Extending Working Life

Annex 6: Audit of research relating to impacts on NHS Employees

Report on Findings – May 2013

Prepared by:
Andrew Weyman
Pamela Meadows
Alan Buckingham
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Summary

The average age of NHS employees (currently 43yrs) 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 details 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.
NHS demographics
The average age of NHS employees is 43.7 years (projected to rise to 47yrs 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+ leaver’s appear to continue working, but outside the NHS.

50+ Employment migration
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 are 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. 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 amongst 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 worker. 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 health care 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.

**Occupational health**

There is a need for a risk-management perspective: a more proactive approach focused on prevention of harm and promotion of wellbeing 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 pro-active 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).

**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.

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
- 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.
- 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.
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.

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. its components are currently not well mapped.

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.

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.

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.

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.

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

- 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.

- 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.

- 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.

- 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 wellbeing 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.
1.0 Background and context

Proposed changes to the National Health Service Pension Scheme, to be introduced in 2015, combined with a general profile of an ageing workforce have significant implications for employees and employers in the delivery of public health services. A key challenge for 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. It is, for example, known that older workers often have different preferences in terms of work-life balance (Saba et al., 1998; HSE, 2012); are prone to exhibit higher rates of long-term sickness absence (HSE, 2005) and are more likely to suffer from diminished physiological capacity, either due to past injuries or as a product of the natural ageing process.

Beyond issues of capacity to work, an additional challenge is that rises in pension age are in tension with employee expectations over retirement. Although it was common in the 1950’s for people, men in particular, to remain in paid work well into their sixties, the following five decades witnessed a steady reduction; a trend which only began to reverse over the past decade. Social expectations reflect this. Recently announced rises in State and employer pension age represent significant challenges to notions of social equity, fostering widespread resentment, which seem likely to result in negative impacts on older employee motivation and engagement with work (Weyman et al., 2012). The observable rise in the mean age of retirement, and rises in post 60 / 65yrs employment in recent years have essentially been the result of people choosing to remain in paid work where they had the opportunity to do so. However, the next decade is likely to witness an increase in the number of older people needing to work for financial reasons.

The experience of increasing rates of older worker employment over the past decade has been largely positive. There is considerable consensus that a pro-active approach by employers, that takes account of employee work preferences and retirement objectives, e.g. the availability of flexible work; that extends to modifications to the design of work, combined with an active managed approach to workability and rehabilitation (Black 2008; Black and Frost, 2011) embodies the potential to enhance the experience of employees and employers (Weyman, et al., 2012). However, there is currently very little guidance for employers on the formulation and configuration of good practice in this area. Moreover, it is important that where there are choices to be made by employees, for example, over alternative pension schemes, early pension draw-down, reduced hours or phased retirement, they need to be well informed, such that they make good choices in terms of their long-term wellbeing.

The requirement to link public sector employee pension age with State Pension Age (Hutton, 2011), represents a particular challenge for the NHS, not only because it is the largest UK employer, but because a significant proportion of staff are engaged in physically demanding work, often in high stress contexts (see Watson et al, 2003). Extending working life (EWL) not only increases the probability of injury and illness (more years of exposure), but also raises issues of employee capacity and willingness to continue in established roles. Further
challenges relate to the differential impacts of the changes on different groups of employees, i.e. dependent on age, job role and pension type, this will range from modest to far reaching and fundamental.

An examination of the current health sector demographic reveals that the average age of employees is rising, and this trend looks set to continue. Arguably, recently announced rises in State Pension Age have brought issues of older workers into sharper focus, but underpinning this are the broader challenges and implications for delivering services with an ageing workforce.

An intuitive conclusion arising from the increase in State Pension Age and removal of the mandatory retirement age is that people will retire later. While this is likely to be the case for a proportion of employees, there are grounds for speculating that this may not prove to be the more significant picture, or at least that impacts will vary demographically and in systematic ways. For some extending working life will mean the opportunity to continue in their chosen role, possibly with adjustments to working hours, for others it will require migration to alternative roles, while others may feel unable to continue and find employment elsewhere.

Reasons for concluding this, in the absence of significant changes to the way work and retirement options are configured within the NHS, are that despite the observable shift in average age, even taking account of those groups with special status, it is apparent that many leave the NHS significantly before their likely pension date. While some of these are retiring (either through ill health or other forms of early retirement) many leave the NHS for other jobs, suggesting that for a significant proportion of NHS staff the point at which they start to draw their pension and the point at which they leave the NHS are already several years apart.

While the array of push and pull factors is essentially known, little is known about their relative importance in relation to different staff groups within the NHS, neither is the scope for their mitigation well mapped. Similarly, patterns of age-related migration in earlier working life e.g. transitions to community health, private sector health care and non-health sector employment, are widely recognised, but statistical evidence on this seems to be limited.

Arising implications are that perspectives on good practice and support in the context of extending working life need to extend beyond bespoke solutions aimed at individuals, on a case-by-case basis, to consider structural elements. In particular, it is important to gain an appreciation of differential impacts on different demographic groups, by job role, grade and function, with a view to using this insight to develop a strategic, segmented approach to intervention, oriented around mitigating the precursors of early exit. More broadly, it is apparent that headline causes of early exit: musculoskeletal injury, work stress; inflexible working hours; and shift working, represent a risk to the continued engagement of workers of all ages; but their impact becomes amplified with age.
2.0 Scope

In order to provide the NHS Working Longer Review Group with a clear understanding of what research is already available we are seeking to conduct an audit to identify and analyse existing academic evidence and employment practice on the issues relating to working beyond 60yrs including workforce patterns and environment in a range of occupational groups across both public and private sectors including healthcare.

This review was commissioned by NHS Employers on behalf of the NHS Working Longer Review Group to identify and summarise contemporary international academic and employment practice evidence on issues relating to working beyond the age of 60, with a view to identifying evidence gaps and the need for primary research. Of particular salience was the exploration of elements relating to:

- impacts on physical, psychological and emotional health
- factors influencing the retirement decision making
- impact on the delivery of safe and effective patient care
- future health and wider workforce demographics
- age equality issues – identifying the specific needs of older people including later career transitions
- productivity and performance
- multi-generational working
- good employment practice e.g. health and wellbeing initiatives; restructuring career pathways; recruitment and retention of older people.

2.1 Aims

- To review contemporary academic and employment practice evidence relating to working beyond age 60, including working patterns and environment, in a range of occupational groups, including healthcare.
- To provide recommendations relevant to the approach to managing extended working life in the NHS.
- To identify evidence gaps and future research needs.

2.2 Approach

The review set out to distil UK and international published evidence from:

- peer reviewed published research
- Government funded research
● grey literatures (principally management and human resource profession publications / web-based media)
● demographic evidence derived from the quarterly UK Labour Force Survey.

The University of Bath's ELIN system was used to access international peer reviews journals, periodicals and published texts. Grey literature were accessed via web-based key word searches. The reference frame was limited to material published 2002-12. In view of the very highly geared delivery time-scale for the review and the importance relevance of recent changes in pensions and associated employment policy searches focused on (although were not limited to) the first page of references identified in search engine listings.

2.3 Status of evidence

The inclusion of findings from the grey literature was based upon the authors’ professional judgement of the soundness of material, e.g. sample characteristics and the professional standing of the source. The grey literature was viewed as a supplement to academic findings, in particular to highlight gaps in and lag effects with the peer reviewed literatures, e.g. in the area of human resource practice.

The exploration of quantitative social survey evidence was restricted to published findings from the Department for Work and Pensions Attitudes to Pensions Surveys 2006; 2009 and 2012 and the UK Labour Force Survey for the years 2007-2012. Other sources referred to include the HSE Survey or Workplace Absence and Ill Health (SWASH, 2005) and the DWP / HSE Employee and Employer Quality of Working Life Surveys (2012).

In view of the extensive review work that has been conducted on a number of the issues of interest, in particular UK employee attitudes to EWL and retirement planning, and issues related to older workers' physical and mental capacity, secondary sources will be included as a component of our review. We have concentrated on literature that is likely to be relevant to NHS staff and employers, and have excluded studies of occupations or organisations that are less relevant (e.g. studies of the productivity of office workers, factory workers, university academics or judges).

A limitation of the evidence base is that there have been very few dedicated UK studies of health care employees. While it has been possible to derive health employee samples from social survey evidence, notably as sub-samples of the Labour Force Survey, most findings have, by necessity, been derived from studies of general populations.

Beyond quantitative social survey evidence, e.g. the DWP's attitudes to pensions surveys and the Labour Force Survey, evidence in this area is dominated by qualitative findings, and very few studies involve methods that would score high values on the Maryland scale. This does not mean the underlying studies are not done to a high standard and are not informative, but they use different approaches from those commonly used in healthcare research.
A corollary of this is that the evidence base does not lend itself to meta-analysis or similar reductive techniques that underpin many contemporary systematic reviews. Thus, what is possible here is a review of the relevant literature not a systematic review. However, we have cited robust quantitative evidence, including several meta-analyses, where possible.

Published evidence reveals a preponderance of studies that focus on the individual, in terms of health status, capacity to work and motivation to extend working life. By contrast relatively few studies have focused on the role of employer practices and work environment (physical and social) factors that can facilitate / support (or diminish) rates of employment amongst older people. Research into contextual (socio-cultural, workplace climate / culture and structural) influences has been modest, and largely limited to tapping into public / employee beliefs surrounding these. This imbalance within the evidence base constitutes an important limitation to perspectives in this area.

A final caveat is that given the trend to earlier retirement observed in recent decades across most countries, there are inevitably relatively few studies of people aged over 60 (and even fewer of people over 70yrs) in any kind of workplace. Moreover, those who have been working in these age groups have tended to be well-motivated volunteers, in robust health, who constitute a biased sample; some might suggest ‘a survivor population’.

2.4 Core themes

Key questions that this review aims to address are:

- 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 & wellbeing?
- Implications of multi-generational working - in particular psychosocial influences on employee engagement & 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?
3.0 What factors influence employee decision-making over extended working life, pension investment, retirement planning and transitions to alternative employment?

Summary

Underpinning orientations to extending working life?

- Rises in pension age challenge people’s perceptions of fairness and equity, and feed mistrust of future arrangements. This may present a barrier to effective engagement with employees over pensions and later working life arrangements.

- 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 to offsetting this.

- Many find the prospect of working full-time unattractive and would prefer to work fewer hours in later life. For the UK as a whole, around 50% of people aged 50+yrs express an interest in paid work beyond the former State Pension age, but most of them want to work reduced or flexible hours. However, care should be taken to avoid over-interpreting a desire for more-flexible work as an older workers issue, as this feature is valued by workers of all ages.

- Advancing age brings with it uncertainty over future health status and a sense that time is limited. Many view retirement as ‘time for me’, which tends to result in a shift in work life balance preferences, with greater value placed on leisure time. However, this tends to be tempered by the capacity to finance this, which likely goes some way to explaining the attractiveness of part-time work.

- The prospect of retirement tends to bring worries over the sufficiency of income. Recent changes and the post-2008 financial crisis have increased worry and uncertainty in this area. People exhibit a strong desire for certainty. Configuring structural arrangements and communications that increase perceptions of certainty over income levels are more likely to be effective in engaging older workers than those that feed anxiety.

- A significant proportion of NHS staff over the age of 50 already 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 choose to stay in their NHS jobs until the point at which they can draw their pensions.
Variables impacting on decision making over how and when to retire?

- Financial considerations play a role in decisions over the date of retirement but for many people this is not the only, or even the primary, criterion. Equally, a rise in State Pension age is a factor in people's decision making over retirement, but current retirement norms suggest that it would be unwise to assume that it will constitute the dominant factor.

- Work versus retirement decisions 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 (intrinsic job-satisfaction, working hours; employer attitudes/norms) and structural influences (availability of work; State benefit/tax arrangements).

- Health status is the most salient individual-based determinant of early withdrawal from work. Job design and occupational exposures play a significant role here, in so far as work can constitute causal or exacerbatory factor for a range of health conditions, most notably mental health and musculoskeletal disorders.

- Relatively few precedents and worries over how managers/employers might interpret requests likely inhibit employees from initiating discussions with their employer over the configuration of later working life, suggesting that employers need to take the lead in this area.

- People have only vague awareness and understanding of their options and choices over the configuration of work in later working life, and their implications.

- The concept of phased retirement is unfamiliar to most people, however, there seems to be significant attraction to the idea.

- Demand for down-shifting 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.

- Where there is demand for a move to alternative types of work this tends to be most apparent amongst those in semi/unskilled and unskilled jobs.

- Findings on re-training are mixed, with evidence of resistance amongst both employees and employers. The picture on demand for re-training is clouded by what seem to be limited opportunities and a lack of established norms in this area.

Decision making over pensions

- Active engagement in decision-making over pensions is a minority activity. Despite widespread worry over the sufficiency of pension values this tends not to increase motivation to engage with detailed consideration of options e.g. pension choices, calculation of pension values or phased retirement. Historically, public sector employees have had little need to engage with pension choices. It is unlikely that education initiatives would have a major impact on this.

- What people find difficult/routinely retreat from is active, systematic appraisal of option
values, e.g. scheme a versus scheme b, or the implications of features such as early or partial pension draw-down, pension deferral or lump-sum choices.

- When people do make decisions, they are prone to fall back on simple impressionistic criteria, which may be inaccurate, e.g. 'if I keep working I will lose all my pension in tax', and more fundamental decision biases, e.g. risk / loss-aversion, lump-sum preferences and unrealistic optimism.

- The way in which pension choices are configured (choice architecture) can impact on the options people select. It is important to take account of known biases and the tendency to fall back on partial, impressionistic criteria when communicating with employees over pension options.

- Much has been made, of late, of the advantages of configuring choices, including pension options, in ways that Nudge people to make better decisions, i.e. to take account of known decision biases – to 'save them from themselves'. The use of defaults such as auto-enrolment schemes reflects this, and appears effective in channeling choice. But, configuring ‘better’ choices can be problematic.

- Status-quo bias – people are prone to stick with options that are familiar, for fear that they may make the wrong choice, i.e. the avoidance of regret. Sometimes people make poor choices because they are afraid to make mistakes.

- If faced with too many choices and / or high levels of complexity, particularly where outcomes embody uncertainty, e.g. choices over alternative pension schemes, people are likely to procrastinate. Minimising the number of choices and their complexity is desirable.

- The complexity of calculating retirement income, in particular the interplay of employer, State and other benefit income is beyond most individuals. As a result, misunderstandings over the tax and income implications of working longer are widespread.

- Evidence of predominantly vague and impressionistic understandings of pensions; the tax system; and working options (e.g. part-time work), combined with a general reluctance to engage with the detail in this area raises questions over the utility of using financial incentives to influence employee decisions.

- Recent and on-going changes in State and employer pension arrangements appear to increase people's focus on 'living for today' and may foreseeably inhibit retirement planning and pension investment.

- The choices people make can be sensitive to whether options are framed as gains or losses. In many instances people are loss-averse. Framing options, e.g. in communications with employees, as avoiding financial penalties are likely to be more effective than a focus on portraying gains.

- People are prone to assign money / income to different ‘mental accounts’, e.g. 'holiday money'; ‘retirement fund', which they treat as essentially discrete. There is scope to take advantage of mental accounting when setting incentives and offering choices that are attractive to people.
Information needs, knowledge gaps and misunderstandings

- Knowledge and understanding of pension matters, options over flexible working and their implications for income is low. At a technical level, plugging knowledge gaps is relatively straightforward in communication terms - although this is frequently not done well. However, *education solutions* are bounded by the reliance on people engaging with the content. Most people exhibit low motivation to engage in this area.

- Even where people are better informed, this does not guarantee that they will make good choices, given evidence of their susceptibility to an array of decision biases. These insights should be taken account of, in the production of communication material.

- In the context of pension choices, working arrangements and retirement, most people are not options seeking, i.e. they tend to react to options presented to them. They are also prone to selecting options that have intuitive appeal, rather than systematically evaluating the relative gains / losses. Thus, the way in which choices are presented (the decision architecture) can have a significant impact on the options that people select, and it is important to take account of this.

- The idea of phased retirement is unfamiliar to many and there is limited understanding of the options or their implications. Similarly, 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.

- Levels of awareness and understanding of the financial implications associated with options over early draw-down or pension deferral are low. The complexity of pensions increases the probability of people making poor pension choices, blunts their motivation to actively engage in decision making, and contributes to public uncertainty and a sense of helplessness over planning for later working life and retirement.

- There is fairly strong evidence of employee preference for individually tailored, bespoke, pension forecasts over generic information.

**Note:** A significant proportion of the evidence on this topic is derived from studies of people's attitudes to pensions and working longer. The reader is reminded that attitudes can be weak predictors of behaviour and can also embody a range of biases, perhaps most notably what psychologists call self-serving biases, e.g. the propensity to blame external forces rather than one's own limitations in the event of undesirable consequences. This means that evidence of this type requires careful interpretation. However, it is generally accepted that people's beliefs (accurate or otherwise) impact on their attitudes and their behaviour, it is also important to discover not only what people believe, but why they believe what they believe.

### 3.1 Underpinning orientations to extending working life

An intuitive assumption arising from the increase in State Pension Age is that this will result in people working longer. However, it is apparent that a significant proportion of the working population already cease employment significantly earlier than the established 60 / 65 yrs
norm, and this seems likely that this will continue. Evidence that the recent rise in State Pension Age for women (a phased increase from 60 to 65, which has currently reached around 62 and a half) has had a modest impact on age of retirement would seem to lend weight to this conclusion. Vickerstaff et al report, "...no evidence to suggest a strong link between the policy initiative and women's likely retirement timing." (Vickerstaff et al, 2008, p.94). However, it is apparent that the mean age of retirement has been rising in recent years (Office for National Statistics, 2012).

While there appears to be widespread public acceptance of the logic that people should work longer as a consequence of increased longevity, this does little to diminish any sense of loss experienced by individuals when faced with the proposition of extending their own working life (Vickerstaff et al, 2008).

For most people, retirement represents a rite of passage, a deserved reward, a period in which to spend the short time remaining as one chooses. Being able to choose how to spend your time, rather than having this determined by others is highly valued by people of all ages, but seems to be a key attraction of retirement. Early retirement, or perhaps more accurately the option for early withdrawal, is attractive and highly valued (Philipson and Smith 2005; Maitland, 2010, Vickerstaff et al, 2008; Hedges et al, 2009).

The Department for Work and Pensions reports around a quarter of middle and higher income respondents (£29K+ P.A.) retaining aspirations to retire in their 40's or 50's (Attitudes to Pensions Survey 2006; 2009; 2012). Although, the reader is reminded that aspirations are not necessarily a good predictor of behaviour, or the financial capacity to retire early. Notably, the Eurobarometer Survey 2003, found an average disparity of four years between preferred (58 years) and expected age of retirement (62 years) (Esser, 2005).

Primary tensions surround the fact that people interpret recently announced rises in pension / retirement age as a fait accompli, underpinned by a sense of loss and resentment. Rises in pension age challenge beliefs about social equity. People feel cheated out of their just deserts and denied a rite of passage enjoyed by earlier generations. At the root of this for many, the issue seems to be not so much the prospect of working longer, but the denial of choice over this and the prospect of working at full capacity for longer (Vickerstaff, et al, 2008).

The most pervasive finding from survey evidence of the over 65's intentions and aspirations over extending working life is that only ~10% are attracted to the prospect of full-time work, and this may also be true of the over 50's (Hedges, et al, 2009 - also see Cleary et al, 2007). Various sources suggest that this reflects a shift in work-life balance preferences amongst the over 50's (Saba et al, 1998; Vickerstaff, et al; 2008; HSE, 2012). While this may be the case, it should be kept in mind that reduced hours / flexible working are attractive to around 50% of employees of all ages (Maitland, 2010). Additionally, at the time of Hedges et al survey respondents would likely have been expecting to use part-time income to complement their pension(s) income. For most, this will no longer be the case in view of progressive rises in pension age to 68yrs. This may mean that despite aspirations to work
fewer hours, that this will not translate into demand for part time-work amongst the 65-68yrs cohort, particularly those on low income.

Increased opportunities for part time and flexible working perhaps have some potential to reduce the sense of loss associated with having to work longer, particularly if their configuration embodies choice (See Vickerstaff et al, 2008; Weyman, et al. 2012). However, employee options can be bounded by adverse impacts on pension values (Watson et al, 2003) and limited opportunities, particularly opportunities that allow employees to retain their established grade and status (CIPD, 2007; Siegenthaler and Brenner, 2008).

3.2 Variables impacting on decision making over how and when to retire?

**Push and pull influences**
Historically, for the majority of people decision-making over when and how to retire was essentially a non-issue, i.e. it was not an area where people expected or experienced choice. Rather, retirement represented an abrupt transition from full-time status to being completely retired. As such it is an area of decision making that is not deeply culturally embedded, that remains relatively unfamiliar with comparatively few cultural precedents (Siegenthaler and Brenner, 2008).

Casting retirement / working longer as the product of individual decision making tends to give the impression that the act is the product of individual volition on the part of employees. While this can be the case, the reality for most people is that decisions are bounded by an array of contextual influences, widely conceptualised to as push and pull factors. Principal among these are:

- **Individual factors** – physical and mental health status, psychological dispositions - attitudes / beliefs, and knowledge of pensions / retirement options.
- **Financial factors** – pension value, other savings and financial obligations, e.g. dependants, mortgage status.
- **Family and social network factors** – caring responsibilities, retirement date of partner and reference group retirement norms.
- **Workplace factors** – job quality, job design, job demands, employer policies and practices, e.g. opportunities for flexible working, retention of older workers.

(See: Shacklock, et al, 2007; Armstrong-Stassen, 2009; Maitland, 2010)

Philipson and Smith note that "... it is unclear regarding the extent to which individuals in their 50's or 60's make detailed financial calculations on the relative merits of working over retiring." (Phillipson and Smith, 2005). Indeed, the balance of evidence suggests that while financial considerations play a role, this is only one criterion and may not represent the primary consideration (see Vickerstaff et al, 2003). A key distinction is between those who are pushed towards withdrawal from work, e.g. due to enforced redundancy, ill health / incapacity, or caring responsibilities, and people who have more choice in the matter.
Debilitating ill health, in particular mental health and musculoskeletal disorders (HSE, 2012) represents the most salient individual determinant of early retirement and tends to be more prevalent amongst those in lower status / front line positions, largely due to workplace exposures and to some degree due to broader cultural / lifestyle effects (Mac Innes et al, 2009; also, see Marmott et al, 1991). There have been notable advances in reducing musculoskeletal exposures, however the incidence of work stress continues to rise. A number of authors attribute the latter to an intensification of work in recent decades (Philipson and Smith, 2005), although other sources paint a more complex picture of the stress epidemic (see Cox, 1993). What is apparent is that large numbers of the over 50’s cite work-intensification-stress as an important criterion in their motivation to withdrawal from employment. A third of those who rate their work as ‘high stress’ report planning to retire before State Pension Age compared with a 20% average (Philipson and Smith, 2005). Nursing staff working in operating theatres, intensive care and mental health services have been identified as being at particular risk of exposure to high work stress. Additionally, health care delivery as a whole represents a high stress context. Against a UK average of 17%, 28.4% of nurses, 27.8% of doctors and 33.4% of managers report mental health issues (see Watson et al, 2003). In terms of age related effects Watson et al report; "There was a widespread feeling among the nurses interviewed...that stress and the associated burnout were major influences on decision making with regard to employment over the age of 50." (Watson et al, 2003). While these authors go on to conclude that many nurses over the age of 50 years report that they cope well with the physical and mental demands of their work, it should be kept in mind that this cohort may represent a survivor population.

For most people, retirement ambitions are likely to be moderated by the financial considerations. Unprecedented levels of personal debt, greater mortgage debt, later receipt of inheritance and higher costs of education, than those experienced by earlier (post-war) generations, will foreseeably impact on disposition to remaining in paid employment for longer. Nearly a quarter of 56–59yr olds report a need to provide financial support to their offspring (Maitland, 2010).

Beyond early exits attributable to ill health and non-work commitments, thus far, it has been assumed that decision making over work and retirement reflects individuals making rational choices based on complete knowledge of the options available to them.

Knowledge and engagement

However, there is strong evidence that most people’s knowledge over options for later working life is vague and incomplete. Almost all sources indicate that most people are not proactive option-seekers in this area. "In general, relevant information held by respondents seemed to have been acquired piecemeal and incidentally rather than [having been] systematically sought out... " (Hedges et al, 2009 p102, see also Clery et al, 2006). Systematic calculation of the associated financial considerations appears to constitute a minority activity (Weyman et al, 2012). For most people pre-retirement behaviour is more appropriately characterised as reacting to events and options that are presented to them, or as they unfold, routinely in the context of incomplete knowledge (Vickerstaff et al, 2008).
It can be tempting to conclude that people should be more engaged with planning and active decision making over later working life, however, the reality is that many are not, and the weight of evidence suggests that this is unlikely to change (Weyman, et al, 2012). There are also grounds for concluding that people feel disempowered in this area, in so far as, while they may exhibit preferences over work and retirement, they may feel that they have limited control over key criteria, such as the availability of part-time work, flexible working options or employer policies over phased retirement (Gough and Hick 2009; Wicks and Horack, 2009; Philipson and Smith, 2005; Hedges et al, 2009).

There are widespread claims that employers provide little information on options or their implications. The Equality and Human Rights Commission reports 38% of men and 46% of women being unaware of their right to request flexible working hours (Maitland, 2010). Similarly, "... people didn’t know whether gradual retirement was available to them or not." (Vickerstaff et al, 2008). Thus, many people have only a vague and impressionistic awareness of the options open to them, or their implications. As Watson et al, in their study ‘Nurses over 50’, concluded "A picture emerges of nurses at a stage in their life and career who require sound advice prior to making any decisions but who are, essentially, left to their own devices." (Watson et al, 2003).

Norms and nudges
Social norms1, particularly workplace derived common experience, play an important role in setting the parameters of employee mental models2 of the configuration of employment and retirement options. "... the influence of workmates or even acquaintances on individuals attitudes [can be also] very significant." (Vickerstaff et al, 2008), as people tend to reference their own options and choices to the observed behaviour and opportunities open to others.

Recent changes in retirement age in the health sector, and elsewhere, will challenge and/or remove a number of established norms, but their impact will likely take time to percolate. Currently, the relative dearth of precedents acts as a barrier to change amongst employers and employees (Hedges et al, 2009). Their absence tends to restrict and channel employee perspectives on the options open to them. As Hedges et al have noted, when engaging with employees on phased retirement and other flexible working options “… many people seemed to be reviewing the ideas we presented to them for the first time.” (Hedges et al, 2009). The relative scarcity of precedents also tends to feed employee reticence over requesting flexible or part-time options, for fear that managers and employers will interpret such requests as evidence diminished commitment to work (Hedges et al, 2009; DWP, 2013; Gleeson and Gallagher 2005; Smeaton et al 2009; McNair et al 2007; Weyman et al 2012; Yeomans 2011; European Foundation 2012; Watson et al 2003). This can be a source stress where employees are experiencing difficulty in meeting job-demands, and there is evidence that this inhibits employees from reporting ill health (Maitland, 2010), leading to the risk that health conditions will worsen.

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1Norms in this context relates to the influence of shared beliefs, attitudes and behaviours, on individual (and group) orientations and actions, i.e. social norms are, in essence, ‘rules’, customs and practices that represent the status quo / natural order of things.

2Mental models - sense-making and understanding of the world, and how variables relate / inter-relate
Evidence that people are more disposed to reacting to choices presented to them highlights the need for an employer-led, managed, approach in this area, with a focus on bespoke solutions tailored to meeting individual needs and preferences e.g. the availability of flexible working arrangements, part-time work, design of work / adaptations in cases of debilitative ill health or diminished capacity etc. (Maitland, 2010). Health sector specific evidence appears to reflect this; "It was very uncommon for individualised face to face advice [initiated by the employer] to be provided and information came from informal advice from colleagues in canteens." (Watson et al, 2003; also see Davey, 2007). However, the perspective should, necessarily, not be limited to a focus on individual solutions. Employer policies, practices and the underpinning culture play a defining role (see, Schrank and Waring, 1989; Vickerstaff, et al 2003, Philipson and Smith, 2005; Siegenthaler and Brenner, 2008; vanDalen et al, 2008; Weyman et al, 2012). Variously referred to as organisational climate (Cox and Flin, 1998), or the decision architecture (Thaler and Sunstein, 2008), the way in which choices are presented to employees impacts people's disposition and capacity to work longer and the options that they select.

There is extensive evidence that older employees are more attracted to part-time and flexible work, for a range of reasons, prominent amongst which are non-work commitments e.g. caring for dependants, a desire to minimise exposure to work stress or fatigue, diminished physical capacity and shifts in work-life balance preferences, partly reflecting the fact that older age groups whose children are no longer financially dependent, and whose mortgages have been paid off, are more likely to be able to afford to take a reduced income (see, for example, Saba et al; Philipson and Smith, 2005; Vickerstaff et al, 2008; Hedges, et al 2009). Where work can be configured to take account of / support these needs and preferences rates of employment may be enhanced. Conversely, where options that meet these needs are not available, rates of employment can be predicted to fall, or result in employees experiencing varying degrees of hardship / dissatisfaction with work. On this issue, Watson et al note that "The key issue in deterring older nurses, as well as attracting them back to the NHS is flexibility." (Watson, et al, 2003).

The array of established and potentially configurable options essentially nudge people to stay in or withdraw from work. Therefore, it is important that employers understand how aspects of the prevailing (and alternative) decision architecture impacts on employee behaviour. Some of these nudges are articulated in this review, however, they can be subtle and highly context dependent. Therefore, there is a need for employers to undertake dedicated research into how the current architecture impact on employee behaviour, and explore the foreseeable impact of alternative configurations. It is important that this assessment goes beyond objective elements of the architecture, to include employee beliefs and understandings (mental models), in particular misunderstandings about the decision architecture, and that these are addressed (Weyman et al, 2012). As Shacklock et al (2007) note, "... there is a gap in the literature concerning employment arrangements that would be attractive to older people choosing to remain in or re-enter the workforce." (Also, see DWP, 2013). Relatedly, while significant numbers work through their 60's into their 70's we know remarkably little about how they cope with work (Ilmarinen, and Rantanen, 1999).
Findings on phased retirement are mixed. Despite widespread claims that that employees prefer a phased retirement, to make the transition smoother, rather than an abrupt end to working life (see, for example, Davey, 2007), behavioural evidence indicates that take-up rates can be low and its availability does not seem to lead to a significant increase in older worker participation rates (Taylor, 2002). However, the way in which options are configured seems likely to impact on their attractiveness and rates of take up.

**Recognition & respect**

A number of sources point to the value placed upon the contribution of older employees by managers and colleagues as a criterion in decision making over retirement. Many report feeling undervalued (Murray and Syed, 2005; Smeaton and McKay, 2005; Davey, 2007), with limited management support (Saba, et al, 1998) and insufficient recognition and respect for their experience (CIPD, 2011). Restricted opportunities / employer emphasis on older employee training and personal development is said to reinforce this perspective (NPAW, 2000; Watson et al, 2003; Davey, 2007). It is difficult to be certain that equivalent findings might not be elicited from younger cohorts, but in any event it seems reasonable to conclude that where employees feel undervalued and under-invested in this is likely to impact on intention to quit.

The evidence on employer age discrimination is mixed, which may indicate notable employment sector differences. McNair et al, (2007); Bytheway (2010); Maitland (2010), Metcalf and Meadows (2010), all lay claim to high levels of employer discrimination, although effects seem to be most apparent in recruitment practices. By contrast Porcellato, et al, found relatively few established employees reported direct experience of age discrimination (Porcellato, et al (2010). Similarly, Watson et al in their study of practices in the NHS report “... in general, older nurses did not feel they experienced ageism from their employers.” (Watson et al, 2003). However, an important issue here is that the belief that employers discriminate is widespread, and this belief has the potential to impact negatively on older employee motivation, attachment to work and retirement decisions.

The overriding conclusion here is that employees need help to engage with options in this area, and employers should take the lead. While, it needs to be recognised that some employees will choose to retire / withdraw irrespective of how options are configured, positive action to address known push and pull effects associated with the design and configuration of work is likely to result in higher numbers choosing and being able to work longer. The configuration of an employer-led managed approach would benefit from further dedicated research into variables impacting on decision-making, amongst health care employees, especially regarding the timing of decisions about retirement and the optimum (life-cycle) time to influence decisions, and how this might vary in terms of employee demographics, e.g. by profession, job role and grade.

**Demographic differences**

While most sources highlight the importance of choice in people in decisions over “... when to retire or to continue working, the ability to exercise choice is unevenly distributed.” (Vickerstaff et al, 2008). Professionals and senior managers historically enjoy greatest
choice in the timing and trajectory of retirement, in particular over hours worked. They also benefit from more generous pension values, more pension options e.g. early draw-down, and more opportunities to continue in their established career path, with their established employer (Philipson and Smith, 2005; Clery et al, 2006; Siegenthaler and Brenner, 2008). They also tend to be the most disposed to extend working life, plausibly due to greater intrinsic satisfaction with work. The primary contrast is with the low / unskilled, where levels of engagement are widely reported to be modest (Hedges et al, 2009).

Despite evidence that basic financial necessity is the most important reason for working longer for around half 50–59 year olds, and a quarter of those over 65yrs (Maitland, 2010), the conclusion that rises in pension age will result in low income groups working longest is tempered by the fact that strata is more likely to suffer from age-related ill-health and has less marketable skills (McNair et al, 2007; Clery et al, 2006).

On the whole, gender differences appear to be modest, the work / retirement profiles for men and women show increasing alignment (Davey, 2007), although there is evidence that women experience more work-related stress than men (Griffiths, 2000). It seems possible that this reflects differences in job type / profession and grade. Rates of degenerative joint disease are also higher for women than men. By age 75, 20% of men and 40% of women exhibit evidence of osteoarthritis (HEA, 1993).

Evidence of preferred age of retirement indicates 63yrs for men and 62yrs for women (Clery et al, 2006). Single persons work longer than those who are living together, and single women tend to retire later than single men. This is generally ascribed to financial need, and disparities in male and female income levels. In the case of those who are married / co-habiting, there is a tendency for alignment with the retirement date of the older partner (Philipson and Smith, 2005; Clery et al, 2006; Clery et al, 2006; Davey, 2007). Given traditional coupling norms in the UK this may go some way towards accounting for the marginally earlier retirement age for women.

The need to provide care for grandchildren and elderly adults is common amongst those aged 50–55yrs (39%) and disproportionately impacts on women as they are more likely to adopt caring roles (McNair et al, 2007, also see Watson et al, 2003; Reday-Mulvey, 2005; Davey, 2007). However, while the need to provide care for others can push people out of employment, it can also operate as a financial incentive to stay at work for longer (Maitland, 2010). Notably, there is evidence that health professionals engage in higher rates of on-work caring activities (notably elderly adult care) than the general population, plausibly because of their expertise in this area (Watson et al, 2003).

3.3 Decision making over pensions

An uncertain world
For many, decision making over pensions is framed by a general loss of confidence in financial institutions (post-2007/08), media coverage of earlier high profile failures, e.g. Equitable Life, the rise in State Pension Age, and changes to employer pension

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arrangements. Not surprisingly, numerous authors highlight an erosion of confidence, underpinned by an air of mistrust, cynicism and uncertainty (NAPF, 2010; Clery et al, 2006; Hedges et al, 2009; Wicks and Horack, 2009; Pettigrew et al, 2007; Thomas and Allen, 2008).

Uncertainty in this domain extends to:

- uncertainty over whether pension choices will prove to be sufficient to support retirement ambitions
- uncertainty over which pension options to select, and
- uncertainty over pension values (notably due to the move to defined contribution schemes and career average arrangements)
- uncertainty over future State Pension Age and its value.

A net result of recent changes in State Pension Age (including alignment impacts on public sector pensions) is that this has introduced uncertainty into an area where there was previously high certainty. People have "... a sense that the goal posts kept moving and it was quite difficult for the individual to do the right thing." (Vickerstaff et al, 2008; also see Mayhew 2002, NAPF, 2010; Clery et al, 2006; Pettigrew et al, 2007, Thomas and Allen, 2008; Hedges et al, 2009; Wicks and Horack, 2009).

Many see change in this area as permission for further change. What presents as fluidity in fundamental aspects of pension arrangements and the limited scope for individuals to impact on this, combined with the inherent complexity and un-knowable elements, gives rise to the following:

- it increases the probability of people making poor pension choices
- it seems to blunt (already weak) motivation to actively engage in decision making
- it contributes to public uncertainty and a sense of helplessness over planning for later working life and retirement
- it increases the orientation towards 'living for today'.
  (Wicks and Horack, 2009; Weyman et al, 2012)

This potentially adds a further challenge to effective discourse between employers and employees over pension issues.

Only around a third of the UK working age population report high confidence in their pension providing sufficient income in retirement (NAPF 2010). What is less clear is the extent to which this reflects a recently emerged erosion of confidence, or represents a finding common to earlier times. Historically, public sector employees have reported higher confidence (Clery et al, 2006), but it seems foreseeable that this may become eroded following recent changes (The Pensions Bill 2011).
Knowledge and engagement

For most people knowledge of pensions types and options is, at best, characterisable as vague and impressionistic, tending to be limited to headline-line conceptions of the type 'state pension age is going up', similarly, the belief that 'goal-posts are prone to move around in this area'. Only around 5% of adults rate their knowledge of pension arrangements as 'good'; and around 25% claim to possess little or no knowledge (Clery et al, 2006). Similarly, levels of awareness and understanding of the financial implications associated with work / pension options / implications tend to be poor, e.g. options over early or deferred draw-down and how this intersects with selected age of retirement. Many simply assume that the employer pension will be paid at State Pension Age. So the question 'When should I start drawing my pension' tends not to be salient (Hedges et al, 2009). Most people's understanding of changes and options is the product of becoming aware of them in an incidental ad hoc, manner, though media coverage, colleagues, and employer communications. This general population finding appears to reflect employee experiences within the NHS; "Older nurses obtained more information from their colleagues than from their employers." (Watson, et al, 2003). Active engagement and pro-active information seeking represents a minority activity (Hedges et al, 2009).

Despite high levels of public concern over pension issues, this seems to sponsor further retreat from arising issues, rather than stimulating active engagement. “Not knowing how much income to expect in retirement is very unsettling... " But, rather than this stimulating engagement worry this "...tends to [further] paralyse already weak impulses to plan ahead" and seek out information on options (Hedges et al, 2009), many tend to retreat from active engagement, seemingly hoping for the best. While it has long been recognised that most people shrink from active pension planning (see Weyman et al, 2012), there are demographic differences. Active planning for later working life and retirement becomes more common as we move up the social strata, being more routinely encountered amongst senior managers and professionals (Vickerstaff et al, 2008).

Evidence that "... most had only a relatively superficial grasp of how things work – and a small number appear to have scarcely any understanding at all." (Sykes et al, 2008), combined with evidence that many seem to make non-rational choices (Wicks and Horrack. 2009), has led some to conclude that there is a need for public employee / public education initiatives in this area (see Hedges et al, 2009). An intuitive conclusion is that there are knowledge gaps that need plugging and that if the options are presented in a simple straightforward format people will be more motivated to engage and will make more rational choices (after Fischhoff, 1995).

Producing material that meets these criteria is both possible and desirable (see, in particular, Morgan et al, 2002). However, there are grounds for concluding that impacts on employee behaviour are likely to be modest, as the more fundamental issue relates to people’s motivation to engage. "Most people do not find pensions [and other retirement planning] interesting. Even when they are within 10 years of likely retirement age, many [43% Mayhew, 2002] individuals will not have given much thought to their retirement circumstances... " (Vickerstaff, et al. 2004), similarly, "... most admitted that they would not
have sought out material on this subject in real life – or probably even read it, if it had been handed to them or dropped through the letterbox." (Hedges et al, 2009; also see Gough and Hick 2009; Clery et al, 2006; Wicks and Horack, 2009; Philipson and Smith, 2005; Hedges et al, 2009).

A further fundamental challenge to effective communication in this area relates to employee trust in the source of education / publicity material e.g. over pension options / choices. The impact of even the best crafted message is likely to be blunted if the source and its motivation are distrusted, or otherwise viewed as unreliable (see Pidgeon, et al. 2003). A legacy of previous pension choices / arrangements, in the recent past, which have since proved to be non-permanent, or to yield less favourable returns than forecast, is their impact on employees' preparedness to trust advice over future pension choices.

While it seems that most of the blame for later receipt of pension is directed at the Government: "There was widespread cynicism in relation to the Government's motives for intervention in matters relating to pensions and retirement." (Vickerstaff et al, 2008), rather than employers, and some sources indicate that employers are one of the more trusted (perhaps least distrusted?) sources for information and advice over pensions (NAPF 2010; Thomas and Allen, 2008), what is less clear is the degree to which public sector employees view their employer as independent of Government / Ministerial interests, i.e. it is not clear how discrete the (dis)trust profiles are. There is also evidence of employee concern over employer motives and competence in the area of pension advice and options (Vickerstaff, 2008; Hedges et al, 2009). High levels of public concern over pension issues seem to sponsor further retreat and paralysis, rather than stimulating engagement (Hedges et al, 2009). However, there are demographic differences. Active planning for later working life and retirement is more common as we move up the social hierarchy and most frequently encountered amongst senior managers and professionals (Vickerstaff et al, 2008).

Although active retirement planning represents a minority activity, it is clear that some individuals do engage / attempt to engage. For these individuals, in particular, it is important that they are able to grasp salient facts and that their misunderstandings are addressed. To a lesser degree, for the wider population that is prone to adopt a less systematic approach, it is important that the rules of thumb that they apply are appropriate and substantially correct. Good communication practice involves understanding what employees already understand, what criteria they consider in their decisions and building on this.

**Pension choices – making 'good' decisions**

In considering the issue of pension options, it is clearly important that employees make *good choices*. However, the net result of incomplete knowledge; reticence to engage with detail; the presence of un-knowable elements, combined with the relative complexity of calculating retirement income, is that people tend to apply more impressionistic criteria in their decision making. In particular, there is a risk that certain features of the way options are presented (sometimes referred to as 'framing') will be picked-up on which 'feed' known decision biases, with the result that people make poor choices.
As noted elsewhere, people are prone to deviate from rational, systematic contemplation of options in some areas, pension investment being one of them (Thaler and Sunstein 2008; Goda and Flaherty, 2010; Kahneman, 2011). People routinely exhibit a range of decision biases, such as a preference for sure gains in the near future, which may come to represent poor decisions when considered against a longer time frame, e.g. selecting a lump sum option, linked with reduced regular pension payments, such that in the long-run they lose out (Kahneman and Tversky, 1981; Gazzale and Walker, 2008; Thaler and Sunstein, 2008; Dolan et al, 2010). The phenomena known as ‘Mental accounting’ can also play a role, i.e. people are prone to allocating sums of money to discrete ‘pots’, e.g. if offered a lump sum pension option people may be seduced by the opportunity this presents to pay-off their mortgage, other accumulated debts; or perhaps the education fees of offspring and similar, but they may lose out in the long run.

Notable findings on known decision biases include:

- Aversion to loss, e.g. presenting pension choices as gains or losses can impact on which option people select. People are generally loss averse. They are prone to select a lower value sure gain rather than chose a higher return option if there is risk of a loss, even if the probability of this is low.
- Focusing on the consequences of undesired events, even when the probability is low, e.g. the tendency to over-estimate the likelihood of pension failure or age-related ill health.
- Consider an option referenced to a known value, e.g. X is larger than Y, in essence a focus on relative rather than an absolute value in options appraisal.
- A preference for gains in the ‘here and now’, over future benefits, particularly where the future is uncertain, e.g. attraction to lump-sum options.
- A propensity to stick with established choices (status-quo bias) even when offered options with better returns, e.g. current pension scheme versus new enhanced scheme - in essence: ‘better the devil you know’.

(see, in particular, Tversky and Kahneman, 1981; Kahneman and Tversky, 1984; Kahneman and Miller, 1986; Fagley and Miller, 1990; Thaler & Sunstein, 2008).

As well as exhibiting decision biases, people are also prone to retreat to rather more impressionistic and emotive approaches when contemplating pension choices. Potential pitfalls include focusing on only a subset of the variables they need to consider, or following the choices made by colleagues. These and related insights are relevant when asking employees to make choices over alternative pensions as the way in which pension options are presented (by intention, or inadvertently), can seduce (nudge) people to choose certain options over alternatives. Thus, there is a risk that the way options are presented, and known decision-making characteristics can lead people to select choices that may not be in their best interest.

There is little to be gained from the perspective that decision biases and the tendency to fall
back on impressionistic rules of thumb are something that can or should be discouraged or addressed through education. Rather, the key insight relates to accepting that these are characteristics of human decision making and it is important to take account of them when configuring options and choices.

These insights underpin thinking behind the UK Government's auto-enrolment pension scheme introduced in autumn 2012 and similar schemes in the USA, e.g. the Save More Tomorrow scheme (see Thaler, 2001). In these examples, pension options offered by employers embody a default setting whereby employees are automatically enrolled in the scheme, but are free to opt-out should they choose to. Status-quo bias and inertia are said to result in higher rates of enrolment than if people had to consciously choose to opt in. Setting options in this way is another example of choice architecture. Thaler and Sunstein, hold that options should be presented in ways that take account of human decision making fallibilities, in order to help people make better decisions (Thaler and Sunstein, 2008; also see Kahneman, 2011).

The issue of better decisions remains contentious. But, aside from overt attempts at channelling choices, the key insight is that the way pension options are configured can impact on the pension options that people select. When configuring options it is important to understand what criteria people are applying to their pension decisions in a given context. Ideally, this should be based on evidence gathered within the work organisation.

Despite evidence of widespread angst and confusion over pension values and options, levels of employee interest in personal forecasts appears to be, modest. However, people prefer bespoke forecasts to generic information. Low take-up of forecasts has been attributed to a combination of fear of bad news and what amounts to fatalist orientations (Hedges et al, 2009; Wicks and Horack 2009). It is also apparent that most people do not spend much time contemplating this until they reach their 50’s, by which time it is difficult to make significant improvements to retirement income through, for example, additional contributions or a supplementary pension. For younger workers the issue is, for the most part, very much not on their radar (Hedges et al, 2009; Wicks and Horack, 2009). As elsewhere, it is perhaps tempting to conclude that people should consider these issues earlier. However, in the absence of prompts to make decisions (most saliently, either from Government, the employer, or trade union) the reality is that few will do so, with the net result that they may come to suffer retirement hardships that they might otherwise have avoided. As elsewhere the evidence highlights the need for a managed approach and the key role played by employers.

3.4 Decisions over transitions to alternative employment

Down shifting
Much has been written about the demand for down shifting to part-time and/or less demanding jobs in later working life. The headline finding is that down shifting is widespread amongst the over 50’s and that rates increase with age (12% of 50-55yr olds; 21% of 50-59yr olds, 38% of 60-64yr olds and 75% within the 65-75 years cohort – Maitland, 2010; also
see CIPD, 2011). However, key questions surround the extent to which this reflects lifestyle choices or the realities of a restricted employment market for older workers. Most down shifting reflects a move to part-time working, although there is also some movement into lower status employment.

Findings indicate that demand for migration to alternative employment is modest, with around 3/4 of individuals reporting a preference is to remain working for their current employer, and in their established job role / profession (Maitland, 2010). Not surprisingly, those who are seeking alternatives tend to report being unhappy with their current job. Principal sources of dissatisfaction relate to hours of work and (in)flexibility (Maitland, 2010; also, see McNair et al, 2007; Vickerstaff et al, 2008).

While it is established that a large number are attracted to down shifting in the sense of reducing their working hours (see, for example, Vickerstaff et al, 2008), it seems that few (4% of the over 50's) report that they are seeking down-grading to less onerous jobs. Additionally, this is outweighed by those still seeking promotion (11% of the over 50's - Maitland, 2010; also see Saba et al, 1998; Siegenthaler and Brenner, 2008). Combined with the finding that around 2/3 of workers in their 50's report feeling as fit as they ever have, Maitland's findings would seem to suggest that a high proportion of age related down shifting in the general population reflects restricted employment opportunities, leading to migrations to lower status, less secure part-time work, more commonly with a new employer; rather than reflecting a lifestyle choice (also, see Shacklock, et al, 2007).

**Mobility and migration**

In terms of job-mobility, quoting ONS data, McNair et al note, job mobility declines with age, although the effects are said to be less pronounced amongst those educated to degree level and above (McNair et al, 2007). It has been suggested that the over-50's have two primary fears about changing jobs: fear of rejection by employers and concern over the financial implications in the run-up to retirement (Maitland, 2010). It seems possible that similar fears may surround age-related re-deployments in the same organisation, although no empirical evidence was found on this issue. Perhaps unsurprisingly, individuals with a more varied / chequered employment history, in particular the lower skilled (39% of over 50's, Maitland, 2010) are more disposed to engage with alternative job choices in later life (and probably earlier) (Hedges et al, 2009).

Usefully viewed within the context of findings that older workers value recognition of their skills and experience, while at the same time valuing reduced job demands in terms of time pressure and work load, opportunities to migrate to training and / or mentoring roles possess intuitive appeal as an avenue for meeting the needs of older employees to the benefit of younger employees (Saba, et al, 1998; Murray and Syed, 2005; Smeaton and McKay, 2005; Davey, 2007; Davey, 2007; Fredericksen, 2006).
4.0 What support do older workers need to stay in work and/or change career and how does this differ from younger employees?

Summary

Retention
For staff to remain productively employed there needs to be a 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.

Much of the relevant literature is focused on preventing early retirement. Moving into different types of work does not generally feature. 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.

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 amongst 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.

The maintenance and updating of skills also make an important contribution. Older workers are less likely to receive job-related training than younger people, and this needs to be addressed. There is evidence of older employee inhibition to request training and the limited social norms in most work organisations, highlight the need for a managed approach initiated by the employer, i.e. there is a need to go beyond making training and development available on request. Line managers play a critical role as gatekeepers or enablers.

Some migration to alternative job roles already takes place, but there is scope for more actively carving out mentoring and support roles for experienced older professionals.

Down-shifting and flexible hours
There are widespread claims of a dislocation between the way that jobs have traditionally been configured and the preferences and needs of significant segments of the workforce: older workers, young parents and disabled people.

Opportunities for flexible or reduced hours are limited. The scope for configuring flexible and part-time options varies by job-role and grade. Changes to pension arrangements, e.g. the shift away from final salary pensions and winding-down options have potential to make part-
time working towards the end of the career a viable option for employees, so that demand for reduced hours might grow in the future, although this may be mitigated by cost of living rises.

There is evidence of older employee inhibition in requesting reduced or flexible working hours, notably due to worry that this might be interpreted by managers as indicative of a lack of commitment to work, highlights the need for a managed approach initiated by the employer, i.e. there is a need to go beyond making reduced of flexible hours available on request.

Opportunities to step down to jobs with less responsibility. Demand for this appears to be present, but modest, and significantly less than the desire for down-shifting to reduced hours. 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.

Recognition
Older workers have a strong desire for a sense of feeling valued. Older employees are prone to feel that they are socially marginalised in the workplace, in particular that their skills and experience are under-valued, which both demotivating. This has implications for their commitment to work, and disposition to remain in work.

Recognition that older workers are increasingly likely to have caring responsibilities for older people (e.g. parents), such that they need access to working arrangements (e.g. reduced or flexible hours; unpaid leave) that assist people to meet these non-work commitments.

Line management
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 will 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.

Note: There is a large degree of overlap between the issues discussed in this section and those discussed in Section 7, which covers good practice in human resource management more generally. The emphasis in this section is on measures which intend to help older people remain in their jobs for longer than they otherwise would. But this section should be read while bearing in mind that human resource management practices and policies influence the motivation and retention of all staff, not just those in older age groups.
4.1 Workability

There are three broad aspects to the issue of supporting older people to remaining in work. There is the issue of continuing employment (of any kind); the issue of continued employment with an existing employer (whether or not in the same job or type of work) and there is the issue of continuing in the current job. Thus, there are general principles that apply across a whole range of jobs. There are job specific issues (many of which will apply across all ages) and there are issues which relate to the current employer, and which may relate to a range of different types of job, and some of which apply just to older people.

Much of the relevant literature focuses on predicting the probability of early retirement and actions that can be taken by individuals and employers to reduce that probability. An influential strand is based on the concept of work ability. This was developed in at the Finnish Institute of Occupational Health by Ilmarinen and his colleagues (Tuomi et al 1997a, 1997b, Ilmarinen 2001, Ilmarinen and Rantanen 1999). The work ability index is designed to predict whether an individual will remain in their current job. It is based on four dimensions:

- the demands of the job and the physical working environment
- the way in which work is organised and the social interactions that take place at work
- the individual’s health and functional capacity, and lifestyle factors
- the maintenance of work-related skills.

Thus, the concept of work ability goes beyond the concept of employability, because the emphasis in work ability is on the fit between the employee and the job. Someone might have relatively low work ability in one job, but much higher work ability in another. Many people’s work ability index changes little over time. However, on average there is a decline with age. Heavy physical demands and low levels of job control are associated with declining work ability over time. By contrast jobs with higher mental demands and greater autonomy are associated with the maintenance of work ability as workers age (Costa and Sartori 2007).

More generally, the four dimensions of employability are not equally important. Tuomi et al (2001) estimate that the most important sources of differences in work ability scores are work demands and the work environment (responsible for around 28 per cent of the variation). The next most important is work organisation and the work community. The individual factors (health and functional capacity) and the maintenance of skills only account for 13 per cent of the variability in individual work ability scores. This has important implications for interventions which are intended to maintain or improve work ability, and ensure that employees are able to remain in work. Where there is an observed decline in work ability it is more likely to driven by factors related to the demands of the job and the organisation of the workplace than it is to factors related to the individual and any health problems or impairments that they may have developed. Thus, while occupational health and lifestyle interventions can be useful, in addressing problems, they are unlikely on their own to help people remain in their jobs and perform them to a suitable standard.
There is evidence, related to a variety of interventions, which address all parts of the work ability construct. Apart from those that focus purely on lifestyle issues, the purpose of the others is to improve the individual’s relationship with his or her work, and to improve their motivation to stay. Many of the interventions are as relevant to younger people as they are to those later in their careers, even where they have been developed specifically to support older workers.

In principle, the support systems could fall into three broad groups:

- support which enables the employee to continue in his or her existing role
- support which enables the employee to move into a different but related role with the same employer
- support which enables the employee to move into a job with another employer.

In practice, the literature does not have examples of the third group. This is likely to be because most of the support systems that have been put in place are funded by employers in the expectation that they would help in employee retention and would reduce absenteeism, thus repaying the investment. Nevertheless, interventions of the third type would represent a viable option, both for improving the wellbeing of employees, and for controlling pension costs. There is evidence that individual health and wellbeing as well as income is higher among those who continue in paid work, compared with those of the same age who retire (Wadell and Burton 2006; Dave et al 2008; Calvo 2006). Where individuals who leave an employer to take another job defer taking their pension this has long-term income advantages to themselves, and provides short-term savings to the pension scheme.

### 4.2 Supporting employees to remain in their established role

There are two parts to this: support which provides extra support to the individual to enable them to continue to perform the existing role without any adjustments to the job, and adjustments to the job, which enable the employee to continue working, but in a slightly different way. These adjustments need not be based on any inability to perform the job, or to work as productively as younger employees. In many ways it is more important to maintain and encourage employee commitment and motivation as it is to make adjustments for any deterioration in capacity.

This is because the widely held view that older people are less productive than their younger counterparts is largely mistaken. There is well-established evidence, based both on laboratory testing and on studies of the general population that ageing is associated with reductions in some physical and mental attributes that might have a bearing on work performance: hearing, vision, lung capacity, muscular strength, bone structure, speed of activity and reaction and memory (Park and Reuter-Lorenz, 2009; Salthouse, 2009; Peeters and van Emmerik 2008; Yeomans 2011; Benjamin and Wilson 2005; Bohle et al 2010; Crawford et al 2010, 2009; Warr 1994; Salthouse 1997; Hjort 1997; Mitchell 1990;Anderson 1993; Griffiths 2000).
Furthermore, there are also some attributes that tend to improve, at least up to the age of 70. These include tests of knowledge, comprehension and verbal meaning (Bohle et al 2010; Ilmarinen 2001). Even where there are differences in average performance of people of different ages there is significant variation around the average for all age groups, to the extent that differences within age groups (both younger and older people) are larger than the differences in the averages of older and younger people.

However, not all these elements of deterioration of performance with age observed in laboratory settings or population studies affect all or even most of the members of an age cohort. The fall in the average performance of older age groups may be driven by a marked deterioration in a small minority while others are hardly affected at all. Benjamin and Wilson (2005) citing a Department of Health analysis of the 2000 Health survey of England found that only 5 per cent of people over 65 showed marked cognitive decline. Although the ability to process information and react rapidly falls markedly from the thirties onwards across the whole population, in general, observed differences in average performance between older and younger age groups are due to the deterioration in the performance of a minority of older people. In fact, younger people show greater variability in both physical and cognitive performance than older people do. In cognitive tests, some older people perform at well above the average for younger people, while others do much worse. In physical capacity tests, active 65 year olds do as well as active 25 year olds, but inactive 65 year olds do much worse than their younger counterparts (Crawford et al 2009).

Moreover, when it comes to performance in the workplace, as opposed to testing of general abilities, the evidence suggests strongly that in most jobs there is no difference between the performance of older and younger workers (Ng and Feldman 2008; Warr 1994; Warr and Birdi 1998; Benjamin and Wilson 2005; Yeomans 2011, Crawford et al 2009). There is evidence that work performance falls with age in some jobs: those that make heavy demands on sensory perceptions, selective attention, working memory, and processing of new information, and those requiring rapid reaction time or physical strength. But only a small minority of jobs have these characteristics. Although many roles in healthcare have some of these attributes, the available evidence suggests that the demands are not of the intensity found in the kinds of work where performance is known to deteriorate with age: professional sports people and athletes, racing drivers and fighter pilots. In these types of job people generally move on to other types of work in their twenties and thirties because they are no longer able to maintain appropriate speeds.

In most jobs, there is little or no difference between the performance of older people and those aged 25–50 who are doing the same job. Those under 25 tend to have lower productivity than both groups. Warr (1994) reviewed over a hundred studies. Benjamin and Wilson (2005) some 200 and Ng and Feldman (2008) conducted a meta-analysis of 380 studies. All these reviews concluded that even where physical and cognitive capacity has declined with age, the effect on performance is compensated for by social citizenship aspects of work (attendance, collaboration, compliance with safety rules, lack of aggression) which all tend to be better in older age groups than younger groups. Generally, the studies
find that the performance differences within each age group are significantly larger than those between different groups.

The key caveat to these findings is that older people observed in the workplace (particularly those over 65) are generally there through choice and may represent the healthier, fitter and better motivated members of their cohort. They are therefore likely to be biased towards better performance (Silverstein 2008). Those whose job performance is less good are likely to have moved into other types of work or retired. Nevertheless, there should be no presumption that people in their sixties are intrinsically less able to achieve the same job performance as younger people.

The literature covering both the general working population and healthcare workers identifies support in an employee’s existing role into three groups:

- adjustments to the way the job is configured
- adjustments which aim to improve or maintain individual performance at work
- giving employees a sense of feeling valued.

### 4.3 Adjustments to the way the jobs are configured

#### Ergonomic design

The design of workstations, work area lighting, the visibility of monitoring devices, the installation of lifting devices and the reduction in ambient noise levels can all contribute to improving the effectiveness and maintaining the health and wellbeing of older workers in healthcare settings (Hart 2007; Walker and Taylor 1998; Peeters and van Emmerik, 2008; Benjamin and Wilson 2005; Alspach 2007). Ilmarinen (1995) has argued strongly that poor ergonomic design is the main cause of declining work ability in older workers and that adjustments in this domain are likely to make the greatest contribution to retention.

#### Lifting

A particular issue in ergonomic design for healthcare workers relates to lifting. It is well established that older age groups are more likely to have musculoskeletal problems (Peeters and van Emmerik 2008; Crawford et al 2010; EUMusc.net 2011). The use of lifting devices by nursing staff, porters and paramedics is one form of adjustment that is likely to be beneficial to all age groups. The higher prevalence of musculoskeletal problems (most notable lower back pain) among older people is generally thought to be an outcome of the wear and tear that has occurred over the years (Bohle et al 2010). If younger people do less lifting in the present they are less likely to experience problems in the future.

In Bon Secours Hospitals in Richmond, Virginia they have deployed specialist lift teams so that nurses do not have to lift patients. The hospital estimates that the effect has been to retain experienced nurses for an extra two to three years. This hospital group has nurses working at the bedside into their eighties. A third of the staff in the group are over 50 and 3 per cent over 65 (The Lewin Group 2009).
Shift patterns

Shift working is common in healthcare and is an intrinsic part of a 24-hour service. It is well-established that shift working can have detrimental effects on health for people in all age groups, most notably because it leads to sleep disruption. This is discussed in more detail in Section 5.3 below. The issue considered in this section is whether there is evidence that older people are more susceptible to the adverse effects of shift working than younger people are, and whether as a consequence there should be differential treatment of older workers with regard to shiftwork.

There is some evidence that older workers adjust less well to shift working than younger workers (Saksvig et al 2011; Costa and Sartori 2007; Kawada 2002). The critical age for increasing intolerance to shift and night work is reported to be around 45–50yrs of age. Costa and Di Milia cite evidence that attributes this to chronobiological, psycho-physical and social conditions. At a biological level older people are said to experience greater disruption to circadian rhythms, as well as physiological fatigue from working extended shifts. There is a consensus in the evidence that older people need a longer recovery period, particularly from shifts of 12 hours or more (Griffiths 2000; Costa & Di Milia, 2008; Costa and Sartori 2007; Saksvig et al 2011). However, one of the complications of the evidence is that it is not always consistent with respect to age. Moreover, the research literature on shiftwork generally suggests strongly that some shift patterns are more detrimental than others, so that it may not be possible to conclude that there is a general relationship between the detrimental impact of shift working and age. A range of recent authors, some of them reviewing a wide range of evidence find no relationship between shiftwork tolerance and age (Burch et al, 2009; Farrow and Reynolds, 2012; Conway et al, 2008; Blok and De Looze 2011; Saksvik et al 2011).

Nevertheless, unwillingness to continue to work shifts is one feature of working life that is associated with leaving a particular job (Tikkanen, 2006; Pisarski et al, 2006). Where it is not possible to move to a job with the same employer that does not involve shifts (for example moving into working in outpatients or primary care for nurses), the need to work unattractive shift patterns can lead to people retiring or moving into other types of work.

Shift working options that have been tried as a way of encouraging older employees (particularly older nurses) to remain include offering the chance to work only the shifts which younger people do not want to work for example weekends or nights (Alspach 2007; The Lewin Group 2009; European Foundation 2012; Kilpatrick and Lavoie-Tremblay 2006). An alternative is to reconfigure shift patterns to offer shorter shifts, possibly by two staff members sharing a 12 hour shift by working six hours each, or by having some roles where shifts are generally shorter than the norm (The Lewin Group 2009; Alspach 2007). There is in any case evidence that longer shifts in healthcare are detrimental generally and contribute to higher error rates and accidents (Keller 2009; Poissonet and Veron 2000; Rogers et al, 2004), so that the argument for the availability of shorter shifts may be beneficial for a wider range of people than older age groups. For example, one study of healthcare workers found that sleep deprivation was greatest among nurses who had dependent children and who worked rotating shifts (Costa and Sartori 2007).
Costa and Sartori (2007) who found falling work ability from age 35 among healthcare workers working shifts recommended that older workers should be moved off night work and be given priority for moving to day work, as well as the ability to choose their own shifts. Although these recommendations are widely cited in the literature, apart from allowing people to choose unpopular shifts (which was probably not what the recommendation intended anyway) there is no evidence in the literature of any employers having acted on these particular recommendations. This may be due to the fact that the Costa and Sartori conclusions are disputed by other research. But, in any case, it is doubtful that it would be legal in the UK to offer such options to older people without offering them to younger people as well.

**Task mix**

The lifting example discussed above is an example of changing the task mix within job roles. Nurses in the hospital involved continued to perform their patient care responsibilities, but the lifting part of their task was done by special members of the healthcare team.

All jobs consist of a bundle of different responsibilities, roles and tasks. There will inevitably be circumstances where older members of a working team may no longer be able to perform particular elements of the job as well as younger people, but there will also be elements that they can perform better. Under standard arrangements an individual unable to deliver to an appropriate standard on one element of their job may feel obliged (or may be forced) to consider retirement. However, that is not the only option if they are able to deliver effective work on other elements of what they do. For example, a recent study of American anaesthetists over the age of fifty found that the proportion of their working time spent in direct patient care was 81 per cent in those aged 50–59, 79 per cent in those aged 60–69, but only 65 per cent in those aged 70–79 who spent a higher proportion of their time in research (Orkin et al 2012). There are likely to be examples in other groups where for example visual or manual accuracy problems will make some elements of work more problematic, but where reorganising work within a team will ensure that skills can be retained and outcomes for patients maximised.

**Reduced hours**

Although some older workers would like to work reduced hours because they have health problems or impairments that mean that they find full-time work very tiring, in many cases older people are looking for reduced hours because they have family commitments (for older people or grandchildren) or because they would like a better work-life balance. Because they are at the stage in life where their financial commitments are less onerous (where their children are no longer dependent on them financially, and perhaps their mortgage is paid off) they are able to manage on lower earnings.

Final salary pension schemes have long been an obstacle to reduced hours working by older people. This is because it would lead automatically to a reduction in income in retirement. The move towards a career average system therefore has the potential to allow voluntary reductions in hours without the same detrimental effect on pension entitlements.
The option of reduced hours is already made available to people over state pension age working in at least one NHS Trust in England. University Hospitals Coventry and Warwickshire NHS Trust has 4 per cent of its employees over state pension age. Staff have the option of stepping down to a less demanding role or to shorter hours, with the latter being a commonly chosen option (Smeaton et al 2012). The international literature contains a large number of examples of older workers in healthcare choosing to work reduced hours (The Lewin Group 2009; Storey et al 2009; Peisah et al 2009). There is also evidence of older workers in healthcare and more generally who would prefer to work fewer hours given the choice, and who would see reduced hours as means of working for longer, although some are reluctant to raise the issue with their employers as they fear they will be regarded as lacking commitment (Gleeson and Gallagher 2005; Smeaton et al 2009; McNair et al 2007; Weyman et al 2012; Yeomans 2011; European Foundation 2012; Watson et al 2003; Hedges et al, 2009; DWP, 2013).

4.4 Intervention at the level of the individual

Maintaining skills
One of the keys to maintaining work performance in older workers is ensuring that their skills are maintained and kept up to date. People who maintain and update their work related skills have higher productivity and better work ability scores than those who rely on outdated skills (Walker and Taylor 1998; Ilmarinen and Rantanen, 1999; Silverstein 2008; McNair et al, 2007). However, older people are less likely to be involved in professional development and training of any kind. For example, a study of NHS nurses and midwives over fifty found that only 20 per cent had had any professional development in the previous year, compared with 70 per cent of those under fifty (Watson et al 2003). It is not clear whether this difference reflects problems in accessing professional development activity or a reluctance to take part. Another study of NHS nurses found that they felt that professional development activities were focused on addressing the needs of younger nurses and older nurses found it less relevant to their own concerns (Wray et al 2009). This is a common issue across a wide range of occupations and countries (Cedefop 2010).

Some of the GPs in London taking part in the Flexible Careers Scheme, which is aimed among other groups at older GPs who wish to work part-time as an alternative to retirement, also reported problems in accessing professional development opportunities (Viney et al 2007).

Line managers have a critical role to play both as gatekeepers to training opportunities and as providers of encouragement for staff of all ages to take part. Line managers can take a variety of approaches to the training of older employees ranging from the hostile and discouraging, through the passive (possibly colluding with a reluctant employee), to the positive, indeed insistent (McNair et al, 2007).

Interventions to promote individual health and wellbeing
Maintaining health and wellbeing is one of the keys to ensuring people can remain in work and reducing absenteeism. Thus, although these initiatives to promote health and wellbeing
are often valuable to older employees, their impact is not restricted to older people. Indeed, their main focus is often on reducing short-term sickness absence rather than long-term retention.

Typical health and wellbeing programmes involve targeted regular health checks, healthy living seminars providing advice on nutrition and wellbeing; stress management workshops; subsidised gym memberships; healthy meal options in staff canteens; or the organisation of various sports activities/clubs for staff members (CEEP 2012).

Coventry and Warwickshire NHS Trust has a Health and Wellbeing Programme as part of the occupational health department. The scheme was piloted in 2011 to address the two main causes of sickness absence within the NHS (and more generally) musculoskeletal problems and psychological conditions associated with, for example, stress. Staff are pro-actively encouraged to live a healthier lifestyle and improve their work life balance. But there is also fast track access to physiotherapists and psychologists, to enable staff to return to work more quickly if they are off sick. As the pilot was successful in reducing absence the scheme has been rolled out more permanently (Smeaton et al 2012).

A meta-analysis of studies of health and wellbeing programmes found that they do have an impact on absenteeism and employee motivation (Parks and Steelman 2008). However, a systematic review by Crawford et al (2010) found that few health and wellbeing interventions had been properly evaluated. However, the authors concluded, as the review by Dame Carol Black found, that occupational health intervention can reduce the risk of early retirement from the workplace. General health promotion and lifestyle interventions are well-regarded by older workers, so they may increase employee motivation and attachment, but there is no evidence that they improve the work ability or performance of older workers.

Valuing employees
The literature suggests that older workers are less likely to choose to retire if they feel that they and their work are valued by the organisation they work for (Ilmarinen et al, 1997; Payne and Doyal 2010; Storey et al 2009; CEEP 2012; Saba, et al, 1998; Murray and Syed, 2005; Smeaton and McKay, 2005; Davey, 2007; Davey, 2007; Fredericksen, 2006).

Employees feel valued if their views are listened to and they are treated flexibly as individuals. It is critical that employees of all ages are valued, otherwise there may be intergenerational tensions (The Lewin Group 2009; Benjamin and Wilson 2005).

A change of role
There are suggestions within the literature that older employees should be offered the opportunity to move into roles carrying less responsibility or stress, where their experience can be used without the full range of demands being placed upon them (Costa and Sartori, 2007; Ilmarinen, et al, 1997). However, The Coventry and Warwickshire experience document by Smeaton et al 2012 is that moving into a less responsible or less demanding role, while available, is seldom chosen. This concurs with the findings of other authors. For
example, Vickerstaff et al 2008 found that only 4 per cent of older workers would prefer to move to a role with less responsibility.

There are already role shifts that happen now out of choice. Wray et al (2009) and Wray et al 2003 found that older nurses had moved out of hospitals into community roles or into NHS Direct, where jobs were less physically demanding, or did not require shiftwork. Our analysis of the Labour Force Survey (reported in more detail in Section 8 below) finds that a large proportion of older healthcare staff already leave NHS employment before they reach retirement age, with a majority going to other jobs outside the NHS.

The deployment of older nurses in purely mentoring roles outside line management has been found in a range of hospitals in different parts of the USA (The Lewin Group 2009) and in Britain (McNair et al 2007). Organisations that have measured the impact of mentoring initiatives have found a reduction in turnover among newly qualified nurses, leading to savings in recruitment costs.

A not-for-profit hospital in California found that their nurse mentoring programme led to a fall in hospital acquired pressure ulcers by 38 per cent and the number of adverse events fell by 47 per cent. The programme therefore more than paid for itself by generating reductions in the length of hospital stays (The Lewin Group 2009).
5.0 What are the implications of EWL for physical, psychological & emotional health & wellbeing and performance?

Summary

Performance
Evidence suggests that the impact of extending working life on physical, psychological and emotional health and wellbeing is likely to affect individuals differently. Although there is an association between ill health 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.

The overwhelming evidence from the many reviews and meta-analyses of older workers and work performance is that, overall, they perform as effectively as their younger counterparts.

Diminished capacity, 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 evidence related to professional drivers and pilots (closest equivalent to ambulance drivers) is that slower reaction speed is compensated for by experience and the probability of accidents or errors is below that of drivers in their twenties and similar or better than that of drivers in their 30s and 40s. Driving (but not workplace) accident rates do go up in general population, but this does not seem to be reflected among professionals, perhaps because they continue to drive on a regular basis, while driving declines in the general population, particularly after retirement from work. There may be a case for introducing a testing / assessment regime similar to that for HGV and PSV drivers for paramedics and hospital transport drivers.

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 (both attributable to peak exertion and working long hours).

Health and sickness absence
Ill health represents a primary, if not the primary, cause of early withdrawal from employment amongst the over 50s; possibly over 40% of cases. Musculoskeletal disorders and mental health issues, in particular psychological stress, represent the headline causes of absence and early withdraw from work.

Older workers exhibit higher rates (annual days lost) of sickness absence than their younger counterparts. But, headline figures disguise differences in patterns of absence. Older employees tend to exhibit fewer spells of absence, but these tend to be of longer duration. Comparisons of sickness absence by age are complicated by the fact that older employees represent a survivor population, those forced to withdraw from work earlier in life due, to ill
health, a significant proportion of which is attributable to workplace exposures, are simply not there.

After taking account is higher rates of involvement in caring responsibilities, women exhibit higher average sickness absence than men.

Older age groups appear to have more effective coping strategies for dealing with stress than younger groups do. However, making comparisons between younger and older employees on this issue is complicated by the fact that older employees likely represent a survivor population, i.e. those who are able to cope with the stress levels associated with their job remain, while others leave earlier in life.

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.

Chronic conditions are seen as a barrier to continuing to work by some people but as something to be worked around by others. Their impact on the ability to work is related to attitudes as much as to physical capacity.

**Shift work**

There is some evidence to suggest that shifts longer than 8 hours can be detrimental to older workers health, but other evidence (especially multivariate and meta-analysis studies) finds no association with age and no evidence that it is worse for the over 60s than it is for people in their 50s.

There is some evidence that older workers' performance is adversely affected by night shifts, but there is also evidence that younger workers' performance is adversely affected by morning shifts.

Contemporary shift working practices in the health care sector are cited as an important influence on intention to quit. Time needed for recovery tends to increase with age, this is particularly relevant in the context of extended (e.g. 12 hour) shifts.

**Presenteeism**

There are grounds for believing that rates of sickness presenteeism (working when sick leave should have been taken) 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. Presenteeism can exacerbate health conditions and elevate work stress; and have negative impacts on productivity and performance.

Work provides self-esteem and social engagement for some, with positive effects on
Extending Working Life
Audit of research relating to impacts on NHS employees

psychological and physical health, but for others it is an unwelcome burden and a source of stress, with adverse outcomes for health and psychological wellbeing.

5.1 Managing the health of older people at work

There are two dimensions to the issue of managing and maintaining the health of older people at work. The first is that older people are more likely than younger people to have long-term or chronic health conditions. In some cases these conditions may affect their work, but in many cases people just learn to live with and work around their conditions so that their work is not affected.

The second aspect is the need to ensure that work itself does not adversely affect the health of employees, particularly in the case of conditions to which older people appear to be more vulnerable. But it is important to bear in mind that although work can be a source of stress and can place physical demands that may cause problems, there is also evidence that for older people paid work is better for their physical and mental health than not working (Waddell and Burton, 2006). This may arise in part from the fact that work often involves physical activity which has a positive impact on health generally. Those who have retired from paid work are less likely to engage in any form of physical activity than those who continue working. Similarly, work is an important source of social interaction for many people, and a reduction in social interaction after retirement may have an adverse effect on health (Dave et al 2008). The beneficial effects of working on health have been found even among people who work in less desirable jobs (Calvo 2006).

5.2 Health conditions and older people

As people age they experience a general decline in many aspects of physical health. These include muscle strength, bone density, cardiac function and aerobic capacity. However, the extent of decline varies markedly between individuals. It is affected by genetic factors, lifestyle, smoking, exercise and body weight (Bohle et al 2010; Crawford et al 2010; Peeters and van Emmerik 2008; Yeomans 2011; Benjamin and Wilson 2005; EUMusc.net 2011). For example, on average 65 year olds have 10–25 per cent less strength than 40 year olds.

However, there is a large degree of variation within age groups. Some 40 year olds will have less strength than the average 65 year old, and some 65 year olds will have considerably more strength than most people in their forties. There is some evidence to suggest that those who use their physical strength in their jobs (refuse collectors and power line workers have both been studied) retain much better strength than other occupational groups who do not need to deploy strength during their work and who therefore do not retain muscle and joint capacity (Crawford et al 2009).

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 (Peeters and van Emmerik 2008; Crawford et al 2010; Bohle et al 2010; EUMusc.net 2011; Macllnnes et al 2009; Rose 1993). Each year In the UK more than
a quarter of female patients aged 45 to 64 and around one in five male patients consults a GP about musculoskeletal problems. This rises to over a third of female patients aged 65–74 and over a quarter of male patients (EUMusc.net 2011). By age 75, 20% of men and 40% or women exhibit evidence of osteoarthritis (HEA, 1993).

As musculoskeletal problems tend to intensify with age but the age at which they become sufficiently acute as to interfere with the ability to work varies, it is likely extending working life will mean that some people whose condition would have been manageable up to a previous retirement age may find that it becomes a problem between that age (55 or 60) and their new retirement age.

However, the impact is difficult to estimate with certainty. This is because there are several possible outcomes. The first is that the person continues working for the NHS, in the same job role, but takes more sickness absence. The second is that the person continues to work within the NHS but in a different job role which has lower musculoskeletal demands and continues to work in this new role until normal retirement. The third option is that the person continues working outside the NHS in a job which places less stress on the affected part of the body and draws their deferred pension at their normal retirement age. The fourth possibility is that the person concerned takes early retirement through ill health. There are obviously also some variants of these outcomes with different timings. The impact on costs to the pension scheme, to their NHS employer and to the individual will vary according to which option is pursued and the age at which it is pursued.

Given that musculoskeletal problems are the single most important cause of early retirement from the NHS (see below), it is likely that extending working life will result both in an increase in ill health retirement and in a continuing exodus of older people from the NHS into employment elsewhere (see Section 8 below). Two factors that can influence the proportions falling into each of these categories are the way in which work is organised (see Griffiths 2000) and the role of occupational health (Black 2008; Black and Frost 2011 and Borman 2009). These and related issues are discussed more fully in Section 7.

Cardio-vascular problems are increasingly likely in older age groups (Hottop 2007; Wadell and Burton 2006; Yeomans 2011; Peeters and van Emmerik 2008; Crawford et al 2009).

However, these problems need not prevent people from working, nor affect their performance at work. The same is true of other conditions where prevalence rises with age such as diabetes (Yeomans 2011; Peeters and van Emmerik, 2008; Waddell and Burton 2006; Crawford et al 2009). Their impact on the ability to remain in paid work appears to be related more to attitudes than to physical capacity per se. Studies of people with long-term conditions find that even where people have the same condition there are differences in the way in which they approach it and the extent to which it interferes with their daily life (Vickerstaff et al 2008).

There is evidence that older people need longer recovery times, both from exertion, and from accidents or injuries (Crawford et al 2009; Costa and Di Milie 2008; Griffiths 2000;
Costa and Sartori 2007; Saksvig et al 2011; Yeomans 2011). This has particular implications for shift patterns (discussed below and in Section 7).

In terms of mental health there is an age-related decline in some aspects of cognition. Laboratory and population studies show that some but not all cognitive abilities deteriorate with age (some studies suggest from the early 20s onwards). There are reductions in processing speed, working memory, and long-term memory (Park and Reuter-Lorenz, 2009; Salthouse, 2009; Peeters and van Emmerik 2008). Even so, the deterioration is not generally marked before the age of 70, and possibly older (Yeomans 2011). The Department of Health Health Survey of England for 2000, cited by Benjamin and Wilson 2005, found that only 5 per cent of people over 65 showed any sign of cognitive impairment. Moreover, language ability and the ability to process complex problems improve (Bohle et al 2010; Ilmarinen 2001). In most cases serious decline in memory or intelligence is not apparent until the age of 85 (Murray and Syed 2005).

Even where there is some cognitive decline among people in their fifties and sixties, this is not generally reflected in work performance. Most people function at work well within their cognitive capacity. Thus, even if they experience some decline in cognitive ability over time this is unlikely to mean that their work performance declines similarly. Laboratory tests often remove aids such as notes which are likely to be available in the workplace.

Mental health problems do not appear to be more prevalent in older age groups. The prevalence of depression in particular tends to fall with age. The prevalence of work-related stress problems appears to peak in the early fifties and decline thereafter. This may be related to some evidence that older workers have better coping strategies for stress (Yeomans 2011; Benjamin and Wilson 2005; Peeters and van Emmerik 2008, Crawford et al 2009; Bohle et al 2010). However, it might also reflect the fact that those less able to cope with stress in the workplace tend to leave, either to move to other jobs, to move into long-term sickness or to retire. Thus, it may not be surprising that the survivor population in any particular workplace consists of those who are best able to cope with stress.

Older workers are at a lower risk of accidents than younger staff, but where they are involved in accidents they are more likely to involve serious injury or be fatal. In other words, the lower accident rates found among older workers reflect the fact that they have lower rates of minor accidents (Farrow and Reynolds 2012; Crawford et al 2010; Benjamin and Wilson 2005; Costa and Sartori 2007).

**Sickness absence**

On average, across the working population as a whole in 2011, 4.5 working days were lost through illness or injury. The most frequent form of sickness absence across the working population as a whole is short-term absence for minor conditions. This pattern of sickness absence is more common among younger workers than among older people. However, in terms of the total number of days of absence, musculoskeletal problems are the most serious, accounting for around a quarter of all absence. Mental health problems account for around a fifth of all absence (ONS 2012). Older workers take slightly more days than
younger workers, and they do so in longer, certified spells (HSE 2005). In 2011 people aged 16–34 lost around 1.5 per cent of their working days to absence, while those aged 50–64 lost around 2.4 per cent (ONS 2012). However, it is probable that older workers with the most severe health problems are no longer working, so that sickness absence data will tend to underrepresent health problems in older people.

Health problems among NHS staff
People working in healthcare have a higher incidence and prevalence of health problems than people working in other types of work (Crawford et al 2009). Across the population as a whole 1.9 per cent of employee days were lost to sickness or injury in 2011. Women have higher sickness absence rates than men in all age groups (ONS 2012).

Absence rates among NHS staff are considerably higher. According to the latest published figures (July–September 2012) ambulance staff in England has the highest absence rate of all NHS occupational groups at 6.24 per cent of working days. This is followed by healthcare assistants (6.15 per cent) and nurses and midwives (4.93 per cent). Using a different source (compiled from self-report rather than employer records) our analysis of the Labour Force Survey discussed in Section 8.5 below found that unlike the pattern in the general population, only NHS staff under the age of 30 (who in any case make up only 14 per cent of NHS staff) had a relatively low sickness absence rate. The number of days of absence of NHS staff in all age groups over the age of 30 was very similar, averaging around 8.5 days (or just under 4 per cent of available days). Thus, for NHS staff, unlike for the general working population, the rate of absence does not appear to increase with age. NHS staff who are aged over 60 do not have higher absence rates than those in their forties and fifties. Again, we need to be wary about drawing general inferences from a survivor population who are likely to be working out of choice. Nevertheless, there is no particular reason to believe that average absence rates will be affected by the presence of an older age group, unless there are other interventions which succeed in reducing absence by younger staff but not their older colleagues.

For nurses and paramedics musculoskeletal disorders are the most common source of sickness absence. These two groups are at higher risk of musculoskeletal disorders than the population generally (Rodgers 1998). In the USA nurses are classified as having the sixth highest risk of occupational illness or injury (Letvak and Buck 2006). A study in eight Dutch hospitals found that 75 per cent of all nurses reported lower back pain during the course of a year (with 12 per cent reporting severe pain), while 59 per cent of operating room nurses reported neck or shoulder pain (Bos et al., 2007 cited in Crawford et al 2009).

Although other health conditions such as dermatitis are also more common among healthcare workers than among the rest of the population, their prevalence does not appear to increase with age (Costa and Sartori 2007). Musculoskeletal problems are critical, however. They are the most common cause of early retirement due to ill health for NHS staff in Scotland, being responsible for 38 per cent of ill health retirements (Brown et al 2005). In England and Wales they are responsible for 49 per cent of ill health retirements among all NHS staff, including 68 per cent of ambulance staff retirements and 50 per cent of nurses
and midwives (Pattani et al 2001). Given the increased prevalence of such problems with age, without preventive intervention, it is likely that the continued employment of an older workforce will result in people in their sixties retiring early due to musculoskeletal problems. Some of this will reflect the inevitable worsening of these types of problems due to injury earlier in life, but people whose jobs require them to do lifting, for example, may continue to add to earlier injuries.

The next most common sources of ill-health retirement among NHS staff are psychiatric disorders (20 per cent in England and Wales, 21 per cent in Scotland) and cardio-vascular problems (11 per cent in England and Wales) (Pattani et al 2001; Brown et al 2005). The prevalence of mental health problems generally does not increase with age, and the prevalence of depression in particular tends to fall with age. Whatever the cause, the continued employment of an older workforce should not increase the prevalence of mental health problems across the NHS workforce as a whole.

5.3 Shift working and health

Shift working is common in healthcare and is an intrinsic part of a 24 hour service. There is a considerable amount of literature on the relationship between shift working and physical and mental health and wellbeing for people of all ages. Although a minority of shift workers would choose to work shifts, shift working is generally unpopular. It is disruptive to family life, but above all it is disruptive to sleep patterns and is associated with a range of adverse physiological and physical symptoms (Costa and Di Milia 2008; Costa and Sartori 2007). There is some evidence that some patterns of shift working and types of rotation have worse impacts on health than others (see Folkard and Tucker 2003), and that adherence to best practice in organising shifts can mitigate some of the adverse impacts.

Some of the literature has considered whether the adverse impact of shift working is greater in older workers than in their younger colleagues. Some studies do find that the impact is worse for older age groups, but others find no differential impact. In the current state of the evidence it is not possible to conclude that shiftwork is worse for older age groups than it is generally. The one unambiguous finding from the literature is that older people are less tolerant of shifts of twelve hours or more, and need longer recovery times (Griffiths, 2000; Costa and Sartori, 2007; Saksvig et al 2011; Costa and Di Milia 2008).

Shift working is known to be disruptive to sleep patterns, which leads to fatigue. With adequate recovery time between shifts older workers manage to cope with this (Ell 1993). There is some evidence that younger people have a greater need for deep sleep and that sleep disruption is therefore more detrimental to those in younger age groups (Boourdouxhe et al, 2010). But there is also evidence that older people experience more sleep disruption, particularly those working longer shifts (Saksvig et al 2011; Costa and Sartori 2007; Kawada 2002). However, there is also research that disagrees that there is an association between age and problems with shift working. For example, Burch et al (2009) found that older people working in healthcare were able to adapt more effectively to varying shift patterns than younger people. Farrow and Reynolds (2012) found no evidence that accidents or errors
were more likely among people over 60 who worked shifts than among younger people. Conway et al (2008) in a study of Italian healthcare workers found sleep disruption was common among shift workers, but was no worse among older age groups than among younger people. Two recent reviews of the evidence on shift working and age concluded that while older people respond less well to night working, younger people respond less well to morning working, and that overall there is no evidence that shift working causes greater problems for older than for younger people (Blok and De Looze 2011; Saksvik et al 2011).

Overall, therefore the evidence suggests that shift working per se can have detrimental effects on health for all age groups, but the evidence that it affects older people disproportionately is contested.

Nevertheless, shift working is not popular and is an important influence on decisions to leave a particular job (Tikkanen, 2006; Pisarski et al, 2006). Where it is not possible to move to a job with the same employer that does not involve shifts (for example moving into working in outpatients or primary care for nurses), the need to work unpopular shift patterns can lead to people retiring or moving into other types of work. What is clear is that ensuring that older workers have sufficient recovery time between shifts, and ensuring that shift lengths are limited, can make an important contribution to people’s willingness to tolerate shift work.

5.4 Driving: a specific area of concern

One area of particular concern relates to paramedics, who in addition to lifting, which is an issue for a number of other groups, also have to drive, sometimes at high speed. Driving is a complex task which requires good vision, the ability to process the information the vision is providing, and the physical response of the driver’s hands and feet to the outcome of that processing.

A study of truck drivers in the USA found that age was significantly related to deteriorations in speed and accuracy in performing complex tasks with slower response times for drivers 65 years old or older compared to those under 50 years old (Popkin et al., 2008). Similarly, in a study of 60–64 year old bus drivers, it was found that this age group had fewer accidents than drivers in any other age category possibly because judgement and patience compensated for declines in reaction time (Shephard, 2000a).

There are studies of accident rates and the number of errors per drive in the general population. These generally show that younger people have the highest accident and error rates. The rates then decline steadily up to the mid-sixties where they tend to plateau. They then rise again. People in the sixties and seventies commit more errors per drive than people in their forties and fifties. Drivers in their eighties, particularly females, have accident rates similar to those of young people (Evans 2000; Dawson et al 2010; Slamatiadis and Deacon 1995; Makishita and Matsunaga, 2008).

However, one problem with these studies is that they do not take into account how frequently older people drive. Given the evidence from the workplace that skills decay with non-use,
this is also likely to be true of driving skills. Middle-aged people are likely to be regular drivers and many of them will be using their cars daily to travel to work. Older people who are retired are not going to be driving to work, and are likely to drive less frequently than daily. Some will only be occasional drivers. It is likely that under these circumstances their driving skills will deteriorate. The driving skills of occasional retired drivers may not be directly relevant to the issue of the driving skills of older paramedics.

There are no studies in the literature that specifically relate to driving by paramedics. There are, however, studies of professional drivers and airline pilots, where the issues of concentration and reaction times are similar to those for paramedics and where those concerned are engaged in regular practice of the relevant skill. The parallels are not absolute to the extent that paramedics may be driving at high speed in complex traffic conditions, while other professional drivers are more likely to be driving with the traffic. Nevertheless, the issues which emerge from the research on professional drivers are likely to be relevant.

A review of the evidence related to professional heavy vehicle drivers found that accident rates tend to decline up to the age of 63 then begin to increase. The highest accident rates were found in drivers under the age of 27. Thus, although drivers in their late sixties have slightly higher accident rates than people in their forties, they are no higher than people in their thirties (Duke et al 2010). Another study of professional truck drivers up to the age of 76 found that drivers over fifty had less accurate vision. However, only a third of the measures of driving quality showed any deterioration, while on two measures older drivers scored better than younger drivers. The authors suggest that driving ability is more closely related to cognitive measures than to age, and that experience can compensate for decline (Llaneras et al 1998). A study of 60–64 year old bus drivers found that they had lower accident rates than younger groups, perhaps because they had greater patience and better judgement, which compensated for their slower reaction times (Shephard 2000).

A study of truck drivers in the USA found that age was significantly related to deteriorations in speed and accuracy in performing complex tasks with slower response times for drivers 65 years old or older compared to those under 50 years old (Popkin et al., 2008). Similarly, in a study of 60–64 year old bus drivers, it was found that this age group had fewer accidents than drivers in any other age category possibly because judgement and patience compensated for declines in reaction time (Shephard, 2000a).

Taylor et al (2007) undertook a three-year longitudinal study of airline pilots aged 40–69. The older pilots showed less decline in performance over the three years than the younger pilots did, although at baseline the older pilots’ performance was slightly worse than that of the younger pilots, particularly in terms of following flight control instructions. The authors conclude that in undertaking a highly skilled task with which they are familiar, the older pilots’ experience and expertise enables them to maintain their performance.

The broad conclusion from these studies seems to be that the performance of the vast majority of professional drivers in their sixties is not markedly different from that of drivers in
Extending Working Life
Audit of research relating to impacts on NHS employees

their fifties. However, there is an association between driving performance and cognitive decline, although this generally manifests itself among people over 70. But given the variability in cognition that begins to manifest itself during the sixties, there will inevitably be some increased risk of accidents by older paramedics. The risk is likely to be small but there may be a case for driver testing. Currently, professional bus and HGV drivers have to have a medical examination every five years from the age of 45 to 65, then every year thereafter in order to be able to continue to drive professionally. This may provide the basis of a model for paramedics, although the latter might require greater emphasis on reaction time given that they are more likely to drive at higher speeds.

5.5 Presenteeism

Compared with sickness absence, the issue of sickness presenteeism remains under-evidenced. Presenteeism refers to the phenomena of employees working at times when they could legitimately have taken sick leave. While work embodies benefits, in terms of psychological wellbeing, physical health and social participation (see, for example, Black, 2008), going to work whilst ill brings costs to the individual (e.g. potential to exacerbate health conditions and elevated work stress) and employers (reductions in productivity) (Burton et al., 2003).

Available evidence suggests that presenteeism is widespread (37% of employees Aronsson et al., 2000; 54% Aronsson & Gustafsson, 2005) and has a high prevalence amongst public sector employees (HSE, 2005) including health sector employees (Borman, 2009), some sources suggesting higher rates than within the private sector (Aronsson et al 2000 Aronsson & Gustafsson, 2005; HSE 2005). In terms of age, results are mixed and may relate to job role / profession. Arronson et al report highest prevalence in the 35–55yrs cohort (Aronsson et al, 2000). Rosvold & Bjertness, in a study of physicians, found 20–39yrs as the peak, but go on to report that 86% of their sample had engaged in presenteeism in the reference period (Rosvold & Bjertness, 2001).

No dedicated studies of presenteeism amongst older employees were identified. However, findings from the Department for Work and Pensions Attitudes to Health Survey (2011) indicate that rates are comparable to, and possibly higher than, the wider population. For the 51–64yr cohort: 65% of back pain sufferers reported being ‘very’ or ‘quite’ likely to go to work when experiencing pain; similarly 60% of those reporting acute depression, while 73% claimed to have gone to work when feeling ‘quite unwell’ in the 12 months reference period. Corroborative evidence is provided by The Work Foundation (2013), reporting on a similar cohort, record 44% of their respondents claiming to have engaged in presenteeism. Both sources suggest that older workers are prone to presenteeism as a compensation-behaviour, in order to avoid giving colleagues and managers the impression that they are not fit for work due to their age. Parker and Bevan (2011) reports general population rises in rates of presenteeism in an unfavourable economic climate, but offers no indication of any age related effect, although in view of the general profile of ill-health absence, there might be a case for concluding that negative health impacts may be greater for older workers.
6.0 Implications of multi-generational working – in particular psychosocial influences on employee engagement & age cohort effects

Summary

Attitudes to work
There is some evidence that different generations have different attitude, expectations and orientations to work. However, there are grounds for concluding that, while generational differences may be present, this is 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 changes as they get older. Some sources attribute the higher demand for part-time work amongst older employees to an age related shift in work-life balance. It is common for employees of all ages to feel under-valued, or that their contribution is under-recognised, however, it seems that these effects may become during later working life, i.e. older employees may be more prone to perceiving that their contribution is under-valued.

Multi-generational teams
The migration of older employees to mentoring roles has been shown to have positive benefits for both older and younger workers. It can enhance self-esteem and afford a way of recognising the experience and skills of older employees. Within nursing, older employee mentoring has been shown to reduce the incidence of errors among inexperienced nurses by nearly 50%, leading to shorter hospital stays for patients.

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.

Job design for older employees should reflect different skills, abilities and employee preferences, e.g. among American anaesthetists in their 50s, 80% of their time was spent in patient care, while among those in their 70's it was 65%.

There is evidence which suggests that there can be tensions between older and younger employees particularly over issues of work-commitment and promotion, as well as the value placed upon practical skills and experience.
6.1 Generation X and Generation Y Orientations to work

For the first time in history four generations are working in the same workplace. Strauss and Howe (1991) characterise these as:

- traditionalists born before around 1945
- the baby boomers born between 1945 and the mid 1960s
- Generation X born in the late 1960s and 1970s
- Generation Y born in the 1980s.

This characterisation is inevitably over-simplistic, but the framework serves as a reminder that individuals' attitudes are shaped by their education, the social, economic and political environment in which they grew up, and by their experience, both of life and of work.

The four generations are claimed to bring different perspectives and attitudes into the workplace as well as different skills, reflecting their different styles of professional training and subsequent experience. Although there are differences within generations, generalisations can be helpful in providing insight about how they approach the workplace and what they are expecting to gain from work.

Traditionalists (in some instances, termed 'Silents', Strauss and Howe, 1991) are said to have had World War II as the key event in their childhoods. They are held to have a strong work ethic and sense of discipline. Organisational loyalty is said to be important to them. The baby boom generation were the first to experience mass affluence and youth culture. They are characterised as idealistic and optimistic. They too have a strong work ethic, but are said to be less conformist than the traditionalists. They like their work to have meaning. Some of this generation will have caring responsibilities for elderly relatives (and possibly grandchildren). Generation X moved into the workplace during the high youth unemployment of the late 1970s and early 1980s. They are characterised as valuing independence, being less trusting of authority, and less committed to organisations, but confident users of technology. Many of them will have dependent children. Work-life balance is said to be more important to them than it was to older generations at the same stage in their careers. Generation Y have grown up with technology as a background feature in all aspects of their lives. They are confident, social and team-oriented and global in outlook. They tend to like structure (Society for Human Resource Management 2009; Glass 2007; Pitt-Catsouphes et al 2009; Sherman 2006).

Commentators on the implications of this typology for the world of work have focused on what are cast as fundamental differences in world view, highlighting the scope for resentment of other generations, and the suggestion that each wants different things from work, which in itself is said to contribute to them and us orientations within multigenerational teams. To date, most attention has been paid to claims of differences between Generations X and Y (see Tulgan, 1996; Hu, et al, 2004; Jenkins, 2007; Wilson et al, 2008).
There are claims of the type: "... issues between nursing staff of different generations can often be unpleasant or unproductive, which can lead to work conflicts and interpersonal tension... [health sector employers should be] working with their employees to fully understand each generation's perspectives, work habits and communication styles." (Hu et al, 2004; also see Sherman, 2006). Similarly, with respect to working in teams, there are said to be generational differences with respect to working habits and norms, with Generation X's being cast as dismissive of aspects of traditional custom and practice valued by Baby boomers (Dittman, 2005).

If the generational differences are as marked as some authors cast them, then the different world views are of strategic significance for organisations in managing a multi-generational workforce, not least because it suggests the need for a different approach to getting the most out of the different cohorts. However, if generational attitude differences are modest, attempts to customise management strategies to meet the needs of the different groups have the potential to dissipate resources and erode generational harmony (Hudson, undated).

There is some evidence that the different generations respond positively to different management styles. Traditionalists tend to prefer clear, consistent, direct but respectful managers. Baby boomers prefer a democratic mission-focused approach to management and value the social aspects of the workplace. Generation X responds well to informal and flexible management with a strong emphasis on the achievement of goals and on personal development. Generation Y likes to see their managers as facilitators: providing motivation, coaching and feedback to help them to achieve organisational goals. Both younger generations are more likely to see work as a means of progressing their own careers and facilitating what they want to do with their lives. They value autonomy and challenge (Society for Human Resource Management 2009).

This framework provides a useful way of identifying the challenges of managing a multi-generational workforce and ensuring that they are able to collaborate to deliver good patient outcomes. However it is not rigid. As Hagen says "with a few exceptions it is impossible to generalize about older employees—their individual differences are at least as great as those of any other age group...they include the wise and the foolish, the bitter and the cheerful, the dedicated and the clock-watchers, the slipshod and the careful workers" (Hagen 1983).

Generation theory benefits from strong intuitive appeal and has stimulated significant interest and debate, particularly in human resource and management related publications. However, critics of the perspective claim that the world view characterisations may be little more than elaborations of widely held stereotypes, with modest empirical evidence to support them (see Jorgensen, 2003). More fundamentally, it is suggested that interest in identifying differences has resulted in an over-emphasis on the degree of social difference, where the more dominant picture is one of similarity on most criteria (Hudson, undated). Hu et al, for example in their empirical study of nurses, report no significant difference between Generation X and Y respondents in terms of workplace communication preferences (Hu et al, 2004). Similarly, Wilson et al, conclude: "Generational cohorts did not differ in satisfaction
Wilson et al go on to articulate some of the challenges to gathering reliable evidence in this area. For example, findings which highlight generational differences in extrinsic job satisfaction with respect to pay and benefits need to take account of linkages between age and grade seniority. Similarly, with regard to intrinsic elements, more senior grades (generally older employees) routinely enjoy more autonomy over how they organise their work than more junior grades. However, this does not mean that younger staff may not become disaffected by such arrangements, "... health care organisations need to recognise their current structure many not be conducive to retaining younger nurses." (Wilson et al, 2008; also see, Pitt-Catsouphes and Matz-Costa, 2008).

Typically, critics of the perspective do not deny the potential for differences in socialisation to impact on the attitudes of different generations, rather they suggest that the implications for managing this in terms of orientations to work are modest in comparison to the degree of similarity between the generations. They also suggest that chronological age is unlikely to be a strong predictor of employee attitudes and behaviour in relation to work, given the array of other influences. Additionally, it has been suggested that effects in empirical work attributed to evidence of Generation theory typologies may owe more to general maturation effects than some fundamental cultural difference in perspective, i.e. there may be stronger grounds for believing that observed generational differences in attitude owe more to shifts in work practice norms and established cultural habits over time, and associated resistance to change, than fundamental differences in the nature of employees and their aspirations and orientations to work.

As Hudson concludes, both Generation X and Y place high value on good leadership, opportunities for personal development and a healthy balance of autonomy and support. This they share. However, their different experiences, particularly with respect to changes in education, training and career aspirations and the organisation of work, do seem to embody differences in perspective, e.g. older employees tend to place higher value on practical experience, they also tend to believe that they are over-managed and their experience under-valued (Hudson, undated).

Arguably, the most pertinent finding from the work alighted with Generation theory is that it highlights the potential for social differences, which reflects alignment with the broader finding that different groups of employees may have different aspirations and orientations to work; this suggesting the need for organisations to consider demographic differences when configuring interventions to achieve change. However, on balance the evidence does not point to age cohort differences as a primary contrast.
6.2 Managing multi-generational teams

Managing multi-generational workplaces involves recognising that the different generations can contribute differently to teams, to the benefit of all team members, and for overall outcomes. Older workers can contribute knowledge and experience, while younger workers can contribute greater physical strength and greater familiarity with technology. Older workers are the custodians of organisational knowledge. If they work in teams with younger people they are able to share this knowledge to the benefit of their younger colleagues (CEEP 2012). However, it is important to ensure that all generations feel they are being treated equally, even if at times they are treated differently. It is also valuable to focus on issues which are important to all groups, such as work-life balance. People at different life stages want work-life balance for different reasons (young people possibly to travel, those with children to balance work and family, and older age groups who may have caring responsibilities or who are willing to trade income for leisure time. Older age groups sometimes report that work-life balance opportunities are restricted to those with young children (Pitt-Catsouphes et al 2007; Wray et al 2009).

Promotion and training and development can sometimes be sources of conflict between generations. Younger people can see older people as blocking their promotion opportunities. Older people who themselves are interested in promotion often find themselves overlooked by managers who assume that they are happily coasting into retirement (James et al 2007). Transparency over the criteria for and method of selection for promotion is potentially an important way of managing these tensions. Having conversations with all staff, including older people, about their promotion aspirations as part of the appraisal process helps to avoid false assumptions being made. Some would argue that formal succession planning can play a role as well although this is not risk free, as those who are not selected to be successors can be demotivated whatever their age (Society for Human Resource Management 2009).

In terms of training and personal development, older workers are less likely than younger people to be offered training opportunities, and are less likely to take them up when they are made available. In some cases this is because they are anxious about their ability to learn new skills, but it can sometimes reflect a view that the content and approaches involved in the development opportunities that are available are geared to the needs of younger people (James et al 2007; Wray et al 2009; Davey 2007; McNair et al 2007; Watson et al 2003). Nevertheless, investing in regular updating of employees’ skills is essential in any workplace where technology and working methods are changing (CEEP 2012). Maintaining and upgrading skills is also one of the key ways in which the productivity of older workers can be maintained (HSE 2010; Walker and Taylor 1998; Ilmarinen and Rantanen 1999; Silverstein 2008; McNair et al 2007).

6.3 Multi-generational working in the healthcare sector

The studies of multi-generational workforces within healthcare have generally focused on nurses. Traditionally nurses were over twenty and under fifty, so that there would have been
two and a bit generations in a workplace. The combination of improving health, longer life expectancy and later retirement, combined with employer initiatives to combat shortages means that there are now three generations of nurses in most workplaces, and as more nurses work into their sixties there will be four.

Wolff et al (2010) reviewed 19 studies of multi-generational nursing workforces. They concluded that there are likely to be tensions between colleagues, reflecting the fact that there are perceived differences in their attitudes to work. Both older and younger nurses work less well with colleagues who they believe do not share their values.

The sample studied in a Canadian hospital by Lavoie-Tremblay et al (2010) included 42 per cent nurses, but also included office-based staff, support staff and health professionals and technicians. They found Generation Y hospital workers felt significantly less challenged in their work than did Baby Boomers. Baby Boomers were more aware of conflict within the workplace and were less likely than Generation Y staff to regard their workplace as warm. Generation Y nurses were much more likely to be planning to quit than older nurses, and than other staff groups from their own generation, largely for career development reasons.

Sherman (2006) stresses differences in coaching style and motivating for different groups of nurses. Traditionalists like one-to-one interaction and formal instructions. They value experience in their managers and they like to have their efforts formally recognised. Baby boomers prefer collegial styles of working and peer-to-peer coaching. They too like public recognition for a job well done, but also value perks such as parking spaces. Generation X nurses are hungry for promotion, have a strong belief in merit over seniority. They do not like to be micromanaged. They value paid time off or participation in cutting edge projects over other forms of recognition. Generation Y nurses expect more coaching and mentoring. They want clear structures and guidance.

Managing teams that include these different working styles can be a challenge. Traditionalist nurses prefer one-to-one face to face communication, baby boomers prefer team meetings and Generation Xers prefer email or text. Generation Y nurses do not read much, so lengthy staff handbooks and instructions may go unread.

Sources of conflict identified by Sherman (2006) and Kuppershmidt (2006) include the perceived difference in work ethics between the generations, and the use of technology. The younger generations are less willing to work overtime or change shifts at short notice, which the older generations regard as lack of commitment. Generation X nurses can be perceived as arrogant by older nurses for behaviour that the younger nurses themselves regard as self-reliance. Younger nurses are frustrated by older nurses’ unwillingness to use technology even when it would make them more productive. Older nurses are upset by what they perceive as a lack of respect for their knowledge and experience by younger colleagues. But if these conflicts are unresolved they can lead to errors, high staff turnover and lower patient satisfaction. Focusing on mutual respect and a shared commitment to patient care are
essential if these conflicts are not to get in the way of effective working. Moreover, Kupperschmidt (2006) identifies unresolved conflict and incivility as key sources of burnout.

Recognising the unique contribution that each generation can make also helps. Traditionalist nurses are able to improvise when technology fails. Baby boomer nurses have acquired both clinical and organisational skills which they can share with younger colleagues. Generation X nurses are often able to design and implement innovative approaches to nursing care delivery. Generation Y nurses, although novices in nursing terms can coach older colleagues in how to get the best out of technology (Sherman 2006). Nurses from different generations do not need to adopt each other’s working styles, but they do need to be able to understand them and work with them, whether as a manager or a colleague (Kupperschmidt 2006).

When multi-generational teams value each other’s contributions and work together to ensure effective patient care they can be more effective than single generation teams, but this will not happen without effort by managers and colleagues.
7.0 What constitutes employer good practice for managing the implications of extended working life?

Summary

Components of good practice
Good practice relates to 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.

Workability assessment
The Finnish Workability perspective appears to offer a useful starting point, but is bounded by retaining a primary focus on individual (employee) assessment and bespoke solutions.

It is important that workability assessment is not limited to capacity to work elements, as it is likely to be perceived as threatening to employees, and risks underplaying important elements associated with the design of work, managerial practices and underpinning organisational culture. 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.

Defining older workers
The definition 'older worker' is variously used to refer to people aged 45yrs+; 50yrs+ and 55yrs+. More fundamentally, when considering policies towards older workers, chronological age is unlikely to offer the best predictor of work preferences or ability.

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.

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 which groups are at risk, from what, and in what way(s) offers the potential for a strategic approach to intervention.

Occupational health
Beyond traditional treatment and health monitoring / screening perspectives, there is a need for a more proactive approach to occupational health that embodies early intervention.
Building on established good practice, e.g. manual handing (reduction) systems, there is a need to engage with less familiar areas, such as mental health / work related stress and lifestyle-health. Proactive intervention is about managing the potential for undesired outcomes, and thereby mitigating the risks to employee health, safety and wellbeing.

The reviews by Black (2008), Black and Frost (2011) and Borman (2009) emphasise the benefits of forging closer linkages between employers and health treatment providers, advocating a more managed approach to sickness absence. Examples of how this can be achieved include, offering employees regular health screening / monitoring, facilitating early access to treatment and through employers making changes to the configuration of work, e.g. reduced or flexible hours, redeployment to alternative or ‘lighter’ roles and attention to ergonomics elements.

Lifestyle-health interventions in the workplace, e.g. physical fitness, smoking cessation and reduced alcohol consumption have potential to contribute to net gains in public health, and bring benefits to individual employees. There are claims that they do contribute to a reduction in sickness absence, but hard evidence of this is limited. They are routinely difficult to sustain and there is no evidence that they reduce early withdrawal from work. They can make a contribution as a component of a comprehensive package of intervention.

**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 individual and broader, more fundamental, levels.

**Part-time and flexible work**

Configurations of flexible working arrangements 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. There are widespread claims that flexible working, in particular reduced hours, can reduce the duration of sickness absence. Despite strong intuitive appeal, no rigorous empirical evidence was found to substantiate this. There is also some evidence that flexible and part-time working leads to increased costs to employers; and lower organisational committment amonst part-time workers.

There may be pitfalls from estimating the demand for part-time and flexible work based on employee expressed preferences, as this may not be a good predictor of behaviour, e.g. financial considerations may preclude realisation of ambitions in this area. Some health sector evidence suggests that rates of employee take-up may be low. This presents a barrier to employer capacity to predict the level and profile of demand for transition to part time and
flexible work. However, it is foreseeable that financial considerations will play a bigger role in the decisions of those on lower income.

Employers need to do more than simply offering flexible options. Many employees are unaware or uncertain of the options available to them. They may be inhibited from requesting reduced hours for fear of how their motives might be interpreted by managers and colleagues. There is considerable scope for employee misunderstanding of the implications for pensions and tax liabilities, particularly in a context where these are changing. This may inhibit take-up of options, or cause employees to make poor financial decisions. Thus, employers adopt a pro-active managed approach, for example harmonising later working life intentions and options as a formal component of established annual reviews procedures (e.g. every five years after age 45).

Training and personal development
Mirroring findings on other topics, there are grounds for concluding that 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. They have considerable discretion over determining the options available to individuals, but also have to balance meeting the needs of older workers against meeting operational performance needs and objectives of the work unit. There are also claims that line managers / supervisors are prone to fail to recognise, value, or respect, the contribution of older employees. 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.

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.

Age discrimination
Evidence on the prevalence of age discrimination by employers is mixed. A potentially important element related 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.
There are widespread claims that perspectives on older workers in human resource departments are dominated by issues of capacity to work, focused on diminished capability (cognitive; physiological; health status; skill-base and motivation) with a rather under-developed perspective on conservation in later working life.

There are widespread beliefs amongst older works regarding the presence of age-discrimination, by managers and employers. The prevalence of such beliefs is likely to impact on how older employees interpret the actions of employers, managers and colleagues towards them.

There is very little evidence on how younger cohorts view age-specific polices 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.

**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.

**Cited features of good practice**

A summary of identified features of good practice is provided in Table 1.

<table>
<thead>
<tr>
<th>Table 1. Features of Good Practice – Summary of findings</th>
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<tbody>
<tr>
<td><strong>Occupational health &amp; wellbeing</strong></td>
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<tr>
<td>Monitor demographic patterns of sickness absence &amp; presenteeism to identify vulnerable groups by job role and gather epidemiological data on known risk factors.</td>
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<tr>
<td>Management Standards For Stress at Work.</td>
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<tr>
<td>Managed approach to access to treatment &amp; rehabilitation to work - extending to individual case managers.</td>
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<td>Regular individual health monitoring e.g. for 40+ age group.</td>
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### Limit exposure to heavy & high stress work.

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### Regular individual workability assessment - using risk assessment & management principles (avoid limiting workability assessment to health elements).

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<td>Ilmarinen, 1999 &amp; 2012 Capita, 2012</td>
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### Ergonomics

- **Physical Work Environment** - Consider lighting levels, noise levels and thermal environment.
  - Australian Public Safety Commission 2003
  - Siegenthaler et al, 2008
  - Walker & Taylor, 1999
  - EHEA, 1993; NPAW, 2002

- **Job design** - Promote employee control & autonomy over their work. Reduce physical loads. Set appropriate work rate standards, production targets & workloads.
  - Costa and Sartori 2007
  - Costa and Di Milie, 2008

- **Equipment Design** - Dexterity & ease of use issues; Inclusive design; rehabilitative adaptations.

### Shift working

- Workers ages 45-50+ extend recovery periods; minimise exposure to long shifts. e.g. 12hrs; night work and rotating shifts.
  - Costa and Sartori 2007
  - Costa and Di Milie, 2008

### Flexible work

- Where possible increase availability of:
  - Hours of work
  - Part-time work
  - Flexi-time
  - Annualised hours
  - Compressed hours
  - Job-sharing
  - Home working
  - Unpaid leave
  - Special leave - e.g. for caring responsibilities
  - Phased retirement.
  - Involve employees’ representatives in devising options (all ages)
  - Mixed-age teams.
  - Survey employee views on attractive options (inc’ demographic differences).
  - Widely cited - see for example: Siegenthaler & Brenner, 2008; Tikkanen, 2012; NPAW, 2000

### Training & Development

- Equalise opportunities by age - life-long learning.
  - Walker (1999); Dworschak et al, 2006; Cedefop 2012

- Managed bespoke, individualised approach to increase participation rates.
  - Tikkanen, 2012
  - Renkema & van der Kamp, 2012
  - Davey, 2007; NPAW, 2000

- Migration of older workers to mentoring roles for younger employees.
  - Saba et al 1998
  - Lewin Group, 2009

- Opportunities for promotion (including part-time staff).
  - Saba et al 1998

- Carer change re-training options.
  - Dworschak et al 2006
### Refresher courses for returnees.

Larsen (undated)

### Train managers (in particular line managers / supervisors) in managing older worker issues.


#### Recruitment & retention

**Formal individualised (whole) career planning - linked with staff review procedures.**

Siegenthaler & Brenner, 2008
Clas & Heymans, 2006;
Walker & Taylor, 1998; Saba et al, 1998; DWP, 2013;
Philipson & Itzin, 2012;
Tikkanen, 2012; Dworschak et al 2006; Larsen 2012; Larsen (undated)
Buck & Dworschak, 2003; Smeaton et al 2012

**Collate reasons for quitting - exit interview data.**

Shacklock, et al 2005
Capita, 2012

**Embed EWL in broader equal opportunities / diversity policies.**


**Remove age barriers in recruitment procedures.**

Walker (1999)

**Focus on contextual (psychosocial & socio-technical) elements - not just (individual) capacity to work.**

Tikkanen, 2012; Ilmarinen, 2012; Clas & Heymans, 2006

**Remove redundancy options that target older workers.**

Capita, 2011

**Well-defined opportunities for horizontal moves & voluntary down-shifting - by profession / job role.**


#### Organisational Culture & Learning

**Visible senior management commitment to EWL policies.**

Siegenthaler & Brenner, 2008
Walker & Taylor, 1998

**Barometer measure(s) of employee EWL aspirations, intentions.**

Shacklock, et al 2005

**Barometer audit measure(s) of adherence to good practice.**

Philipson & Itzin, 2012; NPAW, 2000

### 7.1 Good practice – primary domains

Good practice in age management at work has previously been cast as relating to five domains: recruitment & retention; training, development & promotion, flexible working, ergonomics design and changing the attitudes of people towards older workers (Casey et al, 1999; also see Walker & Taylor, 1999), to this may be added occupational health and aspects of performance management. Research contributions in this area are multi-disciplinary, with contributions from sociology, psychology, ergonomics, economics,
physiology / biomechanics, occupational health and management science. While the literature offers examples of good practice, no single source provides what could be regarded as a comprehensive, definitive account or vision. In many respects, the amassed evidence reflects the orientations of the respective authors, tending to either focus on health, social or organisational elements. Much of the general perspective casts good practice as combating age barriers and providing equal opportunities for older workers, but there is a need to go beyond this. A further limitation is that many sources limit comment on good practice to the level of principle, e.g. improving communication with employees; redesigning tasks so that they are less physically demanding, increasing the range of flexible working options. While there is value in this, what is routinely missing is detail on the specifics and practicalities of how this might be achieved.

A focus on older workers risks masking elements of good practice relevant to employees of all ages (see, for example, Walker & Taylor, 1999). In order to take account of this it has been necessary to expand the scope of the evidence reviewed beyond that dedicated to older employees, to consider elements of good practice identified within broader literatures on wellbeing and working life.

In some areas good practice represents the absence of poor practice, or practices that lead to poor outcomes, and not necessarily just for older people, for example, job-stress and musculoskeletal disorders and the unpopularity of certain shift patterns represent casual influences in the early exit of employees of all ages (see, for example, Tikkanen, 2006; Pisarski et al., 2006). These are discussed in Sections 4 and 5 above. For these reasons this section will also make reference to poor, weak and unhelpful practice and its impacts.

Pausing to consider the definition 'older worker', variously, sources peg the point of transition at 50yrs+ (Watson et al., 2003), others at 55yrs+ (EU Lisbon benchmark) and the Nordic nations at 45yrs+. An observation is that the phrase is now applied to people formerly referred to as 'middle aged' (Tikkanen, 2006). More fundamentally, when considering policies towards older workers, it needs to be born in mind that chronological age is unlikely to offer the best predictor of work preferences or ability. Older workers are a very diverse group; "There is a large overlap in the capacities of different age groups... there is more difference within age groups than between them." (Anderson, 1993).

The scope for good practice is extensive, encompassing aspects that relate to: employee motivation / lifestyle preferences; the design of work (including options available to employees); human resource (recruitment / retention practices); occupational health, (sickness absence / rehabilitation and lifestyle issues) and communication with employees, as well as fundamental aspects relating to organisational learning and cultural change. Reflecting on contemporary practice, Walker and Taylor note "There is a continuum of [employer] good practice, stretching from very limited narrowly focused measures to more comprehensive ones." (Walker & Taylor, 1999). Moreover, there is a strong consensus that good practice is more than a series of ad hoc themed initiatives, it requires a significant reorientation, leading to embedded cultural change in employer policies and practices. However, "... there is no blueprint for the way forward... Each community and organisation
must find its own pathway, based on dialogue with stakeholders, listening in particular to the views of the older workers themselves.” (Tikkanen & Nyham, 2006; also see DWP, 2013).

The generalisability of many of the identified features of good practice to all employees is valuable, in so far as this embodies the potential to reduce the scope for stigmatisation and resentment of older workers as well as challenge on grounds of inequity / positive discrimination.

7.2 Occupational health

The Borman review contains extensive articulation on the features of good practice in managing occupational health within the NHS (Borman, 2009). The conclusions and recommendations of that review are endorsed by the current authors. Rather than repeating this, the content of the following section seeks to complement them through a focus on older employees and a broadening of the perspective on prevention.

Widely encountered stereotypes of older workers tend to focus on diminished capacity, in terms of cognition and physical ability (see Saba et al, 1998; Griffiths, 2000; Tikkanen & Nyham, 2006; Weyman, 2009; Formo-Bernstein, 2013). However, the overwhelming evidence from the many reviews and meta-analyses of older workers and work performance is that, overall, they perform as effectively as their younger counterparts (Anderson, 1993; Griffiths, 2000; Park and Reuter-Lorenz, 2009; Salthouse, 2009; Peeters and van Emmerik 2008; Yeomans 2011; Benjamin and Wilson 2005; Bohle et al 2010; Crawford et al 2010, 2009; Warr 1994; Salthouse 1997; Hjort 1997; Mitchell 1990). This is discussed in Section 4 above.

In terms of cognitive ability, while laboratory studies have produced measurable declines, the balance of evidence is that effects are slight and offset by experience and well honed skill sets, to the extent that there is no appreciable decline in job performance (Warr, 1994; Warr & Birdi, 1998; Peeters and van Emmerik 2008; Ng and Feldman 2008; Yeomans 2011; Benjamin and Wilson 2005; Bohle et al 2010; Crawford et al 2010, 2009). For the majority serious decline in memory or intelligence is not apparent until 85ys+ (Murray & Syed, 2005). While there is evidence of a slowing of reaction time with age, this has a marginal impact on performance (typically fractions of seconds) in most real world contexts. Moreover, as Griffiths notes; “In the absence of any hard evidence of a relationship between age and work performance, except in certain well-defined jobs, organisations may have a hard time defending any discriminatory policies and practices.” on the basis of diminished cognitive ability (Griffiths, 2000).

Some degree of decline in physical capacity occurs with age, tending to become manifest from the mid-60's onwards but, as with cognitive abilities, impacts are counterbalanced by experience and maturity (Bartel & Sicherman 1993, or offset by allowing longer recovery times (Griffiths, 2000). An importation important factor however, is that older employees have a higher incidence of musculoskeletal issues, attributable to past exposures, as well as the potential for developing age related conditions (Peeters and van Emmerik 2008; Crawford et
al 2010; Bohle et al 2010; EUMusc.net 2011; MacInnes et al 2009). As Rose notes, "Degenerative joint disease is a major source of disability from the mid-50's" (Rose, 1993). Notably older employees have historically been exposed to intrinsically higher-risk manual handling practices. Given the high incidence of musculoskeletal injury within the health care sector leading to early withdrawal, particularly amongst nursing staff, there are also grounds for viewing older employees as constituting a survivor population.

Despite claims to the contrary (Waddel & Burton, 2006), there is strong evidence that, as a sub-population, older workers exhibit higher rates (annual days lost) of sickness absence than their younger counterparts (HSE, 2005; ONS, 2012). This is discussed in Section 5 above. However, what headline figures disguise is that the patterns of absence for older workers tend to be different, in so far as periods of absence may be less frequent, but where they do occur they tend to be of longer duration. Nonetheless, comparisons of absence by age are complicated by the fact that older employees represent a survivor population, those forced to withdraw from work due to ill health are simply not there.

It is well established that ill health represents a primary, if not the primary, cause of early withdrawal from employment. International studies show rates as high as 46% (Schofield, 2008).

It is clear is that musculoskeletal disorders and mental health issues, in particular psychological stress, represent the headline causes of absence and early withdraw from work across the age range (HSE, 2012), with cumulative effects from extended exposure being concentrated amongst older workers (Dworschak et al, 2006). Studies have found this to be true for NHS staff as well (discussed in more detail in Section 5). As Griffiths notes, both are strongly associated with the way work is designed, organised and managed and highlight the need to design work to fit human capability and capacities (Griffiths, 2000). To this can be added employer policies and practices towards older workers (Vickerstaff, et al, 2003; van Dalen, et al, 2008). "If workers are required to perform work under adverse conditions on a permanent basis, they will almost inevitably encounter health and performance problems as they grow older." (Dworschak et al, 2006).

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 (Bongers et al 1993; Theorell & Karasek 1996) hence, many of the features of good practice discussed in this section are applicable to workers of all ages and do not need to be labelled 'older worker policies' (also see Walker & Taylor, 1999). Further age related challenges in the health care delivery context have been ascribed to the ageing patient population, which, against a background of budgetary constraints, has been said to “… lead to a rising intensity of work, which in turn creates rising rates of absence due to exhaustion and sickness amongst those employed. These trends are visible in the exit patterns found in the hospital.” (Olofsson, 1993).

While paid employment can be an important source of health gain, e.g. in terms of activity, self-esteem and social contact, it is important that this constitutes 'good work' (see Black, 2008) as work has traditionally constituted a major contributor to ill health and disability
Extending Working Life
Audit of research relating to impacts on NHS employees

(Walker, 2005). Reporting on health sector workers in Sweden, Olofsson reports: “The group who has early retirement due to disability is very large and almost as large as those who retire at statutory pension age.” (Olofsson, 1993).

Additionally, there is a need for employers to engage with the implications for capacity to work attributable to non-work related ill health and disability. “Unless the factors which limit workability are mitigated... then it will not be possible for active ageing to be achieved... nor will the ageing workforce become a reality” (Walker, 2005). If the work-related risks to employee health are effectively controlled and/or suitable adjustments made to the way in which work is configured, then this will increase people’s capacity to work, and likely their disposition to extend their working lives.

A prevention orientation
Beyond traditional treatment and health monitoring / screening perspectives there are calls for a more proactive approach to occupational health that embodies early intervention, attempting to change the natural or prevailing order of things, whether this be in established domains, such as manual handing (reduction) systems, or in newer, less familiar areas, such as mental health / work related stress and lifestyle-health (see Borman, 2009). Proactive intervention is about managing the potential for undesired outcomes, and thereby mitigating the risks to employee health, safety and wellbeing (see, for example, Ilmarinen & Rantanen, 1999; Kilbom, 1999). Achieving this requires effective data capture within an evidence-based perspective (Black, 2008; Weyman, 2012).

All large work organisations benefit from a wealth of human resource related data. However, an observation is that the type of data that predominates tends to be focused on outcomes rather than causes, e.g. sickness absence, accident and injuries by type, labour turnover rates, and similar. In some cases this is supplemented by surveys of staff attitudes. In each case the product routinely tells us more about ‘what’ and ‘how much’ than ‘why’. ‘Why’ elements are key to organisational learning to inform the design of effective interventions to achieve change and improvement. Much of the human resource data that organisations collect is not well suited to interrogation to identify patterns of workforce behaviour and, in particular how this relates to the design of work, working practices and impacts on staff.

The Black review ‘Working for a healthier tomorrow’ (Black, 2008) and the subsequent review of Sickness absence (Black & Frost, 2011) called for a paradigm shift in employers’ approach to occupational health. What was asked for was for employers to engage in a more managed approach orientated around prevention, to supplement the traditional treatment perspective. Prevention, in the sense of identifying and, where possible, reducing the risk of injury or ill health and mitigation of consequences to individuals, e.g. proving access to rehabilitative treatment, combined with adaptations to the design of work (see Macdonald & Santani, 2010; WHO, 2011). The realisation of this vision requires consideration not only of individuals but an epidemiological perspective on the potential for harm, an essentially more strategic approach, based on discovering which groups of individuals are potentially exposed to harm, the nature of that harm and finding ways to
mitigate this, either by reducing it at source or by motivating some change in behaviour of those at risk, or those who place others at risk.

At the level of the individual, good practice might involve regular assessments of workability, embodying elements not only relating to capacity to work but also psychosocial aspects associated with employee preferences and perceived capacity to cope with job demands. The Finnish Workability perspective appears to offer the most advanced and embracing model in this respect. Beyond elements arising from biological ageing, proponents emphasise the need to consider aspects relating: lifestyle, disease and work design, and interactions between these variables, i.e. lifestyle, work and ageing impact on the severity of disease. In the absence of disease, lifestyle and work affect, indirectly, the rate of ageing. The presence of disease modulates lifestyle and work, and may influence ageing and both disease and ageing modify lifestyle (see Ilmarinen et al, 1991).

A limitation of the Finnish model is that it remains fundamentally focused on the individual and essentially represents an extension of the attrition model, based on reduced capacity / reduced motivation. The perspective on change is essentially limited to adjustments to working hours, ergonomics solutions and redeployment. However, later iterations of the concept do, usefully, include consideration of psychosocial and socio-technical elements, e.g. social support and team working. They also include a workability index, said to embody the capacity to predict early retirement in individuals and, in aggregated form, demographic patterns within work organisations (Ilmarinen et al., 1991 and 1997; Tuomi et al, 2001).

It is important that the auspices and character of workability assessment of this type is not limited to capacity to work elements, as this is likely to be viewed as a threat by employees. It also risks underplaying important elements associated with the design of work, managerial practices and background culture (Griffiths, 2000).

A growing body of authors argue that it is necessary to take the perspective beyond the individual, and beyond outcome data (ill health, accidents, labour turnover etc.) to a focus on precursors and root causes (potential for unwanted events). The peaky, chance related profile of outcome data tells little about the latent potential for such events, or how well risk management measures are functioning. Many organisations lack good quality feedback on their performance in this area. Even in traditional high investment areas (lifting technologies and staff training) such as manual handling, most organisation have few active measures of the effectiveness or status of solutions, still less in the area of psychosocial elements that impact on employee wellbeing, in particular work-stress.

Organisations need effective measures of the potential for harm, e.g. via staff surveys or point of work audit data, and other complementary indices, to identify precursors (essentially symptoms) that provide early warning of emerging issues. Authors from this perceptive argue that quite a lot is known about the causes of ill health and other influences on employee wellbeing (see, for example, Cox et al, 2003; 2007; 2009). In essence, an epidemiological approach is advocated that embodies effective data capture systems that identify and monitor (a) known challenges to employee health and wellbeing and (b)
organisational performance in mitigating these, that can be interrogated to identify, demographically, who (which groups of employees) are at risk and in what way(s). For example, Watson et al, 2003 point to high vulnerability amongst mental health nurses. It is this type of thinking that underpins the Health and Safety Executives Management Standards approach for dealing with work-related stress (HSE, 2013; Bond, et al., 2006; Yarker et al., 2007).

While retaining the familiar job-demands-control-support model of work-stress (see Theorell and Karasek 1996), the focus is on identifying causal influences and vulnerable groups of employees within a given organisation, department or profession -e.g. by job role, function, age, or gender. The focus on vulnerability reflects alignment with the risk assessment / control model that is established within the safety-risk domain. Solutions essentially relate to job-redesign to reduce exposure. A claimed strength is the capacity to highlight early warning demographic ‘hotspots’ of high risk employees (see Cox, 2009). However, some authors have suggested that to be applied effectively this type of approach needs to be applied on a broad front, rather than to a single issue, such as occupational stress (see Biron et al., 2012).

The adoption of an epidemiological risk-based perspective to inform evidence-based approach to organisational learning and intervention represents a significant reorientation of traditional perspectives on occupational health. Adopting such approaches reflects alignment with the workability concept (see Finnish National Programme on Ageing Workers, 2000). Examples of organisations utilising such approaches are countered, but remain an exception rather than the rule (Weyman, 2012).

**Sickness absence & rehabilitation**

As noted elsewhere, on average older workers exhibit higher rates of sickness absence (days lost) than their younger counterparts. Gender differences are also apparent, with women exhibiting higher rates than men, even when account is taken of their higher involvement in caring responsibilities (HSE, 2005; ONS, 2012). Given other evidence of differences in patterns of absence by age, notably the longer duration of periods of absence amongst older workers, this might reasonably be taken to highlight the need for timely access to treatment and attention to rehabilitative elements. "*Employers have significant scope to facilitate early return from sickness absence.*" (Black, 2008). The reviews by Black (2008), Black and Frost (2011) and Borman (2009) emphasise the benefits of forging closer linkages between employers and health care providers, advocating a more managed approach to sickness absence. Examples of how this can be achieved include, offering employees regular health screening / monitoring, facilitating early access to treatment and through employers making changes to the configuration of work, e.g. reduced or flexible hours, redeployment to alternative or ‘lighter’ roles and attention to ergonomics elements.

The recently introduced *Statement of Fitness for Work* (‘fit-note’) system for General Practitioners, focused on capacity to work, rather than incapacity, reflects this thinking (see DWP, 2010). Black (2008) cites the need for employers to take a proactive approach through initiating engagement with General Practitioners, with a view to informing decisions
on capacity to work and necessary changes in the workplace and proving access to specialist treatment, (e.g. physiotherapy, occupational therapy, cognitive behavioural therapy and counselling). While there are claims of good practice in the area of facilitating access to treatment, it seems clear that linkages between employers, General Practitioners, and specialist health service providers are frequently weak (Wainwright, et al., 2011; Lalani et al, 2012). Strengthening such links has intuitive appeal and the potential to bring benefits to employees and employers. The absence of detailed guidance aimed at employees on what constitutes good practice likely represents a notable barrier to change in this area.

A core element of the Black review is its focus on claimed benefits arising from early intervention and the need for a holistic approach that extends beyond traditional perspectives on biological aspects of health to consider psychosocial elements, i.e. impacts on mental health and wellbeing as well as wider elements, such as home and family life. To achieve this, the review provides recommendations for the assignment of individual case managers, combined with suitable training and education of line managers (Back, 2008).

**Presenteemis**
While disposition to go to work when ill likely reflects individual differences, cultural norms and organisational climate are also important, in particular absence management policies. (Rosvold & Bjertness, 2001). Linkages have also been found with job (in)security (Bevan, 2011); work overload / control (Gupta and Beehr, 1979); high levels of stress and low social support (Winslow et al., 2009). Notably, these findings indicate more consistent correlations with presenteeism than absenteeism (Caverley et al., 2007).

In terms of good practice, and the general (low) profile of presenteeism as an issue, there is a case for suggesting that organisations should develop measures of its prevalence, that embody the capacity to examine demographic differences by job-role and function in a manner mirroring that outlined in elsewhere in this section. However, although care would be needed in configuring these if respondents are to feel confident in reporting. Preserving anonymity would seem to be a prerequisite. Attention should also be paid to normative influences at the level of the work-team, department and organisation as a whole, including aspects of leadership / management style, particularly at line management level, as well as the broader approach to sickness absence management within the HR function. Linkages are also apparent with the concept of individual (ill health / absence) case managers, as employees with on-going health conditions tend to be particularly prone to presenteeism (HSE, 2005).

**Lifestyle health**
In addition to advocating a more managed employer led approach to sickness absence, the Black review also highlighted the role of lifestyle health issues, notably smoking, obesity, alcohol consumption and physical fitness and their role in capacity to work. The concept of ‘active ageing’ emphasises the linkage between activity and health and employer contributions to healthy ageing (WHO 2001; Borman, 2009), i.e. poor health limits activity (which is a major factor in early retirement); equally, activity makes an important contribution to health. It is this area which appears to represent the most enduring legacy of the Black
review, in so far as a large number of employers have developed initiatives aimed at changing lifestyle choices and behaviour.

Workplace health promotion activity is fairly widespread, particularly amongst larger employers. Potential benefits to employees, their dependants, society and health services are fairly transparent. Claimed benefits to employers include reductions in sickness absence and enhanced organisational commitment (Black, 2008). However, despite intuitive appeal, and some extravagant claims within the grey literature, there is no strong independent evaluation evidence to substantiate linkages with reduction in sickness absence (Marlow, 2008; Crawford et al, 2010). Although there have been evaluation studies many have been small scale and qualitative. This could reflect difficulties in demonstrating cause and effect in a relatively hostile real-world experimental environment, but equally may reflect their modest impact. Lifestyle health initiatives and interventions have a role as a component of a broad based occupational health strategy, but where they come to represent the limits of a proactive approach on the part of employers they are unlikely to make a significant contribution to reducing the headline (musculoskeletal injury and stress) causes of ill health and health related retirement.

The popularity of lifestyle health interventions in the workplace likely owes much to the relative ease with which they can be configured, and their modest implications for resources. Common experience is that they are generally difficult to sustain.

7.3 Ergonomics

Ergonomics (otherwise referred to as Human-factors) is the science of how human beings interact with technology and social systems, it is an amalgamation of social and physical science disciplines spanning engineering, anatomy / biomechanics, psychology, sociology and management theory. As a discipline its boundaries are not easily defined, however, within health care settings it is most commonly encountered in the areas of equipment design e.g. manual handling aids, computer workstations, systems to reduce human error e.g. labelling and safety signs; design of personal protective equipment and aspects of staff training e.g. manual handling.

The potential contribution of the discipline is broader than this, notable in the current context with respect to the design and layout of the built environment as well as workspaces and associated technologies. Relevant aspects of the built environment include physical design: stairs and ramps and, in particular, accessibility as well as thermal environment: cold, damp, heat; and sensory aspects: acoustics, lighting, comfort and communication (Abbott, undated).

Philosophically, Ergonomics complements, but represents an inversion of perspectives that focus on the selection and assessment of individuals to fit them to a given role in the workplace (fitting the person to the task). Rather, its primary focus is on designing work to fit the capacities and capabilities of human beings (fitting the task to the person), and aiming to
achieve this in ways that are socially inclusive, i.e. designing systems that can be used by people with a wide range of (primarily cognitive and physiological) abilities and disabilities.

The strong design focus of the discipline reflects its focus on prevention of harm and maintenance of wellbeing, as such it is closely aligned with the broader risk management perspective (see HSE 2013; Walker, 2005).

The need to address ergonomics issues has been given a high profile with far reaching implications by some authors, for example: “... designing work to fit human capability rather than hope the humans will fit the workspace. The science and practice of ergonomics is fundamental to workplace design and allowances for adjustment for ageing should be built in wherever possible.” (HEA, 1993; p.51). It is perhaps notable that this statement was made 20 years ago, and while it remains valid, the intervening period has seen perspectives on ergonomics practice diminish to a point where it is most commonly encountered in the UK in the restricted contexts of equipment design and manual handling. The profile of ergonomics within the Finnish perspective on workability appears to be more closely aligned with the HEA vision (see Ilmarinen & Rantanen, 1999; National Programme for Ageing Workers, 2000). It is important to keep in mind that attention to ergonomics elements can bring benefits to individuals, as part of a bespoke package that facilitates rehabilitation or diminished capacity, but its more fundamental potential contribution relates to increasing inclusiveness in the design of broader technologies and environments (see, for example, King Rogers, 2011; Perry, undated). In many instances, designs that are of good fit with the capacities and capabilities of older workers will tend to bring benefits to the wider population, including those with disabilities, in terms of ease of use, reduction in the likelihood of error, reduction in the potential for injury (see, for example. Sargeant-Matthews, 2005). The Australian Public Safety Commission (2003) has produced a checklist of strategies and activities when considering design for ageing workforce (Figure 1).

7.4 Shift working and long hours

Amongst employees of all ages, while a minority appear to prefer (usually fixed) shifts, a more general finding is that shift working is unpopular, and rotating shifts the least popular, due to the disruptive influences on social and family life. Sleep disruption and other physical and psychological influences have long been recognised (see, for example, Costa & Di Milia, 2008). However, shift working remains a reality for organisations that operate on a 24/7 basis. Some of the more disruptive aspects of rotational shifts can be mitigated by adherence to good practice, in particular the direction of rotation. (see Folkard & Tucker, 2003).

Figure 1: Checklist of strategies and activities when considering design for ageing workforce  Australian Public Safety Commission 2003

<table>
<thead>
<tr>
<th>Improve work task design</th>
<th>Improve job design and work organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>· Promote employees’ control over their work depending on agency</td>
<td>· Avoid monotony, short cycle</td>
</tr>
</tbody>
</table>
needs and employee preferences.
· Reduce physical loads.
· Ensure good visibility of task-related information.
· Improve posture.
· Set reasonable work rate standards, production targets or workloads.

times.
· Improve work scheduling.
· Allow flexibility in taking rest breaks.
· Allow individuals time to adapt to new tasks.
· Support flexible employment conditions.

Improve the physical work environment
· Minimise glare.
· Ensure good lighting levels.
· Minimise noise levels.
· Eliminate hazards that may cause slips, trips and falls.
· Make allowances for working in heat.

Support and improve people’s performance capacities
· Develop best practice performance standards.
· Improve training programmes
· Develop and maintain support systems.
· Improve employee morale and expertise.

Contemporary shift working practices in the health care sector have been cited as an important influence on intention to quit (see, for example, Pisarski et al, 2006). These authors provide evidence that suggests that tolerance of shift working diminishes as people get older. Watson et al (2003) attribute the higher age profile of community nurses and health visitors to these roles representing a refuge from shift working. However, there is evidence that compressed hours, or continuous nights remain attractive to some, where such arrangements are of good fit with non-work commitments, e.g. caring responsibilities (Lewin Group, 1999).

Monk et al (1997), report negative age-related impacts on alertness and performance efficiency depending upon the duration of the previous waking period. An apparently complementary finding is provided by Ell, who reports positive impacts on the performance of older employees within the German road transport sector arising from increasing employee recovery time by switching shift patterns from five days ‘on’ one ‘off’ to four days ‘on’ two ‘off’ (Ell, 1993). By contrast, other findings point to greater negative performance impacts on younger employees, this being attributed to a greater need for deep sleep (Boourdouxhe et al, 2010). However, these authors go on to note that while the rhythms of older people allow them to fall asleep more readily, they are more prone to disrupted sleep. There is evidence that working long hours / extended shifts is associated with higher incidence of ill health. Kivimaki, for example, reporting on findings from the Whitehall studies have shown that employees who regularly work 11 hour days or longer are 67% more likely to develop heart disease than those who work seven or eight hour days (Kivimaki, et al, 2011). This represents a general finding, rather than an older workers issue per se, however, such findings should perhaps be considered in the light of evidence that older workers need longer recovery times (Griffiths, 2000; Costa and Sartori, 2007). Reporting on a study of older NHS employees, Brownhill found: “... staff reported higher feelings of being worn-out than groups outside the health service.” Brownhill (1993).
Although not universally the case, shift patterns in industry tend to follow regular set patterns, are routinely coordinated centrally by the HR function and follow accepted good practice, in order to minimise impacts on employee performance and wellbeing, in particular minimising disruption of sleep patterns, with adequate recovery times. Common experience is that the arrangement of individual employee shift patterns within health care sector tends to be devolved to intermediate management grades, notably amongst nursing and basic care staff. This may increase the scope for deviation from good practice. It is important that those charged with the organisation of staffing are trained in the principles of good practice in shift pattern design. As on other issues, the potential adverse effects on health and wellbeing is relevant to all age groups (see Boourdouxhe et al, 2010).

7.5 Flexible work

The issue of flexible working has been discussed in some detail in the context of decision making over extending work life / retirement in Section 3, but will be elaborated on here in the context of employer good practice.

Accounts of employee preferences for flexible, in particular part-time, working options are widely encountered, and are variously said to relate to work-life balance preferences, maintaining income in later life, reduced exposure to the stresses of work and caring responsibilities outside of work (see Smeaton, 2012). The principal barrier to the realisation of these ambitions appears to relate to restricted opportunities in the workplace and diminished health status (Siegenthaler & Brenner, 2008; Armstrong-Strassen, 2008; Smeaton et al, 2012). However, "... notwithstanding the power of employers... there is a gap in the literature concerning employment arrangements that would be attractive to people choosing to remain in or re-enter the workforce." (Shacklock et al, 2007).

There is also a danger of over-interpreting what might at first sight present as an alignment of employee and employer attraction to flexible working, as the use of common terminology in this area can obscure significant differences in perspective. Employers tend to be attracted to the opportunity to align staffing levels with fluctuations in the demand for their goods and services, whereas employees are seeking arrangements which fit with their lifestyle choices, health or social needs (Weyman, 2009). A number of authors also point to a dislocation between the way that jobs have traditionally been configured and the preferences and needs of significant segments of the workforce: older workers, young parents and disabled people (see, for example, Armstrong-Stassen, 2008). Moreover, while almost all studies of older employees cite the central importance of flexible working options, it has been observed that; "What is missing in the body of social science research across the board are solid organisational studies that would delve into the full complexities of workplace and human resource arrangements that either remove or hinder greater flexibility [in policies and practices] for older employees.", giving rise to the conclusion that: "There remains a great shortfall of organisational research when it comes to alternative work schedules for older employees." (Siegenthaler & Brenner, 2008).

The finding that flexibility is both attractive and seemingly particularly important where
employees experience diminished capacity, remains under-evidenced in terms of the practicalities of arrangements that might be configured and the types of arrangement that might be feasible in a given employment sector.

Configurations of flexible working arrangements identified within the literature 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 onerous / 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. Some of these are discussed in Section 4.

Beyond employee lifestyle preferences and non-work commitments, the opportunity for flexible working, in particular reduced hours, is widely claimed to reduce the duration of sickness absence and increase the likelihood of return to work (see, for example, Kilbom, 1999). Despite strong intuitive appeal, no rigorous empirical evidence was found to substantiate these claims. Again, arising benefits are said to generalise to workers of all ages, but might be considered to be of particular relevance to older employees in view of their higher likelihood of exhibiting longer spells of sickness absence and progressive (ill)health conditions.

While the Department for Work and Pensions has attributed the limited availability of flexible working arrangements to employer myopia; "Many aren't aware that part-time and flexible working are key to helping many older workers stay in the labour market..." (DWP, 2013), others point to more fundamental barriers, notably the perspective that such arrangements, (in particular part-time working), increase costs (Sandwell, 1987; Rosen & Jerdee, 1990), which may explain why many organisations choose to out-source (sub-contract) their flexible working needs (Siegenthaler & Brenner, 2008).

However, the issue of the additional cost of part-time working is complex, and studies have reached different conclusions depending on whether they look at costs per employee hour or overall labour costs to the organisation. This is because there are clearly costs related to headcount (payroll, supervision, training, appraisal) which make part-time workers more expensive than full-timers per hour worked (see, for example Edwards and Robinson 2004; Golden 2011; Elias 1990). There is a small offset to employers' national insurance contributions, where each worker is entitled to the contribution-free lower threshold. But this is would not offset the full extra cost.

At an organisational level, there is evidence that part-time workers can lead to a reduction in overall labour costs for the same output and an increase in output per worker. This is because some studies have shown that part-time workers tend to have higher hourly output (Golden 2011; Kunn-Nelen et al, forthcoming; Elias 1990; Cataldi et al forthcoming). There are several routes by which this higher output per hour is achieved. Golden (2011) reviewing a wide range of evidence suggests that these fall into two groups: those related to better organisation of work, and those related to better employee motivation. An example of better
organisation of work is the Study by Nelen et al (forthcoming) of community pharmacists in the Netherlands. Pharmacies using part-time staff were able to process more prescriptions per worker hour than those that employed mainly full-time staff. This was because they were better able to match staffing levels to busier and less busy times during the week. Another suggestion in the literature is that worker performance tends to deteriorate during a working day. Thus, those who work shorter days tend to have higher output per hour than those who work longer days. As discussed in Section 4 above, there is evidence that long shifts in healthcare are associated with higher error rates (Keller 2009; Poissonet and Veron 2000; Rogers et al, 2004).

The other potential sources of reduced costs from part-time working reflect better employee wellbeing and motivation. These lead to better motivation and commitment, less stress, better retention rates and lower rates of sickness absence (Golden 2011). These effects are found in a wide variety of sources. The most recent CIPD survey of managers found that (CIPD 2012) found that three-quarters of managers reported that flexible working resulted in better retention while only 3 per cent reported lower retention rates for part-timers. Similarly 72 per cent reported a positive effect on employee engagement and only 4 per cent a negative effect. Edwards and Robinson (2004) in a study of nurses found managers reported better retention of mature staff, better matching of staffing levels to demand peaks, less absenteeism and harder work. A UNISON survey has found a reduction in sickness absence from 12 per cent to 2 per cent among those who worked flexibly (UNISON 2008). The KingsFlex scheme at Kings College Hospital, which allows staff to choose from a variety of flexible work options is one of the methods it is using to reduce sickness absence (UNISON 2008). Employees report that the ability to work part-time enables them to make more sensible lifestyle choices and reduce the amount of time they take off work sick (CIPD 2012).

The costs of failing to retain experienced staff are high, although soundly-based empirical estimates are rare. The most widely cited authority is Fair (1992). This estimated that the costs to an organisation of replacing an experienced employee comprise advertising costs, management time in processing both departures and recruitment, training costs, lost output or temporary staff costs during a vacancy period, and lower initial productivity of a new recruit. In total these are estimated to come to around six months’ salary. This figure has since been frequently cited by CIPD and most recently confirmed in a report by PricewaterhouseCoopers (2010). Other estimates are higher. UNISON (2008) suggests up to two years’ salary, but without indicating the source of the estimate. Golden (2011) found some studies citing up to eighteen months’ of salary costs. One of the challenges is that like is not always being compared with like. Thus most studies (and most organisations) identify advertising or agency costs, and many can identify management time and the costs of temporary cover. Some can identify training costs. However, only a small minority can identify the time it takes for a new employee to be as effective as the one they replaced (ie to make a full contribution to the output of the organisation) or the impact that a less productive new recruit has on the productivity of other members of staff with whom they work (eg by slowing down the work of a whole team).

In the absence of alternative robust evidence, most organisations rely on the estimate of
recruitment costs derived from the regular CIPD surveys of HR managers. For example, the Macinnon Partnership (2010) study for Skills for Health uses this figure in estimating the cost of turnover to the NHS (£5,800 per recruit). However, the published CIPD figure only includes immediate direct costs (advertising, management time involved in processing applications), since three-quarters of their survey respondents do not estimate the fuller costs (CIPD 2012a). A much earlier (but still authoritative) study of NHS recruitment and retention costs (Audit Commission 1995) found that recruiting a replacement NHS staff member cost around £5,000 at the time (which would be around £9,000 at current salaries). This was around a third of the average salary costs. The typical new recruit is only 60 per cent effective, and does not typically reach the same level of output as an experienced staff member until they have been in post for around a year. The direct costs of recruitment (advertising and temporary cover, the sort of items included in CIPD figures) accounted for only about a fifth of the total cost. Subsequent estimates by the Department of Health suggest that the true cost could be up to 114 per cent of salary (Harding 2004).

The estimates found in the literature vary from 32 per cent of salary costs to up to 200 per cent. The lowest figure from the 1995 Audit Commission report is solidly based, but is acknowledged not to include the cost of the lower productivity of new recruits. A reasonable working assumption would be that the true cost of failing to retain experienced staff in the NHS lies somewhere between the 32 per cent Audit Commission figure and the PricewaterhouseCoopers 50 per cent figure. Given that part-time staff have retention rates, there is clear potential for savings which can offset the higher costs.

The median cost of sick pay per full-time equivalent employee in the NHS in England is around £1500 a year, with a range from around £700 to around £2,700 (Audit Commission 2011). In addition to sick pay costs, the cost of replacement temporary staff adds roughly 60 per cent to the cost of the salary paid to the individual who is off sick. This would bring the total to around £2,400 per full-time equivalent employee with a range between £1,000 and £4,250. For NHS organisations with sickness absence costs in the upper part of the distribution, a reduction in sickness absence by, say, a third (which is the target suggested by the Borman review) as a result of a move to part-time working would probably be sufficient to offset the additional overhead costs of a higher headcount.

There are some studies that provide support for the argument that the beneficial effects on work organisation, employee motivation, absenteeism and retention are enough to offset the higher hourly costs of part-time workers. These studies focus on organisational performance. They have found either small positive impacts on both whole organisation productivity and financial performance or no impact either way (Bloom and van Reenen 2006; Nadeem and Metcalf 2007; Whitehouse et al 2007). These studies do not seek to identify which of the above factors (extra hourly costs, organisational benefits or employee benefits) might be driving a link between flexible work and observed outcomes. Thus, they do not provide direct evidence of either the extra costs or the potential offsetting savings. Rather, they look at the availability of flexible work and the observed organisational outcomes. Bloom and van Reenen (2006) stress the association between flexible work and good management more generally, suggesting that managers who organise work well, including having flexible
workers among their employees, have better performance on a range of indicators. But the conclusion of all the studies taken together seems to be that the higher hourly costs of part-time workers are offset by better matching of staffing levels to peaks and troughs in demand, higher hourly productivity, better retention rates and less sickness absence. Thus the costs to the organisation as a whole are either neutral or slightly lower than where full-time workers alone are used.

In grappling with the difficult to evidence issue of impacts of flexible working on staff performance, Saba et al, in a study of public sector workers in Quebec, report: “Surprisingly, older workers who seek flexibility in working conditions and flexibility in retirement are those who feel less committed to the organisation, who were poorer performers and who were less satisfied with their job.” These authors go on to conclude that “Providing older workers with flexibility... encourages older employees disengagement with the organisation.” (Saba, et al, 1998). The significance of this study is that it appears to be one of very few that takes the issue of flexible working, beyond exploring employee preferences, to impacts on behaviour. In doing so, at initial encounter, it casts a shadow over the attractiveness of the concept. These findings give rise to a number of observations. The authors report an association between part-time working and reduced engagement; from this they infer that the former causes the latter. However, from what can be deduced of the evidence they gathered, it seems equally possible that the converse could be the case, i.e. would it really be ‘surprising’ that employees who are less intrinsically engaged with work seek to minimise their exposure to it and, as a consequence, this sub-group over-represents amongst part-time employees?

Part-time work options appear to be fairly widely available, however in most sectors this embodies downsizing not just in terms of working hours but in terms of status and stability of contractual arrangements. The general perspective is that opportunities that allow people to maintain their established job role / status (which is what most individuals desire) is limited, although more widely available within the public sector, and with some established tradition within the NHS, particularly amongst those who have historically had pension options at 55yrs, e.g. staff with Mental Health Practitioner status (see Smeaton et al, 2012).

Numerous authors suggest that employers demonstrate only a lukewarm commitment to increasing opportunities for flexible employment arrangements beyond part-time work. "... flexible schedules toward retirement will not produce real changes unless management becomes more committed to such changes and they are securely embedded in company policies” (Siegenthaler & Brenner, 2008; also see Armstrong-Stassen, 2008; Rosen & Jerdee, 1990).

Sociologists, in particular, tend to cast increasing the availability of flexible work as the solution, to the extending working life (EWL) agenda. While it is clearly attractive to many employees it is likely to remain the case that "... high quality flexible working may only be open to a relatively limited number of occupational groups." (Philipson and Smith, 2005).

A notable challenge for employers rests with: forecasting patterns of later working life and likely retirement age of their employees; how this might vary by job role and function and the
impacts of changes in employment options on this profile, e.g. the impact of increasing flexible working options, by type. The evidence base in this area, as on other EWL issues, is focused on eliciting peoples later working life ambitions, i.e. what they would like to do in the future. It is foreseeable that these ambitions (attitudes) may not be strong predictors of behaviour (see Wicker 1969).

Evidence of later working life behaviour amongst health sector employees is mixed. For example, Craegmoor Health reports increases in numbers of over 60's employed following the introduction of flexible working options, as do NHS trusts in Barnet, Chase Farm, Plymouth, Portsmouth and Coventry. Conversely, ABM University Hospital reports a low rate of uptake of flexible options, and a notable disparity between the proportion of 50-64 yr olds stating they would prefer to work shorter hours and actual take-up rate of only 7% (Capita Consulting, 2011; Smeaton et al 2012). The ABM experience seems to suggest that: either the flexible options offered were in some way intrinsically unattractive, the financial implications were untenable (plausibly magnitude of income reduction / impacts on pension values – see Watson et al, 2003), or the presence of some other inhibitory influence.

It is also foreseeable that rises in cost of living and diminished pension values may mean that continuance in full-time work becomes an economic necessity for those on lower incomes (see Smeaton et al, 2012).

The implication here is that caution should be exercised in basing predictions of rates of take-up of flexible working options on the expressed aspirations and intentions of staff, particularly where the question relates to a time in the relatively distant future (e.g. if people were asked in their mid-40’s). Notably, Larsen reports, as people get older the later they plan to retire (Larsen, 2006). It is also possible that the attractiveness of shorter hours / retirement diminishes once people reach the point where such options are available to them, i.e. knowing that you could reduce your hours, if you wished to / felt you needed to, may operate as a safety valve.

As noted elsewhere, it is also apparent that there are age-related migrations within certain health professions. The profile for nurses, for example, shows that retention is a background issue amongst the under 40’s (Watson et al, 2003), there are age related migrations to the private sector and the over 50’s over-represent in community nursing (24%) and health visitor (29%) roles, compared with 16% of the NHS nursing population as a whole (Buchan & Seacombe, 2002; also see Buchan, 2000). What is less clear is whether the migrations to non-hospital roles are the product of age related preferences, or simply reflect attractive options for staff of all ages and become the destinations of those who have waited longest.

Commentators on the Swedish health care sector highlight barriers to such migrations arising from government led restructuring / decentralisation of their health service. "It has become more difficult for older persons, or those in need of 'easier jobs' to be transferred to other clinics... they are building walls between the units." Olofsson (1993). Smaller units, with discrete budgets are said to reduce the scope for employment transition, reducing the range of options for employment transition.
The Swedish experience with regard to patterns of age related migration is, not surprisingly, that this varies by profession. For nursing staff, most are said to remain their established profession, rather than retraining (Smeaton et al., 2012, suggest an equivalent pattern in their UK Health Trust case study). While some take up administrative positions, this only tends to be an option for more senior grades. Again paralleling the UK picture, there are age related migrations to out-patient clinics, and there is said to be high demand for these positions "Wherever there is a vacancy [for an out-patient post] there are between 30 and 40 applicants." (Olofsson, 1993).

Good practice embodies employers taking steps to offer and broaden the scope of flexible working arrangements to staff in roles where this can reasonably be configured and/or migrating staff to roles that offer greater flexibility. However, it is important that any older age specific policies do not come to represent reverse discrimination at the risk of fostering resentment amongst younger employees (Walker & Taylor, 1999).

There are grounds for concluding that employers need to do more than simply offering flexible options. There is strong evidence that employees may be unaware or uncertain of the options available to them. Additionally, employees may be inhibited from requesting reduced hours, for fear of how their motives might be interpreted by their managers and colleagues. For example, offering flexible working arrangements to older personnel may increase the workload on other team members. Similarly, there is scope for employee misunderstanding of the implications for pensions and tax liabilities. This may inhibit take-up of options, or cause employees to make poor financial decisions (see Barnes et al, 2009; Smeaton et al, 2012 and Section 3.0.

It has been suggested that what is needed is for employers to adopt a proactive managed approach, for example harmonising later working life intentions and options as a formal component of established annual review procedures, e.g. every five years after age 45 (Dworschak et al, 2006; Tikakanen & Nytham, 2006; Smeaton et al, 2012).

7.6 Training and development

The evidence on training and development includes attitudes and orientations of employees, their beliefs regarding employer orientations to investing in older workers and evidence of management practices. Essentially, the role of training and development of older employees is to maintain and enhance skills; to facilitate migration to alternative roles and to counter employee perceptions of social marginalisation and disenfranchisement.

As noted elsewhere, the belief that mental capacity and the ability to learn declines with age is widely encountered but there is little scientific basis for this. Where it has been detected it presents as a modest decline by the time people reach their late 60's, with any decrement tending to be offset by skill and experience related compensation effects (Anderson, 1993; Rose, 1993; Griffiths, 2000; Crawford et al, 2009). The overwhelming picture is that "... in the third age the vast majority of individuals will still be functioning at their optimum [cognitive] level" (Rose, 1993). Notably, the Health and Safety Executive's conclusion that
worker productivity does not usually decline significantly under the age of 70, is qualified by the proviso that older workers receive suitable and sufficient training so that their skills can be kept up to date (HSE, 2010; Cedefop, 2012).

In short, the commonly encountered adage ‘you can't teach an old dog new tricks’ is found wanting when subjected to scientific investigation, in so far as there is no significant age related barrier to learning. To put this further into context; “There is a large overlap in the capacities of different age groups... there is more difference within age groups than between them,” (Anderson, 1993).

European cross-employment-sector findings form the ‘Worknow’ programme indicate that many organisations under-invest in the training of older employees, with a significant proportion viewing such investment as either inappropriate, unlikely to yield viable returns (too few years of working life remaining) or simply not part of their role. Historically, trade unions are also said to have given the issue modest priority (Tikkanen, 2006). The dominant finding is that the employers focus on provision for younger people. "The absence of evidence of training or other support for [job] change was very striking [amongst the over 50's]." (McNair et al, 2007). Similarly, the Equality and Human Rights Commission reports an age-related linear decline in training (50% of workers aged 50-55; 44% for 56–59 year olds, to around 1/3 of 60–64 year olds (EHRC, 2009). There are also reports of a downturn in employer funded training provision for older workers over recent years. However, it is not clear whether this reflects a general reduction, plausibly reflecting prevailing economic conditions, or a specific older-worker effect (Morrell & Tennant, 2010).

Employer accounts tend to centre on claims that older employees exhibit low motivation to engage in training (Watson et al, 2003; Tikkanen. 2006; Armstrong-Stassen and Templer, 2005), and there does appear to be some evidence to support this (Renkema & van der Kamp, 2006). However, there are also reports of high demand amongst older employees. Fredericksen (2006), for example, reports health sector employees rating personal development as highest in a ranking of desirable job attributes. Corroborative evidence is present in studies of older employees in the general working population (see Saba et al, 1998; Taylor & Unwin, 2001, Philipson & Smith, 2005).

On balance, it seems that age-related training deficits likely reflect a combination of limited opportunities and diminished employee disposition to engage. It is difficult to be conclusive regarding the relative strength of these push and pull factors (Unvin, 2004). However, it seems safe to conclude that where worthwhile training options are absent in the workplace skills gaps amongst older workers are likely to remain unchecked.

A focus on the young is not just an issue in terms of social exclusion but likely contributes to older employees’ perceptions of winding-down and disengagement with work (Weyman, et al. 2012). It is also strongly normed in contemporary society, which in itself likely represents a cultural barrier to change (Tikkanen, 2006). Only comparatively recently have phrases like 'life-long learning' begun to enter mainstream discourse. Social marginalisation / exclusion in the area of training and development can feed older workers' perceptions that they are
undervalued and that their (actual or potential) contribution is not recognised. As such it represents a further push towards de-motivation and early withdrawal from work (Davey, 2007; Fredericksen, 2006).

Mirroring findings on other topics, a number of authors point to the need for a managed / management led approach to deliver effective training and personal development for older workers. The observation that "Many employees plan their daily work task in a very rational and efficient way, but not their occupational biographies... workers need to be supported in planning their occupational biography." (Buck & Dworschak, 2003; also see Davey, 2007) echo's findings on retirement planning and pension choices. Self-efficacy (an individual's perceived internal capacity to influence their status) over training and personal development tends to be low and needs to be supported (Saba, et al., 1998; Hedges et al., 2009; Philipson & Smith, 2005; Porcellato et al. 2010). These and other authors point to the need for employers 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 (Armstrong-Stassen & Templer, 2005; Hedges et al., 2009).

However, this is tempered by findings from empirical work that indicate that while a managed individual focused approach can enhance take-up rates, increases tend to be modest (Renkema & Van der Kamp, 2006). The conclusion seems to be that they can usefully operate as a component of an embracing package of measures aimed at older workers, but are unlikely to bring major benefits.

Beyond issues of skill-based training and meeting the personal development needs of older workers, reside issues relating to the need to train managers, in particular line managers, in the principles of good practice for managing an older workforce.

### 7.7 Recruitment and retention practices

Issues of corporate culture and climate are almost universally cast as defining influences on the experiences and behaviour of older employees in relation to work and retirement (Schrank & Waring, 1989; Vickerstaff, et al., 2003; Philipson & Smith, 2005; Weyman, 2009; Weyman, et al., 2012). Salient influences here 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. There are challenges for employers in terms of impression management, particularly in a context where 'bad news' tends to assume a higher profile than 'good news'. Additional challenges are present in organisations where there is a history of suspicion, distrust and what staff might see as broken promises. Employee impressions are important as, whether accurate or otherwise, they impact on attitudes and behaviour. Eroded trust in the employer represents a significant barrier to communication and engagement with employees (Ona & Davis, 2009; Weyman, et al, 2005).

**Institutional discrimination**
Significant debate surrounds the scale of employer prejudice towards the recruitment and retention of older employees. Evidence in this area tends to be dominated by accounts of employee beliefs and commentaries on contemporary practice, typified in sentiments expressed by Murray and Syed: "Organisations must change a plethora of deep seated practices and values that discriminate and progressively impoverish older and mature worker cohorts" (Murray & Syed, 2005; also see Walker, 2005). Employee beliefs are important as they impact on peoples orientation to work, engagement with work and intention to quit (Porcellato, et al., 2010).

Prominent amongst findings from the general population is the belief that managerial practices represent the most significant barrier to employment in later life, and that employers hold deeply rooted prejudices regarding degraded physical ability; higher health related absence; low train-ability, poor return on investment and a reluctance to interact with younger employees are said to be widespread (CIPD, 2007, Davey, 2007; Weyman, 2009). However, reports of direct experience of age-related discrimination are highly variable. The Equality and Human Rights Commission report 5% of men and 3% of women are affected (Porcellato, et al., 2010). Other sources claim rates as high as 70% of the over-50's experiencing some form of age discrimination (Bytheway et al., 2007). Health sector specific findings for nursing staff reveal that most report no experience of employer ageism (Watson et al., 2003).

Most studies relate to recruitment practices, where there are widespread reports of employer resistance to employ the over 50's (McNair et al, 2007; Metcalf & Meadows, 2010). The extent to which this orientation extends to practices relating to established employees is under-evidenced (Porcellato et al., 2010).

What is clear is that there is widespread cynicism and scepticism over employer motivations anti-age-discrimination legislation, to the extent that this acts as a barrier to effective communication with employees over pensions, retirement planning and extending working life issues (Porcellato et al, 2010). Against this background there seems to be a clear need for employers to take overt, high profile, visible steps to demonstrate that discrimination is not present in the area of employment of older people.

**Human resource practices**

Human resource practices are transparently central to the recruitment and retention of older employees. However, "While information on innovative workplace practice is in great demand, there has not been much progress on how to implement age aware human resource policies," (Tikkanen & Nyham, 2006).

There are widespread claims that perspectives on older workers in human resource departments are dominated by issues of capacity to work, focused on diminished capability (cognitive; physiological; health status; skill-base and motivation) with a rather blurred, under-developed perspective on conservation in later working life (‘a depreciation model – Davey, 2007; also see Tikkanen, 2006). It is also reported that few organisations have derived any systematic insight into employee perspectives, preferences or intentions, or how
these might vary demographically within their organisation (Tikkanen, 2006).

While examples of broader perspectives are present (Ilmarinen, 1997), accounts of human resource practice indicate that in most instances the focus is on the individual, either in terms of capacity to work or working hours preferences. Evidence of proactive epidemiological perspectives, orientated around identifying patterns of: risk, migration, absence, health status, retirement, and more, by job role and function is sparse (see Section 7.2). Relatedly, Tikkanen notes, “Research on practical measures for older workers has been least developed at the organisational level. This is unfortunate, since it is the workplace realities that in the end determine the conditions for the use and development of older workers skills.” (Tikkanen, 2006). The concept of ‘resilience’ is widely encountered within human resource management publications, notably within the context of organisational change arising from the 2007/08 economic crisis. Reflecting established precedents, occupational health and human resource perspectives on resilience tend to be focused on finding ways to increase staff resilience to a changing world e.g. offering individual counselling services or stress management training (see, for example, Gibbs, 2001; Tugade & Fredrickson, 2004; Jackson et al., 2007).

However, a comprehensive perspective extends to the design and configuration of work and finding ways to mitigate aspects that erode / challenge staff resilience and consequent impacts on organisational performance (Fox, 2009). Restricting the scope for intervention to attempting to change employees, rather than systems of work, is not only partial but, is said to risk propagating a climate of blame orientated around older workers' inability to ‘cope’ with what may be a challenging work environment for workers of all ages (see Maddi, 2002; Johnson & Down, 2012). Currently, there is limited evidence of organisations engaging with the broader perspective on resilience. Having a resilient workforce is widely held to be a critical component of a healthy organisation (Russ et al., 2008). It is important to gather good quality evidence on the climate, culture (values and attitudes), systems of work and management practices at an organisational level that both challenge and contribute to employee resilience and their implications for organisational performance.

Critics of contemporary human resource practice point to perspectives on diversity that seem to give modest attention to issues of ageing (Department for Work and Pensions, 2013). Indeed, a number of authors suggest that diversity should be the starting point in this area, rather than a focus on age specific measures (Tikkanen, 2006; Smeaton et al., 2012).

While most accounts cast human resource practices towards older workers in a negative frame, in particular in the area of recruitment (see for example, Billett and van Woerkom, 2006), there are claims from within the profession that principal barriers to change relate to senior management / board level resistance (Shacklock et al, 2007, also see Walker and Taylor, 1999). An air of optimism surrounds claims that as the proportion of older employees rises, older worker issues will naturally rise up the human resource agenda. However, some commentators are more pessimistic “... while there is growing interest [within human resource departments] in retaining older workers in the workforce, this is within a context that
ultimately may not be particularly supportive." (see Billett & van Woerkom, 2006).

Forward thinking human resource perspectives include calls for the development of organisational policies and practices that go beyond chronological age as the criterion for initiating older worker related policies, e.g. retirement planning. For example, in the area of employee retention, there are calls for "... practices based on long-term HR policy, preventative and tailor made to individuals or sub-groups... " of all ages (Pisarsky et al, 2006; also see Saba et al. 1998; Dworschak et al, 2006; Lewin Group, 2009).

Recognition of the diversity of older employees in terms of their preferences, job roles and capacity to work apparently leads to the conclusion within HR circles that resolution lies in developing individual-centred bespoke packages (see, for example, Saba et al, 2008). While this represents a positive feature, an observation is that it maintains the focus on individuals, and risks contributing to a perspective that underplays the need to attend to more fundamental, macro level elements relating to the design of systems of work and working arrangements (see Section 7.2).

Failures to improve practices in relation to recruitment and retention increases the risk of skills shortages; corporate memory decrements, discrimination claims, diminished staff morale, increased labour turnover and increased health-related absence.

**Line management**

As in other domains, line managers are widely identified as playing a key role in the management of older worker issues (Saba, et al. 1998; Murray and Syed, 2005; Armstrong-Stassen, 2008; van Dalen, et al., 2008). "Line managers can exert considerable discretion over determining the options available to individuals... " (Philipson & Smith, 2005). It is this strata which has to balance the interests of older employees against meeting operational objectives, e.g. organising shift rotas, coping with staff absence and achieving performance targets as well as managing social relationships (see Smeaton et al, 2012).

The pivotal role of line mangers in defining culture and climate, in particular custom and practice at the level of the work-team, has long been recognised (see Cox & Flin, 1998). A generic finding within the organisations and management literatures is a tendency to problematise the line management function. The literature on older workers mirrors this. A superficial interpretation routinely gives rise to the conclusion that intervention at this level will bring about resolution. A more considered perspective is that intervention at this level is necessary, but there needs to be a recognition that competing pressures pinch points, of the type referred to above, reflect external variables, notably senior management commitment, availability or resources, time pressure, and these also need to be addressed.

There are also claims that line managers / supervisors are prone to failing to recognise, value, or respect, the contribution of older employees (this potentially contributing to job-stress and intention to quit – Murray and Syed, 2005; Smeaton and McKay, 2005; Davey, 2007; Davey, 2007; Fredericksen, 2006; Ilmarinen et al, 1997; Payne and Doyal 2010; Storey et al 2009; CEEP 2012). Various authors highlight the need for organisations to
provide training in good practice for intermediate grades (Davey, 2007; Armstrong-Stassen, 2008; Smeaton, et al. 2012). In most medium and large organisations, line managers will have responsibility for staff annual reviews, and thus potentially occupy a pivotal position in terms of exploring employee ambitions and preferences for later working life. They need to appear, and be, receptive to employee aspirations, but also, given evidence of employee reluctance to initiate discussion on this topic (see Tikkanen, 2006); “Line managers and supervisors need to know how to prompt discussions...” (Department for Work and Pensions, 2013) and play their role in identifying solutions (also, see Finnish National Programme on Ageing Workers, 2000).
8.0 Interrogation of Labour Force Survey data to explore NHS age demographics; age related patterns of migration; and forecasts of alternative futures

Summary

- The NHS workforce is ageing and traditional efforts to retain employees may need to be adjusted to their specific needs e.g. preferences for more flexible work patterns.
- The average (mean) age of NHS employees is 43.7 years, which is similar to all public sector employees but, nearly three years higher than the private sector average. 51% of NHS employees are aged 40+ and 32% are aged 50+.
- The modal (most commonly found) age category of NHS employees is 40–45yrs. This seems to be a tipping point, after which there is a significant drop in numbers employed, particularly after age 50 (for all occupational groups). This ‘drop off effect’ occurs just seven years beyond the current mean age (and the mean age is rising year on year).
- When analysing the over-50s it is important to distinguish between retirement and exit from the NHS. While the mean retirement age is 62 years of age, only a fraction of employees remain in employment within the NHS until that age, with the vast majority having exited significantly earlier. It is perhaps therefore early exit rather than retirement where the analysis should be focussed.
- It is possible that many who exit NHS employment subsequently return to the NHS after 12 months (or some may be re-employed in ‘private sector’ health jobs which involve agency work for the NHS). This may also partly explain the high average age of NHS new recruits (43 years of age). However, the fact remains that, looking at the distribution of NHS employee ages as a whole, the number of employees drops sharply shortly after the age of 50.
- The proportion of nurses under 30 has more than halved since 1993, to just 1 in 10 of all nurses. This drop is more pronounced than in the other occupational groups within the NHS. Correspondingly there has been a large rise in the proportion aged 50–59. Nearly two thirds of nurses are aged 40+.
- Up to age of 55, less than 30% of employees are employed in part-time work. This rises to 50% by age 60 and 80% by age 65.
- As NHS employees get older more say they would prefer to work shorter hours. 37% of those aged 50–59 and 46% aged 60+. MDs have a particularly strong preference for working shorter hours.
- Only 12% of those who prefer to work shorter hours report having approached their employer on this issue. Of those who have approached their employer over reducing their hours, 55% claim that their employer can’t or won’t allow them to work fewer hours.
- As NHS employees get older they suffer from more health problems. 20% of those in
their 30s claim a longstanding health problem, this rises to 40% for those in their 50s and 46% for those aged 60+. But, unlike the wider working population, older NHS employees do not have a higher average (number of days) sickness absence. 15% of males and 3% of women who exited NHS employment said they left for health reasons.

- There are three distinct age points at which employees exit from NHS employment: just after 55, just after 60, just after 65 and the late 60s. At age 57 19% of employees have exited, rising to 31% by age 62 and 52% by age 65.

- Predictably, nurses over 50yrs imputed to be of ‘special pension status’, had the highest exit rate at 32% annually. However, those nurses imputed to be ‘section 1995 status pension’ also had a high exit rate, approximately one quarter of all over 50s leaving annually.

- Of those who exit NHS employment (all ages), 51% go into another job outside the NHS, 21% retire, 11% either re-train, go into education or become unemployed, 9% exit to family or home care, 2% are sick or injured and 7% are recorded as ‘not working – other’.

- Of those aged 50+, 41% move into retirement, but a higher proportion (43%) exit NHS employment to take jobs elsewhere. 3% exit by moving to ‘sick or injured status’ and a similar proportion exit for reasons of family or home care.

- Of all exiters from NHS employment and who move to other jobs, 57% move into occupations which are still health related and 76% of these are in the private sector. For the over 50’s, the proportions are lower with 40% moving into non-NHS health related occupations.

- Of exiters from NHS employment aged 50+yrs who were previously working full-time and who went into non-NHS employment, 16.5% took part-time work and the remainder took full-time work.

- Pay does not seem to be a motivation to leave the NHS: Exiters were paid an average of £453 in their NHS occupation and £469 in their new occupation outside the NHS.

### 8.1 Health sector demographics

The historically high vacancy rates witnessed in the early part of this century for many NHS professional occupations have reduced in recent years. However, the long-term world-wide shortage of health professionals (supply side) coupled with the increasing need for more health care staff as the population ages (demand side) mean that the issue of staff recruitment, retention and extending working life (EWL) remain central strategic staff planning and policy issues.

Given the historic and persistent issues of staff shortages in the NHS, particularly among nurses, GPs and other clinical staff (Wanless, 2002), research has tended to focus on recruitment of school leavers into training for the professions, encouraging the return of staff who have left the NHS and efforts to retain existing staff (Frijters, 2004). More recently, the
focus has shifted towards the retention of older employees. This is for a number of interconnected reasons:

- Demographic changes within the UK mean that the supply of school leavers available to enter nursing is dropping. Analysis of ONS census data³ (see Figures 2 and 3) predicts a 17% increase in the English and Welsh population between 2011 and 2035 but only a 11% increase in the under-20 population compared with a 29% increase in the over-50 population. In other words, while the pool of potential new recruits to the NHS will drop (relative to the population size), the demand for NHS services is likely to increase from a quickly expanding older population. Added to this, the NHS workforce is ageing and traditional efforts to retain employees may need to be adjusted to their specific needs e.g. preferences for more flexible work patterns.

- There is increased pressure on NHS employees and employers to extend working life following the Hutton report. In part, this reflects the need to balance the cost of NHS pension arrangements with increased life expectancy. Set against this, it has become commonplace for older employees to take early retirement. There is a risk that if this pattern of early exit continues, it will exacerbate problems of staff shortage. Recent legislative changes have potentially extended people’s working lives. In 2008 the pension age for new NHS employees was raised to 65 (with women gradually being brought into line with men). This represented a rise of between 5 and 10 years. In future years the retirement age will eventually increase to 68 years. Women will see the largest change (75% of NHS employees are women). In practice, at present many employees retire well before the State Pension Age, and a larger number leave the NHS in their fifties to go to other jobs. It is not clear how such employees can be incentivised to extend their NHS working lives.

Figure 2: Predicted population increase 2011-2035 in England and Wales

![Figure 2: Predicted population increase 2011-2035 in England and Wales](http://www.ons.gov.uk/ons/rel/npp/national-population-projections/2010-based-projections/sum-2010-based-national-population-projections.html)
Extending Working Life
Audit of research relating to impacts on NHS employees

Figure 3: The distribution of the population in 2010 and predicted in 2035

Source: ONS Census data

- Relatively little is known about current employment demographics within the health sector, e.g. the age profiles and date of retirement / withdrawal from the NHS, and how this might vary by profession, job role and grade. Insight into this is important as, without this, it is difficult to judge the size and profile of challenges to service delivery, i.e. knowing, demographically, which staff, by type, leave early by choice, leave due to ill health, or remain in service up to and/or beyond State Pension Age etc. is important from the perspective of setting priorities for interventions.

- Key questions surround:
  - What is the current age profile of NHS employees by occupation, how is it changing over time and what might it look like in the future?
  - What are the exit patterns of NHS employees by occupation? This analysis will provide insight into issues of retention an early retirement, e.g. do certain professions exhibit higher or earlier exit rates? What are the migration patterns and destinations? Is the exit rate increasing or decreasing?
  - What can we know of the reasons for exiting NHS employment? Might conditions of employment, illness and pay be implicated in early employment exit? Are they exiting to private health sector or non-health sector employment?
  - What are the work preferences of older NHS employees?
8.1 Data analysis and methods

Data used in this analysis come from the Office for National Statistics (ONS) Labour Force Survey (LFS). This is a representative national quarterly survey of approximately 80,000 adults which studies employment circumstances. It has been collected on a quarterly basis since 1983.

Two different types of datasets based on the LFS are used in our analysis. The first is the Annual Population Survey (APS). This combines consecutive waves of the LFS and adds the local Welsh, Scottish and English labour surveys to produce a much larger (360,000 individuals) dataset. The size of the data set enables a considerable amount of subset analysis i.e. ‘drilling down’ to relatively small groups within the population. The dataset also contains a wide variety of variables about employment conditions and individual characteristics.

The second dataset is the five-quarterly longitudinal LFS (5QLFS). The LFS follows all respondents over five consecutive quarterly interviews. By linking each individual over these quarters it is possible to produce a record of their employment history over one year (the 5QLFS). There are only a few nationally representative longitudinal datasets available and none contain detailed, quarter by quarter employment data.

Longitudinal datasets offer the ability to analyse changes in the circumstances of the same individuals over a period of time. In our analysis, longitudinal data are useful because they allow the examination of exits from employment in the NHS and subsequent destinations. There are a number of technical issues and caveats to the creation and use of these data. In particular, the resulting sample size drops dramatically and so, to enable sufficient sample numbers, for the subsequent analysis the latest 16 consecutive 5QLFS were combined, spanning the period January 2009 to October 2012.

There are some limitations and caveats to what can be achieved using LFS. Firstly, despite being a large dataset, when drilling down to look at specific types of employee sample sizes reduce quite quickly, e.g. sub-set analysis within the NHS by age group and profession can result in small sample cell sizes, which can increase the potential for error. Secondly, the LFS was not designed for studying the employment patterns of older NHS employees and therefore a number of potentially important areas are not covered in the survey, e.g. there are no questions about work preferences and little on reasons for early retirement.

8.2 Describing the 2011 NHS workforce

Looking at all NHS employees, nurses and midwives are the largest single group, making up 28% of the workforce. MDs account for 11% and associated professionals, e.g. IT support and administrative staff, 22%. Figure 4 and Table 2.

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4 A detailed discussion of how the quarterly LFS was derived and its limitations can be found here: http://www.ons.gov.uk/ons/guide-method/method-quality/specific/labour-market/labour-market-statistics/longitudinal-guide.pdf
The average (mean) age of NHS employees is 43.7 years regardless of gender, which is similar to all public sector employees but nearly three years older than the private sector average. 51% of NHS employees are aged 40+ and 32% are aged 50+. See Tables 3–5.

Three-quarters of NHS employees are female and this proportion varies little until we get to the tiny fraction of the NHS labour force which is over 65 years old, where the proportion of female employees drops to 65%. Figure 5.

While the modal (most commonly occurring) age category of NHS employees is 40–45, this seems to be a tipping point, after which there is a relatively steep linear drop in numbers employed, particularly after the age of 50 (for all occupational groups). It is notable that this effect seems to occur at just seven years beyond the current mean age, and it is apparent that the mean age is rising year on year (see below). Higher professionals such as managers and MDs drop at a slower rate than less highly skilled occupations. Figures 6 and 7.

---

5 Standard Occupational Classifications.
### Table 2: Occupations within each occupational category

<table>
<thead>
<tr>
<th>Occupational category</th>
<th>Occupations within category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital and health service managers</td>
<td>Clinical manager, Health Service Manager, Manager (hospital service)</td>
</tr>
<tr>
<td>Medical practitioners</td>
<td>Anaesthetist, Consultant (hospital service), Doctor, General Practitioner, Medical Practitioner, Physician, Psychiatrist, Psychoanalyst, Registrar (hospital service), Surgeon</td>
</tr>
<tr>
<td>Nurses and midwives</td>
<td>Nurses, Midwives</td>
</tr>
<tr>
<td>Health professionals other</td>
<td>Psychologists, Medical radiographers, Health professionals, Physiotherapists, Occupational therapists (plus all others with SOC 2 occupations)</td>
</tr>
<tr>
<td>Paramedics</td>
<td>Public services associate professionals, laboratory technicians, IT support, HR Medical secretaries, receptions, administrator (All of category 3 apart from paramedics, and all of 4 &amp; 7 occupations)</td>
</tr>
<tr>
<td>Nursing auxiliary</td>
<td></td>
</tr>
<tr>
<td>Ambulance staff</td>
<td></td>
</tr>
<tr>
<td>All manual, personal service</td>
<td>Cleaners, porters, carers, cooks etc. (all SOC categories 5, 8 &amp; 9, plus the remainder or category 6)</td>
</tr>
</tbody>
</table>

Source: Cross-sectional single year APS data, 2011

### Table 3: Mean age of NHS employees

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>43.65</td>
</tr>
<tr>
<td>Minimum</td>
<td>18</td>
</tr>
<tr>
<td>Maximum</td>
<td>70</td>
</tr>
</tbody>
</table>

Source: Cross-sectional single year APS data, 2011
Table 4: Average age NHS, public sector & private sector employees

<table>
<thead>
<tr>
<th>Employment sector</th>
<th>Mean (average)</th>
<th>Standard deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS</td>
<td>43.6</td>
<td>11.3</td>
</tr>
<tr>
<td>Public sector</td>
<td>43.4</td>
<td>11.6</td>
</tr>
<tr>
<td>Private Sector</td>
<td>40.7</td>
<td>13.2</td>
</tr>
<tr>
<td>Total</td>
<td>41.4</td>
<td>12.8</td>
</tr>
</tbody>
</table>

Source: Cross-sectional single year APS data, 2011

Table 5: Workforce % by age NHS and Public and Private Sector

<table>
<thead>
<tr>
<th>Age</th>
<th>NHS</th>
<th>Public sector</th>
<th>Private Sector</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;30</td>
<td>14.5%</td>
<td>17.2%</td>
<td>26.6%</td>
<td>24.1%</td>
</tr>
<tr>
<td>30-39</td>
<td>24.0%</td>
<td>21.9%</td>
<td>21.8%</td>
<td>21.9%</td>
</tr>
<tr>
<td>40-49</td>
<td>29.8%</td>
<td>29.6%</td>
<td>24.5%</td>
<td>25.8%</td>
</tr>
<tr>
<td>50-59</td>
<td>24.6%</td>
<td>24.0%</td>
<td>18.2%</td>
<td>19.7%</td>
</tr>
<tr>
<td>60+</td>
<td>6.9%</td>
<td>7.3%</td>
<td>8.9%</td>
<td>8.5%</td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Source: Cross-sectional single year APS data, 2011

Figure 5: Changing gender distribution by age

Source: Cross-sectional single year APS data, 2011
Figure 6: Comparison of the distribution of ages by occupation (professionals)

Source: Cross-sectional single year APS data, 2011

Figure 7: Comparison of the distribution of age by occupation (all occupations)

Source: Cross-sectional single year APS data, 2011

8.3 Demographic change since 1993

In this section LFS and APS data from 1993 through to 2011 are compared in order to describe changes in the age profile of NHS employees over time. Matching the demographic change within the UK as a whole, APS and LFS data show that NHS employees have been getting older. In 1993 the average age was 38.8 years and by 2011 it had reached 43.7 years. Between 1993 and 2011, the biggest changes in age profile come from a drop in those under 30 and a correspondingly large rise in the proportion aged 50-59. Figures 8 and 9.
The proportion of young nurses (under 30) has more than halved since 1993, to just one in ten of all nurses. Figure 10a. This drop is more pronounced than in the other occupational groups within the NHS. Figure 10b-i. In part this may reflect demographic changes but it may also reflect historic recruitment drives and the extension of the period of training to become a registered nurse. The average age at which nursing students currently register is 29 compared with just 20 in the 1960s (Ball and Pike, 2005). Matching the decrease in younger nurses has been a large increase in older employees. Nearly two thirds of all nurses are over 40 years old. Figure 11. The sharpest increase has been amongst those over 50, who have risen from one in seven nurses and midwives to nearly one in three between 1993 and 2011; Figure 10a.
Figure 10a: Nurses and midwives’ age distributions

Source: Cross-sectional single year LFS & APS data, 1993–2011

Figure 10b: Hospital managers age distributions

Source: Cross-sectional single year LFS & APS data, 1993–2011
The rate of increase since 2003 of older employees (50+ yrs) working in the NHS and for older employees in UK employment as whole is very similar increase since 2003. The key difference, however, is that the NHS started from a higher base of over 50s in 2003. Figure 12.

Source: Cross-sectional single year LFS & APS data, 1993–2011
Figure 10e: Paramedics age distributions

Source: Cross-sectional single year LFS & APS data, 1993–2011

Figure 10f: Associate professional and administration age distributions

Source: Cross-sectional single year LFS & APS data, 1993–2011

Figure 10g: Nursing Auxiliary age distributions

Source: Cross-sectional single year LFS & APS data, 1993–2011
Figure 10h: Ambulance staff age distributions

Source: Cross-sectional single year LFS & APS data, 1993–2011

Figure 10i: Manual, personal service and elementary occupations age distributions

Source: Cross-sectional single year LFS & APS data, 1993–2011

Figure 11: % of older employees in age band

<table>
<thead>
<tr>
<th>Age</th>
<th>%</th>
<th>Valid %</th>
<th>Cumulative %</th>
</tr>
</thead>
<tbody>
<tr>
<td>40-54</td>
<td>50.5</td>
<td>80.7</td>
<td>80.7</td>
</tr>
<tr>
<td>55+</td>
<td>12.1</td>
<td>19.3</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>62.6</td>
<td>100.0</td>
<td></td>
</tr>
<tr>
<td>Missing</td>
<td>37.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Cross-sectional single year APS data, 2011
Figure 12: Change in employee age profile: over 50s NHS vs non-NHS employees

Source: Cross-sectional single year LFS & APS data, 1993–2011

8.4 What might the NHS labour force look like in 2023?  

Extrapolating from these established and consistent trends, a simple linear model predicts that for every decade, the average age of the NHS workforce increases by 3 years. Therefore, by 2023 the average age of NHS employees is predicted to be 47.8; Table 6.

Table 6: Past, current and predicted age profile of NHS employees

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Mean age 1993</th>
<th>Mean age 2011</th>
<th>Mean age 2023</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital and health service managers</td>
<td>41.2</td>
<td>47.4</td>
<td>51.1</td>
</tr>
<tr>
<td>Medical practitioners</td>
<td>38.4</td>
<td>41.7</td>
<td>43.8</td>
</tr>
<tr>
<td>Nurses and midwives</td>
<td>36.7</td>
<td>43.7</td>
<td>48.3</td>
</tr>
<tr>
<td>Health professionals (other)</td>
<td>37.8</td>
<td>41.9</td>
<td>44.5</td>
</tr>
<tr>
<td>Paramedics</td>
<td>–</td>
<td>43.4</td>
<td>50.5</td>
</tr>
<tr>
<td>Associate professionals and admin</td>
<td>39.2</td>
<td>45.5</td>
<td>49.7</td>
</tr>
<tr>
<td>Nursing auxiliary</td>
<td>40.7</td>
<td>44.3</td>
<td>47.2</td>
</tr>
<tr>
<td>Ambulance staff</td>
<td>38.5</td>
<td>48.6</td>
<td>55.3</td>
</tr>
<tr>
<td>Manual, personal service and elementary</td>
<td>40.4</td>
<td>45.8</td>
<td>49.8</td>
</tr>
<tr>
<td>All</td>
<td>38.8</td>
<td>44.0</td>
<td>47.8</td>
</tr>
</tbody>
</table>

Source: Cross-sectional single year LFS & APS data, 1993–2011

The following predictions do not take account of current exit trends. Exit rates tend to steadily increase as early retirement ages approach and there are higher exits towards early retirement or ‘downshifting’ to fewer hours, more flexible work or a less stressful occupation. These factors may mitigate the ageing effect in future years.
This picture varies by occupational group. The predicted age for ambulance employees by 2023 is 55.3, 51.1 for managers and 50.3 for paramedics. Table 6. For MDs and medical professionals (e.g. radiographers) the predicted ages are 43.8 and 44.5, respectively.

8.5 Changes in characteristics and preferences as NHS employees get older
Until the age of 55, no more than 30% of employees were employed in part time work. Thereafter, it increases quite rapidly, to 50% by age 60 and 80% by age 65; Figure 13. This rise is reflected in the reduced hours that older employees work, dropping from a mean (excluding over-time) of 37 hours in their 30s, to a mean of 31 and 25 hours respectively for those in their 50s and 60s; Table 7.

Figure 8a: Age distribution of NHS employees by full-time and part-time work

![Age distribution of NHS employees by full-time and part-time work](image)

Source: Cross-sectional single year APS data, 2011

<table>
<thead>
<tr>
<th>Age group</th>
<th>Mean (average)</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-19</td>
<td>16.8</td>
<td>6.9</td>
</tr>
<tr>
<td>20-24</td>
<td>36.8</td>
<td>13.1</td>
</tr>
<tr>
<td>25-29</td>
<td>36.7</td>
<td>12.6</td>
</tr>
<tr>
<td>30-34</td>
<td>33.3</td>
<td>11.1</td>
</tr>
<tr>
<td>35-39</td>
<td>32.6</td>
<td>12.0</td>
</tr>
<tr>
<td>40-44</td>
<td>31.3</td>
<td>12.0</td>
</tr>
<tr>
<td>45-49</td>
<td>30.6</td>
<td>11.2</td>
</tr>
<tr>
<td>50-54</td>
<td>31.0</td>
<td>11.1</td>
</tr>
<tr>
<td>55-59</td>
<td>30.1</td>
<td>12.9</td>
</tr>
<tr>
<td>60-64</td>
<td>27.7</td>
<td>10.7</td>
</tr>
<tr>
<td>65-99</td>
<td>23.3</td>
<td>16.7</td>
</tr>
<tr>
<td>Total</td>
<td>31.8</td>
<td>12.0</td>
</tr>
</tbody>
</table>

Source: Cross-sectional single year APS data, 2011
Work preferences of older employees also differ. As they get older more would prefer to work shorter hours. 37% of those aged 50–59 and 46% aged 60+ would like to work reduced hours; Table 8. Broken down by occupation, it is perhaps striking that MDs have a strong preference for working shorter hours with, for example, 78% of female MDs answering in the affirmative; Table 9.7

| Table 8: NHS employees preference for shorter hours – even if less pay % |
|------------------------|-----------------|-----------------|-----------------|
| Age        | Yes     | No     | Don't know | Total |
| <30        | 27.4    | 71.0   | 1.6        | 100.0 |
| 30-39      | 29.0    | 69.5   | 1.5        | 100.0 |
| 40-49      | 31.5    | 65.0   | 3.5        | 100.0 |
| 50-59      | 36.9    | 59.7   | 3.4        | 100.0 |
| 60+        | 45.7    | 51.8   | 2.5        | 100.0 |

Total 32.8 64.5 2.8 100.0

Source: Cross-sectional single year APS data, 2009

| Table 9: Preference (%) to work fewer hours even if lower pay (50–59 year olds) |
|------------------------|-----------------|-----------------|-----------------|
| Gender      | Occupation                             | Prefer| Not prefer | Don't know |
| Males       | Hospital and health service managers   | 29.5 | 68.5        | 2.0        |
| Males       | Medical practitioners                  | 60.7 | 33.6        | 5.6        |
| Males       | Nurses and midwives                    | 27.4 | 70.5        | 2.1        |
| Males       | Health professionals (other)           | 32.1 | 62.4        | 5.5        |
| Males       | Paramedics                             | 76.9 | 17.0        | 6.1        |
| Males       | Associate professionals and admin      | 20.1 | 75.8        | 4.1        |
| Males       | Nursing auxiliary                      | 6.9  | 89.5        | 3.6        |
| Males       | Ambulance staff                        | 22.5 | 70.5        | 7.0        |
| Males       | Manual, personal service and elementary| 25.2 | 66.1        | 8.7        |
| Females     | Hospital and health service managers   | 29.1 | 69.7        | 1.2        |
| Females     | Medical practitioners                  | 77.9 | 13.1        | 9.0        |
| Females     | Nurses and midwives                    | 35.2 | 63.3        | 1.4        |
| Females     | Health professionals (other)           | 40.8 | 52.9        | 6.3        |
| Females     | Paramedics                             | 12.6 | 82.1        | 5.3        |
| Females     | Associate professionals and admin      | 33.0 | 62.9        | 4.1        |
| Females     | Nursing auxiliary                      | 23.9 | 74.8        | 1.2        |
| Females     | Ambulance staff                        | 48.3 | 51.7        | 0.9        |
| Females     | Manual, personal service and elementary| 30.6 | 68.5        | 2.8        |

Source: Cross-sectional single year APS data, 2009

7 It should be noted that across all age groups, MDs have a high preference for working reduced hours. This may be a function of the much longer hours MDs claim to work. Table 10 shows that over 50 year old MDs worked for a claimed average of 54 hours a week compared to 41 hours for NHS employees as a whole (including paid and unpaid overtime). An alternative explanation is that the relatively high pay of MDs means that a loss in earnings for less pay is a weak disincentive to wish to reduce hours.
Table 10: Average hours worked (over 50 years of age)

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Actual hours excluding overtime</th>
<th>Actual hours of unpaid overtime</th>
<th>Actual hours of paid overtime</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital and health service managers</td>
<td>35.9</td>
<td>7.2</td>
<td>0.3</td>
</tr>
<tr>
<td>Medical practitioners</td>
<td>39.4</td>
<td>8.8</td>
<td>6.1</td>
</tr>
<tr>
<td>Nurses and midwives</td>
<td>34.3</td>
<td>5.1</td>
<td>2.7</td>
</tr>
<tr>
<td>Health professionals (other)</td>
<td>34.4</td>
<td>5.0</td>
<td>1.9</td>
</tr>
<tr>
<td>Paramedics</td>
<td>38.8</td>
<td>0.1</td>
<td>2.8</td>
</tr>
<tr>
<td>Associate professionals and admin</td>
<td>34.3</td>
<td>2.5</td>
<td>1.7</td>
</tr>
<tr>
<td>Nursing auxiliary</td>
<td>33.3</td>
<td>.6</td>
<td>2.6</td>
</tr>
<tr>
<td>Ambulance staff</td>
<td>39.5</td>
<td>2.2</td>
<td>4.1</td>
</tr>
<tr>
<td>Manual, personal service and elementary</td>
<td>33.7</td>
<td>1.8</td>
<td>2.0</td>
</tr>
<tr>
<td>All</td>
<td>35.1</td>
<td>4.4</td>
<td>2.4</td>
</tr>
</tbody>
</table>

Source: Cross-sectional single year APS data, 2011

The fact that working shorting hours as well as the inability of employers to offer more flexible employment affects those of all ages suggests that the problem of flexible work affects all groups.

Only 12% of those who prefer to work shorter hours report having approached their employer on this issue; Table 11. Of those who have approached their employer over reducing their hours, 55% claim that their employer ‘can’t’ or ‘won’t’ allow them to work fewer hours; Table 12.

Table 11: Older NHS employees who have approached their employer about working fewer hours %

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>12.3</td>
</tr>
<tr>
<td>No</td>
<td>87.7</td>
</tr>
<tr>
<td>All</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: 5QLFS data, 2009–2012
Table 12: Is your employer able to let you work fewer hours? %

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>44.9</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>55.2</td>
<td></td>
</tr>
<tr>
<td>All</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

Source: 5QLFS data, 2009–2012

It is well recognised that as employees get older they tend to suffer from more health problems. LFS data confirms this, whereas 20% of those in their 30s claim a long standing health problem, this rises to 40% for those in their 50s and 46% for those aged 60+: Table 13.

Table 13: NHS employees with a health problem lasting more than 12 months (self-report) %

<table>
<thead>
<tr>
<th>Age</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;30</td>
<td>17.0</td>
<td>83.0</td>
</tr>
<tr>
<td>30-39</td>
<td>20.2</td>
<td>79.8</td>
</tr>
<tr>
<td>40-49</td>
<td>29.5</td>
<td>70.5</td>
</tr>
<tr>
<td>50-59</td>
<td>39.7</td>
<td>60.3</td>
</tr>
<tr>
<td>60+</td>
<td>46.3</td>
<td>53.7</td>
</tr>
<tr>
<td>Total</td>
<td>29.1</td>
<td>70.9</td>
</tr>
</tbody>
</table>

Source: 5QLFS data, 2009–2012

Figure 14: Days off sick per year of NHS employees by age

Source: Cross-sectional single year APS data, 2011
However, this does not appear to impact on the average number of days sickness absence, i.e. NHS employees over the age of 30 exhibit an essentially equivalent average of around 8.5 days per year, despite age related rises in longstanding (ill)health; Figure 14.

8.6 Patterns of exit from NHS employment

The analysis in this section first looks at length of tenure of employees. The analysis then examines exit from NHS employment among NHS employers of all ages as well as conducting analysis into older employees.

**Job tenure**

NHS employees have been employed in their job for longer durations (longer job tenure) than employees in other organisations (11.5 years vs 9.0 years); table 14. More than one in six NHS employees have been employed with the organisation in their job continuously for more than 20 years compared with slightly more than one in nine for all other employees; Table 15a.

<table>
<thead>
<tr>
<th>Table 14: Average number of years in current job</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean (years)</td>
</tr>
<tr>
<td>---------------</td>
</tr>
<tr>
<td>Nurses and midwives</td>
</tr>
<tr>
<td>All NHS employees</td>
</tr>
<tr>
<td>All other employees</td>
</tr>
</tbody>
</table>

Source: Cross-sectional single year APS data, 2011

<table>
<thead>
<tr>
<th>Table 15a: Tenure – mean years with NHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Years</td>
</tr>
<tr>
<td>-------</td>
</tr>
<tr>
<td>1 year or less</td>
</tr>
<tr>
<td>2-4 years</td>
</tr>
<tr>
<td>5-9 years</td>
</tr>
<tr>
<td>10-19 years</td>
</tr>
<tr>
<td>20+ years</td>
</tr>
<tr>
<td>All</td>
</tr>
</tbody>
</table>

Source: Cross-sectional single year APS data, 2011

Turning to older staff (>50 years of age), job tenures tend to be far longer. NHS employees 50–59 years of age had been employed in the NHS for an average of 16.4 years. This rises to an average of 17.1 years for those over 60. Correspondingly, a large proportion of older
employees had worked for the NHS in excess of 20 years (35% and 37% respectively for 50–59 year olds and those aged over 60); Tables 15a and 15b.

Examining nurses and midwives, the average length of tenure within the NHS for all ages is 13.4 years; Table 14. This rises to an average of 20.1 years for those between the ages of 50 and 59; Table 15b. In fact, over half of all nurses and midwives over the age of 50 have worked continuously for the NHS for in excess of 20 years.

<table>
<thead>
<tr>
<th>Age</th>
<th>All NHS employees</th>
<th>Nurses and midwives</th>
</tr>
</thead>
<tbody>
<tr>
<td>50-59</td>
<td>16.4</td>
<td>20.1</td>
</tr>
<tr>
<td>60+</td>
<td>17.1</td>
<td>22.2</td>
</tr>
</tbody>
</table>

Source: Cross-sectional single year APS data, 2011

It follows that a large proportion of nurses and midwives will be special class pension members, with an estimated 43% of nurses in the 40–54 age category eligible for the earlier special class pension retirement age of 55; Table 17.8

<table>
<thead>
<tr>
<th>Eligible (%)</th>
<th>All Nurses and midwives</th>
<th>Nurses and midwives 40-54 yrs of age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>30.7</td>
<td>43.0</td>
</tr>
</tbody>
</table>

Source: Cross-sectional single year APS data, 2011

8.7 Rates of exit from NHS employment

---

8 Table 17 shows that an estimated 31% of all nurses are eligible to retire at age 55 (presuming that none of these have swapped to 2008 section). 43% of 40–54 nurses have been working for the NHS for 17 years of continuous employment and may also be eligible for special class status of pension. These nurses amount to 105,000 of the 488,000 employees classified as nurses or midwives according to LFS data. This means that 21.5% of the total may have this status. This is obviously an estimate since we cannot know how many have opted out of the scheme and it does not take into account others with non-continuous service who may be eligible.
In the 12 month period covered by the longitudinal data, 9% of all NHS employees exited NHS employment; table 18. For those over the age of 50, the percentage who exited NHS employment was 17.6%; Table 19.

Predictably, as employees get older, a greater proportion exit NHS employment. The increase in the rate of exit begins around mid-50s. There are four distinct peaks where exit rates are highest: just after 55, just after 60, just after 65 and the late 60s. At age 57 19% of employees exited, rising to 31% by age 62 and 52% by age 65; Figure 15.

Analysis by gender shows that the trends are generally similar, except that exit occurs approximately three years earlier for women.

Exit rates vary dramatically by occupational group. Looking at the all age sample, managers had the highest rate (16%) and ‘health professionals’ (see Table 2 for definition) the lowest (5.7%); Table 18.

Table 18: Turnover and exit of NHS employees per year (all ages) %

<table>
<thead>
<tr>
<th>Occupational Group</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital and health service managers</td>
<td>16.1</td>
</tr>
<tr>
<td>Medical practitioners</td>
<td>8.3</td>
</tr>
<tr>
<td>Nurses and midwives (special class pension)</td>
<td>9.2</td>
</tr>
<tr>
<td>Health professionals (other)</td>
<td>5.7</td>
</tr>
<tr>
<td>Paramedics</td>
<td>6.0</td>
</tr>
<tr>
<td>Associate professionals and admin</td>
<td>8.9</td>
</tr>
<tr>
<td>Nursing auxiliary</td>
<td>9.8</td>
</tr>
<tr>
<td>Ambulance staff</td>
<td>8.6</td>
</tr>
<tr>
<td>Manual, personal service and elementary</td>
<td>8.8</td>
</tr>
<tr>
<td>All</td>
<td>9.1</td>
</tr>
</tbody>
</table>

Source: 5QLFS data, 2009–2012

Completing the same analysis for older employees (50+yrs), the picture changes dramatically. In this instance it is ambulance drivers and nurses who exhibit the highest rates of exit; Table 19.
Table 19: Exit rates of older (>50) NHS workers per year %

<table>
<thead>
<tr>
<th>Category</th>
<th>Exit Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital and health service managers</td>
<td>19.9</td>
</tr>
<tr>
<td>Medical practitioners</td>
<td>8.0</td>
</tr>
<tr>
<td>Nurses and midwives (special class pension)</td>
<td>32.4</td>
</tr>
<tr>
<td>Nurses and midwives (2008 section pension)</td>
<td>25.1</td>
</tr>
<tr>
<td>Health professionals (other)</td>
<td>24.0</td>
</tr>
<tr>
<td>Paramedics</td>
<td>11.0</td>
</tr>
<tr>
<td>Associate professionals and admin</td>
<td>6.7</td>
</tr>
<tr>
<td>Nursing auxiliary</td>
<td>4.8</td>
</tr>
<tr>
<td>Ambulance staff</td>
<td>56.2</td>
</tr>
<tr>
<td>Manual, personal service and elementary</td>
<td>20.0</td>
</tr>
<tr>
<td>All</td>
<td>17.6</td>
</tr>
</tbody>
</table>

Source: 5QLFS data, 2009–2012

Figure 15: NHS employee exit rate by age

Predictably, nurses imputed to be of special pension status had the highest exit rate at 32% in one year (i.e. nearly a third of over 50s leaving each year). However, even those nurses imputed to be ‘section 1995 status pensions’ had a high exit rate with one quarter of all over 50s leaving per year. Over one year, 52% of all exiters from the NHS were older employees (over 50 years of age); Table 20.
Table 20: Age at point of exit from NHS Employment

<table>
<thead>
<tr>
<th>Age group</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-24yrs</td>
<td>5.4</td>
</tr>
<tr>
<td>25-29yrs</td>
<td>7.0</td>
</tr>
<tr>
<td>30-34yrs</td>
<td>6.8</td>
</tr>
<tr>
<td>35-39yrs</td>
<td>7.9</td>
</tr>
<tr>
<td>40-44yrs</td>
<td>10.2</td>
</tr>
<tr>
<td>45-49yrs</td>
<td>10.7</td>
</tr>
<tr>
<td>50-54yrs</td>
<td>13.7</td>
</tr>
<tr>
<td>55-59yrs</td>
<td>14.7</td>
</tr>
<tr>
<td>60-64yrs</td>
<td>15.3</td>
</tr>
<tr>
<td>65-69yrs</td>
<td>7.1</td>
</tr>
<tr>
<td>70 and over</td>
<td>1.2</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Five-Quarter longitudinal LFS data, 2009–2012

Given that these two occupational groups (nurses and ambulance drivers) have high proportions of their respective totals in their 50s and older, such high exit rates may have important implications for approaches to recruitment and retention of these groups. It is notable that there are two clear trends that are difficult to reconcile: a relatively old and ageing NHS workforce, but high rates of early exit from employment once past 50 years of age in some occupations.

Earlier analysis indicated that NHS employees have long employment tenures and that it lengthens with the age of the employee. Loss of these employees embodies the potential to lead to increase costs, loss of experience, loss of skills, institutional stability and loss of tacit knowledge. On the other hand, it can lead to the recruitment of people with fresh ideas, greater flexibility and higher rates of productivity (MacKinnon Partnership, 2010). Whatever view is taken on this, Table 21 shows that those exiting the NHS had longer years of continuous service than those who stayed within the NHS for the entire 12 months. *Exiters* had been employed in the NHS for 13.8 years compared with 10.4 years for the ‘*stayers*’.*9 The same pattern plays out for older employees, except that, unsurprisingly, the total years of service for both *exiters* and *stayers* are higher than for younger employees; Table 21.

* The difference is not an artefact of ‘exiters’ being older than stayers since subsequent analysis of length of service by precise age of employment showed that for every year over the age of 49, exiters had served longer than stayers.
Table 21: Stayers and Exiters Yrs worked in NHS

<table>
<thead>
<tr>
<th>Age</th>
<th>Exiters (Yrs service)</th>
<th>Stayers (Yrs service)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;30</td>
<td>4.3</td>
<td>3.9</td>
</tr>
<tr>
<td>30-39</td>
<td>6.6</td>
<td>7.1</td>
</tr>
<tr>
<td>40-49</td>
<td>10.0</td>
<td>11.3</td>
</tr>
<tr>
<td>50-54yrs</td>
<td>13.7</td>
<td>16.6</td>
</tr>
<tr>
<td>55-59yrs</td>
<td>21.0</td>
<td>18.2</td>
</tr>
<tr>
<td>60-64yrs</td>
<td>21.8</td>
<td>18.4</td>
</tr>
<tr>
<td>65-69yrs</td>
<td>18.1</td>
<td>15.5</td>
</tr>
<tr>
<td>70 and over</td>
<td>13.6</td>
<td>–</td>
</tr>
<tr>
<td>Total</td>
<td>13.8</td>
<td>10.4</td>
</tr>
</tbody>
</table>

Source: Five-Quarter longitudinal LFS data, 2009–2012

8.8 Destinations of those who exit NHS employment

Of those who exit NHS employment (of all ages), 51% go into another job outside the NHS, 21% retire, 11% either re-train, go into education or become unemployed, 9% exit to family or home care, 2% are sick or injured and 7% are recorded as ‘not working – other’; Table 22.

Table 22: Destinations of NHS Leavers %

<table>
<thead>
<tr>
<th>Type</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment/self- employment</td>
<td>51.0</td>
</tr>
<tr>
<td>Unemployment/education/training</td>
<td>10.6</td>
</tr>
<tr>
<td>Retired</td>
<td>21.3</td>
</tr>
<tr>
<td>Sick or injured</td>
<td>1.6</td>
</tr>
<tr>
<td>Family/home care</td>
<td>8.6</td>
</tr>
<tr>
<td>Not working other</td>
<td>6.9</td>
</tr>
<tr>
<td>All</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Five-Quarter longitudinal LFS data, 2009–2012

The pattern for those aged over 50 is rather different. It might be hypothesised that most who exit in their 50s and 60s would take retirement. Indeed, 41% did move into retirement. However, a higher proportion (43%) exited NHS employment to take employment elsewhere. A further 3% exited by moving to ‘sick or injured status’ and a similar proportion exited for reasons of family or home care; Table 23.
Examining the older NHS leavers by gender, 52% of males go to employment elsewhere and 25% retire, while 6% exit because they are sick or injured.

For females, retirement is the most common reason for exit, accounting for 48% and 39% exit for employment elsewhere; Table 23.

<table>
<thead>
<tr>
<th>Destination</th>
<th>Male</th>
<th>Female</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unemployment/education/training</td>
<td>4.3</td>
<td>3.9</td>
<td>4.0</td>
</tr>
<tr>
<td>Retired</td>
<td>25.7</td>
<td>47.6</td>
<td>41.0</td>
</tr>
<tr>
<td>Sick or injured</td>
<td>6.3</td>
<td>1.7</td>
<td>3.1</td>
</tr>
<tr>
<td>Family/home care</td>
<td>4.5</td>
<td>2.9</td>
<td>3.4</td>
</tr>
<tr>
<td>Not working other</td>
<td>7.3</td>
<td>4.4</td>
<td>5.3</td>
</tr>
<tr>
<td>Employment</td>
<td>51.9</td>
<td>39.2</td>
<td>43.2</td>
</tr>
<tr>
<td>All</td>
<td>100.0</td>
<td>100.0</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Five-Quarter longitudinal LFS data, 2009–2012

While some of those who leave the NHS to take employment elsewhere do so to change careers, 57% move into occupations which are still health related and 76% of these are in the private sector. For those over 50 years of age, the proportions are lower with 40% moving into non-NHS health related occupations; Table 24.

<table>
<thead>
<tr>
<th>Destination</th>
<th>% all NHS who change job</th>
<th>% NHS 50+ who change job</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-health related occupation</td>
<td>42.9</td>
<td>60.4</td>
</tr>
<tr>
<td>Health related occupation (private)</td>
<td>43.3</td>
<td>30.9</td>
</tr>
<tr>
<td>Health related occupation (public/charitable)</td>
<td>13.7</td>
<td>8.7</td>
</tr>
<tr>
<td>All</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source: Five-Quarter longitudinal LFS data, 2009–2012

Of the remainder of the over 50s who exited NHS employment and did not find employment elsewhere, 14% said that they would like to be in employment; Table 25.
Table 25: Disposition to work after exiting NHS employment

<table>
<thead>
<tr>
<th>Attitude to work</th>
<th>All who exited but not to another job (%)</th>
<th>Over 50s who exited but not to another job (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Would like work</td>
<td>30.1</td>
<td>13.5</td>
</tr>
<tr>
<td>Would not like work</td>
<td>69.9</td>
<td>86.5</td>
</tr>
<tr>
<td>All</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Five-Quarter longitudinal LFS data, 2009–2012

8.9 Reasons for exiting from NHS employment

Generally, the LFS does not record attitudinal data and so instead of self-report reasons for exit from employment we must rely on indirect measures, which plausibly correlate with exit from employment. Previous research highlights a range of reasons for exit from employment, including pay, conditions of employment, desire for reduced hours, health and illness. Unfortunately, the longitudinal LFS contains a limited subset of the full list of LFS variables, which hinders the ability to conduct detailed or robust analysis.

Retirement

The most obvious reason for exit from employment among the over 50s is retirement. Earlier data showed that after exiting NHS employment, 25% of males and 48% of women leavers took retirement. Of those who took retirement just over half of men took it early (rather than at the ‘pension age’) and 36% described their retirement as ‘early’; Table 30. This makes it clear that a large proportion of NHS employees are exiting for retirement well before the state pension age.

LFS data show that retirement begins at about 50 for women and 55 for men. From 55, the cumulative number of retirements increases rapidly for women and by age 60, 40% have retired and by 65 it is 95%. For men, the rate of increase begins five years later at 60 where just 13% have retired. By 65, 49% have retired and by 68, 88% had retired. Overall, the mean age for retirement of both men and women is 62.3 years. It is important to remember, however, that this is the age of retirement of those who remain in employment within the NHS into their 50s. As we have seen in figure 8a, only a small fraction of NHS employees remain in employment until their 60s, with the vast majority having exited earlier.

Desire to reduce hours/work more flexibly

While many may wish to retire, some may exit NHS employment in order to reduce their work hours. Earlier evidence indicated that many older employees had taken part-time work. Evidence also indicated that many employees also work long hours. Tables 9, 11 and 12 indicate that there is a strong preference among many employees for reduced hours, but it is apparent that of those who requested shorter hours their employer refused the request for shorter hours in the majority of cases. The question therefore arises whether employees
might be exiting inflexible jobs or long working hours in search of more flexible or shorter hours.

<table>
<thead>
<tr>
<th>Full time or Part time work</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full-time</td>
<td>16.5</td>
</tr>
<tr>
<td>Part-time</td>
<td>83.5</td>
</tr>
<tr>
<td>All</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Five-Quarter longitudinal LFS data, 2009–2012

Examining those aged 50+yrs who had exited the NHS by wave five and were previously working full-time, of those who went into non-NHS employment, 16.5% took part-time work and the remainder took full-time work. Although it cannot be known whether the shift to part time work was the cause of exiting the NHS, it seems clear that a significant proportion choose to reduce their hours or change their work patterns after leaving the NHS; Table 26.

Figure 16: Cumulative total of those NHS employees who take retirement by age

Further evidence of the preference for reducing hours comes from the analysis of the average number of hours worked by those who stay within the NHS over the five quarters of the study compared with those who left. Older NHS ‘exiters’ show a slight two hour reduction in average weekly hours worked compared with NHS ‘stayers’; Figure 17.
To increase pay
The econometric evidence on the impact of pay as a motivational factor in employees exiting NHS employment is disputed (Frijters et al., 2004). Analysis of longitudinal LFS data here, however, suggests that, for NHS employees of all ages, those who left and those who stayed saw broadly equivalent modest pay increases over the 12 month period. For older employees there is a small difference. While stayers saw a small drop in pay over the period – £501 to £495 per week – exiters were paid £453 in their NHS occupation and £469 in their new occupation outside the NHS. This difference is quite small and, overall, it seems unlikely that pay could be a significant motivator for older employees exiting NHS employment; Table 27.

<table>
<thead>
<tr>
<th>Employment status</th>
<th>Gross pay at wave 1 (£)</th>
<th>Gross pay at wave 5 (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employed in NHS waves 1 thru 5 (all ages)</td>
<td>502</td>
<td>516</td>
</tr>
<tr>
<td>Employed in NHS wave 1 but elsewhere by wave 5 (all ages)</td>
<td>498</td>
<td>517</td>
</tr>
<tr>
<td>Employed in NHS waves 1 thru 5 (all ages)</td>
<td>501</td>
<td>495</td>
</tr>
<tr>
<td>Employed in NHS wave 1 but elsewhere by wave 5 (all ages)</td>
<td>453</td>
<td>469</td>
</tr>
</tbody>
</table>

Source: Five-Quarter longitudinal LFS data, 2009–2012

Exit due to ill health
The final reason for exit examined was ill health. LFS data show that older NHS employees have a high prevalence of long-standing illnesses. Both exiters and stayers over the age of 50 have a similar probability of recording an illness lasting more than one year (39% and
40% respectively). Of note, while a prevalence of 40% for over 50 year olds may seem high, it is only marginally higher than the LFS all age sample figure of 35%; Table 28.

### Table 28: Long-standing illness among older NHS employees %

<table>
<thead>
<tr>
<th>Health problem lasting more than 1 yr</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employed in NHS waves 1 thru 5</td>
<td>39.6</td>
<td>60.4</td>
</tr>
<tr>
<td>Employed in NHS wave 1 but elsewhere by wave 5</td>
<td>39.1</td>
<td>60.9</td>
</tr>
</tbody>
</table>

Source: Five-Quarter longitudinal LFS data, 2009–2012

Long-standing illnesses vary in severity and so it is difficult to know, despite similar rates of illness, whether one group may suffer from more severe illnesses than the other. In fact, LFS data show that those who had a long terms illness and exited the NHS were more likely to claim that the illness affected the kind of work they could do (38% of exiter and 25% of stayers); Table 29.

### Table 29: Exiters from NHS – whether ill health affects job choices %

<table>
<thead>
<tr>
<th>Cross-tabulation</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employed in NHS waves 1 thru 5</td>
<td>25.4</td>
<td>74.6</td>
</tr>
<tr>
<td>Employed in NHS wave 1 but elsewhere by wave 5</td>
<td>38.5</td>
<td>61.5</td>
</tr>
<tr>
<td>Total</td>
<td>27.2</td>
<td>72.8</td>
</tr>
</tbody>
</table>

Source: Five-Quarter longitudinal LFS data, 2009-2012

This picture is further confirmed by the fact that 15% of males who exited NHS employment said they left for health reasons. The same applies to 3% of females. Overall, although long-standing ill health would seem to explain a portion of exits from the NHS, the portion is relatively small; Table 30.
### Table 30: Reason Given for Leaving Last Job (50+ NHS employees)

<table>
<thead>
<tr>
<th>Reason</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health reasons</td>
<td>14.7%</td>
<td>3.4%</td>
</tr>
<tr>
<td>Early Retirement</td>
<td>21.1%</td>
<td>26.5%</td>
</tr>
<tr>
<td>Retired at pension age</td>
<td>20.9%</td>
<td>46.3%</td>
</tr>
<tr>
<td>Family/personal reasons</td>
<td>0.2%</td>
<td>4.2%</td>
</tr>
<tr>
<td>Other</td>
<td>43.0%</td>
<td>19.6%</td>
</tr>
<tr>
<td>All</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Source: Five-Quarter longitudinal LFS data, 2009–2012
9.0 Evidence gaps

- The 'local' decision architecture, will impact on employee understandings of choices, and their behaviour in relation to this. There is very little NHS specific evidence on how the prevailing decision architecture impacts on employee behaviour in relation to extending working life / early withdrawal.

- 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. Relatedly, little is known of employee perspectives on what change might be made to mitigate their impact.

- The costs of failing to retain experienced staff are high. Fair (1992) estimated it around six months’ salary and this is has since been frequently cited by CIPD and most recently confirmed in a report by PricewaterhouseCoopers (2010). This takes account the cost of carrying a vacancy, training costs for new recruits and the reduced productivity of new recruits as well as the normal costs of recruitment, including senior management time.

- 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.

- 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.

- 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 were well advanced. Local (sector specific) solutions are needed to take account of the prevailing culture(s); institutional arrangements; established ways of working and the scope for change.

- 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, turnover and exit, they typically know little about: 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. They also lack robust evidence on the effectiveness of policies and initiatives.

- There is a need to gather health sector 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.

- 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.

- There is a lack of evidence on how employers might use epidemiological perspectives 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 has been little application of a risk-based approach to identify vulnerable groups by job-role and function.

- 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. its components are currently not well mapped.

- 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, and there are also potential legal pitfalls in treating people of different ages differently.

- 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.

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

- The finding that flexibility is both attractive and seemingly particularly important where employees experience diminished capacity or motivation, remains under-evidenced in terms of the practicalities of arrangements that might be configured in a given employment sector. 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.

- Little is known of the factors to motivate presenteeism in older workers and the impacts of this on longer term health status and organisational performance. There are grounds for believing that rates of presenteeism will vary by job role and function. Mapping who (by job role / function) is more prone to exhibiting presenteeism within the NHS would contribute to controlling risk in this area.
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?
10.0 Conclusions and recommendations

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.

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.

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.

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 wellbeing 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.
References


Audit Commission (2011) Managing sickness absence in the NHS.


CIPD (2011) *Happy and productive workers are those that find their work stimulating and interesting, and are reasonably confident they can continue to find suitable work throughout their working life*. [http://www.cipd.co.uk/comment-insight/comment/career-management.aspx](http://www.cipd.co.uk/comment-insight/comment/career-management.aspx)


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Extending Working Life
Audit of research relating to impacts on NHS employees


