According to the Statistics of Finland the employment rate (2014) for 15-64 years old was 68.7% for males and 67.9% for females. In the 55-64 age group, the respective employment rate was 56.8% versus 61.4%.

Health of older workers

Health inequity in the over 65s is widening at the fastest rate of any age group (Institute of Health Equity, 2012). This is related to a higher prevalence and earlier onset of chronic disease and a lifetime of socio-economic disadvantage, which does not support healthy ageing (Ben Shlomo & Kuh, 2002). Certain conditions are more prevalent such as musculoskeletal problems, with a significant increase experienced by those aged over 50 (Table 3).

Around half of the UK workforce has a long-term condition (LTC) (Phillips C, 2013). From age 40 onwards, chronic disease becomes increasingly prevalent and is typically related to social class. This suggests a life-course approach to preventative action to avoid the over 50s having to leave work early and risk becoming financially and socially vulnerable in later life (Department of Health, 2015).

There are more people aged between 50 years and state pension age with health conditions in work than out of work (2.6 million, or 58%). Furthermore, labour force survey data shows that the likelihood of older people staying in work after becoming ill is improving (DWPii, 2014).

However, the picture in relation to mental health is less promising and more needs to be done to help people with poor mental health to return to, or stay in, work. Whereas there could be as many as 61% of people with diabetes working, only round 14% of people with a psychological illness are working, with this rising to 25% for those diagnosed with depression (ONS, 2011). Just under one in every two disabled individuals is working (ONS, 2011).

Developing a health condition or disability is not an absolute barrier to staying in employment

Prevalence of selected long-term health conditions by age group	18-24	25-49	50-SPA
Musculoskeletal problems	3%	9%	21%
Chest or breathing problems, asthma, bronchitis	5%	5%	8%
Heart, blood pressure or blood circulation problems	1%	4%	17%
Stomach, liver kidney or digestive problems	2%	3%	7%
Diabetes	1%	2%	7%
Depression, bad nerves or anxiety	3%	6%	8%
Other health conditions	7%	9%	17%

Table 3: Prevalence of selected long-term health conditions by age group [3]

[3] Labour Force Survey, Q2 2013 – Q4 2013 see Fuller Working Lives Background Evidence p.31

Support for people to stay in work following acute illness varies across the health care sector. Twenty five per cent of strokes occur in working age adults and the number of strokes in this cohort is rising. A survey of stroke survivors and bosses working in SMEs about their attitudes towards hiring stroke survivors was revealing: 70% of survivors said that work was important to their recovery.

Employers said they would be worried about the risk of another stroke or whether the survivor could undertake their role (Stroke Association, 2015). Access to vocational rehabilitation focused on return to work was found to be patchy. The Care Quality Commission found that only 37% of areas provided this type of support (Care Quality Commission, 2011).

Work and health are inextricably linked. That relationship is played out in a number of ways:

- **good work can strengthen health and wellbeing**
- **poor quality work can be detrimental to health and wellbeing**
- **health conditions can impact on an individual's ability to get into and stay in work**
- **sustained unemployment can be detrimental to health and wellbeing**

The relationship between mental health and wellbeing and work is more pronounced:

- **many people with severe mental illness want to work and estimates suggest 30-50% are capable of working, though only 10-20% actually do**
- **over a four month period of one study, a third of new jobseeker's allowance claimants reported that their mental health deteriorated, while those who entered work reported improved mental health (McManus, et al., 2012)**
- **poor mental health is a predictor for workforce departure in mid-to-late adulthood, particularly early retirement (Doshi, Cen, & Polsky, 2008). Older workers who report depressive symptoms are at increased risk of early transition out of work**
- **in a 2011 survey of employees (Young & Bhaumik, 2011), 36% of people with depression, bad nerves or anxiety believed their condition was caused by work life, and 55% believed that work made their symptoms worse**

There is broad agreement that remaining in work can be good for mental health and wellbeing, and can to some extent aid recovery and condition management (Royal College of Physicians, 2015); (Thomas, Secker, & Grove, 2005); (Seymour & Grove, 2005).

The incidence of stress reflects not only the interaction between the worker and their workplace, but their wider context. For example, poverty, debt, educational attainment, need for re-skilling and training may impact individual resilience and response to stress (Salmela-Aro, Mutanen, & Vuori, 2012).

This suggests that any intervention to resolve mental health and work must take a bio-psychosocial approach, that is one that systematically considers biological, psychological and social factors and their complex interactions in understanding health, illness and health care delivery.

The Health and Safety Executive website presents evidence to suggest that although certain changes in functionality such as hearing loss due to ageing are predictable, key functions around cognitive performance like intelligence, knowledge and language do not show a marked decline until age 70 onwards.

Older workers typically compensate for changes in their health through experience and better job knowledge. They may be more prone to accidents, falls and slips at work but there is little evidence to support this, although when they do have an accident it is often more serious and the employee needs extended time off work to recover. However, this should not be a basis for not hiring or removing older workers from the workforce.

The HSE provides clear guidance on employer and employee responsibilities and good practice in managing older workers. Significantly, risk assessment is not determined by a worker's age.

A common misconception is that older workers are less able to learn, develop new skills or operate as effectively in the workplace as their younger colleagues.

Certainly in some businesses, such as construction, a person's work ability may change as they grow older, however there is no evidence to support a blanket view that older workers are a risk to productivity and profit. Even within construction, keeping and re-skilling workers must be the first choice and supporting their transition to another sector must rank highly. Changes in a person's work ability are predictable and evidence from Finland shows that early and repeated intervention through one-to-one contact between worker and line manager is beneficial. These contacts are underpinned by a commitment at the organisational level.

A person's work ability is measured by the resources they have, along with factors that can impact on their working life and role. Work ability is not an inevitable downward trajectory in ageing, but may vary at career or life stages.

In terms of health, there may be cycles linked to the management of a health condition, e.g. arthritis, which call for accommodation of regular working patterns. In many cases, a worker will not be able to influence or control all aspects on their own, so active and ongoing support from management is essential.

AWiW recognises that the incentives to change behaviour will be different for employers, professionals and individuals. However, each group will benefit directly from a new approach to work for older people, as set out below (Table 4).

Group	Incentives
Employers	• workplace skills retention • lower levels of sickness absence • reduced staff turnover and associated costs • minimised risks to pension fund sustainability or future increases in employer contributions • wider recruitment pool • CSR visibility – company marketing
Health and social care services	• individuals remain healthier for longer • reduced number requiring high level support • need for high level support happens later • reduced social isolation in older age • better condition management and recovery
Individuals and communities	• reduced risk of becoming socially isolated • financial benefits • choice and control over how they approach work as they get older • eligibility for post-retirement loans and mortgages • increased community resource and volunteering capacity • better health for longer

Table 4: A new approach to work for older people [4]

[4] Proposed by Haines and Hopkins based on a review of the evidence

Inequalities in ageing well in work

It is important to recognize that there are inequalities across the protected equality characteristics plus socio-economics that must be recognized and addressed through a proportionate universalism approach, i.e. focusing action relative to need and potential for benefit, to achieve population level improvement.

These inequalities manifest themselves across the various aspects of ageing well in work. There are inequalities in the likelihood of staying in work (DWP, 2005), with people less likely to continue working longer if they are single, male, from some ethnic minority groups e.g. Indian, Pakistani and Bangladeshi, have lower educational qualifications and / or lower income jobs.

These are also apparent across associated factors such as caring responsibilities and health problems. For example, 24% of women providing unpaid care at the age of 50-74 compared to 17% of men (compared to 13% and 8% respectively at age 25-49) (ONS, 2013).

The age of no retirement: Changing our view on engagement

In the 1950s the average retirement age was around 67 for men and around 64 for women. More recently, permanent retirement from work has tended to occur at a fixed point linked to a person's age rather than their individual choice, ability and the contribution they might continue to make. Pension arrangements encouraged the 'baby boomers' to take early retirement.

Policy and state benefits incentivised people in poorer health to retire on the grounds of ill-health or disability. Retirement was, therefore, seen as a passive and permanent status.

In the UK, an ageing society and workforce has necessitated a radical shift in thinking, leading to the abolition of the state retirement age, talk of unwinding careers and portfolio working, a drive to tackle ageism in the workplace, championing the assets of older workers as part of an inter-generational workforce with unique skills and experiences, as well as heralding an era of active ageing (active ageing is not solely based on the ability to be physically active), all in order to optimise our health, participation and security throughout ageing.

Moving from	Moving to
• deficit model that emphasizes the impact of an ageing population on public services	• older people as assets. Recognition that older people are key to sustaining economic growth and creating thriving independent communities
• emphasis on the economic benefits of work • unclear about the benefits to the health and wellbeing of older people of staying in employment or work longer	• advocates that there are significant long term health and social benefits to remaining in good quality work in addition to financial benefits • the social benefits of work, such as reduced social isolation should be embedded in work and health policies
• individuals with health conditions need to be protected from work • early ill-health retirements are perceived to be good for health and employers	• proposes the need to normalise working with/speed up return to work with a health condition or following major illness • argues for greater understanding of the business/social case of facilitating worker health and wellbeing, accommodation of need and recognition of assets (be it as older worker and or one with a health condition)
• plan for retirement in the years running up to retirement	• take a life course approach to ageing to ensure that people can choose the type of work they do as they get older • explicitly not only about people staying in the same employment for longer but about supporting people to make choices and plan early and repeatedly for later life
• services to carers and those in receipt of social care services do not routinely include support to enter work and retain employment.	• individuals take on a plurality of roles as employees, carers, parents, volunteers, which provide resilience and challenge; Return to work needs to be facilitated whether due to change in health/caring status, return from unemployment or even retirement.
• retirement from one role means the end of end of having a career. • people assume one role either in paid employment or civic roles/ volunteering.	• supports a holistic definition of work to include not only paid employment, but self- employment, carers, training, civic and voluntary participation

Table 5: Re-working The Concept Of Later Living [5]

[5] Proposed by Hopkins and Haines based on a review of the evidence

The portfolio of work (DWP, 2014) (DWPii, 2014) undertaken by the Fuller Working Lives Team at DWP and Baroness Ros Altmann, the Pensions Minister and former Business Champion for Older People, has articulated the case for economic growth.

- **Gross Domestic Product (GDP) could have been £17bn higher in 2014 if the employment gap between people in their 40s and those aged over 50 was halved**
- **if everyone worked one year longer, GDP would increase by 1%**
- **a person retiring from work ten years early could see their pension pot shrink by one third**
- **national figures show differences in exit patterns by gender and sector of employment: one in six women and one in four men have not worked since the age of 55**

This work has been instrumental in raising the profile and spelling out the business case in relation to improving age management in the workplace Their narrative is succinctly captured in the strapline; retain, re-train and re-hire, in relation to older workers (Altmann R, 2015). In terms of demographic, economic and social changes we are facing currently, it means that it is essential that people continue to learn and develop their skills across their life course.

Older workers are at the height of their career not the end; their value to employers and society is pivotal, and training can further enhance their value. This may be even more necessary as new policy becomes more focused on reducing retirement and encouraging people to work into their late 60s. People may need to adapt as their current work role evolves, or be ready and able to change roles either in the paid labour market or outside it.

A Foresight report reveals that, rather than increasing, participation rates in learning activities for older people are falling, particularly if they are from poorer backgrounds or of lower educational attainment. Older workers have diverse training needs. Age stereotypes may be influencing the offer and take-up of training to older workers. Policymakers and employers must develop a new approach and commitment to lifelong learning, relevant to the challenges of an ageing workforce and population (Foresight Government Office For Science, 2014).

The Department for Business, Innovation and Skills asked the National Institute of Adult Continuing Education (NIACE) to develop and implement a pilot project to look at a mid-career review as a tool to extend working lives and to aid individuals to access advice and training at key transitions. NIACE's work has a particular leaning towards career and employment, however information, advice and guidance was more holistic since it also included health and social topics, which were intertwined with work.

NIACE piloted a blend of approaches including group work, face to face and telephone engagement. Some pilots included partnering with employers, which meant greater understanding of organisational as well as employee needs. Pilot leads developed relationships with other partners including Job Centre Plus which improved referral pathways (NIACE, 2014).

Although health and social needs were sometimes addressed, this is one aspect that needs to be more routinely included. In an aligned move, Step Change is a proposal by the 'Age of No Retirement' and builds on the mid-career review and proposes a comprehensive review of all facets of an individual's life. It advocates a focus on in and out of work populations.

Normalising working with a health condition or disability

Employment rates amongst people aged 50-64 in GM who report no disability are practically identical to those for England as a whole. The higher local rate of disability is a factor in the lower employment rate experienced for persons reporting a disability. If national employment rates were to be observed in GM for people aged 50-64, employment would increase by around 17,000 people. Of these, 12,000 are due to higher disability rates in GM, with around 5,000 due to lower employment rates for persons reporting a disability in GM.

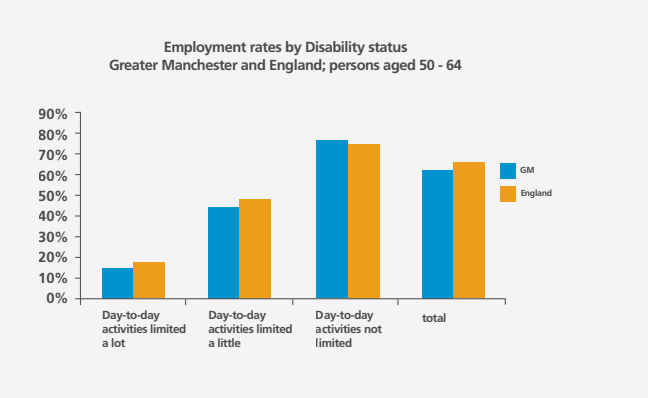

Figure 1: Employment rates by disability status [6]

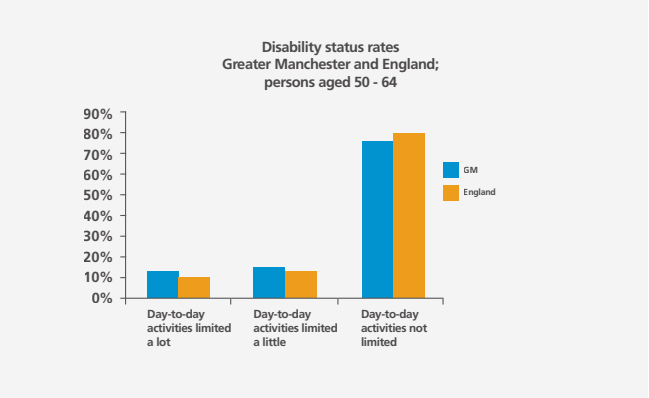

Figure 2: Disability status rates [6]

Amongst economically inactive groups, the percentage permanently sick or disabled varies from 7% in Stockport to 17% in Manchester, whilst the GM average is 11%. This may reflect differences in socio-economic characteristics and earlier onset of long-term conditions and functional decline, suggesting that responses need to be tailored and timed to reflect those differences (Table 6).

[6] https://census.ukdataservice.ac.uk/use-data/guides/microdataOffice for National Statistics, 2011 Census: Aggregate data (England and Wales) [computer file]. UK Data Service Census Support. Downloaded from: http://infuse.mimas.ac.uk. This information is licensed under the terms of the Open Government Licence [http://www.nationalarchives.gov.uk/doc/open-government-licence/version/2].

	Bolton	Bury	Mcr	Oldham	Rochdale	Salford	Stockport	Tameside	Trafford	Wigan	Greater MCR
Econ active (exec FT students), PT employee	17%	14%	13%	15%	13%	13%	15%	14%	15%	16%	15%
Econ active (exec FT students), PT employee	35%	40%	34%	38%	36%	36%	41%	41%	40%	39%	38%
Economically Inactive, Retired	19%	19%	15%	19%	17%	17%	16%	16%	16%	20%	17%
Economically Inactive, Student	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Economically Inactive, Looking after home/family	3%	2%	4%	3%	4%	3%	3%	3%	3%	2%	3%
Economically Inactive, Permanently sick/disabled	10%	9%	17%	10%	13%	15%	7%	11%	8%	11%	11%
Economically Inactive, Other	2%	1%	4%	2%	2%	2%	2%	2%	2%	2%	2%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Table 6: Economically active, grouped by Local Authority, aged 50-64[7] [Columns may add up to less than 100 per cent as lines of data have been removed]

The role that work plays in reducing social isolation and future need for services is not well understood amongst health and social care professionals.

Insight undertaken in GM as part of the Work for Health workstream revealed that people are not always given the right messages on their work ability and the support available to help them remain in work. Health professionals and family members are key influencers on a person's decision whether to return to work, and that decision is made early on in a period of ill-health (Guest S, 2014) .

As part of the Work for Health workstream, a Healthy Work Conversations (HWC) training package was commissioned by GMPHN and developed and delivered by the University of Salford to Allied Health Professionals (AHP) and Psychological Wellbeing Practitioners (PWP).

It revealed hesitance/lack of confidence amongst some professionals to give advice relating to work. This anxiety prevents some professionals from having a meaningful conversation with an individual about their ambitions and concerns around staying in, or getting back into, work. Many AHPs and PWPs believe that professional specialists such as occupational health practitioners should be responsible for such conversations.

To reduce stigma and normalise health conditions in the workplace, there is a need to move away from rehabilitation which focuses on a person's medical condition. Instead, a vocational rehabilitation model should be used which focuses on what a person can do in order to participate in work.

In the spirit of Making Every Contact Count, HWC training has built understanding and confidence and emphasised to professionals undertaking the training that the most important thing is how they engage with clients, not how much engagement they do. Some professionals might only be planting a seed about health and work, whereas others might be engaged in more substantial return to work planning (Parker et al., 2015).

Making the business case

Business is beginning to understand that more can be done to prevent sickness absence and improve and preserve employee health and wellbeing.

Organisations are increasingly recognising the strong business case for keeping their workforce in prime health through a robust organisational offer that spans health promotion, early identification and intervention, and covers role, workload and pattern modification (Cavill Associates Limited and University of Salford, 2014).

[7] https://census.ukdataservice.ac.uk/use-data/guides/microdata . "Office for National Statistics, 2011 Census: Aggregate data (England and Wales) [computer file]. UK Data Service Census Support. Downloaded from: http://infuse.mimas.ac.uk. This information is licensed under the terms of the Open Government Licence [http://www.nationalarchives.gov.uk/doc/open-government-licence/version/2]."

PHE has made a strong case for the workplace being an ideal setting for preventative action to improve health and wellbeing, applied across the whole workforce

In June 2014, PHE published the first set of national standards for workplace health, the Workplace Wellbeing Charter, which aims to engage business in improving workforce health and wellbeing.

The Charter provides employers of all sizes and sectors with a systematic, evidence-based approach to workplace health improvement. PHE has also commissioned specific guidance in relation to older workers, which is built on the understanding that poor work contributes directly to early departure from work and is likely to reinforce health and social inequalities.

Recent guidance published by NICE, Workplace Policy and Management Practices (2015), makes recommendations on improving the health and wellbeing of employees, with a focus on recognising the role of organisational culture and context, and in particular the role of line managers.

The guidance includes details on the benefit to business, calculating the business savings versus investment and clear evidence on good practice for business. However, employee wellbeing is not mandatory, and relies on organisational buy-in and action nudged by initiatives such as the Workplace Wellbeing Charter and the Public Health Responsibility Deal (PHRD).

Lendlease the property and infrastructure group is one organisation which has made great strides through the development of a Health and Wellbeing strategy and other initiatives to reduce site accidents as well as improving staff mental wellbeing.

In 2008, the cost of sickness absence to business was estimated to be around £8 billion. This is less than the cost of presenteeism[8] which is estimated at £15 billion (Black C, 2008).

The Boorman report (2009) indicated high levels of presenteeism in the NHS (Department of Health, 2009). There is no evidence that older workers are any more likely to take sick leave than younger colleagues but, once they do, they are likely to be absent for longer.

Absence is often a result of musculoskeletal injuries or conditions, common mental health issues (Department of Health, 2009) (NHS Employers, 2013), and medical conditions such as cancer and diabetes. Most individuals return to work within 4 weeks but longer term absence (over 4 weeks), makes individuals more vulnerable to falling out of the labour market and onto benefits (Waddell & Burton, 2006).

There is a common assumption that individuals with long-term conditions need to be protected from the workplace. Remaining in work can, in fact, prevent a primary condition from worsening and overlooking this can lead to co-morbidity and social isolation

Growing evidence shows that informal personal contacts such as through work can reduce the onset of physical and mental health problems (Mental Health Foundation, 2013). Further, retaining individuals in the workplace can be beneficial and part of the recovery.

[8] The loss in productivity that occurs when employees come to work but function at less than full capacity because of ill health

Aircraft manufacturer Airbus experienced high sickness absence in its highly skilled workforce, with poor psychological health the primary reason for absence. The company developed an innovative partnership with the NHS with the result that sickness absence was reduced significantly. Airbus used the initiative to heighten managerial awareness of the issues and tackle stigma, which may have prevented workers disclosing health problems (DWPii, 2013).

Some employers have tailored their offer, recognising the diverse make-up of the workforce and also the fact that the workforce was ageing. Sandwell Homes recognised that the average age profile of its workforce was increasing. Its workforce was diverse as employees worked across multiple sites and ranged from non-skilled to professional workers.

The organisation started making an earlier and appropriate offer to staff in order to speed up referral and intervention to target mental health and musculoskeletal conditions where individuals' work was being affected and a nurse-led service was engaged to provide specific return to work advice (DWPii, 2013).

The Fit for Work scheme commenced in December 2014. Designed to support people return to work, Fit for Work helps with sickness absence and provides an occupational health assessment, along with health and work advice to employees, employers and GPs.

This is crucial since an occupational health offer is only available to around 34% of the UK workforce (Faculty of Occupational Medicine of the Royal College of Physicians, 2006). GP referral is the main mechanism after four weeks of absence, but employer referral is also available.

The service aims to make first contact within two days of referral and develop a personalised plan for return to work using a bio-psychosocial approach. The self-employed are out of the scope of this service. The service may wish to consider creating a bespoke offer for older workers.

Articulating the extended role for health and social care and the voluntary sector

There is a clear relationship between being in employment, life chances and health and wellbeing, which begins before birth. For this reason, there is a strong imperative for public health agencies to lead the way and to use duties vested in them, including the Social Value Act, to reduce the burden of worklessness and increase the provision of high quality work. This is a key tenet of the Due North report (University of Liverpool and CLES, 2014).

Local authorities are active commissioners of services that can influence the life course journey and help the long-term unemployed return to work.There are also a number of organisations such as housing associations and third sector organisations that apply a bio-psychosocial model to work with workless populations to bring them closer to the labour market. Elements of learning from this may be transferable to in-work populations who are at risk of falling out of work.

Local government is in a key position to exert greater influence regarding some of the key challenges to job security, for example: threat of redundancy; zero hours contracts; the cycle of low pay / short term jobs; and lower pay for part-time workers. These all impact on individual health and wellbeing and ultimately on the need for health and social care support. The TUC and other unions have so far taken a lead on these matters.

Due North makes a number of decisive recommendations about how local authorities can make a positive impact, via procurement, to improve the quality of employment and affordable housing and lead by example to ensure that they and local employers end in-work poverty and pay the living wage (University of Liverpool and CLES, 2014).

Many public sector organisations are currently restructuring and reducing their workforces. The possible consequences of exit from the workforce vary according to an individual's circumstances. Less widely acknowledged, however, are the consequences for those who remain, such as higher workloads and reduced opportunities for flexible working or retirement, an issue raised in the interim findings from a review undertaken on behalf of the NHS Working Longer group.

This review raised the issue of inter-generational tensions, as some perceive that extending and making working life more flexible for older workers blocks younger workers' career progression and limits their opportunities. This can be countered partially given that there will be a massive shortfall in the pool of skilled workers available to business, and retaining or rehiring older workers could address this.

Moreover, those local authorities that are successful and employing older workers are also successful at employing younger workers (BITC and ILC, 2014). Evidence from Nordic countries concur that where older workers continue to participate in the labour market, jobs are also created for younger workers (Kadefors R, 2013).

Any business serious about age management and inter-generational harmony needs to address such tensions and be ready to set straight any myths about older workers curbing the opportunities for younger generations (NHS Working Longer Review, 2014).

Although additional pressure on health and social care services is expected to be an inevitable consequence of an ageing population, the evidence collected through AWiW clearly shows that this is not the case. Taking action to ensure that older people, and people in their 40s and 50s, are equipped to deal with changes in their lives and stay active and independent as they get older may help stave off social isolation and its consequences and reduce future pressures on health and social care services.

Being in good employment has benefits for later living including facilitating social connectedness. Social detachment varies according to a range characteristics including occupation, gender and most commonly socio-economic status (Jivraj, Nazroo and Barnes, 2012). Ill-health, particularly in men, reduces the likelihood of social and cultural participation by one third.

Some baby boomers are also more likely to be affected due to fractured kinship, but we should be cautious of making sweeping generalisations about baby boomers as a single cohort as it hides striking variations e.g. women in Wokingham live on average 15.5 years longer than women in Manchester (Ready For Ageing Alliance, 2015).

In 2008, the Foresight Mental Capital and Wellbeing project made a clear recommendation that agencies not only tackle mental health in a timely fashion, but also ensure that individuals stay engaged as they age. It recommends promoting social networking (educational and social activities to prevent isolation and loneliness, such as volunteering and contact with friends), continued learning in older age, which preserves cognitive function, and employment beyond retirement age. Indeed, in relation to the last point, some people even return to work after retiring because they miss the social aspects so much (Altmann R, 2015).

Current practice is to act much later in the life course, by which time people are already isolated and in crisis and the cost of help is much higher. The interest in age and workforce management is a great opportunity for health and social care providers to intervene with employers much earlier and develop social protection and planning for later life within the workplace and at transition points.

A Joseph Rowntree Foundation commissioned report recommends this as an essential part of a pre-retirement offer (Davis Smith J, 2005). The Ready For Ageing Alliance recommends that national government should consider a pre-retirement pack that includes a focus on retention and the development of social connectedness and participation as well financial resilience and future proofing our housing and health prevention (Ready For Ageing Alliance, 2015).

5.3 Summary of findings linked to Public Health Outcomes Framework

A 28 year prospective follow up study in Finland demonstrated that poorer work ability in mid-life is associated with accelerated deterioration in health and functioning (von Bonsdorff et al., 2011). AWiW set out to test the relationship between working longer and prospects for later living.

PHE's North West Knowledge and Intelligence Team tested the supposition that being in employment is a tool to prevent future ill-health amongst the population, thereby supporting a model of early intervention. The objective of this work was to explore the potential for developing the PHOF to include indicators of employment in older age corresponding to those in the AAI.

Robust and consistent predictive models of healthy life expectancy were found, applying constituent indicators from the 2013-2016 PHOF, modified with dummy variables for area classifications from the 2001 census. Both male and female models were strongly predictive of locality variation, predicting 83% and 86% respectively.

Populations with less smoking and less alcohol-related hospital admissions were found to be consistently healthier. Also strongly associated with improved health were populations with less poverty, higher recorded responses to standard questions on 'wellbeing', lower recorded diabetes in primary care, and lower rates of hospital admission for violent injury.

For all indicators of health expectancy, weaker but significant associations were also found with a bundle of indicators of health and social stress in teenagers and younger adults, including first time entrants to the youth justice system, teenage pregnancy, injuries at ages 0-14 and chlamydia diagnoses at ages 15-24. These indicators were not however sufficiently stable and consistent in respect of different years of observation for inclusion in definitive PHOF models.

By adding employment rates into the menu of indicators for potential inclusion, employment at ages 50-64 and employment at ages 65 plus were both found to enter strongly into various explanatory models, with the exception of disability-free life expectancy for males at 65.

The explanatory power of these models of healthy life expectancy for males and females increased to 85% and 87% respectively, and in each case the indicator of employment in older age was amongst the strongest components of the new models. No indicators of employment for those under 50 were found to be significant model components.

Applying the method of Two-stage Least Squares Regression demonstrated that the association between employment aged 50-64 and healthy life expectancy is causally determinative. Where local employment rates for those over 50 increase, this can be shown to result in increased local healthy life expectancy.

> The analysis demonstrates that healthy life expectancy is strongly and consistently associated both with lower exposure to known 'risk' factors, such as smoking and alcohol-related harm, and is also associated with increased access to 'asset' factors, such as higher wellbeing and lower poverty

This analysis provides important emergent data in England, which provides new evidence on the longer-term health benefits of remaining active in good work. Employment in persons over 50 functions as a key 'asset' factor that is strongly determinative of improved health expectancy.

An associated analytical study of longitudinal datasets shows this relationship as applying through the mechanism of improved recovery in disability and long-term conditions. Persons aged over 50 who maintain access to opportunities for continued employment, will tend to recover sooner, have less likelihood of condition recurrence, and are less likely to die.

5.4 Learning from EU partners

A fundamental element of this study was to draw on the expertise and learning from three European countries – the Netherlands, Finland and Sweden – which are tackling issues of employee health and wellbeing, age management and retirement. Some of the evidence resonates with good practice in England. In other cases, the evidence is not transferable to the UK setting.

Case Study 1: Visit to the Netherlands

The Government of the Netherlands has prioritised and put in place measures to extend working lives:

- **pension and tax reform to reverse financial incentives to retire early, e.g. stopping previous national early retirement scheme**
- **increasing national state retirement age, including linkage to healthy life expectancy from 2024. Considerations for future changes include: i) Varied retirement ages for different professions / sectors; ii) Creation of 'bridge employment'**
- **medical reassessment of people on work related benefits approximately ten years ago (previously referred to as 'Dutch disease') reducing those on long-term sickness benefit from ~6% to ~3.9%[9]**
- **the sickness absence pathway (including state involvement) is paid for by employers and return to work is delivered by occupational health with a plan delivered by 12 weeks. Employer liability may be extended beyond two years if they have provided insufficient assistance**

Findings

1. A well developed and resourced occupational health system exists in the Netherlands

All Dutch employers provide occupational health support, with SMEs investing in insurance, although this is not legally mandated.

- **employers pay for treatment and adaptations**
- **workers and employers share responsibility for return to work**
- **there is a focus on 'reintegration' into the workplace and/or work, with return to a different job if the previous role is no longer possible or, in rare cases, collaboration with other employers to move to another company. Funding of training or subsidising wages take place if necessary**
- **the employer's responsibility relates only to permanent staff, encouraging increasing employment through short-term contracts or agencies to avoid this liability**

[9]Academic partners were not able to advise whether any evaluation of this was undertaken, but anecdotally felt it had reduced costs but had limited impact on returning people to the workforce, i.e. reduced number of benefit recipients but had limited effect on employment rate.

2. Sector-specific innovation has been seen in industries with higher rates or risk of chronic disease or conditions within their workforce, e.g. an umbrella occupational health service provider for the construction and haulage industries.

- **funding is provided from a small percentage of employee wages, i.e. proportionate to the size of the company**
- **this provides access to specialist occupational health support and services, i.e. based on insight of risks and needs of sector workforce and uniform for all size companies**
- **tailored health promotion activities are provided appropriate to the sector**
- **this is a highly developed and responsive occupational health system and supportive services, with much shorter waiting times for both primary and secondary care services, e.g. physiotherapy**

3. General Practitioners within the Netherlands don't appear to take responsibly for work outcomes and return to work as part of their patients' treatment plans. While this appears to be similar to the UK perspective, ultimately it has less impact in the Netherlands as the more developed occupational health sector essentially circumvents this issue.

4. Some employers have also responded to the issue, for example:

- **allowing older workers to change their working hours to support them to remain in work**
- **developing 'bridge employment', i.e. more flexible jobs for people who have retired**

5. EMGO+ shared a range of research findings outside the scope of 'managing chronic conditions in the workplace' that provide the following useful insights:

- **workers retiring early are not only influenced by measures at political and societal level but also by health and work-related factors. Self-perceived health and chronic disease is a key factor**
- **diseases, or exposure to peers or loved ones affected, are predictive for early retirement**
- **in addition, work-related factors such as physical work demands, work pressure and low job satisfaction and support form line managers are also key influences on a person's decision to leave the workforce early**

6. Direct comparison and transferability between the Netherlands and the UK is limited by contextual differences:

The Netherlands provides a more generous state pension.

It is mandatory for individuals in the Netherlands to pay into a pension scheme.

- **there is a mandatory retirement age in the Netherlands that is stipulated in employment contracts**
- **pre-employment health screening is illegal in the Netherlands. This appears to have limited impact of low levels of employment of people with long-term conditions**
- **work-related sickness benefit payments, equivalent to ESA in England, are linked to average state salary in the Netherlands. The payment model rate is 80% of the average salary**

Case Study 2: Visit to Finland

Like most EU countries, Finland has an increasingly ageing workforce. Finland has started to put some measures in place to support its ageing population. An enhanced pension provision is offered to individuals that choose to work right up to full retirement age, to incentivise working in older age. There is a flexible retirement age between 63 and 68 where individuals can decide themselves when to retire. The infrastructure and occupational health provision in Finland differs considerably to that of the UK.

- **employers have greater responsibility to look after the health and wellbeing of their staff. Each must have access to occupational health services as a minimum, and many financial implications associated with disability allowance would fall back to the employer**
- **fully qualified occupational health teams are in place as part of a paid-for package to carryout workplace preventative checks as well as supporting individuals during periods of ill-health, at an increased cost to the employer. There is also a close working relationship between occupational health, HR and the line manager**
- **Finland acknowledges that approaches, knowledge and attitudes vary between blue and white collar workers**

Findings

Finland provides a number of conceptual tools to guide understanding and the operation of age management in the workplace.

1. In Finland, workplace adaptations are seen as a part of the evolving cultural attitudes towards an ageing workforce. Ageing is seen as a challenge, an opportunity and finally a part of equal opportunities.

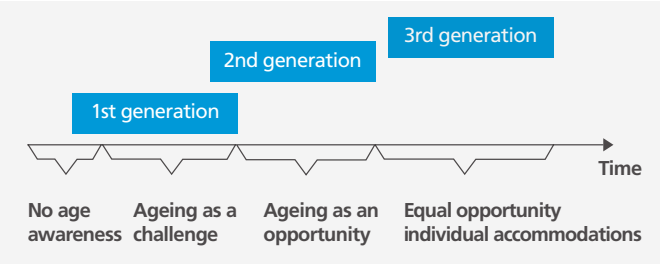

Figure 3: Typology of age management [10]

Attitudes about working in older age from employees, line managers and the organisation itself are determining factors as to whether a person wants to work beyond 50 years of age. It is recognised that if these attitudes can't be changed, strategies need to be put in place to at minimum counteract them.

Businesses' response to older workers can be seen as a spectrum between reactive approaches, i.e. being surprised by sickness absence rates and taking remedial action, and proactive approaches, i.e. putting in place robust active ageing strategies that support older workers and exploit their skills and expertise.

[10] Finnish Institute of Occupational Health

2. Finland has the advantage of legislative support making health and rehabilitation the responsibility of the employer in co-operation with occupational health services and employees. This gives greater emphasis and support for using assessment tools such as work ability scores.

In the work ability house model the figures represents explanatory power of the regression models (R^2) for the work ability index in the 55-64 age group.

The promotion of work ability should include extensive activity that seeks improvements in all of the core structures of work ability; health, expertise, attitudes, work, family, and the close community maintaining mental and physical resources and activity, as well as strengthening expertise is important.

For the older age group (55-64) maintaining mental and physical resources and activity, as well as strengthening expertise is important. Whereas work motivation and sufficient income were important with respect to the work ability of younger people.

Work ability is an internationally-recognised assessment tool, used to consider how to maintain a continued productive workforce. The concept is that people with high work ability scores have a lower risk for early retirement and a higher quality of life – even after retirement. This is not a tool to assess a person's employability.

An individual's work ability score takes into account not just health and work demands but motivation and social circumstances. Work ability fluctuates throughout the life course and this isn't always a downward trend into old age. We know from research that many carers do not want to exit work life due to caring duties, however they have no other choice if the employer does not provide flexible working hours or remote work opportunities.

Variations in work ability occur at transitions, for example when caring for others, individual resources may be compromised and regular demands of the work may become too burdensome resulting in unnecessary exit from the labour market. Should the work demands be diminished and resources increased that would have compensated lower individual resources and the work ability would have remained at the previous levels.

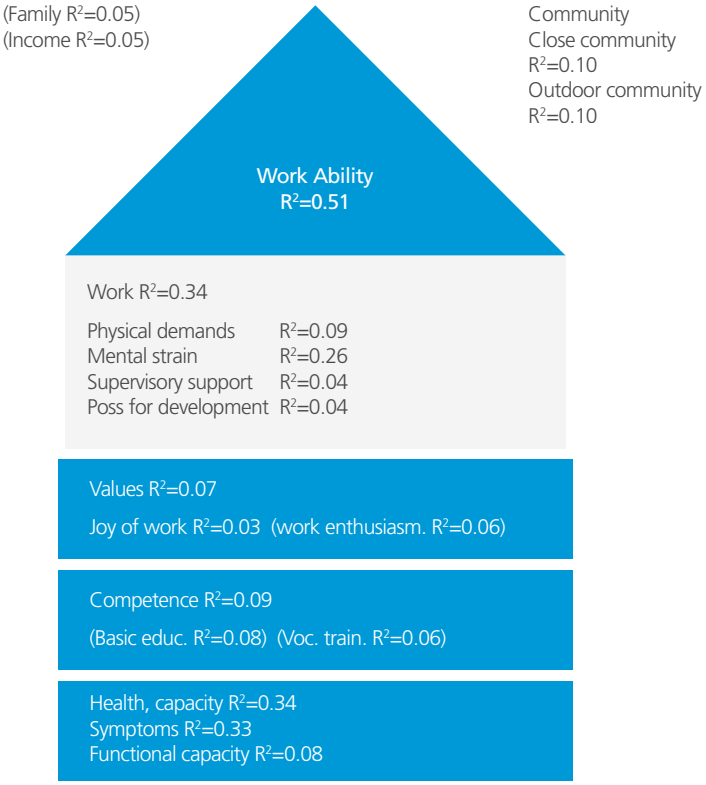

Figure 4: The Work Ability House [11]

[11] © Finnish Institute of Occupational Health


Best Ager

3. The concept of career preparedness or career management was developed in the 1990s during a period of high unemployment in Finland, with a focus on addressing depression and other mental health conditions, but being transferrable to many physical health conditions.

For an individual, enhancing career management preparedness, there are a number of distinct stages:

- **recognise future needs and set goals**
- **identify the skills needed to achieve these goals**
- **develop these skills at a practical level**
- **identify any risks**
- **establish some solutions to potential setbacks**
- **put this plan into practice**

preparedness model in Finnish workplaces, a number of challenges are now being faced with this model, as identified by Professor Jukka Vuori. These include the availability of funding as a result of the recession, engagement with SMEs and micro-businesses and questions around ownership of the initiative and maintaining momentum.

4. The Finnish Institute of Occupational Health conducted a typology of age management practices across the EU, breaking the approach into five key themes:

1. Tackling Problems
2. Decreasing work load/ demands
3. Enhancing resources i.e. utilising strengths
4. Intergenerational learning
5. Life course approach

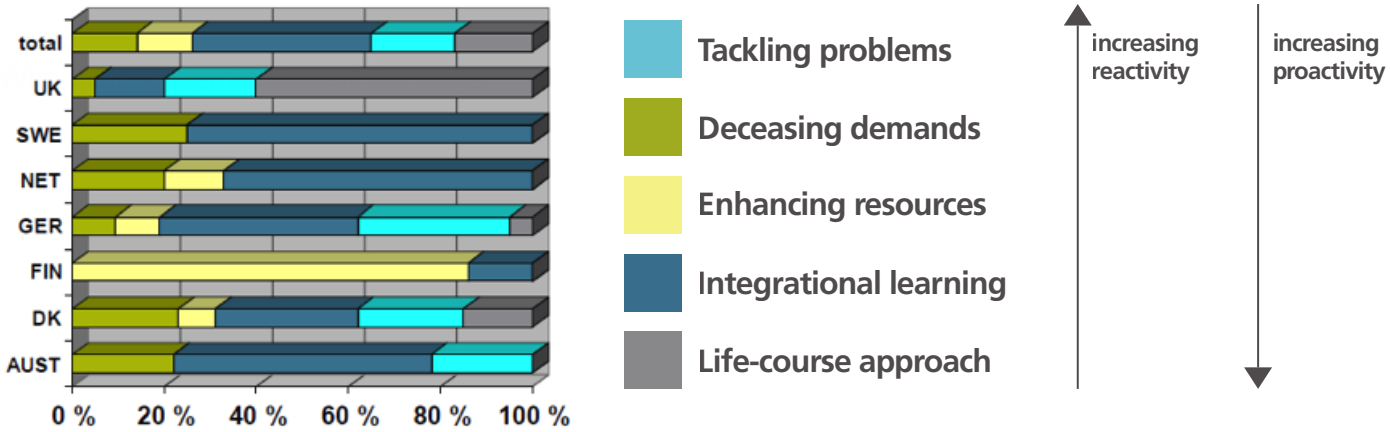

Figure 5: Typology of age management practices [12]

[12] Finnish Institute of Occupational Health

Tackling problems as they arise is categorised as the least proactive response. Enhancing resources or an asset-based approach sits mid-way between a reactive and proactive approach. The life course approach is said to predominate in organisations in the UK. In essence this means an approach based on equal opportunities so all workers are encouraged to enhance assets and initiatives such as flexibility in the workplace is afforded to all workers at different stages of their career and lives.

Countries that are most proactive have organisations that are well prepared by using and analysing existing data of age and work ability within their organisations. The approach of managing an older workforce and which of the five typologies is most heavily weighted is determined by organisational preparedness. This largely dictates whether the organisation is reactive or proactive.

Focusing on the business case, and the potential return on investment, was a key way of engaging businesses in this agenda. This could be through calculating the revenue lost through sickness absence in particular departments or teams, in-house measures of productivity, or staff satisfaction and considering the potential impact on the staff-customer interface. Good leadership was also key, as well as a general sense of fairness in the workplace.

In terms of roll-out, the Finnish experience was that engaging some forerunners or early-implementers was a good technique. Their experience would be key in engaging others, and would help generate a sense of competition from other organisations working in that space. This resonates with findings from Sweden where business was swayed by good practice of other organisations.

Finland uses the term 'career preparedness', however people in the UK that work often don't consider themselves to have a 'career' but a 'job'. The language would need to be adjusted for UK audiences to accommodate a bricklayer in the same way as a solicitor. The concept is about preparing your skill set to accommodate working during older age.

Case Study 3: Visit to Sweden

Mitigation of the impact of ageing including workplace reform is a national priority for government in Sweden. Individuals have a legal right to work until they are 67 and this may increase to 69. There are age limits and economic disincentives in place that help to influence and shift the timing of retirement. Life expectancy in Sweden is amongst the highest in the world and the proportion of over 80s is the second highest in the EU.

Sweden's ordinary retirement age was lowered from 67 to 65 in 1976. Other structural policies also have had a significant impact. From the 1970s, claiming a disability pension became easier, particularly for those aged 60+. Medical and labour market considerations were weighted together in any decision to award a disability pension. In the first half of the 1990s when the economic crisis hit, older workers began to fall out of the workplace in large numbers. However, the subsequent upturn in the economy was not marked with the return of older workers to pre-crisis levels. It is claimed that this led to changes in perceptions around normal retirement age and may have contributed in part to employers' negative attitudes towards an ageing workforce (Olofsson, 2001).

Although ageing of the workforce is occurring in Sweden at a slower rate compared to many other EU countries, unemployment varies both between and within regions and lack of a skilled labour force is a significant problem in parts of the rural north. Barriers to the widening participation of older people in the workforce are based on concerns about a deterioration in health and competence of older individuals, even though the scientific evidence refutes any reduction in ability and productivity.

Immigration has to some extent improved the demographic potential, with the arrival of younger migrant workers. However, the picture is mixed since in some areas depopulation has led to an ageing population and a range of issues in both the economy and communities.

In terms of occupational health services, there has been a gradual decline of businesses hosting such services in-house. Provision is largely outsourced or individuals present at their own doctors. This has led to some disconnect between occupational health professionals and their understanding of the business in which individuals work. There is less emphasis on preventative work but individuals can consult the service even if not on sick leave. The employer is responsible for paying for the occupational health service.

Findings

1. The Best Agers, a collaborative project in the Baltic Sea Region included partners from Sweden, Denmark, Latvia, Germany, Lithuania and Poland. The University of Göteborg was involved in the project's labour market and employment work stream with four sub-themes: demography, employment, policy, and barriers to implementation.

Researchers undertook 140 qualitative interviews to understand what encourages individuals that retire early.

The themes elicited related to health barriers, e.g. perceived need to slow down; employer or other employee attitudes, e.g. older employees less competent and able to cope with new technologies; cultural barriers, e.g. lack of understanding about the benefits of older workers in the workplace; financial barriers which can facilitate or make retirement more difficult and spousal factors, e.g. since spousal retirement decisions are often inter-linked.

Best Agers developed a 17-point programme for sustained employability with recommendations at the individual, organisational and societal levels (Best Agers, 2013). For individuals, recommendations included building competence, seeking 'good' employers, building relationship with managers, engaging with trade union activity to enhance age management, avoiding repetitive and strenuous work and engaging in physical activity in free time.

For employers their role was to make roles fit capacity, embed culture of positive age management across the organisation, develop career plans for individuals, initiate mentoring programmes for inter-generational learning.

At the societal level the recommendations were to revoke any form of age discrimination, make sure this is also reflected in the work of the government, engaging older people in parliamentary and other high profile governmental roles.

2. The Best Agers Lighthouses is an extension project (Best Agers Lighthouses, 2013) which evaluated scientific and applied work as a response to an ageing workforce. The project developed recommendations in four domains:

- **change perceptions about ageing and demographic change, e.g. communicate impact of demographic change and combat ageism**
- **identify and promote good practice, e.g. raise awareness of the positive impact of age management on economy and promote work ability**
- **lead the way and set good examples, e.g. collective agreements within sectors and serve as role model within a sector**
- **change laws and regulations, e.g. adopt life course approach, facilitate work life balance and flexible and phased retirement**

3. Sweden provides a number of significant age management case studies:

- **the Vasterbotten area in northern Sweden had a particular issue with declining numbers of medical professionals. The strategy adopted in response was to stimulate workers aged above 65 to remain in work. A raft of measures were implemented including: a salary increase, offering full and part-time working arrangements, encouraging individuals to come out of retirement, galvanising middle management to stimulate discussions with staff and to talk to individuals as individuals and, above all, to be flexible. Annual reviews were initiated with all employees and discussions about retirement were started at the age of 40 as it was considered too late to start at 55**

- **Vattenfall, one of Europe's leading generators of electricity and heat, was losing its skilled older workforce. It recognised the need to transfer knowledge between generations and to change company culture in relation to age management. Key personnel from the organisation were made available to share learning and exchange competences. There were events to motivate the whole workforce. The company developed a programme in order to retain older staff called (80, 90, 100), which meant that individuals worked 80% of the time for 90% of the pay and 100% of the pension (Mykletun & Furunes, 2010)**

As part of their collaborative work in the Baltic region, our academic hosts presented some findings from other countries.

- **In Kiel, a community-operated recycling and waste collection company had an ageing workforce and there were difficulties recruiting younger personnel. Applying the work ability house model was useful to help address issues and change the culture within the organisation. Different projects were adopted to improve health, the company initiated training to address lifelong learning and changes were made to the physical environment. In terms of a response, it was found that staff were better motivated, in improved health, reduced sickness and there was reduced need to recruit new staff. An economic evaluation showed that the age management programme was cost-effective mostly due to a reduction in sickness absence**

4. In Sweden, there appears to be a sound rationale for making interventions around age management, although there have been few scientific evaluations using cost benefit analysis. Whether age management is adjudged as profitable for employees and employer depends on the model used. If purely economic models are used then it is likely that no payback will be found particularly in the short to medium term. However, if life span career development models are adopted then there is likely to be a discernible return over three to five years.

Malmqvist, outlined the benefits and costs of age management. Benefits of interventions included reduced sick leave and higher productivity (Malmqvist, 2007). This sits well with work undertaken in the UK, which emphasises gains in terms of reduced recruitment costs and preservation of corporate memory. Costs included those of developing initiatives and evaluating success.

- **car maker BMW has experienced reputation benefits as a result of adopting a range of age management strategies within the organisation.It has promoted itself in advertisements as a good employer to gain an edge over competitors in terms of employee recruitment and reputational benefits with customers.**

5. Findings from Swedish literature in relation to retirement behaviour indicate there has been a change overall and individuals are staying in the workplace longer. However, there are discernible differences between sectors. Comparing professions, whereas doctors tend to continue working past the age of 65, this is not common amongst nurses.

This is compounded by the fact that the private sector appears more attractive to the new generation of managers. White collar and academic professions tended to work longer than blue collar workers (Kadefors R, 2007). In Finland, blue collar workers with limited work ability prematurely exit labour force due to disability pension twice as often as white collar workers (Saarelma-thiel & Wallin, 2015).

The literature review provides little evidence of differences between women and men. New evidence from Sweden (2015) shows that the gender difference has become smaller gradually and in fact has now disappeared; in 2006 women exited 2.3 years earlier than men, whereas in 2011 there was no longer any difference, according to new analyses. Both men and women increased their work participation, but women more so.

Strong social care provision for older people and affordable day-care mean that caring responsibilities were less of an issue in decisions to retire in Sweden. There is a consensus that economic incentives alone will not encourage individuals to stay in the workplace. Influences on early retirement are self-perceived health, particularly in women, work satisfaction and the perception of control, gender, age, position in the organisation, spousal retirement and meaningful life.

6. Sweden has recognised and prioritised extending working lives including pension reform and developing and strengthening age management in the workplace. Specific responses to early retirement have been developed:

- **age management in the workplace is based on a wealth of research and evidence. Responses are also based on local need both in terms of geography and organisation**

- **responses are based on a need for change at the individual, organisational and societal levels**

7. The role of society in Sweden is to revoke age discrimination and ensure that the government leads by example and engages older people in the work of government.

Case study 4: First reciprocal learning event in Manchester

Dr Cécile Boot from EMGO+ Institute, the Netherlands shared her detailed research findings with stakeholders during a two day visit to Manchester in December 2014.

Findings

- **almost half of older workers in the Netherlands have a chronic disease; this should be taken into account in ageing worker policies**
- **workers with very different chronic diseases might benefit from similar interventions**
- **older workers with mental disorders require additional attention**
- **interventions should focus on supporting workers how to manage their work, in addition to optimising the work environment**
- **work adjustments are often implemented following sick leave. It is advised that supervisors should gain insight into the needs of workers with chronic disease earlier, to be able to implement work adjustments to prevent sick leave**

Case study 5: Second reciprocal learning event in Manchester

A two day reciprocal learning visit took place in March 2015 involving partners from Sweden and Finland: Professor Roland Kadefors from the University of Gothenburg and Dr Marjo Wallin from the Finnish Institute of Occupational Health.

On the first day, the AWiW team gave presentations to the visitors. On day two, an academic session was convened at the University of Manchester. Presentations were given by two academics from the university and by the Swedish and Finish partners.

Findings

Dr Marjo Wallin's presentation was titled Enabling Longer Working Careers With Peer Group Method. A number of findings were included:

- **by promoting wellbeing at work we can improve quality, productivity as well as work participation**
- **wellbeing is a collaboration between employees, employers and society**
- **challenges in work ability occur at times of transition, e.g. retirement and rehiring**
- **the biggest benefit of the peer method was found in those participants at risk of depression. Incidence of mental health issue highest between the ages of 30-54 whereas MSK increases from the age of 30**
- **the topic of retirement/transition rarely discussed**
- **the method connects the goals of early prevention, work ability and maintenance and the method builds 1) preparedness of the individual, 2) career management and 3) organisational readiness**

Professor Kadefors' presentation related to Age Management in Sweden. The following headline contextual information was provided:

- **Sweden's population is not ageing as fast as in other European countries**
- **the rationale for working longer is rooted in keeping the pension system healthier**
- **due to an ageing population, even in times of high unemployment there will be a skills shortage**
- **lost working years were lowest in groups such as lecturers and health professionals, except for nurses. Blue collar workers were more likely to retire early**
- **the 2012 Pension Age Commission led to a number of strategic responses to an ageing population**
- **the Best Agers projects revealed that barriers to remaining in the workplace were related to health, competence and attitude**

Key age management issues were also disseminated:

- **development of an organisation and work conditions that stimulate employees to work beyond 65+**
- **continued salary increase and competence development after the age of 60**
- **possibilities to work full or part time – individual adjustment**
- **for those who have retired: provisions to return to work and to work periods according to their wishes**
- **middle management must prepare and stimulate**

5.5 Findings from insight in relation to NHS Health Checks and Health Trainers

The AWiW project team undertook insight work with NHS Health Check (HC) commissioners and Health Trainers in GM to scope out the feasibility of introducing healthy work conversations.

An early conversation was undertaken with GM NHS Health Check Leads to elicit their views of adding healthy work conversations (HWC) to the Health Check. Responses are summarised below:

there was broad agreement that it is important for Health Care Professionals (HCPs) to have conversations about ageing well and health and work

they were concerned that adding another strand might dilute the potential of the HC. Any attempt to include conversations about work and health would need to be well planned and rehearsed

current priorities were centred around increasing uptake not adding new strands. Aligned to this was a reluctance to add another strand to the workload

leads suggested that Health Trainers may be better placed to deliver HWC

As a second strand, two project team members spoke to GM Health Trainers at one of their forum meetings. This elicited the following features of the service, which suggest that is well placed to provide both targeted and anticipatory interventions:

targeting of 'seldom heard' or protected groups

encourages healthy behaviour and uptake of preventative services.

provides opportunities to gain skills and employment and to reduce health inequalities

tackles health and non-health issues, which prevent people from getting into work

provides NHS HC within the work setting and using that as an opportunity to provide a brief intervention or signpost

A set of key skills and competencies of Health Trainers was also identified, which underlined their expertise to engage in health and work conversations:

skill set around tailored behaviour support/ change

expertise and knowledge of local and cross agency advisory services

provision of single point of contact

promotion and support of Workplace Wellbeing Charter

provides an early warning system. Pick up shifts in need e.g. middle classes requiring debt management skills

trusted by clients and increasingly trusted by primary care and opportunities for co-location

The project team also identified a number of opportunities and threats in relation to engaging Health Trainers to deliver HWC:

helping to optimise health whilst in work, but could also help early planning for retirement, encouraging civic and voluntary participation and targeting of key groups prone to early retirement (Opportunity)

many Health Trainer services in GM are out to tender. Few services are growing (Threat)

no national model but driven by local commissioning priorities, therefore need to find a common approach (Opportunity / Threat)

Health Trainers noted that some of the employers they engage with are trailblazers and will buy into the service and release staff. Others need to be persuaded, so more work would need to be undertaken to achieve wider buy in (Opportunity / Threat)

The small number of health trainers engaged were receptive to the HWC focus and felt that it was part of their remit, however the size of the service was a limitation. NHS HC is a universal offer, but variations in uptake and the fact that providers are covering key tasks means that any additional focus would need to be carefully considered.

6. Conclusions

Society needs to define and embrace new models of positive ageing. Everyone benefits from communities and workplaces that promote and flourish with active and visible participation of older people. As part of this repositioning, the view of good work and its influence on healthy life expectancy has been reworked, as has a view of retirement which is no longer determined by chronological age and characterised by passivity, decline and dependence (WHO Ageing & Life course 2012).

The evidence base internationally and from the UK demonstrates that mid-life is a time when health, social and employment opportunities converge and it is a key point to build resilience and future-proof opportunities for later living

This is not to suggest that chronological age should determine intervention; life tends to be fluid as individuals have to cope with the ups and downs of illness, caring responsibilities and aspects of work life for example.

Moreover, individuals act and may respond differently to similar circumstances. Nonetheless, it is a time when individuals may have a greater sense of ageing and be more receptive to messages and interventions to prepare, plan and assume control over the next chapter in their lives.

A life course approach allows a call to action which takes account of a plurality of perspectives since some individuals may be looking forward to a life stage spanning three or four decades blessed by good health, surrounded by friends, active in their communities and financially resilient, whilst others may face a bleaker experience as the antecedents, such as a poor start in life and early onset of LTCs, have influenced access to skills, opportunities and determined poorer health and social outcomes throughout their life with later living being no exception.

Although life expectancy is improving and more individuals are living fuller lives, the vision must be for individuals to plan for, and look forward to, later living.

There are key settings for action which include the workplace and communities. Good work is a determinant of health and wellbeing. This project has demonstrated that good work and working beyond the age of 50 is a key indicator and asset, which shapes ageing successfully. Sweden, Finland and the Netherlands have provided evidence as well as conceptual and applied approaches to age management and improved work ability to be used by businesses of all sectors and all sizes.

At home, there is abundant good practice to share and apply which addresses how to manage long-term conditions, support carers, tackle ageism and offer life-long learning, be it in the workplace, community or health care settings. Equally there is more to be done to optimise the likelihood of keeping individuals engaged in the labour market and work as they age.

Ageing Well in Work has embraced a wider definition of work and participation in other forms of asset or social capital-building work such as volunteering and civic participation.

Good volunteering is like a golden thread, which should be interwoven across the life course and be representative of the population as a whole. It is not just the preserve of older middle class people on retirement, although clearly transition out of the labour market is a key time to encourage retention of social connectedness and volunteering is an important part of the mix. Equally, business may directly and indirectly benefit from facilitating volunteering for altruism as part of career development.

AWiW constructs a strong case for a proactive and preventative approach to planning early for later life, which could potentially keep people active and independent as they get older, stave off social isolation and its consequences and ultimately reduce spiralling budgets for health and social care.

Prevention and up-stream investment and action in partnership by a range of system players will be required. These include local government, NHS agencies, third sector partners, employers and citizens.

A call for prevention, earlier identification and management of long-term conditions, facilitating the role of carers, mainstreaming volunteering and improving access to life-long learning for all citizens are some of the themes to unify and galvanise these system players into action.

7. Ten priorities for action

Ageing is a societal phenomenon that requires a whole system approach to ensure that it is a beneficial development for individuals, communities and the economy.

Ageing Well in Work has highlighted areas where concentrated action can facilitate healthy ageing in work, in particular support for health and employment aspects of mid-life. Mid-life is a time of transition, a nexus where health, social and employment issues come together to shape future opportunities and outcomes. It presents challenges but also opportunities, requiring robust planning and management.

Based on the international evidence and experience reviewed by this project and summarised in this report, there are ten priorities for action. In most cases, employees, employers, statutory and third sector organisations will be required to work in partnership to optimise the opportunities.

THEME	PRIORITY 1	ACTION BY
All - Cross cutting	**Age as an asset: Age Positive** Secure widespread recognition that an age-diverse and older workforce is an asset. Counter ageism and stereotypes through evidence and messages that reinforce the positive role and contribution of older workers and older citizens (including those seeking to return to employment). Tackle historic perspectives on age and health and the relationship to work ability. Harness the opportunity of re-engaging individuals with their local communities through support to foster social connectedness. Use a proportionate universalism approach, to ensure specific focus on groups across the equality characteristics which are subject to increased challenges / poorer outcomes in older age (e.g. certain ethnic groups, single people, lesbian, gay, bisexual and transgender individuals).	All

THEME	PRIORITIES 2 - 5	ACTION BY
Age-Friendly Workplaces	**Work ability** Support employers to implement a structured, proactive approach to age management, reviewing and adjusting work and workplaces to exploit the skills and expertise of ageing and older workers.	Employers Local authorities DWP Academic partners
	Workplace Wellbeing Enable employers to understand the business benefits of good health and wellbeing of staff of all ages, and how to protect and improve it. Long-term health conditions are becoming a norm in society and the workforce, so need to be considered as an aspect of 'business as usual'. For example, the Workplace Wellbeing Charter, which provides a framework for employers taking action, and condition-specific resources e.g. Dementia-friendly employers.	Employers Local authorities Local Enterprise Partnerships (LEPs) Voluntary and community sector
	NHS Health Checks Maximise the opportunity presented by NHS Health Checks to identify and manage health risks as people enter mid-life. This includes increasing uptake through greater use of workplaces as accessible settings and embedding healthy work conversations within the process. Use Checks to prevent the socioeconomic gradient in health conditions and associated departure from work.	Local authorities Public Health England Employers Individuals Employees/Citizens
	Facilitate caring Realign employment practices with social changes to take into account the increase in caring responsibilities and mitigate the risks of falling out of employment. It is important to recognise that caring responsibilities are normally not a choice and therefore a systematic approach adopted through a corporate carers' strategy, providing flexible/agile working options and tailored support as well as creating an environment where staff can talk about caring responsibilities.	Local authorities Employers Individuals Employees/Citizens

THEME	PRIORITIES 6 - 8	ACTION BY
Age-Friendly Support	**Fit For Work Service** Develop specialist advice and support for older workers through the Fit For Work Service, and to consider ways of supporting self-employed individuals – who are currently out of scope.	DWP FfW providers
	Work As A Clinical/Social Outcome Establish work as a clinical/social outcome in the health and care system, recognizing the virtuous circle between health and work and the positive impact good quality work has in prevention and prevention of health conditions more prevalent with age which impact on work ability. In the spirit of Making Every Contact Count, support a view that the wider health, social and third sector workforce may have routine, meaningful healthy work conversations with clients.	NHS England DH DWP
	Into-work support Provide into-work support appropriate to older workers who may have had a break for employment and/or have skills and experience that need to be developed or presented in a way suitable for the changing job market.	DWP Voluntary sector Local authorities Employers

THEME	PRIORITIES 9 - 10	ACTION BY
Age-Friendly Communities	**Commit and support life-long learning** Support people of all ages in continuing professional development throughout life, including addressing the inequality for older workers. Learning can take place in a variety of settings – educational, at work, at home – and has work and health benefits which benefit the employee and employer.	Individuals Employers Training organisations Employees/Citizens
	Mainstream volunteering Develop partnerships that systematically promote and expand community volunteering opportunities as an integrated career development opportunity, realising synergies for employers and communities. These include improved employee wellbeing, career development and the building of relationships between employees and the communities they work with, which can support improved transitions into later life.	Local authorities Employers Voluntary sector Individuals Employees/Citizens

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Glossary

AAI	Active Ageing Index
ACAS	Advisory, Conciliation and Arbitration Service
AHP	Allied Health Professional
AWiW	Ageing Well in Work
BITC	Business in the Community
CCG	Clinical Commissioning Group
CESI	Centre for Economic and Social Inclusion
DH	Department of Health
DPH	Director(s) of Public Health
DWP	Department for Work and Pensions
ENEI	Employers Network for Equality and Inclusion
ESF	European Social Fund
EU	European Union
FfW	Fit for Work
GDP	Gross Domestic Product
GM	Greater Manchester
GMPHN	Greater Manchester Public Health Network
H&SC	Health and Social Care
HCP	Health Care Professional
HSE	Health and Safety Executive
HWC	Healthy Work Conversation
ILC	International Longevity Centre
JRF	Joseph Rowntree Foundation
LEP	Local Enterprise Partnership
LTC	Long-Term Condition
MHF	Mental Health Foundation
MoU	Memorandum of Understanding
NEETs	Not in Education, Employment or Training
NHS	National Health Service
NHS HC	NHS Health Checks
NIACE	National Institute for Adult Continuing Education
NICE	National Institute for Health and Clinical Excellence
NOMIS	National Online Manpower Information System
OH	Occupational Health
ONS	Office for National Statistics
PHE	Public Health England
PHOF	Public Health Outcomes Framework
PHRD	Public Health Responsibility Deal
PWP	Psychological Wellbeing Practitioners
SEN	Special Educational Needs
SME	Small and Medium Enterprise
TUC	Trades Union Congress
WW	Workplace Wellbeing Charter
YH	Yorkshire and Humber

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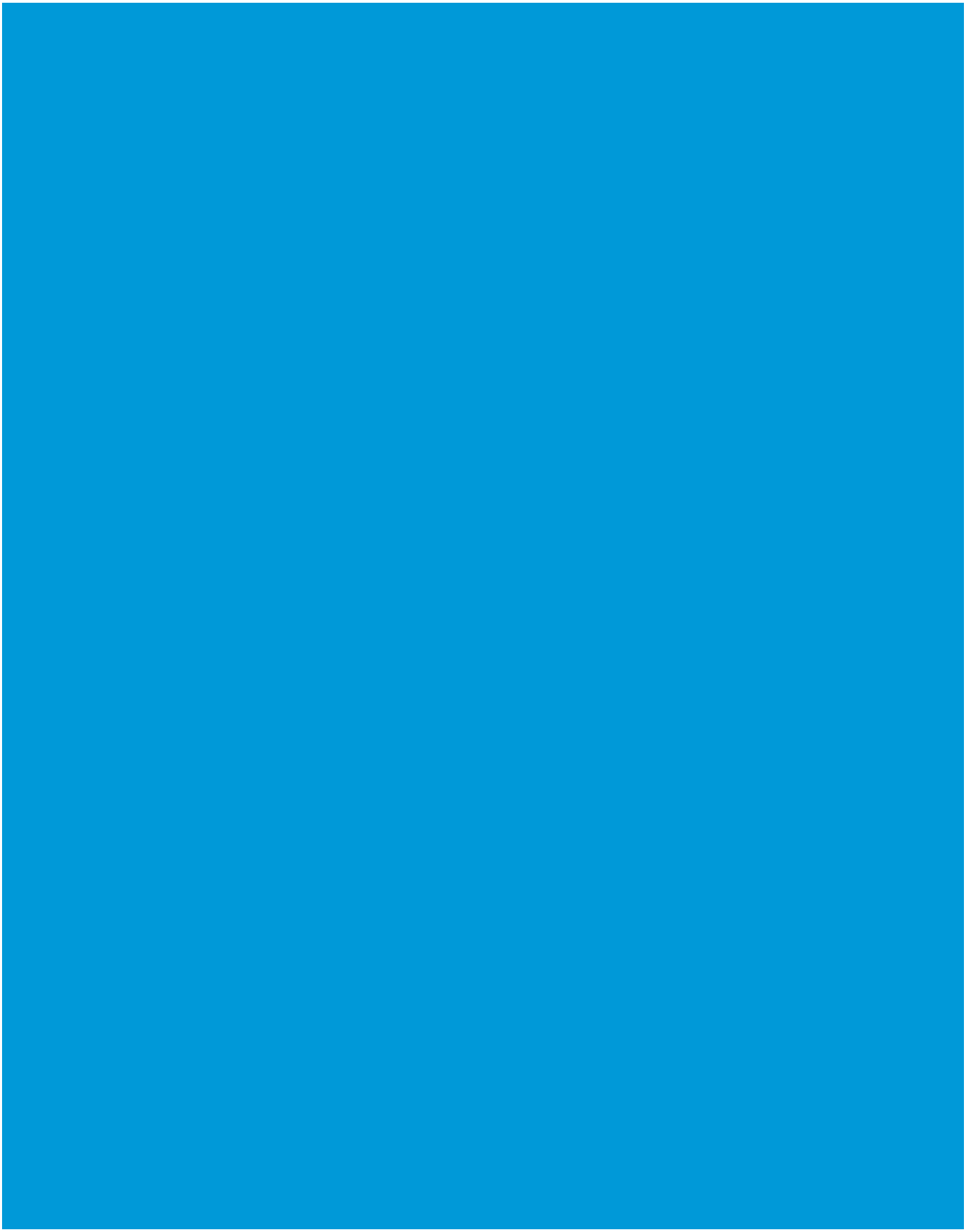


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