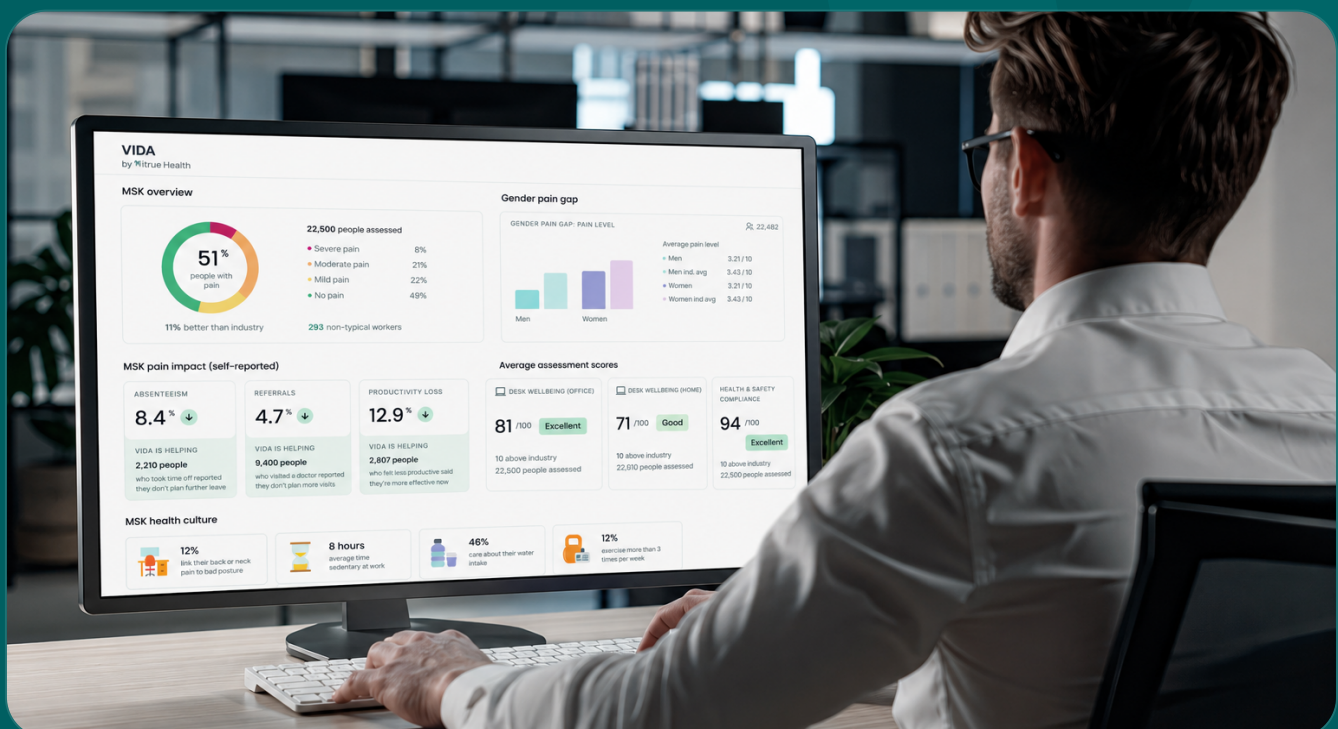


EVIDENCE-LED DSE REPORT

Beyond DSE *Completion*

How H&S teams can strengthen follow-up, reduce administration and evidence risk reduction





What is inside

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EXECUTIVE SUMMARY

Where DSE effort actually *pays*

Most organisations do not need another annual form. They need to stop a high-volume compliance process consuming specialist capacity while the risks it identifies wait for action.

WHAT THE EVIDENCE SAYS

Across 23,414 workplace assessments, how people positioned themselves at the desk was linked to reported pain more than three times as strongly as the equipment they had been given. Wrist and chair positioning led. Equipment setup came last of the four factors measured. A standing desk that nobody stands at performs like no standing desk at all. Reported pain also varied across groups: women reported more pain than men in every setting measured, and the gap was wider at older ages.

WHY THE COST STAYS INVISIBLE

DSE programmes are graded on completion rate, which records whether a form came back rather than whether a risk changed. The cost of that gap never appears as one budget line. It appears as specialist hours spent chasing, as equipment bought because purchasing was quicker than checking, and as flagged risks left open because no owner or due date was ever attached to them. HSE guidance is also explicit that a self-assessment counts as a valid risk assessment only where the worker has first been given suitable training.⁵

FOUR NUMBERS BEHIND THE ARGUMENT

THE STRONGEST SIGNAL

3.2×

Wrist positioning was linked to pain 3.2 times as strongly as equipment setup, across 23,414 assessments.¹

WHAT IT COSTS BRITAIN

7.1m

Working days lost to work-related MSDs in 2024/25.⁴ 51% of organisations name them in their top three causes of long-term absence.⁷

WHERE RISK CONCENTRATES

+12pp

Higher pain prevalence in women than men, 58.7% against 46.4%, in every setting measured.¹

SHARE OF ILL HEALTH

27%

Musculoskeletal disorders as a share of all work-related ill health in 2024/25.⁴

WHAT CHANGES IT

Point the assessment at positioning and use rather than equipment alone. Check how a workspace is actually used before approving a purchase. Give every flag an owner, an action and a due date. Then measure resolution rather than completion. Part one sets out the evidence. Part two sets out the operating model.

This is not an argument for a bigger DSE programme. It is an argument for a differently weighted one, and for a much shorter route from a flagged risk to a resolved one.

PART ONE

The *evidence*

What more than 23,000 workplace assessments, and the regulator's own guidance, say about where desk-based risk actually sits.

-
- | | | | |
|----|---|----|------------------------------------|
| 01 | Completion is not control | 05 | Reported pain varies across groups |
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CHAPTER ONE

Completion is not *control*

■ A DSE programme has two jobs. Completion rate only measures one of them.

Recording an assessment is one stage of fulfilling the duty. Employers must also act on identified risks and check that the response has addressed the problem. HSE guidance is explicit on this: trained assessors should review results, give feedback and make sure problems are put right. Most programmes still grade themselves on completion percentage alone.

That is understandable. Completion is countable, it is defensible in an audit, and it can be chased. It is also subject to Goodhart's law, which holds that a measure stops being a good measure the moment it becomes the target. When the process exists mainly to produce a green tick on a dashboard, the link between "assessed" and "safe" weakens quietly. Completion rates keep climbing while the underlying risk does not move.

Behaviour change research, summarised in the Fogg Behaviour Model, holds that an action needs three things to line up at the same moment: a reason to care, the ability to act easily, and a prompt at the right time.⁹ Measured against that model, a typical annual DSE cycle misses all three. The motivation on offer is avoiding trouble. The ability on offer is a long form, often the same one as last year. The prompt is a chasing email. That combination reliably produces completion. It does not reliably produce safety.

A MORE USEFUL DEFINITION OF COMPLETION

An assessment is administratively complete when the required answers are recorded. A case is operationally complete when the action has been taken, the employee knows what happens next, and the outcome has been checked. Both belong in reporting. Only one of them is evidence of control.

COMPLETION-LED

- An annual event
- Generic advice
- Manual chasing
- Risk stored as a record
- Success equals completion rate

PREVENTION-LED

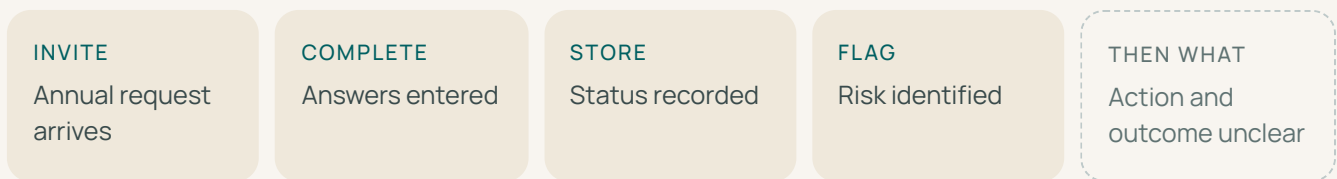
Triggered by work and risk change
Personal actions, given immediately
Automated routine follow-up
Risk routed to a named owner
Success includes action and reduction

CHAPTER TWO

The cost of completion without *resolution*

A process can look controlled while consuming capacity and leaving the risk unchanged.

A completion-led DSE programme has four visible milestones and no fifth. Invitation, completion, storage, flag. What happens after the flag is often less well defined.



A completion-led DSE journey. Good programmes already work to close the final step; the aim is to make that easier and more visible.

Where the value leaks

- Specialist capacity is absorbed by reminders, status handling and manual follow-up rather than higher-risk support.
- An annual cadence encourages people to repeat last year's answers, even when location, symptoms, equipment or working habits have changed.
- Risks stay open because the next action, the accountable owner and the due date are not visible in one place.
- Equipment becomes the easiest response, even when positioning, adjustment, movement or work pattern are what actually need attention.

THREE AVOIDABLE COSTS

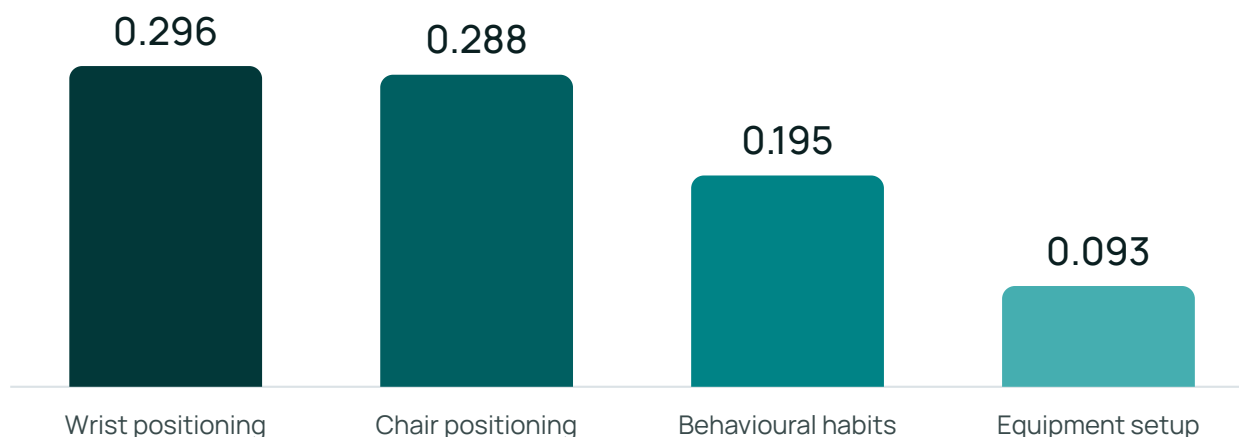
Completion without resolution produces administration that buys nothing, support that arrives late, and intervention aimed at the wrong thing. None of the three appears as a line item, which is precisely why they persist.

CHAPTER THREE

Positioning shows the strongest *signal*

Equipment setup showed the weakest association of the four factors measured.

Across 23,414 desk assessments, wrist positioning (0.296) and chair positioning (0.288) were the factors most strongly associated with reported pain. Equipment setup came last, at 0.093.



Strength of association with reported pain, by workplace factor. Spearman rank correlation, $n = 23,414$. Taller bars mean a stronger association. These are cross-sectional associations, not evidence that equipment matters less. Vitruve Health platform data, a sample of more than 20,000 desk-based workers.¹

Behavioural habits sat in between, at 0.195. Every relationship was statistically significant at that sample size, and higher overall workplace scores were associated with lower reported pain (rank correlation -0.314 , $p < 0.001$). The assessment covered pain across 22 body regions alongside equipment setup, work habits and breaks, chair and wrist positioning, and posture.

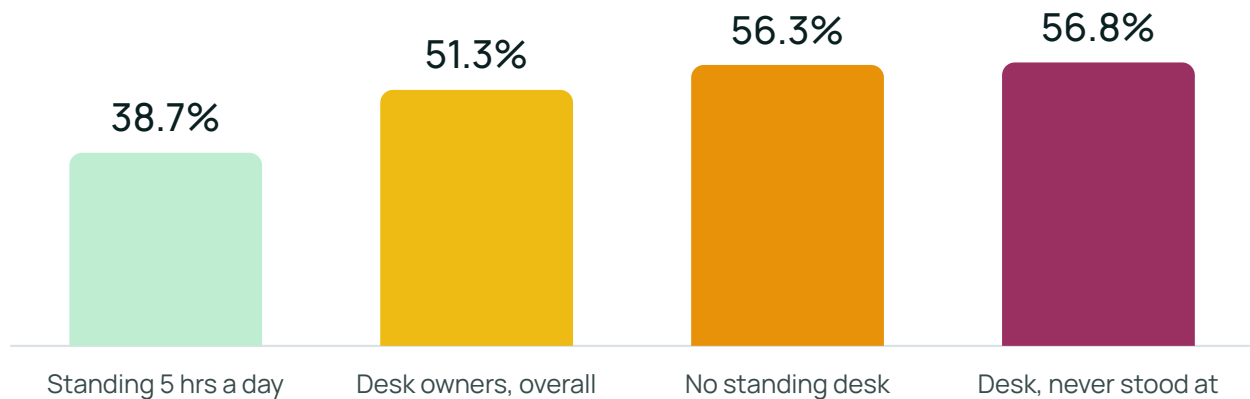
None of this says equipment is irrelevant. It says equipment is a smaller lever than most DSE budgets assume. A better chair can help. It is not the first thing the data points to. A DSE assessment that checks only whether the right kit is present is checking the weakest of the four signals it could be measuring.

CHAPTER FOUR

The standing desk *test*

■ The equipment alone showed no association. How it was used did.

People who had a standing desk but stood at it for zero hours a day reported pain at the same rate as people with no standing desk at all, at 56.8% against 56.3%.



Share reporting any pain, by how the desk is used. Vitru Health platform data, n = 20,793.³

Desk owners did report less pain than non-owners overall (51.3% against 56.3%, $p < 0.001$), but the difference was associated entirely with how the desk was used. Pain fell steadily as standing time rose, reached its lowest point between three and five hours a day, then climbed back toward the starting level beyond five ($r = -0.88$ across the nought to five hour range).

This is the equipment-versus-behaviour finding in miniature. A standing desk that is never stood at showed no associated benefit. The equipment is not the intervention on its own. The pattern of use is where the difference sat, and that is precisely what an annual tick box cannot see.

38.7%

reported pain at five hours standing a day

The lowest point in the sample, against 56.8% among desk owners who never stood at all. The likeliest read is that the gain comes from postural variety rather than from standing itself.

CHAPTER FIVE

Reported pain varies across *groups*

Treating desk workers as one uniform group misses the clearest pattern in the data.

Women reported more pain than men in every setting measured. Prevalence was 12 percentage points higher, 58.7% against 46.4%, and mean pain was 2.7 against 1.9 ($p < 0.001$).

WOMEN

58.7%

reported any pain

MEN

46.4%

reported any pain

MEAN PAIN SCORE

2.7 vs 1.9

women against men

The gap held in two large, independent groups of workers, at 60.6% against 46.5% and 60.9% against 47.9%, both $p < 0.001$.² The gender mix was broadly similar across groups, so composition is not driving it. Consistency across independent samples is what makes a pattern worth acting on.

Age band	Gender gap in mean pain score
18 to 30	0.56
31 to 50	0.83
Over 50	1.01

The gender gap in mean maximum pain score, by age band, among the 13,262 workers with both fields recorded. All three gaps $p < 0.001$. Vitruve Health platform data.² These are unadjusted associations and may reflect job role, work pattern, workplace design, health factors and differences in reporting.

The gap also widens with age, from 0.56 points at 18 to 30 to 1.01 over 50, which is the opposite of what a simple "younger workers report more pain" story would predict. Age moves how many people report pain far more than it moves how bad that pain is. Once someone is in pain, mean severity sits in a narrow band of roughly 4.2 to 4.8 out of 10 across every age group.

CHAPTER SIX

Assessed is not the same as *safe*

Recording an assessment is one stage of the duty, not the whole of it.

The reassuring version of DSE is that no one is prosecuted for it, so a recorded assessment is enough. That reading is too narrow. HSE guidance is specific about what a valid assessment requires, and about the follow-up that has to sit behind it.

DSE risk does not usually appear in enforcement statistics as its own line item, but the duty is not discharged by recording a form. HSE expects trained assessors to review results, give feedback and make sure problems are put right, with its checklist requiring follow-up to confirm the action resolved the problem.

HSE GUIDANCE

Working with display screen equipment (DSE) at home⁵

What organisations assume	What HSE guidance actually says
"A self-assessment tick box is enough."	A self-assessment counts only where workers "have been given suitable training", for example by explaining how to use the checklist or tool.
"Hybrid workers are covered by the office assessment."	"Where workers use DSE in the home and office, the assessment should cover both situations", not only the location an H&S team can see.
"There is a legal five minute break every hour."	The law requires that "employers must plan work so there are breaks or changes of activity". It sets no fixed number of minutes.
"We have to buy every home worker a desk and chair."	The duty is assessment-led. Where the assessment indicates equipment is needed, "workers cannot be charged for this". There is no blanket obligation to furnish every home identically.

The training requirement is where most programmes are thinnest, and the effect is easy to spot once you know where to look. Without training, people carry over last year's answers, whether or not anything about their setup or symptoms has changed, because nobody ever explained what a different answer would look like. A self-assessment cannot catch a new problem if the person completing it was never shown what a new problem looks like.

The practical question is not whether you will be prosecuted. It is what a self-certified green tick is worth when pain is reported later and nothing in between changed.

CHAPTER SEVEN

Three common approaches, and what each *needs*

Each can be appropriate after assessment. Each needs something in place to work.

When engagement or setup problems show up, facilities and H&S teams tend to reach for one of three fixes. All three are attempts to substitute for the same missing layer.

01

The Budget

"Here is an allowance, set yourself up."

What it needs. Guidance on what a good setup looks like, so the allowance maps to assessed need rather than preference and the spend is defensible.

02

The Kit List

H&S provisions the right equipment centrally.

What it needs. A way to check use and positioning first, so equipment is fitted to the assessed need rather than sent out as the default fix.

03

The Ultimatum

"Cannot set up properly? Come to the office."

What it needs. To stay a last rung on the escalation ladder, not a blanket policy: as a default it can discourage honest reporting, so self-assessments come back green while the problem stays put.

The missing layer

All three are trying to stand in for a trustworthy read on where people actually work, how they work, and what has changed since last time. Get that layer right and any of the three starts to work properly. Without it, each one risks producing paperwork rather than measurable protection.

Part two is about building that layer, and about the operating model it needs behind it. A better read on risk is only useful if something reliably happens next.

PART TWO

The operating *model*

What happens after the assessment is where prevention is either delivered or quietly lost. This part is the operating detail, not the theory.

-
- | | | | |
|----|---|----|--|
| 08 | Check use before you approve the purchase | 11 | Automate the admin, keep the judgement human |
| 09 | What should happen when risk is flagged | 12 | Measure beyond completion rate |
| 10 | A practical operating model for employers | | |



CHAPTER EIGHT

Check use before you approve the *purchase*

Start with the flagged risk, the person, and how the workspace is actually used.

The 23,414-assessment analysis gives an evidence-led reason to look past equipment first. In practice that means a decision sequence rather than a purchase order.

	Decision	What it means in practice
1	Clarify the signal	Where is the pain, how severe is it, when does it occur, and has it changed since last time?
2	Check use before purchase	Wrist and chair position, screen and desk arrangement, support, task pattern and time spent static.
3	Give immediate low-cost actions	Adjust what is already there, vary position, build movement into the day, and explain why the action matters.
4	Provide equipment when indicated	Use the assessment to select and fit the right control. Price and novelty are not a proxy for suitability.
5	Confirm the outcome	Check that the action happened, and whether the reported risk or discomfort actually changed.

An employer decision sequence, interpreted from the cross-sectional analysis. Not a clinical treatment protocol.¹

COMMERCIAL DISCIPLINE

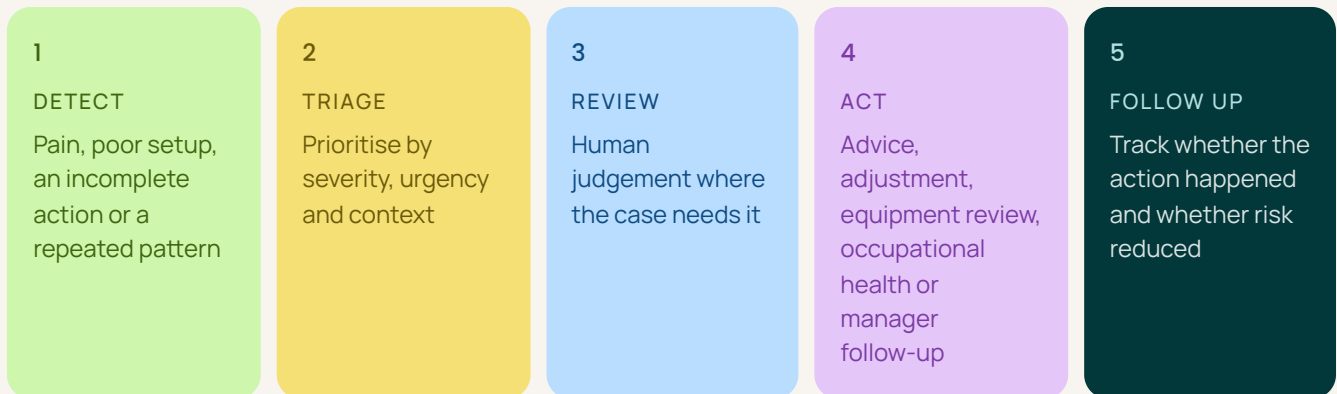
Equipment still matters when it is unsuitable, missing, or cannot be adjusted to the user and the task. Checking use first reduces avoidable purchases and makes the spend you do approve far easier to justify. The evidence argues against equipment-only thinking, not against appropriate equipment.

CHAPTER NINE

What should happen when risk is *flagged*

■ A flag is the start of a managed case, not the end of an assessment.

Most DSE processes are well designed up to the point a risk is identified, and undefined immediately after it. That is where prevention is won or lost.



A controlled, human-supervised pathway for a flagged DSE risk.

The minimum control fields

If a flagged case cannot be described in these six fields, the programme cannot demonstrate it managed the risk, whatever the completion dashboard says.

- Risk level, and the reason for the flag
- A named owner and a due date
- The action selected, and why
- The escalation route for pain, complex symptoms or sensitive cases
- Employee contact and acknowledgement
- Follow-up result, recorded as completed, improved, unchanged, worse or under further review

SAFEGUARD

Automation should not make clinical decisions about people. Higher-risk, complex and sensitive cases still require human review, and employees should understand how their assessment information is used and who sees it.

CHAPTER TEN

A practical operating model for *employers*

Clarify ownership before adding more reminders, forms or equipment routes.

Most DSE programmes have one owner in practice and five in theory. Naming who does what, and when they hand over, removes more admin than any new form ever will.

Role	Core responsibility	Escalate when
Employee	Describe the current work setting honestly, apply the immediate actions, report discomfort or change.	Pain is persistent or worsening, or the action cannot be completed.
Manager	Create time and permission for adjustments, breaks and follow-up. Remove local blockers.	Work design or performance pressure is preventing safe action.
H&S or DSE lead	Own process design, triage rules, assessment quality, case oversight and the audit trail.	Higher risk, repeated flags, unclear control or overdue action.
Facilities or workplace	Resolve workspace, furniture and equipment controls. Support fitting and deployment.	Specialist need, no suitable standard control, or repeated equipment failure.
Occupational health	Provide clinical or functional review within local governance and professional scope.	Complex symptoms, persistent pain, a health condition or a fitness-for-work question.

Five implementation moves

- 01 Map the current journey end to end, from invitation to verified outcome, and mark where it currently stops.
- 02 Define triage levels, owners, response expectations and escalation routes before the next assessment cycle.
- 03 Give immediate guidance for the setting the person is actually using now, not for an ideal desk.
- 04 Automate reminders, routing and audit records while preserving human judgement on the cases that need it.
- 05 Review outcome measures monthly and the operating model quarterly.

CHAPTER ELEVEN

Automate the admin, keep the judgement *human*

■ The line that matters runs between administration and judgement.

None of this requires doing everything by hand, and none of it should be handed entirely to a machine. Automation can organise all of it. It should not decide any of it.

Safe to automate

Assessment invitations.
Reminder emails.
Completion tracking.
Routine reporting. Record keeping and the audit trail.

Automate, with review

Risk flagging. Prioritisation.
Trend detection across teams and work patterns.
Follow-up prompts and overdue escalation.

Keep human

Clinical judgement.
Occupational health escalation. Reasonable adjustments. Sensitive or complex cases.

Why spreadsheets become expensive at scale

A spreadsheet can list open cases. It is less suited to prompting the right person at the right time, adapting guidance to context, preserving a case history, or showing whether risk actually reduced after an intervention. The cost of that gap appears as fragmented time, slower hand-offs and weak visibility rather than as one obvious budget line, which is why it survives every review.

Teams tracking hundreds of assessments by hand tend to describe the tracking itself as a second job. That is the cost that automation removes, and it is the reason human time is not available for the cases where it would make a difference.

DESIGN PRINCIPLE

Automate routine administration so that scarce human time moves towards review, judgement, conversation and complex support. That is the work that cannot safely be reduced to a status field.

CHAPTER TWELVE

Measure beyond completion *rate*

Keep completion. Stop asking it to stand in for engagement, action and health.

Completion rate answers one question well and every other question badly. Seven measures, read together, describe whether a programme is actually reducing risk.

Measure	Example indicator	What it tells you
Reach	Invitation delivery, eligible population covered, assessments started	Access and coverage
Completion	Completion rate and median time to complete	Process throughput, not risk reduction
Engagement	Immediate actions viewed or acknowledged, reassessment after a real change	Whether the process is being used
Risk	Rate and distribution of pain, poor setup and repeated flags	Where support may be needed
Response	Time from flag to triage, contact and action	Operational control
Resolution	Actions completed, follow-up outcome, reopened or overdue cases	Whether identified risk actually moved
Equity	Outcomes by relevant worker group and work pattern, with privacy safeguards	Whether support reaches people fairly

Build the commercial case from local baselines

Before claiming a return, measure what the current process costs. Track hours spent on invitations, chasing and case administration. Track external referrals and their unit cost. Track equipment purchases and rework, time from flag to action, and repeat risk in the same population. Those are where value shows up if it is there at all.

No single metric proves risk has reduced. Completion can rise because chasing improved. Flag rates can rise because reporting became safer, a good sign easily misread as a bad one. Read the measures together, sample case quality by hand, and do not claim a return until the baseline and the attributable change are both clear.

A BETTER GOVERNING QUESTION

Of the people and risks we identified, what happened next, and what evidence do we have that the response was appropriate?

RESOURCE

The programme review *checklist*

Ten questions for reviewing a DSE operating model, in the order they tend to break.

	Area	Review question
01	Purpose	Can employees see a personal health benefit, not only a compliance request?
02	Context	Does the assessment reflect where and how the person is working now?
03	Training	Have people been given suitable training before self-assessing, as HSE guidance requires?
04	Behaviour	Does it address wrist and chair positioning, work habits and movement, as well as equipment?
05	Feedback	Does every assessment end with two or three actions a person can take that day?
06	Access	Can people report discomfort and changes easily, between annual cycles?
07	Triage	Are severity, urgency, repeat patterns and context used to prioritise cases?
08	Ownership	Does every flag have a named owner, a due date and an escalation route?
09	Human review	Are complex, higher-risk and sensitive cases reviewed by a person?
10	Measurement	Do leaders review reach, response, resolution and equity alongside completion?

THE COMMERCIAL CASE, IN ONE PARAGRAPH

Outcome-led DSE reduces avoidable administration, protects the equipment budget, focuses specialist time on higher-risk cases, and creates a visible route from a flagged risk to a resolved one. The evidence does not support simple claims about causation. It does support moving attention from form completion to better-targeted action.

The practical test. If the dashboard says complete but nobody can show what happened to the flagged risk, the process is not yet beyond the tick box.

CASE STUDY

Reach

Reach plc: less admin, fewer referrals, *lower costs*

Measured, not modelled, across 3,566 employees.

Reach plc, the UK's largest commercial national and regional news publisher, ran DSE the way most organisations do. An annual form, chased by a small H&S team, with external occupational health referrals arriving almost weekly. It was not visibly helping employees, and it was not visibly helping the team running it either. Reach rolled out VIDA to 3,566 employees. Twelve months on, the results were measured rather than projected.⁸

PAIN SEVERITY

12%

Average reduction in reported MSK pain severity across the workforce.

EXTERNAL REFERRALS

~50%

Fewer external occupational health referrals, from about one a week to one a fortnight.

REFERRAL COST

£15k

To £16k estimated annual saving from fewer external referrals.

EMPLOYEE ACTION

92%

Of employees took at least one self-directed follow-up action.

The referral pattern is the clearest before-and-after, easing pressure on external support and on the budget behind it. More than 3,000 self-directed health actions were completed beyond the core assessment, an average of five per employee who engaged. That is the behaviour-change argument from part one showing up as a measured outcome rather than a theory.

“One of the best decisions we have ever made. The software is great, feedback from staff is brilliant. VIDA has saved us time and it has reduced our external occupational health costs. If you look at what VIDA costs us versus the saving we have made, it is saving us money.”

LJ

Luke James

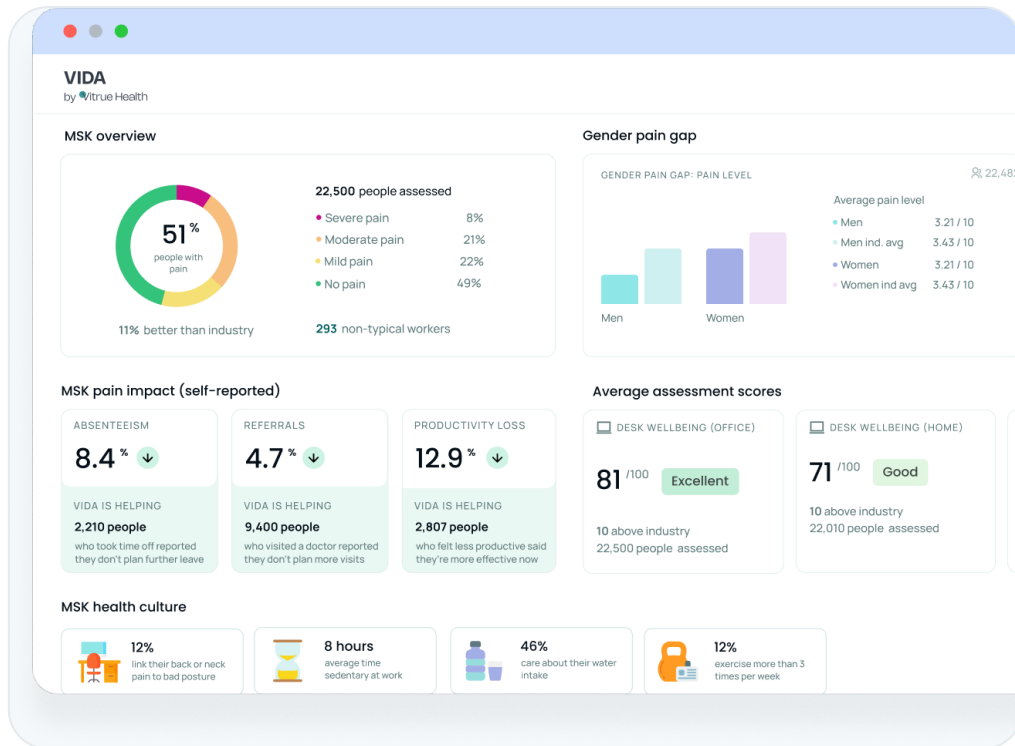
Head of Group Health & Safety, Reach plc

These are results from one organisation over twelve months. They are not a controlled comparison, and outcomes will vary by workforce and by how a programme is implemented.

THE PLATFORM

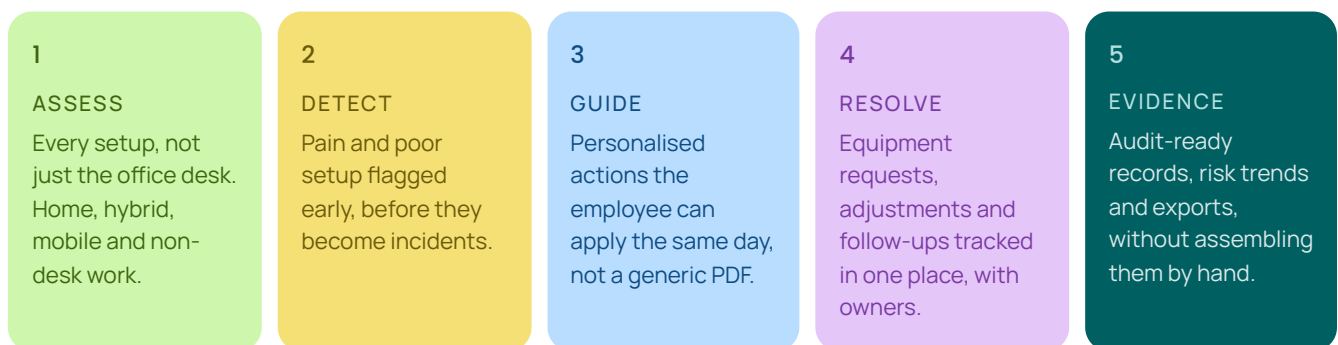
What VIDA actually *does*

See where risk builds up, and run a programme employees actually want to join.

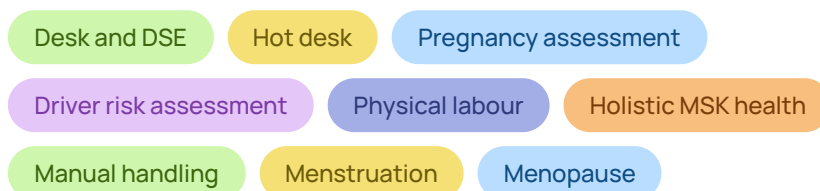


The H&S risk view: assessment coverage, reported pain and MSK impact in one place.

VIDA replaces a long annual form with a five minute assessment that predicts risk, returns a personalised action the same day, and routes what needs a person to a named owner.



FINDS RISK AT EVERY STAGE OF AN EMPLOYEE'S WORKING LIFE



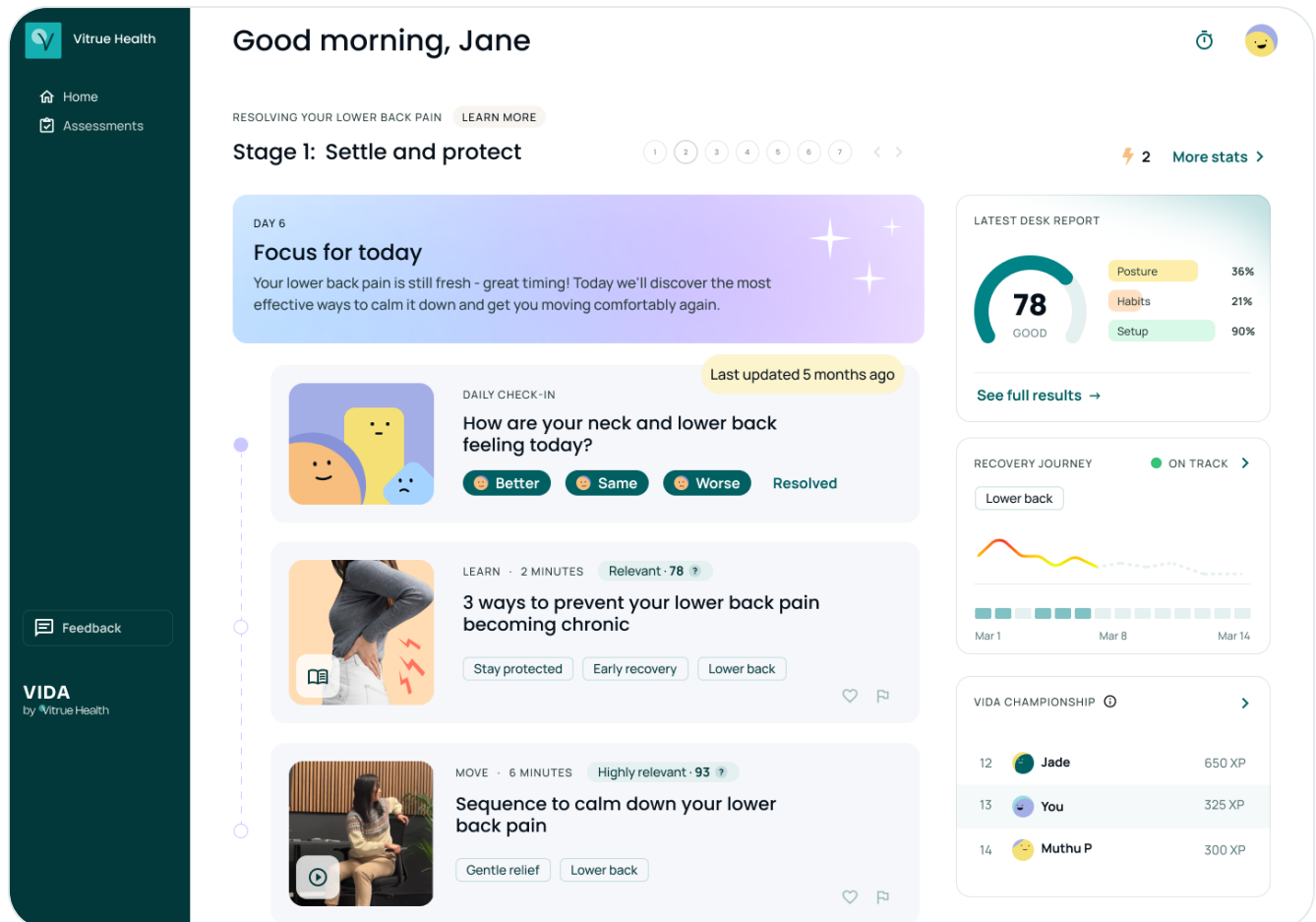
WHAT IT AND SECURITY WILL ASK



FOR EMPLOYEES

A platform employees choose to *engage with*

An AI-powered DSE assessment that gives something back the same day.



The employee view: today's focus, a guided action plan and the latest desk report.

AI-POWERED DSE

Five minutes, on any device. Risk predicted from how the person actually works, not a checklist.

A PLAN, NOT A PDF

A staged, guided action plan with a daily focus, so progress is visible week to week.

THEIR OWN SCORE

A desk report broken into posture, habits and setup, with what to change first.

WORTH COMING BACK TO

Check-ins, short learning and movement sequences, with a team championship.

92%

of employees took at least one self-directed action

Across 3,566 employees at Reach plc, with more than 3,000 self-directed health actions completed beyond the core assessment.⁸

THE BUSINESS CASE

What changes, and what it is *worth*

The case for prevention-led DSE is not softer than the case for compliance. It is more specific.

The cost lines that move are equipment spend, occupational health referrals, MSK claims and administrative time. All four are measurable before you start.

-90%

Admin time

The chasing and status handling that consumes specialist capacity.

-70 to 80%

Equipment spend

Ergonomics and workstations, once use is checked before purchase.

-60 to 75%

OH referrals

Earlier action resolves cases before they escalate.

-20 to 25%

Claims cost

MSK-related healthcare and private medical claims.

95%+

Completion

Against the 40 to 60% most manual programmes reach.

+15%

Productivity

In desk-based roles, treated as upside rather than the core case.

Indicative value areas to baseline and measure, not guaranteed outcomes. Ranges are drawn from comparable VIDA deployments and depend on your starting point, definitions and implementation. Confirm each against your own figures.

Component	What it sets out
Your cost baseline	Absence days, equipment spend, referrals, claims and admin hours, from your own figures.
Projected saving by line	Each line separately, sourced as your data or as benchmark, never one blended number.
Licence cost	Priced for your headcount and term, set against that saving rather than quoted alone.
Return and payback	Direct return on hard savings, the compliance uplift, and when the investment is covered.

THE NEXT STEP

Twenty minutes, then a costed case *on your own numbers*

A walkthrough of the employee assessment and the H&S risk view, then a business case built from your baseline. No obligation.

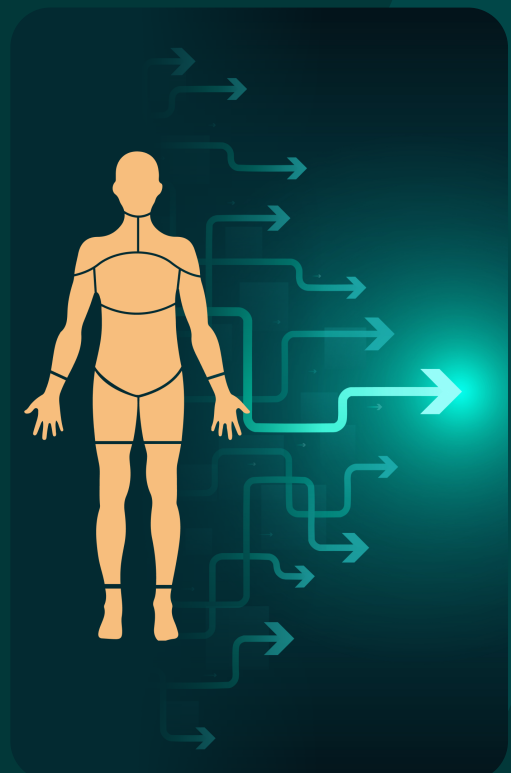
[Book a walkthrough →](#)

sales@vitruethealth.com

TRUSTED BY TEAMS AT



NEXT15



APPENDIX

Sources and *methods*

Every figure traces to one of the sources below. External context is taken from the regulator or statistics body named, not from a secondary summary of it.

VITRUE HEALTH PLATFORM DATA

1. Beyond Equipment. What Drives Desk-Related Pain? Cross-sectional analysis of 23,414 workplace assessments. N. Tik, MD, Vitru Health, 2026.
2. Working from Home vs the Office. A Pain Analysis. 20,487 desk assessments completed during 2025. Gender and age breakdowns use the subsets with both fields recorded, $n = 19,152$ and $n = 13,262$.
3. Do Standing Desk Users Have Less Pain? Cross-sectional analysis of 20,793 desk assessments.
8. Reach plc customer data. 3,566 employees, measured over twelve months of VIDA use, 2026.

EXTERNAL SOURCES

4. Health and Safety Executive. Work-related musculoskeletal disorders statistics, Great Britain, 2025. 7.1 million working days lost and 511,000 workers affected in 2024/25, 27% of all work-related ill health cases. hse.gov.uk/statistics
5. Health and Safety Executive. Working with display screen equipment (DSE) at home. hse.gov.uk/msd/dse/home-working.htm
6. Health and Safety Executive. Annual Report and Accounts 2024 to 2025, HC 1407. 246 prosecutions completed at a 96% conviction rate, more than £33 million in fines, over 4,400 notices, MSDs assessed during almost 3,000 inspections.
7. Chartered Institute of Personnel and Development and Simplyhealth. Health and wellbeing at work survey, September 2023. 51% of organisations named musculoskeletal injuries among their top three causes of long-term absence, from 918 organisations covering 6.5 million employees.
9. B. J. Fogg. Behaviour design model, motivation, ability and prompt. Referenced as operating guidance rather than as a finding from the analyses above.

METHODS NOTE

Pain is each person's self-reported maximum pain score, nought to ten, across their assessments in the relevant period, alongside a binary indicator for whether any pain was reported. Severity bands used throughout are none (0), mild (1 to 3), moderate (4 to 6) and severe (7 to 10). Group differences were tested with non-parametric methods, Kruskal-Wallis for three or more groups and Mann-Whitney U for pairwise comparisons, or chi-square and t-tests where specifically noted. Only differences reaching conventional significance thresholds ($p < 0.05$) are described as significant. Counts such as 23,414 refer to individual workplace assessments completed in the relevant period, not necessarily unique workers.