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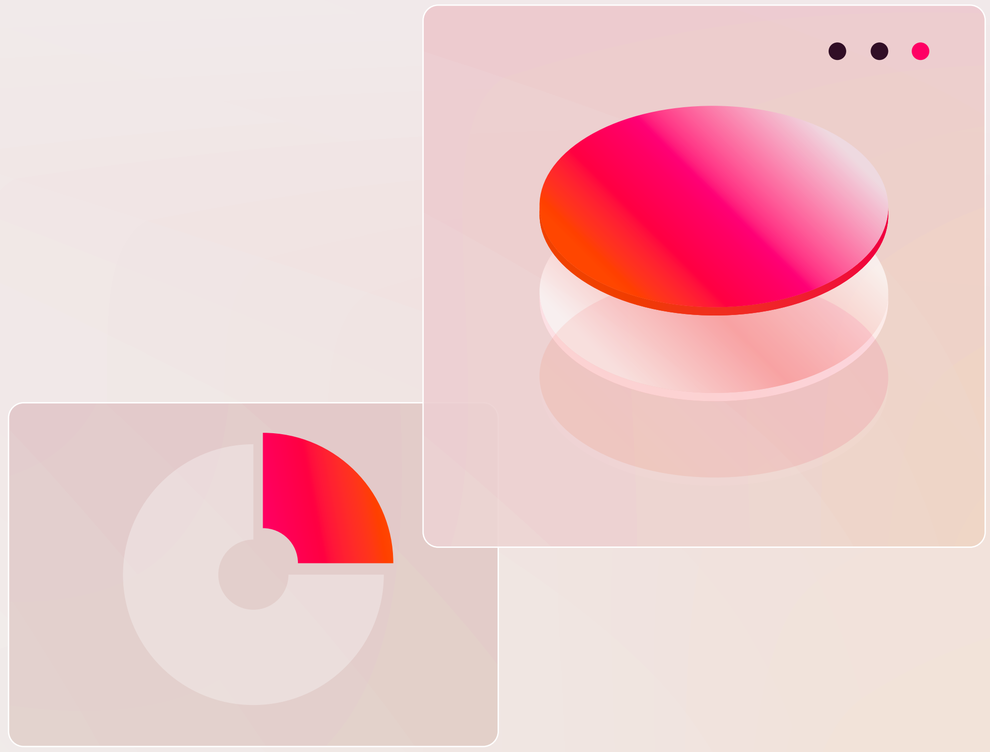

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# 2026 Champion Health Workplace Health Report

# Contents

# Foreword

Every organisation I speak to wants to do right by its people, and they're doing more about it than they ever have. EAPs, awareness programmes, benefits platforms, private medical cover. That's huge progress since 2021, when we started capturing this data.

The problem isn't effort or investment. It's visibility. Two types, specifically: where in your workforce the pressure is building, and what the people there are actually dealing with. Without both, even a well-funded strategy is just a guess.

This report comes from more than 35,000 working people, and it's specific on both counts. Anxiety and depression peak in the under-25s and fall with every decade after. Joint and muscle pain does the opposite, from 31% of the under-25s to 57% of the 55 to 64s. Same workforce, two risks running in opposite directions. An average tells you neither.

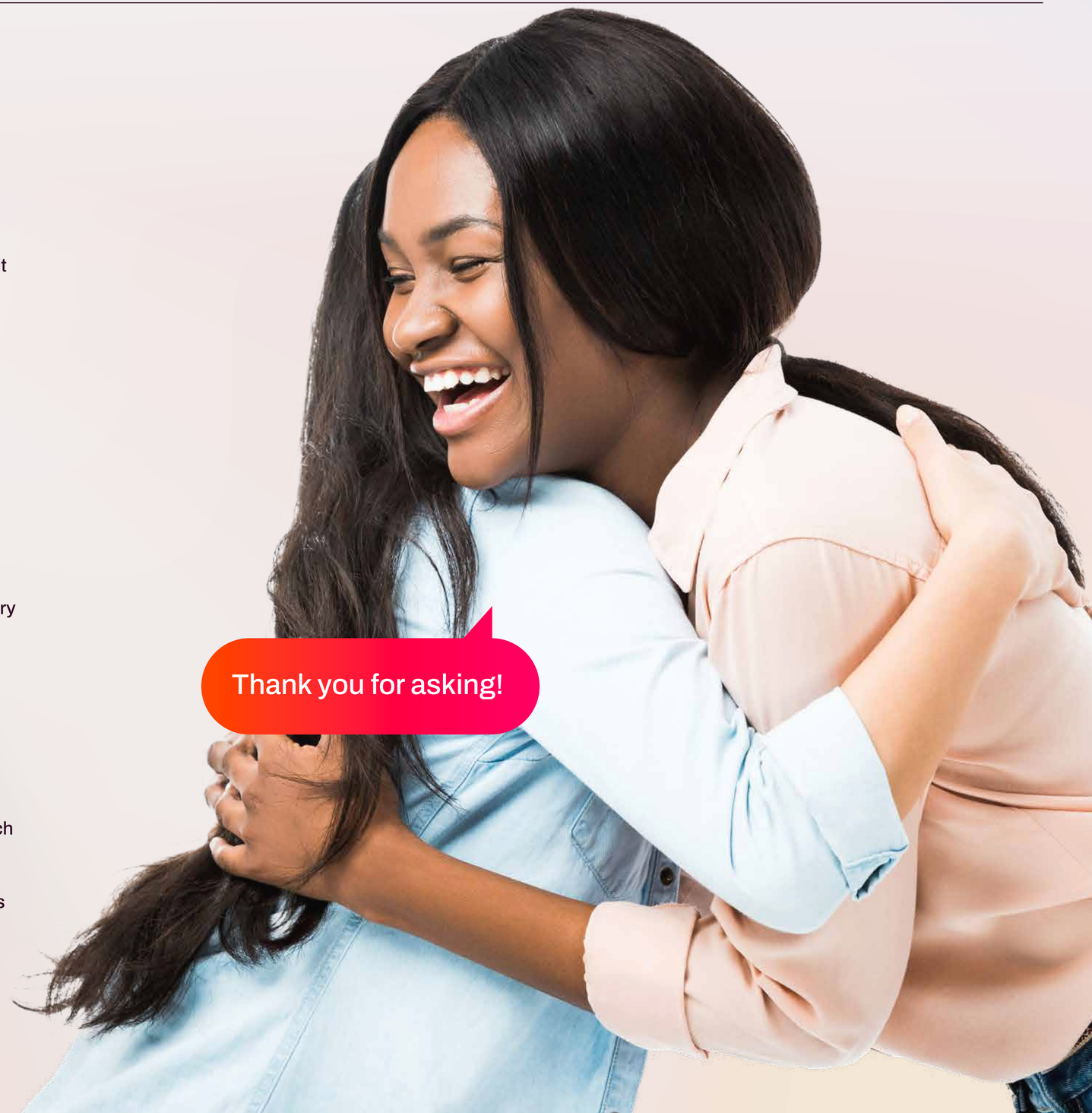
Twelve per cent of these people are carrying poor sleep, no energy and high stress at the same time. Only three per cent have reached the point where it shows in their work. For every person you can see struggling, there are three more quietly holding it together. They are at their desks, hitting their deadlines and nobody is worried about them yet.

That gap is what we want to close. Months of warning, in people who haven't broken and most organisations already have the support that would help. The trouble is it only reaches those comfortable with putting their hand up, and asking for help.

This report is written for anyone responsible for people at work. Whether you work in HR, wellbeing, reward or health and safety. My parting question, once you've read it, is how much of this you can see in your own workforce, and how early?

The organisations that act earliest are rarely the ones spending the most. They are the ones who know where to look.

James Haggarty
Global Wellbeing Lead at Champion Health



# Executive Summary

This report draws on 35,837 health assessments completed between 2021 and 2025, the largest dataset Champion Health has published. It covers mental health, burnout, musculoskeletal pain, belonging and financial wellbeing. One pattern runs through all five findings: these risks compound, and they are visible in the data before they show up as cost.

*1 in 3* **employees now screen at risk for anxiety and depression at the same time.** Mental health is at its worst point in five years, and 2025 saw the sharpest deterioration we have recorded. The shift holds across every age group and both genders.

*35%* **of the workforce shows burnout risk indicators, and most do not know it yet**. This has held at around one in three for three years. The majority are not in visible decline. They are stressed and depleted but still functioning, which is exactly why it goes unnoticed.

*43.8%* **are living with musculoskeletal pain,** most of them for years. It is strongly associated with poor sleep, low energy and elevated mental health risk. Those rating their pain severe are more than twice as likely to screen at risk for depression as those with mild pain.

*66.6% vs 30.7%.*

Employees who feel they do not belong screen at risk for depression at more than twice the rate of those who do. Belonging scores fell across all five dimensions between 2024 and 2025. This is no longer a culture question. It is a health risk leaders are uniquely placed to influence.

*Nearly 7 in 10* workers carry money worries.

Financial pressure is structural, not cyclical, and it sits beneath a significant share of the mental health risk in this report.

*This is what compounding costs. Employees carrying both mental health risk and MSK pain lose more than four times the days of those with neither, and together those groups account for 85% of all self-reported absence days. The question for leaders is not whether to act. It is where to begin, and that starts with knowing where the risk sits in your own workforce.*

# Who Completed This Assessment

The 2026 Champion Health Workplace Health Report draws on 35,837 health assessments completed between 2021 and 2025. It is the largest dataset we have ever published from, and the most representative picture of workforce health we have produced.

The people behind this data work across a wide range of industries: utilities, retail, healthcare, education, charities, professional services, and the public sector, among others. They work in offices, from home, in hybrid arrangements, in clinical settings, and on shop floors. They are early in their careers and approaching retirement. They are dealing with the same pressures most working adults face: demanding jobs, financial uncertainty, health challenges they may or may not feel able to raise at work.

All data is self-reported via the Champion Health platform assessment. To encourage honest responses, all data is completely anonymous and aggregated, no individual can ever be identified from the findings in this report, and we are transparent about that from the start.

As with all self-reported data, findings are subject to recall and social desirability bias. Year-on-year comparisons use age and gender standardisation to account for shifts in sample composition between years. Where the 2025 sample is notably larger than previous years, this is flagged in the relevant sections.

Where questions have not been completed, those records are excluded from the relevant analysis rather than estimated or substituted. Any sub-group too small to draw reliable conclusions from is flagged accordingly.

| Gender | % |
|---|---|
| Woman | 61.8% |
| Man | 37.3% |
| Other / Prefer not to say | 0.9% |

| Age Group | % |
|---|---|
| Under 25 | 10.3% |
| 25-34 | 26.1% |
| 35-44 | 26.9% |
| 45-54 | 23.5% |
| 55-64 | 12.4% |
| 65+ | 0.8% |

| Work Type | % |
|---|---|
| Hybrid | 45.8% |
| Office-based | 17.1% |
| Home-based | 15.1% |
| Other | 8% |
| Retail | 7.1% |
| Education setting | 4.5% |
| Healthcare setting | 2.5% |

# The State of the Workforce

*What the Data Tells Us*

1.0 Mental Health & Stress

2.0 Burnout

3.0 Musculoskeletal Health

4.0 Belonging

5.0 Financial Wellbeing

# Mental Health & Stress

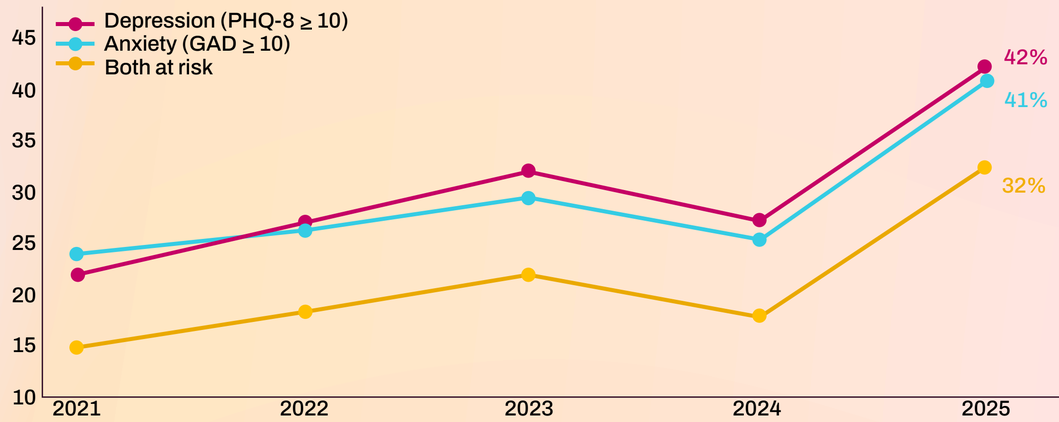
## *The 2025 Mental Health Spike*

**Stress, anxiety, and depression** are the defining health challenge in this year's data. The scale is significant, and in 2025, it got worse.

53% of people completing a Champion Health assessment in 2025 reported high stress. More than 4 in 10 met the clinical screening threshold for anxiety, and the same proportion met the threshold for depression.

These are screening thresholds, not clinical diagnoses but they represent a level of symptoms that warrants attention.

**Mental health risk hit a five-year high in 2025**




% screening at risk by year (GAD-7 / PHQ-8 ≥ 10). Champion Health Workplace Health Report, 2021-2025. Screening cut-offs, not diagnoses.

### The 2025 Picture

After a genuine improvement in 2024, 2025 saw the sharpest deterioration in mental health we have recorded. **Anxiety rates rose from 25% in 2024 to 41% in 2025**. Depression followed the same pattern, from 27% to 42%.

This shift holds across every age group and both genders after standardisation. It is not a statistical artefact. Something meaningfully changed in 2025.

### Anxiety and depression rarely travel alone

Of those flagging at risk on either measure, roughly 3 in 4 are at risk on both. By 2025, 1 in 3 workers met the threshold for anxiety and depression simultaneously, up from around 1 in 5 in previous years.

This matters for how organisations respond. Treating these as separate conditions with separate interventions misses the reality of how they present together.

# Mental Health & Stress

### Who is most affected

Younger workers carry a disproportionate burden. Under-25s show anxiety rates of 44% and depression rates of 45%, the highest of any age group. Risk decreases consistently with age.

Women report higher anxiety rates than men (38% vs 29%). The gap for depression is smaller but consistent (39% vs 31%).

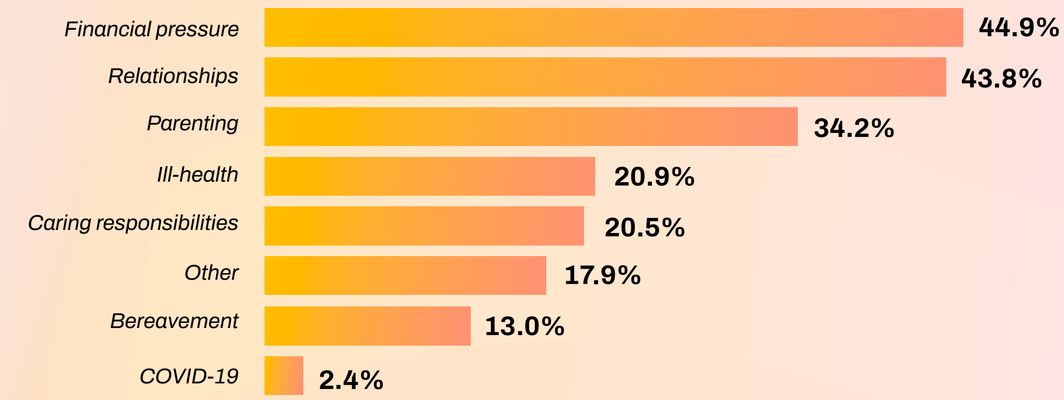
| Age Group | Anxiety at risk | Depression at risk |
|---|---|---|
| Under 25 | 44.4% | 44.7% |
| 25-34 | 40.7% | 40.8% |
| 35-44 | 34.2% | 34.9% |
| 45-54 | 27.5% | 30.5% |
| 55-64 | 23.9% | 27.2% |
| 65+* | 19.9% | 20.6% |

### Where the pressure concentrates

Healthcare and retail carry the highest money worries (75.1%, 74.4%), healthcare the highest MSK pain (52.6%), retail the highest burnout risk (38%).

*Smaller sample size than other cohorts

### What is driving stress outside of work




### Stress does not stay at the office door

Nearly half the workforce reports high in-the-moment stress, and the drivers are not purely work-related. Financial pressure (45%), relationship difficulties (44%), and parenting demands (34%) are the most commonly cited outside-work stressors.

People carrying these pressures show significantly elevated stress levels regardless of whether they attribute it to work itself.

The boundary between life stress and work stress has, for many people, effectively disappeared.

# Burnout

*Chronic, not a crisis*

Burnout is not a new crisis in this data. It is a persistent, chronic reality that has sat at around 1 in 3 workers for three years running.

In 2025, 35% of respondents showed burnout risk indicators, defined as meeting 2 of 3 domains: high stress, depleted energy, and low productivity.

**A baseline, not a spike**

Unlike anxiety and depression, burnout did not reach new highs in 2025. The rate is consistent with 2022 (34%) and 2023 (35%), after an unusually low 2024 (24%).

The more uncomfortable finding is not the 2025 figure in isolation. It is that one third of the workforce has been showing burnout risk indicators, consistently, for three years.

| Year | % |
|---|---|
| 2021 | 16.1% |
| 2022 | 33.9% |
| 2023 | 34.5% |
| 2024 | 24.4% |
| 2025 | 34.9% |

Running on empty

The most common burnout profile in the data is not someone who has collapsed. It is someone who is stressed and depleted but still functioning. High stress combined with low energy accounts for the largest single group, 16% of all respondents.

These are people who are at their desks. They are showing up, but the warning signs are there, and without intervention, the trajectory is predictable.

| Burnout profile | % of all respondents |
|---|---|
| High stress + low energy | 16.4% |
| High stress + low productivity | 7% |
| Low energy + low productivity | 4.3% |
| All three domains | 4.5% |
| Total at risk (2+ domains) | 32.1% |

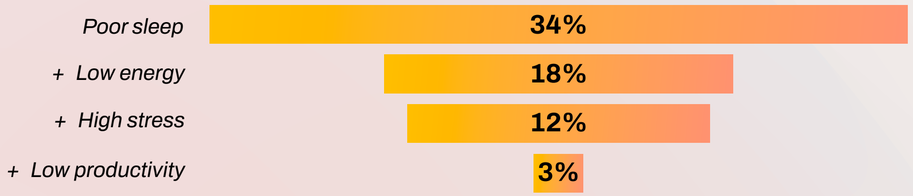
### The warning signs come first

The data points to a clear escalation pattern. One in three workers report poor sleep. Of those, just over half also report low energy. Of those, two thirds also report high stress. Each stage compounds the next.

What is striking is where the pattern stops. Only 3% of all respondents reach the point where all three are present alongside visible productivity decline. Most people carrying this burden never make it onto anyone's radar.

That is the problem. Managers notice missed deadlines and declining output. Those are the last things to change. Disrupted sleep, persistent low energy, and high stress come long before, and none of them show up in a performance review. By the time productivity is impacted, it may have been building for months.

### Most burnout risk never reaches visible decline




Only 3% reach visible decline. The warning signs appear months earlier.

*% of all respondens at each escalation stage. Champion Health Workplace Report, 2021-2025.*

### Who is the most affected?

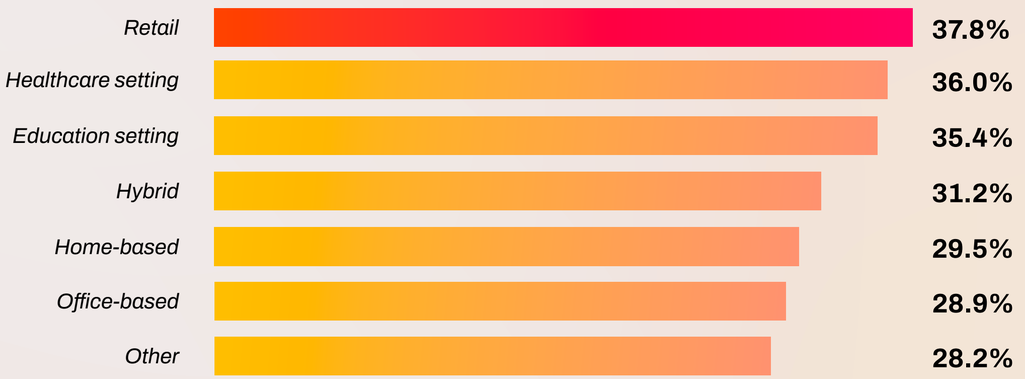
Younger workers carry the highest burnout burden. The under-25 and 25 to 34 age groups show near-identical rates, and both sit meaningfully above every other age group. Risk decreases consistently from 35 onwards. Women show higher rates than men (35% vs 29%), though the gap is narrower than for anxiety or depression.

| Age Group | % at risk |
|---|---|
| Under 25 | 35.4% |
| 25-34 | 36% |
| 35-44 | 32.8% |
| 45-54 | 29% |
| 55-64 | 26.8% |
| 65+* | 19.5% |

### Where burnout hits hardest

Burnout rates vary meaningfully by working environment. Retail (38%), healthcare (36%), and education (35%) settings sit above the overall average, reflecting the particular pressures of front-line and public-facing roles. Office-based and home-based workers fare comparatively better, though both still approach 1 in 3.

### Burnout risk is highest in front-line settings




*% at burnout risk by work type. Champion Health Workplace Health Report, 2021–2025.*

# Musculoskeletal Health:

## *The silent majority*

Nearly half the workforce (43.8%) is currently living with joint or muscle pain. Of those, three quarters (75.9%) have been living with that pain for two years or more and more than half have never sought specialist treatment.

### Who is most affected

Age is the clearest driver, and it moves in the opposite direction to mental health. MSK risk climbs steadily across every decade of working life, while anxiety and burnout peak in younger workers. Women report pain at a higher rate than men (46.7% vs 37.1%).

| Age group | Reporting MSK pain |
|---|---|
| Under 25 | 31.5% |
| 25–34 | 36.7% |
| 35–44 | 43.5% |
| 45–54 | 50.1% |
| 55–64 | 57.0% |

### MSK pain is highest in healthcare settings

More than half of those in healthcare settings (52.6%) reported MSK pain, around 6 percentage points higher than the next highest work type. Office-based and retail workers report the lowest rates, though both are still above 40%.


*% reporting current MSK pain by work type. Champion Health Workplace Health Report, 2021–2025.*

### What the pain looks like

Lower back is the most commonly affected site (27.6%), followed by knee (16.9%), neck (12.4%), and shoulder (12.3%). Nearly 3 in 10 rate their pain as severe. The median duration is 2 years, and 75.9% have been living with their pain for two or more years. Despite this, just 47.8% have sought specialist treatment.

### The wider impact on health metrics

Pain does not stay in the body. It reaches into sleep, energy and mental health. People with current pain are 14 percentage points more likely to report low energy and 12 points more likely to report poor sleep.

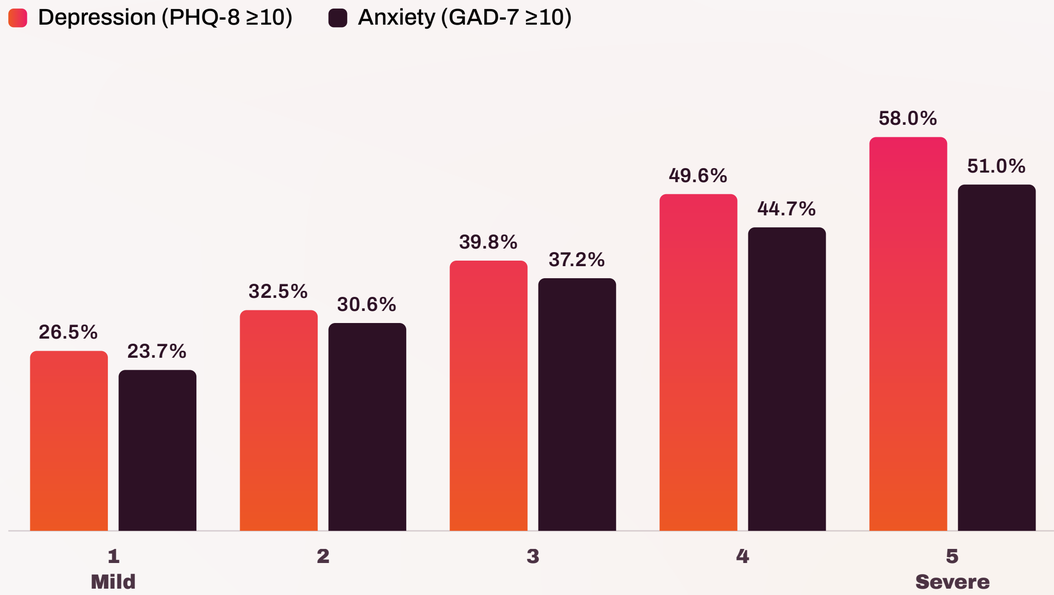
They are also markedly more likely to screen at risk for depression: 41.1% against 30.8%of those without pain.

### Health metrics: with pain against without

| Metric | No pain | With pain | Difference |
|---|---|---|---|
| High stress (≥4) | 45.0% | 49.8% | +4.7pp |
| Low energy (≤4) | 27.2% | 41.4% | +14.2pp |
| Poor sleep (≤4) | 28.3% | 40.4% | +12.2pp |
| Anxiety at risk (GAD-7 ≥10) | 30.9% | 37.9% | +7.0pp |
| Depression at risk (PHQ-8 ≥10) | 30.8% | 41.1% | +10.3pp |

### Depression and anxiety risk climb with pain severity

Among those rating their pain mild, 26.5% screen at risk for depression. Among those rating it severe, that more than doubles to 58.0%.




*% screening at risk by self-reported pain severity (1–5). Champion Health Workplace Health Report, 2021–2025. Screening cut-offs, not diagnoses. n=15,650.*

### The physical activity connection

Strength training is the most consistent protective factor in the data. Those doing two or more sessions a week report MSK pain at 38.0%, against 47.1% among those doing none. 55 to 64 year olds have the highest MSK prevalence (57.0%) and the lowest strength training participation (25.4% meeting guidelines). The peoplewho would benefitmost are the least likely to be doing it.

# Belonging

*Feeling heard is the foundation*

Workers with low belonging are more than twice as likely to meet the clinical screening threshold for depression. Belonging is no longer a culture question. It is a health risk indicator, and one leaders are uniquely placed to influence.

## What we measured

From 2024, Champion Health began measuring workplace belonging across five dimensions, each rated from 1 to 5:

1. *How respected at work do you feel?*
2. *How supported at work do you feel?*
3. *How trusted at work do you feel?*
4. *How listened to at work do you feel?*
5. *How much do you feel part of a team at work?*

Based on 22,396 assessments completed in 2024 and 2025. With two years of data we can begin to observe patterns, though more will be needed before drawing confident conclusions about direction of travel.

## Feeling listened to is the weakest belonging dimension

Feeling trusted is the strongest dimension across the dataset, with only 5.9% scoring very low. Feeling listened to is the weakest, at 14.9% — nearly 1 in 7 workers.


*% scoring very low (1–2 of 5). Champion Health Workplace Health Report, 2021–2025.*

## What changed between 2024 and 2025

All five dimensions recorded a higher proportion of low scores in 2025 than in 2024. The most notable shift was in feeling listened to, which rose from 9.9% to 16.0%, an increase of 6.1 percentage points in a single year.

This warrants attention, though with two data points it is too early to call a trend. It is one to watch closely as 2026 data becomes available.

## Where it varies

Working environment makes a meaningful difference. Hybrid workers score best across all five dimensions. Home-based workers are the most likely to feel unheard (16.4%) and disconnected from their team (12.4%), pointing to the specific belonging challenges of remote work. Retail workers report the lowest scores for feeling supported (18.3%) and respected (13.5%).

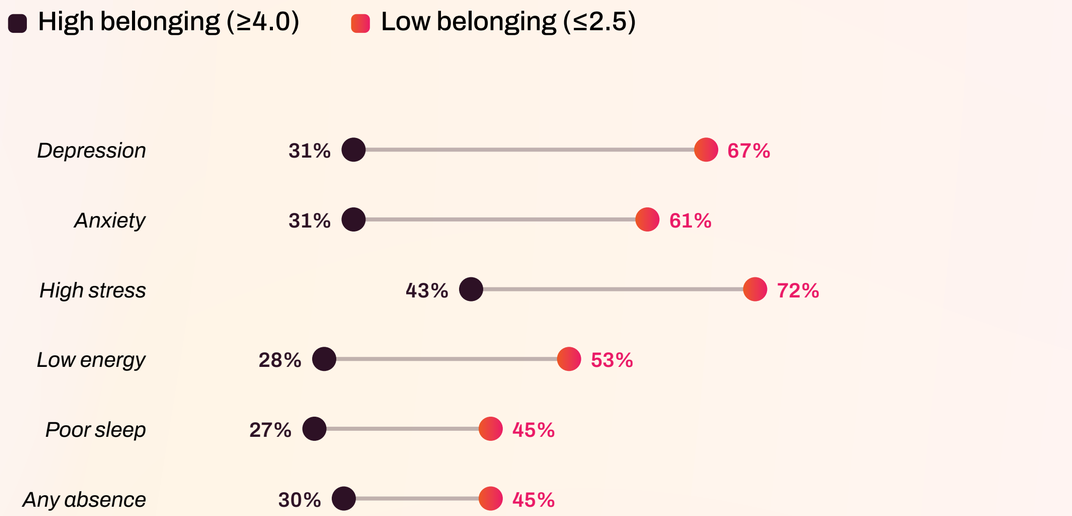
## Belonging by working environment

| Work type | Respected | Supported | Trusted | Listened | Team |
|---|---|---|---|---|---|
| Hybrid | 7.9% | 10.4% | 5.0% | 13.6% | 9.1% |
| Healthcare | 10.6% | 15.1% | 3.2% | 12.6% | 9.4% |
| Office-based | 10.5% | 13.3% | 6.4% | 14.6% | 10.6% |
| Home-based | 10.2% | 13.0% | 6.0% | 16.4% | 12.4% |
| Education | 10.7% | 12.6% | 7.2% | 13.2% | 12.6% |
| Retail | 13.5% | 18.3% | 6.4% | 16.6% | 11.3% |
| Other | 18.5% | 20.5% | 9.9% | 21.9% | 15.6% |

*% scoring very low (1–2 of 5) on each dimension, by work type.*

## Low belonging tracks with worse health on every measure

Of those with low belonging scores, 66.6% meet the clinical screening threshold for depression, against 30.7% of those with high belonging.




*% at risk by composite belonging score. Champion Health Workplace Health Report, 2021–2025.*

## The link to health

Each respondent's five dimension scores were averaged into a composite belonging score. Those scoring 2.5 or below were classified as low belonging, those at 4.0 or above as high belonging.

These are cross-sectional associations and cannot establish direction of causality. What the data does show is that low belonging and poor health appear together consistently, across every health measure we track.

# Financial Wellbeing

*Financial stress is the norm*

Nearly 7 in 10 workers (68.7%) experience money worries at least sometimes. For many that pressure does not stay at home: it follows people into work, affects their sleep, and sits underneath a significant share of the mental health risk in this report.

### The scale of financial pressure

Money worries are not a minority experience. 68.7% of respondents report experiencing them at least sometimes, a figure that was essentially unchanged between 2024 (69.2%) and 2025 (68.6%). Financial stress is not responding to the same year-on-year shifts we see in mental health. It is a persistent, structural baseline.

There is, however, a subtle shift worth noting at the top end. The proportion describing themselves as very comfortable fell from 12.3% in 2024 to 9.4% in 2025. The struggling categories edged upward in the same period.

### Financial position, 2024 to 2025

| Financial position | 2024 | 2025 | Change |
|---|---|---|---|
| Very comfortable | 12.3% | 9.4% | –2.9pp |
| Relatively comfortable | 52.0% | 53.1% | +1.1pp |
| Cannot afford luxuries | 27.3% | 27.7% | +0.4pp |
| Only just able to cover essentials | 7.2% | 8.2% | +1.0pp |
| Unable to cover essential costs | 1.2% | 1.6% | +0.4pp |

The one shift worth noting is at the top end. The proportion describing themselves as very comfortable fell from 12.3% to 9.4%, while every struggling category edged upward.

### Where the pressure concentrates

Pressure peaks in the middle working years. 73.4% of 25 to 34 year olds and 72.3% of 35 to 44 year olds report money worries, reflecting the particular financial demands of that life stage. Healthcare (75.1%) and retail workers (74.4%) report the highest rates by working environment.

*Financial wellbeing questions were introduced to the assessment in 2024. This section draws on 22,341 assessments completed in 2024 and 2025.*

### What financial pressure does to health

Of those experiencing money worries, 72.8% say it affects their mental health. 40.8% say it disrupts their sleep. 14.2% say it affects their performance at work directly.

### What money worries affect

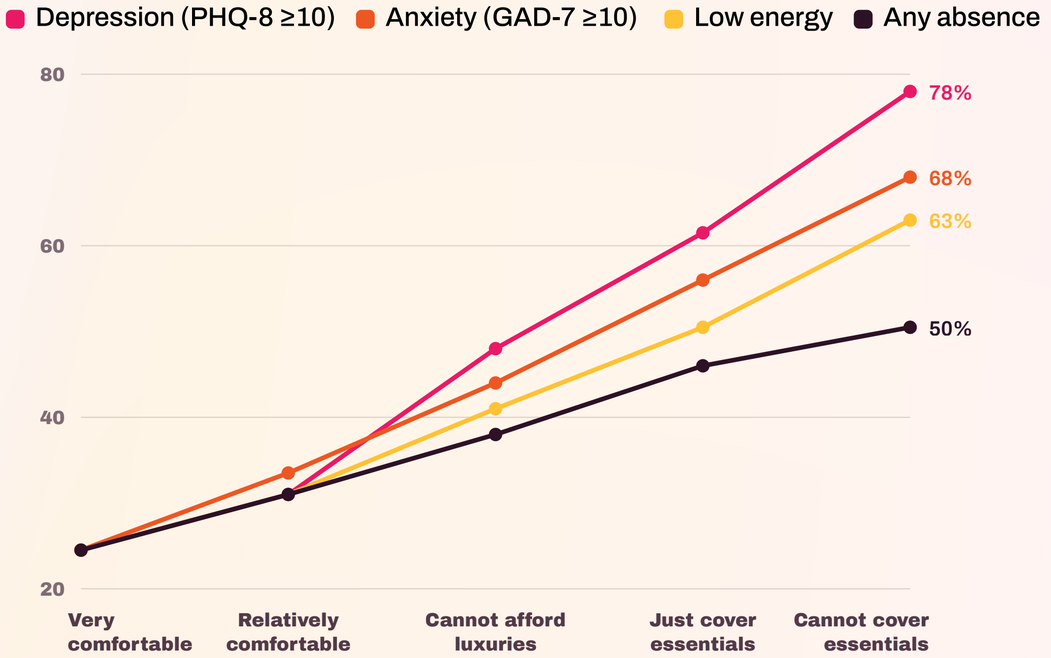
| Impact area | % reporting |
|---|---|
| Mental health | 72.8% |
| Ability to sleep | 40.8% |
| Relationships | 39.0% |
| Job satisfaction | 24.9% |
| Physical health | 16.2% |
| Work performance | 14.2% |
| Alcohol consumption | 8.4% |

Workers with money worries are nearly twice as likely to report low productivity as those without (27.7% vs 14.7%).

| Money worries | Low productivity (≤4/10) |
|---|---|
| Yes | 27.7% |
| Sometimes | 18.7% |
| No | 14.7% |

### Health risk rises in lockstep with financial pressure

The relationship between financial position and mental health is one of the clearest dose-response patterns in the entire dataset. Among those unable to cover their basic living costs, nearly 8 in 10 meet the clinical screening threshold for depression.




*% at risk by self-reported financial position. Champion Health Workplace Health Report, 2021–2025.*

### The advice gap

23.3% of respondents say they cannot meet their financial goals. Only 12.8% have sought financial advice. Nearly half (48.7%) say they do not feel comfortable discussing money. The support exists in many organisations. The access to it, and the psychological safety to seek it, often does not.

# The Cost of Inaction

# The Compounding Burden

The data in this report does not describe a workforce in crisis. It describes something more uncomfortable: a workforce absorbing an enormous amount of strain, quietly, before it becomes visible.

By the time poor health shows up as a productivity problem, it has usually been building for months. Productivity is the last domino, not the only one.

### What poor health costs: the absence burden

The cost of poor mental health and musculoskeletal conditions is not abstract. It shows up directly in sickness absence.

Using 2025 Champion Health data, we modelled the excess absence cost for an employer of 1,000 people, based on an average UK salary of £35,000 (ONS, 2024). Employees were segmented into four groups: mental health risk only, MSK pain only, both conditions, and neither, to avoid double counting.

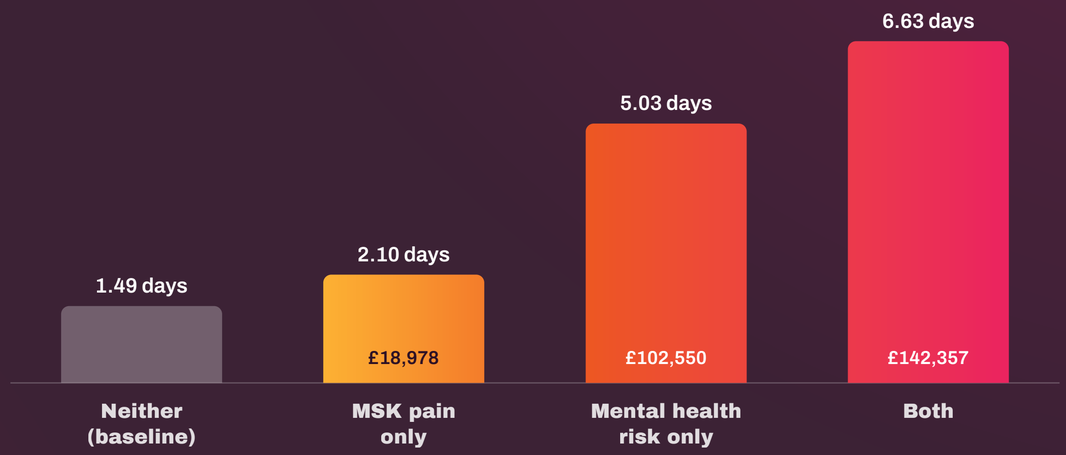
**ESTIMATED EXCESS ABSENCE COST**

## £263,884 per 1,000 employees, per year

**Attributable to poor mental health and musculoskeletal conditions.**

### Workers with both conditions lose over four times the days

Mean sickness-absence days per person in 2025, with the modelled excess cost per 1,000 employees shown inside each bar.




*Mean sickness-absence days and modelled excess cost per 1,000 employees. Champion Health Workplace Health Report, 2021–2025.*

### Why they cannot be treated in isolation

Employees carrying both conditions lose more than four times the number of days as those with neither. That compounding effect is the clearest illustration in this data of why these conditions cannot be treated in isolation.

This figure covers direct salary cost of absent days only. It does not account for presenteeism, staff turnover linked to poor health, management time, or cover costs, all of which would increase the true figure substantially. Nor does it account for the well-documented tendency to under-report sickness absence in self-reported data.

**Absence over productivity**

The productivity link with MSK pain shows up most clearly in absence, not self-reported productivity. Pain sufferers average 51% more days absent than those without pain, and the 11+ day absence group is 57% higher. The self-reported productivity gap is negligible, likely because presenteeism (showing up despite pain) is masking the true impact.

| Group | Mean days absent | Any absence | 11+ days |
|---|---|---|---|
| With pain | 3.43 days | 37.2% | 7.1% |
| No pain | 2.27 days | 31.3% | 4.5% |

**Sickness absence by working environment**

In 2025, 35.7% of workers took at least one day of sickness absence - the highest figure in the dataset. Among those with any absence, the mean days lost was 8.2 days per person.

Education and healthcare settings carry the heaviest burden, with absence rates above 39% and 35% respectively, and mean days lost above four per person. This is more than double the rate seen in hybrid and home-based workers.

| Work type | Any Absence | Mean Days Lost |
|---|---|---|
| Education setting | 39.7% | 4.34 days |
| Healthcare setting | 35.8% | 4.33 days |
| Retail | 39.1% | 3.12 days |
| Other | 35.1% | 3.12 days |
| Hybrid | 30.4% | 2.39 days |
| Home-based | 29.8% | 2.19 days |

## The productivity picture

The average worker completing a Champion Health assessment reports 3.28 factors negatively affecting their productivity. Among those reporting six or more factors, 33.7% rate their productivity as low, compared to 8.5% among those with just one. Health risk compounds. So does its cost.

The three most cited barriers are tiredness (77.7%), high stress (44.0%), and poor mental health (37.2%, up from 29% in 2024). These are not separate problems with separate solutions. They are the same underlying risk profile showing up in different places.

| Factors | % of reporters |
|---|---|
| Tiredness | 77.7% |
| High stress | 44% |
| Poor mental health | 37.2% |
| Headaches / Migraines | 24.2% |
| Female health issues | 16.9% |
| Inactivity | 18.8% |
| Poor nutrition | 15.5% |
| Dehydration | 14.3% |
| Lower back pain | 11% |
| Neck pain | 6.8% |

## The compounding reality

No health risk in this report exists in isolation; MSK pain disrupts sleep, poor sleep depletes energy, low energy compounds stress, low belonging amplifies depression risk. Financial pressure sits underneath all of it.

The cost of inaction is not the sum of each risk. It is the product of all of them together, and it accumulates long before it appears in absence figures or performance reviews.

## Why early identification matters

In our data, people carrying mental health risk and/or MSK pain account for 85% of all self-reported absence days. Both are measurable and both show clear warning signs in the data before they become absence. Identifying risk early, at the workforce level, creates the opportunity to act before the cost becomes unavoidable.

**See where risk sits in your workforce: championhealth.co.uk**

# What Good Looks Like

*Where to start*



# What the Data Tells Us About Intervention

The data in this report points consistently in one direction. Stress, poor mental health, MSK pain, low belonging, and financial pressure do not arrive separately. They compound and they are measurable - long before they show up as absence, low productivity, or a conversation with HR.

The question is not whether to act. It is where to begin.

**What the data tells us about intervention**

Several protective patterns emerge consistently across the dataset. Physical activity is one of the strongest. Meeting the recommended 150 minutes of aerobic activity per week is associated with meaningfully better outcomes across sleep, energy, MSK pain, and mental health. Strength training shows a specific protective association with MSK pain that aerobic exercise alone does not replicate.

Sleep regularity matters more than sleep duration. An irregular sleep pattern is the single strongest lifestyle predictor of poor sleep quality in this dataset: a 28.7 percentage point difference between those with regular and irregular patterns. Consistent sleep schedules are a more powerful lever than most people expect.

Belonging is one of the strongest buffers against mental health risk in the entire dataset. Workers with high belonging scores show depression rates less than half those of workers with low belonging. The protective effect holds across every mental health measure we track

These are not independent findings. They point to the same underlying principle: consistent, preventable factors drive a significant proportion of the health risk we see across the workforce.

# The Prevention-First Principle

Most organisations respond to workforce health reactively. Support is made available after someone struggles, through an EAP, a referral, or a return-to-work process.

**That support is necessary but it addresses the symptom, not the source.**

The data in this report shows that risk is visible before it becomes absence. The escalation pattern in the burnout data, from poor sleep to low energy to high stress, precedes visible productivity decline by months. The mental health and MSK profiles that drive the majority of workplace absence are measurable at a workforce level, before they become a crisis for the individual.

Prevention-first means identifying risk early, prioritising the cohorts who need support most, acting with targeted interventions, and measuring whether they work. The return on that approach, based on Deloitte's analysis of employer mental health investment, is £4.70 for every £1 spent, rising to £6.30 for universal, early intervention programmes.

*Deloitte UK (2024). Mental Health and Employers: The case for employers to invest in supporting working parents and a mentally healthy workplace. Deloitte LLP.*

**Read the Deloitte report**

# For Individuals

**No single action fixes everything, but the data is consistent about where the biggest gains are.**

**Sleep**
Prioritise consistency in your sleeping pattern. Going to bed and waking at the same time each day is the highest-impact change most people can make to their sleep quality. In this dataset, an irregular sleeping pattern is associated with a 28-percentage-point higher rate of poor sleep quality than a regular one, a larger effect than alcohol, caffeine, shift work, or parenting demands combined.

**Movement**
Aim for 150 minutes of aerobic activity per week, and include strength training. The MSK data shows a 9-percentage-point reduction in joint and muscle pain among those doing two or more strength sessions per week, a protective effect that aerobic activity alone does not replicate. Over a third of the workforce does no strength training at all. Movement does not need to be intense to be effective.

**Mental load**
The early signs of burnout show up well before any visible decline in performance. In the escalation model, poor sleep gives way to low energy, then to high stress: 12% of the workforce is already carrying all three, yet only 3% have reached the stage where productivity is visibly affected. The window for self-intervention is long. Recognising those early signs, and naming them, is where that window opens.

**Connection**
Feeling listened to at work is the weakest and fastest-deteriorating belonging dimension in the data, and the association with mental health is striking. Employees with low belonging scores are 36 percentage points more likely to screen positive for depression than those with high belonging. If something feels off in a working relationship or team dynamic, raising it early is consistently associated with better outcomes than absorbing it alone.

# For Organisations

**Workforce health strategy works best when it is built around data, targeted at the right populations and sustained.**

**Measure before you act**
The single most common barrier to effective workforce health strategy is acting without data. Most organisations have no reliable picture of the health risks within their workforce, only the ones that have already surfaced. A structured workforce health assessment changes that. It gives leaders the risk profile they need to prioritise the right cohorts and target the right support.

**Invest in line manager capability**
The belonging data tells a clear story. Feeling listened to is the weakest dimension overall and deteriorated more than any other between 2024 and 2025. Line managers are the primary lever for belonging, and for early identification of struggle. Investing in their capability to hold genuine, consistent wellbeing conversations is one of the highest-return interventions available.

**Address mental health and MSK together**
The data shows these risks do not exist in isolation. Workers with both conditions lose more than four times the days of those with neither. A workforce health strategy that addresses only mental health, or only physical health, misses the interaction between them, and the compounding cost that follows.

**Build financial wellbeing in, not on.**
Financial stress is structural and persistent. It underpins a significant proportion of the mental health risk in this dataset and was present long before the 2025 deterioration in mental health outcomes. Signposting financial support and building psychological safety around money conversations are relatively low-cost, high-impact steps.

**Start with a workforce health assessment: championhealth.co.uk**

# About This Report

The 2026 Champion Health Workplace Health Report draws on 35,837 health assessments completed between 2021 and 2025. It is the largest dataset we have ever published from, and the most representative picture of workforce health we have produced.

All data is self-reported through the Champion Health platform assessment, and is anonymised and aggregated. No individual can be identified from any finding in this report.

Year-on-year comparisons are age and gender standardised to account for shifts in sample composition. Incomplete responses are excluded from the relevant analysis rather than estimated, and any sub-group too small to support reliable conclusions is flagged in the text.

As with all self-reported data, findings are subject to recall and social desirability bias. Screening thresholds indicate symptom levels that warrant attention; they are not clinical diagnoses.

**About Champion Health: championhealth.co.uk**

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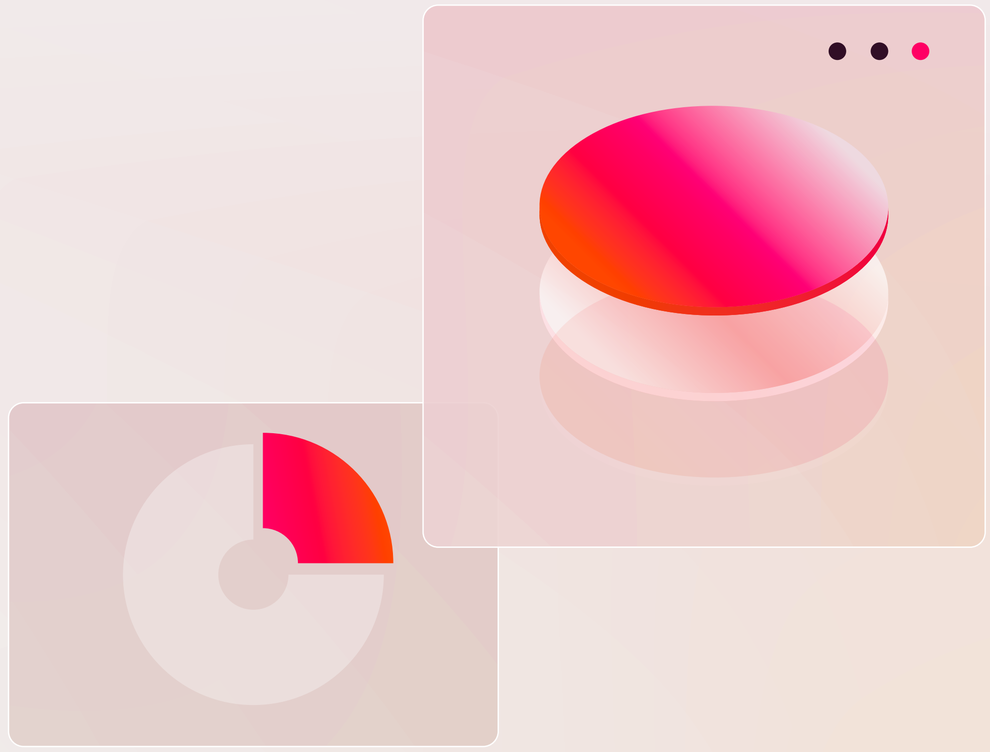

See what this data looks like in your own workforce.

Book a Champion Health assessment at **championhealth.co.uk**

# Let’s do something special, together.