

DATA AND AI FOR WORK AND HEALTH

A PROSPECTUS FOR A UK WORK AND HEALTH TOOLKIT

Prepared for Keep Britain Working, a national programme sponsored by the Department for Work and Pensions, the Department for Health and Social Care and the Department for Business, Innovation, Science and Trade.

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Executive summary

This prospectus was prepared for Keep Britain Working by the Civic Health Innovation Labs (CHIL) at the University of Liverpool. It proposes a UK Work and Health Toolkit (WHT): a worker-centred way to identify work-and-health problems as they emerge and to ensure workers receive personalised guidance. The toolkit would also generate intelligence for employers and public services, while keeping each worker's information confidential. The chapters that follow describe the status quo and the case for early, supportive contact between workers, their employers and health services; then introduce the toolkit and its data governance. Worker scenarios and data-sharing models are set out for testing with a Citizens' Panel. Later chapters cover the risks and the safeguards proposed against them, how outcomes would be evaluated, and a phased, evidence-led pathway from co-design to wider implementation.

The UK experiences a vicious circle of ill health, economic inactivity and socioeconomic disadvantage. Its work-and-health system is reactive and fragmented, and the failures of that system fall hardest on the most disadvantaged communities, where ill health starts earliest and support is thinnest. As a result, mental and physical health problems and unmet needs for disability support often remain invisible until they disrupt work. Employers lack a consistent view of the health pressures emerging in their workforces, public services lack timely information on where those pressures are rising, and individuals often receive support only once problems have escalated. The consequences are avoidable absence, weaker employee retention and widening inequalities in health and in social and economic wellbeing.

International models – Finland's work-ability approach, the Netherlands' Gatekeeper Protocol and Denmark's flexjob scheme – show different ways of making early contact between a worker, their employer and health services, when health begins to affect work.

They also demonstrate approaches to coordinating support around the person – setting out who is responsible for what and of adjusting work to what a person can do. Their experience reinforces the importance of connecting information to practical assistance and evaluating outcomes. The opportunity for the UK is to bring these elements together in modern, worker-centred tools and support, benefiting workers, employers, public health and the economy.

Trustworthy data and AI would be central to the WHT, helping to identify problems early and signpost users to sources of support. This would begin with questions that people could answer quickly via a website, app or voice AI. Their responses would help identify emerging pressures and inform immediate, personalised guidance. Individuals would have clear choices over how their information is used, be able to correct factual errors and challenge AI-generated outputs, and choose whether to share personal insights with their GP or a trusted support provider, potentially through future NHS App integration. Employers would never receive identifiable health data through the WHT – only aggregate, non-disclosive, actionable insights. A worker could choose to pass on their own summary to their employer to help get support, but nothing would ever be shared automatically. This boundary is intended to protect workers' trust while giving employers intelligence they can act on.

The WHT could enable a systemic shift in the UK approach to health at work, by providing the worker-facing front end through which early signals of problems could be identified. A Workplace Health Intelligence Unit (WHIU) as recommended by the Keep Britain Working Review could turn those signals into consistent, comparable evidence for employers, providers and policymakers. Together, they could build a national picture of work-and-health pressures across regions and sectors from non-identifiable signals.

Public services and policymakers could use this intelligence to target support where ill health starts earliest; to coordinate NHS, workplace health and employment services; and to inform outcome-based incentives. Combined with clearer employer responsibilities and accessible workplace health provision, the WHT-WHIU system could help people stay in work and, over time, reduce avoidable demand on GPs and other public services.

The model requires trusted, independent custody of data and clear safeguards. The prospectus sets out how a worker-initiated toolkit could be developed and tested under existing law, and what further legal provision would be needed for the proposed wider, system-initiated model of support and coordination.

Above all, the toolkit must be co-produced with citizens, not imposed on them. Deliberative work is planned to begin with the Citizens' Panel in Liverpool City Region in autumn 2026, testing acceptable uses of data, consent preferences and conditions for trust. Further panels across the UK are recommended.

The immediate task is a governed, resourced programme to test the WHT with citizens, employers and providers, with clear decision points at which to proceed, revise or stop. Done well, this approach could provide earlier help, strengthen retention, improve productivity and protect citizen autonomy. We envision a fairer and more supportive work-and-health system, built with the communities most affected.



Status quo: delay and fragmentation

Linked work and health problems have become a major concern for the labour market as much as public health. More than one in five working-age people are out of work and not looking for work, higher than in comparable European countries, and long-term ill health is the commonest cause.¹ Around 2.8 million people are economically inactive because of health conditions, 800,000 more than in 2019, with a further 600,000 projected to leave work by 2030 without action.² Annual spend on working-age health and disability benefits reached £45 billion in 2024 and is forecast to rise to £65 billion by 2030.¹ The disability employment rate is 52.8% compared with 82.3% for non-disabled people, and the gap, which is one of the widest in Europe,³ appears to be widening.² Only around one in five people who become inactive through long-term sickness move directly from a job; most were already out of the labour market for another reason.⁴ The preventable part is the flow out of work: more than 300,000 people a year leave work with a work-limiting condition;⁵ around one in ten employees who experience a decline in their health leave work, most within a year of falling ill;⁶ and former workers in retail, transport, hospitality, care, construction and manufacturing, and in the lowest-paid occupations, are over-represented among the long-term sick.⁴ These individuals are under-served by a system that reacts – to absence, to fit notes, to benefit claims – rather than prevents.

Across the UK, work and health are too often managed through late signals and fragmented pathways. Problems become visible only once they have disrupted work, wellbeing or retention. Mental and physical health problems – anxiety, depression, musculoskeletal disorders, chronic pain and poor sleep among them – affect, and are affected by, work.⁷ These pressures accumulate quietly, and effective support tends to arrive only when someone is struggling, taking sickness absence or leaving work.

An estimated 148.8 million working days were lost to sickness or injury in the UK in 2025, 9.8 million more than in 2019.⁸ Disability support is similarly delayed. The Keep Britain Working Review found long delays and delivery problems in the Access to Work scheme.¹ In the 2024–25 survey of workers by the Department for Work and Pensions (DWP) 73% of those with a long-term health condition had not heard of the scheme and only 4% had received support through it.⁹

Fit notes are issued once health is already affecting fitness for work rather than providing an early-warning system. They can record that someone ‘may be fit for work’ with suggested adjustments to their role or workplace.¹⁰ However, 93% of fit notes in England classify the recipient as ‘not fit for work’, and they are often extended without further consultation.¹ More than 11 million fit notes were issued in 2025, most without a coded diagnosis; among those with a diagnosis code, mental health (36%) and musculoskeletal (18%) conditions dominated.¹⁰ Employers responding to the government’s call for evidence on fit note reform wanted more detail so that they could plan adjustments and safe returns.¹¹ In May 2026 the government announced pilots in four areas of England, running from July 2026, that offer up to 100,000 appointments and test alternatives to certification, with support alongside it, through personalised work-and-health support and plans agreed with employers.¹² Occupational health services can offer more proactive, personalised support, but access is highly unequal: in the DWP survey, 76% of employees in organisations with at least 250 staff had access, compared with 23% in organisations with 2–49 staff and 9% of self-employed workers.⁹ Occupational health intervention alone, however, may be insufficient to tackle underlying problems; therefore, coordination with wider health and care services is vital.

The situation is worse in socioeconomically disadvantaged areas, where combinations of health conditions arise at younger ages – the onset of multimorbidity occurs 10–15 years earlier in the most deprived areas than in the most affluent.¹³

Among workers with a long-term condition, those in the most deprived areas are the most likely to say it limits the work they can do (53%, compared with 35% in the least deprived areas).⁹ Workers in the North of England are twice as likely to lose their job after a spell of ill health as those elsewhere in England, and northern workers with no qualifications are nine times less likely to remain employed after falling ill than those with A-levels.¹⁴ Regional health inequalities have also widened: age- and sex-adjusted excess mortality among working-age people aged 25–49 years in the North of England (including the Midlands) compared with the South rose from 13.2% in 1981 to 42.4% in 2024.¹⁵

A major blind spot is the absence of reliable early information about people's work-and-health situations. Disability employment is measured nationally, but understanding inclusion and unmet support needs within workplaces depends heavily on voluntary disclosure. The mandatory disability pay gap and workforce reporting that was confirmed in March 2026 for employers with 250 or more staff will still rest on self-declaration. This means the figures need to be interpreted with caution alongside published declaration rates.¹⁶ Concerns about stigma, discrimination and career prospects discourage people from sharing information:¹ in the DWP survey, only 58% of employees with a long-term health condition had discussed it with their employer, although 89% of those who had found their employer supportive.⁹ These information gaps limit workforce planning and workplace improvement. The aim should be to make sharing support needs safe and useful, not to compel disclosure or simply count declared disabilities.

Information gaps extend across the system. Employers and policymakers need aggregate insight into trends such as rising musculoskeletal pressures or health patterns associated with shift design; a few large employers and providers hold deep datasets, but most do not,¹ and sickness absence is tracked inconsistently while return-to-work outcomes are rarely measured.¹⁷

Providers and voluntary-sector organisations need clearer referral routes and visibility of unmet need. Individuals need flexible processes rather than a fixed menu of options that rarely fits their circumstances, and support that reaches those least able to navigate existing pathways.

These gaps have real consequences: ill health costs employers an estimated £85 billion a year, and the country as a whole around £212 billion a year in lost output, welfare payments and NHS demand, a figure that includes the cost to employers.¹ Collecting more data is not enough. Existing services need to be connected through simple, trusted routes for people to describe their situation early, receive personalised guidance and access practical support. Better information must lead to timely help and workplace adjustments, not another reporting burden.

Today we have a system that too often cannot see what matters soon enough to act: individuals lack personalised early guidance; employers lack actionable insight; providers lack consistent information; and policymakers lack comparable evidence for outcome-based incentives and targeted interventions.¹ It is a reactive system, organised around absence, certification and benefit claims. Stemming the flow of people leaving employment for health reasons requires a proactive, preventive approach: early, supportive contact when problems emerge, personalised guidance, and workplace adjustments made before absence begins rather than after it has become entrenched. Achieving this demands a data-driven, multi-agency system designed around workers and continuously improved by employers, healthcare providers and civic partners.

Why now: the case for early, supportive contact

The case for earlier support is compelling. In evidence cited by the Keep Britain Working Review, employees absent for four to six weeks had a 96% chance of returning, compared with less than 50% for those absent more than a year.¹ Around one in ten employees whose health declines leave work, most within a year of falling ill.⁶ These figures underline the value of maintaining contact and offering timely help, without implying that everyone can return quickly or that necessary recovery time should be curtailed. The opportunity is to recognise emerging difficulties before absence becomes prolonged and, where possible, before it starts.

Other countries have built structured contact into their work-and-health systems. Finland's 2012 '30-60-90' reforms introduced checkpoints linking notification of sickness absence with assessment of rehabilitation needs and remaining work ability. An evaluation limited to public-sector employees found some short-term improvement in sustained return to work, although this was not consistent across absence durations,¹⁸ and a later national evaluation found increased participation in rehabilitation but no improvement in employment one year later.¹⁹ These mixed findings underline the importance of measuring sustained work outcomes, not just contact or rehabilitation uptake. Policymakers should not assume that more contact necessarily leads to better outcomes.

The Netherlands' Gatekeeper approach requires an occupational health assessment after six weeks of absence and a joint employer-employee action plan by the eighth week, backed by continuing reintegration responsibilities and up to two years of employer-funded sick pay.²⁰ Research found that the Dutch reforms, combining stronger employer financial incentives with monitoring obligations, reduced disability-benefit receipt and increased employment after health shocks.²¹

These findings show the benefit of a wider system of responsibilities and support; they do not evaluate standalone early-insight tools.

Denmark's flexjob scheme, introduced in 1998, takes a different route: it subsidises adjusted jobs, with reduced hours or lighter duties, for people whose working capacity is permanently and substantially reduced, and covered around 60,000 people by 2012. It shows that adjusted work can be organised at scale, but its evaluations are cautionary: few participants move back into unsubsidised work, reductions in the subsidy shifted hiring towards existing employees rather than people out of work, and the scheme did not reduce the flow onto disability pensions.²² Subsidised adjustment late in the course of ill health is not a substitute for early contact.

More directly relevant to the Work and Health Toolkit (WHT), a Finnish randomised trial used a questionnaire to identify workers at high risk of sickness absence and offered them targeted occupational health consultations. Those offered the intervention had, on average, 11 fewer absence days over a year (95% confidence interval: 1-20) than those receiving usual care; telephone advice offered to a separate intermediate-risk group produced no reduction.²³ A Dutch trial of structured early consultation for high-risk office workers found a similar reduction, of about 12 days a year in a modified intention-to-treat analysis, with fewer long-term absences in per-protocol analysis.²⁴ The practical lesson is to connect early identification with effective assistance, rather than rely on check-ins or advice alone.

Trusted data stewardship and clear choices over data sharing would support participation, while employers would receive only aggregate, non-disclosive insights, at sector or area level where a workforce is too small; anything an individual chose to share with an employer would be their own act, never automatic. The toolkit should strengthen access to workplace adjustments and services, not substitute for them.

The policy direction creates a practical opening. The government's ambition of an 80% employment rate and its Get Britain Working programme support locally coordinated employment, health and skills provision.²⁵ England's 10 Year Health Plan prioritises prevention and digital services,²⁶ and fit note reform pilots were announced for launch in July 2026.¹²

The Keep Britain Working Review recommended a vanguard phase, in which employers test new approaches, and the creation of the Workplace Health Intelligence Unit (WHIU).¹ Its June 2026 update goes further: it proposes work and health checks at key points in the employment lifecycle, learning from Finland and Japan, aggregated through the WHIU and co-designed with citizens through deliberative approaches such as citizens' assemblies.²⁷ The checks could potentially be delivered digitally by an independent entity with assurance that no person-level data would be shared with employers. The WHT is the instrument through which that concept can be tested with citizens, through the Citizens' Panel described later in this prospectus. It connects these developments through earlier signals, personalised guidance and comparable outcome measures.

There is also an opportunity to clarify the legal arrangements; we cannot assume that recent legislation has already authorised the proposed data flows. The Data (Use and Access) Act 2025 introduced 'recognised legitimate interest' as a lawful basis for specified purposes; its applicability depends on the purpose and organisation involved.²⁸ Health information still requires a separate special-category processing condition.²⁹

The Digital Economy Act 2017 provides gateways for defined public-service objectives, but its public service delivery arrangements exclude health and adult social care bodies in England.³⁰ Applicable confidentiality duties must also be addressed.³¹ The legal basis chapter (expanded in the appendix) examines which existing routes are suitable and where further provision may be needed.

Liverpool City Region (LCR) offers a credible setting for co-production and evaluation of the WHT. It can draw on linked NHS data platforms at local, regional and national levels, experience of linking health and housing data across Cheshire and Merseyside, and the Civic Health Innovation Labs' (CHIL) work with residents on uses of data and AI, including the LCR Community Charter on Data and AI.^{32,33} The LCR Combined Authority is one of the Review's regional vanguards, and its Get Liverpool City Region Working Plan brings together NHS, employment, skills, business and community partners.^{27,34} Mayoral authorities could convene employers and unions, connect early-support tools with local provision and coordinate evaluation across regions. Common standards would support comparison, while testing in other regions and UK nations would assess transferability.

Together, the evidence, the policy direction and the institutional partnerships make a strong case for prototyping the WHT with citizens. The immediate task is to test whether it leads to earlier, effective support, better health and sustained participation in suitable work. The next chapter describes what the toolkit would offer.

Introducing the Work and Health Toolkit

The Work and Health Toolkit (WHT) is a proposal for a worker-centred way to describe emerging work-and-health problems and receive personalised guidance. It would benefit workers first, while generating safe, aggregate intelligence that employers and public services could use to improve support and prevent avoidable disengagement from work. The Keep Britain Working Review's June 2026 update explores independently delivered 'work and health checks', with no person-level data shared with employers.²⁷ The WHT is a concrete way to test that concept. Its content and delivery would be co-designed with citizens, guided by four proposed features.

First, a short question set linked to relevant help. People would answer questions in minutes through a website, app or voice AI, with assisted and non-digital routes for those unable to use digital channels. The initial target is around twenty items, subject to testing. A brief common core could be supplemented by relevant follow-up questions, with wording, accessibility and burden assessed during development. Established measures would be used where suitable. The single-item Work Ability Score, for example, has been associated with sickness absence and subsequent disability pension awards in longitudinal studies.^{35,36} Its suitability across diverse UK workers and delivery channels would still need testing. It could sit alongside broad questions about symptoms, work demands, existing adjustments and what would help.

The immediate value should be guidance tailored to the person's circumstances, with clear next steps and connections to appropriate support. This could include NHS and other public services; employer-funded occupational health, employee assistance programmes and other workplace provision; community and voluntary-sector services; private or insured care; and self-help. Signposting should reflect eligibility, availability and cost, rather than simply provide a list of links.

With the worker's explicit permission, and never automatically, a relevant summary could be shared with a chosen provider so that a supported conversation could begin without repeating the whole story. The toolkit could also help people prepare to discuss workplace adjustments or phased returns, drawing on NICE guidance.³⁷ The trials discussed in the previous chapter support testing early identification linked to effective assistance, rather than assuming that check-ins or advice alone will improve outcomes.^{23,24}

Second, autonomy and control. People would have clear choices about participation, data sharing and how they interact with AI. They would be able to correct factual errors, challenge AI-generated outputs and access human support. The WHT would provide guidance, not diagnosis or decisions about fitness for work, benefits or employment. Clinical safety would be managed throughout development and deployment, following the applicable requirements of NHS clinical risk management standards DCB0129 and DCB0160, with clear routes to appropriate services when further assessment is needed.^{38,39} The legal basis chapter addresses permitted data uses and automated decision-making.

Person-identifiable information would be held by a trusted independent custodian, separately from employers' systems. Sharing identifiable information with a GP or chosen support provider would require the individual's permission, potentially through future NHS App integration or links with the developing Single Patient Record programme.²⁶ Employers would never receive individual worker health data through the WHT.

Third, insight that employers can act on. Employers would receive only aggregate, non-disclosive information about emerging problems, such as musculoskeletal symptoms in particular roles, health patterns associated with shift arrangements or barriers to disability inclusion.

Reporting would draw on the 'safe outputs' principles used in NHS secure data environments, with disclosure checks before release.⁴⁰ Controls would need to address small groups and combinations of results that could reveal individuals. Where employer-level reporting could not be made safe, broader sectoral or regional insights could provide an alternative.

The WHT would complement, not replace, engagement surveys, occupational health, employee assistance programmes or statutory health surveillance. Its added value would be an independent worker-facing route, consistent measures and connections across services, rather than another employer questionnaire. Line managers would receive practical guidance and prompts, not workers' individual responses or scores.

Fourth, a clear place in the wider system.

The WHT would be the worker-facing front end, not the intelligence function behind it. The Review recommended that a Workplace Health Intelligence Unit (WHIU) be set up as an independent body to bring together work-and-health information, benchmark outcomes and support innovation.¹ This body, or an organisation like it, could then have a guardianship role for WHT data: holding individual health and work-ability profiles securely and managing onward sharing only with consent.²⁷ The relationship between that body's role and WHT data custody would need to be defined, with clear responsibilities and distinct permissions for personal support and analysis.

For public services and policymakers, this connection between the WHT and the WHIU or a similar body would offer a third use case alongside individual guidance and employer insight. It could help build a national picture of work-and-health pressures across regions, sectors and occupations, identifying unmet needs and informing the evaluation of support. This evidence could help target investment, coordinate NHS, workplace health and employment services, reduce avoidable demand on primary care and inform outcome-based incentives.

Interpretation would need to account for differences in participation and coverage. Questionnaire responses would contribute to understanding what works, but would need to be connected with outcome evaluation rather than treated as evidence of effectiveness on their own.

The consent and data-sharing models in this prospectus are illustrative, not final designs. They distinguish personal sharing for support from governed analysis that produces aggregate insights, and provide a basis for testing acceptable uses, preferred custody arrangements and conditions for trust with the Citizens' Panel. Deliberation would shape the model's acceptability and legitimacy; prototype testing and prospective evaluation would assess usability, safety, effectiveness and equity.

The aim is a toolkit that is simple for individuals, actionable for employers and useful to public services, without compromising trust. Success would mean earlier access to effective support and sustained participation in suitable work, not simply more data collected or another form completed.

Legal basis for data use and consent

The Work and Health Toolkit (WHT) can be built and tested under the law as it stands. What the law does not yet provide is a dependable route for the system, rather than the worker, to start the process and coordinate support across the NHS, occupational health, employment services, benefits and the workplace. This chapter summarises our legal analysis, which is set out in full in the appendix, and what it means for the opportunity and potential reach and impact of the WHT.

What the law already allows. UK data protection law is an enabling governance rather than an obstacle. Organisations may process personal data for a public task with a clear basis in law. Health data may be processed where an Article 9 condition and, usually, a Schedule 1 condition of the Data Protection Act 2018 are met.²⁹ The common law duty of confidentiality is a separate layer: confidential patient information may be used with consent, within the reasonable expectations of direct care, under specific statutory authority, or exceptionally where an overriding public interest justifies disclosure in an individual case. Section 251 of the NHS Act 2006 and the Control of Patient Information Regulations allow confidentiality to be set aside for defined medical purposes, including eligible research and evaluation, under strict governance; they are not a gateway for routine NHS-to-DWP flows.⁴¹ The Digital Economy Act 2017 lets 'specified persons' share data for objectives set by regulations. Combined authorities and the Greater London Authority are already specified persons, alongside DWP and councils, but there is no work-and-health objective and English health bodies are absent from the schedule by a policy decision of 2017, not a statutory bar.^{30,42} Every proposed flow must pass all of these tests together: relevant functions and powers, the data protection conditions, a route through confidentiality, and necessity and proportionality.

What can be done now. The WHT is designed around what current law permits. The worker completes the questions, sees the feedback and decides whether to seek support. Identifiable responses stay with an authorised clinical or occupational health service; the employer receives only what the worker chooses to share, plus aggregate workforce intelligence. Anonymous data can flow to the Workplace Health Intelligence Unit or a similar body for evaluation. Where an occupational health professional forms part of a person's care, as in some WorkWell and fit note pilot pathways, limited information may be shared under the ordinary direct-care route and, where its conditions are met, section 251B of the Health and Social Care Act 2012; Article 9(2)(h) expressly covers occupational medicine and the assessment of working capacity where a confidentiality-bound professional is responsible.⁴³ Evaluation can proceed in secure data environments and, where the statutory criteria are met and consent is impracticable, with section 251 support. Vanguard can therefore begin with worker-authorized plans, clearly defined direct-care pathways, aggregate employer intelligence and secure evaluation. The prospect of new law is not a reason to delay what is already lawful.

Where the law runs out. The complete legal route does not exist for a dependable, system-initiated coordination service: notifying an accredited work-and-health service when a fit note reaches a defined duration; combining health, benefit and employment-support information to identify an offer of help; several public bodies maintaining one operational plan. Consent cannot carry such a service alone – it may not be freely given where there is a power imbalance, it can be withdrawn, and every source body would still need a function and a power to disclose. The missing components are specific and finite: an express civic function for strategic authorities; a named Digital Economy Act objective, with the relevant NHS bodies added to Schedule 4 and the 2017 pause on health bodies lifted; a narrow statutory gateway through health confidentiality for a minimum dataset;

and, where national completeness matters, a proportionate duty to cooperate rather than a merely permissive power. Where no existing Schedule 1 condition is suitable, ministers can consider the regulation-making power in section 10 of the Data Protection Act 2018, which allows conditions and safeguards to be added or varied subject to the affirmative procedure.⁴⁴ Separate primary legislation may still be needed for the proposed civic function, the confidentiality gateway and any duty to cooperate. Section 74 of the Data (Use and Access) Act 2025 is not the relevant power for varying conditions that apply to existing health-data processing.⁴⁵

A civic purpose with a place-based home.

Our legal analysis suggests that government could establish in law a civic health, work and opportunity purpose: to identify residents at material risk of avoidable exclusion from education, training or sustained good work because of ill health, disability, caring responsibilities or connected disadvantage; to make a timely offer of voluntary support; to coordinate the services the person chooses; and to evaluate whether they work. It would hold two protected pathways, one for young people's participation (the concern of the Milburn review⁴⁶) and one for working-age health and employment, each with its own permitted data, triggers, recipients and retention rules. Mayoral strategic authorities are the natural home. The English Devolution and Community Empowerment Act 2026 gives them competence in skills, employment support and health, a duty to have regard to health inequalities, a power to convene partners, a right to request new functions and, through Schedule 27, a route for ministers to confer functions and run time-limited pilots.⁴⁷ It contains no data gateway for this purpose, so devolution provides the institution, not the data governance. Scotland shows what the missing pieces look like: its approach to young people rests on statute, a single accountable body and a common identifier, and its health data access on NHS-owned safe havens and the Public Benefit and Privacy Panel.^{48,49}

The durable model is corporate controllership by the strategic authority, visible accountability through a mayoral commissioner, an independent civic data board, and source bodies remaining controllers of their own records; 'controller in common' is not a category in current law, and a data-sharing agreement cannot create powers that statute has not given.³¹

The Health Bill. The Bill, now at Report stage in the Commons, could allow regulations to establish the single patient record, require providers to contribute and provide that processing under the regulations does not breach the duty of confidence.⁵⁰ Its own explanatory material says it creates no new gateways for secondary purposes.⁵¹ Two opportunities follow. The regulations could allow an accredited occupational health clinician who delivers part of a person's care to have role-based access to a minimum dataset. The wider civic purpose would need its own provision: a regulation-making power permitting specified NHS bodies and GP practices to disclose a minimum dataset to specified public bodies for that purpose, subject to a statutory public-interest test; independent advice of the kind the Confidentiality Advisory Group gives; transparency through the NHS App; the national data opt-out; and the right to decline the offer. A gateway drafted to that standard could answer the National Data Guardian's and the BMA's concerns about the Bill,^{52,53} whether it comes by amendment or by dedicated primary legislation.

Safeguards that make the model

trustworthy. Four planes of information would be kept apart: the source records, which stay with their existing controllers; the minimal civic coordination record held by the authority; the functional summary or stay-in-work plan that a worker may choose to share, which is all an employer would ever see of an individual; and the toolkit's own aggregate reports to employers. Information supplied to obtain help must never be reused for benefit sanctions, workplace discipline, recruitment screening, immigration control, unrelated policing or insurance, and that firewall should be in law.

AI would coordinate, not decide: it must not diagnose, declare someone fit for work, determine entitlement or withhold support, and significant decisions using health data remain subject to the stricter conditions and rights that survived the 2025 reforms. The eighth Caldicott principle, often summarised as ‘no surprises’, informs the requirement to explain how confidential information is used and what choices people have,⁵⁴ and the pandemic’s lesson is to set purposes, duties, oversight and infrastructure in place before pressure forces improvisation.⁵⁵

What legal change would help. The steps are few and specific. Government could define the civic purpose in law and confer the devolved function on strategic authorities, making each authority the accountable controller for its coordination record.

A common governance framework, published nationally, would let a lawful vanguard start now under existing powers. Creating a Digital Economy Act objective for the purpose and adding health bodies to Schedule 4 would reopen the data-sharing route that the 2017 pause closed. A narrow health-confidentiality gateway would complete it for a minimum dataset. The non-sanction firewall could be put into law, so that information supplied to obtain help could never be turned against the person who supplied it. And the Workplace Health Intelligence Unit, or a similar body, could be established as the trusted learning nexus, with a regulatory sandbox for coordinating AI.

What the law allows today	What would need new provision
Worker completes the WHT, controls sharing and receives guidance	System-initiated contact when a fit note reaches a set duration
Identifiable responses held by an authorised clinical or OH service	Combining health, benefit and employment data to identify an offer
Employer sees only what the worker shares, plus aggregate intelligence	Several public bodies maintaining one operational plan
OH clinician within direct care under section 251B and Article 9(2)(h)	An express civic function for strategic authorities
Anonymous data to the WHIU; secure evaluation, section 251 where eligible	A Digital Economy Act objective with NHS bodies added to Schedule 4
Combined authorities as specified persons under the 2017 Act	A narrow statutory gateway through health confidentiality
Devolved competence, convening and pilot powers under the 2026 Act	A duty to cooperate where national completeness matters

Consent and data sharing: who sees what

The Work and Health Toolkit (WHT) should make data use understandable at each step: what information is needed, who would receive it, why it would be used and what choices the worker has. The models below are illustrative, not final designs. They translate the preceding legal analysis into practical arrangements for testing with the Citizens' Panel, distinguishing provision of personal guidance from sharing for support and from learning across the system. Three figures illustrate personal guidance and sharing for support (Figure 1), analytical uses (Figure 2) and the boundary between acceptable and unacceptable uses (Figure 3).

Personal guidance without onward sharing.

A worker describes their situation and receives personalised guidance through the WHT. Participation is voluntary and every question can be skipped. Identifiable responses would be held under trusted independent custody, separate from employers' management systems. Completing the questions would not automatically trigger a referral, notify an employer or give other organisations access to the responses, and no individual responses, records or scores would be sent to the employer. The worker could review their answers, correct factual errors, challenge AI-generated guidance and decide whether to seek further help. Assisted and non-digital routes would offer equivalent choices.

Sharing to obtain support. A worker could choose to send a relevant summary to a named GP, occupational health professional or other support provider. The summary would contain the information needed for that purpose, rather than the whole questionnaire or access to the person's underlying records. Before sharing, the worker would see what would be sent, to whom and why.

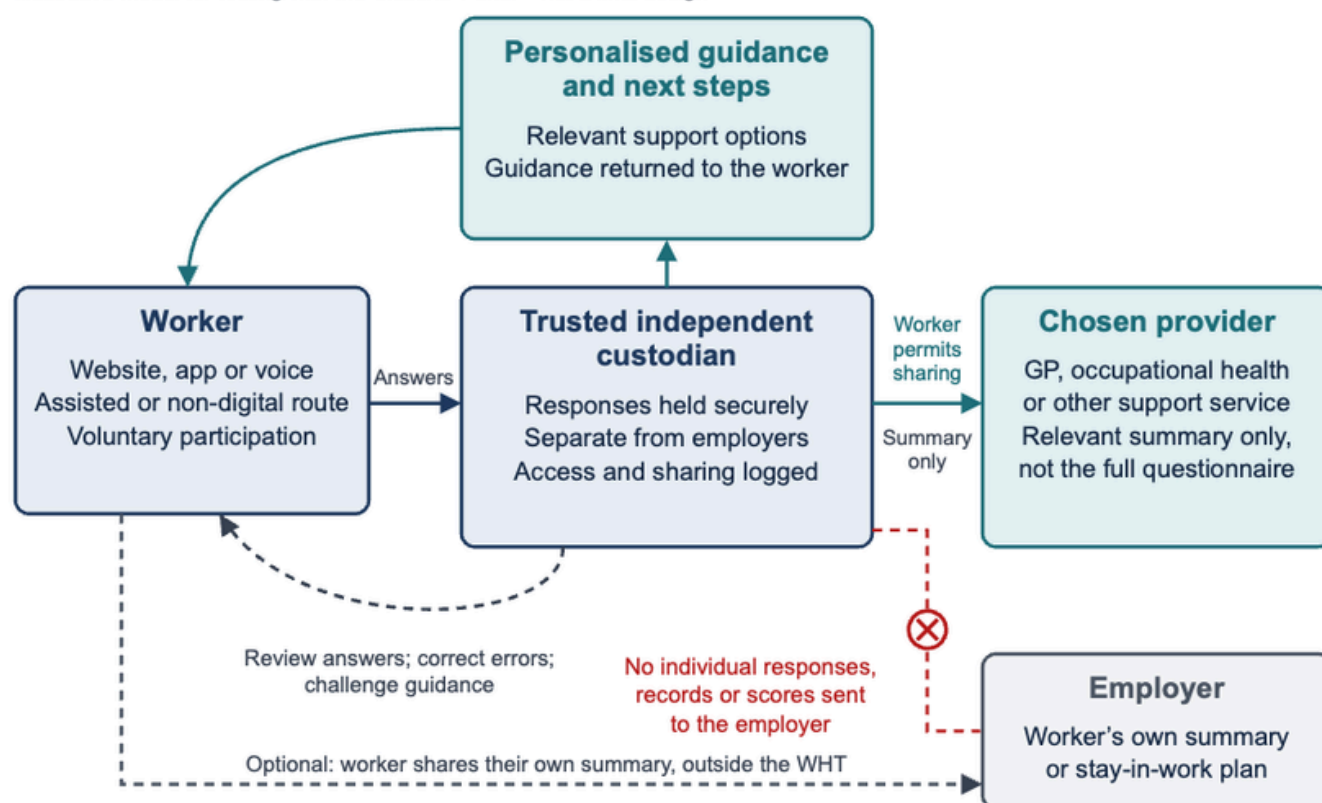
Support could come from NHS, employer-funded, community, voluntary-sector, private or insured provision, according to the person's circumstances and preferences.

A worker could also use the guidance to prepare a functional summary or stay-in-work plan for discussion with their employer, covering matters such as changes to hours, duties or working conditions. They would decide whether to share that summary themselves, and it would still be personal information, not anonymous simply because it omits a diagnosis. This is distinct from the WHT supplying individual questionnaire responses, health records or risk scores to employers, which it would never do; employer-facing reporting from the WHT would remain aggregate and non-disclosive. Figure 1 brings these elements together: guidance returned to the worker, permission-based sharing with a chosen provider, the correction loop, and the worker's own separate choice about an employer summary.

Learning without exposing individuals. Information from many participants could help employers improve working conditions and enable the Workplace Health Intelligence Unit (WHIU) or a similar body, providers and policymakers to understand unmet need and evaluate support. This analytical purpose would be governed separately from personal referrals. As shown in Figure 2, individual responses would be de-identified, analysed in an approved secure environment by authorised users, and released only as aggregate outputs that have passed disclosure control, with small numbers suppressed and combinations of results checked.⁴⁰ Employers would receive workforce insight in that form; providers and policymakers would receive comparable, non-identifiable evidence. Findings would be interpreted in context and linked to appropriate actions or further investigation. Where reporting for a particular employer could not be made safe, sectoral or regional findings would be used instead.

Figure 1. Worker-initiated guidance and sharing for support

Illustrative model for testing with the Citizens' Panel – not a final design



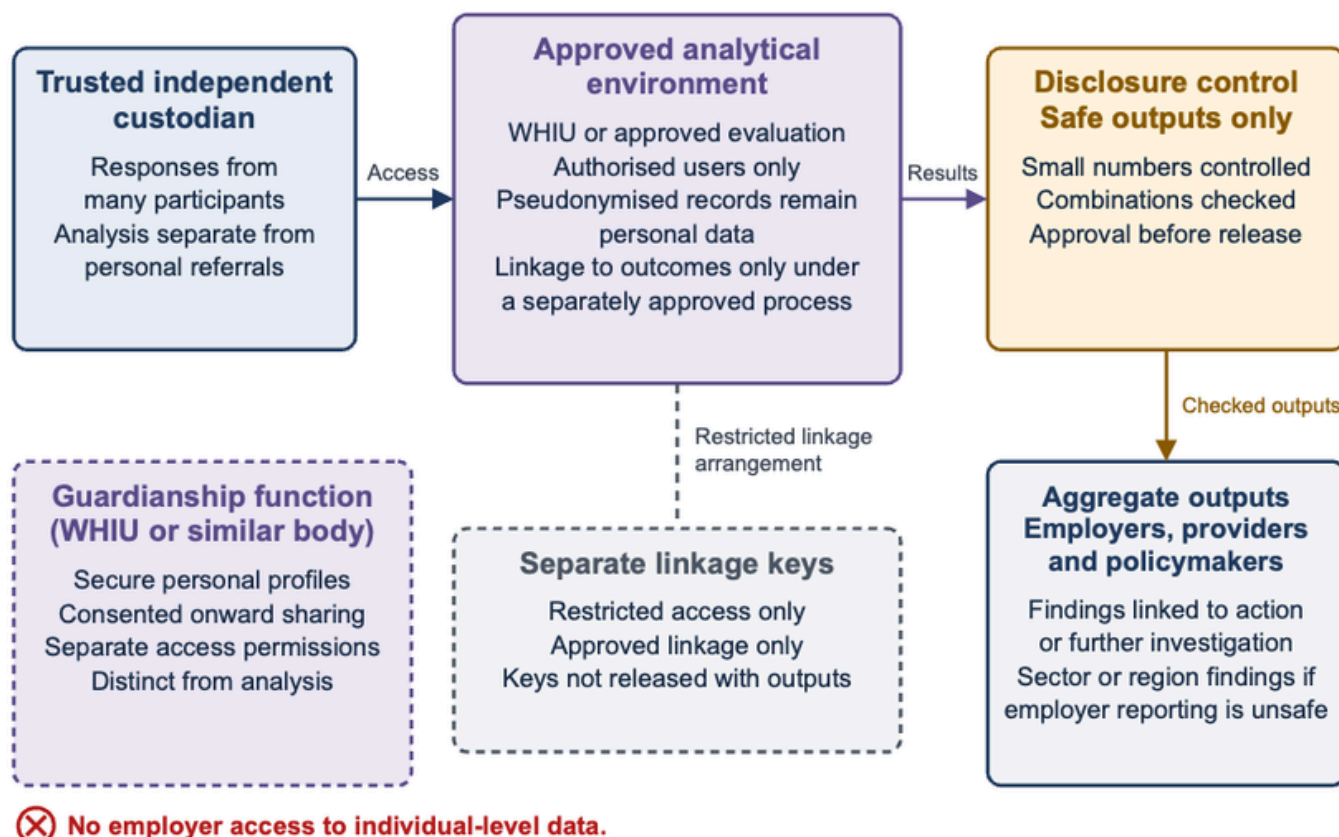
A functional summary remains personal information, even when it omits a diagnosis.

Linkage keys would be held separately under restricted access, and linking responses with later health or employment outcomes would require a separately specified and approved process. Pseudonymised records that can be reconnected to individuals remain personal data; they should not be confused with the anonymous aggregate results released from analysis.^{31,40} The guardianship role the Keep Britain Working Review's June 2026 update proposes for the WHIU or a similar body – holding personal profiles and managing onward sharing with consent – would be governed separately from its analytical role, with distinct purposes and access permissions. Personal sharing for support would follow its own authorised pathway, not a flow of person-level findings from the analytical environment.²⁷

System-initiated offers as a distinct future model. The legal appendix proposes a further pathway in which specified services could identify an emerging need and offer voluntary support, rather than waiting for the worker to initiate contact. It is presented separately from the worker-initiated WHT and appears in Figure 3 as a conditional future model. It would depend on the legal powers, confidentiality arrangements and safeguards identified for that pathway, not on a blanket consent obtained when someone first uses the toolkit. Under the proposed civic model, source organisations would retain responsibility for their records, while the strategic authority would hold only the minimum coordination record needed for its defined role. Meaningful choices and accountable custody. Agreeing to use the WHT, permitting a referral and allowing information to contribute to evaluation are different matters.

Figure 2. Governed analysis and safe outputs

Illustrative model for testing with the Citizens' Panel – not a final design



A worker's permission to share information for support is also distinct from the lawful basis on which each organisation processes it. The model must explain these distinctions without requiring people to understand legal terminology.^{31,56} Declining optional sharing or participation in evaluation would not affect access to the toolkit's core guidance; any information necessary for a requested referral would be explained.

People would be able to review and change their sharing choices, to withdraw consent where it is relied upon, and to get help in exercising their rights. Explanations should state what withdrawal would stop and whether any information must still be retained for a separately justified purpose, rather than promise that every record can always be erased.⁵⁶ Responsibilities for custody, access, retention, complaints and oversight would be explicit, with access and sharing recorded for audit.

The boundary. Figure 3 draws the line the models rest on. On one side are uses that serve the worker or that learn from de-identified information under governance: personalised guidance, signposting, a summary shared with a provider the worker chooses, a plan the worker chooses to share with their employer, disclosure-checked aggregate insight, and securely governed evaluation.

On the other are uses that would expose an individual to their employer, monitor or coerce, automate decisions about fitness for work, benefits or employment, or reuse information supplied for support for any purpose the person was not told about. Exceptional disclosure would require a specific legal justification, a named authorising role, the minimum necessary information and an audit record; it would not create a general override of the stated purpose restrictions.

The Citizens' Panel would examine these models alongside the worker scenarios: which proposed uses are acceptable, which should be rejected or redesigned, and what further safeguards are needed. It would consider which arrangements for accountable control, independent oversight and secure custody inspire trust, including the respective roles of NHS bodies, an organisation like the WHIU, an independent data trust and mayoral strategic authorities.

It would also examine how choices should be presented, how granular they should be, and what should happen when someone declines sharing or changes their mind. The aim is not a single permission to 'share my data', but understandable choices within a system whose responsibilities and limits are clear.

Figure 3. Acceptable and unacceptable uses

Illustrative model for testing with the Citizens' Panel – not a final design

Acceptable uses	Unacceptable uses
- Personalised guidance and next steps for the worker. - Signposting to public, workplace, private, community and voluntary provision. - Sharing a relevant summary with a provider the worker chooses. - A summary or stay-in-work plan the worker chooses to share with their employer. - Aggregate, disclosure-checked insight for employers. - Anonymised or securely governed data for evaluation and learning.	- Individual responses, health records or risk scores reaching employers or line managers through the WHT. - Covert or coercive monitoring, or employer surveillance through the WHT. - Automated decisions about fitness for work, benefits or employment. - Reuse of information supplied for support for benefit sanctions, workplace discipline, recruitment screening, immigration control, unrelated policing or insurance decisions. - Identifiable information used for a purpose the person has not been told about.
Conditional future model: system-initiated offers of voluntary support Dependent on the specified legal powers, confidentiality arrangements and safeguards; not authorised by blanket consent to use the WHT.	

Exceptional disclosure requires a specific legal justification, a named authoriser, minimum necessary information and an audit record. It does not create a general override of the stated purpose restrictions.

The Citizens' Panel will test acceptability and identify any additional safeguards needed.

Designing with users: methodology and personas

The Work and Health Toolkit (WHT) is a service, well beyond a questionnaire. It will be developed using human-centred design, working to the GOV.UK Service Standard and Service Manual.^{57,58} In practice this means starting from people's circumstances rather than from the question set, designing the whole service rather than the interface, testing with those who find services hardest to use and those with the greatest concerns about how their information is used, and changing the design in response to what testing shows. The sections below set out how that approach applies to a toolkit, which must be trusted by workers most of all if it is to be used and to add value.

The design problem goes beyond usability.

The toolkit must be easy to use, but that alone will not yield accurate data about workers' lives. In the DWP survey, only 58% of employees with a long-term health condition had discussed it with their employer,⁹ and the Keep Britain Working Review describes a culture of fear in which employees fear disclosing conditions and employers fear acting on them.¹ A worker in a low-trust relationship with their line manager, using a tool made available through their employer, may have good reason to be wary of a question about their mood. The design decisions that bear on this are not cosmetic: who holds the responses, what a person is shown before they answer rather than afterwards, what the employer is visibly unable to see, and whether the route in feels like the worker's own. These are testable factors and testing them is part of the design work rather than a communications exercise that follows it.

An entry point that requires no declaration. Almost every existing route into work-and-health support begins with someone declaring a problem: reporting absence, requesting an adjustment, obtaining a fit note, applying for a scheme. That threshold excludes precisely the people the toolkit is intended to reach, who are still working and have not defined themselves as unwell.

Designing an entry point that does not require a declaration, and does not create a record that behaves like one, is a specific design objective and a condition of the preventive claim.

More than one user. The toolkit is worker-centred, but it has other key stakeholders to design for. Line managers would receive practical guidance and prompts when information-sharing is initiated by the worker concerned. Employers would receive aggregate, disclosure-checked reports on work and health trends in their organisation. GPs, occupational health professionals and other providers would receive worker-shared summaries that need to be usable inside a consultation. Some employers have no HR function, no occupational health and no awareness of their existing duties: in the DWP survey, 23% of employees in organisations with 2–49 staff had occupational health access, compared with 76% in organisations with at least 250 staff.⁹ A small employer who never touches the toolkit is still a user of the system around it, and designing only for the worker would leave that gap unexamined.

What citizens decide, and when. The Citizens' Panel described later in this prospectus will test potential consent and data-sharing models: which uses are acceptable, which should be rejected or redesigned, and what further safeguards are needed. This is deliberative testing of models that have been formed in advance, and it is the right method for questions of acceptability and legitimacy. It is not, on its own, co-design of the toolkit. Separate design activity will develop and test the question set, the guidance, the sharing choices and the assisted and non-digital routes with workers, employers and clinicians. For deliberation to be meaningful, the decisions it can change must remain genuinely open: the custody model, the granularity of sharing choices, the content and framing of the question set, and the conditions under which any system-initiated pathway would be acceptable. Where the Panel's conclusions would require the model to change, the programme should be able to change it and say so.

Design as a means of managing risk. The risks set out later in this prospectus – misleading guidance and missed needs, exclusion and unequal benefit, added demand on primary care, employer disengagement and misinterpretation of aggregate findings – are largely design risks, and several are addressed by design decisions rather than by governance alone. Accessibility, plain language, conversational and non-digital routes and correctable inputs will be designed in from the start rather than added after prototyping.

How to read the personas. The three personas that follow are composites, not research participants. Their current-state pathways are drawn from the published evidence in this prospectus and from clinical commentary on how those pathways typically unfold, including the referral thresholds and consultation constraints described in the fit note chapter. Their proposed-state pathways are design hypotheses: statements of what the toolkit would need to do, offered for scrutiny and testing, not predictions of what it will achieve. They are used because a service proposal should be examined against different circumstances – a large employer with occupational health, a micro-enterprise without it, a long-term condition already adjusted for and since outgrown – and because those differences are difficult to see in aggregate figures. Each persona opens with a shared moment and then splits into two paths: the journey as it typically unfolds today, and the proposed journey with the WHT. The two paths use the same time points so that the person's position can be compared at each, but a check-in and its guidance always sit together, because the toolkit answers immediately.

Darren

44 · Knowsley · Warehouse operative

Large employer, 2,000+ staff | Chronic lower back pain and depression

A long absence that began as a back that 'everyone has'



1

Darren starts to experience back pain.
He is already sleeping badly and has stopped playing five-a-side football. He puts all of it down to shift-working.

Employer: No interaction (Nil).
Health system: Nil.

Today's journey

Week 6	Month 6	Year 1	Year 3
 T1 He pushes through it. The pain is worse at the end of a shift and Darren is only sleeping for four hours a night. He tells nobody, because he thinks 'everyone here has a bad back'. Employer: Nil. Health system: Nil.	 T2 A GP appointment about back pain. Eight minutes, painkillers, no referral – episodes are too short to meet the threshold. GP doesn't ask about the sleep, and he doesn't raise it. Employer: No record. Health system: Analgesics only, no referral.	 T3 Two weeks off, and a fit note. Darren hands the note to Priya, his line manager. She is supportive but has no route to specific support, no budget and no guidance. The note names his back pain and nothing else. Employer: Records absence. No support route, no plan. Health system: Certifies. No feedback.	 T4 Long-term sick. Darren is off work for four months, on repeat prescriptions for painkillers, and increasingly withdrawn. The longer he is off work, the less likely he is to come back. Employer: Long-term absence review concluded; case closed. Post being covered. Health system: Repeat prescriptions, no referral.

Future WHT-supported journey

Week 6	Month 6	Year 1	Year 1
 Darren answers the WHT check-in on the way home and gets advice. Twenty questions by voice, four minutes, standing beside his car before heading home. Nobody at work sees it. Guidance covers poor sleep and low mood as part of the picture, not separate from the back pain: a sleep routine, movement rather than rest, a self-referral to talking therapies – and it tells him this is worth a GP appointment. Employer: Nil. Health system: Nil. WHT: Asks about pain, sleep and mood in the same place, and offers personalised guidance.	 He is taking action. Darren has self-referred to talking therapies, is moving rather than resting, and has been logging the pain and the sleep. The pattern is written down. Employer: Nil. Health system: Talking therapies under way. WHT: Follow-up check-in records the pattern. A GP appointment is now recommended, not just mentioned.	 Eight minutes with a GP, and he raises his mental health. Darren has words to describe his health and reminders of what he wants to say written down. The consultation covers back pain, sleep and mood. His occupation is recorded, and a documented history of symptoms meets the referral threshold his short episodes never did. Employer: Nil. Health system: Occupation recorded. Back pain clinic referral made, mood addressed. WHT: Shared by Darren with his GP, at his choice.	 Still on shift. Darren is picking rather than lifting: an adjustment agreed with his employer through workplace health provision once physiotherapy was complete. He is sleeping well, and has had no period of long-term absence. Employer: Sees rising back-pain signals across the site, never Darren's name. Health system: Condition managed, work discussed. WHT: Aggregate insight only, never identifiable.

Blessing

29 · Liverpool · Nail technician

Owner-operated salon, four staff | Chronic contact dermatitis and anxiety

A work-related condition that nobody connects to the work

	1 Blessing's hands start to itch. She assumes it is the cold, or a product she has switched to. Employer: No interaction (Nil). Health system: Nil.
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Today's journey

Month 2	Month 8	Month 14	Month 20
 T1 She changes hand creams and wears gloves when she remembers to. Blessing mentions it to nobody. Statutory sick pay would not cover her rent, so stopping is not a thing she considers. Employer: Nil. Health system: Nil.	 T2 Blessing's skin is worse and she is working through it. Yemi – her boss – notices and says nothing, because she does not know it is hers to act on and is frightened of losing a technician. Employer: Notices, no action. Health system: Nil.	 T3 Eight minutes at the GP, who asks about her job. Blessing's hands are examined and she leaves with a prescription. The job is mentioned in the room and goes no further. There is no link from the GP surgery to the salon. Employer: Nil. Health system: Treated by GP. No occupational health route.	 T4 Cut back to three days. Blessing's condition is worse, her income has dropped, and she has started to wonder whether she can stay in the job she enjoys at all. Employer: Losing a technician. Health system: Repeat prescription.

Future WHT-supported journey

Month 2	Month 8	Month 14	Month 20
 A WHT check-in comes through work, and a question asks what she handles all day. Yemi makes the WHT available by signing up to the scheme – she needs no training. Blessing completes the check between clients; nothing she enters goes to Yemi. Acrylics, gels, eight clients, six days. Asks about her hands and sleep together, so she does not have to choose which problem to raise. Guidance suggests quick glove and product changes, and a GP appointment. Employer: Provides access, sees nothing. Health system: Nil. WHT: Reaches a salon with no HR. Connects work to the hands; practical steps she can start now.	 The GP asks what she does, and this time there is an answer on the record. Six months of exposure, documented, with the products named. That makes it a work-related diagnosis rather than an unrelated skin complaint, which changes how the referral to a dermatology clinic is treated. Employer: Nil. Health system: Occupation recorded. Work-related diagnosis, referral prioritised. WHT: Shared by Blessing, at her choice.	 Treating the cause. Blessing receives dermatology advice on the products, not just the symptoms; her hands are improving and she has a written diagnosis. Employer: Nil. Health system: Treating the cause. WHT: Follow-up check-in. Hands and sleep both improving.	 Still working six days, and the salon has started to change. Yemi has seen aggregate insight for salons in her area and sector, and has changed two products. She still has no training, no occupational health service and nobody who has told her what her duties are. Employer: Reached by trend data, not yet fully equipped to respond but taking steps. Health system: Condition managed. WHT: Aggregate area and sector insight, never business specific.

Mariam

51 · Liverpool, remote-first · Senior policy adviser
Central government, about 3,000 staff | Rheumatoid arthritis and perimenopause

Adjustments that worked, written for a job she no longer does

	Mariam's previously effective support has been lost. Perimenopause diagnosed three years ago and rheumatoid arthritis seven years ago; occupational health assessment done; adjustments agreed in writing. The adjustments worked well but they are no longer in place after changes at work. Employer: Adjustments in place. Health system: Consultant review scheduled.
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Today's journey

Year 1	Year 2	Year 3	Year 3.5
 New role, new manager, new team. Twice. The menopause and arthritis adjustments were written for a job Mariam no longer does. Nobody has re-read them. Employer: No record of the change. Health system: Nil.	 Rheumatology clinic appointment covers her arthritis only. History, examination, blood tests, medication. Fifteen minutes and Mariam is told she is doing well. Nobody asks what she does for a living or whether it still works. The perimenopause is not mentioned, because it belongs to a different appointment. Employer: Nil. Health system: Condition reviewed. Work never discussed.	 A bad flare, on top of months of poor sleep. Mariam works from home for a week and does not report it as sickness absence, because that is what she has always done. Every route into support starts with declaring a problem, and she has been careful not to have one for fear of being passed over for promotion. Employer: No absence recorded. No case, no flag. Health system: Nil.	 She is exploring reducing her hours. Mariam has thirty years of experience and an employer who would have acted. A set of adjustments nobody re-read means that she feels she cannot continue full time. Employer: About to lose her. Health system: Repeat prescription.

Future WHT-supported journey

Year 1	Year 2	Year 3	Year 3.5
 The role changes, something prompts her, and perimenopause is one of the questions. Mariam receives a check-in she can complete at home without telling anyone she has a problem. Nobody has named perimenopause as a work-and-health issue before, and she has not been sure it counted. The guidance notes that her adjustments predate her current role and suggests things she can do herself alongside anything clinical. Employer: No case, no flag. Health system: Nil. WHT: No declaration required. Names perimenopause as valid and flags adjustments are out of date.	 The same consultant appointment, with more information in the room. Mariam brings a record of how flares track against her working pattern and raises perimenopause. The appointment covers her arthritis, work and symptoms she had assumed belonged elsewhere. Employer: Nil. Health system: Condition reviewed. Work and perimenopause both discussed. WHT: Shared by Mariam, at her choice. Her colleagues were told nothing.	 Adjustments reviewed for the job she does. Mariam chooses to share a functional summary with her manager; the adjustments are rewritten for the current role, with a review date. The flare, when it comes, is managed within them rather than hidden. Employer: Reviews current-role adjustments after Mariam chooses to share. Health system: Condition managed, work discussed. WHT: Follow-up check-in. The summary was Mariam's to share.	 Still in post, full time. Thirty years of experience is retained, and Mariam has a review date in the diary rather than an expired document nobody re-read. She is performing well and up for promotion. Employer: Sees that adjustment reviews lapse at restructure, across the department. Health system: Condition managed. WHT: Aggregate insight only, never identifiable.

Fit note workflow

The fit note is intended to support safe participation in work, but too often certification is not connected to practical support. Employees can self-certify for the first seven calendar days of sickness absence.⁵⁹ Yet in the Department for Work and Pensions' 2024–25 survey, 12% of employees who had taken sickness absence in the preceding year reported that their employer required a fit note on or before day seven.⁹ More than 11 million fit notes are issued in England each year, around 93% recording 'not fit for work'.^{10,12} The alternative, 'may be fit for work', can carry advice on adaptations but is used in only a small minority of notes.¹⁰ Among surveyed recipients of such notes, 72% found the suggestions helpful and, where suggestions were included, 80% said their employer implemented them at least partly.⁹ These findings suggest the value of actionable advice, although they do not establish its effect on sustained return to work.

Clinicians are limited in their ability to provide work-and-health advice. The clinician signing the fit note usually has no sight of the job, and most GPs have neither occupational health training nor the time to assess function in detail.¹ In the government's call for evidence, primary care respondents described limited consultation time, insufficient workplace knowledge and difficulty accessing occupational health expertise, and only 29% agreed that issuing fit notes was a good use of GP time. Employers wanted clearer recommendations on adjustments and return-to-work timescales, while patients valued the fit note's role in legitimising absence, protecting recovery and supporting access to sick pay.¹¹ These were the views of self-selected respondents, not representative estimates. Notes are often extended without further consultation,¹ and the task is to improve the connection between certification and support.

The problem lies not in the consideration of support, but instead in the lack of a dependable connection between assessment, workplace action and follow-up. In evidence cited by the Keep Britain Working Review, employees absent for four to six weeks had a 96% chance of returning, compared with less than 50% after more than a year.¹ This association reinforces the case for timely help; it does not mean that recovery periods should be cut. A certificate should be a point from which support is coordinated, not a reason to wait until its expiry.

The fit note journey. Figure 4 traces a single episode – a worker whose back pain begins while they are still at work – through six stages: onset, coping alone, the trigger that leads to absence, the fit note, the handoff and the position six months later. In the current state the worker copes alone until two weeks off work brings a GP appointment and a note; the note is handed to HR but does not trigger coordinated support. The employer had no earlier signal and holds only the note; the GP gets no feedback and extends the fit note. At six months he is still off, the pain is worse and the employer closes the case. Six months is the end point of the illustrated journey, not a legal threshold. The gap is the handoff: a certificate is issued and passed on, but no service is waiting to act on it. In the proposed state the same worker checks in through the WHT while still working, raises the problem early and receives guidance and self-help; when a fit note is still needed, a summary the worker chooses to share gives the clinician the context for a work-aware note, and a vocational adviser within workplace health provision receives the case, and the plan is reviewed alongside any necessary clinical reassessment or further certification. The current state was mapped with a GP and is consistent with the Review's findings; the proposed state combines the WHT, workplace health provision and the evidence below. Cells shown in italics in the figure are design hypotheses to be tested, not findings.

There is trial evidence for active vocational support.

In the Study of Work and Pain (SWAP) trial, adding a vocational advice service to primary care for patients with musculoskeletal pain who were struggling at work or absent for less than six months reduced mean days off work over four months from 14.4 to 9.3 (adjusted incidence rate ratio 0.51; 95% confidence interval: 0.26–0.99).⁶⁰

The Royal College of General Practitioners' response to the fit note call for evidence points the same way: support outside primary care for patients likely to need an extension; a working interface between general practice, occupational health and employers; and digital forms that ask what symptoms make work difficult and what the employer could do.⁶¹

Figure 4. The fit note journey

Current pathway and proposed support model. Read left to right through the six stages and compare the two panels.

Current state

	Onset	Coping alone	Trigger	Fit note	Hand off	Six months
Worker	Pain starts	Copes alone	Two weeks off	Gets note	Hands to HR	Pain worse
Employer	No signal	No record	Records absence	Waits	No support route	Case closed
Health system	No contact	Painkillers	GP appointment	Certifies	No feedback	Extends

The certificate is issued and handed over, but no support follows.

Proposed state

	Onset	Coping alone	Trigger	Fit note	Hand off	Six months
Worker	Pain starts	Checks in	Raises it early	Work-aware note	Referred	In work
Employer	No signal	Not told	Absence logged	Worker shares note	Agrees adjustments	Trend data
Health system	No contact	No contact	GP appointment	3-week note	Refers with consent	Reviews as needed
Work and Health Toolkit		Signals early	Guidance and self-help	Shared by worker		Aggregate insight
Workplace Health Provision				Vocational adviser	Receives case	Reviews plan

A signal while the worker is still working, and a receiver when the note is handed over.

Review timing is agreed individually; support and adjustments are reviewed before the six-month outcome assessment.

Key the gap new service *Italic* design hypothesis, not a finding no activity in this lane

Current state from a mapping session with a GP, consistent with the Keep Britain Working Review. Proposed state combines the Work and Health Toolkit, Workplace Health Provision, the RCGP response to the fit note call for evidence and the SWAP trial. Italic cells are design hypotheses, not findings. Draft, September 2026.

Figure 4. The fit note journey: an illustrative current pathway and proposed support model. Read left to right through the six stages and compare corresponding stages between the two panels. Coral highlights gaps; teal identifies proposed additions; italic cells are design hypotheses. The proposed pathway is for testing, not a demonstrated outcome. Clinical certification remains separate from the WHT, and individual sharing remains worker-controlled.

The WHT should complement wider reform, not compete with it. In May 2026 the government announced pilots in four WorkWell areas for launch that July, in which Community Work and Health Teams develop 'Workability' plans with patients and employers, addressing what people can do, what support they need and when time away is appropriate.^{12,62} The Keep Britain Working Review proposed return-to-work plans supported by workplace health provision from two weeks and no later than six weeks into absence, with fit notes remaining at least initially.¹ Its June 2026 update commits to clarifying the role of primary care and incorporating the ongoing fit note reforms.²⁷ Changing certification arrangements is a wider policy task. What the WHT could improve is what happens before and around them.

Sudden illness, injury and necessary recovery will still require clinical assessment and, where appropriate, certification. The WHT could provide an earlier route to help when difficulties emerge, and remain useful during absence and return. A worker could describe symptoms, functional difficulties, work demands and existing support, receive personalised guidance and identify possible next steps. With their permission, a concise, worker-reviewed summary could go to their GP or another chosen clinician, providing context for assessment and discussion of adjustments. Responsibility for any fit note would remain with an eligible healthcare professional, not the toolkit or its AI.⁵⁹ Participation would not be a condition of obtaining care, a fit note or sick pay.

Where a fit note is issued, the WHT could help turn advice into a practical stay-in-work or return-to-work conversation. The worker could choose to share a separate functional summary with their employer, supported where needed by a workplace health professional or employee representative. A plan should identify agreed adjustments, responsibilities, timescales and a review date, with follow-up to establish whether support arrived and the adjustments helped.³⁷

Individual responses, health records and risk scores would not be sent to employers through the WHT; its employer reporting would remain aggregate and non-disclosive. That protection should enable, not replace, a worker-controlled conversation about individual needs.

Follow-up should respond to recovery and changing circumstances rather than simply the certificate's end date. Existing guidance allows employees to return before a fit note expires when they feel able, without obtaining a new note signing them back to work, provided suitable working arrangements are discussed with the employer.⁶³ The WHT could help workers prepare for these discussions and reviews, without pressuring them to return prematurely.

Across these episodes, separately governed evaluation could provide comparable evidence on what people needed, what they were offered, whether they received it and whether they remained in or returned to suitable work. Success would mean earlier effective support, better health and sustained work participation – not simply fewer certificates or GP appointments. The WHT cannot itself supply treatment capacity or implement workplace adjustments, but it could make the need for action clearer and help establish whether that action followed.

Citizens' Panel on the responsible use of data and AI for work and health

The Citizens' Panel will help establish the conditions under which the Work and Health Toolkit (WHT) could be acceptable, trustworthy and useful to the people affected by it. Its purpose is to ensure their views shape the proposal, including which uses should not proceed, rather than to secure endorsement of a predetermined design.

The Keep Britain Working Review's June 2026 update identifies deliberative approaches, including citizens' assemblies, as a way to shape what data should be collected and how.²⁷ Our Citizens' Panel is planned as the programme's first dedicated deliberative exercise on the WHT. It builds on the experience of the Liverpool City Region Residents' Assembly on Data and AI, which examined residents' expectations for data and AI use in public services,³³ to consider the specific choices raised by the toolkit. The exercise is planned for Liverpool City Region in autumn 2026. An application has been submitted for University of Liverpool research ethics review, and the exercise will proceed subject to approval. The proposed approach combines independent facilitation with accessible evidence prepared by the University of Liverpool's Civic Health Innovation Labs. Participants would be able to question the evidence and hear alternative perspectives.

Recruitment will seek a diverse range of work-and-health experiences across the city region, including employees, self-employed people, people on sickness absence and those recently out of work for health reasons. People living with long-term or complex health conditions and disability will be deliberately included. The findings will describe participants' reasoned views and the conditions they identify, rather than estimate the prevalence of opinions across the population.

Employers, including the region's Keep Britain Working vanguard businesses, and employee representatives will be invited to contribute evidence and hear the Panel's conclusions, without displacing workers' voices in the deliberation itself.

Through a series of facilitated deliberative discussions, participants will examine the personas, illustrative consent and data-sharing models set out earlier. The format, participant numbers and opportunities for learning and reflection will be specified in the final protocol. Four questions will guide the discussions:

- **Acceptable uses.** Which proposed data uses should be accepted, rejected or redesigned, and what additional safeguards are needed?
- **Meaningful choices.** What choices should people have about sharing, how granular should they be, how should withdrawal work, and what should happen when someone declines sharing or changes their mind?
- **Accountable custody.** Which arrangements for control, oversight and secure custody inspire trust, including the respective roles of NHS bodies, a guardianship function within the Workplace Health Intelligence Unit or a similar body, an independent data trust and mayoral strategic authorities?
- **Questions, access and transparency.** What are people willing to be asked, through which channels and assisted routes, and what do they need to see afterwards about access to their information and any action it prompted?

The Panel will shape the toolkit's design by identifying acceptable uses, required safeguards and conditions for trust. It will not replace the separate co-design, usability testing, clinical safety assessment and outcome evaluation described elsewhere. Before deliberation begins, participants will be told which decisions remain open, which legal and safety requirements cannot be changed, and who is responsible for taking forward their recommendations.

The sessions will be trauma-informed. This means recognising that participants may have experienced ill health, job loss, discrimination or difficult encounters with services, and organising the exercise to support safety, choice and control rather than repeat harmful experiences.⁶⁴

Participants will know in advance what will be discussed, take part on their own terms, and be able to pause or withdraw.

Facilitators will be trained to recognise distress, with a protocol for support during and after sessions. Participants will not be expected to disclose personal health or employment experiences to justify their views. Ground rules will explain confidentiality and its limits, and how contributions will be recorded and reported.

Practical arrangements will include British Sign Language interpretation, translated and easy-read materials, accessible venues and online options according to participants' needs. The delivery protocol will specify arrangements for reimbursing participants for their time and meeting participation costs. The same principle of understandable choices applies to the toolkit itself: the eighth Caldicott principle, 'no surprises', described in the legal appendix.⁵⁴ The Panel will examine whether the proposed explanations and controls meet that expectation.

The outputs will be:

- design principles for consent and data sharing, grounded in the deliberation, with recommendations and reasons for accepting, rejecting or redesigning proposed uses;
- conditions for legitimacy, including requirements for custody, oversight, transparency and accessible participation;
- a plain-language summary developed with participants and returned to them;
- a public report describing the methods, recruitment and limitations, findings and areas of disagreement, with recommendations for WHT development and relevant pilots.

The Panel is the beginning of the deliberative work, not its end. Its findings will inform prototype development and subsequent testing in Liverpool City Region. Further deliberation in other regions and UK nations, using common core questions and materials adapted to local circumstances, could assess which conditions are shared and which require different arrangements.



Risks and safeguards

The Work and Health Toolkit (WHT) should be developed with explicit recognition of what could go wrong, how problems would be detected and who would respond. The safeguards described earlier are design requirements, not evidence that risks have been eliminated. They must be tested alongside the toolkit's usefulness, with clear authority to change, restrict or pause functions that are unsafe, ineffective or unacceptable.

Trust, privacy and misuse. Participation must remain voluntary, with understandable choices about personal sharing and separately governed analysis. Declining optional sharing must not disadvantage a worker or prevent access to the toolkit's core guidance. Consent, where relied upon, must be supported by genuine choice rather than pressure from an employer or service.⁵⁶ Independent custody, restricted access, audit records and disclosure checks would support the boundaries set out in Figure 3.⁴⁰ Employers would receive only aggregate, non-disclosive reporting through the WHT. A functional summary that a worker chooses to share themselves remains personal information, and the toolkit should help them understand and limit what they disclose. The proposed prohibitions on surveillance, sanctions and other incompatible uses must remain explicit throughout procurement, delivery and evaluation.

Misleading guidance and missed needs.

Providing guidance rather than diagnosis does not remove the risk of harm. Advice could falsely reassure, cause unnecessary alarm, contradict existing care or direct people towards unsuitable support. Clinical content and AI-generated outputs would therefore require testing against realistic scenarios, including incomplete answers, interacting conditions and differences between text and voice responses. Users would be able to correct factual errors, challenge outputs and access an appropriate human route.

Clinical risk management would follow the applicable requirements of DCB0129 and DCB0160, with documented hazards, controlled updates and incident review.^{38,39} The WHT must not imply that responses are continuously monitored by a clinician unless a service is explicitly staffed and accountable for doing so.

Immediate risk and non-engagement.

Responses that indicate immediate risk to the person or to others, in the questionnaire or in free text, must trigger clear signposting to urgent help, with an agreed protocol for interaction with clinical services. The toolkit cannot act on silence: the people least likely to engage are often those at greatest risk. Non-participation must not become a signal about an individual, and employers would never learn who has or has not taken part; but aggregate participation patterns should inform outreach through assisted routes, trusted intermediaries and workplace health provision. Reaching people who do not come forward is the purpose of the system-initiated pathway set out in the legal chapter, which would need its own safeguards and legal basis before it could operate.

Exclusion and unequal benefit. A short digital questionnaire may still be difficult to use because of disability, language, literacy, insecure access to technology or lack of privacy. Assisted and non-digital routes should be tested alongside the website, app and voice options, not added after the main design is settled. Recruitment and testing should include people in disadvantaged communities, small workplaces, insecure employment and self-employment. Evaluation must examine who is reached, who disengages and who receives useful support, rather than assume that accessible design produces equitable outcomes.

Information without effective support.

Identifying unmet need could increase appropriate demand on GPs and other services before any reduction in avoidable demand occurs. The response is to plan capacity and referral arrangements, not suppress indications of need.

Signposting should reflect eligibility, availability and cost, and take account of support already in place. Where personal information is shared for assistance, the receiving service's responsibilities and expected response should be clear. Failed referrals, long waits and duplicated or contradictory advice should be monitored. The toolkit cannot compensate for unavailable treatment or workplace adjustments that are never implemented.

Employer burden and disengagement.

Employers may see the WHT as another survey or as a source of demands they cannot meet. Its relationship with engagement surveys, occupational health, employee assistance programmes and statutory health surveillance must therefore be clear. Employers, providers and employee representatives, including unions, should help test reporting and response arrangements. Line managers need practical guidance, proportionate expectations and access to advice – not individual health scores or an expectation that they become clinicians. Small employers require particular attention because a useful signal is not the same as the capacity to act on it.

Misinterpretation and distorted incentives.

Aggregate findings must be interpreted alongside participation, missing responses, workforce characteristics and local service provision. Low reported need should not automatically be read as a healthy workplace, nor high reported need as poor employer performance. Benchmarking and any future outcome-based incentives should avoid rewarding suppressed disclosure, selective participation or the exclusion of workers with greater needs.

A programme risk register would bring these issues together, assigning each risk an accountable owner, preventive controls, monitoring measures and an escalation response. Public feedback, complaints, safety incidents and evidence of unequal benefit should inform regular review. Safeguards would be judged by how they operate in practice, not simply by whether a policy or consent statement exists.

Evaluation: what success might look like

Success would mean earlier access to effective support, better health and sustained participation in suitable work, achieved without compromising autonomy or widening inequalities. Completing questionnaires, generating guidance or producing dashboards would demonstrate activity, not benefit. Evaluation should examine the whole pathway from an emerging difficulty to assistance and outcomes, while distinguishing the contribution of the WHT from that of the services and workplace changes around it.

Following the citizens' panels, a staged evaluation would likely be needed, informed by the MRC–NIHR framework for complex interventions and NICE's evidence standards framework for digital health technologies.^{65,66} Early studies would assess acceptability, usability, safety and feasibility. Later studies would assess whether offering the WHT and its connected support improves outcomes compared with the support otherwise available.

Measures that matter. A common core of measures should be agreed with workers, employers, providers and policymakers before live evaluation. The following are proposed domains, not a final outcome set.

Domain	What evaluation should establish
Workers' health and participation	Changes in health, wellbeing and ability to work; sustained participation in suitable work; sickness absence and recurrence; and health-related limitations while working. A move to a more suitable job or agreed reduction in hours should not automatically count as failure.
Earlier, effective assistance	Time from identifying a need to receiving appropriate help; whether referrals are completed; whether adjustments are implemented and reviewed; and whether workers judge the assistance useful.
Trust, safety and equity	Understanding of data use and sharing choices; perceived pressure to participate; errors, complaints and harms; and differences in access, experience and benefit across groups and delivery channels.
Workplace response	Whether employers understand aggregate reports and act constructively; whether managers can support individual conversations; and the effects on retention, productivity, workload and costs.
Services and policy intelligence	Referral quality, duplication, waiting times and resource use across public, workplace, private and voluntary provision; the coverage and comparability of aggregate evidence; and whether that evidence informs service improvement and investment.

Measures should be proportionate to the question being tested. Evaluation should not turn the short worker-facing toolkit into a lengthy research survey: additional measurement could be collected through separately agreed follow-up or approved linkage. The protocol should specify the primary outcomes, follow-up periods, data sources and handling of missing information before results are examined.

Test the pathway, not just the questionnaire. Initial prototype testing should establish whether people understand the questions and choices, receive safe and relevant guidance, and can reach the suggested assistance. It should also test the usefulness of worker-reviewed summaries within real consultations and workplace discussions. The additional value of AI should be examined against a simpler guidance route, rather than assumed from its inclusion.

Where feasible, later evaluation should use randomised allocation of participating workplaces or services. Where this is impractical, a prospectively designed quasi-experimental comparison should establish a credible account of what would have happened without the intervention. Baseline information and changes in service provision would need to be recorded. Interviews and process evaluation should explain how the toolkit was used, where the pathway broke down and why outcomes differed.⁶⁵ Where the WHT is introduced alongside additional vocational or clinical support, findings should not attribute the effect of the combined package to the toolkit alone.

Assess reach as well as outcomes among users. Participation and follow-up may differ between workplaces and population groups. The patterns of participation need to be evaluated over a sufficient time period and diversity of target users that we can test whether those most likely to need help are adequately reached and supported, and develop and test targeted outreach and assistance accordingly.

Further, the evaluation should distinguish the effect of offering the WHT from outcomes among those who complete it, and report the limits created by non-participation and missing data. Comparisons should account for relevant differences in health, occupation, employer size, deprivation and existing support. Personal data used for evaluation would remain subject to the separate permissions and governance described in the preceding chapters; employers would not receive individual evaluation records.

Assess value across the system. Economic evaluation should include development and operating costs, workers' time, employer and manager workload, workplace adjustments and changes in service use. Productivity should encompass absence and health-related limitations while working, without treating necessary recovery as a cost to be minimised regardless of health. A reduction in GP appointments is beneficial only if appropriate care and outcomes are maintained or improved. Conversely, an initial increase in appropriate help-seeking may be consistent with the toolkit reaching unmet need.

Progression criteria should be agreed before each stage. These should cover unresolved safety and privacy concerns, accessibility, the ability to connect people with assistance, feasibility of follow-up and the balance of benefits, harms and costs. Results should support a decision to proceed, revise, repeat testing or stop. The WHIU or a similar body could help establish common definitions and comparable reporting, but an improving dashboard alone would not demonstrate that workers' lives had improved.

Implementation and next steps

Developing the WHT would have to progress through a staged programme that builds on existing prototype work, connects to practical support and expands only as evidence justifies it. This section sets out what such a programme could look like, following the citizens' panels.

The initial service should focus on worker-initiated guidance, optional sharing with chosen providers and safe aggregate reporting, under the arrangements described in the legal and consent chapters. The proposed system-initiated pathway should remain a separate workstream, dependent on its specified legal powers, confidentiality arrangements and safeguards. Uncertainty about that future pathway should neither delay appropriately governed prototype work nor be treated as permission to introduce wider data flows.

Governance, clinical safety, accessibility, public involvement and evaluation would begin at the outset and continue throughout – not follow regional deployment or national scaling.

Phase 1: co-design and preparation. Existing prototypes from the Keep Britain Working prevention and early support sprint would provide starting material for testing, not a settled question set or production service. Work with citizens, employers, employee representatives, clinicians and other providers would refine the questions, guidance, sharing choices, summaries and reporting. The Citizens' Panel's recommendations would inform this work.

Preparation should establish the delivery model, data custody, clinical responsibilities, security, accessibility arrangements and evaluation protocol. Services receiving referrals should be involved before a live offer is made. A costed delivery plan should identify the staff, support capacity and funding needed, with named responsibilities for decisions and escalation.

Phase 2: limited regional testing. A limited deployment in Liverpool City Region, with participating employers and providers, would test the complete worker journey. Sites should include different employer sizes and levels of workplace health provision, with routes for people who cannot access the toolkit through an employer.

Testing would examine guidance quality, comprehension of sharing choices, referral completion, the usefulness of summaries, employer reporting and the burden on services. It would also establish whether safeguards work in everyday use. Moving beyond this stage would require resolution of material safety and privacy issues, usable access routes and evidence that people can connect with the support being offered.

Phase 3: comparative evaluation. Once delivery is sufficiently stable, the programme would undertake the comparative evaluation described in the preceding chapter. This would assess health, work participation, trust, equity and costs, while identifying which components and service arrangements contribute to benefit.

The work should align with relevant Keep Britain Working vanguards and fit note reform activity. Shared measures could support learning across programmes, while changes to the toolkit and surrounding services would be recorded so that results remain interpretable. Further testing in other regions and UK nations would assess transferability.

Phase 4: evidence-led expansion and integration. Wider adoption would depend on evidence of benefit, an acceptable balance of harms and costs, adequate support capacity and accountable governance. Common standards for questions, summaries, data quality and safe outputs would support comparison while allowing local adaptation.

Integration with existing services and, potentially, future NHS App or similar infrastructure should solve demonstrated problems rather than become a prerequisite for testing the core service.

Procurement should address interoperability, continuing support and the ability to change suppliers. Monitoring, public involvement and evaluation would continue after adoption, with reassessment when the question set, AI, data uses or service pathways change materially.

Responsibilities and immediate next steps.

A delivery agreement should distinguish responsibility for developing the toolkit, providing support, holding data, conducting evaluation and authorising progression. CHIL could contribute research, design and evaluation expertise; Keep Britain Working could provide policy alignment and connections with employers and providers; regional partners could convene local services and participating workplaces. These contributions would not remove the need for a named accountable service operator, clinical safety leadership and independent oversight.

The next steps would be to:

- **agree a costed development and evaluation plan**, identifying the accountable organisations, proposed sites, funding requirements and decisions needed before live testing;
- **prepare and iterate the prototypes** with workers and delivery partners, incorporating Citizens' Panel findings, testing assisted routes and clarifying how managers and providers would respond;
- **establish the safeguards and evidence requirements**, including custody and sharing arrangements, clinical safety, referral responsibilities, baseline measures and criteria for proceeding, revising or stopping.

The immediate task is not to commit to national deployment, but to establish a governed, resourced programme capable of showing whether the WHT helps people obtain effective support earlier. That would provide a basis for wider implementation: learning from workers' experiences, preserving their autonomy and connecting better information to better work-and-health outcomes.

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Appendix: The legal basis for sharing data for health, work and opportunity

Data governance and the cross-sector, person-centred coordination challenge – findings of the Keep Britain Working Data and AI Taskforce

This appendix sets out in further detail the legal analysis behind the chapter on the legal basis for data use and consent. It describes the current legal position, the gaps in it, and what could be done in future to address them. It sets out what could be done; it is not a statement of Keep Britain Working's position.

Purpose

Keep Britain Working (KBW) explores something the UK has never done consistently at scale: notice early that a working person's health is beginning to put their job at risk, and act before a manageable problem becomes prolonged absence and economic inactivity. The KBW report found that 93% of fit notes in England record that a person is 'not fit for work', and that the early weeks of an absence are when timely support makes the greatest difference. Yet the health professional who signs the note rarely knows the job, the workplace or the adjustments an employer could make.^{1,2}

The GP knows the diagnosis but not the job. The employer knows the job but normally neither needs nor is entitled to see the medical record. Occupational health care can translate between the two, but most small employers and many workers cannot access it. The Department for Work and Pensions (DWP) sees the benefit claim; an NHS integrated care board commissions WorkWell; a local authority social care service or voluntary, community, faith or social enterprise organisation may hold another fragment. Individual organisations may perform their own functions correctly while the system as a whole fails the person.

That is a coordination problem that needs joined-up information about a person – what has happened, what the person wants, who owns the next step and whether support was taken up. The aim is not to share more data per se. It is to move the minimum information needed to produce timely support, under rules people can understand and trust.

Alan Milburn's investigation into young people not in education, employment or training (NEET) uncovered a similar problem at the start of working life. Schools, the NHS, social care, welfare and justice organisations each see a warning sign through a different window on the person's life; the civic system lacks the combined intelligence to turn those signs into coherent help; roughly 314,000 young adults are NEET and invisible to the benefit system altogether.³ NEET and Keep Britain Working share one civic purpose: preventing avoidable loss of health, work and opportunity by making an accountable offer of support before disengagement becomes entrenched. Civic systems need the data, information systems and AI that can coordinate the support in a trustworthy and efficient way.

This appendix explains what the law already allows on data sharing, where it runs out, what the Health Bill and the English Devolution and Community Empowerment Act 2026 change, whether a mayoral strategic authority – and a mayoral commissioner – can lawfully hold that civic purpose as a 'controller in common', and what Parliament and ministers would need to do so that the Work and Health Toolkit, Workplace Health Provision, the Workplace Health Intelligence Unit and the AI systems that will increasingly coordinate care, benefits and work can be built, tested and trusted.

The proposition in brief

England already has substantial legal capacity to use data for direct care, for worker-authorized occupational health support, for public functions, for planning and for research.

Data protection law should not be seen as an obstacle but as enabling governance here. What England lacks is a coherent operational framework for data sharing across clinical care, occupational health, employment support, benefits, education, social care and the workplace. Existing powers are fragmented by organisation and purpose. They do not reliably tell a frontline team who may initiate a flow, what may be disclosed, who may act on it, or how the person can see, correct and challenge the result.

Government might consider establishing in law a civic health, work and opportunity purpose, with protected pathways for young people's participation and for working-age health and employment. Mayoral strategic authorities are the natural civic home, and the 2026 Act gives them the institution, the competence and the accountability to hold it. But devolution provides a civic framework, not a data governance framework. A statutory route is still needed to enable the necessary data governance and service coordination. The Health Bill, considered at Commons Report stage on 7 and 8 September 2026, does not itself create that route; it is one immediate legislative opportunity to do so, subject to scope and parliamentary agreement, and dedicated primary legislation is the alternative.

What 'public interest' can and cannot do

Much of the confusion in this field comes from one phrase doing four jobs. In the UK GDPR and the Data Protection Act 2018, 'public task' and 'substantial public interest' are conditions under which an organisation may process personal data. A public authority relying on public task must be performing a function with a clear basis in law; health data also needs an Article 9 condition and, usually, a condition in Schedule 1 to the 2018 Act.⁴ These rules govern purpose, necessity, proportionality, transparency, security and individual rights. They do not give an organisation a new function and they do not require any other organisation to disclose anything.

The common law duty of confidentiality is a separate layer, owed by every clinician and NHS body to the patient, in Scotland as in England. Confidential patient information may be used with consent, within the reasonable expectations of direct care, under specific statutory authority, by court order, or – exceptionally – where an overriding public interest justifies disclosure. That last route is a case-by-case response to serious risk or harm. It is not a basis for a routine national flow covering millions of people.⁵

Section 251 of the NHS Act 2006 and the Control of Patient Information Regulations 2002 (COPI Regulations) provide the statutory mechanism by which confidentiality can be set aside for specified medical purposes under strict governance.⁶ They can support eligible research and service evaluation where the statutory tests are met and consent is impracticable; they are not a gateway for routine NHS-to-DWP disclosures for benefit administration or employment support. Occupational medicine and the assessment of working capacity can fall within health purposes where they are genuinely part of a person's care, but a service does not acquire a medical purpose merely because it helps someone stay in or return to work. And in policy, 'the public interest' is the argument for Parliament to act, not a substitute for Parliament acting.

The practical rule is that a proposed flow must pass all relevant legal tests. The organisations must have relevant functions and powers; the data protection conditions must be met; confidentiality must be respected or lawfully addressed; and the resulting use must be necessary, proportionate and fair. Scotland's approach to NEET rests on section 20 of the Post-16 Education (Scotland) Act 2013, which lets Ministers require organisations to supply information about people aged 16 to 24 to Skills Development Scotland, and its health data access rests on a single identifier, NHS-owned safe havens and the Public Benefit and Privacy Panel.⁷⁻⁹

The lesson is statute, a single accountable body and a common identifier – all of which England can enact.

What can be done now

The proposed Work and Health Toolkit is being designed around what current law already permits. The worker completes a periodic or event-triggered questionnaire, sees the feedback and decides whether to seek support. Identifiable responses stay with the authorised clinical or occupational health service. The employer receives only what the worker chooses to share, plus aggregate workforce intelligence. Anonymous data may flow to the Workplace Health Intelligence Unit for evaluation; where person-level data is pseudonymised rather than truly anonymous, it remains personal data and requires an identified purpose, lawful bases, confidentiality route, transparency, safeguards and, where required, a data protection impact assessment.¹⁰ These components can be designed lawfully, but the person acting as a conduit does not itself create a lawful basis for processing or disclosure.

The fit note itself works the same way: it is given to the patient, who decides whether to pass it to an employer or to DWP, and a GP report requested by an employer is protected by the Access to Medical Reports Act 1988.^{11,12} In some WorkWell and fit note pathways, an occupational health professional may genuinely form part of the direct-care team. WorkWell began in fifteen pilot areas in October 2024, and four fit note reform pilots, announced on 20 May 2026, began operating in WorkWell sites in July 2026.¹³ In such a pathway, appropriately limited information may be shared under the ordinary direct-care confidentiality route and, where its conditions are satisfied, section 251B of the Health and Social Care Act 2012. Section 251B applies only where disclosure is likely to facilitate the person's care, is considered in their best interests and is not displaced by an objection or another restriction; it does not override data protection law or confidentiality.

Article 9(2)(h) expressly covers occupational medicine and the assessment of working capacity where a professional bound by confidentiality is responsible.¹⁴ This route must be judged on the substance of the service, not its label: a provider does not become part of direct care because it holds an NHS contract. Information passed to the employer remains a distinct disclosure, normally limited to functional advice the worker has authorised – capabilities, restrictions, possible adjustments, expected duration and a review date.

England can also learn what works without waiting for new law. Truly anonymous information falls outside data protection law; pseudonymised information remains personal data and may be linked only where there is a defined purpose, a UK GDPR Article 6 basis, an Article 9 condition, an appropriate route through confidentiality and the necessary research safeguards. Secure data environments such as the NHS Research Secure Data Environment network and the ONS Secure Research Service reduce risk; they do not themselves supply a legal basis. The Ministry of Justice's Better Outcomes through Linked Data programme shows health data crossing a departmental boundary for properly governed analysis under section 251 support.^{15–17} Vanguard can therefore begin with worker-authorised plans, clearly defined direct-care pathways, aggregate employer intelligence and secure evaluation, and should assess whether each defined evaluation is eligible for section 251 support and, where the criteria are met and consent is impracticable, apply. The anticipation of new law need not become an excuse to delay what is already possible.

One civic purpose, two protected pathways

The statutory purpose should describe a service to the citizen, not data processing as an end in itself.

A workable formulation is: to identify residents who face a material risk of avoidable exclusion from education, training or sustained good work because of ill health, disability, caring responsibilities, educational disengagement or connected disadvantage; to make a timely offer of voluntary support; to coordinate the services the resident chooses; and to evaluate whether those services improve health, participation and sustained good work. That joins Milburn and Mayfield at the point where government should act – finding a person at risk, offering support, coordinating a multi-agency response and learning whether it worked – and it fits the statutory tests for a Digital Economy Act public service delivery objective, which expressly include physical and mental health, contribution to society and social and economic well-being.^{18,19}

The umbrella purpose should contain two pathways. The opportunity pathway governs education, training, safeguarding and transition to work for young people, with age-appropriate rights. Sections 68 to 78 of the Education and Skills Act 2008 support participation services and information sharing for ‘young persons’ aged 13 to 19 and for ‘relevant young adults’ aged 20 to 24 who have special educational needs; they do not provide universal coverage through age 24. The Children’s Wellbeing and Schools Act 2026 is framed around children and stops at 18.^{20,21} A universal opportunity pathway through age 24 would therefore require an extension of existing coverage, rather than its first extension beyond 18. The work-and-health pathway governs prevention of health-related job loss, safe return to work, occupational health and employment support for working-age adults. Each pathway should have its own permitted data, triggering conditions, recipients, retention periods and decision rules. They may share governance, standards and privacy-preserving infrastructure, but not a general pool in which children’s, health, benefit and justice records become interchangeable.

Devolution: a place-based home, not a data pipe

The English Devolution and Community Empowerment Act 2026 received Royal Assent on 29 April 2026 and supplies most of the institutional shell.²² Section 2 lists ‘skills and employment support’ and ‘health, well-being and public service reform’ among the areas of competence; Schedule 6 extends the general power of competence to combined authorities and their mayors; section 45 places a duty on authorities and mayors to have regard to the need to improve health and reduce health inequalities, defined by reference to housing, employment, access to services and other general determinants; section 22 gives mayors a power to convene local partners, who must respond; and section 53 gives the mayors of established mayoral strategic authorities – at present the Greater London Authority (GLA), Greater Manchester, Liverpool City Region, West Yorkshire, South Yorkshire, the West Midlands and the North East – a right to request changes in law, funding or functions, to which the Secretary of State must respond with reasons within six months. Schedule 27 allows the Secretary of State by regulations to confer any eligible public function within an area of competence on a category of strategic authorities, including by time-limited pilot schemes.^{22,23}

These powers may be sufficient to establish a carefully scoped voluntary civic service, to commission parts of it and to hold the information generated through it, subject to the authority’s constitution and devolution arrangements, and to public law and the applicable procurement, confidentiality and data-protection requirements. Seven established mayoral strategic authorities already receive Connect to Work funding through integrated settlements.^{23,24} All English areas are expected to develop local Get Britain Working plans, and eight Youth Guarantee trailblazers have tested place-based coordination in specified mayoral areas; the two groups are not identical.^{25,26} 27

The merger of the National Careers Service and Jobcentre Plus in England, due on 1 October 2026, is also designed around enhanced collaboration with local partners.²⁷ Crucially for what follows, combined authorities, combined county authorities and the GLA are already ‘specified persons’ under Schedule 4 to the Digital Economy Act 2017, alongside DWP and county and district councils.²⁸ Part of the cross-government gateway therefore already exists, though section 35 permits sharing only for a specified objective, in connection with the participants’ functions and subject to every other legal restriction, including confidentiality. The Mayoral Data Council established in November 2025 and the Secretary of State’s June 2026 commitment to standardised public-sector data-sharing agreements show that government recognises the need to make it work.^{29,30}

What the 2026 Act does not do is noteworthy. Its only information-sharing provision relevant here is section 50, which adds combined authorities and combined county authorities to the bodies that may receive disclosures under section 115 of the Crime and Disorder Act 1998 – a gateway confined to the purposes of that Act.³¹ It contains no gateway for a health, work and opportunity purpose, no amendment to Schedule 4 to the Digital Economy Act, and no duty on NHS bodies, integrated care boards or DWP to supply information to a strategic authority. A duty to have regard to health outcomes does not make a strategic authority an NHS body; the NHS Act 2006 definition of ‘local authority’ excludes combined authorities from the general NHS cooperation duty; and section 116ZA of the 2007 Act does not make a combined authority a mandatory member of an integrated care partnership, though one may be appointed.^{32,33} The Health Bill would in any case abolish integrated care partnerships and instead require a member nominated by each mayor of a mayoral strategic authority on the relevant integrated care board – a significant new point of strategic alignment, but not a data gateway.³⁴ A power to convene does not override purpose-bound disclosure restrictions.

A power to conduct research does not authorise access to a care or service record. Where Parliament intends data sharing to accompany a devolved function, it must say so.

A controller in common: can a mayoral commissioner hold the purpose?

The key question is whether a mayoral strategic authority could go beyond convening data controllers to establish a common governance arrangement for multi-agency data flows, where seeking repeated, similar decisions from hundreds of constituent controllers would be impractical. Could the key role be a data guardian who is one of the statutory commissioners a mayor may now appoint? The answer has three parts: what ‘controller in common’ now means, what a commissioner legally is, and what controllership can and cannot achieve.

‘Controller in common’ is a term from the Data Protection Act 1998, which defined a controller as a person who determines purposes and means ‘either alone or jointly or in common with other persons’. The UK GDPR has no ‘in common’ category: organisations are either joint controllers under Article 26, where they genuinely determine purposes and means together and must set out their respective responsibilities in a transparent arrangement, or independent controllers of their own processing.^{35,36} Each Get Britain Working arrangement we studied – South Yorkshire’s Pathways to Work, the Leeds and West Yorkshire trailblazer, and Greater Manchester’s Live Well and Skills for Growth programmes – uses the independent-controller model, with the combined authority controlling its own commissioning and monitoring data and councils and DWP controlling theirs, linked by data-sharing agreements.^{37–39} This may be the practical governance arrangement intended here, but it should not be described as a current legal category of ‘controllers in common’. The breadth and depth of data-sharing agreements vary widely.

Some are so narrow that new agreements must be established repeatedly for similar purposes, making it difficult for civic systems to support necessary data flows as requirements evolve. But the Information Commissioner's data sharing code is explicit that a sharing agreement cannot create legal powers; it must identify the powers on which the sharing depends.⁴⁰ Controllershship allocates responsibility for processing. It never supplies a missing function, a missing disclosure power or a missing route through confidentiality.

The 2026 Act does not establish a mayoral commissioner as a separate statutory corporation or nominate the commissioner as a controller. Section 9 and Schedule 3 allow a mayor to appoint up to ten commissioners to assist with the mayor's general functions across the areas of competence and to arrange for a commissioner to exercise delegated functions. A commissioner may be appointed under a worker's contract, under another contract with the authority or otherwise as an office-holder under the authority; appointment does not of itself confer membership of the authority. For processing undertaken solely in exercising the authority's functions under its governance, the authority would ordinarily be the controller; however, controllershship remains a functional question under Article 4(7), determined by who actually decides the purposes and means of processing.⁴¹ That contrasts with a Police and Crime Commissioner or the Children's Commissioner for England, each of which is a corporation sole created by statute and registers as a controller in its own name.^{42,43} If Parliament wished to establish a Commissioner for Health, Work and Opportunity as a separate statutory controller, it would have to create the office as a statutory corporation, confer functions and information powers on it, and provide for its liabilities and continuity. That adds machinery without obvious benefit, and would reopen the question of how the corporation sole obtains the data in the first place.

The durable model is therefore corporate controllershship by the mayoral strategic authority, visible accountability through a mayoral commissioner, and an independent civic data board. The authority would be the controller of the civic coordination service and its operational record and could act as the lead coordinating body; 'lead controller' is not a separate status under the UK GDPR. GPs, NHS bodies, DWP, the Department for Education (DfE), councils, schools and colleges would remain controllers of their source records and their initial disclosures; the authority and a partner would be joint controllers only for processes in which they genuinely determine purposes and means together, such as the rules for deciding whom to contact. Technology suppliers acting only on documented instructions would be processors; the roles of service providers would depend on their actual responsibilities and decisions about the purposes and means of processing. Two statutory routes can support that model on the health side. Section 65Z⁵ of the NHS Act 2006 allows NHS England, an integrated care board, an NHS trust or an NHS foundation trust to arrange for functions to be exercised by, or jointly with, a combined authority; this can align a devolved function such as WorkWell with the strategic authority, but it does not of itself create joint controllershship – the parties' actual decisions about purposes and means determine their status.⁴⁴ And the Digital Economy Act already names the authority as a specified person, so that if a work-and-health objective is specified and the relevant NHS bodies are added to Schedule 4, section 35 may permit sharing among those participants for that objective and in connection with their functions, subject to the Code, data protection law, confidentiality and any other applicable restriction.²⁸

Do the laws exist to enable a Work and Health Toolkit?

For a voluntary, person-controlled civic service – the Work and Health Toolkit, worker-authorised plans, genuine direct-care occupational health, aggregate employer intelligence and secure evaluation, commissioned or coordinated by a mayoral strategic authority acting as an independent controller or, where purposes and means are genuinely shared, as a joint controller – existing law may support properly designed components today. The English Devolution and Community Empowerment Act 2026 provides relevant competence, powers and accountability, subject to the authority's constitution and applicable devolution arrangements; section 65Z⁵ provides a route to exercise or jointly exercise an NHS function; a Digital Economy Act objective could add a public-service sharing route among specified participants; and the data protection conditions can be met where processing is necessary and proportionate and the Article 6, Article 9 and Schedule 1 tests are satisfied. None of these provisions creates a general entitlement to health information.

For a dependable, system-initiated coordination service – notifying an accredited work-and-health service when a fit note reaches a defined duration; combining health, benefit and employment-support information to identify an offer of help; allowing several public bodies to maintain one operational plan; giving a participation service sight of a young adult who has disappeared from every system – no, the complete legal route does not exist. Consent should not be the sole system-wide legal foundation for an essential, population-scale public service: it may not be freely given where there is a power imbalance, it can be withdrawn, and every source body would still need a function and a power to disclose. Consent may nevertheless remain relevant to voluntary participation, confidentiality and particular disclosures.

The missing components are specific and finite: an express civic function for the strategic authority; a named Digital Economy Act objective with relevant NHS bodies added to Schedule 4 and the 2017 policy pause on health bodies lifted; a narrow statutory gateway through health confidentiality for a minimum dataset; an extension of youth participation duties to provide universal coverage through age 24, if Parliament adopts that policy, with defined sharing powers and a consistent identifier; and, where national completeness matters, a proportionate duty to cooperate or disclose rather than a merely permissive power. A new statutory function may provide the basis for reliance on Article 6(1)(e) where the processing is necessary and proportionate; health data would still require an Article 9 condition and, where applicable, a Schedule 1 condition. Existing conditions – including health or social care purposes and substantial public interest for statutory and government purposes – may suffice, depending on the precise design and participating bodies, but that conclusion must be tested against each proposed flow. Where no existing Schedule 1 condition is suitable, ministers should consider the regulation-making power in section 10 of the Data Protection Act 2018, which allows conditions and safeguards to be added or varied subject to the affirmative procedure.⁴⁵ Separate primary legislation may still be needed for the proposed civic function, the confidentiality gateway and any duty to cooperate. Section 74 of the Data (Use and Access) Act 2025 is not the relevant power for varying conditions that apply to existing health-data processing.⁴⁶

Where current law runs out, in detail

The Digital Economy Act 2017 is the most promising existing framework, and its limits are precise. Section 35 permits specified persons to share for objectives created by affirmative regulations;

the current objectives are multiple disadvantage, fuel and water poverty, television retuning, Scottish childcare and identity verification, with energy-debt relief laid in draft in July 2026 and a 'passport benefits' objective still awaited.^{19,47} There is no work-and-health or youth-participation objective. English health and adult social care bodies are absent from Schedule 4 and the Code of Practice directs that sharing arrangements should not include them – a policy decision of 2017, reversible by regulations and a revised Code, not a statutory bar.¹⁸ The research chapter, by contrast, excludes health bodies by statute in section 65(4); the Government agreed in March 2025 to review that exclusion and has not yet done so.^{48,49} Even where the Act applies, it supplies a power to disclose, not an override of confidentiality; a health body added to Schedule 4 would still need a confidentiality route.

The DWP, education and justice gateways are purpose-bound. The Social Security Administration Act 1992 and sections 130 to 133 of the Welfare Reform Act 2012 permit defined disclosures for benefit administration and prescribed welfare services, with criminal sanctions for unlawful disclosure, and do not name NHS bodies. Under section 76 of the Education and Skills Act 2008, DWP may supply only a young person's name, address and date of birth for participation services. Sections 68 to 78 cover young persons aged 13 to 19 and relevant young adults aged 20 to 24 with special educational needs; section 77 expressly includes integrated care boards among bodies that may supply information, although NHS trusts are not listed.²⁰ The Children's Wellbeing and Schools Act 2026 adds a safeguarding duty to share and provides for a consistent identifier to be specified by regulations; the Act does not select the NHS number. It is framed around child welfare and stops at 18.²¹ The Offender Management Act 2007 allows probation to share with government departments and councils for offender management;

the serious violence duty in the 2022 policing Act expressly exempts patient information – a recent parliamentary choice to keep health data out of a cross-agency demand power.⁵⁰

The Health Bill: useful, but not sufficient

The Health Bill was introduced in May 2026 and was considered at Commons Report stage on 7 and 8 September 2026. It is the most significant immediate legislative opportunity. Clause 51 would insert sections 250E and 250F into the NHS Act 2006, allowing regulations to establish the single patient record, to require providers including GP practices to contribute, to control access, to impose financial penalties, and to provide that processing in accordance with the regulations does not breach an obligation of confidence.^{51,52} The Bill is a framework: its effect will depend on the regulations, the data categories selected and the roles authorised. The Explanatory Notes say it 'does not create, nor enable the creation of, new legal gateways for data to be used for secondary purposes', and the fact sheet says the record may be a source for other purposes only where a separate legal basis already exists.^{53,54} Nothing in it gives employers, work and wellbeing coaches, participation teams or analysts in a prospective Workplace Health Intelligence Unit access.

Two opportunities follow. First, the regulations and guidance should make clear that an accredited occupational health clinician may participate where they genuinely deliver part of the patient's care and need specified information to do so – role-based access to a minimum dataset, not occupational health or employer access to the whole record – with purpose limits, access logs, professional accountability and correction rights stated expressly rather than left to implication. Second, the wider civic coordination purpose needs its own provision, which the Bill as it stands does not contain.

An amendment during the Bill's remaining stages is one possible vehicle, if it is within scope and Parliament agrees; dedicated primary legislation is the alternative. Either way the provision should be a regulation-making power permitting specified NHS bodies and GP practices to disclose a minimum dataset to specified public bodies, including strategic authorities and accredited providers, for the civic health, work and opportunity purpose, subject to a statutory public-interest test, independent advice of the kind the Confidentiality Advisory Group gives, consultation, transparency to the person through the NHS App, the national data opt-out, and the right to decline the resulting offer. The British Medical Association (BMA) has objected that the Bill's direct-care limitation is not stated on its face. The National Data Guardian opposed wholesale disapplication of confidentiality, supported an express care-purpose limit and called for independent oversight and an explicit public-interest requirement for access beyond care.^{55,56} A gateway drafted to that standard would respond to those professional concerns and could provide a cross-government health-data power with confidentiality built in rather than bolted on. The policy should choose the vehicle; a direct-care record should not be stretched beyond the purpose for which Parliament created it.

A person-controlled information architecture

Law and trust are easier to sustain if the system separates four planes of information. Source records – health, education, benefits, social care, justice and employment – stay with their existing controllers; joining the civic service transfers neither ownership nor reciprocal access. The civic coordination record, held by the strategic authority, contains only the minimum needed to contact the person, record the offer they accept, coordinate agreed actions and identify who owns the next step; clinical and educational detail stays at source;

young people receive age-appropriate explanations and rights, and workers can see and shape their plan. Workplace action rests on a concise functional summary or stay-in-work plan that the worker controls: the employer sees agreed adjustments, capabilities, restrictions, timing and review arrangements. The service would provide employers with functional advice rather than diagnoses or access to clinical records; this would not restrict a worker's choice to disclose information themselves. Organisational and national learning uses aggregate information for employers and anonymous or securely governed data in the Workplace Health Intelligence Unit, which evaluates both pathways without turning analytical linkage into an operational case-finding power.

These boundaries should be enforceable in law. Information supplied to obtain help must not be repurposed for recruitment screening, performance management, immigration enforcement, unrelated policing, insurance or benefit sanctions. A person must be able to see who has accessed their information, correct material errors and challenge a consequential recommendation. This architecture turns the Work and Health Toolkit from a questionnaire into a front door to a personal plan and, with permission, a coordinated pathway; for the Milburn agenda it lets a warning sign generate an accountable offer rather than a hidden risk score.

Learning from the COVID-19 pandemic

COVID-19 showed that the country can mobilise health data within weeks when government provides a clear purpose, a lawful instrument, common requirements and secure infrastructure. Notices under regulation 3(4) of the COPI Regulations required GP practices, NHS bodies and councils to process confidential patient information for defined purposes, while data protection law continued to apply;

the flows supported shielding, vaccination, testing, surveillance and research. OpenSAFELY and the NHS Secure Data Environment showed the value of taking analysis to data across 58 million records rather than distributing extracts.^{57,58} The CIPHA system showed the value of health-system-wide linked data and digital workflows, for example, by underpinning the world's first evaluation of city-scale, voluntary mass testing.⁵⁹ COPI notices were not required where direct-care rules or another statutory public-health power already provided a sufficient route. Their distinctive effect under regulation 3(4) was to require specified processing at scale, removing the need for each controller to make the same permissive-disclosure judgment, while leaving UK GDPR obligations in place. The Confidentiality Advisory Group's review also recorded the cost of broad emergency authority without oversight: weak patient involvement, variable transparency and uncertain governance.⁶⁰ The lesson is not to normalise emergency notices but to establish purposes, duties, oversight and infrastructure before pressure forces improvisation. Economic inactivity driven by ill health is that pressure now.

AI that serves and coordinates, not decides

Civic systems need more than passive intelligence: they need AI that can coordinate data-driven tasks across primary and secondary care, occupational health, social care, employment support, benefits and the workplace. The personas in the prospectus, from a warehouse operative with chronic back pain on shift work to a senior civil servant whose rheumatoid arthritis and perimenopause are invisible to her organisation, are the beginning of a specification for such systems.¹⁰ Carefully governed AI could help a worker describe how health interacts with their job, identify possible support, route referrals, reconcile competing plans, track actions and prepare a summary the worker approves. It should be a coordinator, not a gatekeeper:

it should not diagnose, declare someone fit for work, determine entitlement, recommend dismissal or withhold support. Those decisions carry clinical, employment or financial consequences and require an identified human decision-maker, intelligible reasons and an effective route to challenge.

AI training and testing are legally distinct purposes. Training needs linked, longitudinal, representative data spanning the settings in which the system will operate. Effectively anonymised data, and synthetic data that does not permit individuals to be identified, may be used outside data protection law; however, producing those datasets may itself involve regulated processing, and the risk of re-identification must be assessed. Pseudonymised data remains personal data and requires a specified purpose, an Article 6 basis, an Article 9 condition, a route through confidentiality where patient information is involved, and appropriate minimisation, security and research safeguards. Secure data environments reduce risk but do not supply a missing legal basis. The statutory exclusion of health bodies from the Digital Economy Act research power is one significant obstacle to cross-domain development, alongside the need to align the existing research and confidentiality routes.⁴⁸ Testing a coordinating system is different: it must be evaluated on whether its actions improve outcomes for real people in real workplaces, and where testing affects live services or triggers action it is an operational purpose requiring the operational gateway described above or another clearly identified lawful route. A regulatory sandbox – which we propose is sponsored jointly by the Information Commissioner, the National Data Guardian and the vanguard in which AI-assisted coordination is trialled under the new gateway with full transparency to participants – is the natural mechanism. The Liverpool City Region vanguard is the natural site, given the city region's Office for Public Service Innovation and allied Civic Health Innovation Labs.^{61,62}

Evaluation must go beyond predictive accuracy to false reassurance, unnecessary escalation, discriminatory performance, inadvertent disclosure, conflicting clinical advice, impractical workplace recommendations and automation bias.

The law already constrains what such systems may decide. The Data (Use and Access) Act 2025 reformed the rules on solely automated decisions, but significant decisions using special-category data remain subject to stricter conditions and to rights to information, to make representations, to obtain human intervention and to challenge the decision. All relevant profiling remains subject to fairness, transparency, minimisation and accuracy; public authorities and bodies exercising public functions must also comply with the public sector equality duty. Under the Human Rights Act, an interference with private life must be in accordance with law, pursue a legitimate aim and be necessary and proportionate.^{63,64} Many coordination functions will not themselves be significant decisions where a professional reviews and controls the action, but a human name on a workflow is not enough – review must be meaningful. The Intelligence Unit should keep separate environments for development, independent evaluation and live operation, publish model and data documentation, monitor performance after deployment and retain an auditable record of recommendations, human actions and outcomes. The Citizens' Panels commissioned in this prospectus should set the boundaries of acceptable use, and the eighth Caldicott principle – no surprises – should be a design requirement.⁶⁵

What government could do

Establishing the civic purpose and the devolved function. Government could define the civic health, work and opportunity purpose in legislation, with separately safeguarded opportunity and work-and-health pathways, and use the Schedule 27 function-conferral and pilot machinery – in response to a request made

under section 53 by the established mayoral strategic authorities – to give participating authorities an express coordination and commissioning function. The government's response to Milburn, due this autumn, would be the natural vehicle for the opportunity pathway.

Making the mayoral strategic authority the controller of the civic service. The authority's corporate body could control the civic operational record and act as the lead coordinating body; a mayoral Commissioner for Health, Work and Opportunity could provide visible leadership and public accountability, supported by an independent civic data board with worker, young-person and citizen representation. Source bodies would remain controllers of their records; joint control would be used only for processes in which purposes and means are genuinely determined together. Section 65Z⁵ arrangements with integrated care boards could formalise the exercise or joint exercise of health functions, while the parties' actual roles determine controllership.

Beginning a lawful vanguard now. The Department of Health and Social Care (DHSC), DWP, DfE and the Ministry of Housing, Communities and Local Government (MHCLG), with the Information Commissioner and the National Data Guardian, could publish a common governance framework for voluntary referral, worker-authorized plans, genuine direct-care pathways, direct collection from residents and secure evaluation, building on the standardised data-sharing agreements the Secretary of State announced in June 2026. For each proposed evaluation, the vanguard would determine whether section 251 is available and necessary and, where the statutory criteria are met and consent is impracticable, apply for support.

Creating the Digital Economy Act objective. Affirmative regulations could specify a civic health, work and opportunity objective, add NHS England's successor, integrated care boards, GP contractors and accredited Workplace Health Providers to Schedule 4,

revise the Code of Practice to lift the 2017 pause on health bodies, and prescribe the two pathways, participating bodies and functions, minimum datasets, recipients and onward-disclosure limits. The objective would not itself override confidentiality, so the health gateway would need to be legislated separately. Where national coverage is essential, Parliament could add a proportionate duty to cooperate or disclose. The review of the research-power health exclusion promised in March 2025 could be completed.

Legislating for a narrow health-confidentiality gateway. The Health Bill could be used for its stated direct-care purpose, including accredited occupational health clinicians where they genuinely form part of care. For the distinct civic purpose, an amendment during the Bill's remaining stages, if within scope and agreed by Parliament, or dedicated primary legislation, could provide it. The gateway would permit minimum-dataset disclosure to specified bodies, with a statutory public-interest test, independent advice, transparency, the opt-out and the right to decline. The new function and gateway would be drafted so that the necessary Article 6, Article 9 and Schedule 1 conditions can be met. If a bespoke Schedule 1 condition were required, the regulation-making power in section 10 of the Data Protection Act 2018, subject to the affirmative procedure, could be used, or the Act amended directly; section 74 of the 2025 Act is not the relevant power for existing health-data processing.^{45,46}

Putting a non-sanction firewall into law. Information obtained for civic support would be protected in law from reuse for benefit sanctions, workplace discipline, recruitment screening, immigration control, unrelated policing, insurance or credit. Justice information would be separately justified and confined to safeguarding or resettlement; operational police data would not enter the civic platform.

Establishing the Workplace Health Intelligence Unit or a similar body as the trusted learning nexus, with a data trust providing secure access for accredited analysis, evaluation and AI development across both pathways, a firm line between analytical and operational data, and a regulatory sandbox for coordinating AI with published results. Public legitimacy could be built into the governance: transparency would cover not only what is held but also what action was triggered, what outcome is being optimised and which uses are prohibited.

A new settlement for health, work and opportunity

The prize is not more data sharing. It is a better, data-enabled experience when someone's health begins to threaten their livelihood. Instead of a fit note and several disconnected systems, a worker would have a route to early help, an intelligible plan and control over what reaches their employer or GP. The GP could coordinate with occupational health services with the worker's consent and in co-production with them. The employer would receive practical functional advice rather than medical history. Public services would know who owns the next action. The country would learn, systematically, which interventions prevent avoidable loss of work. The same civic service, under its own protected pathway, would let a young person whose disengagement is visible only in fragments receive an accountable offer rather than invisible surveillance.

Data protection and confidentiality are not obstacles to that settlement; they are part of its legitimacy. But they must be translated into dependable routes for responsible action rather than left as fragmented rules each professional must interpret alone. England can begin now: existing law can support carefully designed voluntary civic vanguards, worker-controlled support, genuine direct care, secure learning and a strategic authority as accountable controller.

The devolution settlement provides the institution, and the Digital Economy Act can provide much of the public-service gateway once the objective and participants are specified. The remaining health-confidentiality gap will close only if Parliament creates a narrow gateway – through an agreed amendment to the Health Bill or through dedicated primary legislation – with a duty to cooperate where completeness matters and with the safeguards set out in this appendix. That is how the law can support health, work and opportunity as one civic purpose while preserving the boundaries on which public trust depends.

Notes and acknowledgements

Legal position stated as on 9 September 2026. The Health Bill's clause numbering should be checked at final proof; Report stage was taken on 7 and 8 September 2026. The relevant devolution provisions are in force: section 9 and Schedule 3, together with section 45, commenced on Royal Assent; sections 22 and 53 to 55, with Schedule 27, commenced on 29 June 2026. Milburn's final blueprint and the government's response to the Digital Economy Act 'passport benefits' consultation were outstanding at the date of writing.

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