NHS Working Longer Review
Audit of existing research
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Proposed changes to the National Health Service Pension Scheme, to be introduced in 2015, combined with the general profile of an ageing workforce, have significant implications for employees and employers in the delivery of public health services. A key challenge for health sector employers is one of maintaining service delivery performance and meshing this with finding ways to effectively manage the implications of supporting staff to work longer.

While rises in Pension Age may lead to some health sector employees retiring later, it is clear that many leave the NHS significantly before their pension date. The array of push and pull factors is essentially known. Critically, these factors are relevant to workers of all ages, but come into sharper focus in later working life. However, there is currently very little guidance for employers on the configuration of good practice in this area.

This review, commissioned by NHS Working Longer Review Group, set out to summarise the academic and employment practice evidence on managing an ageing workforce. In particular, the Working Group sought insight into:

- What factors influence employee decisions over: extending working life, pension choices, retirement planning and transitions to alternative employment?
- What support do older workers need to stay in work and/or change career and how does this differ from younger employees?
- What are the implications of EWL for physical, psychological and emotional health and well-being?
- Implications of multi-generational working - in particular psychosocial influences on employee engagement and age cohort effects.
- What constitutes employer good practice for managing the implications of extended working life?
- What is known of the current age demographics of health sector employees – including established and foreseeable patterns of age-related migration?

Evidence was gathered from UK and international published evidence:

- Peer reviewed published research
- EU and UK Government funded research
- Grey literatures (principally management and human resource profession publications)
The average age of NHS employees (currently 43 years) is rising, year on year. A high proportion of NHS employees leave the NHS significantly before their pension age, many in their 50’s. Important push influences appear to be attributable to the configuration of work, in particular the limited availability of part-time employment and current shift-working practices. If current patterns of early withdrawal continue, in the context of a rising average age, as these demographics come into alignment there is a risk of future staff shortages. To counteract this, there is a need to mitigate the impact of factors that motivate early withdrawal.

The evidence on retaining (and recruiting) older employees highlights the need for a managed, employer-led approach, that takes account of employee work preferences and retirement objectives (e.g. the availability of flexible work) in later (50yrs+) working life, combined with a bespoke, person-centred, approach to workability and rehabilitation focused on supporting people to stay in work longer. More fundamentally, there is a need to go beyond a focus on individuals, to address the scope for reconfiguring established systems and methods of working such that push factors that are known to motivate early withdrawal are mitigated.

The following sections detail headline findings, examples of good practice cited in the literature and evidence gaps. Within each section, the order of presentation reflects the authors’ professional judgement of relative priority, based on their interpretation of the balance of evidence. These rankings should be considered indicative, rather than definitive, and alternative interpretations of priority are possible.

**Headline findings**

**Capacity & performance**

Diminished capacity and performance, in terms of cognition (mental ability and agility) is slight for most people in their sixties, and effects are offset by experience and established skills. The dominant finding is that older people (in good health, with up-to-date skill sets) perform as well as their younger counterparts. Physical strength does diminish with age, but (in the absence of an underlying health condition) there is as much variability within younger and older employee cohorts as there is between them. There is evidence that older employees benefit from longer recovery periods following physical exertion (peak exertion and working long hours). Although there is an association between capacity to work and age, it is not simple and the variation between individuals is large and can be affected by lifestyle factors, non-work sources of stress, and the availability of occupational health support. But the conclusion of the evidence is that people are likely to be capable of continuing to work in their existing roles until they reach the new retirement age, but in practice may not be motivated, or otherwise able, to do so.

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Due to the relative absence of dedicated studies of older UK health sector employees, most findings have, necessarily, been derived from general population evidence. A limitation, in this respect, is that impacts of NHS specific arrangements remain opaque and under-evidenced. However, it has been possible to derive some NHS-specific evidence from the quarterly Labour Force Survey.
NHS demographics
The average age of NHS employees is 43.7 years (projected to rise to 47 years by 2023). 51% of NHS employees are aged 40+ and 32% are aged 50+. Nearly two thirds of nurses are aged 40+. The proportion of nurses under 30 has more than halved since 1993, to just 1 in 10 of all nurses. There is a significant drop in numbers employed particularly after age 50. This ‘drop off effect’ occurs just seven years beyond the current mean age and significantly before pension age. 43% of 50yrs+ leavers appear to continue working, but outside the NHS.

50+ employment migrations
A significant proportion of staff over the age of 50 leave NHS employment before reaching their normal retirement age. A minority do retire from paid work at this point, but many move into alternative health-related employment in the private sector, typically with shorter hours. Although the age at which NHS staff are able to draw their pensions is going to increase, this may not mean that people will choose to stay in their NHS jobs until that point.

Push and pull variables
Employee decisions over remaining in work versus withdrawal / retirement are subject to a range of push and pull factors. Key amongst these are: health status, financial status, family commitments, peer retirement norms, job characteristics (e.g. intrinsic job-satisfaction, working hours; employer attitudes / norms) and structural influences (e.g. availability of work; State benefit / tax arrangements). Health status is the most salient individual-based determinant. Around 2/5th of 50-yr olds report on-going ill-health conditions, and 15% of 50+ yr old leavers cite ill health as their reason for exit. Job design and related occupational exposures are a significant causal / exacerbatory factor in headline mental health and musculoskeletal disorders. Financial considerations play a role in decisions over the date of withdrawal / retirement but for many are not the only, or primary, criteria. Equally, a rise in pension age will be a factor in people’s decisions over retirement, but it would be unwise to assume that it will constitute the dominant factor.

Staff retention
For staff to remain productively employed there needs to be a good fit between the demands of their job, their working environment, their personal circumstances and their capability. Retention is driven more by the features of the job than the capabilities of the individual. Where the fit is poor this tends to encourage withdrawal. Support which changes the job demands (particularly heavy physical demands and long hours) and responds flexibly to individual circumstances is likely to be the most effective way of retaining and motivating staff to work longer.

Demand for reduced-hours / flexible work
An element of choice over hours worked is attractive to employees of all ages, but particularly to older workers. 37% of 50-59yr old and 46% of 60+yrs NHS employees express a preference for shorter working hours. While attractive to many, most people have limited knowledge of the range of potential configurations of flexible / part-time working arrangements, or how income interacts with pensions and other benefits. The perception that working longer is a forced option, rather than a matter of choice, seems to be at the heart of resentments over rises in pension age. The availability of meaningful and attractive choices, over key elements such as hours worked and type of work, may go some way towards offsetting this. Evidence of older employee inhibition over requesting reduced or flexible working hours highlights the need for an employer-led approach, i.e. there is a need to go beyond making reduced of flexible hours available on request.
**Down-shifting**
Demand for down-shift to intrinsically less demanding / less stressful work appears to be modest, although remaining attractive to some. Most people would prefer to down-shift in the sense of fewer hours, in their established profession, in some instances with a change in job-role, e.g. a move to mentoring / training or community-based work. Evidence of older employee inhibition in requesting step-downs, highlights the need for a managed approach initiated by the employer, i.e. there is a need to go beyond making step-downs available on request. The idea of phased retirement is unfamiliar to many and there is limited understanding of the options or their implications.

**Management training**
Line managers need training and support to manage older employees, in particular they play a key role in managing the day-to-day job demands, relating to the organisation of work, including important aspects such as configuration of shift rotas. In most large organisations they are likely play a key role in staff appraisal, training and development, as well as the point at which staff requests for alternative working arrangements will be raised, at least in the first instance. They also have a need to balance the needs of older people with the demands of service delivery / unit performance.

**Employee Knowledge**
People have only vague awareness and understanding of their options and choices over the configuration of work in later working life and pension options, and their implications. The concept of phased retirement is unfamiliar to most people. However, there seems to be significant attraction to the idea.

**Communication with employees**
Rises in pension age challenge people’s perceptions of fairness and equity, and feed mistrust over future arrangements. This is a potential barrier to effective engagement with employees over pensions and later working life arrangements. Knowledge and understanding of pension matters, options over flexible working and their implications for income is low and partial. At a technical level, plugging knowledge gaps and designing accessible material should follow established good practice guidance.

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**Costs of flexible / part-time employment**
There is robust evidence that marginal rises in administration costs associated with increasing numbers of part-time employees are generally offset by: enhanced scope for matching staffing levels to peaks and troughs in demand; enhanced employee motivation; higher hourly productivity; better retention rates and less sickness absence. Thus, while part-time employment can increase costs, per employee hour, a broader perspective indicates that the impacts at an organisational level tend to be either cost neutral or slightly lower than if full-time workers (only) were employed. Many organisations underestimate the cost of failing to retain experienced staff. It has been estimated that replacing an existing member of staff with a new recruit costs at least four months’ salary. Measures which improve retention can lead to better outcomes for staff, for organisations and for patients.
However, education solutions are bounded by the reliance on people engaging with the content. Most people exhibit low motivation to engage in this area. There is also fairly strong evidence of employee preference for individually tailored information, e.g. bespoke, pension forecasts, over generic information.

**Decision making over pensions**

Represents a minority activity. Widespread worry over the sufficiency of pension values tends to sponsor retreat rather than active engagement with pension choices, calculation of pension values or phased retirement. People are prone to select options that have intuitive appeal, rather than systematically evaluating the relative gains / losses. Thus, the way in which options are presented (the decision architecture) can have a significant impact on the choices people make. It is important to take account of this otherwise people may make poor choices. The design of options needs to take account of extant employee mental models (accurate and inaccurate beliefs) and known decision biases.

**Age discrimination**

Evidence on the prevalence of age discrimination by employers is mixed. A potentially important element relates to human resource practices at the point of recruitment. Beliefs in employer discrimination are widespread, but are balanced by evidence of relatively few established employees reporting direct experience of discrimination. The prevalence of such beliefs is likely to impact on how older employees interpret the actions of employers, managers and colleagues towards them. Against this background, there seems to be a need for employers to take overt, high profile, visible steps to demonstrate that discrimination is not practiced.

**Training and development**

For the UK as a whole, there is a linear decline in training with age. This is said to reflect restricted availability and emphasis on the part of employers and reduced engagement among older employees. However, some sources report high rates of interest amongst older employees, but difficulty in gaining access or finding that the training available does not address their needs. The relative scarcity of social precedents for older worker training and development in the workplace is said to be a contributory influence.

**Sickness absence**

Older workers exhibit higher rates (annual days lost) of sickness absence than younger workers. But, headline figures disguise differences in patterns of absence. Older employees tend to exhibit fewer spells of absence, but of longer duration. A significant proportion of musculoskeletal problems become manifest or more acute in later life. They can be the product of repeated exposure, or aggravation of earlier injuries, age-related degenerative effects and lack of physical fitness, as well as acute traumas potentially suffered by employees of all ages. Preventative action, principally through the design of work and related handling systems / technologies, needs to begin early and applies to employees of all ages. There are grounds for believing that rates of sickness presenteeism (working when sick) may be higher for older employees. It is likely that rates will vary by job role and grade, e.g. higher prevalence in situations where presence is critical to service / team functioning.

**Shift-work**

There is evidence that shift work (particularly some types of rotation) is detrimental to health across all age groups. The evidence is mixed, but some sources suggest that working longer than 8 hours can be detrimental to older workers’ health, while others (especially multivariate and meta-analysis studies) find no association with age and no evidence that it is worse for the over 60s than it is.
for people in their 50s. However, contemporary shift working practices in the healthcare sector are cited as an important influence on intention to quit. The devolution of the management of shift rotas to local unit level may mean that best practice in shift patterns is less likely to be followed than in organisations where shift patterns are centrally managed.

**Recognition**
Older employees are prone to feel that their skills and experience are under-valued, and feel socially marginalised in this respect. There is potential for this to have negative impacts on motivation and commitment to work, as well as disposition to remain in work.

**Multi-generational working**
While there is evidence of generational differences in attitudes and orientations to work, the balance of evidence suggests that these are outweighed by the degree of commonality and similarity between the generations. There is some evidence that people’s priorities and what they value about work and work-life balance preferences change as they get older. There are findings that multi-generational teams that are composed of a mix of older and younger people have greater strengths than single age teams, but that they need more careful management. The migration of older employees to mentoring roles has been shown to have positive benefits for both older and younger workers, and some studies suggest beneficial outcomes for patients as well. There is scope for intergenerational tension in the areas of promotion opportunities and age-related preferential working arrangements.

**Identified features of employer good practice**

**Components of good practice**
Six domains: recruitment & retention; occupational health; education, training, development & promotion; flexible working, systems of work and ergonomics design; changing the attitudes of people towards older workers and evidence based measures of organisational performance to support this. While the literature offers examples of good practice, no single source provides what could be regarded as a comprehensive, definitive account or vision. A focus on older workers risks masking elements of good practice relevant to employees of all ages. While older workers might be considered a higher risk or more vulnerable group, they essentially exhibit the same set of vulnerabilities as workers of other ages.

**Workability**
The Finnish Workability perspective appears to offer a useful starting point as a model for good practice. It is important that workability assessment is not limited to individual-focused capacity to work assessment. The perspective on intervention and change needs to extend beyond individuals, to a more holistic perspective on systems of work and the configuration of work, orientated around sustaining older employment.

**Organisational learning**
Challenges to sustaining employment are not evenly distributed. Some working arrangements are more challenging / onerous than others and this varies by job role, and grade within a given organisation. An organisational epidemiological perspective, focused on profiling the differential (by job role and grade) salience of known ‘push’ influences that sponsor early withdrawal and the impact of interventions aimed at enhancing retention offers the potential for a strategic evidence-based approach to intervention.
Training and personal development
Employers need to develop forward-focused individual training and development procedures, as part of a managed process that extends beyond passively making training options available to older employees. This should take account of the needs, preferences and learning styles of older workers. Beyond issues of skill-based training and meeting the personal development needs of older workers, are issues relating to the need to train managers, in particular line managers, in the principles of good practice for managing an older workforce.

Line-management
Line managers are widely identified as playing a key role in the management of older worker issues. Notable challenges relate to the need to balance older worker considerations with meeting operational performance needs and objectives of the work unit. Managers (younger managers in particular) need to recognise that older subordinates may need different approaches from those they use with people from younger age groups. There is a risk of problematising the line management function, as an obstacle to meeting the needs of older employees. Evidence from other domains emphasises the need for support at this level.

Occupational health
There is a need for a risk-management perspective: a more proactive approach focused on prevention of harm and promotion of well-being with a dual focus on (i) systems of work and (ii) individuals. Examples of how this can be achieved include: identification of vulnerable / high risk groups by job role and mitigation of impacts through risk assessment leading to changes in the design / configuration of work; offering employees regular health screening / monitoring, facilitating early access to treatment and through employers, e.g. reduced or flexible hours, redeployment to alternative or ‘lighter’ roles; attention to ergonomics elements; and lifestyle-health interventions, e.g. physical fitness, smoking cessation and reduced alcohol consumption.

Human factors / ergonomics
Ergonomics issues are relevant at a micro and a macro level. At a micro level are aspects that relate to bespoke solutions for individuals, e.g. alterations to work-station design. Macro level aspects relate to more fundamental changes to the design of work, associated technologies and the work environment. It is important that attention to ergonomics issues are addressed at both micro and macro levels.

Part-time and flexible work
Configurations include: flexitime; annualised hours; job sharing; reduced hours / part-time; compressed hours; seasonal work; home working; unpaid leave; career breaks / sabaticals; phased retirement; migration to less oneros / strenuous / stressful roles; job-rotation; mentoring of younger / less experienced staff; amendments to shift patterns e.g. shorter working day / longer rest periods between shift change overs; mixed-age teams. Evidence of limited employee awareness, and inhibition over requesting options indicates that employers need to adopt a proactive managed approach, for example harmonising later working life intentions and options as components of established annual reviews procedures (e.g. every five years after age 45).
**Age discrimination**
There are widespread calls for cultural change in human resource departments, with greater emphasis on conservation and retention of older employees, i.e. a primary orientation on policies and working arrangements that enhance capacity to work, rather than a focus (diminished) capability (cognitive; physiological; health status; skill base and motivation). Widespread employee beliefs of age discrimination, by managers and employers need to be countered by actions that challenge such beliefs.

**Organisational culture and climate**
Issues of corporate culture and climate impact on the experiences and behaviour of older employees in relation to work and retirement. Influences range from overt policies and practices, to softer more subtle effects relating to established norms, e.g. visibility of examples of flexible working arrangements, to aspects of corporate body language. Important elements relate to how employees interpret the motivations and behaviour of their organisation and its management function in relation to older workers. Eroded trust in the employer represents a significant barrier to communication and engagement with employees on pensions and extending working life issues.
Evidence gaps

Understanding why people retire when they do
While the array of push and pull factors that impact on early withdrawal are essentially known from the general literature, there is little NHS specific evidence on their relative importance and how this might vary demographically.

There is a need to gather NHS specific information on the employment arrangements that would be attractive to older employees. Relatedly, ‘good work’ is under-defined, as are perspectives on variables contributing to quality of working life and how this may vary with age. The approach to sampling should take account of demographic differences (grade, job role and profession) and include exit interview data.

Facilitators and barriers to flexible working
Reduced hours and flexible working options are widely cited as being attractive, particularly for 50+ employees. Key elements here relate to the types of flexible option that can be configured in a given workplace / job role context and their attractiveness to employees. The review revealed examples, but there is little health sector or NHS specific evidence on this issue. There is a need to identify and map facilitators and barriers to flexible working and the array of flexible working options that might be configured.

Guidance on good practice for the NHS
While examples of good practice exist, there is little guidance on what a comprehensive package of employer practice would look like, i.e. details of the structures, processes and procedures. None of the examples of good practice identified could be considered comprehensive, although some are well advanced. There is widespread endorsement of the Finnish Workability approach, tempered by calls to broaden its scope beyond what remains a fundamentally biomedical perspective based on (in)capacity to work, i.e. more attention to aspects such as organisational culture, fundamental changes to the design of work, and prevention orientated approaches. Local NHS solutions are needed to take account of the prevailing culture(s); institutional arrangements; established ways of working and the scope for change.

Preventative occupational health
Occupational health and human resources perspectives on older workers are focused on degraded capacity and managing individuals. This represents a partial focus on managing extending working life. There is limited evidence of organisations addressing more fundamental aspects associated with the design and management of work, and the scope for aligning this with the preferences and capabilities of an ageing workforce. Despite calls for a paradigm shift in human resources and occupational health practice, away from a ‘depreciation model’ of employee performance to a ‘conservation model’, the latter remains under-articulated, i.e. it’s components are currently not well mapped.

Equality issues
There is limited evidence on the scope for integrating ageing workforce issues with broader equal opportunities / diversity policies. Relatedly, there is an absence of evidence on how younger
workers might view any dedicated arrangements for older employees.

**Pension education**

There are likely to be significant knowledge gaps and misunderstandings amongst NHS employees over pension options, extended working life choices and their implications. It is important to configure communication material that is of good fit, with the established understandings (essentially mental models) of the target audience(s). While some relevant elements can be inferred from the evidence review, there is a need to gather context specific evidence on this issue for NHS staff. This should take account of demographic differences.

**Role of line managers**

There is a lack of evidence surrounding the nature of support that line managers need in order to effectively manage extending working life issues, in particular aspects relating to the logistics of managing teams.

**How do younger workers fit into this?**

There is very little evidence on how younger cohorts view age-specific policies in the workplace, in particular little is known of the social legitimacy of age-related privileged access to certain work arrangements, e.g. reduced or flexible working hours.

**Impact of working arrangements**

Little is known of the impact of established working arrangements (including perceptions of options over the configuration of work) on the motivations of potential returnees, i.e. in the case of the health sector, what arrangements might encourage older health professionals to return to the NHS?

There is a lack of high quality, robustly evidenced intervention studies that demonstrate impact of EWL policies and practices.
Conclusions and recommendations

Data, data, data
Work organisations tend to be data poor, or unsighted on a range of fronts in the later working life domain. Beyond headline outcome data on accidents, absence, staff turnover and exit, they need to gather evidence on:

- employee preferences / intentions
- the impact of current policies and practice on employee behaviour
- impacts of job design on health / capacity to work, including demographic differences.

There are grounds for concluding that employers would benefit from adopting an epidemiological perspective to add to organisational learning in this area, notably to underpin a more informed, strategic approach to intervention; with effective performance measures. In particular, there are arguments for adopting a risk-based approach to identify vulnerable groups by job role and function. There is also a need to gather robust evidence on the effectiveness of older worker policies and initiatives.

Employee choices and behaviours
The workplace decision architecture (including employee beliefs surrounding this) will impact on employee understandings of choices, and behaviour. There is a need to gather NHS specific evidence on how the prevailing decision architecture impacts on employee behaviour in relation to extending working life / early withdrawal. This should extend to addressing, structural, practical and cultural barriers to change. Relatedly, there is a need to gather information on the impact of alternative work configurations on employee attitudes to later working life. A staff survey approach is recommended, that provides a profile of key variables and which permits profiling of demographic differences, by job role, function and staff grade with a view to identifying priority issues and groups.

Future forecasting
Evidence from the analysis of Labour Force Survey (LFS) data suggests that there are potentially far-reaching implications of contemporary NHS labour migration patterns, possibly leading to longer term staff shortages if ways cannot be found to retain a higher proportion of older workers. With a view to further verification and enhanced insight, thought should be given to an appraisal of NHS employer human resource data, if possible using an approach that mirrors that adopted for the interrogation of LFS data. Together this evidence should be used for future forecasting and mapping economic (financial) implications of alternative futures, i.e. to inform insight into the relative costs and benefits of introducing changes to working practices that impact on staff retention / length of working life and relative impacts on NHS performance.

Impact of practice
There should be a review of the impacts of current practice on older workers referenced to NHS specific data, of the type outlined above, informed by insights from the review of evidence and allied agendas e.g. contemporary thinking on health, work and well-being with a view to defining and mapping good practice for the NHS. Consideration should be given to tapping multi-disciplinary external expertise in occupational health, ergonomics, psychology, sociology and management and human resources, perhaps in the form of an expert panel / advisory resource. Evidence of the impact of (to be defined) good practice arrangements should be gathered by means of robustly evidenced pilot studies.
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