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Understanding the provision of occupational health and work-related musculoskeletal services

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May 2020

Understanding the provision of occupational health and work-related musculoskeletal services

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Statement of Compliance

This research complies with the three pillars of the [Code of Practice for Statistics](#): value, trustworthiness and quality.

Value of this research

- Findings from this report have informed the ongoing development of policy decisions relating to occupational health
- The research also provides a description of the current occupational health market and work-related MSK provision, and contributes to the growing evidence base

Trustworthiness

- This research was conducted, delivered and analysed impartially by IFF Research, working to the Government Social Research code of practice
- Authors: IFF Research – Angus Tindle, Lorna Adams, Isabel Kearney, Zainab Hazel and Sam Stroud

Quality

- The survey was carried out using established quantitative and qualitative research methods
- The research has been quality assured using IFF Research's internal quality checking processes, which have been shared with the Work and Health Unit
- The report has been checked thoroughly by Work and Health Unit analysts to ensure it meets the highest standards of analysis and drafting

Executive summary

This short summary presents the key findings from research conducted by IFF Research on behalf of the Work and Health Unit (WHU). The research aimed to examine current provision of occupational health (OH) and the commissioning of NHS work-related musculoskeletal (MSK) services and is intended to inform the ongoing development of policy relating to OH. The research used a combination of; in-depth expert interviews, semi-structured surveys with OH providers and Clinical Commissioning Groups (CCGs), and in-depth qualitative case studies with OH providers, employers that have used their services and employees receiving them. The research aimed to:

- Examine the private and NHS models of OH service provision available;
- Investigate how these are commissioned, resourced and accessed;
- Examine the workforce of private and NHS providers;
- Investigate the commissioning of MSK and work-related NHS services.

Private OH providers placed considerable importance on tailoring services to specific employer needs and this was reflected in the wide range of services on offer. The most commonly commissioned services were health surveillance and assessments of fitness for work. While employers dominated the commissioning of OH services, SMEs were under-represented. Experts and OH providers both felt that employers were most commonly motivated by legal obligation, with more ‘aspirational’ improvements to productivity and wellbeing being secondary motivations.

OH providers and employees in receipt of OH services confirmed the view of the experts that line managers were of key importance to the success of OH provision. The efficacy of the line manager’s involvement varied according to their engagement with, and understanding of, OH.

When the NHS was established, OH was not included in its responsibilities, but responsibility fell to the employer instead. In the experts’ view, the NHS’s traditional stance has contributed to employment outcomes being largely overlooked in studies of health interventions. While nearly all providers reported their services interacted with the NHS, many felt that OH was not considered to be a priority by GPs. The majority of CCGs reported that none of their MSK services were commissioned specifically with employment needs in mind, and while tailoring accessibility of services to the working age population was common, tailoring of the services themselves was rare.

Most OH providers are small-scale businesses with relatively few members of staff, and use subcontracting. Accordingly, small scale providers had smaller capacity in terms of numbers of individuals they could provide support to. The small-scale nature of OH provision is potentially reflective of the size of demand, as only a minority of providers were delivering at full capacity. Despite this, OH providers felt they had

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limited need to use marketing to attract customers: targeted marketing was rare, and a substantial proportion did no marketing at all.

Experts and providers both reported a threat to the future of OH provision in the reduction of qualified OH physicians and nurses in recent years. Providers confirmed that they were most likely to have vacancies in these roles, and there were more NHS and private providers with training posts available than those with posts that had been filled.

Both OH providers and CCGs that commissioned MSK services gathered data to monitor the performance of their services, namely through outputs of their services, service statistics and surveys of patient experiences (the latter more commonly used by CCGs than OH providers).

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Authors' credits

Angus Tindle and **Lorna Adams**, Directors, headed up the IFF team responsible for the research. Both have considerable experience in research projects pertaining to interactions between health conditions and employment. **Isabel Kearney**, Research Manager, was responsible for day-to-day management of the study and delivery of findings. **Zainab Hazel**, Senior Research Executive, and **Sam Stroud**, Senior Research Executive, worked on the fieldwork, delivery and analysis. **Siv Svanaes**, **Sarah Brownlee** and **Luke Catterson** supported in production of the final report.

Glossary of terms

Assessment of fitness for work	Assessments designed to make sure an individual is fit to effectively perform the tasks of their job role without risk to their own or others' health and safety
Clinical Commissioning Group (CCG)	Clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area
Continuing Professional Development (CPD)	Learning activities that professionals engage in to develop and enhance their work-related skills and knowledge in a pro-active manner
Employee assistance programmes	A service offered by employers to their employees to assist with personal or work-related issues that may impact on their job performance, health or emotional wellbeing
Fit notes	Issued by doctors to provide evidence of advice a patient has been given about their fitness for work, including details of functional effects of patient's condition to allow the employer to consider ways to help them return to work, and sometimes suggest reasonable adjustments
Follow up support	OH support that is provided after the initial OH service has been delivered, usually to review whether the support has improved the situation
Health surveillance	A system of ongoing health checks to detect ill-health at an early stage to enable employers to introduce interventions to prevent issues from getting worse
Jobcentre Plus	A government-funded employment agency and social security office whose aim it is to help people of working age find employment in the UK
Management referral	The process through which employees are referred for OH support
Multidisciplinary care	Provision which combines or involves several disciplines or specialisations to provide treatment
Musculoskeletal (MSK) provision	Health services commissioned to treat conditions that affect the joints, bones and muscles
Occupational health (OH) services	Advisory and support services which help to maintain and promote employee health and wellbeing. OH services support organisations to achieve these goals by providing direct support and advice to employees and managers,

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	as well as support at the organisational level e.g. to improve work environments and cultures
Safety-critical assessment	Assessments designed to identify whether employees are suffering from any medical conditions or undergoing any medical treatment that could cause a sudden loss of consciousness or incapacity, impairment of awareness, concentration, balance or coordination or significant limitation of mobility
Working age population	For the purposes of this research defined as those aged between 16 and 64 years old
Workplace adjustments	Making changes to the working environment to allow an employee to remain in a role. These can include changes to the physical working environment, for example modifying furniture or tools, or by changing working arrangements, for example a change of working hours or providing help with transport to or from the workplace
Vocational rehabilitation	Process which enables persons with functional, psychological, developmental, cognitive, and emotional disabilities or impairments or health disabilities to overcome barriers to accessing, maintaining, or returning to employment

Abbreviations

CCG	Clinical Commissioning Group
COHPA	Commercial Occupational Health Providers Association
CPD	Continuing Professional Development
DWP	Department for Work and Pensions
DHSC	Department of Health and Social Care
EAP	Employee Assistance Programmes
ESF	European Social Fund
GMC	General Medical Council
GP	General Practitioner
HEE	Health Education England
HR	Human Resources
JCP	Jobcentre Plus
MDC	Multidisciplinary Care
MECC	Making Every Contact Count
MSK	Musculoskeletal
NHS	National Health Service
NMC	Nursing and Midwifery Council
OH	Occupational Health
OHP	Occupational Health Physician
SCPHN	Specialist Community Public Health Nursing
SEQOHS	Safe, Effective, Quality Occupational Health Service
SME	Small or Medium Enterprise
WHU	Work and Health Unit

1 Summary

1.1 Overview

This report presents the findings from research commissioned by the Work and Health Unit (WHU), to map the current provision of occupational health (OH) in the UK¹ and review work-related musculoskeletal (MSK) services in the NHS.

The research aimed to examine the available models of private and NHS service provision; how these are commissioned, resourced and accessed; examine the workforce of private and NHS providers; and investigate the commissioning of MSK and work-related NHS services. The research is intended to inform the ongoing development of policy relating to OH.

The definition of OH used throughout this research is: advisory and support services which help to maintain and promote employee health and wellbeing. OH services support organisations to achieve these goals by providing direct support and advice to employees and managers, as well as support at the organisational level e.g. to improve work environments and cultures.

1.2 Research context

The Work and Health Unit (WHU) is a UK government unit which brings together officials from the Department for Work and Pensions (DWP) and the Department of Health and Social Care (DHSC) to lead the Government's strategy supporting working age disabled people, and people with long term health conditions enter, and stay in, employment. To enable this, the government aims for more individuals to have access to appropriate and timely OH advice.

As set out in the WHU's consultation, 'Health is everyone's business: proposals to reduce ill-health related job loss'², the government recognises that action is required to ensure employers are able to purchase good quality, cost-effective OH services that meet their needs. Complementary improvements will be needed to ensure the OH market has the capacity to respond to greater demand, and is able to deliver these services to employers of all sizes.

¹ Research with NHS bodies was limited to England only

²https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/815944/health-is-everyones-business-proposals-to-reduce-ill-health-related-job-loss.pdf

1.3 Methodology

The research is comprised of five main components, designed to capture a range of perspectives on OH and MSK provision:

- in-depth interviews with 8 experts in the fields of OH and/or MSK, and a literature review;
- a semi-structured telephone survey of 103 OH providers (representing 32% of the sample built of private OH providers);
- a further semi-structured telephone survey of 156 private and NHS providers that sell OH services commercially (representing 36% of the sample built of private and NHS OH providers);
- a semi-structured telephone and online survey of 111 Clinical Commissioning Groups (CCGs, representing 58% of CCGs);
- 15 in-depth qualitative case studies with OH providers and employers that have used their services.

1.4 Main findings

1.4.1 Scoping out the history of OH and MSK provision: Chapter 3

When the NHS was established, OH was not included in its responsibilities, but responsibility fell to the employer instead. In the experts' view, the NHS's traditional stance has contributed to; employment outcomes being largely overlooked in studies of health interventions; and a lack of leadership in OH, resulting in fragmented OH provision.

Experts reported that provision of OH has gradually shifted from an in-house function to an outsourced model, mainly due to employers seeking to reduce costs. However, they felt the training of OH professionals has not been taken up by out-sourced private providers to the same extent, and as a result the pool of UK OH expertise is perceived to be dwindling.

Weaknesses of OH provision identified by experts included; uneven access to OH and work-related MSK services, a missing link between treating health problems and supporting individuals to work, and OH not having been prioritised sufficiently by employers. Experts felt that key elements that contribute to effective provision include; awareness that good quality work can lead to improvements in employee health and wellbeing; employers and managers with strong understanding of and belief in OH; multidisciplinary care; and stratifying patients by severity of condition. The experts, and the evidence from literature, pointed towards some key models used in current delivery of OH and work-related MSK provision. These tended to fall within the domain of the employer, or the individual and their GP.

In the employer domain, Employee Assistance Programmes were felt by experts to be a relatively common pathway for referring employees to OH specialists. Also thought to be relatively common was employer-funded, 'basic' OH provision to meet legal requirements, such as health surveillance. By comparison, a bespoke OH and MSK offer that is fully-tailored to the employer's workforce, was felt to be comparatively rare.

1.4.2 Private providers' OH offer: Chapter 4

OH providers offered a broad range of services. They placed considerable importance on tailoring of services to meet employers' specific needs, even when services were delivered through 'off the shelf' packages. Two services stood out as the most commonly commissioned: health surveillance (33%) and assessment of fitness for work (24%).

A substantial proportion of private OH providers had relatively small-scale capacity. Four in ten (39%) had capacity to support fewer than 200 individuals at any one-time. Demand did not appear to be exceeding supply, as of the available private OH market capacity amongst those who participated in the research, 89% had been taken up over the last 12 months.

Employers were the main commissioners of OH services: almost all providers (97%) had been commissioned by employers. Around half (54%) of OH providers had been commissioned by individuals, often self-employed individuals or those looking for work seeking mandatory medicals.

Line managers and other employer representatives were frequently involved in assessments of fitness for work and workplace adjustments, but their involvement was often limited to the start and end of the process. OH providers noted the importance of involving the line manager in the process, and this was most successful when line managers had a good understanding of OH.

Nearly all OH providers (96%) said their OH support interacted with NHS provision, most commonly recommending employees go to their GP or specialist treatment.

Seven out of ten (69%) OH providers captured data on the outcomes achieved through their support in all or most cases, with 56% capturing it in all or nearly all cases. Providers that did so felt it allowed them to establish trends and identify ways to improve their service. Virtually all (99%) OH providers used some form of training, development or accreditation system, and the majority of these providers (96%) felt these were effective in ensuring quality of service.

Six in ten OH providers (63%) did some form of marketing, mostly directed at employers (97%). Those who did no marketing (37%) did so because they felt they received enough business without it.

1.4.3 OH provider workforce: Chapter 5

Most private OH providers had only a small number of employees (17% were sole traders and 43% had one to nine employees). The majority of private OH providers (82%) subcontracted to additional members of staff on a regular ongoing basis.

On average, two-thirds (64%) of staff employed or subcontracted by private OH providers were medical professionals (e.g. doctors or nurses), and the most commonly employed role was registered nurses with a SCPHN OH qualification³ followed by occupational health physicians (OHP). Eight out of ten private providers (78%) felt they had the right balance of medical and non-medical staff. The more specialised and bespoke job functions were reserved for medical professionals with specialisms or qualifications, while less specialised staff spent more time delivering services that were more process-driven.

Three-quarters (76%) of private and NHS OH providers had access to funding for staff training. Amongst those with access to funding, the organisation themselves partly or wholly funding a course was the main source (61%). A third (35%) of providers funded training posts, although on average there were more training posts available than had been filled.

The majority of private and NHS OH providers (67%) had recruited new staff in the previous twelve months, most commonly registered nurses with a SCPHN OH qualification (37%). Just over a third (37%) reported having at least one vacancy (again most commonly for registered nurses with an SCPHN OH qualification (24%). Just under half (44%) of private OH providers had roles that they were unable to fill, most commonly OH nurse or physician roles. They felt that this was due to a decrease in medical professionals with OH experience in recent years. Specifically, registered nurses with a SCPHN OH qualification (51%), nurses with other OH qualifications (41%) and occupational health physicians (37%) were seen to be the most difficult roles to recruit for.

The most common course of action to take when a role could not be filled was to maximise the capacity of the current workforce, with seven in ten (72%) restructuring teams and workloads and two-thirds (63%) training and promoting existing staff. However, half reported that they had been forced to turn down work (53%) and/or manage the services they were able to provide (49%), for instance by limiting client numbers. While on the face of it this may conflict with the finding that most private OH providers are not operating at full capacity, it is plausible that providers may be (i) turning down work that would see them operating at or above full capacity due to recruitment difficulties; or (ii) managing the services they provide so as to avoid approaching full capacity.

³ Those registered under part 3 of the NMC register, the highest OH qualification a nurse can achieve.

1.4.4 Clinical Commissioning Group (CCG) commissioning of musculoskeletal services: Chapter 6

Nearly all CCGs commissioned MSK physiotherapy (99%); podiatry (97%); injection therapy (96%); joint replacement (95%) and specialist pain clinics (91%). MSK physiotherapy was the most commonly used community-based MSK service among working age people: 88% of CCGs reported that it was in their top three most commonly-used community services. Specialist pain clinics were the most commonly used hospital-based MSK service among working age people (71%).

MSK care for working age people was widely considered a priority area by MSK leads in CCGs, with a quarter (23%) viewing it as a very high priority and half (50%) as a high priority. Common reasons for this included the strategic redesign of MSK services, this being a known NHS priority or the CCG feeling they were not doing enough – all of which may imply a relatively recent shift towards prioritising MSK services for working age people. Responsiveness to demand was also a factor, with 17% reporting that it is a priority because it is the most-accessed service.

Tailoring of MSK services to the health needs of the working age population was widespread among CCGs (91% tailoring to at least some extent; 70% tailoring 'mostly' or 'completely' to these needs). However, this was mostly limited to flexibility in access, such as flexible appointment times (46% of CCGs that tailor their services) or locations (22% of these CCGs). Responsiveness to demand recurs as a theme: tailoring was most commonly driven by perceived needs of the local population or public consultation. Tailoring the services themselves to the needs of the working population was less common, as was tailoring being driven by best practice or expertise.

The majority of CCGs (79%) reported that none of their services were commissioned specifically with employment needs or vocational rehabilitation in mind; MSK physiotherapy and specialist pain clinics were the services most commonly cited as being commissioned on this basis (by 15% and 11% respectively), typically because these services were known to have a better chance of getting people back to work.

Working age patients were most commonly referred via their GP to both community and hospital-based MSK services. Self-referral was also relatively common, particularly for community-based MSK physiotherapy.

The vast majority of CCGs (93%) reported at least some deliberate commissioning of MSK services with the intention of facilitating patient access to multidisciplinary support⁴. However, these multidisciplinary services were not commonly focused on employment needs or vocational rehabilitation. Where these multidisciplinary services *were* commissioned with a focus on employment needs or vocational rehabilitation, most commonly, this was because multidisciplinary MSK services were thought to be effective in ensuring the best possible course of treatment.

⁴ This was defined as support from two or more members of staff from different disciplines, whether clinical or not.

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Four-fifths (79%) of CCG MSK leads agreed that MSK services meet the needs of local working age people, but only 14% strongly agreed, suggesting some scope for improvement. When asked what elements of MSK commissioning are currently working well, efficiency was a recurring theme whereas managing patient demand was seen as a key area for improvement.

2 Introduction

2.1 Background to the research

The Work and Health Unit (WHU) is a UK government unit which brings together officials from the Department for Work and Pensions (DWP) and the Department of Health and Social Care (DHSC) to lead the government's strategy supporting working age disabled people, and people with long term health conditions enter, and stay in, employment. To enable this, the government aims for more individuals to have access to appropriate and timely occupational health (OH) advice.

As set out in 'Health is everyone's business'⁵, the government recognises that action is required to ensure employers are able to purchase good quality, cost-effective OH services that meet their needs. Complementary improvements will be needed to ensure the OH market has the capacity to respond to greater demand, and is able to deliver these services to employers of all sizes. To understand the current state of this market, and related musculoskeletal (MSK) services available, the WHU commissioned research that aimed to:

- Examine the private and NHS models of OH service provision available;
- Investigate how these are commissioned, resourced and accessed;
- Examine the workforce of private and NHS providers;
- Investigate the commissioning of MSK and work-related NHS services.

Better understanding the landscape of OH and related provision will enable the identification of gaps in current provision. Ultimately, strengthening this evidence base will aid the development of policy and practical solutions, and help OH bodies and the wider market to identify how provision could be improved, resulting in better outcomes for both individuals and employers.

The definition of OH used throughout this research is: advisory and support services which help to maintain and promote employee health and wellbeing. OH services support organisations to achieve these goals by providing direct support and advice to employees and managers, as well as support at the organisational level e.g. to improve work environments and cultures.

2.2 Methodology

This research is comprised of five main components:

- A scoping stage which involved a literature review and in-depth interviews with a small group of key experts;

⁵https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/815944/health-is-everyones-business-proposals-to-reduce-ill-health-related-job-loss.pdf

- A telephone survey with private providers of OH about their OH offer;
- A telephone and online survey with private and NHS providers of OH about their current workforce and recruitment;
- Case studies with providers of OH and employers/employees that used their services;
- A telephone and online survey with MSK leads in CCGs about commissioning of MSK services.

2.2.1 Scoping stage

The scoping stage of this research was an iterative process comprised of a literature review and in-depth interviews with a small sample of experts who had different experiences of both practical delivery and strategic issues around OH and MSK services, to help inform development of research instruments.

In the first stage, a rapid literature review was conducted that aimed to explore potential service models, including any evidence on their target client group, the mode of access, how they are organised, and any evidence as to their efficacy.

Following this, five in-depth interviews were completed with experts in the fields of OH and work-related MSK provision. These interviews were used to gather views on initial models of delivering OH services identified in the literature review, alternative models not yet covered, gaps in OH provision, and recommendations for further scoping activity. Recommendations for further sources of literature and experts to interview were also sought.

The findings from the initial literature review and expert interviews were used to develop a conceptual systems map, designed to illustrate the forms of OH support identified. This map was then refined periodically during later stages of research to take into account additional findings (see Figure 3.1).

The final stage of the scoping work has comprised of a literature review of the further sources identified, and three in-depth interviews with OH experts. These final interviews with experts explored views on models mapped out to date, exploration of further models, views of OH provision effectiveness, and recommendations for the remaining stages of the research.

The experts interviewed for the scoping stage included academics specialising in OH, senior figures within the OH industry, and representatives from relevant trade bodies.

2.2.2 Telephone survey of private providers

The WHU commissioned a telephone survey of private providers of OH to understand the services they offer, commissioning of their services, how they interact with customers and the NHS, their capacity for delivering the services, their workforce profile and any skills shortages, and how they market their services.

The survey aimed to speak to as many private providers of OH (i.e. excluding NHS provided services and in-house OH provision) across the UK as possible, as an

attempted census. A starting sample of 322 OH providers for the survey was drawn from three sources to optimise coverage:

- Sample purchased from Market Location, a commercial primary data owner in the UK who independently verify and collect business data;
- Publicly available lists of OH providers who had or were working towards a SEQOHS (Safe, Effective, Quality Occupational Health Service) accreditation⁶;
- Publicly available list of OH providers registered with COHPA (the Commercial Occupational Health Providers Association).⁷

In total, 103 OH providers took part in the survey between 12th November and 7th December 2018. This represents a 32% completion rate and the achieved sample was similar in profile to the starting sample (in terms of spread across the country and number of employees), meaning that the findings are likely to be broadly representative of the starting sample. Due to a lack of completely authoritative population data on UK OH providers, it is not possible to gauge precisely how representative the sample is of UK-wide OH provision, but given the high response rate it is reasonable to conclude that the research included a representative proportion of all OH providers in the UK.

The survey used a semi-structured approach, with a mixture of closed and open-ended questions. Open-ended questions included prompts and probes to elicit more in-depth information. In this report, responses to the closed questions have been reported quantitatively (i.e. with findings expressed as percentages) and responses to the open-ended questions have been reported qualitatively (i.e. using terms such as ‘many’, ‘some’ or ‘a few’).

A previous report published in April 2019, ‘Understanding private providers of occupational health services’⁸, provided an interim summary of findings from one element of this research. Those findings are built upon in Chapters 4 and 5 of this report.

2.2.3 ‘Workforce’ telephone survey of private and NHS providers

The WHU commissioned a telephone survey of private providers of OH, and NHS OH departments that sell their OH services commercially, specifically about their current workforce and recruitment.

Again, the survey aimed to speak to as many private providers across the UK and NHS OH departments across England as possible, as an attempted census. In total, 156 interviews were conducted (104 with private providers and 52 with NHS OH

⁶ <https://www.seqohs.org/>

⁷ <http://cohpa.co.uk/>

⁸

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/848173/understanding_private-providers-of-occupational-health-services.pdf

departments) between 15th August and 20th September 2019. The survey achieved a 36% completion rate.

The same starting sample of 322 private providers was used, and NHS OH department contact details were gathered from publicly available contact details from the NHS Health at Work website. Individuals working in these departments were invited to opt-in to the survey via an email invitation sent via the NHS Health at Work network.

2.2.4 Case studies with providers of OH and employers that use their services

A total of 15 case studies were conducted to illustrate some of the OH models in practice. Case studies were designed to gather a variety of examples (including examples of in-house OH provision within a large employer, and examples of NHS provision for internal staff as well as NHS external provision sold commercially), although the majority of case studies focused on examples of private provision of OH.

The case studies generally followed the model of qualitative interviews outlined below (this was adapted where necessary to cater for the reality of each individual example⁹):

- Interviews with 1-2 employees that had recently received OH support;
- Interviews with the line managers of those employees, or an HR representative directly involved in utilising the OH support with the employees;
- Interviews with frontline OH practitioners working for the provider that delivered the OH support;
- Interviews with 1-2 senior provider decision makers responsible for shaping the services the employees received.

Case studies took place between December 2018 and July 2019. Each interview was a fluid, two-way dialogue, informed by a topic guide (a series of key questions and probes) to ensure all the key points were covered.

2.2.5 Telephone and online survey of CCGs

A quantitative survey was conducted with 87 MSK leads working in CCGs across England. As some of the MSK leads work across more than one CCG, they were able to provide data for multiple CCGs. In total, 111 out of a total of 191 CCGs were represented in the survey, 76 of which were lead CCGs. Lead CCGs commission both community and hospital-based services, and the remaining 35 CCGs commission only community-based services.

⁹ For example, in cases of sole trader or micro OH providers, the senior decision maker and OH practitioner may have been the same individual, or in the case of a self-employed person no line manager or HR interview was conducted.

The survey focused on commissioning of MSK services for working age people (those aged 16-64 years old). It aimed to gather information and data on:

- MSK services commissioned, and which were most used;
- Extent to which MSK is a priority area for CCGs;
- Extent of tailoring of MSK services to the working age population;
- Which, if any, MSK services were commissioned with employment needs in mind;
- Capacity, waiting times and cost to CCGs of MSK services;
- Extent of commissioning of multi-disciplinary MSK services;
- Strengths and weaknesses of current MSK provision;
- Interaction of MSK services with occupational and vocational-related support.

MSK leads were initially invited to take part in the survey online via NHSE bulletins. Additional interviews were achieved by telephone, using publicly available contact details gathered through desk-based research.

2.3 Report structure

The report takes the following structure:

- Chapter 3 provides an account of historical and current OH and MSK provision, drawing on an initial literature review and interviews with experts in the field of OH and work-related MSK provision to inform the later research.
- Chapters 4 and 5 present findings relating to the provision of OH, drawing on the two surveys with private OH providers, and private and NHS providers. Both chapters use the case studies to illustrate findings (full case study findings are in Annex A).
- Chapter 6 presents the findings relating to work-related MSK provision in the NHS, drawing on the survey with CCGs.

Conclusions are drawn from the research conducted and compared to relevant findings from the scoping stage of the research.

3 Scoping out the history of OH and MSK provision

The study began with a scoping research stage, intended to understand the current 'landscape' of occupational health (OH) and musculoskeletal (MSK) provision. The contextual information generated by the scoping stage was used to help develop the materials used in later stages of project, as well as providing a frame of reference when conducting fieldwork and analysing emerging findings. The scoping stage explored:

- the history of OH in the UK, to understand how this has shaped the status quo (Section 3.1);
- perceived gaps and weaknesses of current provision (Section 3.2);
- views on 'what works' (Section 3.3);
- the key models used in current delivery of OH and work-related MSK provision (Section 3.4); and
- approaches that can be applied within OH models to deliver better outcomes (Section 3.5).

Views are from the interviews with experts, including academics specialising in OH, senior figures within the OH industry, and representatives from relevant trade bodies, unless otherwise stated.

3.1 A brief history of OH in the UK and its impact on the current situation

The experts noted that the National Health Service (NHS) was set up to provide safe, affordable healthcare for all, but Aneurin Bevan, Minister for Health at the time, felt OH should be an employer responsibility. The NHS traditionally has sought to manage and treat conditions and symptoms, whereas experts suggested that a key characteristic of OH is it avoids 'medicalising' an individual's issue, instead focusing on what the provision can help the individual to do or keep doing. Experts suggested that NHS provision has historically tended to not focus primarily on an individual's ability to work.

From an OH perspective, experts felt that this lack of NHS focus has led to an 'empty literature', as studies of health interventions largely ignore employment outcomes. In addition, experts felt that the absence of leadership in OH had led to fragmented provision.

OH provision in the UK, according to experts, has historically been an employer-driven specialism. Some General Practitioners (GPs) would notice their patients

needing OH, and would be inspired by that to specialise in it. Major employers would identify that they needed an OH specialist and would take these interested GPs on, training them to meet their business's needs. Ultimately this individual might sit on the board, perhaps as a Chief Occupational Physician.

In the past 20 years, however, major employers have sought to cut costs – and to do this have sought to replace these OH doctors with nurses or (more often) bought-in commercial services. One expert suggested that bought-in, as opposed to in-house, provision comes at the cost of the provision no longer being 'embedded' within the organisation.

The experts suggested that the private sector OH providers have typically relied on OH specialists who trained under the historic model (i.e. major employers training up OH specialists), but have done so without taking on the training of the next generation of OH specialists. As a result, the pool of OH expertise has been decreasing, with a particularly sharp decline in recent years. While medical OH specialists are particularly hard to come by, this skills shortage also applies to OH-trained administrative staff who need relatively advanced skills in areas such as answering immediate queries about accidents.

One expert suggested that the majority of trainees in occupational medicine in England are paid for by the NHS, and to some extent the military, with in-house occupational health training schemes in the private sector decreasingly common. They noted that this can lead to a perception that the private sector is 'poaching' NHS staff, as well as resulting in an antagonism and competition for staff between the NHS and private sector providers. The expert noted that where NHS OH departments train new staff, it is often paid at least in part through income generation from NHS OH departments commercially providing services.

Experts suggested that private sector providers have a tendency to employ OH specialists as contractors rather than as salaried staff, meaning there is little career progression for new entrants. The deficit of OH specialists also causes knock-on problems such as OH physicians finding themselves working in isolation, without colleagues to discuss cases with or provide advice or support.

On the employer side, experts suggested that health and safety legislation has seeded the idea among employers that, as long as they are meeting these legal standards, they don't need to do anything else about employee wellbeing – so only 'enlightened' employers explore employee welfare and health at work in a wider sense.

A couple of the experts estimated that OH services only have 50% population reach currently (this is backed up by DWP research that has shown that 51% of employees have access to OH services provided by their employer currently¹⁰).

¹⁰ Health and wellbeing at work: a survey of employees (DWP, 2015).

3.2 Perceived weaknesses and gaps in provision: views from experts and literature review

The expert in-depth interviews and the literature review highlighted some perceived weaknesses and gaps in current OH provision:

Firstly, OH provision across the UK is uneven:

- SMEs are less likely to have OH services in place¹¹, and among those businesses which do have OH programmes in place, SMEs are less likely to have capacity to accommodate more flexible working practices;
- Occupational health needs of recently hired staff, including those who are returning to the workplace after a period of absence, are less likely to be accommodated by employers (the inclination is often to simply let them go)¹²;
- Access to OH services often comes through Human Resources (HR, either requests to HR, or interventions by HR)¹³ – this raises a problem for companies without a dedicated HR department with expertise in handling OH issues;
- Experts noted that there is particularly low OH coverage among self-employed people;
- Willingness of employers to support OH interventions depends a lot on the employee's job role – those in junior positions are less likely to receive adequate support¹⁴, as are those in more physically demanding occupations where bigger adjustments may be required;
- Experts noted that people on higher incomes experience better access and those on lower incomes and/or disabled people and people with long-term illnesses are 'missing' from those accessing provision. As such, they argue that there is a risk, in any rolling out of OH provision in future, that it reinforces this inequality;
- One expert noted that in some cases 'pseudo-wellbeing' services may be marketed as OH, without being particularly focused on managing sickness absence or health problems in the context of work.

Secondly, experts suggested that there is a missing link between treating health problems and supporting patients to work:

- OH specialists often see a misalignment in aims between themselves and both employers and GPs, with employers and GPs less likely to see work as a

¹¹ Sickness absence and health in the workplace: Understanding employer behaviour and practice: An interim report (DWP/DHSC, 2019).

¹² Understanding the journeys from work to Employment and Support Allowance (DWP, 2015).

¹³ Routes onto ESA (DWP, 2011).

¹⁴ Health in the workplace – patterns of sickness absence, employer support and employment retention (DWP/DHSC, 2019). A separate DWP/DHSC report found that when an employer provides OH they typically do so for all staff, but that more expensive treatment is reserved for more valued staff (Employers' motivations and practices: A study of the use of occupational health services (DWP/DHSC, 2019)).

health outcome. At the root of this is the historic focus of the NHS on symptoms and conditions (rather than what the individual is able to do); and a tendency among employers to assume that people with some conditions would be better off absent from work. One expert felt that sometimes this may be because their remaining in work might benefit the individual but might be more hassle for the employer;

- Pain-based problems are a particular issue – as pain can't be seen, it's harder for employers to be understanding of employees' needs. Additionally, employees/patients are rarely advised about how to find work that will help manage their pain, often dropping out of poorly-suited work instead.

Thirdly, experts identified issues with the prioritisation of OH support:

- OH is often 'downstream' in the overall care pathway, coming only after visiting a GP and seeing other specialists;
- GPs are not trained to take advantage of opportunities to have OH-focused conversations so tend to avoid doing so;
- Existing OH service models are generally not well tailored to individual needs.

In terms of weaknesses specific to work-related MSK provision, experts felt that specialist MSK provision for 14-18 year olds is lacking – paediatric MSK care is not at all tied to the individual's vocational future despite this age period being critical for work outcomes. They also suggested that referral waiting times for MSK support within the NHS are too long, which is particularly problematic given the '12-week window'¹⁵ following a person falling out of work on health grounds, after which interventions become significantly less effective.

3.3 What works well: views from experts and literature review

The expert in-depth interviews and the literature review also highlighted some circumstances when OH works well, including the conditions that make OH delivery effective.

Focusing on the medical side of OH, a number of specific approaches to – or elements of – OH were identified as being important to it working effectively:

- Experts felt that there needs to be raised awareness of the idea that (good-quality, suitable) work can lead to improvements in health and wellbeing;
- Experts noted that when those who have pre-existing relationships with patients deliver the intervention, it is typically more successful than when it is delivered by unfamiliar healthcare professionals. In an NHS context, this could mean primary care providers other than GPs – such as high grade nurses and pharmacists – beneficially getting involved in dealing with OH. In addition to

¹⁵ The '12-week window' refers to the three-month period following a person dropping out of work on health grounds. During this period, interventions to help the person return to work have a significantly higher chance of success.

benefiting from the existing close relationships with patients that such figures are likely to have, such an approach could help to alleviate the burden on GPs;

- Experts noted that multidisciplinary care (MDC), an approach sometimes used within OH provision involving a team of healthcare professionals with different specialities (e.g. physiotherapy, pain management, counselling, job coaching, OH), was very effective (see section 3.5.1);
- One expert noted that stratified care, another approach sometimes used within OH provision, involving ranking/distinction of patients according to the severity of their condition, was effective when applied to OH in terms of both effective use of resources and achieving better health outcomes (see Section 3.5.2). The expert noted that patients respond better when the intensity of the treatment is tailored to the patient's level of risk (of falling out of the workforce).

Focusing on the employer side of OH, several employer-related elements of OH were identified as being important to it working effectively:

- Research with employers found that informal meetings between employees and line managers with a good understanding of the employee's condition(s) are useful in dealing with employment-related health issues.¹⁶ The success of OH interventions by employers was considered to be highly dependent on how accommodating managers and companies are, as well as how interested they are in helping employees. There is some indication that failure to effectively act on OH advice is often linked to companies having limited funds and/or OH providers giving recommendations perceived as unfeasible by the employer¹⁷. However, research to date has not discovered any further patterns in terms of why individual managers or companies are more or less accommodating;
- Experts noted that trade unions – although not often included in conversations around OH – were thought to have the potential to play a beneficial role in supporting OH interventions due to their interest in employee wellbeing and health and safety, and the fact that union representatives are often the first to raise employee health concerns;
- Experts noted that universities, public sector organisations, and the largest companies tend to have reasonably good OH programmes in place. One key reason suggested for this is that larger organisations are more likely to have specialised HR departments with an understanding of what OH delivers, and/or resources to properly identify and manage risks posed by employee illness and/or injury. Other reasons may include the strategic benefits to such institutions in being seen as champions of good practice with regard to

¹⁶ Understanding the journeys from work to Employment and Support Allowance (DWP, 2015).

¹⁷ Employers' motivations and practices: A study of the use of occupational health services (DWP/DHSC, 2019).

employee wellbeing, the ‘public sector ethos’¹⁸, and higher public sector trade union density.

Looking at what works well in terms of work-related MSK provision, one MSK specialist suggested that employers tend to be less understanding of less visible pain-based conditions than more physically evident conditions. Because of this, facilitating an understanding of pain and its impact on work may be key.

3.4 The OH models

A number of different models emerged from the ‘scoping’ stage of the research. This section provides an overview of each of the models, which are largely drawn from the expert depth interviews, grouping them by individuals’ route of access (access via the employer, direct access, or access through Jobcentre Plus or primary or secondary healthcare).¹⁹ The models comprise:

- Commercially available Employee Assistance Programmes addressing OH;
- Bespoke OH offers tailored to the employer’s workforce;
- More rudimentary, less tailored forms of OH provision;
- Self-service, with direct access to private providers;
- Referrals to specialist provision as part of employment programmes; and
- Individual access to specialist NHS vocational rehabilitation-related support.

Models where the employer facilitates access to OH

The scoping stage of the research identified the following three models of OH provision in which access is provided or facilitated by employers:

3.4.1 Commercially available Employee Assistance Programmes addressing OH

Experts noted that to help fulfil their legal duty of ensuring the health, safety and welfare of employees at work, it is relatively common for employers to offer some form of Employee Assistance Programme (EAP).

While the scope of EAPs is broader than OH – covering counselling, money and debt advice, legal guidance, and childcare information services – EAP advisors may suggest that an employee who has made use of the EAP scheme is referred to an OH specialist. As such, EAPs may function as pathways into OH.

¹⁸ This is the notion that public sector organisations have a particularly strong sense of their responsibility to promote the social good and public wellbeing, which includes the wellbeing of their own workforce.

¹⁹ Some of these were refined or elaborated on using findings from the later stages of the project.

Recent research showed that 16% of employers have EAPs, with this rising to 70% among large employers.²⁰

Perceived prevalence: Employee Assistance Programmes were thought to be relatively common compared to other models, particularly among large employers. This is arguably more of an access pathway to OH provision than a model of OH provision.

3.4.2 Bespoke OH offer tailored to the employer's workforce

The employer provides, and pays for, direct access to multi-disciplinary OH and MSK services to keep their workforce well, with these services being designed around the needs of the employer's workforce.

One expert suggested that the ideal version of this model involves an OH specialist undertaking a workplace analysis to understand the employer's workforce, their typical tasks and likely stresses and strains, and then designing an OH team around these needs. The OH specialist may then continue to review the workforce needs over time and adjust the OH offer accordingly. The tailored OH provision may then be put out to tender, either directly or via a broker, for delivery by a private provider. Alternatively, the initial workplace analysis and tailored provision may be supplied by the same provider.

In some cases, the employer may work with an OH provider to build holistic, prevention-focused provision to support and improve employee welfare – for instance, encompassing the design of the office environment (or even the whole building), flexible working hours, and personal reviews to encourage individual employees to develop positive behaviours.

Experts noted that often bespoke provision exists due to a compelling business case for this type of provision – for instance where lives are at risk if the workforce isn't well enough to perform (e.g. the military, aviation), or there is a great deal of money at stake (e.g. firms in the City, where the aim is that staff rarely have to leave the office to deal with health issues so as to maximise the amount of time highly paid individuals spend working). As touched on in Sections 3.2 and 3.3, it is often only larger organisations that have the necessary resources to establish this kind of provision, with factors such as the strategic benefits in being seen as champions of good practice with regard to employee well-being also influencing the decision to offer this. In the case of the construction sector, where this model is becoming more common, one expert noted that it was largely driven by the sector identifying MSK- and mental health-related problems in the workforce as having a negative impact on profits.

²⁰ Sickness absence and health in the workplace: Understanding employer behaviour and practice: An interim report (DWP/DHSC, 2019)

Perceived prevalence: This type of provision was thought to be long-established but rarer – confined to larger organisations that can see a compelling business case for investing in this.

3.4.3 More rudimentary, less tailored forms of OH provision

The employer contracts and pays for direct access to OH and/or MSK services, but these are limited to relatively 'basic' services required to meet legal obligations, such as health surveillance.

As part of the relatively basic OH offering, providers may also provide more in-depth assessments or interventions on an ad-hoc basis, such as recommending that an employee who has received health surveillance receives further treatment, or responding to a one-off request for a management referral.

In some cases, the 'basic' OH offering may over time expand into a more bespoke offering tailored to the employer's workforce. This could be driven by the identification of more cases of ill-health in the workforce²¹, or simply by the development of a closer relationship with the provider (including an improved awareness of the benefits that OH can offer).

Perceived prevalence: This type of provision was thought to be more common than the bespoke model.

Models which the individual accesses OH support directly

The scoping stage of the research identified the following model of OH provision in which individuals access support directly:

3.4.4 Self-service, direct access to private providers

This model most often involves people self-referring to OH providers to receive statutory medical assessments, required for their jobs, such as in aviation. On rare occasions, people may also arrange, and pay for, their own OH provision to help maintain their own fitness to work – for instance, individuals paying for provision from professionals such as physios, chiropractors, osteopaths, or acupuncturists to manage, for example, pain, other MSK issues, and stress. This is either self-funded or claimed back on healthcare insurance.

Perceived prevalence: Self-referral for statutory medical assessments was thought to be relatively common, while self-referral to maintain fitness to work was thought to be rare.

²¹ Employers' motivations and practices: A study of the use of occupational health services (DWP/DHSC, 2019).

Models which the individual accesses via referrals either from Jobcentre Plus or via the NHS

The scoping stage of the research identified the following models of OH provision and work-related treatment services in which individuals access support through referrals either from Jobcentre Plus or from primary or secondary healthcare:

3.4.5 Referrals to specialist provision as part of employment programmes

This provision is linked to JobCentre Plus (JCP), sometimes part-funded by the European Social Fund (ESF). Such services may include specialist help for unemployed people in coping with health conditions in the context of work, alongside other forms of support such as training and skills-development, and extra money to help with the costs of starting work. Specialist help may take the form of collaboration with local NHS bodies to provide occupational therapy, physiotherapy, counselling, and other services to jobseekers with health conditions and disabilities. Experts noted that such specialist provision is, however, very inconsistent, with some geographic areas having far more of this sort of provision than others.

Perceived prevalence: This type of provision was thought to be inconsistent – it was more common in some parts of the country than others.

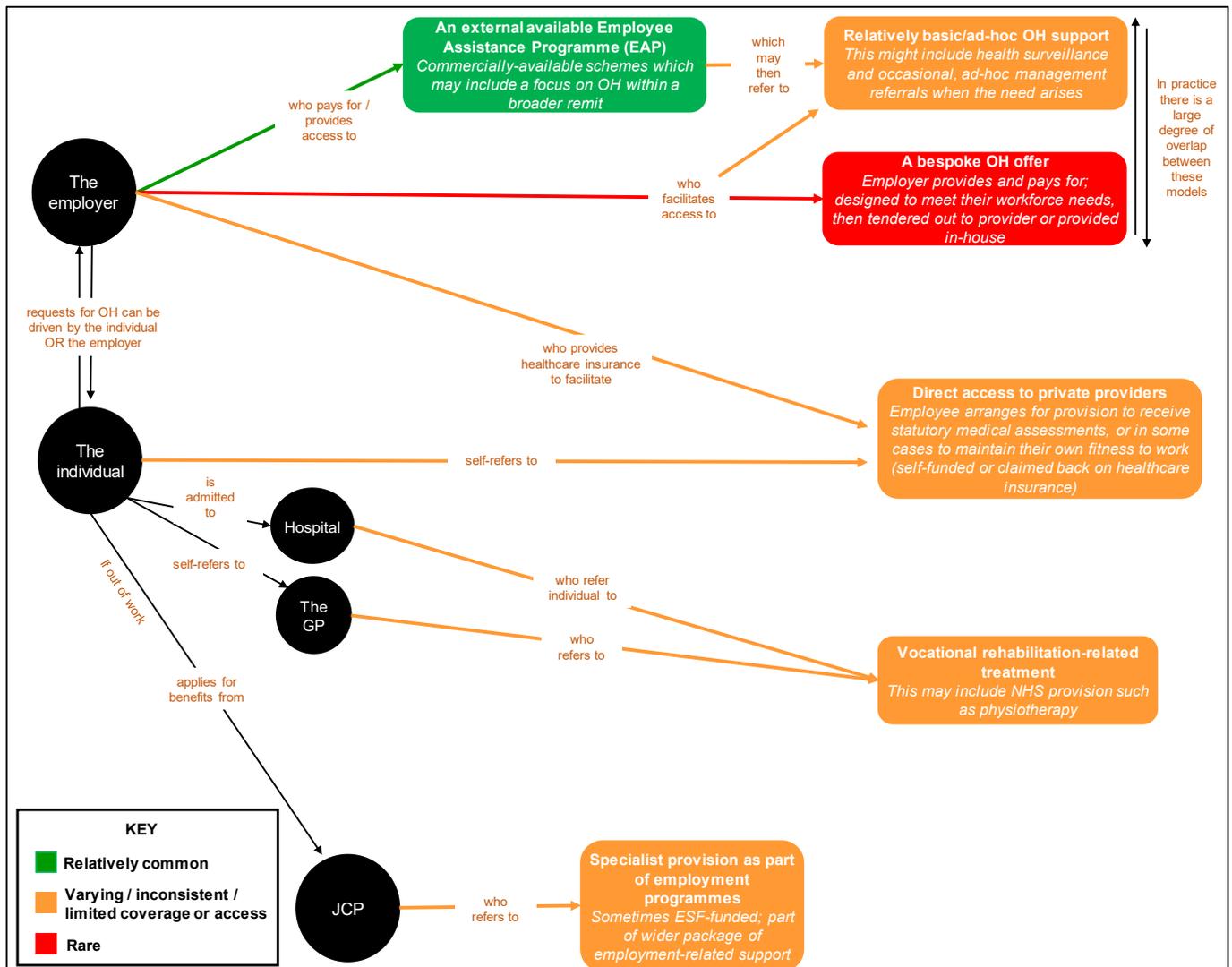
3.4.6 Individual access to specialist NHS vocational rehabilitation-related support

The scoping stage of the research also highlighted cases in which individuals access physiotherapy or other vocational rehabilitation-related treatment services via the NHS. While these services are not work-specific, individuals may access them with the aim of helping to keep them in or return them to work. Individuals may first self-refer to their GP or to an NHS physiotherapist, before being referred onward to secondary care.

3.4.7 An illustration of pathways to different forms of work and health support

The models and pathways identified in the scoping stage of the research are summarised pictorially in Figure 3.1:

Figure 3.1: An illustration of pathways to different forms of work and health support



3.5 Examples of approaches to delivering better OH outcomes

In addition to identifying models of OH provision, the expert in-depth interviews and the literature review also identified some approaches to delivering better OH outcomes. These are not provision models or services in themselves, but are instead ways of initiating conversations with individuals that might lead them towards OH

support, or ways of making OH support more effective.²² This section provides an overview of these approaches, arranged by primary delivery point (either healthcare professional-focused, both healthcare professional- and community-focused, or employer-focused).

Healthcare professional-focused approaches

The scoping stage of the research identified the following two approaches to delivering better OH outcomes which are implemented by healthcare professionals:

3.5.1 Multi-disciplinary care

As previously described, one expert noted that multidisciplinary care (MDC) was very effective when applied to OH. MDC isn't necessary focused on work or OH, but is an approach that can be applied to OH delivery. Experts noted that the following features were important to effective MDC:

- Different specialists getting together in person to discuss the patient's care plan is important.
- It is important that one element of the MDC team takes responsibility for case management – leading, and taking control of, the treatment plan.
- It is important that there is communication and integration between different branches of care, including awareness of the skills of other members of the team and an ability to adjust care across the team depending on changing patient needs.

Expert interviewees have suggested that MDC is effective when applied in an OH context because OH professionals tend to be generalists who benefit from the support of specialists, and because dividing OH responsibilities between teams with different specialisations is more resource efficient and enables a more concentrated focus on specific aspects of care. However, experts also noted that there are mixed feelings among OH practitioners about MDC – while its effectiveness is appreciated, they are concerned about different branches of care 'treading on one another's toes', care becoming too disparate, contradictory advice, and advice or treatment being repeated.

3.5.2 Stratified care approach

A stratified care approach delivers an appropriate level of care depending on the intensity of an individual's condition. This ensures cost-effectiveness, as appropriate treatment is received without affecting patient outcomes. A stratified care approach can thus be useful for allocating resources and alleviating the burden on stretched services and GPs.

²² Some of these were refined or elaborated on using findings from the later stages of the project.

'STaRT Back'²³ is an example of a service that applies the stratified care approach. This is a screening tool (with nine questions) which stratifies patients with lower back pain into three tiers of disability risk (low, medium, high): a recommended / 'matched' treatment approach for each tier is then provided. The approach was developed by the Research Institute for Primary Care & Health Sciences at Keele University, and there is evidence that a key contributor of the approach's effectiveness was found to be stratifying patients in terms of risk, leading to more targeting interventions.²⁴

While the stratified care approach is not necessarily linked to OH, experts identified it as an approach which could be applied within models to increase their efficacy.

Broader healthcare professional- and community-focused approaches

The scoping stage of the research identified the following approaches to OH provision which are implemented by a mixture of both healthcare professionals and individuals working in health-related roles in the wider community:

3.5.3 Making Every Contact Count (MECC)

Making Every Contact Count (MECC) is training for those working in a public-facing health-related role, to help them to use the everyday interactions they have with members of the public to support them in making positive changes to their health and wellbeing, particularly health behaviours like smoking. Experts noted that the MECC approach is a potential opportunity for healthcare professionals to initiate supportive conversations about health and work – which is notable given that, as discussed in Section 3.3, primary care providers who have pre-existing relationships with patients (e.g. pharmacists, high-grade nurses) tend to have more productive interactions with patients about health and work than more unfamiliar healthcare professionals. MECC interactions typically serve to initiate further support or action so could be a first step towards OH support. MECC training is delivered by organisations in-house, with the assistance of E-Learning and other resources collected on the MECC website. MECC is a collaboration between multiple parties: NHS England, Health Education England, Public Health England and local authorities, among others.²⁵

3.5.4 Pain management programmes/self-management focused rehabilitation

This approach combines educational self-management, coping strategies and an individualised exercise plan in the management and alleviation of long-term health

²³ Keele University. 2018. STaRT Back. [ONLINE] Available at: <https://www.keele.ac.uk/sbst/startbacktool/>

²⁴ Hill, J.C et. al (2011) Comparison of stratified primary care management for low back pain with current best practice (STaRT Back): a randomised controlled trial. *The Lancet*, 378 (9802), 1560-1571.

²⁵ Information sourced from the Making Every Contact Count website: <http://www.makeeverycontactcount.co.uk/>

conditions. An example of this approach is the ESCAPE-pain programme²⁶, which applies self-management focused rehabilitation to individuals with chronic joint pain, specifically adults aged 45+ with osteoarthritis. It combines education with an exercise regime, and has been delivered in hospital out-patient departments and a range of community settings.

Several studies by Hurley et al (e.g. 2007,²⁷ 2009,²⁸ 2010²⁹) have provided evidence for the ESCAPE-pain programme in terms of: reduced pain; increased physical and mental function; its cost-effectiveness compared with usual outpatient physiotherapy and usage of other services; its potential for helping to delay or avoid surgery; and its ability to reduce the risk of developing or exacerbating comorbid conditions.

While self-management focused rehabilitation is not necessarily linked to OH, it is another approach which could be applied within models to increase their efficacy.

Employer-led approaches to support employees

Employers may use a range of activities and policies to achieve better OH outcomes. While there is a very broad range of different activities or policies that employers could apply, a number of these can be grouped under the concept of sickness support/attendance management. These activities or policies may interact with, or supplement, OH models. Given the range of potential activities and policies that could be included under sickness support/attendance management, only a few examples are covered below.

3.5.5 Sickness support/attendance management

Sickness support/attendance management is a set of in-work processes and activities that support and educate staff with the aim of reducing the amount of sickness leave. The range of processes and activities used by employers may vary, but examples could include incentive schemes for full attendance at work; or programmes of talks/activities about, for instance, avoiding back pain at work. These programmes of talks/activities might take the form of, for example, talks from physiotherapists or Pilates lessons.³⁰

'Back to work' interviews are also sometimes used to assess reasons for long-term sickness absence and interventions that could be made to help; this could lead to

²⁶ Escape pain. 2018. Enabling Self-management and Coping. [ONLINE] Available at: <http://www.escape-pain.org/>

²⁷ Hurley, M. V. et al (2007) Clinical effectiveness of a rehabilitation program integrating exercise, self-management, and active coping strategies for chronic knee pain: a cluster randomized control trial. *Arthritis and Rheumatism*, 57 (7), 1211-1219.

²⁸ Hurley, M. V. et al (2009) Effectiveness and clinical applicability of integrated rehabilitation programs for knee osteoarthritis. *Current Opinion in Rheumatology*, 21, 171-176.

²⁹ Hurley, M. V. et al (2010) Health beliefs before and after participation on an exercise-based rehabilitation programme for chronic knee pain: Doing is believing. *BMC Musculoskeletal Disorders*, 11 (31), 1471-2474.

³⁰ Improving Lives: Work, Health and Disability Green Paper (DWP/DoH, 2016).

referral to OH or MSK professionals.³¹ The Bradford Factor³² is sometimes applied to assess staff with ‘problematic’ levels of sickness: on the basis of this, a sickness support/attendance management procedure may be initiated with involvement of OH to provide support to increase attendance.³³

One expert suggested that attendance incentives ‘pay for themselves’ in terms of reducing the amount of absence, with an incentive scheme for full attendance, accompanied by a programme of talks and activities about avoiding back pain, having significantly reduced sickness absence³⁴ and promoted a ‘culture of wellbeing’ in a case study conducted by Healthy Working Lives, NHS Scotland.³⁵

However, sickness support/attendance management approaches can be applied on discretionary basis in a way that advantages longer-serving employees; e.g. employees in their probation period may be more likely to see their contract terminated after period of sickness absence than be referred to an OH professional.³⁶ Additionally, such approaches tend to cater more to full-time employees; there is less chance of OH referral among staff working part-time, flexible or limited hours.³⁷ Their use is more common among public sector organisations and medium/large private companies.³⁸

3.6 How the ‘scoping’ stage findings were used

The expert in-depth interviews and the literature review helped to identify several potential models of OH provision, along with a number of approaches which could be applied within these models. In addition, this stage of the project established a historical background to OH provision in the UK, and highlighted expert views both on perceived gaps/weaknesses in existing provision and on what ‘works well’.

This contextual information was used to help develop the research materials used in later stages of project, as well as providing a frame of reference when conducting fieldwork and analysing emerging findings.

³¹ Understanding the journeys from work to Employment and Support Allowance (DWP, 2015).

³² The Bradford Factor is a tool used for measuring the impact of employee absence on an organisation. A score is calculated for an individual employee by taking into account the total number of instances of absence, and the total number of days of absence, for that individual over a set period.

³³ Ibid.

³⁴ It should be noted that reducing sickness absence is not in itself a mark of a successful OH scheme, as such a development may be indicative of ‘presenteeism’ – people coming into work when they are unwell.

³⁵ Healthy Working Lives Case Study, NHS Scotland in Improving Lives: Work, Health and Disability Green Paper (DWP/DoH, 2016).

³⁶ Understanding the journeys from work to Employment and Support Allowance (DWP, 2015).

³⁷ Sickness absence and health in the workplace: Understanding employer behaviour and practice: An interim report (DWP/DHSC, 2019)

³⁸ Ibid.

4 Private providers' OH offer

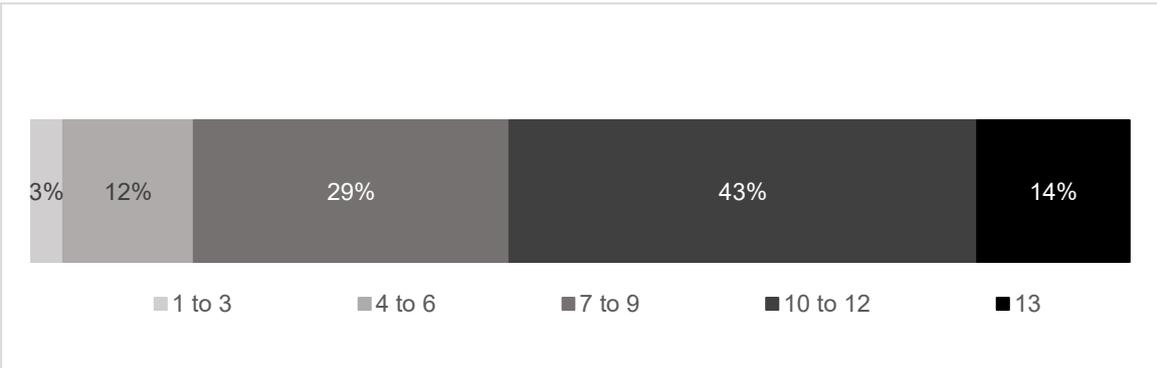
A total of 103 private providers of OH were surveyed by telephone to understand:

- the services they offer (Section 4.1);
- their capacity to provide those services (Section 4.2);
- who commissions services and why, including payment structures (Section 4.3);
- how their provision interacts with the employer, the line manager and the individual (Section 4.4);
- how their provision interacts with the NHS (Section 4.5);
- how service quality is monitored (Section 4.6);
- and how they market their services (Section 4.7).

4.1 Services and packages offered

Overall, private providers of OH offered a wide range of services. Over half (56%) offered 10 or more services, with only 3% offering fewer than 4 services (Figure 4.1). On average, providers offered 9-10 different occupational health services³⁹. There was a general trend that the bigger the provider, the more likely they were to offer a wider range of services; however, this was not statistically significant.

Figure 4.1: Number of services offered by OH providers



Base: All OH providers who participated in private providers survey (103)

The most commonly offered services were advice about workplace adjustments or return to work plans (offered by 94% of providers), assessment of fitness for work for ill employees (offered by 90% of providers) and pre-employment or post-offer of employment health assessments (offered by 88% of providers).⁴⁰

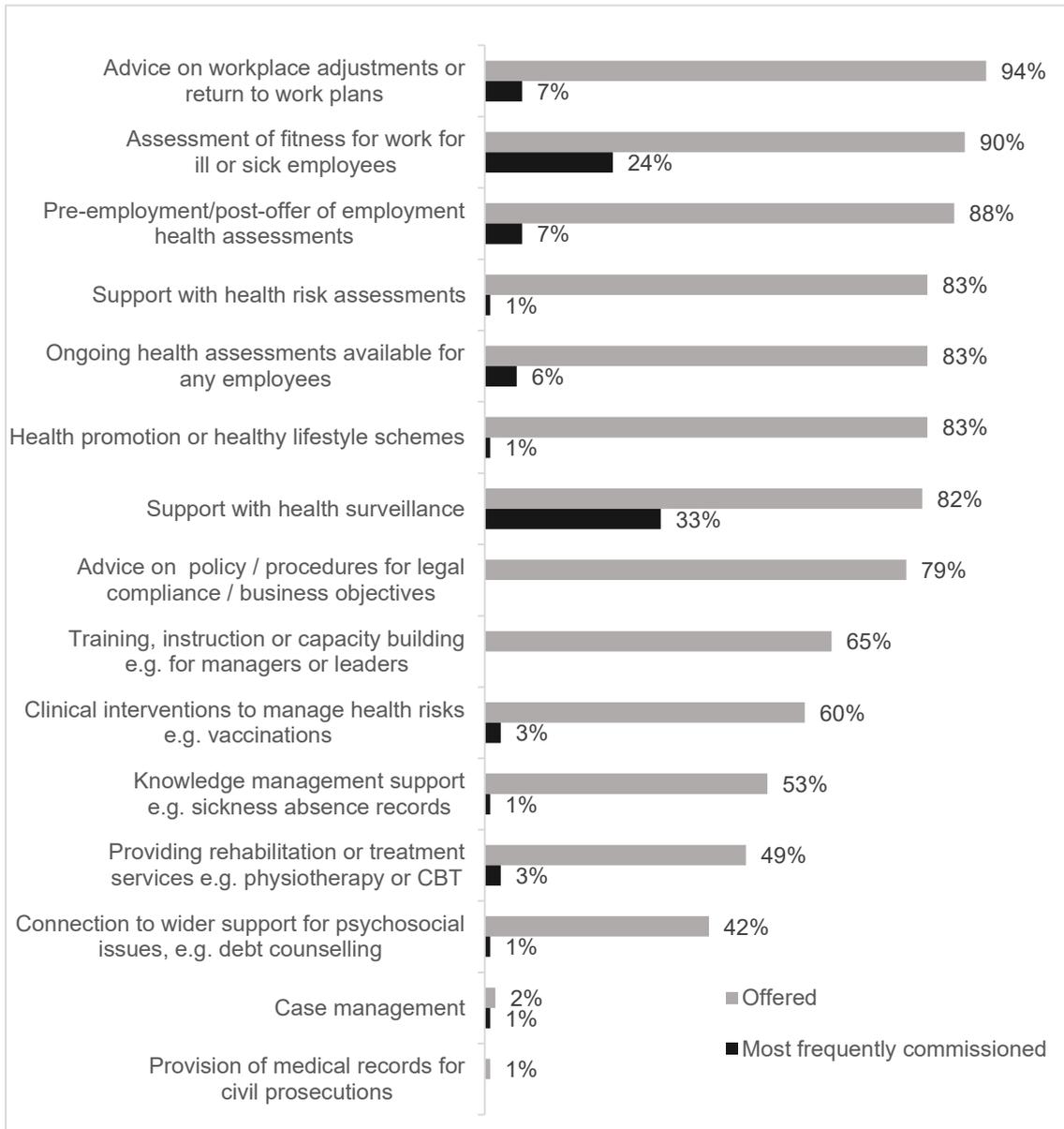
³⁹ See Appendix 8.16 for mean number of services offered

⁴⁰ See Appendix 8.16 for full list of services offered

Understanding the provision of occupational health and work-related musculoskeletal services

When asked about the most frequently used services, two were notably more common: one-third (33%) of providers reported that support with health surveillance was the most frequently used service, and one-quarter (24%) reported assessment of fitness for work was the most frequently used service. All other services were only the most frequently used for 7% of providers or less (Figure 4.2).

Figure 4.2: Services offered by and most frequently commissioned from OH providers



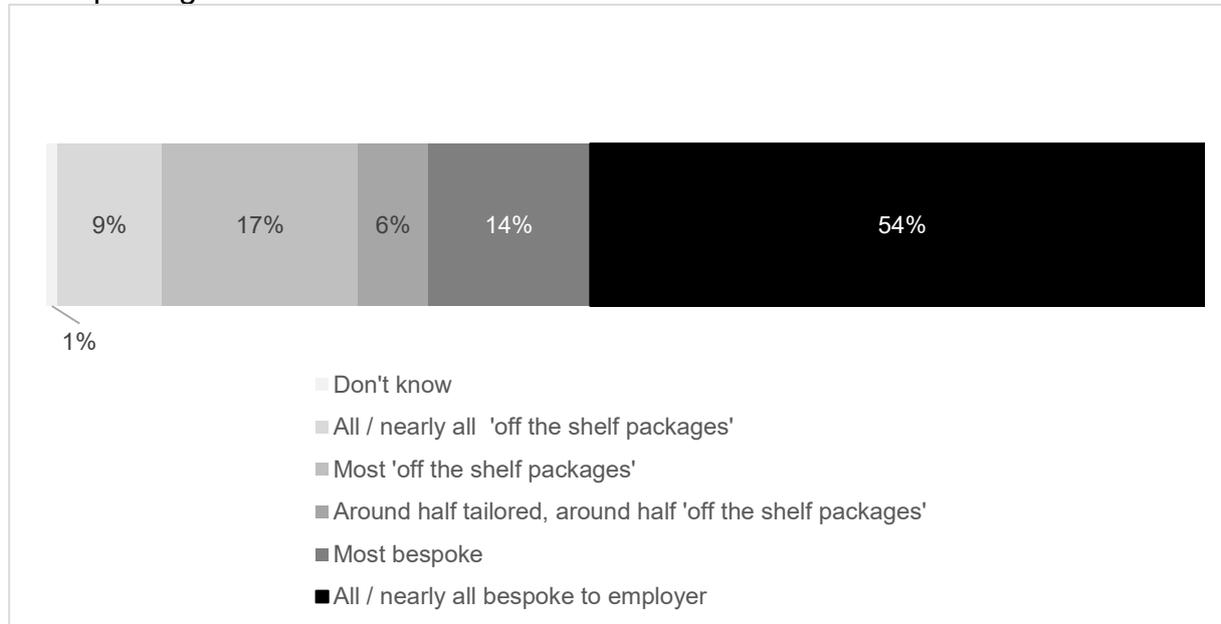
Base: 'Offer': All OH providers who participated in private providers survey (103), 'Most frequently commissioned': those that offer more than one service (102).

This breadth of services was reflected in the variety of 'off the shelf' packages⁴¹ offered to employers. Just under half (45%) of providers offered 'off the shelf'

⁴¹ This research defines 'off the shelf' packages as provision that is not designed especially for a particular employer, but instead is offered as an option to all employers as a pre-defined package.

packages to employers at least some of the time, and for one-quarter (25%) of providers most or all their OH provision was delivered through these packages (Figure 4.3).

Figure 2.3: Amount of provision for employers which is bespoke and / or 'off-the-shelf' packages

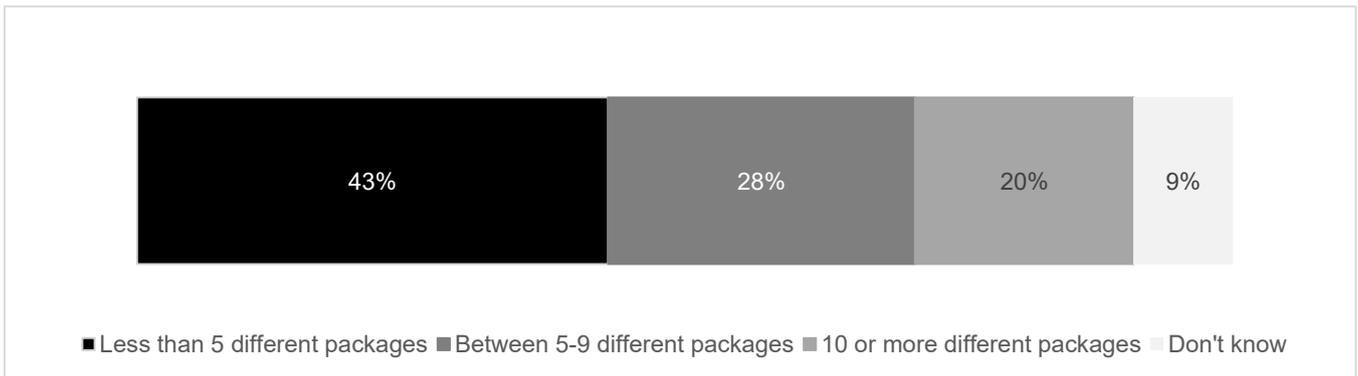


Base: All OH providers who participated in private providers survey (103)

The majority of those who offered 'off-the-shelf' packages (83%) had multiple package options. Of those who offered 'off the shelf' packages, on average five⁴² different packages were offered. That said, 43% of those who offered 'off the shelf' packages offered less than five, 28% offered between five and nine, and a fifth (20%) offered 10 or more (Figure 4.4).

⁴² 5 was the median average number of packages, mean average was 9

Figure 4.4: Number of ‘off-the-shelf’ packages



Base: OH providers that offer ‘off-the-shelf’ packages (46)

Private providers were keen to stress that even when delivering their services through packages, the package would always be somewhat tailored to the specific needs of the employer. The needs of the employer often varied according to industry and the health issues of the employee, for example fitness for work assessments may include asbestos medicals for construction workers, or eye tests for delivery drivers. Because of the level of tailoring, there were no clear patterns of common packages offered by providers (i.e. none of the packages seemed to recur among the sample of providers).

Case study – example of how a provider tailors OH services to employer needs

One private OH provider explained how they determined the services they currently provide to a pharmaceutical company. The pharmaceutical company initially contacted them with a view to implementing health surveillance linked to industry-specific risks to employees. The OH provider worked to implement this service across the company, and then moved on to identify learnings from their experience. In this case, the provider made a recommendation around tackling resilience in the workforce.

They explained how this was typical of how they work with employers:

“We try and, sort of, tailor it right from the word go really as to what they need. Implementation means we go through quite a lot, you know, what's worked well before; what they feel they would need going forwards. Then obviously from our own data, from our management information reports we'll put extra packages together and put them into our reports as recommendations.”

Employer budget is also taken into consideration by the OH provider during this process. For instance, they may suggest a short pre-recorded webinar to train line managers for employers with a limited budget, while for other employers they would suggest a more comprehensive face-to-face workshop.

Amongst those who offered multiple ‘off-the-shelf’ packages, the most common features in their most popular packages were; face to face consultations with

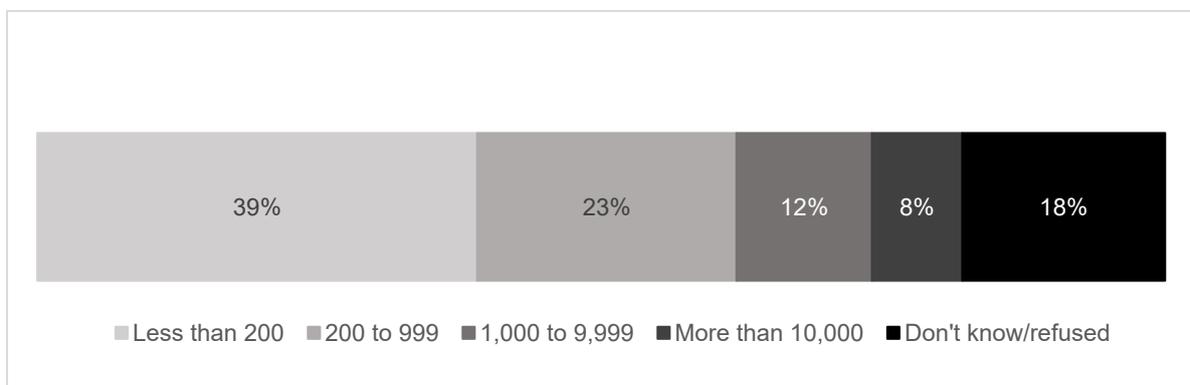
employees, health surveillance, health assessments and safety critical assessments. These were most commonly delivered by OH nurses and OH doctors. However, face to face consultations were the only aspect that featured consistently in the packages on offer. None of the other aspects featured consistently, indicating a wide disparity in packages.

Most OH providers that offered 'off-the-shelf' packages had no eligibility criteria for those packages. Where eligibility criteria did exist, this was based around what the package was designed for, for example workers or businesses in specific high-risk industries.

4.2 Capacity

A substantial proportion of private providers had relatively small-scale capacity: four in ten (39%) had the capacity to provide OH support to fewer than 200 individuals at any one time (Figure 4.5). As might be expected, there was a relationship between the size of provider and their capacity: bigger OH providers had a larger capacity (8% of OH providers had capacity to provide OH services to more than 10,000 individuals, most of these had more than 200 employees).

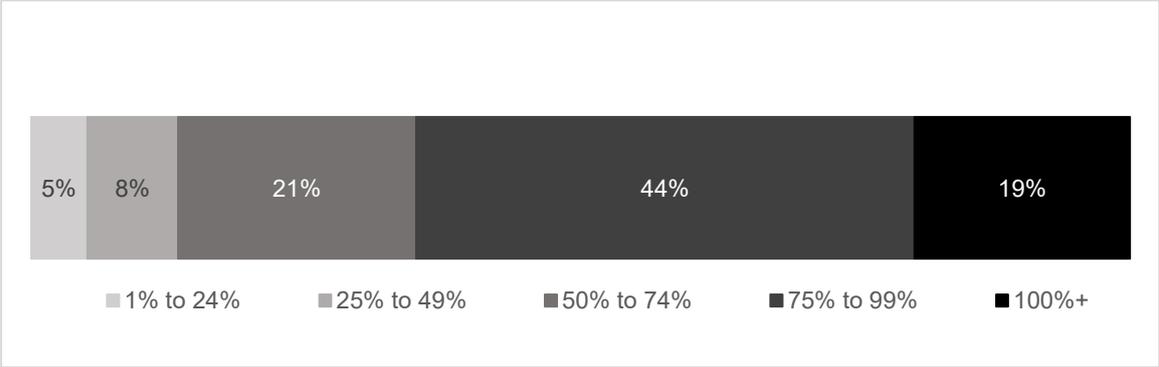
Figure 4.5: Capacity of OH providers in terms of number of individuals they could provide support to at any one time



Base: All OH providers who participated in private providers survey (103)

Of the available market capacity, 89% had been taken up over the last 12 months. Around one-fifth (19%) of providers had 100% of their capacity taken up over the last 12 months (Figure Figure4.6). Only 1% indicated they exceeded their capacity.

Figure 4.6: Proportion of capacity taken up during previous 12 months



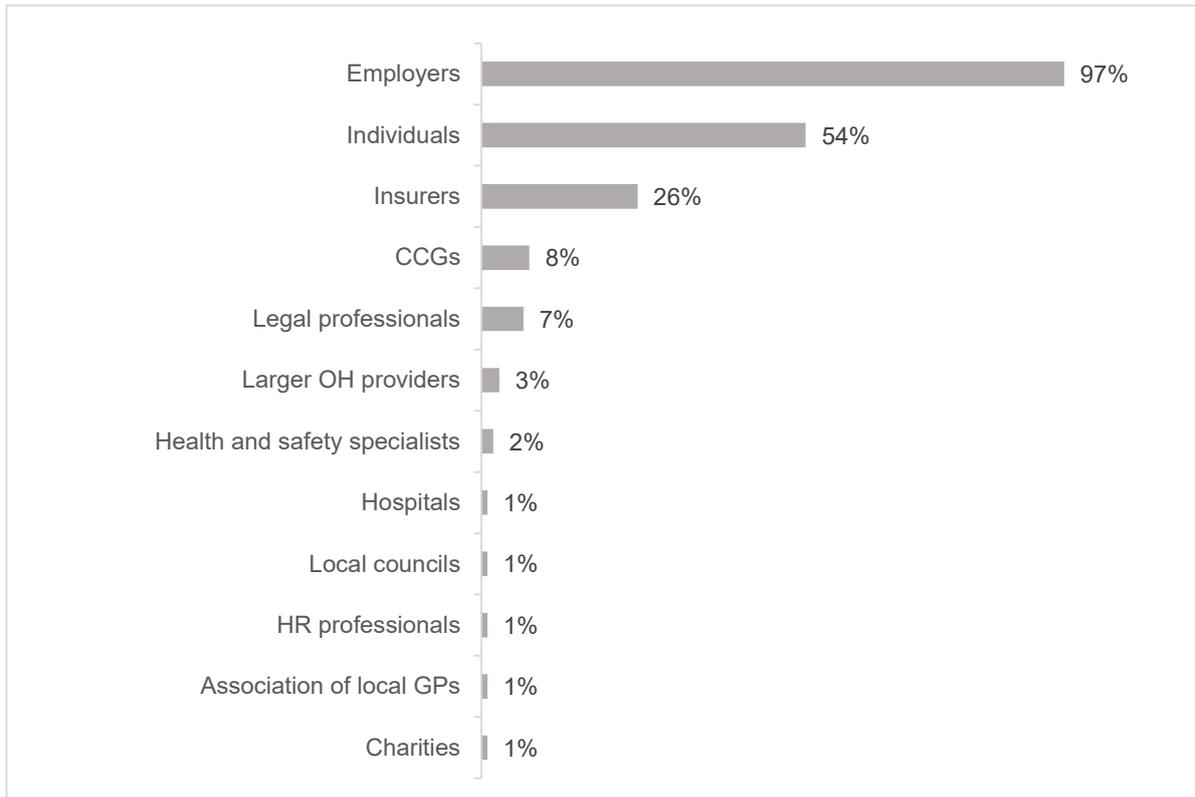
Base: OH providers who participated in private providers survey able to report maximum number of individuals able to provide services for (84)

Smaller providers with under 10 employees, and those who offered less than 10 types of services, were those particularly likely to have had less than a quarter of their capacity taken up (10% such providers compared to none of the providers with more than 10 employees or those that offered more than 10 types of services).

4.3 Commissioning

Almost all private OH providers (97%) had some services commissioned by employers⁴³, around half (54%) by individuals and a quarter by insurers (26%) (Figure 4.7).

Figure 4.7: Who commissions services or interventions from OH providers



Base: All OH providers who participated in private providers survey (103)

A relationship exists between services offered by the provider, and who they are commissioned by. For example, assessment of fitness for work for ill or sick employees is significantly more likely to be offered by those providers who have services commissioned by individuals (96% of providers that were commissioned by individuals offered this, compared to 83% of those who are not commissioned by individuals), as is pre-employment fitness for work assessments (95% vs. 81%) and support with health surveillance (93% vs. 68%).

4.3.1 Commissioning by employers

Providers felt employers had two main motivations for commissioning their services (Figure 4.8). These were:

⁴³ The remaining 3% were more specialist providers that were only commissioned by one of the other types of customers, e.g. individuals or CCGs.

Understanding the provision of occupational health and work-related musculoskeletal services

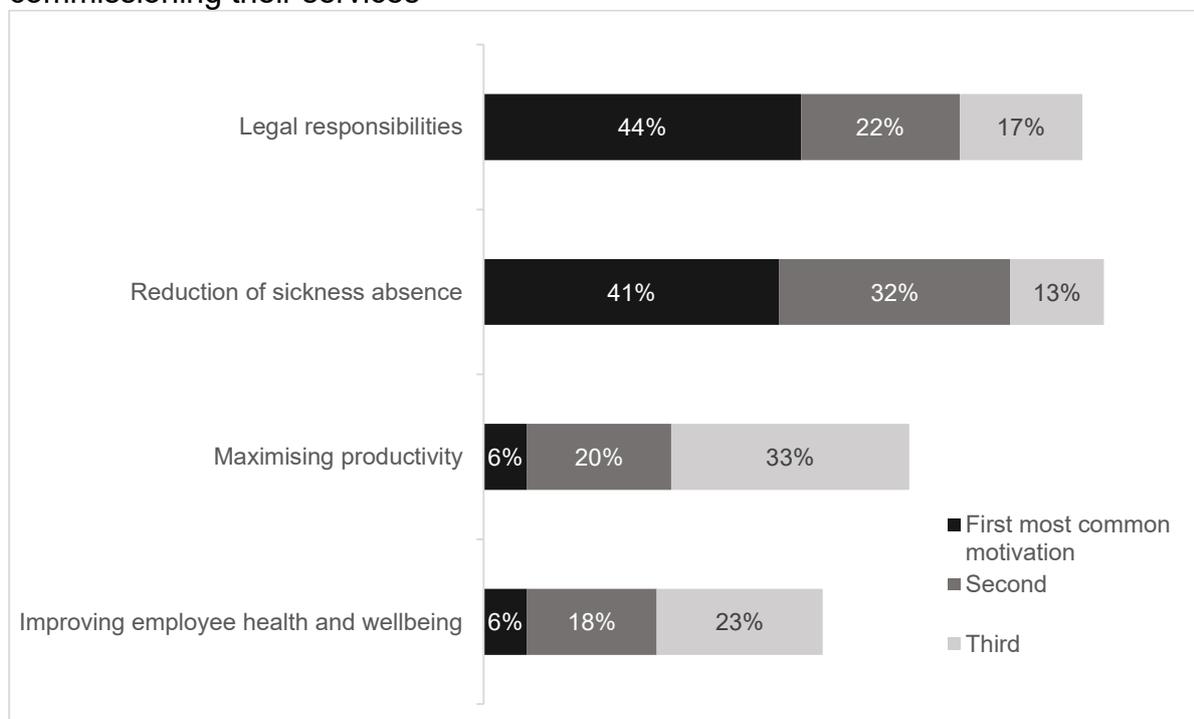
- Meeting legal responsibilities (44% of providers commissioned by employers said this was the most common motivation); and
- Reducing sickness absence (41% said this was the most common motivation).

Common secondary motivations for employers were:

- Maximising productivity (second most common motivation for 20% of providers, third most common for 33%); and
- Improving employee health and wellbeing (second most common motivation for 18% of providers, and third most common for 23%).

These findings corroborate findings from a previous piece of research into motivations for commissioning OH services amongst employers⁴⁴.

Figure 4.8: OH providers views on the most common motivations employers have for commissioning their services



Base: OH providers who have services commissioned by employers (100)

A third (34%) of OH providers had been commissioned by 50 or more employers over the preceding 12 months to provide OH services or interventions. On average, OH providers had been commissioned by 90 employers, and the median OH provider had been commissioned by 30 employers. OH providers with 10 or more employees were at least twice as likely to have worked with 50 or more employers compared to their smaller counterparts (52% compared to 21%). Similarly, those who offered ‘off-the-shelf’ packages were twice as likely to have worked with 50 or more employers as those who did not (46% compared to 23%); on average those with off the shelf

⁴⁴ Employers’ motivations and practices: A study of the use of occupational health services, page 22 (DWP/DHSC, 2019).

packages worked with 135 employers compared to 47 amongst those that did not offer such packages.

On average, 51%⁴⁵ of the employers commissioning OH services from providers were small or medium enterprises (SMEs). According to the Department for Business, Energy and Industrial Strategy 2018 business population estimates, 99.9% of UK businesses are SMEs. This suggests that SMEs are under-represented in the OH provider customer base, and that large employers are considerably more likely to commission OH services; a finding which corroborates previous DWP research.⁴⁶ Furthermore, one in ten (10%) OH providers commissioned by employers had not been commissioned by any SMEs in the last 12 months. This pattern was particularly pronounced in the small sample of medium and large OH providers (n=10)⁴⁷ surveyed: six out of ten of these providers had not been commissioned by any SMEs in the preceding 12 months.

4.3.2 Commissioning by other types of customers

Around half (54%) of OH providers had some services commissioned by individuals (Figure 4.7). The most common reasons OH providers were aware of for individuals contacting them directly was for statutory medicals (39%) and safety-critical assessments (29%), which corroborates the previous finding that providers commissioned by individuals were more likely to offer fitness for work assessments, as statutory medicals and safety-critical assessments may prove or contribute to someone's fitness for work (Section 4.3). These were usually in the context of self-employed individuals, or those looking for work who wanted to show potential employers they were safe to work in the role. Only a minority (16%) of OH providers that were commissioned by individuals reported that lack of support or conflict with an employer was a motivation for individuals to contact them directly.

A quarter (26%) of OH providers had been commissioned by insurers, and only 8% of OH providers had some services commissioned by CCGs.

4.3.3 Service level agreements and payment structures

Most OH providers (86%) sign service level agreements when clients commission their services, although only three in ten (31%) sign them every time they are commissioned. There was wide variation in what was included in service level agreements due to the high level of tailoring to each employer. At a general level, these agreements tended to include timescales for delivery, confirmation of costs, and details on confidentiality of data storage.

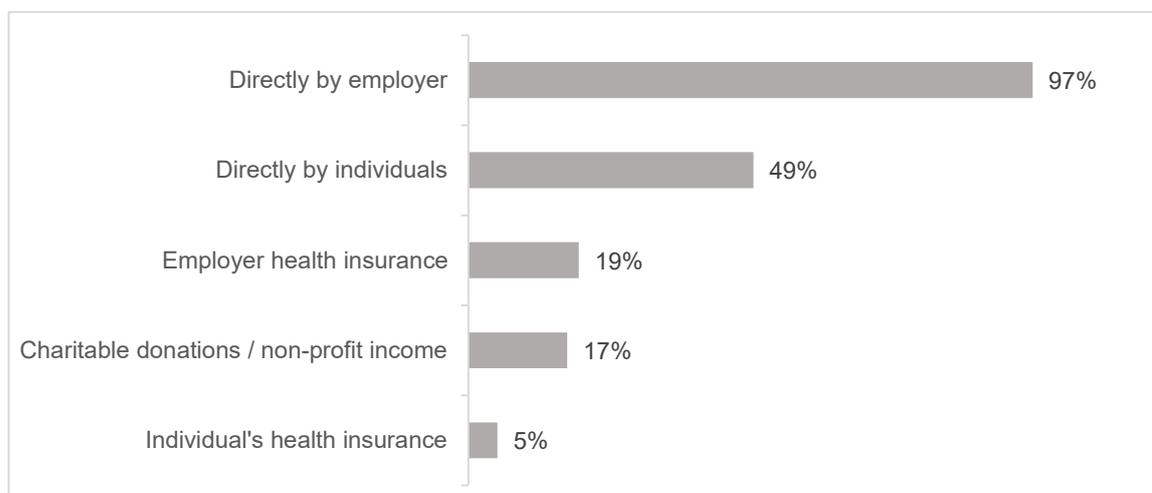
⁴⁵ Based on the mean average of providers' estimates of proportion of employers that commission their services that are SMEs

⁴⁶ Sickness absence and health in the workplace: Understanding employer behaviour and practice (DWP/DHSC, 2019).

⁴⁷ The base of this question is OH providers that were able to provide an estimate of the total number of employers that had commissioned their services in the last 12 months

Payment structures for OH services followed a similar pattern to commissioning (see sections 4.3.1 and 4.3.2). Almost all (97%) of providers had been paid for OH services directly by employers (Figure 4.9), and half (49%) had been paid directly by individuals. This rises to 82% amongst those who have services commissioned by individuals. Payment for OH services via health insurance was relatively low compared to other payment structures: one-fifth (19%) of providers had provided services that were funded by an employer's health insurance and one in twenty (5%) had provided services funded through an individual's health insurance. Around a fifth (17%) had provided services that were funded through charitable donations.

Figure 4.9: Payment structures which OH providers services are paid through



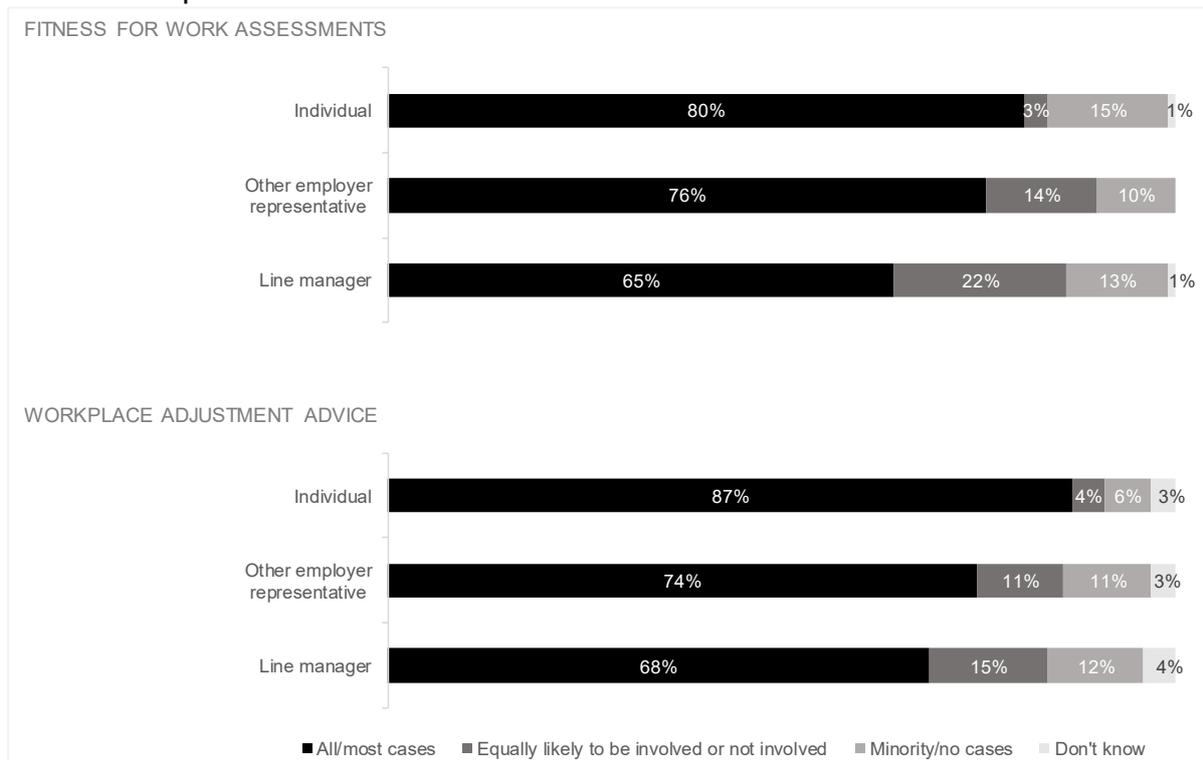
Base: All OH providers who participated in private providers survey (103)

4.4 Involvement of employers, line managers and individuals

Private OH providers were asked about the extent to which line managers and other employer representatives (e.g. HR) were involved in two OH services: assessment of fitness for work; and workplace adjustments or return to work advice (Figure 4.10). Nine in ten OH providers reported that an employer representative (whether a line manager or another representative) was involved in most or all cases (90% for assessment of fitness for work; 88% for workplace adjustments).

Line managers were often involved in assessments of fitness for work and workplace adjustments/return to work advice, although not all the time. 65% and 68%, respectively, of providers reported that line managers were involved in assessments of fitness for work and workplace adjustments/return to work advice in most or all cases.

Figure 4.10: Involvement of line manager, other employer representatives and the individual in provision of OH services



Base: 'Fitness for work assessments' OH providers who offer fitness for work assessments (93), 'Workplace adjustment advice' OH providers who offer workplace adjustment advice (97)

Line managers' involvement was usually limited to the point of referral at the start of the process, for example filling out referral forms, and at the end when line managers are given the final advice and recommendations via a report. OH providers were very aware of the importance of the line manager-employee relationship: line managers had a strong understanding of the requirements of the role of the employee, so were well-placed to discuss options and implement advice.

Additionally, as described in the case studies of OH support (see appendix) line managers in the vast majority of cases act as the 'gatekeeper' for these services, as company processes often require referrals to OH through the line manager and individuals are not able to refer themselves. However, providers noted that the success of line manager involvement varied enormously according to the extent of the line manager's engagement with and understanding of OH and the employee's health issues.

Case study – example of impact of a supportive line manager

A supportive line manager can speed up the process through which an employee's health issue is dealt. One employee explained how his line manager approached him to check he was ok after noticing he wasn't his usual self, which transpired to be due to lack of sleep linked to anxiety. The employee noted that this conversation would not have happened with previous line managers.

"[My line manager] basically said I could come and see him anytime I like if there's anything on my mind. He got me an appointment with the company doctor."

This understanding and proactivity from the line manager meant he was able to access counselling within 3-4 weeks of the symptoms occurring via occupational health, whereas if he had gone through the NHS he was told by his GP that he would have needed to wait for two years.

Case study – example of impact of an unsupportive line manager

One case study illustrated how an unsupportive line manager can prove not only to be an obstacle to resolving issues, but can also be a factor in worsening issues.

The employee was suffering from stress caused by an increase in workload following the departure of a colleague, combined with caring responsibilities for a sick family member. When she initially approached her line manager, it seemed from the line manager that there weren't any adjustments or solutions to be found; reducing workload or going part-time were not possible, and the only alternative to the current situations was for her to quit her job or to place her relative into full-time care:

"She was quite understanding, but odd comments kept creeping in, like 'I'm not sure you'll be able to work anymore', so it quite put me off...I don't feel the sympathy's there with her [the line manager] particularly."

This led the employee to use annual leave and compassionate leave to cope with caring demands, and only once this was used up did she get referred to OH. Once in touch with OH, it became clear to the employee that part-time working options were feasible, and she subsequently put in a request to move to this working arrangement.

Due to her previous experience, the employee was concerned about the line manager's reaction to her request to move to part-time work, so requested that the line manager would not receive the OH report.

"I'm going to come up against a brick wall with her, once I put a request in."

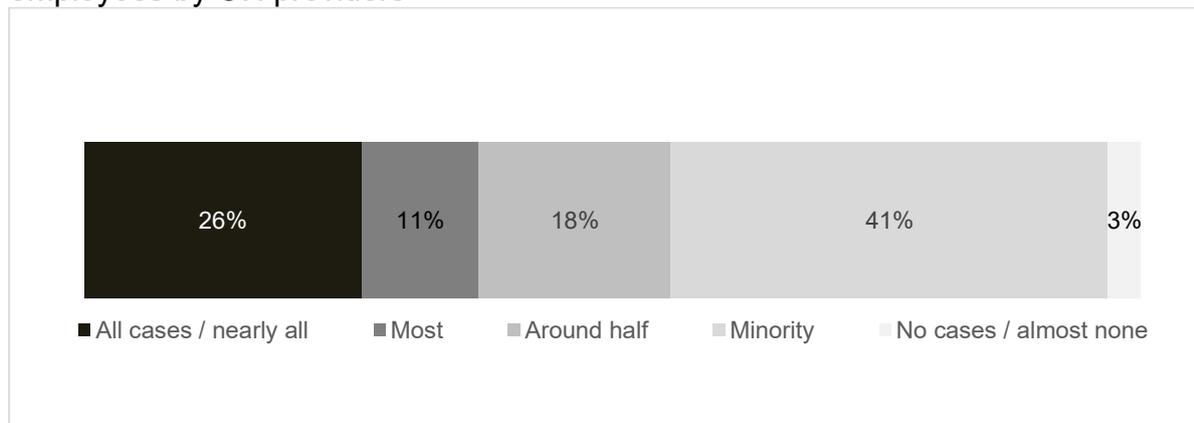
Other representatives of the employer (e.g. HR staff) were also frequently involved: three-quarters of providers reported they were involved in most or all cases (76% for assessment of fitness for work, and 74% in advice about workplace adjustments or return to work). Again, many OH providers mentioned that the success of this involvement varied according to employer understanding of OH. OH providers also pointed to the importance of employers making it clear to all staff how to access OH support and in what circumstances, in ensuring the success of OH support.

Understanding the provision of occupational health and work-related musculoskeletal services

The most common involvement of other employer representatives would only be at the point of receipt of the advice and/or suggested workplace adjustments. Involvement of individuals was mostly based around one-to-one involvement with the provider, e.g. when the assessment was conducted, and they may also be asked to review the resulting report.

Follow up support to employers, line managers or individual employees was not widespread. Only 37% of OH providers delivered follow up support in all or most cases (Figure 4.11).

Figure 4.11: Provision of follow up support to employers, line managers or individual employees by OH providers



Base: All OH providers who participated in private providers survey (103)

The decision on whether to deliver follow up support was often made on a case by case basis, based on whether the OH provider deemed it to be necessary. When follow up support was provided, the timescales of the follow up varied according to the situation or the health condition of the employee.

Case study – example of impact where follow-up support was deemed necessary

Overall, the case studies showed that follow-up support was not widespread and was determined on a case-by-case basis.

One example where the OH provider decided to provide follow-up support, in the form of monthly appointments with the employee, was because the OH provider felt a duty of care to ensure the employee was coping. While his primary issue had been a workplace injury, the employee had developed social anxiety as a result of complications from the injury. This had resulted in a two-and-half-month period of sickness absence.

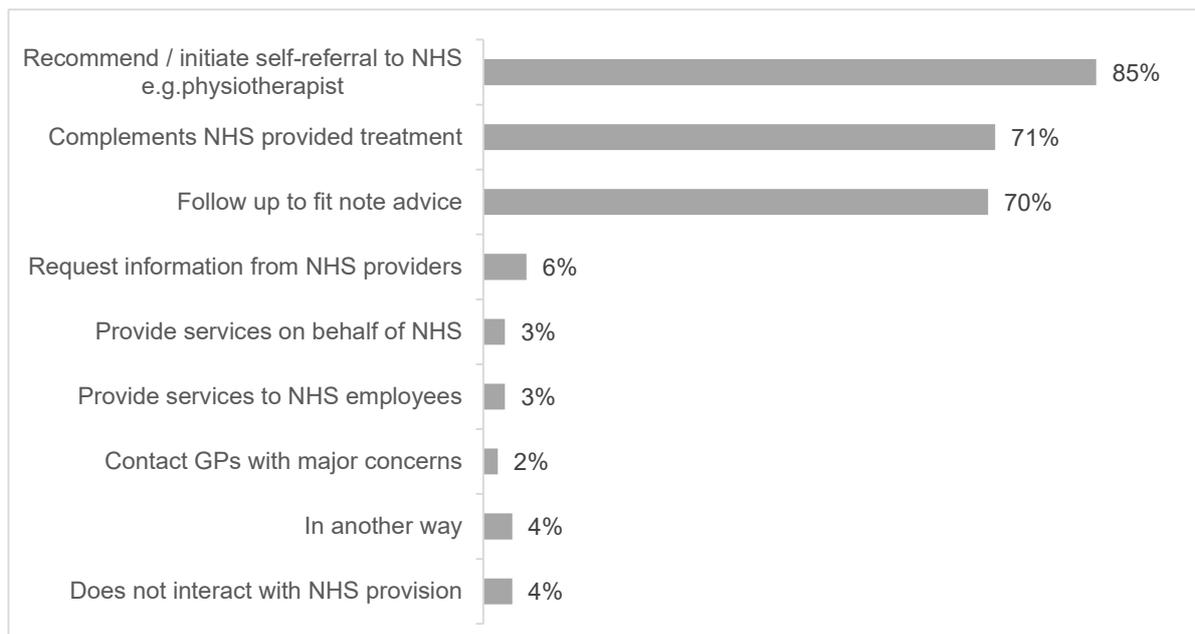
The OH provider helped the company to develop a phased return to work plan for the employee, during which the monthly appointments took place. These continued until the provider felt reassured that the employee was able to cope.

4.5 Interaction with the NHS

Nearly all private providers (96%) said that their OH support interacted with NHS provision in some way (Figure 4.12). For over four-fifths (85%) this took the form of recommending or initiating self-referrals to NHS treatment, most commonly either recommending employees go to their GP (42%) or to specialist treatment (37%).

Seven in ten providers (71%) said that their support could be a complement to NHS treatment, or part of the follow up to fit note advice (70%).

Figure 4.12: OH providers interaction with the NHS



Base: All OH providers who participated in private providers survey (103)

When asked for more detail about this interaction, a third of providers (34%) reported they had been in contact with an employee’s GP about obtaining a medical report. Some providers noted that there could be resistance or delays when contacting GPs, as in their experience GPs did not consider OH a priority. Other forms of interaction with the NHS were rare.

Case study – example of interaction with NHS

One OH provider explained how their interaction with the NHS is usually limited to requesting doctor’s notes, signposting employees to NHS services, or in some cases writing letters to expedite treatment.

An example of this was when working with an employee that had been referred due to an ongoing drug dependency. In this case, the OH provider recommended to the employee that they should go to their GP and ask about drug counselling. The employee admitted this was the catalyst for them to seek help:

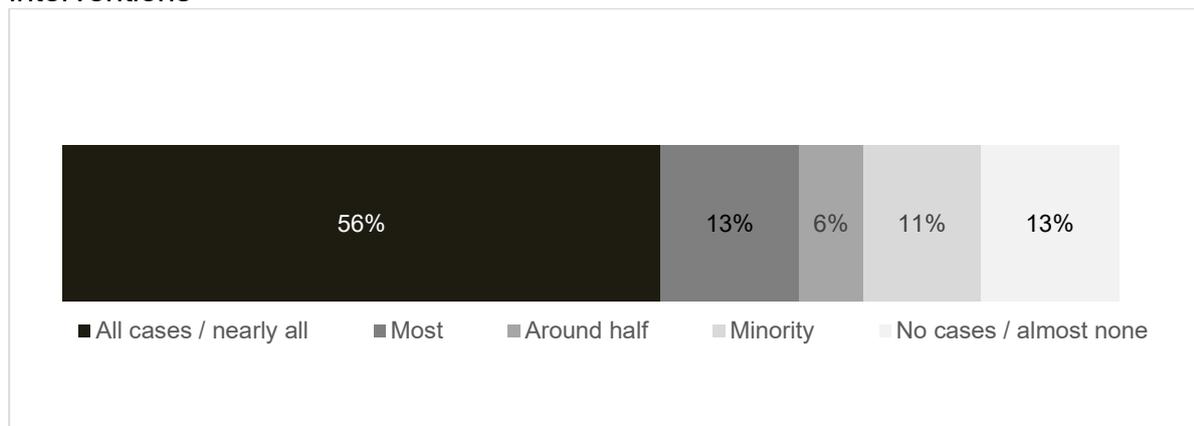
“Without her encouragement I wouldn’t have gone to see the GP. [OH support] was a stepping stone that provided a push and help that meant I received other support.”

4.6 Ensuring quality of service

4.6.1 Data

Seven out of ten (69%) OH providers captured data on the outcomes achieved through their support in all or most cases, with 56% capturing it in all or nearly all cases (Figure 4.13).

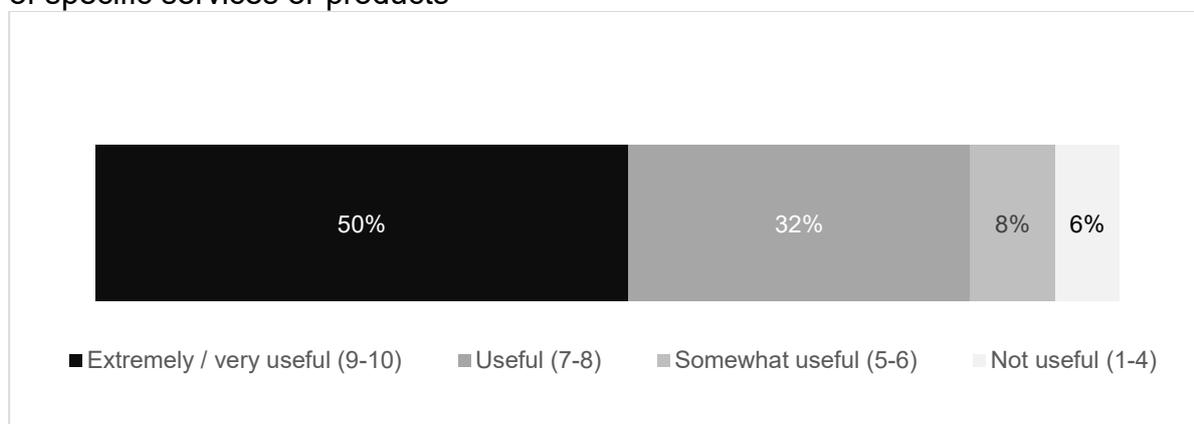
Figure 4.13: Frequency of capturing data on outcomes achieved by OH services and interventions



Base: All OH providers who participated in private providers survey (103)

Most of those that captured outcome data found it useful in demonstrating the effectiveness of specific services or products. On a scale of 1-10, where 1 is not at all useful and 10 is 'extremely useful': over four fifths (82%) rated the usefulness of the outcome data they collected as 7 or higher out of 10 (Figure 4.14). Only 6% thought the outcome data they collected was not useful in demonstrating the effectiveness of services or products.

Figure 34: Usefulness of outcome data collected in demonstrating the effectiveness of specific services or products



Base: OH providers who collect outcome data (88)

Providers who collected outcome data felt it allowed them to establish trends in health issues and identify ways to improve their service. There was a wide variation

in the types of outcome data collected. Most of this data related to the actual results of the services provided, for example sickness absence data or the results of medical tests. A minority conducted feedback surveys with those that had commissioned their services.

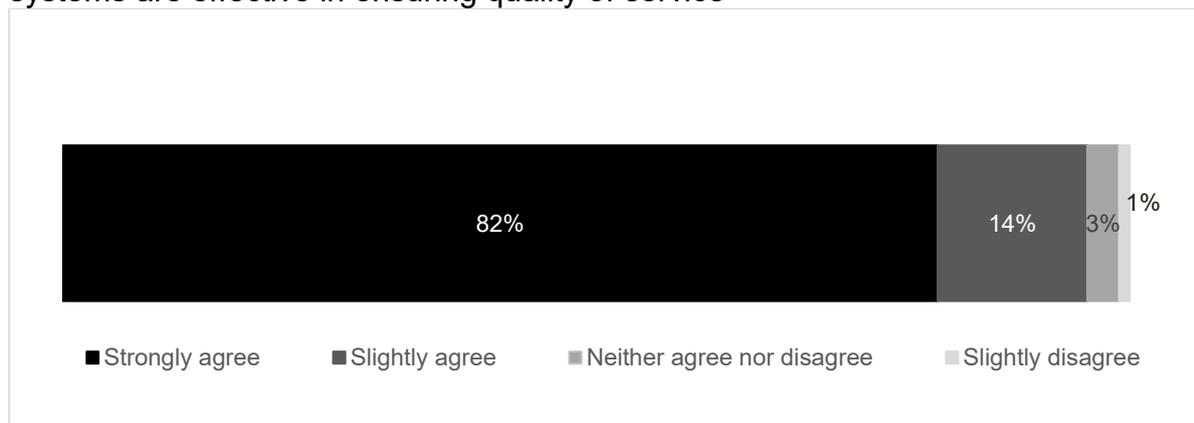
4.6.2 Training and development

Virtually all (99%) OH providers used some form of training, development or accreditation system. There appeared to be a level of self-regulation amongst OH providers, with many conducting their own internal training or regularly sending staff to external training courses to ensure they were able to deliver services to a higher standard. Training received included audiometry, respiratory function and hand arm vibration syndrome courses.

Additionally, OH physicians are required (as are all physicians) to complete CPD which allows them to keep up to date with the latest developments. Many OH providers also undertake accreditations to demonstrate the quality of their service. However, one of the three sample sources for the survey were lists of those with or working towards SEQOHS accreditation, so it is important to recognise that there may have been over-reporting of the proportion of providers with accreditation in the sample. Smaller providers commented they were less likely to have worked towards accreditations due to the cost and time required.

The majority (96%) of OH providers agreed that the training, development and/or accreditation systems they had in place were effective in ensuring quality of service, with 82% strongly agreeing (Figure 4.15).

Figure 45: Extent to which agree training, development and / or accreditation systems are effective in ensuring quality of service



Base: OH providers who models of training (102)

Evidence cited for this effective quality assurance included positive feedback received from clients, internal audits, and high rates of client retention.

Case study – example of self-regulation amongst OH providers

A senior decision-maker at an OH provider explained that they do a variety of things to ensure they and their staff are keeping their knowledge up to date. This included specific training in reaction to requests from employers:

“We’re doing a lot of skin checks for an employer due to hazardous chemical exposure – it wasn’t an area that I felt I had the best knowledge in, so I undertook a day’s study day specifically on skin.”

Additionally, they took a broader view of keeping up to date with developments in OH:

“I went to the NEC exhibition... get an OH magazine and read articles of interest in that. We also get the Society of Occupational Medicine magazine, belong to the Association of Occupational Health Practitioners. A mixture of many varied activities.”

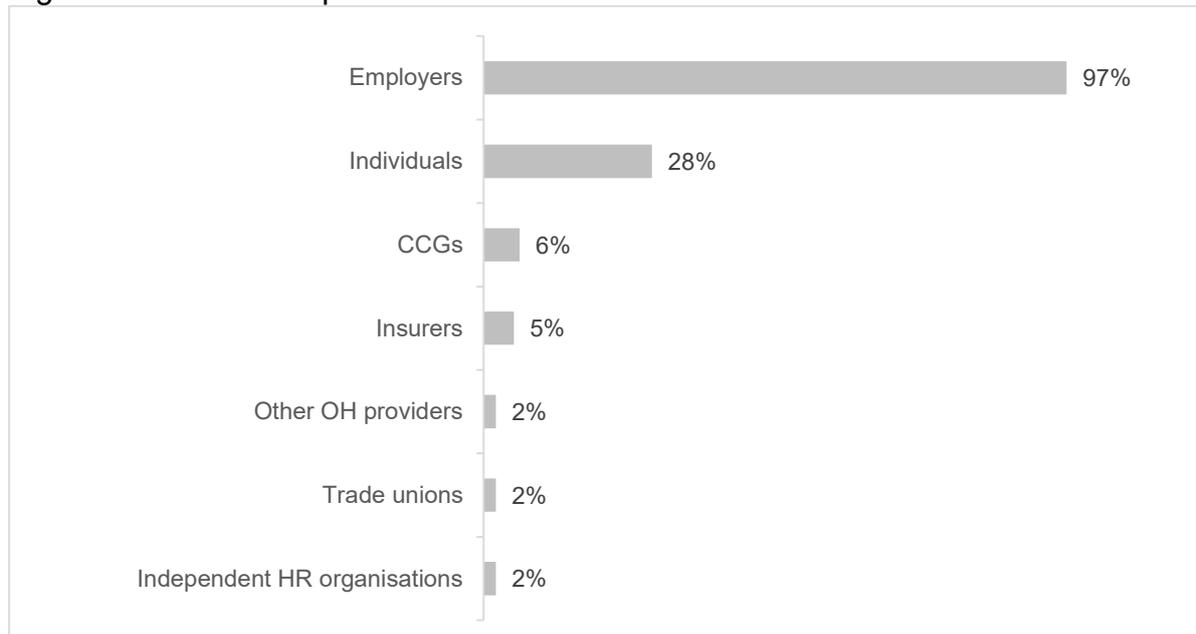
When asked about what they felt worked well about their OH provision, providers most commonly cited their ability to provide a personalised service in a timely manner. Some providers mentioned their expertise as an organisation and the experience and qualifications of their staff were their strong points.

The most common area for improvement that OH providers identified was that they would like to improve the administrative or IT aspects of their business. Other areas for improvement included hiring more staff and offering a wider range of services.

4.7 Marketing

Six in ten private OH providers (63%) did some form of marketing. OH providers who did market themselves mostly did so to employers (97% of those who did marketing). Three in ten (28%) of those who marketed their services did so to individuals. Only a very small proportion marketed their services to CCGs or health insurers (6% and 5% respectively) (Figure 4.16).

Figure 4.16: Who OH providers market their OH services or interventions to



Base: OH providers who market their services or interventions (65).

Targeted marketing to specific sectors was rare, mostly providers would market their services across a range of sectors. Some providers, however, targeted their marketing somewhat to certain sectors that were particularly likely to take up OH services due to legal requirements within those industries, such as engineering, manufacturing, transport and logistics and construction. Few providers marketed their services to specific sizes of company, although a small number mentioned they do target SMEs.

Four in ten (37%) providers did no form of marketing, with many mentioning they felt they received enough business without it. Marketing was much less likely amongst smaller providers with fewer employees, only around half (49%) of those with fewer than 10 employees marketed themselves compared to over four fifths (83%) of those with 10 or more employees.

5 The OH workforce

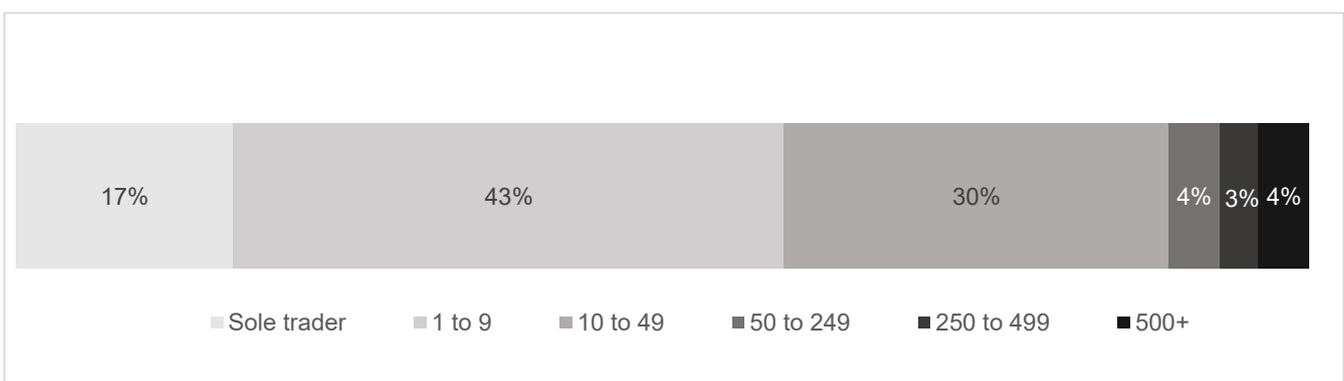
This chapter includes findings from two telephone surveys. The first surveyed 103 private providers of OH. The second survey was designed as a follow-up to focus more specifically on the workforce of OH providers, and surveyed a total of 156 OH providers, this time both private providers (104) and NHS OH departments that sold OH services commercially (52). As this is an important distinction, the chapter specifies which survey the data has come from. This chapter covers:

- Number of staff (Section 5.1);
- Workforce structure (Section 5.2);
- Job functions carried out by role type (Section 5.3);
- Training offered and qualifications required (Section 5.4); and
- Recruitment and response to vacancies (Section 5.5)

5.1 Number of staff

The private providers that participated in the first survey were asked about the number of staff that they directly employ and sub-contract. Most of the private OH providers surveyed had a small number of direct employees. Just under one-fifth (17%) were sole traders, and a further four in ten (43%) had one to nine employees. Three in ten (30%) had between 10 and 49 employees (Figure 5.5). Only one in ten (11%) had more than 50 employees.

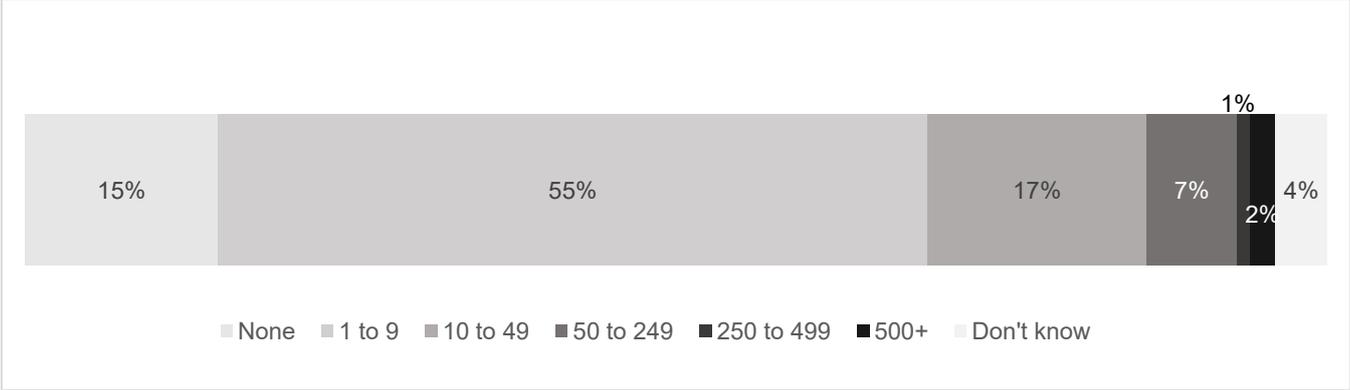
Figure 5.5 : Numbers of employees amongst OH providers



Base: All OH providers participated in private providers survey (103)

The majority of private providers (82%) subcontracted additional workforce requirements on a regular ongoing basis (Figure 5.6). This was mostly on a small scale, with half (55%) regularly subcontracting to fewer than ten individuals.

Figure 5.6 : Numbers of subcontracted staff amongst OH providers



Base: All OH providers participated in private providers survey (103)

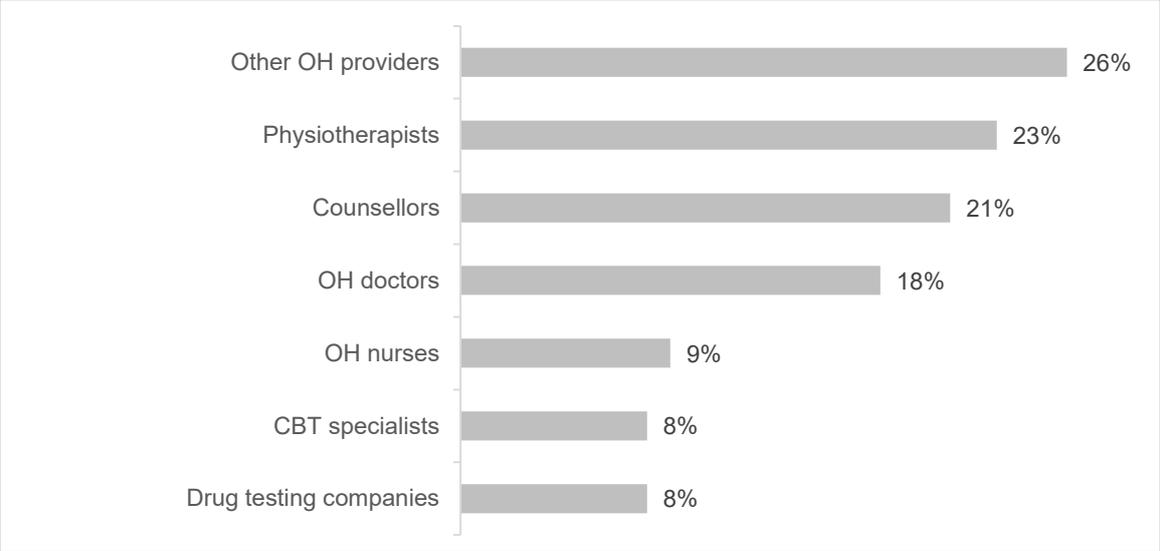
Three quarters (76%) of private OH providers partner with other organisations to deliver some of their OH services. A quarter of these (26%) partnered with other OH providers (

The most common reasons private OH providers worked with these partners was for more specialised knowledge, or to allow them to provide a service to clients that the provider cannot offer themselves. Another common reason for working with a partner was due to a pre-existing relationship between the partner and the client.

Figure 5.7). All of the other most common partnerships were with individuals or companies with specialist skills or knowledge, most commonly physiotherapists (23%), counsellors (21%) and OH doctors (18%).

The most common reasons private OH providers worked with these partners was for more specialised knowledge, or to allow them to provide a service to clients that the provider cannot offer themselves. Another common reason for working with a partner was due to a pre-existing relationship between the partner and the client.

Figure 5.7 : Who OH providers partner with most commonly



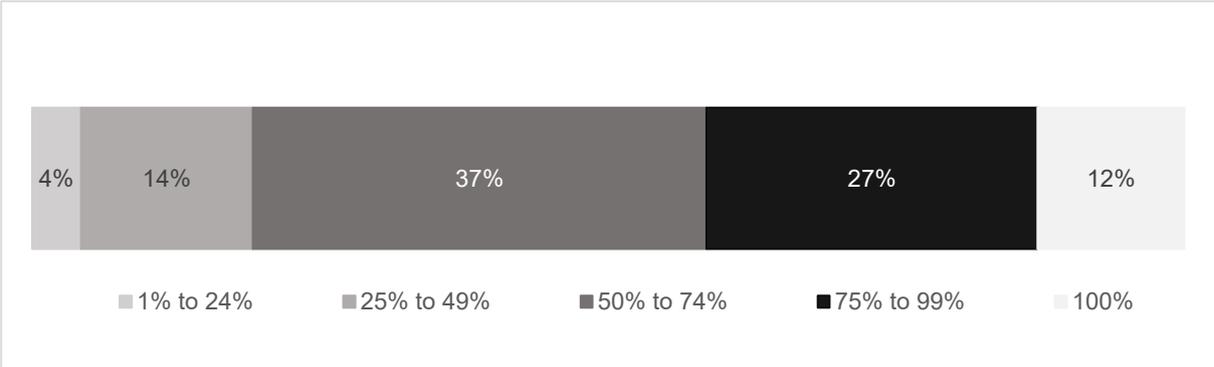
Base: OH providers who participated in private providers survey and partner with other organisations (78)

5.2 Workforce structure

5.2.1 Medical and non-medical staff

Amongst the 83% of private OH providers who employed staff, the majority of their employees or sub-contractors were medical professionals: on average, two-thirds (64%) of employed or subcontracted staff were medical professionals (Figure 5.8).

Figure 5.8: Proportion of employed and subcontracted staff who are medical professionals

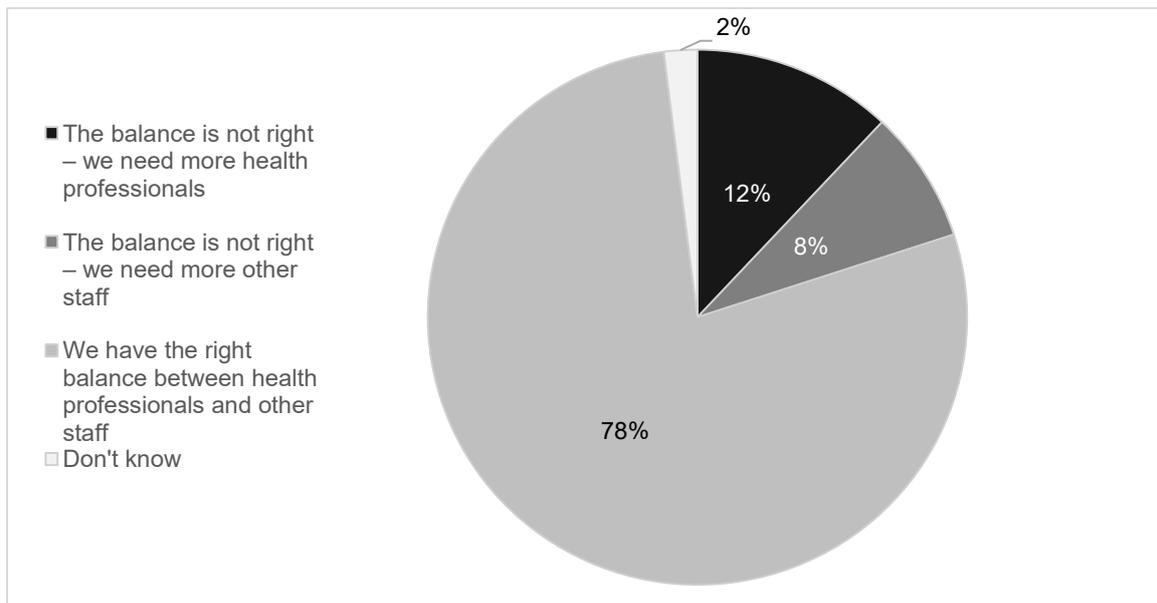


Base: OH providers that participated in private providers survey and have employees or sub-contractors (98)

Eight out of ten (78%) felt that they had the right balance of medical and non-medical staff, 12% felt they needed more health professionals⁴⁸ and 8% that they needed more non-medical staff (Figure 9). Smaller providers with 1-9 employees were twice as likely to indicate they felt in need of non-medical staff (16% compared to 8% overall).

⁴⁸ In the survey, health professionals were defined as those with a formal registration with a recognised professional body, e.g. physicians, nurses and Allied Health Professionals

Figure 9.5: Provider perception of balance of medical and non-medical staff



Base: All OH providers that participated in private providers survey (103)

Amongst those OH providers who employed or subcontracted non-medical staff, the most common background was administration, followed by (non-specialised) healthcare, sales and marketing and HR.

5.2.2 OH professionals

In the survey of both private and NHS providers, respondents were asked about the number of individuals they employed and subcontracted in a variety of OH roles. Registered nurses with a SCPHN OH qualification⁴⁹ were the most common profession to be directly employed: six in ten (62%) providers had at least one full-time employee with this qualification, and almost half (43%) had at least one part-time employee. Registered nurses with a SCPHN OH qualification were also the second most commonly subcontracted roles, with one in three (33%) of providers subcontracting this role (Figure 5.10).

OH physicians⁵⁰ (OHPs) were the next most common profession to be employed by an OH provider, although OHPs were more likely to be employed on a part-time basis rather than full-time roles (30% employed OHPs full-time, while 42% employed them part-time). OHPs were the most commonly subcontracted role: four in ten (40%) of providers subcontracted OHPs (Figure 5.11).

⁴⁹ Specialist community public health nursing (SCPHN) registered under part 3 of the NMC register, the highest OH qualification a nurse can achieve (with the area of practice as occupational health nurse)

⁵⁰ Those registered with the GMC as an occupational medicine specialist

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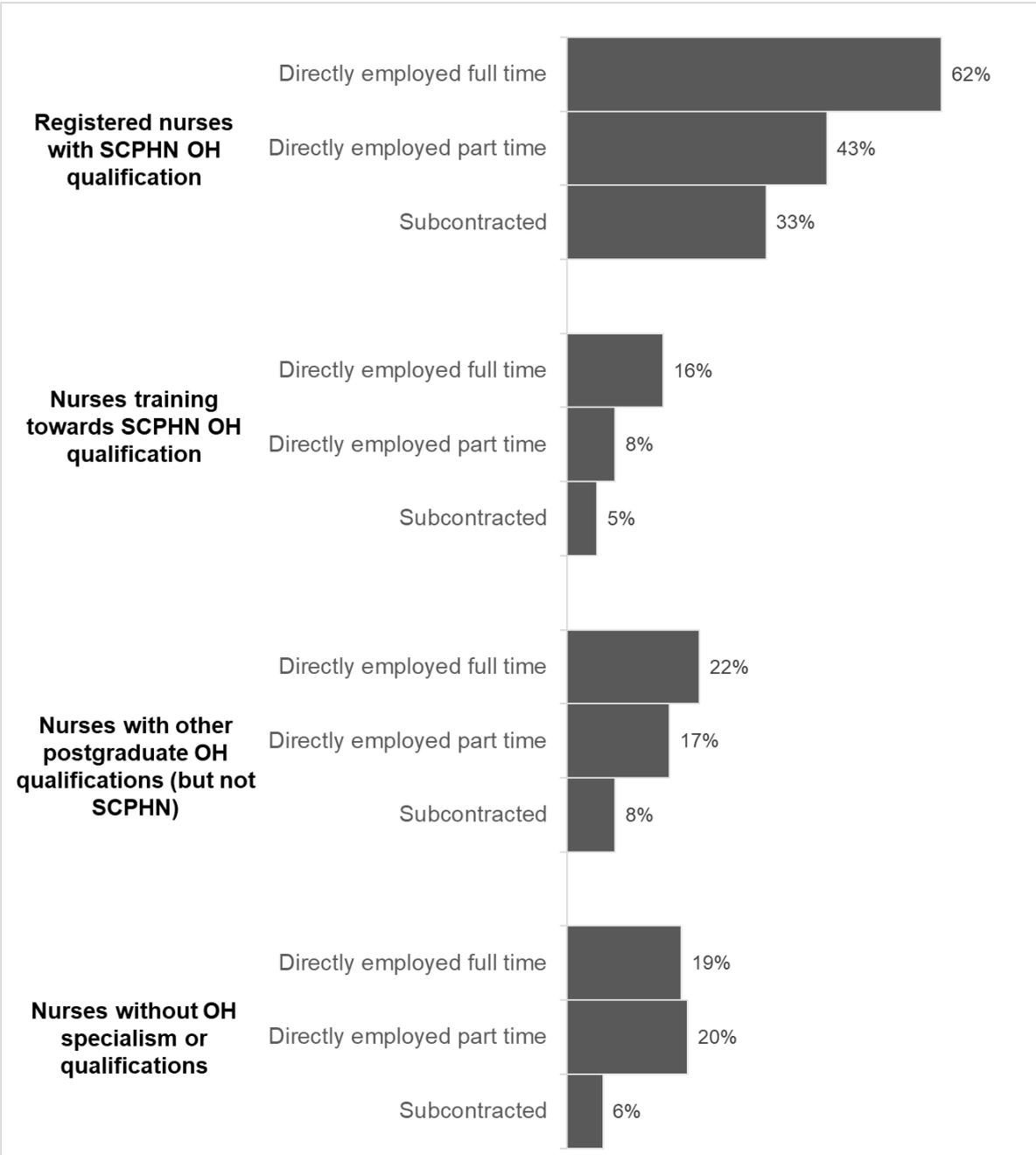
Across all of the OH roles, those with registered OH specialisms were the most commonly employed. Only a small minority employed doctors with no OH qualifications, however employment of nurses with no OH qualifications was more common (19% employed them full-time, 20% part-time and 6% subcontracted to them).

Three in ten (30%) providers directly employed OH technicians or healthcare assistants full-time and a fifth (19%) part-time (Figure 5.12). One in ten (8%) subcontracted this role, although no NHS providers subcontracted OH technicians or healthcare assistants.

Providers with fewer than 10 employees were understandably significantly less likely to directly employ individuals in a variety of OH roles. The roles most commonly directly employed by these smallest providers were registered nurses with a SCPHN OH qualification and OHPs, suggesting that these are the priority.

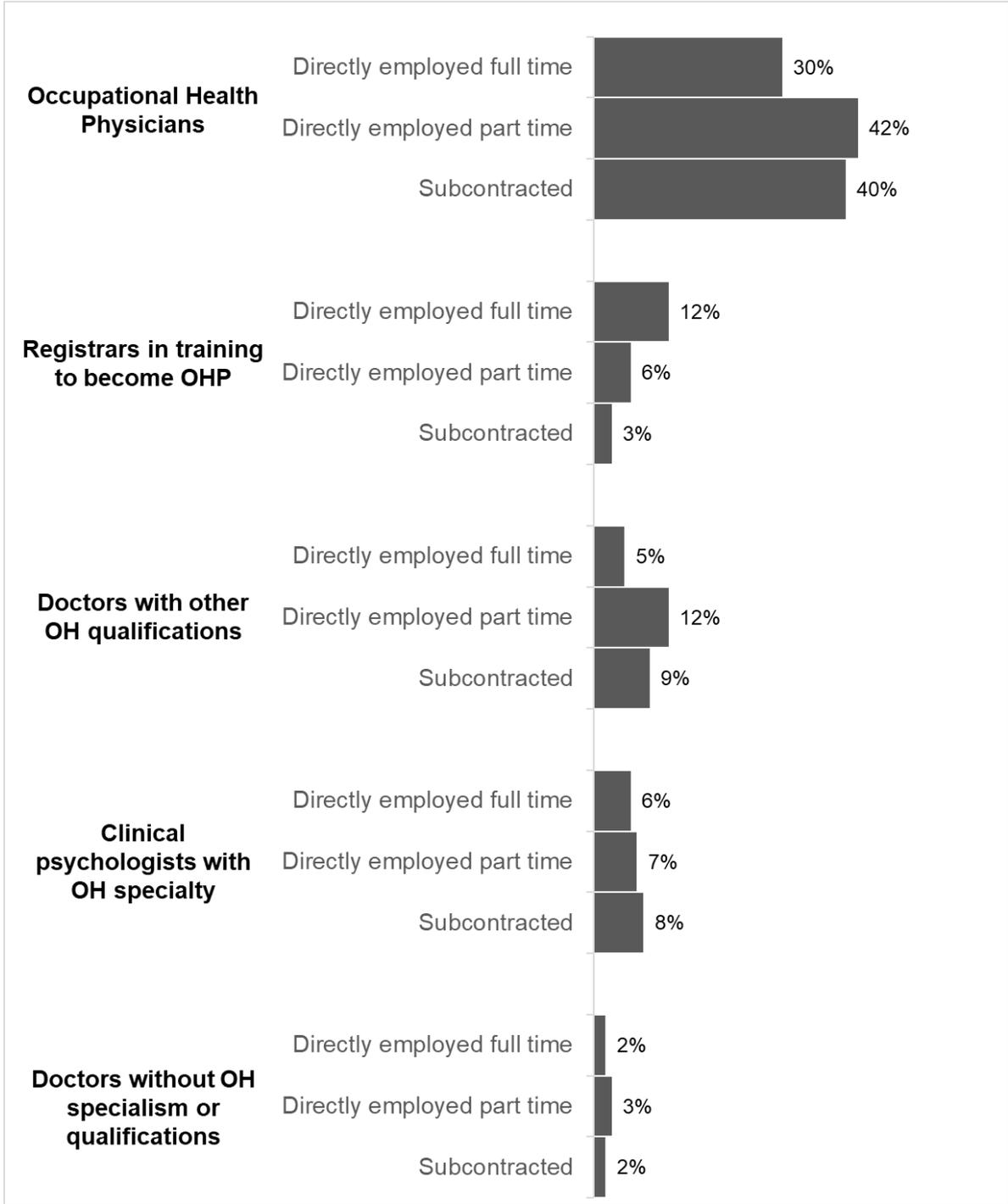
NHS providers were significantly more likely to directly employ individuals in almost all OH roles. This is likely the consequence of NHS OH departments tending to be larger than private providers, although this pattern was most striking across the nursing roles and physiotherapists. Interestingly, there were no statistically significant differences between NHS (15% full-time and 13% part-time) and private OH providers (10% full-time and 3% part-time) in terms of employment of registrars in training to become OHPs.

Figure 5.10: Proportion of OH providers employing or subcontracting nurses by contract type



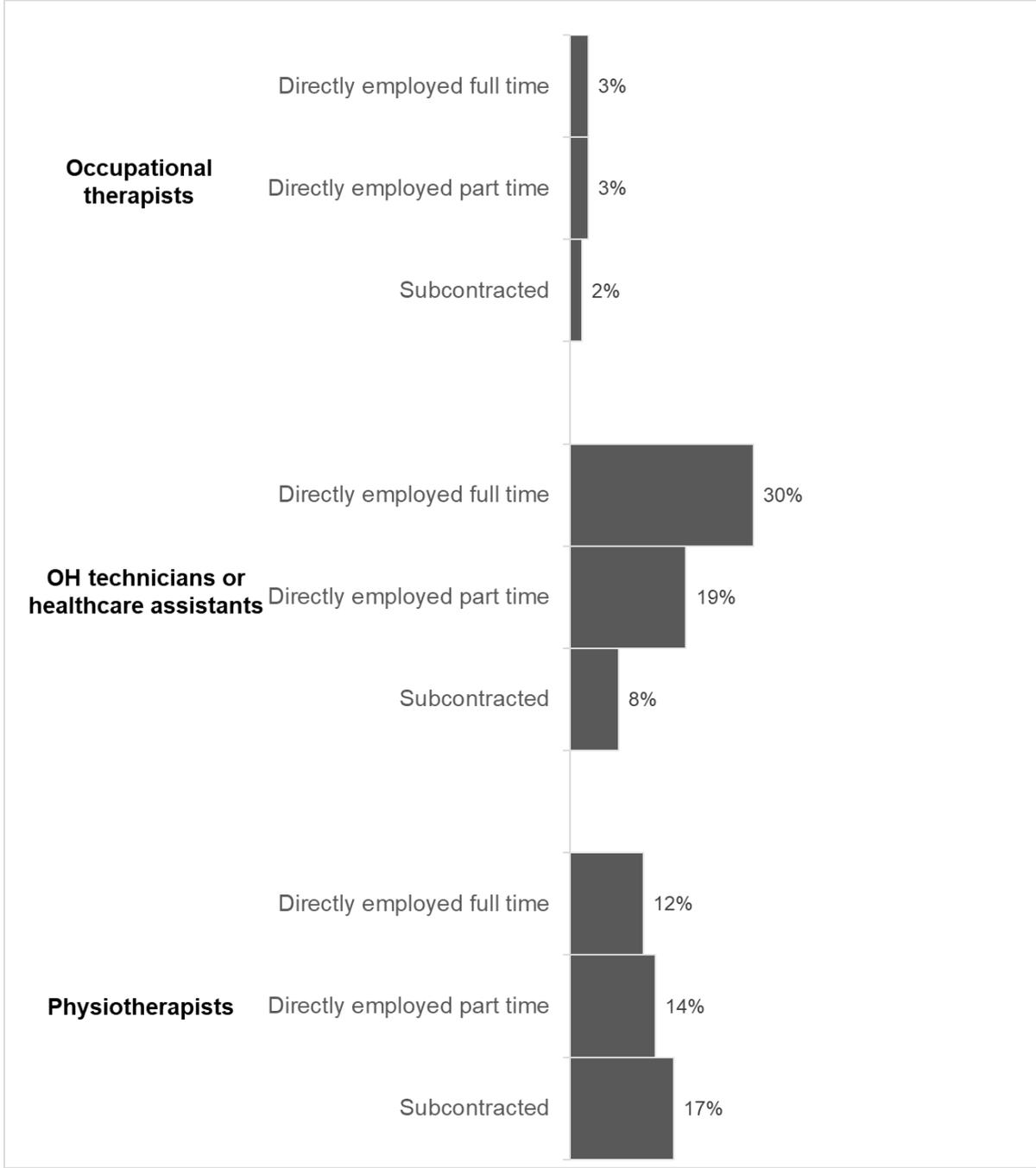
Base: All private and NHS OH providers that participated in workforce survey (156)

Figure 5.11: Proportion of OH providers employing or subcontracting doctors by contract type



Base: All private and NHS OH providers that participated in workforce survey (156)

Figure 5.12: Proportion of OH providers employing or subcontracting other OH roles by contract type



Base: All private and NHS OH providers that participated in workforce survey (156)

5.3 Job functions

In the survey of both private and NHS providers, respondents were asked about the job functions each role they employ undertakes. The three job functions most

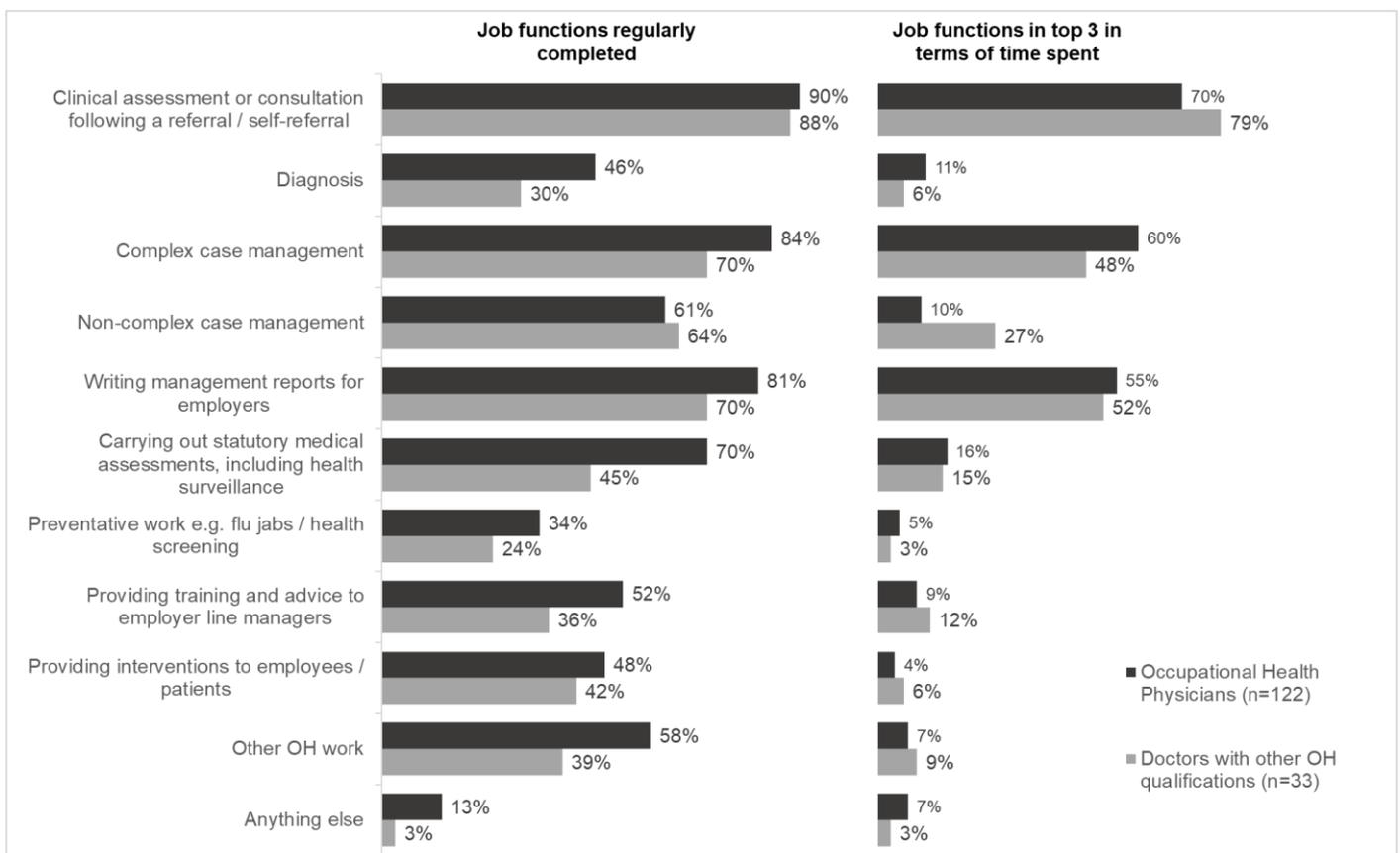
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commonly carried out by doctors with OH qualifications working for OH providers were⁵¹:

- Clinical assessment or consultation following a referral;
- Complex case management; and
- Writing management reports for employers

These also appear to be priorities for doctors with OH qualifications, in that their time was most consumed by these three tasks. Although doctors were likely to have statutory medical assessments as part of their role (70% for OHPs and 45% for doctors with other OH qualifications), this was rarely a task in their top three most time consuming (16% and 15% respectively). Arguably, this suggests that doctors are most involved in the types of tasks that require a more bespoke service that caters to an individual's needs.

Figure 5.13: Job functions completed by doctors



Base: All private and NHS OH providers that employ each role (Occupational Health Physicians: 122; Doctors with other OH qualifications: 33. Roles where base is less than 30 have been excluded)

⁵¹ Refer to Figure 5.9 for percentages

Understanding the provision of occupational health and work-related musculoskeletal services

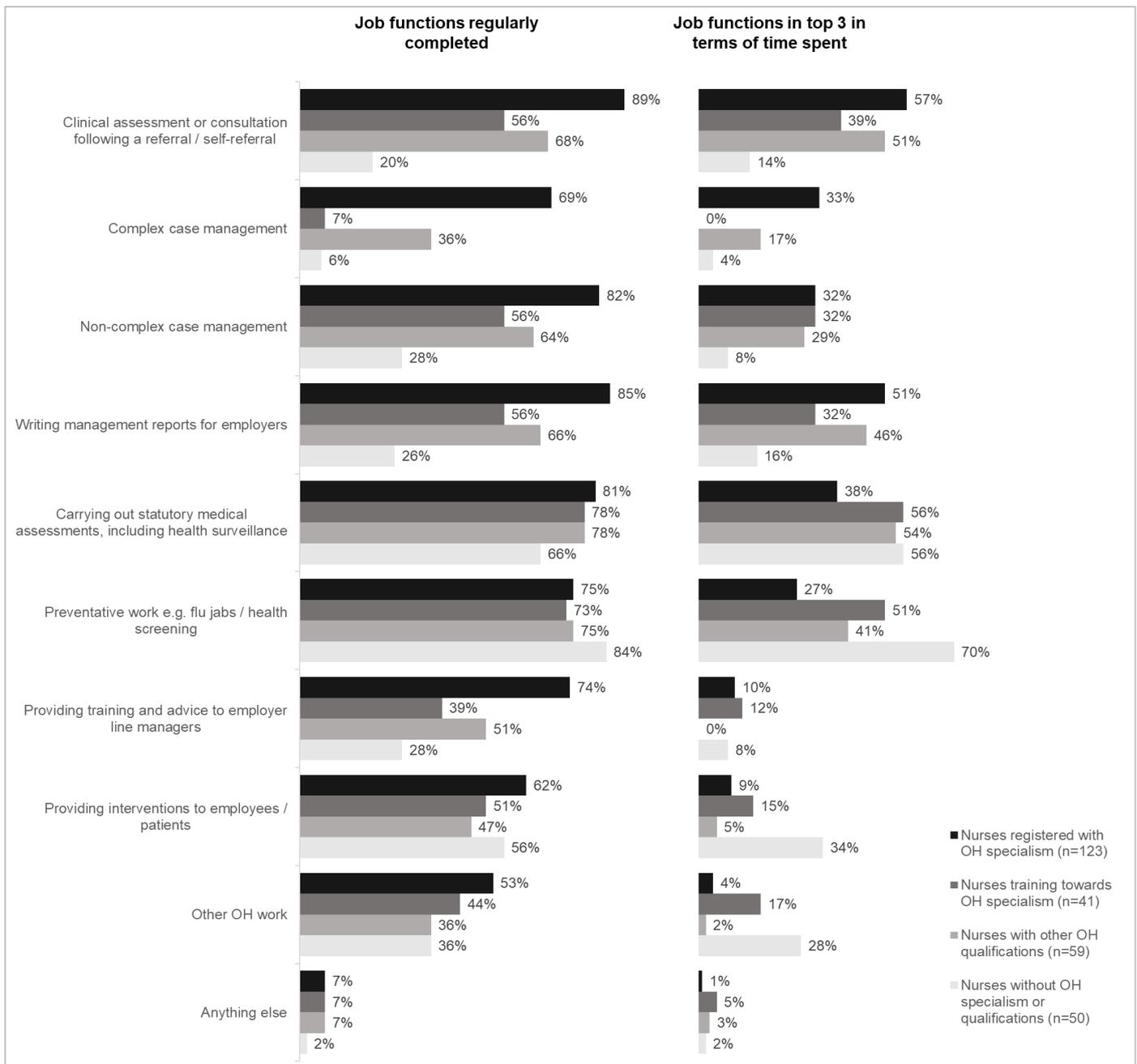
There were variations in the job functions of nurses according to their level of OH qualifications. Registered nurses with a SCPHN OH qualification carried out similar job functions to OH doctors, with their key tasks being⁵²:

- clinical assessments;
- writing management reports; and
- case management (although they were equally likely to be involved in complex and non-complex case management, whereas more doctor time was reserved for complex cases)

Typically, nurses were more likely than doctors to deliver services that are more formulaic and process-driven such as statutory assessments and preventative work, as opposed to tasks that involve responding to an individual's specific case. However, nurses without an OH specialism spent more of their time on such tasks than nurses with an OH specialism or qualification.

⁵² Refer to Figure 5.1410 for percentages

Figure 5.14: Job functions completed by nurses



Base: All private and NHS OH providers that employ each role (Nurses registered with OH specialism: 123; Nurses training towards OH specialism: 41; Nurses with other OH qualifications: 59; Nurses without OH specialism or qualifications: 50)

The job functions for the OH technicians and healthcare assistants displayed the opposite pattern to doctors, in that the tasks they were most likely to be assigned to and spend the most time on were⁵³:

- Carrying out statutory medical assessments, including health surveillance

⁵³ Refer to Figure 5.15 for percentages

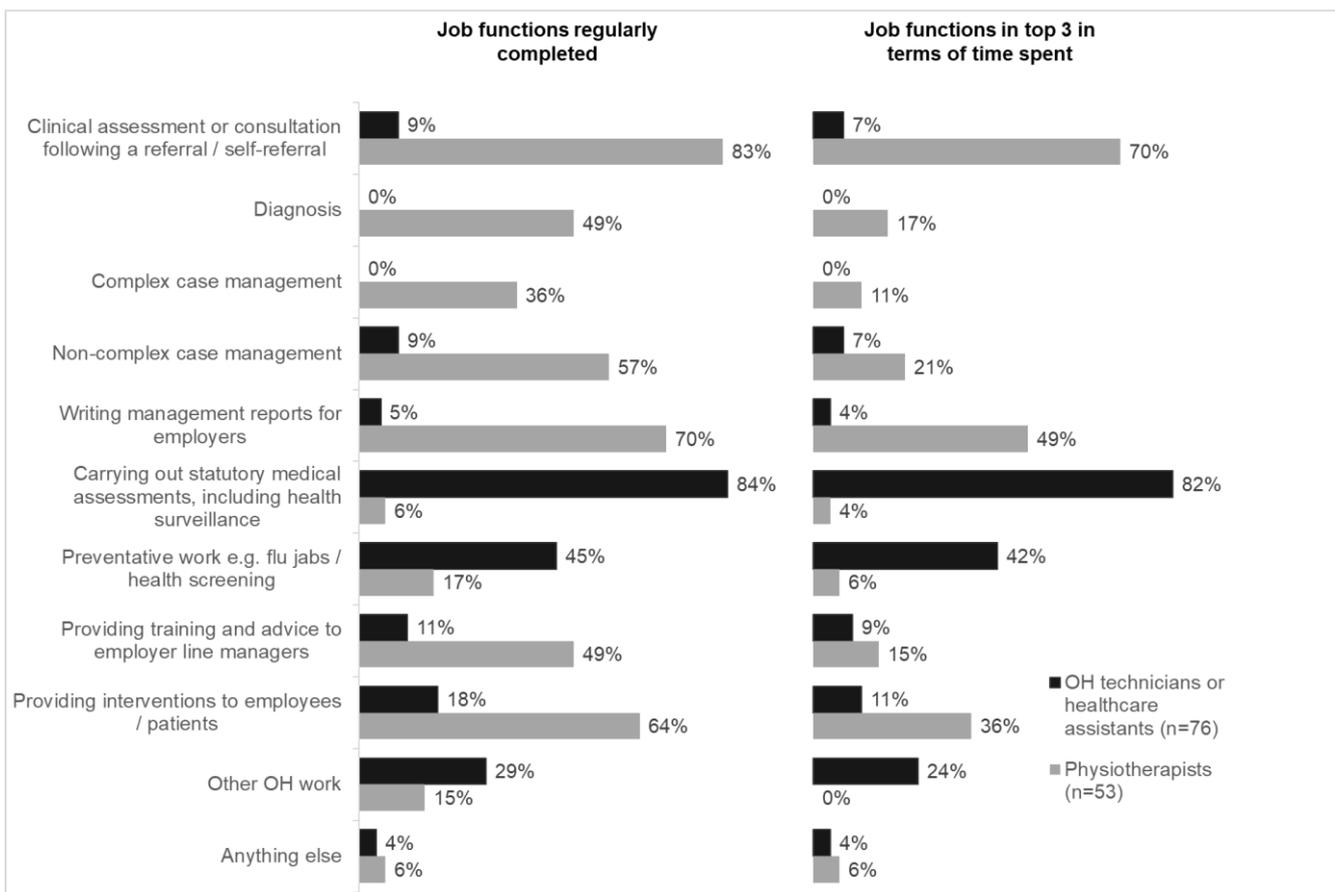
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- Preventative work, such as flu jabs or health screening

Only a minority of providers asked their OH technicians or healthcare assistants to undertake clinical assessments and case management, which are tasks that require more tailoring to an individual's needs.

Physiotherapists job functions were strikingly different again. The tasks providers most frequently assign to them were assessments, management reports and providing interventions.

Figure 5.15: Job functions completed by other OH roles



Base: All private and NHS OH providers that employ each role (OH technicians or healthcare assistants: 76; Physiotherapists: 53. Roles where base is less than 30 have been excluded)

5.4 Training and qualifications

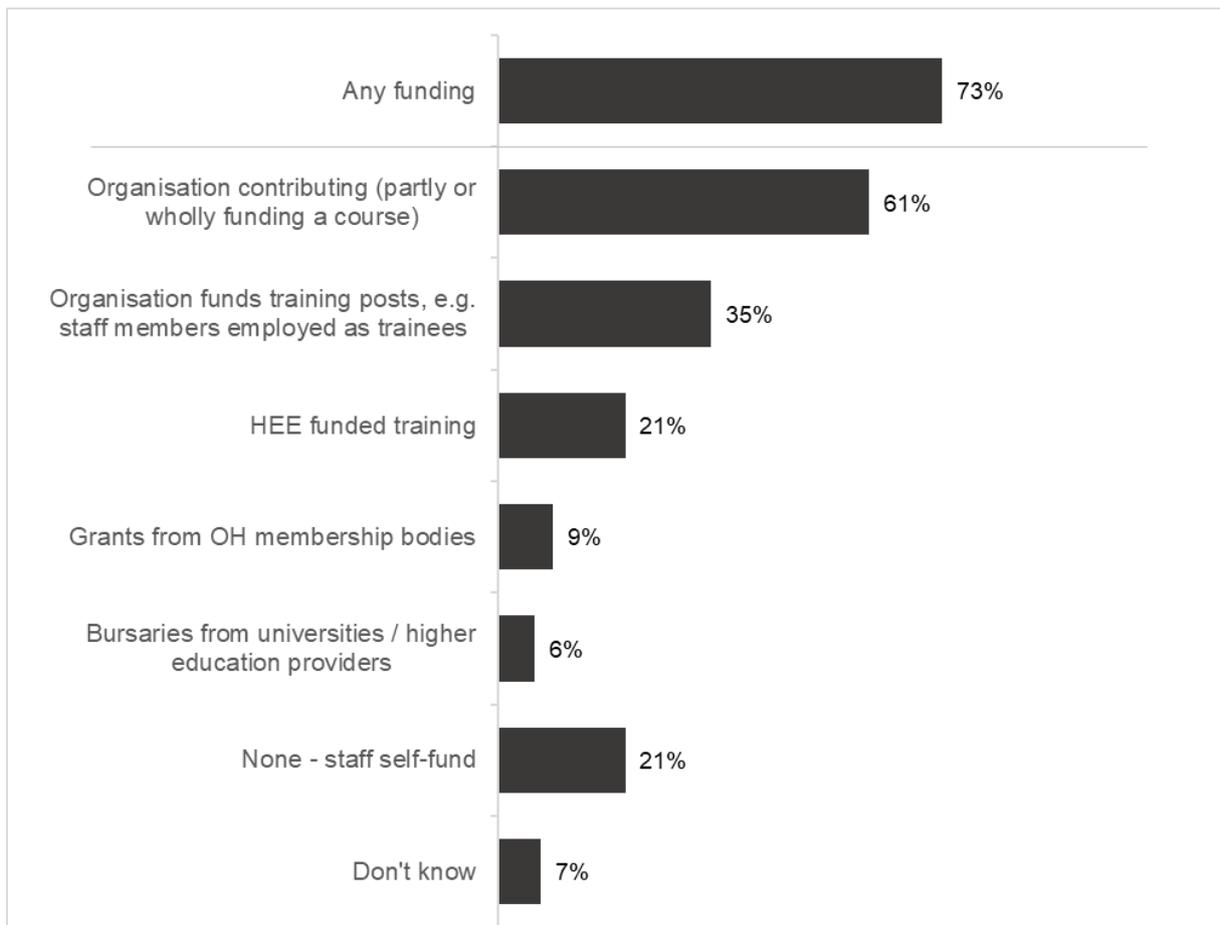
Sources of funding for staff training

Across all providers, both private and NHS, around three-quarters (73%) reported that they have access to funding for staff training (**Error! Reference source not found.**). The most common source of this funding was the organisation contributing (partly or wholly funding a course) (61%), followed by the organisation funding training posts, e.g. staff members employed as trainees (35%), and HEE funded training (21%).

A further 9% receive grants from OH membership bodies and 6% receive bursaries from universities or higher education providers.

Around one-fifth of all providers (21%) reported that they do not have access to any funding for staff training.

Figure 5.16. Source(s) of funding available for staff training

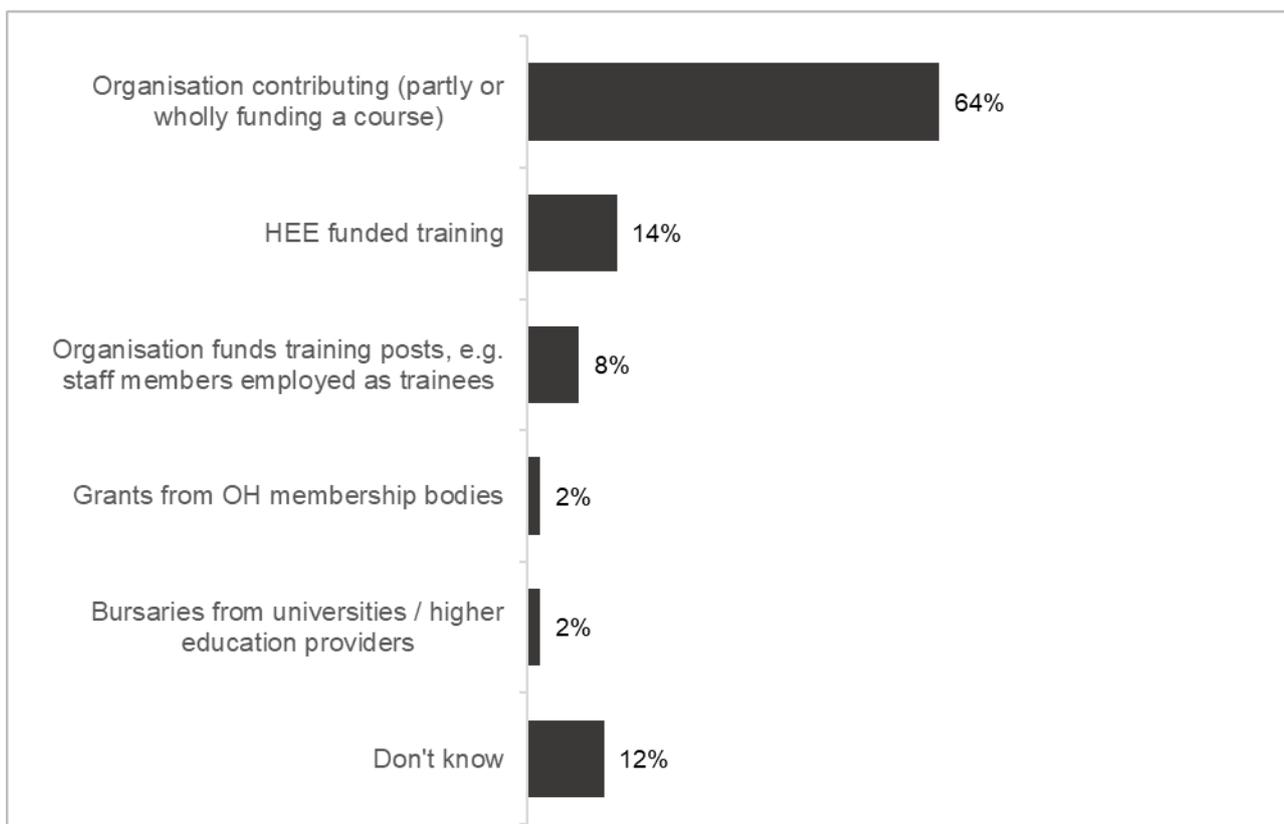


Base: All private and NHS OH providers who participated in the workforce survey (156)

There were some significant differences in the sources of funding available between private providers of OH and NHS OH departments. Overall, NHS providers were more likely to have access to funding (92%) compared to private providers (67%).

Providers with access to more than one source of funding for staff training were asked to report their main source (**Error! Reference source not found.**). The organisation contributing (partly or wholly funding a course) was the main source of funding for two thirds (64%) of providers that offered any funding for training. This was followed by HEE funded training (14%) and the organisation funding training posts (8%). A small proportion of providers said that grants from OH membership bodies and bursaries from universities or higher education providers were their main source of funding (both 2%).

Figure 5.17. Main source of funding for staff training



Base: Private and NHS OH providers who participated in the workforce survey and had access to more than one source of funding for training (118)

Number of fully funded training posts available

Providers who offer training posts (35% of all providers) were asked to report how many fully funded training posts they had available for a selection of the OH doctor and nurse roles.

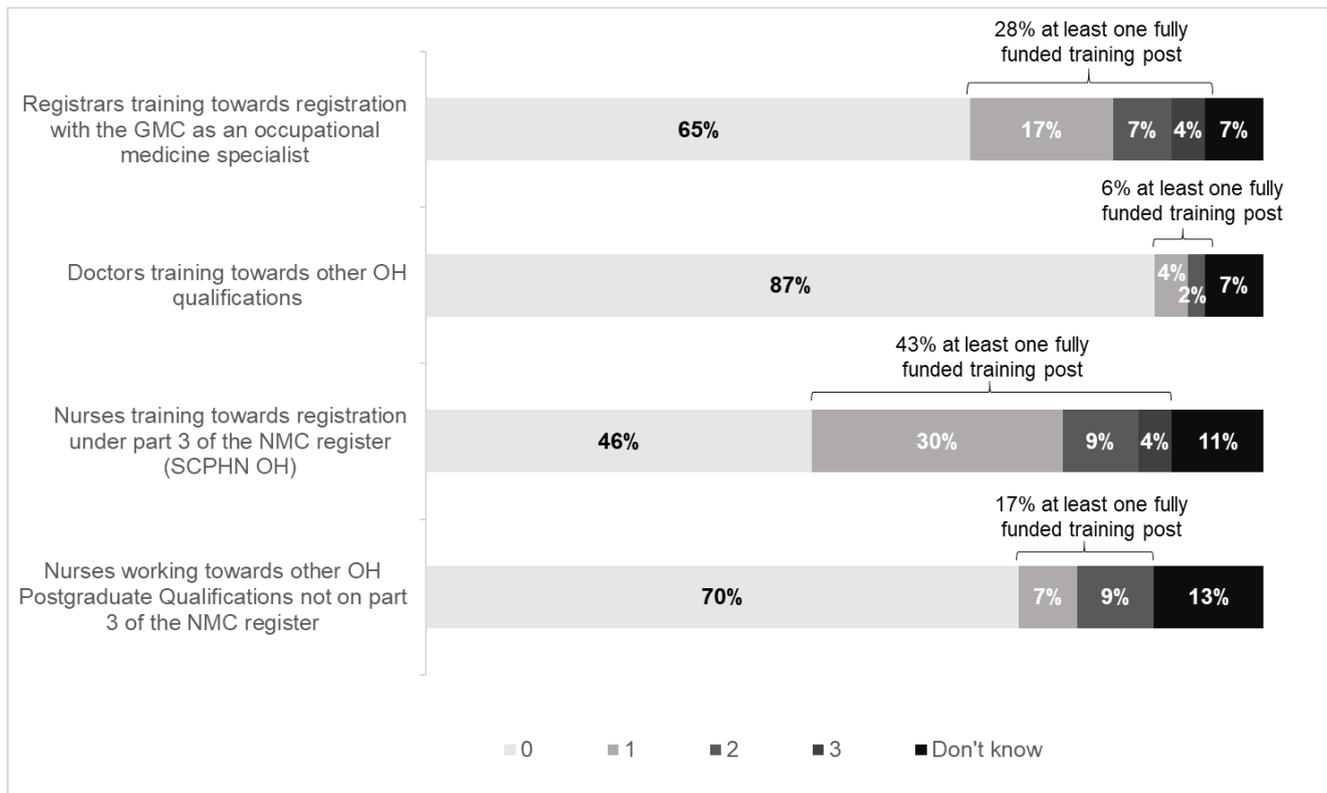
Providers most commonly reported that they had at least one fully funded training post available for nurses training towards registration under part 3 of the NMC register (SCPHN OH) (43%), followed by registrars training towards registration with the GMC as an occupational medicine specialist (28%). A smaller proportion of providers each said that they have at least one fully funded training post available for

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nurses working towards other OH postgraduate qualifications not on part 3 of the NMC register (17%) and doctors training towards other OH qualifications (6%).

OH providers who offer fully-funded training posts most commonly had one post available for each training role, as shown in **Error! Reference source not found.**.

Figure 5.18. Fully funded training posts available for doctor and nurse roles



Base: *Private and NHS OH providers who participated in the workforce survey and offer training posts (54)*

Although not statistically significant, NHS providers were notably more likely to have a fully funded OH training post for registrars training towards registration with the GMC as an occupational medicine specialist compared to private providers (39% and 19% respectively).

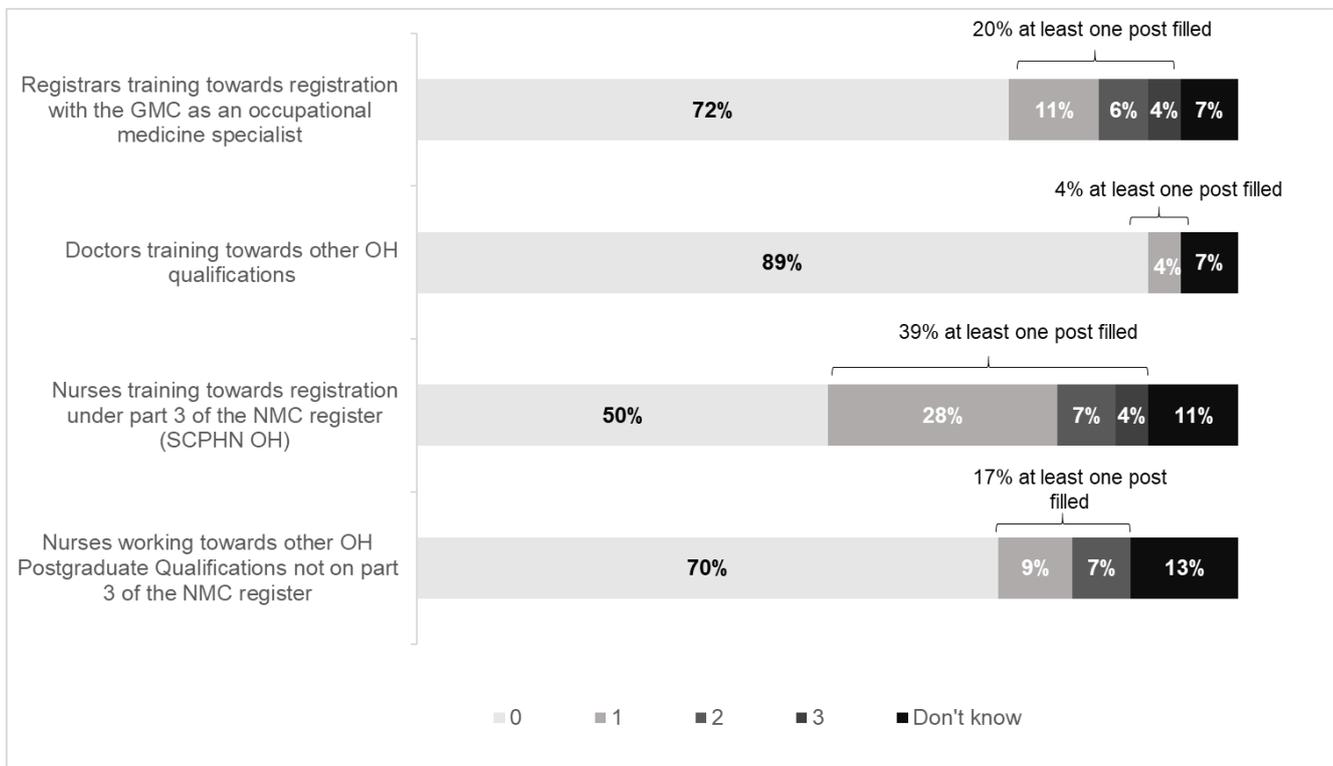
Number of fully funded training posts currently filled

Providers who offer training posts (35% of all providers) were asked to report how many fully funded training posts they had currently filled for a selection of the doctor and nurse roles (**Error! Reference source not found.**).

Around two-fifths (39%) of these providers had at least one currently filled training post for nurses training towards registration under part 3 of the NMC register (SCPHN OH). Around one-fifth had at least one training post currently filled for registrars training towards registration with the GMC as an occupational medicine specialist (20%) and a similar proportion for nurses working towards other OH

postgraduate qualifications not on part 3 of the NMC register (17%). A small proportion of providers who offer training posts had at least one post currently filled for doctors training towards other OH qualifications (4%).

Figure 5.19: Fully funded training posts currently filled for doctor and nurse roles



Base: Private and NHS OH providers who participated in the workforce survey and offer training posts (54)

Across all training roles, aside from nurses working towards other postgraduate qualifications (not on part 3 of the NMC register), more providers had posts available than providers that had posts filled. This suggests there is capacity for providers to train more staff. The role with the biggest gap between posts available and posts filled was for registrars training towards registration with the GMC as an occupational medicine specialist.

5.5 Recruitment and provider response to vacancies

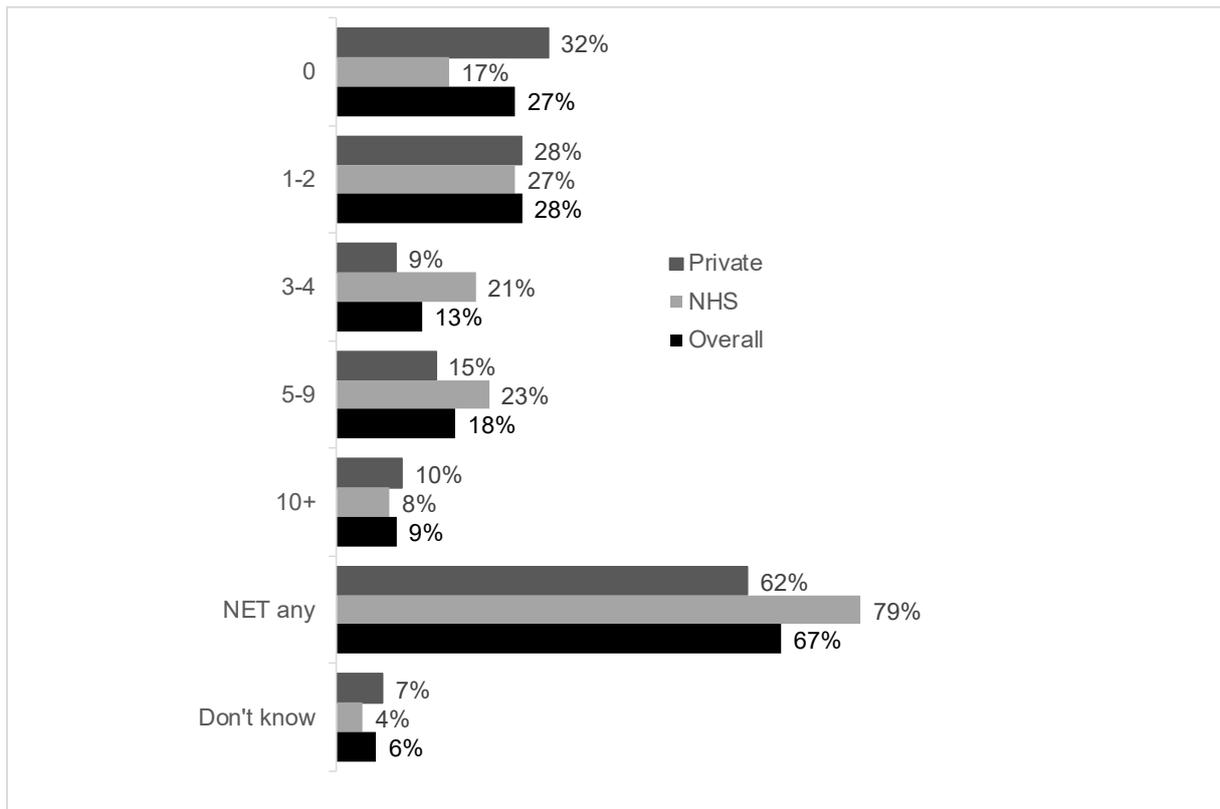
Numbers of staff recruited over the previous 12 months

In the survey of both private and NHS providers, OH providers were asked about the total number of staff they had recruited or sourced (headcount rather than FTE) over the previous twelve months, including both directly employed and subcontracted staff (Figure 5.16). Over two-thirds (67%) of providers had recruited or sourced at least

one member of staff in the last year, and the average number of staff members recruited was 4.5. Just over a quarter (27%) had recruited over five members of staff.

NHS providers were more likely than private providers to have taken on staff (79% of NHS providers had recruited or sourced at least one member of staff, compared with 62% of private providers), although private providers, on average, had recruited or sourced more staff (4.8 per organisation, compared with 3.8 per NHS provider).

Figure 5.16: Number of staff recruited or sourced over the last 12 months (headcount)



Base: All private and NHS OH providers that participated in workforce survey (156)

Providers who used subcontracted workers were more likely to have recruited or sourced staff over the past 12 months (77%, compared with 54% of those which didn't use subcontracted staff), and tended to have recruited or sourced more staff on average (5.9 per provider, compared with 2.6). An explanation for this could be that providers who have turned to subcontracted workers have done so because of their greater demand for staff.

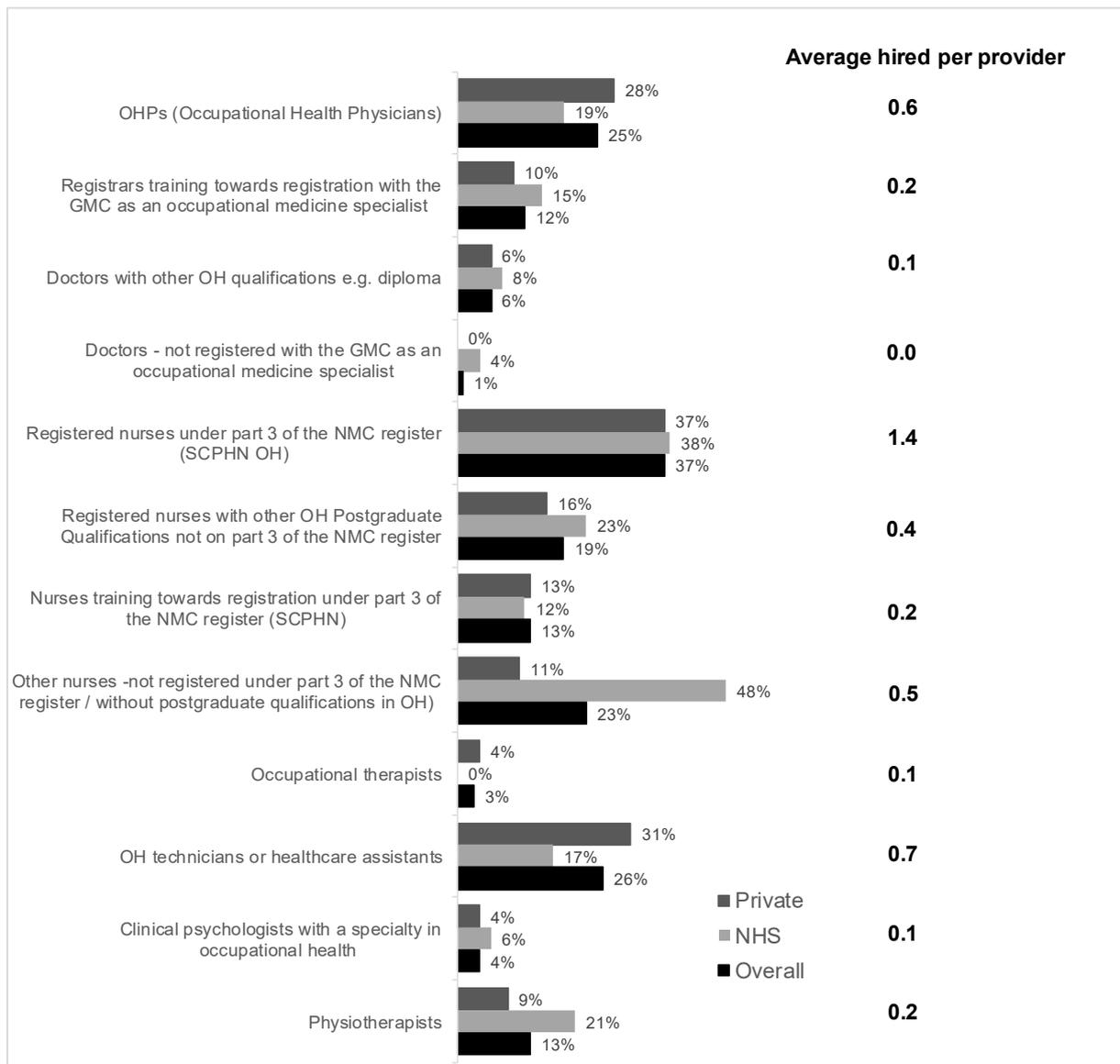
Unsurprisingly, providers with 50 or more employees were more likely to have taken on staff (78%, compared with 62% of smaller companies) and tended to have recruited or sourced more staff on average (8.6 per provider, compared with 2.4). Providers who have funded training available for staff were also more likely to have taken on staff (73%, compared with 44% of those where funding isn't available), and tended to have taken on more staff on average (4.9 per provider, compared with 1.6).

Providers were most likely to have recruited or sourced registered nurses with a SCPHN OH qualification (Figure 5.17). This was followed by OH technicians or

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healthcare assistants, OHPs, and nurses without an OH specialism or qualifications. Providers were least likely to have recruited or sourced doctors without an OH specialism or qualifications, indicating that at least some form of OH-specific qualification is a key requirement for providers when recruiting doctors. Patterns of which professions were most commonly recruited or sourced by providers largely mirror patterns of which professions were most commonly employed by providers (see section 1.2.2.).

Figure 5.17: Whether any staff recruited in particular job roles over the past 12 months



Base: All private and NHS OH providers that participated in workforce survey (156)

Pre-employment roles

In the survey of both private and NHS providers, OH providers were also asked about which organisations their directly employed doctors and nurses worked for

prior to joining them. Across all doctor and nurse job roles, the majority of providers reported the most common previous employer of directly employed staff was the NHS (ranged between 57% and 94% on average across each role). NHS provider employees, in each job role, were more likely to be sourced from the NHS. However, even among private providers, the NHS was the primary source of registrars in training to become occupational medicine specialists (97%), doctors with OH qualifications (84%), doctors without an OH specialism or qualifications (75%), nurses training towards an OH specialism (86%), and nurses without OH qualifications (77%).

To some extent, this simply reflects the fact that, in the UK, doctors and nurses can only be trained in the NHS, as well as the predominance of the NHS within UK healthcare provision more broadly. However, it may also lend some support to the perception, voiced in the expert interviews, that private OH providers are 'poaching' NHS staff. The relatively low proportions of staff being sourced from in-house OH services (ranging between 0% and 22% on average across each role) also potentially supports the expert suggestion that the in-house OH training scheme route into OH is becoming decreasingly common, with the majority of trainees in occupational medicine being paid for by the NHS. However, there could be other explanations for this, for example the fact the private providers tend to employ fewer people than NHS providers. Recruitment from another role outside of OH was also relatively uncommon, with between 0% and 36% of staff on average across each role coming from such a background.

Qualifications or training required for recruiting nurses

Private and NHS providers were asked whether they required their nurses to have achieved specific qualifications or training as a minimum requirement (Figure 5.18).

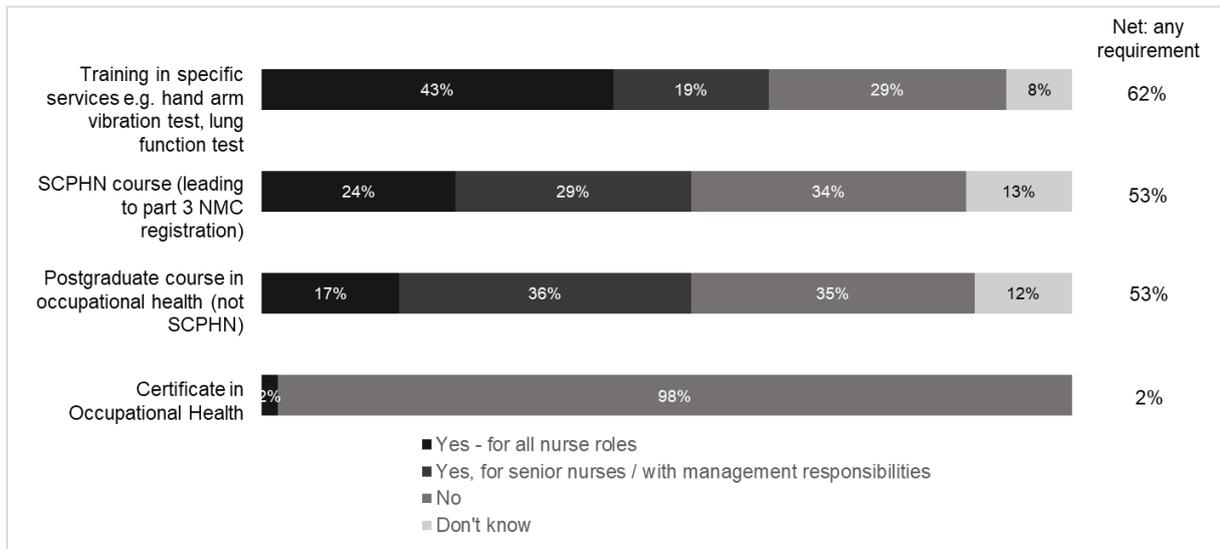
The majority of providers (62%) required at least some of their nurses to have received training in specific services, for example hand arm vibration or lung function tests. Around two-fifths (43%) of all providers required all of their nurses to have received this training, whereas one-fifth (19%) of providers required this for their senior nurses only.

Around a half (53%) of providers required at least some of their nurses to have completed the SCPHN course (leading to part 3 NMC registration), with 24% requiring all nurses to have completed the SCPHN course. Just under a third (29%) required this for senior nurses only.

Similarly, around a half (53%) also required at least some of their nurses to have achieved a postgraduate course in occupational health (not SCPHN), with 17% requiring this of all nurses. A further 36% of all providers required this for senior nurses only.

Just 2% of all providers required at least some of their nurses to have achieved a certificate in occupational health, and these OH providers required this for all their nurse roles.

Figure 5.18. Qualifications or training required for recruiting nurses



Base: Private and NHS OH providers who participated in the workforce survey (156)

NHS OH departments were significantly more likely to require their senior nurses to have completed the SCPHN course (leading to part 3 NMC registration) (56%), compared to 15% of private providers. Likewise, providers with 50 or more employees were significantly more likely to require their senior nurses to have completed the SCPHN course (42%), compared to providers with less than 50 employees (21%).

5.5.1 Numbers of vacancies, roles actively recruiting for or sourcing, and staff who have left

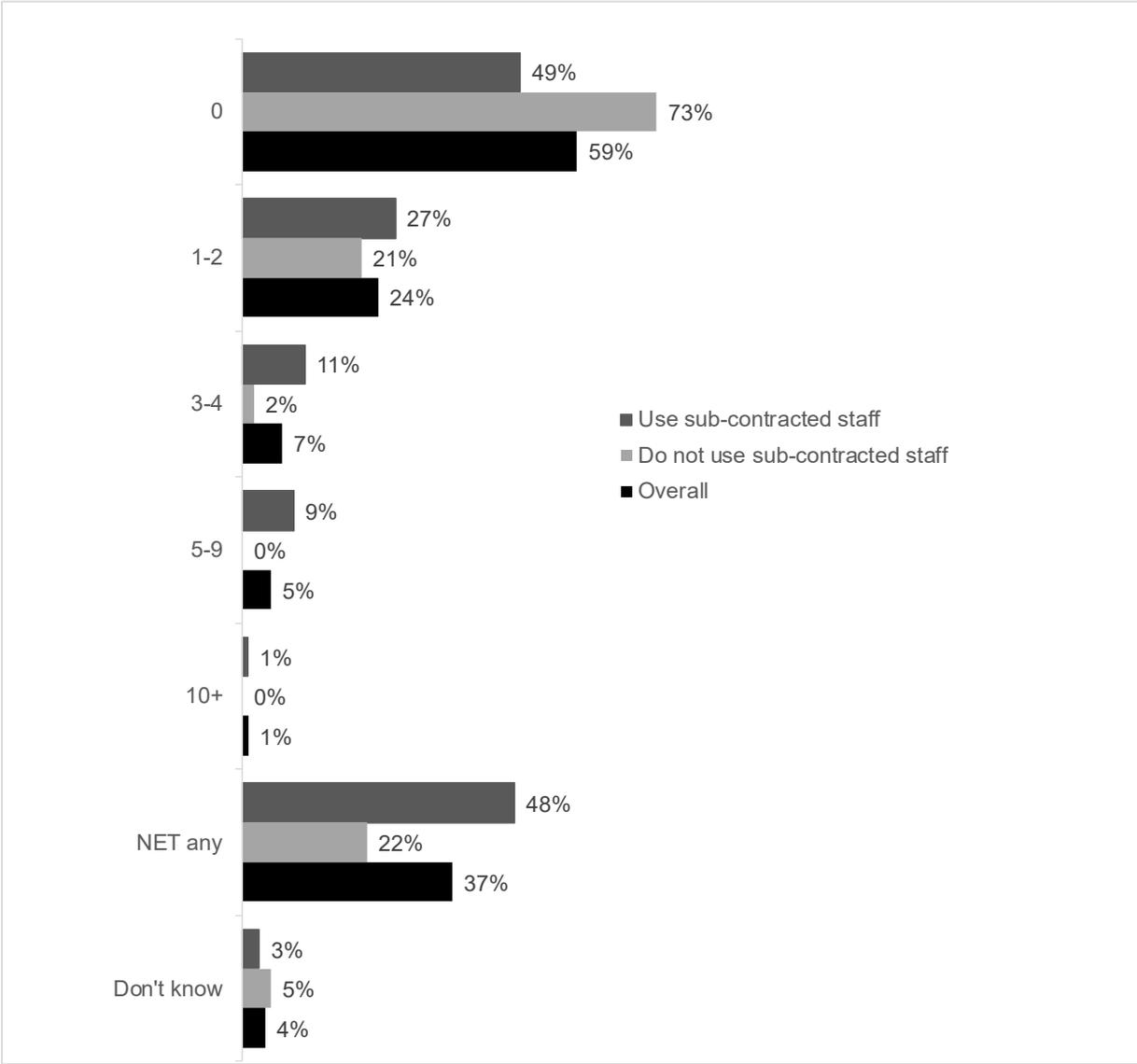
Numbers of vacancies

Both private and NHS OH providers were asked about how many vacancies, including both directly employed and subcontracted staff, they had for different job roles. They were then asked how many of these vacancies they were actively recruiting for.

The majority of providers (59%) did not have any vacancies. Just over a third (37%) of providers reported at least one vacancy (Figure 5.19). The average number of vacancies across all providers was 1.2. Only a small minority of providers (6%) had over five vacancies, with a quarter (24%) reporting one or two vacancies.

Providers who use subcontracted staff were more likely to have vacancies (48% had vacancies, compared with 22% of those which didn't use subcontracted staff), and tended to have more vacancies per provider (1.7, compared with 0.4 among those which do not use subcontracted staff). This may suggest that providers are driven towards using subcontracted staff by persistent vacancies.

Figure 5.19: Number of vacancies



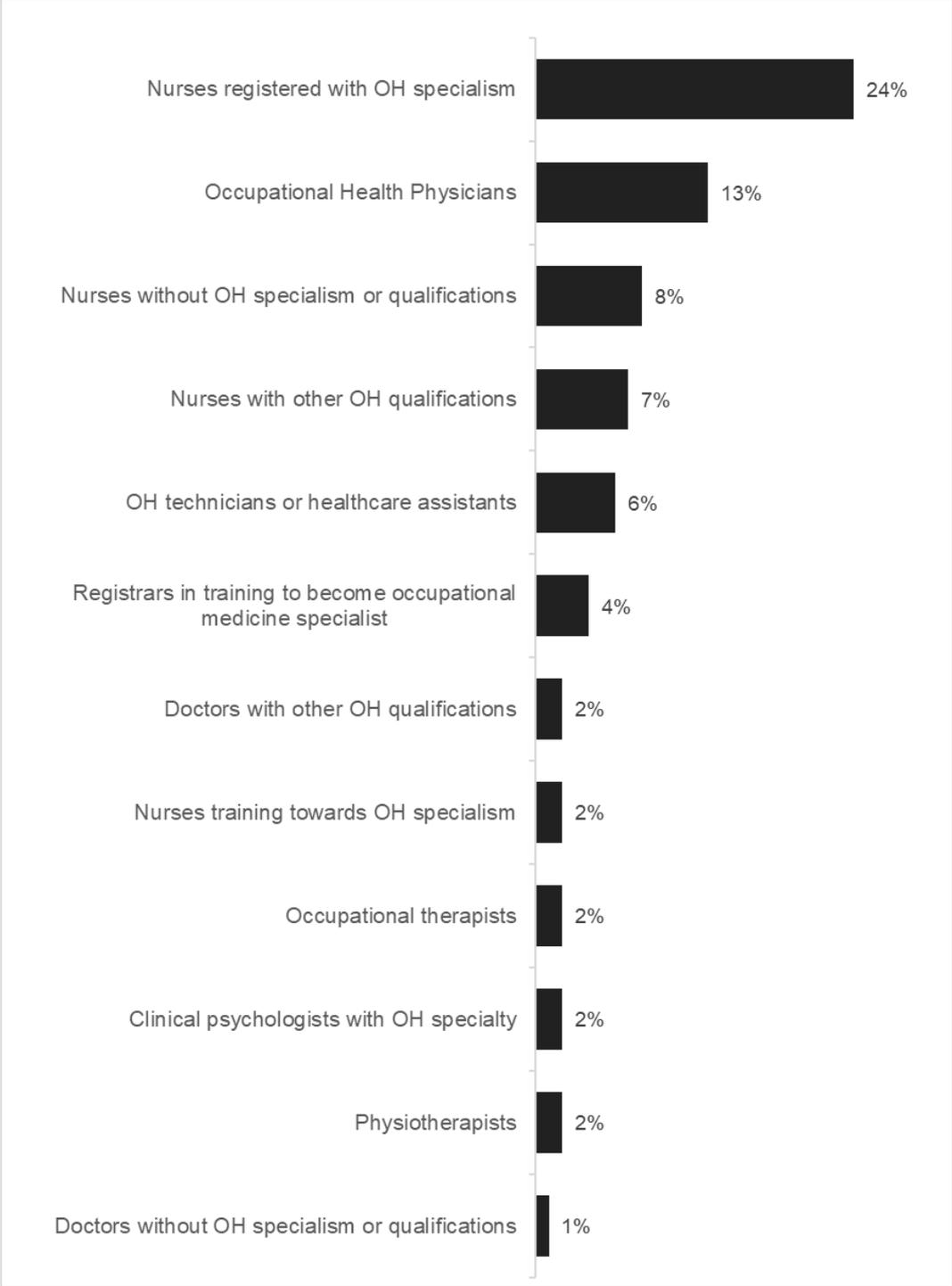
Base: All private and NHS OH providers that participated in workforce survey (156)

NHS providers, and providers where funded training is available were more likely to have vacancies, with higher numbers of vacancies on average. This likely reflects the tendency of such providers to employ higher numbers of staff, as larger providers were also more likely to have vacancies and to have higher numbers of vacancies on average.

Providers were most likely to report vacancies for registered nurses with a SCPHN OH qualification. 24% of providers reported vacancies in this occupation, with an average of 0.5 vacancies per provider: four-in-five of these providers (81%) reported 1-2 vacancies. 13% of providers reported vacancies for OHPs with an average of 0.2 vacancies per provider: 85% of these providers reported 1-2 vacancies, indicating that medical professionals registered with a specialism in OH are in particularly short supply (Figure 5.20). This also potentially corroborates expert suggestions that traditional training routes are failing to generate a sufficient supply of OHPs, and also

corroborates the earlier finding that registrars training in this specialty were the most frequently unfilled training post.

Figure 5.20: Proportion of providers with vacancies in particular occupations



Base: All private and NHS OH providers that participated in workforce survey (156)

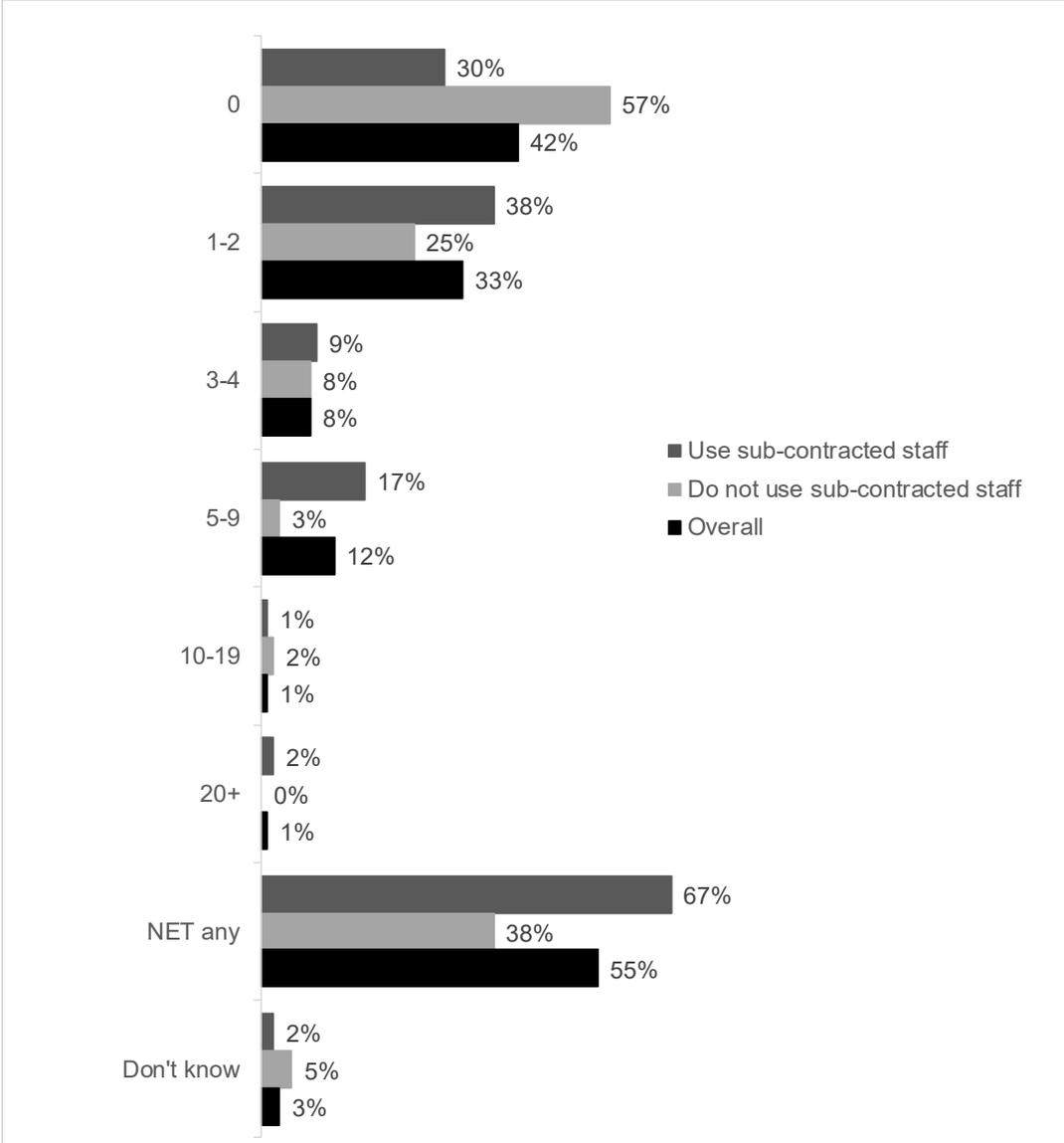
Vacancies actively recruiting for

The vacancies providers were actively sourcing or recruiting mirrored overall vacancies: on average providers were actively recruiting or sourcing for 1.1 vacancies, and nearly a third of providers (29%) were actively sourcing or recruiting for at least one vacancy. This suggests that providers are taking a proactive approach to filling vacancies, with only a minority (7%) of providers who had vacancies not actively recruiting for such vacancies. Active recruitment was most common in the cases of registered nurses with a SCPHN OH qualification (22% of providers were actively recruiting for vacancies in this occupation) and OHPs (10%).

Staff leaving

An average of 2.1 employees had left each provider in the previous 12 months; over half (55%) of providers reported at least one member of staff leaving in the previous 12 months (Figure 5.21). The proportion of providers which reported a member of staff leaving rose to over two thirds (67%) among those using subcontracted staff, which may suggest that subcontracted staff are used as a short-term solution to filling vacancies. Larger providers, NHS providers, and providers where funded training is available were also more likely to report staff leaving – which is likely due to such providers tending to have larger workforces.

Figure 5.21: Number of staff who have left OH department / organisation in last 12 months



Base: All private and NHS OH providers that participated in workforce survey (156)

Nurses with a SCPHN OH qualification (33% of providers reported at least one member of staff in this occupation leaving), nurses without an OH specialism or qualifications (15%), and OH technicians or healthcare assistants (14%) were the roles that OH providers most commonly reported staff having left from in the previous 12 months.

5.5.2 Ease or difficulty of recruiting, and actions taken if a role cannot be filled

Private providers were asked about job roles they had been unable to fill. Over two-fifths (44%) of private providers had roles they were unable to fill, with the proportion higher amongst providers with 10 or more staff (57% of those with 10 or more

employees compared to 34% of those with fewer). Those offering more than 10 types of services were also more likely to have vacancies they were unable to fill (53% compared to 31% of those offering fewer). Most commonly, the unfilled roles were OH nurses or OH doctors. Private providers felt that the main reason they were not able to fill these roles was a lack of clear routes into the sector in recent years, meaning the number of medical professionals with OH experience was decreasing.

Both private and NHS OH providers were asked how easy or difficult it has been over the past three years to recruit for different job roles (Figure 5.22). Across most job roles, the majority of providers found it was difficult to recruit. The only job roles for which the majority of providers said it was easy to recruit were relatively non-specialist: nurses without an OH specialism or qualifications (22% said it was easy to recruit for such positions, compared with 17% who said it was difficult⁵⁴), and OH technicians or healthcare assistants (25% said it was easy, compared with 7% who said it was difficult).

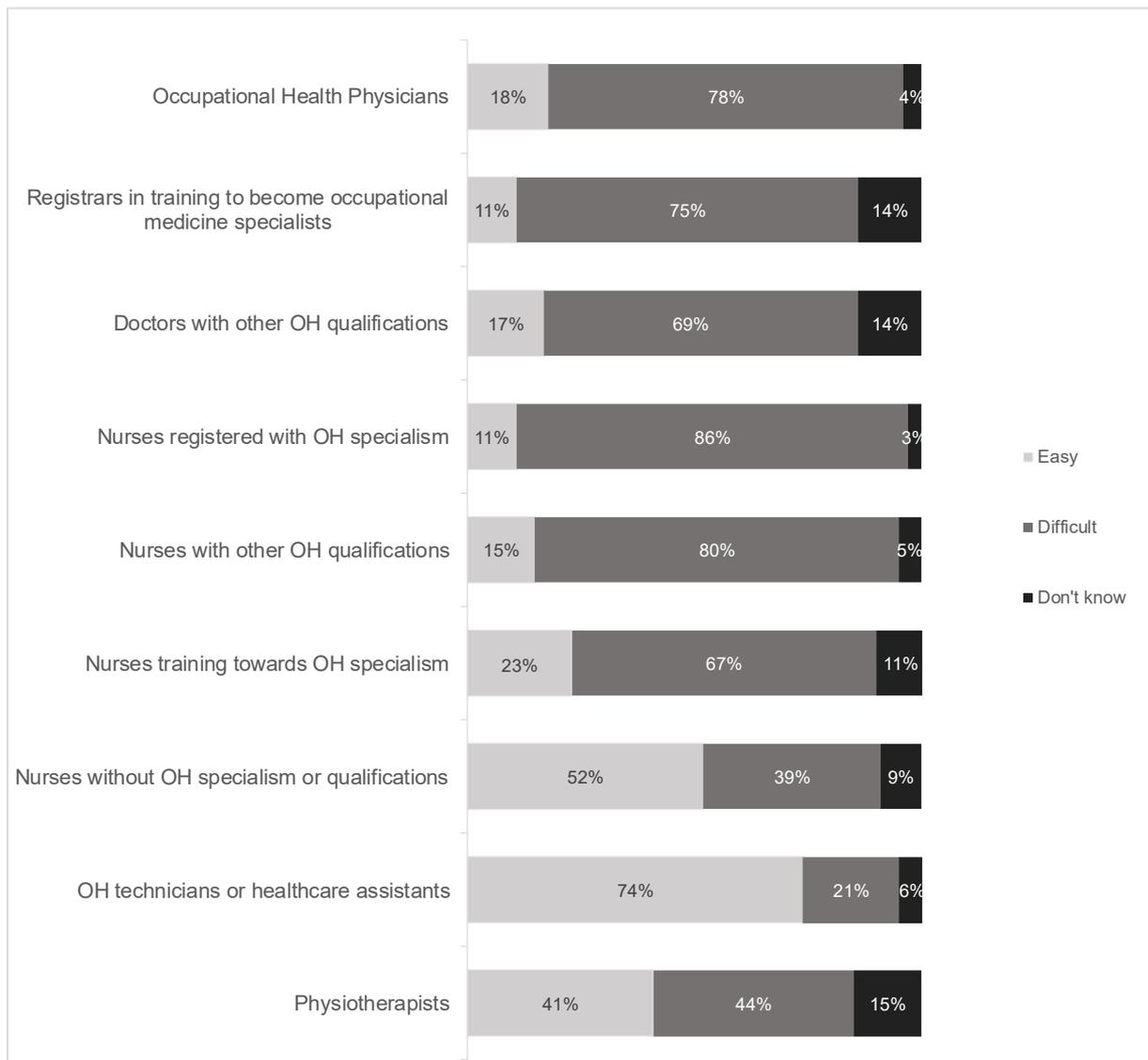
The job roles which providers most struggled to recruit for were relatively specialised roles, and broadly mirror the job roles which providers had vacancies in: nurses with a SCPHN OH qualification (51% found it difficult, compared with 6% who found it easy), nurses with other OH qualifications (41% found it difficult, compared with 8% who found it easy), and OHPs (37% found it difficult, compared with 8% who found it easy). Among those providers who found recruitment difficult, a significant proportion (between around a quarter and a third depending on the job role in question) reported that recruitment had been 'very' difficult.

Providers who use subcontracted staff found it harder to recruit nurses with a SCPHN OH qualification (58% found it difficult compared with 41% which didn't use subcontracted staff) and nurses with other OH qualifications (49%, compared with 30%), which again may suggest that the use of subcontracted staff is a reflection of recruitment difficulties, rather than provider preference. Larger providers, NHS providers, and providers where funded training is available also tended to report greater difficulties recruiting for various job roles – which is again likely due to such providers tending to have more roles to recruit for.

On the other hand, NHS providers found it easier than private providers to recruit nurses training towards a SCPHN OH qualification (15% of NHS providers found it easy, compared with 5% of private providers) and nurses without an OH specialism or qualifications (40% of NHS providers found it easy, compared with 13% of private providers). Larger providers also found it easier than smaller providers to recruit the latter. This could be a reflection of NHS providers and larger providers being able to offer more training opportunities to nurses who have not yet specialised in OH.

⁵⁴ The majority of the remainder said they have not tried to recruit for the role over the past three years, with a small proportion saying they did not know. The same applies across each of the job roles.

Figure 5.22: Ease/difficulty of recruiting for particular occupations



Base: All private and NHS OH providers that employ each role (bases range from 34 to 92. Roles where base is less than 30 have been excluded)

When respondents were asked what they typically do if a job role cannot be filled, the most commonly mentioned courses of action involved attempting to maximise the capacity of the existing workforce: nearly three quarters (72%) of respondents said they restructured teams and workloads, and nearly two thirds (63%) said they looked to train and promote staff from within the organisation (Figure 5.23).

Case study – example of meeting skills gaps through internal training

One OH provider noted that they particularly struggle to recruit individuals who both have experience at a senior level or nursing and also have an OH qualification.

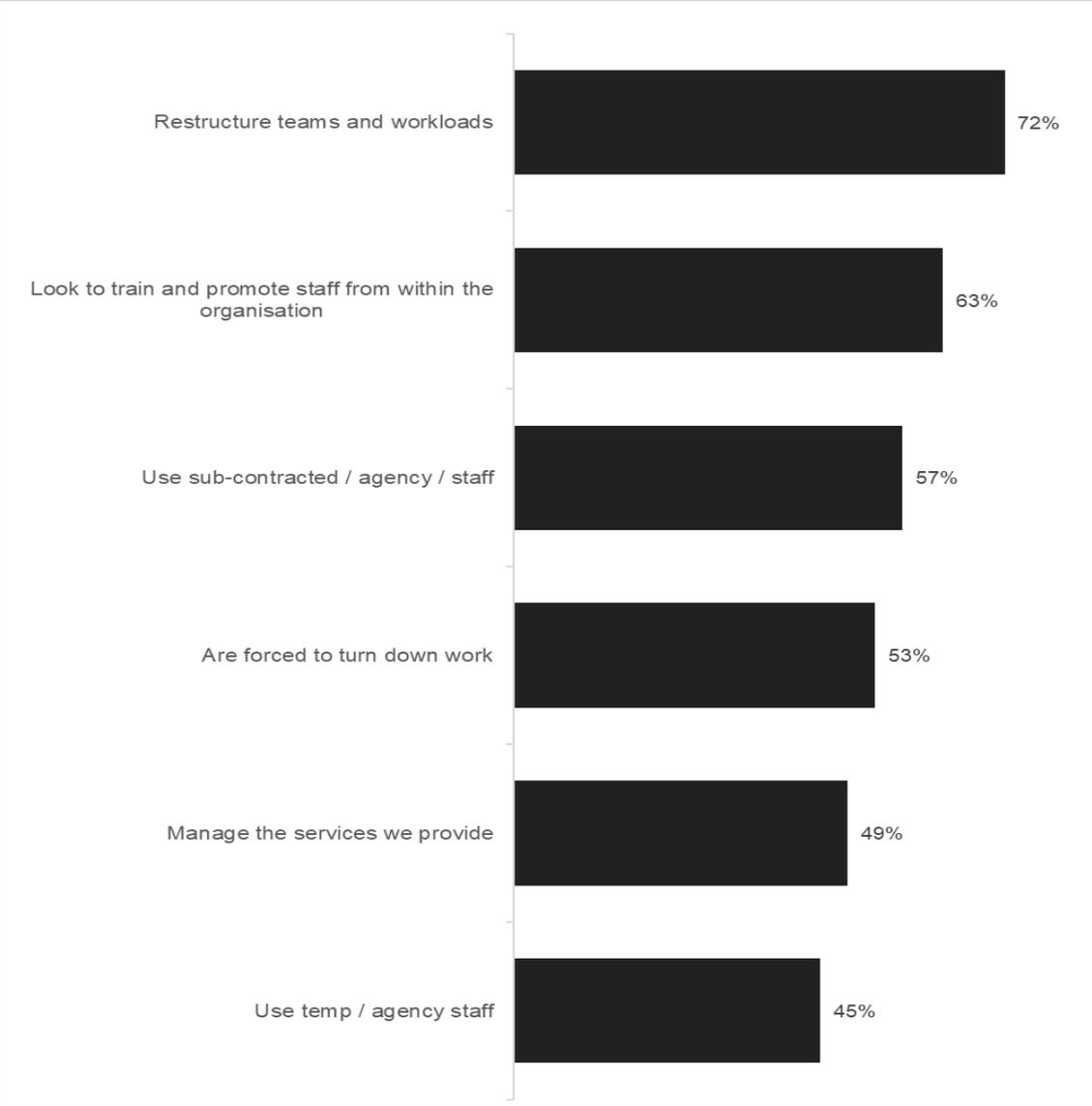
“So, there might be nurses who are working at a band 7 level, a senior nurse level, a ward sister level, but they don’t have the occupational health specialist certificate. So it’s the occupational health specialist qualification and appropriate experience that’s missing.”

To meet this skills gap, their approach is to employ nurses without OH qualifications at a more junior level (typically band 5), and sponsor their OH training. That way, once these nurses are ready to take on more senior roles they do so with the right balance of skills that the provider needs

Recruitment difficulties are clearly having an impact on existing OH capacity: for over two-thirds of respondents (67%), inability to recruit had a negative impact on the amount of work they were able to provide for clients. Over half (53%) said they were typically forced to turn down work if a role could not be filled, and nearly half (49%) said they typically managed the services they provided, for example by limiting the number of clients. While on the face of it this may conflict with the finding that most private OH providers are not operating at full capacity (see Section 4.2), it is plausible that providers may be turning down work that would see them operating at or above full capacity due to recruitment difficulties, or managing the services they provide so as to avoid approaching full capacity.

NHS providers were more likely to take steps which had a negative impact on the amount of work they were able to provide (87%, compared to 58% among private providers) – possibly because the core focus of such providers is the provision of OH care for workers within the NHS, with services for clients treated as secondary to this, and hence reduced when recruitment difficulties are experienced. NHS providers were also more likely to attempt to maximise the capacity of the existing workforce (e.g. 92% said they restructured teams and workloads, compared with 62% of private providers). This could, however, simply be a reflection of the fact that NHS providers tended to be larger than private providers, and larger providers were more likely than smaller providers to take steps in general – which could be linked to their greater capacity and resources to implement measures.

Figure 5.23: Actions typically taken if a role cannot be filled



Base: All private and NHS OH providers that participated in workforce survey (156)

6 Clinical Commissioning Group commissioning of musculoskeletal services

This chapter summarises findings from a survey of individuals who lead on the commissioning of musculoskeletal (MSK) services within Clinical Commissioning Groups (CCGs) across England. The survey focused specifically on the MSK services commissioned by the CCGs and any links to occupational and vocational-related support, which was defined as support that helps an individual with a health problem to stay at, return to and remain at work.

In total, 87 MSK leads participated in the survey, either completed online or via telephone interview. As some of the MSK leads work across more than one CCG, they were able to provide data for multiple CCGs. In total, 111 CCGs were represented in the survey, 76 of which were lead CCGs. Lead CCGs commission both community and hospital-based services, and the remaining 35 CCGs commission only community-based services.

This chapter covers:

- the MSK services commissioned by CCGs (Section 6.1);
- the degree to which MSK is a priority area for CCGs (Section 6.2);
- the level of tailoring of MSK services to the working age population (Section 6.3);
- the level of commissioning with employment outcomes in mind (Section 6.4)
- the capacity of MSK services (Section 6.5);
- multidisciplinary support (Section 6.6);
- what works well in MSK commissioning and areas for improvement (Section 6.7); and
- the use of specific occupational and vocational-related support (Section 6.8).

6.1 MSK services commissioned by CCGs

6.1.1 The frequency with which MSK services are commissioned and used by working age people

Almost all CCGs commissioned the following MSK services (Figure 20):

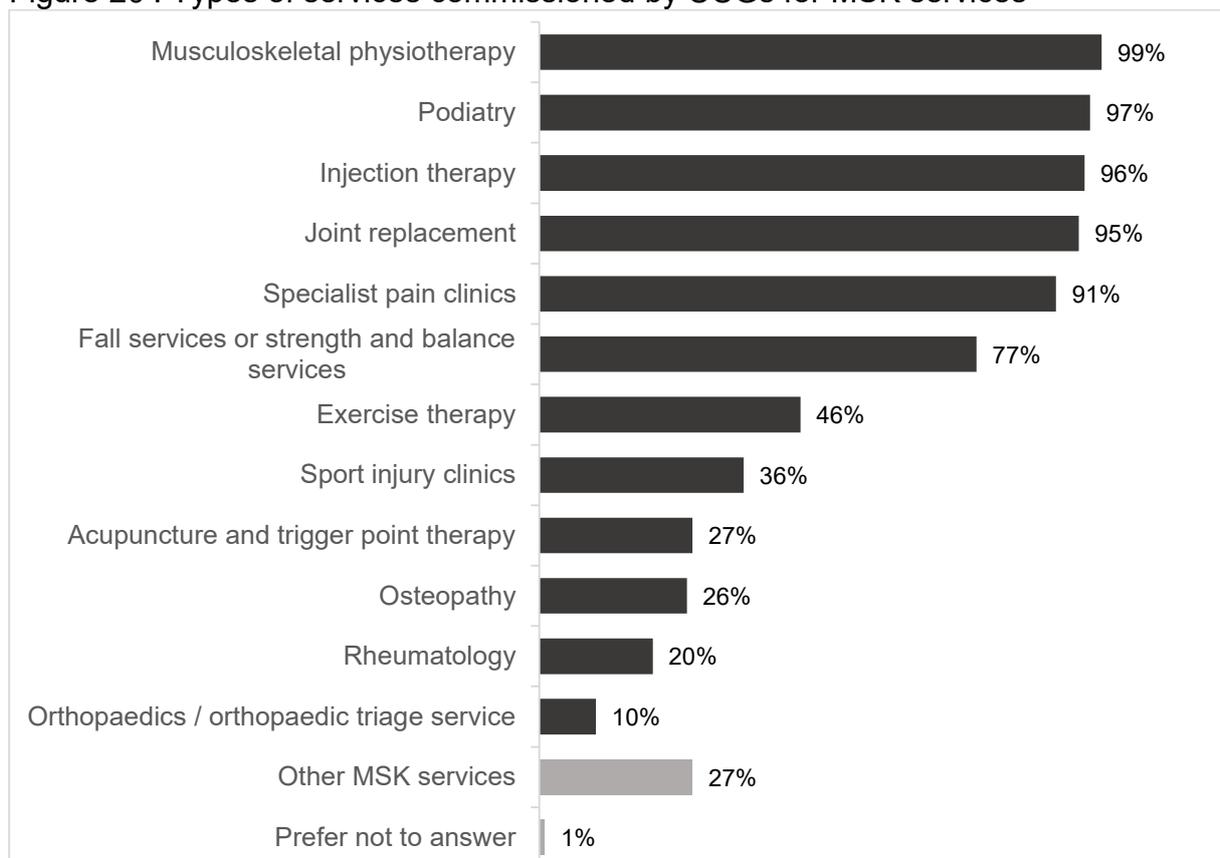
- Musculoskeletal physiotherapy (99% - the only CCG that did not offer this service declined to answer the question);
- Podiatry (97%);
- Injection therapy, such as joint injection or spinal injections (96%);

Understanding the provision of occupational health and work-related musculoskeletal services

- Joint replacement (95%);
- Specialist pain clinics (91%).

MSK services rarely commissioned by CCGs included orthopaedics (10%), and chiropractic services (6%). There were also a variety of services commissioned only by a very small minority (5% or less) of CCGs, for example first contact physiotherapy and bone health services.

Figure 20 : Types of services commissioned by CCGs for MSK services



Base: All CCGs (111)

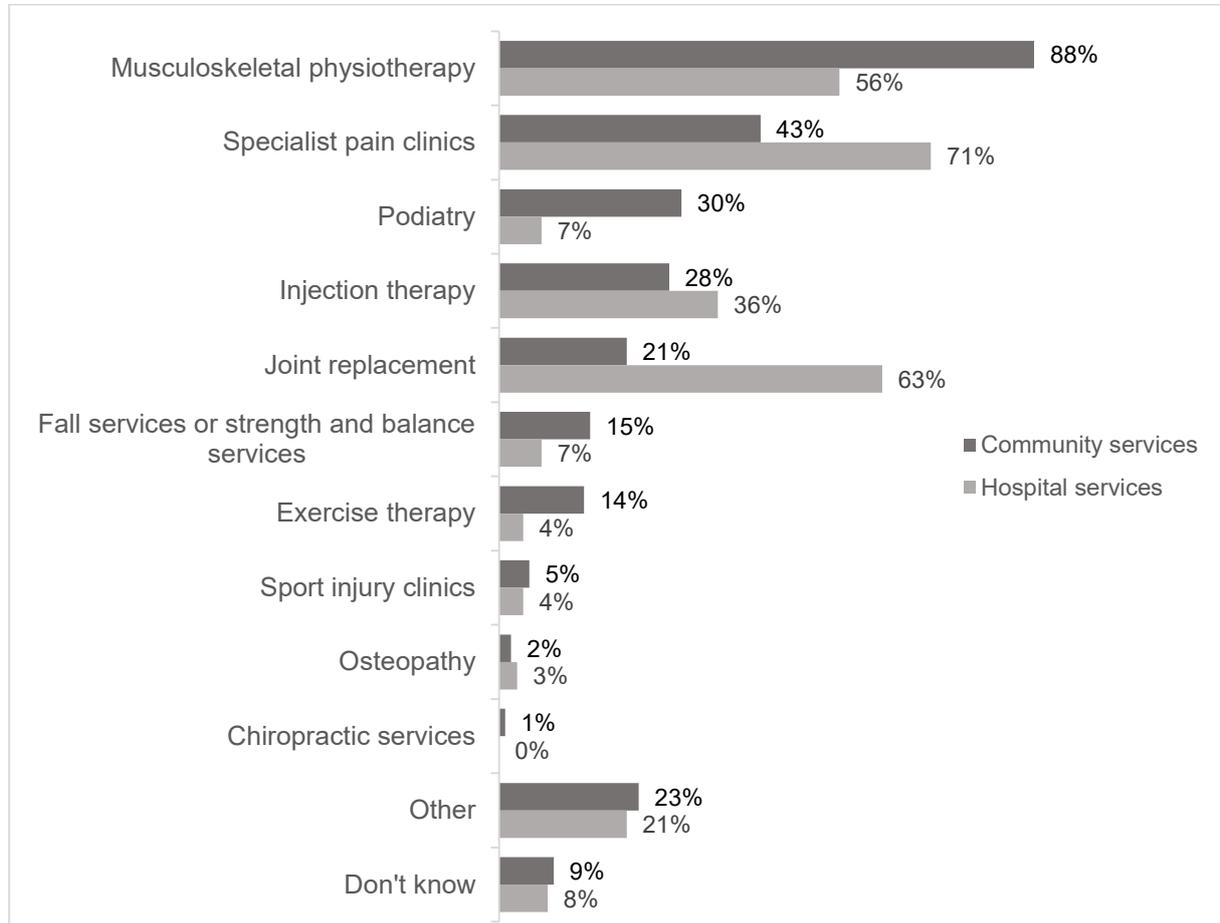
As well as being the most commonly commissioned, musculoskeletal physiotherapy was also reported to be the most commonly used community-based MSK service among working age people: nine in ten (88%) CCGs reported that MSK physiotherapy was in their top three most commonly used community services (Figure 6.2). The next most commonly used community-based MSK services were specialist pain clinics (43%), podiatry (30%) and injection therapy (28%).

Specialist pain clinics were believed to be the most commonly used hospital-based service among working age people (71%), followed by joint replacement (63%), MSK physiotherapy (56%) and injection therapy (36%).

Injection therapy was significantly more likely to be in the top three most used community and hospital-based services for predominantly urban CCGs than for

CCGs with an even mix of rural and urban (40% vs. 16% for community; 50% vs. 25% for hospital).

Figure 21 : Top three most commonly used community or hospital-based services



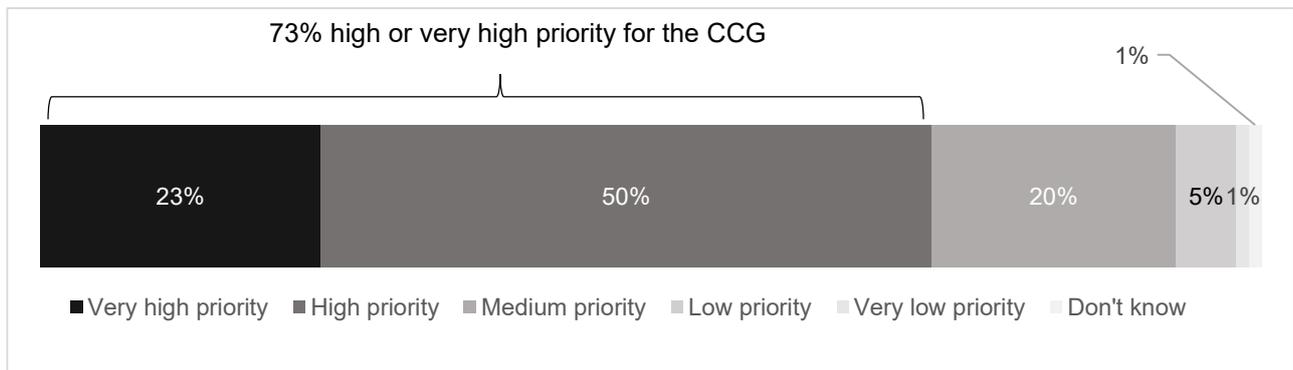
Base: All CCGs that commission three or more MSK services used by working age people (community-based: 109; hospital-based 75)

6.2 Degree to which MSK is a priority area

MSK leads were asked about their views on the extent to which MSK care for working age people was a priority area for their CCG (Figure 22).

MSK care was widely considered to be a priority area for CCGs: a quarter (23%) viewed MSK care as a very high priority, and half (50%) considered it to be a high priority. Only 6% considered MSK to be a low or very low priority for the CCG.

Figure 22: Extent MSK provision for working age people a priority for the CCG



Base: All MSK leads whose CCG commissions MSK services (86)⁵⁵

The most commonly cited reasons for prioritising MSK services related to strategic considerations (Figure 6.4): a quarter (23%) said they were reviewing and/or redesigning their MSK services at the time of the survey⁵⁶, one tenth (10%) said MSK services were an NHS priority and/or they had been directed by NHS England to prioritise them, and 9% explicitly mentioned that MSK services had been identified as a priority in the NHS Long Term Plan.

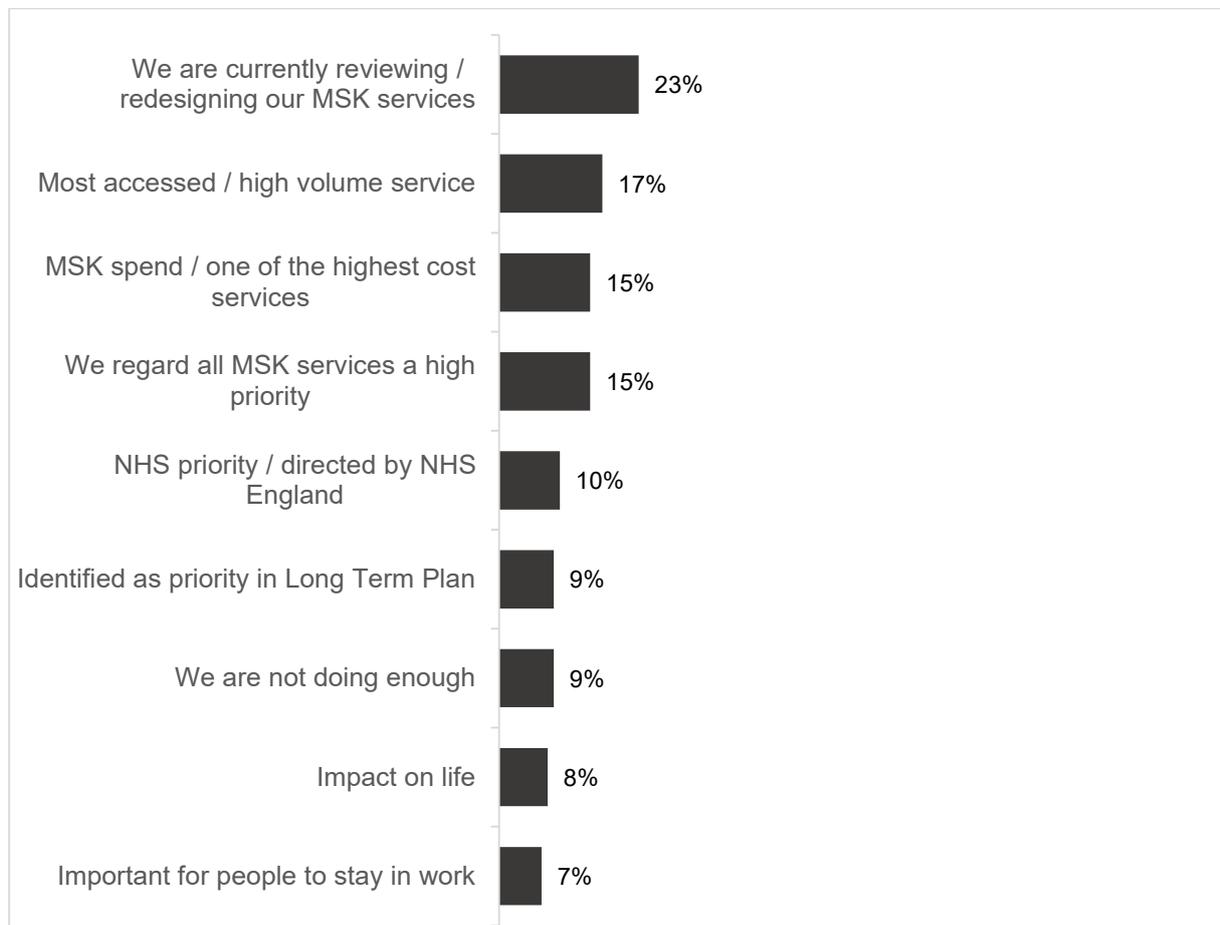
These factors, combined with the 9% of respondents who said they were not doing enough in terms of MSK services for working age people and needed to prioritise them more, may imply a relatively recent shift towards the prioritisation of MSK services for working age people.

The cost of MSK services was also frequently cited by respondents as a reason for their prioritisation: nearly a sixth (15%) mentioned that MSK services for working age people were one of the highest cost service areas. CCGs suggested MSK services were prioritised due to the amount of money being spent – this increased the importance of generating cost-savings, as well as facilitating possibilities for service redesign.

⁵⁵ This comprises all CCG leads, with the exception of the one CCG lead who said, when asked about what types of services for individuals with MSK conditions their CCG commissioned, that they did not commission any MSK services.

⁵⁶ For example, the CCG may have recently conducted a review of their service offering that identified a need for redesign of their MSK services or suggested new MSK services should be developed.

Figure 23: Reason behind the priority level given to MSK services for working age people

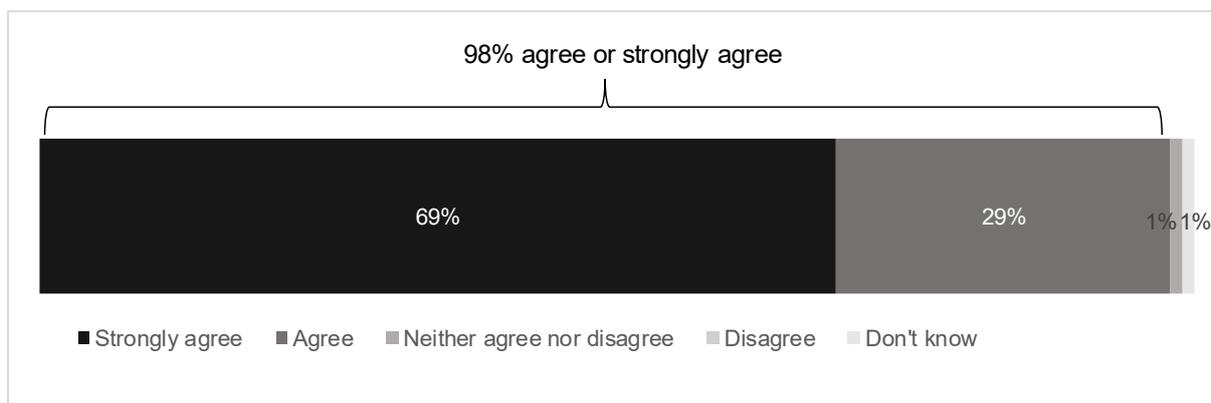


Base: All MSK leads whose CCG commissions MSK services (86). Respondents gave open answers that were subsequently coded, so could have mentioned multiple reasons.

Being responsive to demand also recurred as a theme here, with one in six (17%) MSK leads reporting that it is a priority simply because it is the most-accessed, high-volume service. Explicit recognition that MSK services were important to help working age people stay in work was relatively rare, however only one in fourteen (7%) stated this.

High levels of demand are also reflected in the finding that, when asked whether they agreed that there was high demand for MSK services (Figure 6.5), nearly all (98%) MSK leads agreed or strongly agreed that this was the case – with over two thirds of CCGs (69%) strongly agreeing, and none disagreeing.

Figure 24: Agreement with statement ‘There is high patient demand for the musculoskeletal services’



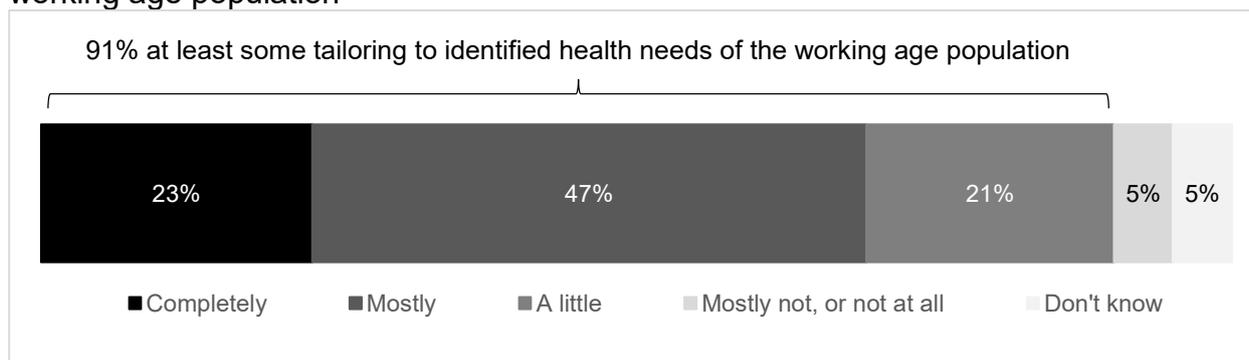
Base: All MSK leads whose CCG commissions MSK services (86)

6.3 Tailoring to working age population

CCGs were asked to what extent the musculoskeletal services they commissioned were tailored to the identified health needs of the working age population (Figure 25).

Some degree of tailoring was widespread: nine in ten CCGs (91%) said that their MSK services were tailored to the identified health needs of the working age population to at least some extent. Two thirds of CCGs (70%) said that their MSK services were tailored ‘mostly’ or ‘completely’ to the needs of the working age population.

Figure 25: The extent MSK services are tailored to identified health needs of the working age population

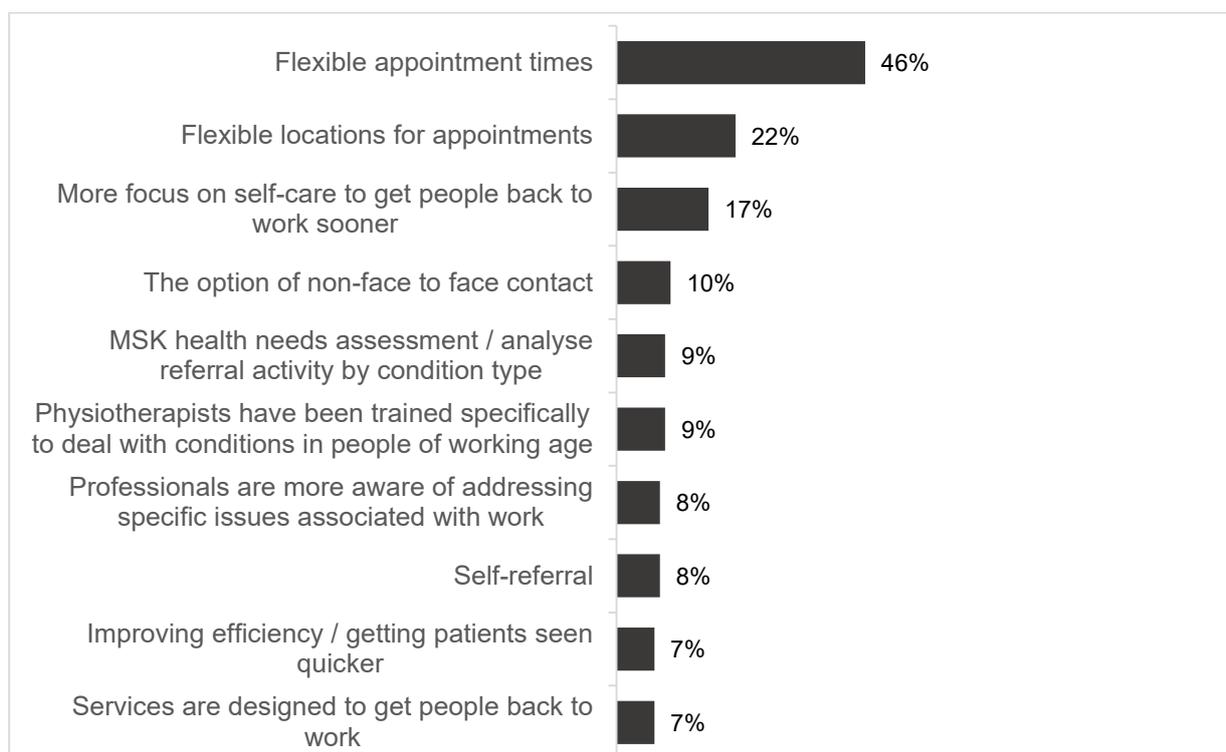


Base: All CCGs that commission MSK services (110)

The most common ways CCGs tailored their services to the working age population were mostly limited to flexibility in access to services (as opposed to tailoring of the services themselves): nearly half (46%) of CCGs that tailor their services said that they offered flexible appointment times, over a fifth (22%) said that they offered flexible appointment locations, and a tenth (10%) mentioned providing options other than face-to-face contact (such as telephone or web appointments) to patients (Figure 26). Other relatively commonly cited examples involved giving patients

greater involvement in or autonomy over treatment: one in six (17%) said they were focusing more on self-care, one in eleven (8%) said they offered self-referral, one in twenty (6%) mentioned the use of shared decision-making and a similar proportion (4%) said that services were tailored through patient engagement sessions. Some CCGs also focused on upskilling existing staff to better meet the needs of the local population: one in ten (9%) said that they had trained physiotherapists specifically to deal with conditions in working age people, and a similar proportion (8%) said professionals were now more aware of addressing specific issues associated with work.

Figure 26: How MSK services are tailored to the working age population

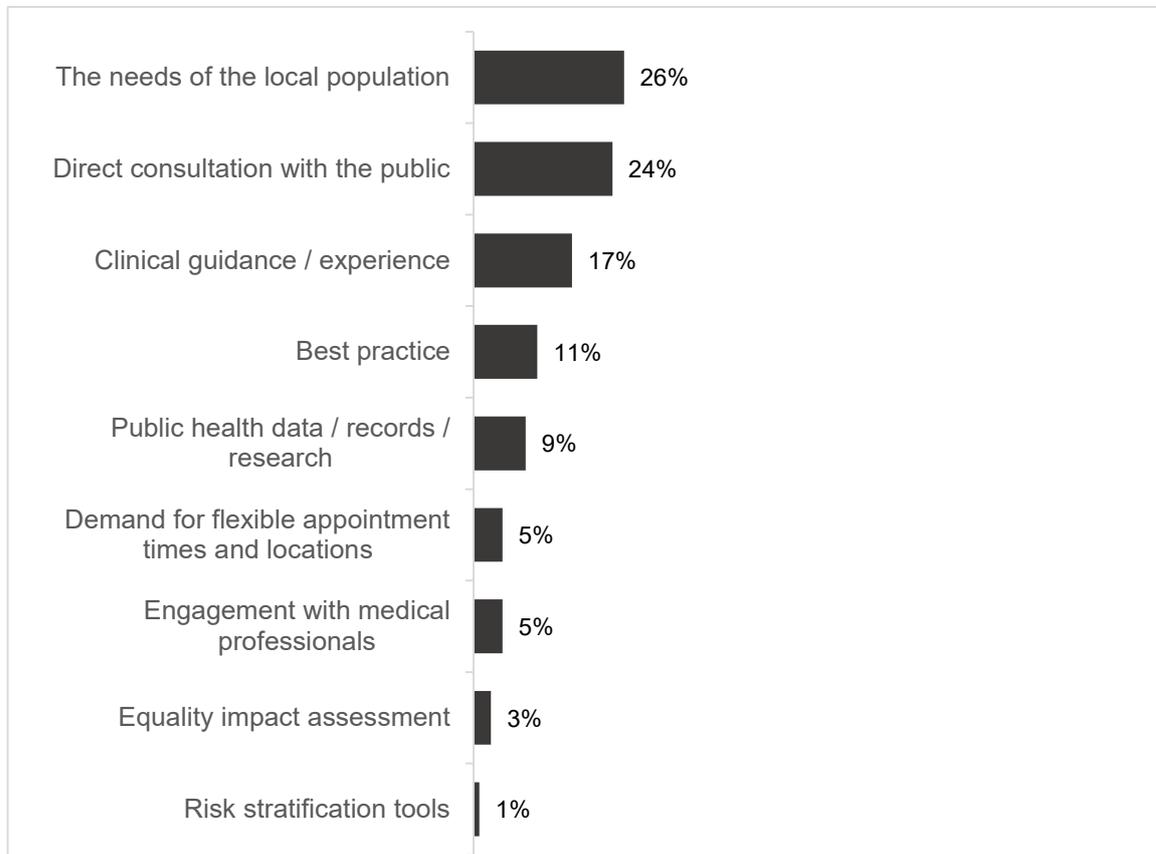


Base: All CCGs that tailor MSK services to the local population (105). Respondents gave open answers that were subsequently coded, so could have mentioned multiple reasons.

CCGs that tailored their MSK services to the local population were also asked what informed the decision to tailor their services (Figure 6.8). The most prevalent factors related to the needs and interests of the local population: a quarter (26%) said the decision to tailor was simply informed by the needs of the local population and a similar amount (24%) said it was informed by direct consultation with the public or local community (a further 5% said the decision was driven by demand for flexible appointment times and locations). Factors related to proven medical effectiveness or expertise were cited less frequently – a sixth (17%) said it was informed by clinical guidance or experience, a tenth (11%) said the decision was informed by best practice, and 5% said it was guided by engagement with medical professionals. This suggests that what tailoring does take place is more commonly related to

accessibility, and informed by public demand, than driven by best practice or expertise.

Figure 27: What informed the decision to tailor MSK services specifically for the working age population



Base: All CCGs that tailor MSK services to the local population (105)

6.4 Commissioning with employment outcomes in mind

CCGs were asked which, if any, of the MSK services they offered were commissioned specifically to support an individual with a health problem to stay at, return to and remain at work, or to meet a local health need for the working-age population (Figure 6.9).

The majority of CCGs (79%) said that none of their services were commissioned specifically with employment needs or vocational rehabilitation in mind⁵⁷. CCGs which cover a predominantly urban area (89%) and lead CCGs (85%) were more

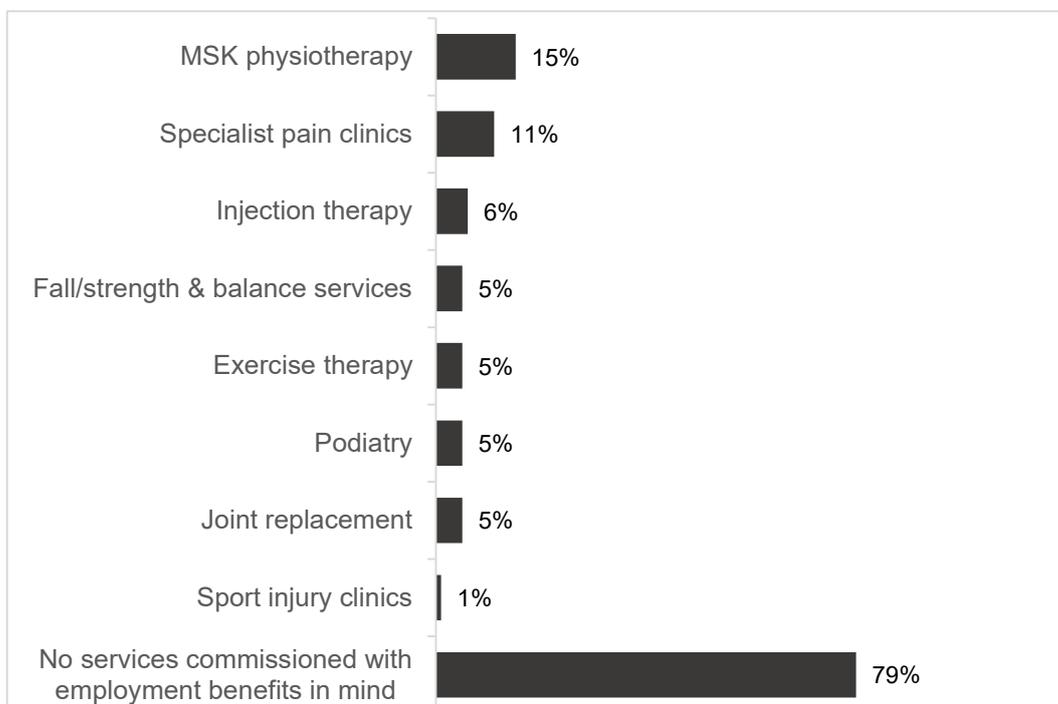
⁵⁷ In the survey, 'employment needs or vocational rehabilitation' was defined as support that helps an individual with a health problem to stay at, return to and remain at work.

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likely to report that none of their services were commissioned specifically with employment needs or vocational rehabilitation in mind.

The services which were most commonly cited as being commissioned specifically with employment needs or vocational rehabilitation in mind were MSK physiotherapy (15%) and specialist pain clinics (11%). Some relatively widely commissioned services (such as acupuncture and trigger point therapy, and osteopathy, both commissioned by around a quarter of CCGs) were not mentioned by any respondents as being commissioned specifically with employment needs or vocational rehabilitation in mind.

Figure 28: MSK services commissioned specifically with employment needs or vocational rehabilitation benefits in mind



Base: All CCGs that commission MSK services (110)

The most commonly cited reasons for commissioning with employment needs or vocational rehabilitation in mind, by the 21% of CCGs that did so, were simply that MSK physiotherapy and pain management are known to have a better chance than, for instance, the use of surgical procedures, of getting people back to work.

Other reasons included a desire to reduce referrals to hospitals, responding to the increasing number of people unable to work due to MSK conditions, and to help patients get seen earlier in their treatment pathway.

6.5 Capacity of MSK services

MSK leads were often unable to answer questions on the capacity⁵⁸ of their MSK services for working age people. While CCGs reported holding this data, many were not able to provide this information during the interview due to the time-consuming nature of accessing and compiling this data. MSK leads were asked about how many people, on average, were on the waiting list for various MSK services on a monthly basis over the previous year; about target and actual waiting times for people seeking to access MSK services; and about the average per-user, per-year cost of MSK services. In each case, the vast majority of respondents were unable to answer the question.

MSK leads were also asked about the proportions of individuals referred to MSK services via different referral pathways. The majority of working-age patients were referred to both community and hospital-based MSK services via their GP. Referral through hospital health care professionals was also relatively common – more so for hospital-based services than community-based. There were also relatively high levels of self-referral, although this was higher for community-based services than hospital-based. Self-referral rates were particularly high for MSK physiotherapy in a community setting.

Table 6.1: Mean proportion of source of referral for community-based MSK services

	BASE ABLE TO PROVIDE ANSWER	GP	HOSPITAL HCP	IAPT SERVICES	OTHER PRIMARY CARE SERVICES	SELF- REFERRAL	OTHER
MUSCULOSKELETAL PHYSIOTHERAPY	73	73%	5%	1%	2%	15%	5%
SPECIALIST PAIN CLINICS	35	79%	10%	1%	0%	0%	7%
PODIATRY	17	84%	6%	1%	3%	6%	0%
INJECTION THERAPY	18	61%	7%	1%	10%	4%	1%
JOINT REPLACEMENT	21	68%	14%	0%	5%	0%	9%
EXERCISE THERAPY	11	51%	31%	0%	7%	7%	5%

Base: MSK physiotherapy: CCGs that commission MSK physiotherapy as a community-based service; all other services: service one of top 3 most used community-based services among working age people, or who offer the service but were unable to select a top 3 most used community-based services.

Note: only services with a base over 10 able to answer shown

⁵⁸ To gauge capacity, a series of questions were asked about numbers of individuals on waiting lists and average waiting times, with the aim of understanding the extent to which services were oversubscribed or not

Table 6.2: Mean proportion of source of referral for hospital-based MSK services

	BASE ABLE TO PROVIDE ANSWER	GP	HOSPITAL HCP	IAPT SERVICES	OTHER PRIMARY CARE SERVICES	SELF- REFERRAL	OTHER
SPECIALIST PAIN CLINICS	37	65%	14%	<1%	<1%	<1%	17%
JOINT REPLACEMENT	24	58%	14%	0%	5%	0%	20%
MUSCULOSKELETAL PHYSIOTHERAPY	27	46%	13%	0%	<1%	2%	22%
INJECTION THERAPY	15	42%	21%	0%	<1%	0%	10%
PODIATRY	5	49%	29%	0%	2%	0%	0%

Base: MSK physiotherapy: CCGs that commission MSK physiotherapy as a hospital-based service; all other services: service one of top 3 most used hospital-based services among working age people, or who offer the service but were unable to select a top 3 most used hospital-based services.

Note: only services with a base over 10 shown

6.6 Multidisciplinary support

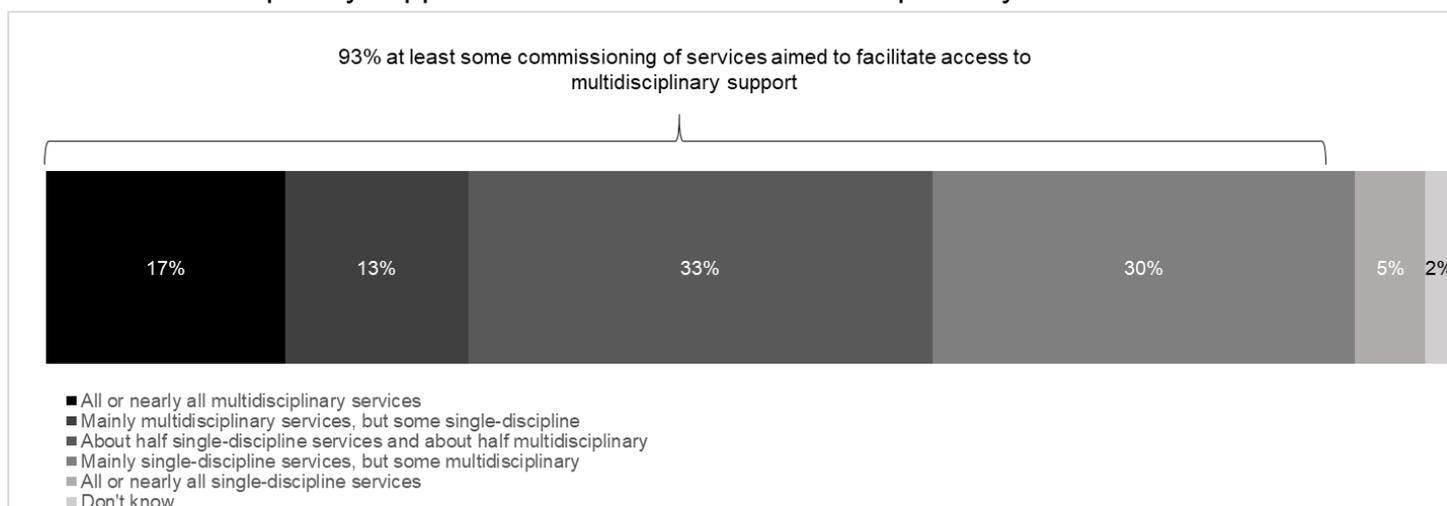
6.6.1 Extent of multidisciplinary commissioning

CCGs were asked to what extent they had deliberately commissioned MSK services that aimed to facilitate patient access to multidisciplinary support⁵⁹ within a service or treatment pathway (Figure 29). It should be noted that the question was not asking whether the MSK services themselves were delivered in a multidisciplinary manner, but rather whether the services were commissioned with the aim of facilitating access to multidisciplinary support.

Commissioning of MSK services that aimed to facilitate patient access to multidisciplinary support was widespread: the vast majority (93%) of CCGs reported at least some degree of deliberate commissioning of MSK services that aimed to facilitate access to multidisciplinary support. A substantial minority (17%) had adopted this approach to the extent that all or nearly all their commissioned MSK services aimed to facilitate access to multidisciplinary support within a service or treatment pathway.

On the other hand, 30% of CCGs said that the MSK services they commissioned were mainly single-discipline, with only some MSK services aiming to facilitate access to multidisciplinary support; and a third (33%) said that their commissioned MSK services were about half single-discipline and half aiming to facilitate access to multidisciplinary support.

Figure 29: Extent MSK services commissioned aim to facilitate patient access to multi-disciplinary support within a service or treatment pathway



Base: All CCGs that commission MSK services (110)

⁵⁹ Multidisciplinary support was defined as support from two or more members of staff from different disciplines, whether clinical or not.

When CCGs that commissioned MSK services aiming to facilitate access to multidisciplinary support were asked whether any of these services were focused on employment needs or vocational rehabilitation, two-in-five (38%) said yes, with most saying either that they weren't (51%) or that they didn't know (11%).

Together, these findings suggest that there is scope for increased use among CCGs of services aiming to facilitate access to multidisciplinary support for employment needs, where this is beneficial⁶⁰, and lessons could potentially be learned from the 17% of CCGs that already employ a model in which all or nearly all services aim to facilitate access to multidisciplinary support.

6.6.2 Examples of multidisciplinary support in practice

The 39 CCGs which said they offered MSK services aiming to facilitate access to multidisciplinary support that focused on employment needs or vocational rehabilitation were asked to provide an example of how this service worked, and the rationale for it being commissioned.

Some CCGs referenced how multidisciplinary teams work closely together: eleven CCGs said that complex patients were discussed by multidisciplinary teams to agree on the course of treatment, and five CCGs mentioned multidisciplinary teams across a range of specialities working together in a 'hub' (a closely linked network of practitioners). Eight CCGs cited the example of patients being triaged by a single professional, with this professional then referring patients on to appropriate experts if necessary. Specific examples of multidisciplinary services focused on employment needs or vocational rehabilitation included pain management, rehabilitation programmes, and function restoration programmes.

In terms of rationale for offering MSK services aiming to facilitate access to multidisciplinary support, the most commonly mentioned reasons related to effectiveness: 17 CCGs said that the service was commissioned to ensure the best possible course of treatment, 11 CCGs said it was commissioned because it would help patients manage their pain more effectively, and six CCGs said that such commissioning was best practice.

It was also clear that services aiming to facilitate access to multidisciplinary support focused on employment needs or vocational rehabilitation were being commissioned because of their greater efficiency and in response to the over-burdening of other services: six CCGs said that the service in question was commissioned to avoid the duplication of services and to ensure a streamlined pathway, five CCGs said that it was commissioned to ensure patients were seen as quickly as possible, and five CCGs said that it was commissioned to make best use of limited secondary care resources.

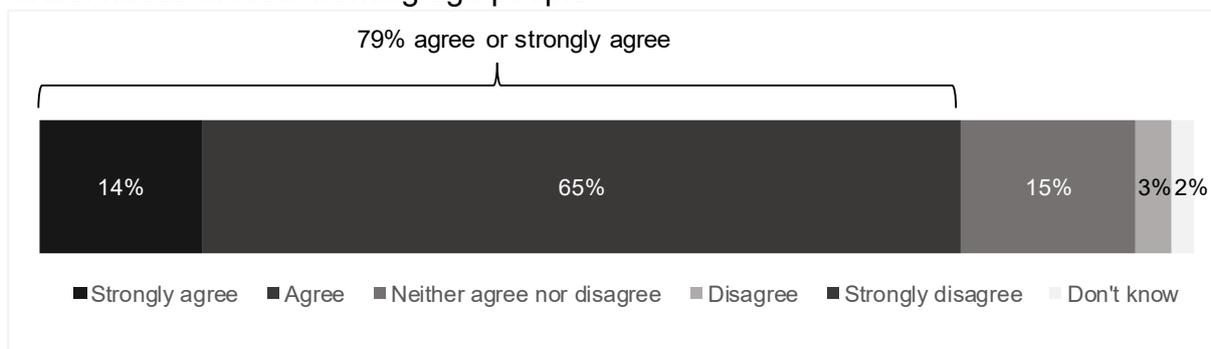
⁶⁰ As discussed below, in section 6.6.2, when CCGs which offered multidisciplinary MSK services focused on OH were asked about the rationale for this, the most commonly mentioned reasons related to the effectiveness of such services.

6.7 What works well in MSK commissioning and areas for improvement

6.7.1 Whether MSK services meet the needs of the working age population

While four-fifths (79%) of MSK leads interviewed felt that the MSK services commissioned meet the needs of local working age people (Figure 6.11), only 14% strongly agreed that this was the case. This suggests that while MSK leads were mostly satisfied that the MSK services they commission meet the needs of their working age population, there was some room for this to be improved. Despite this, only a small minority (3%) of MSK leads disagreed with the statement.

Figure 6.11: Agreement with the statement ‘The musculoskeletal services meet the health needs of local working age people’



Base: All MSK leads whose CCG commissions MSK services (86)

6.7.2 What works well in MSK commissioning

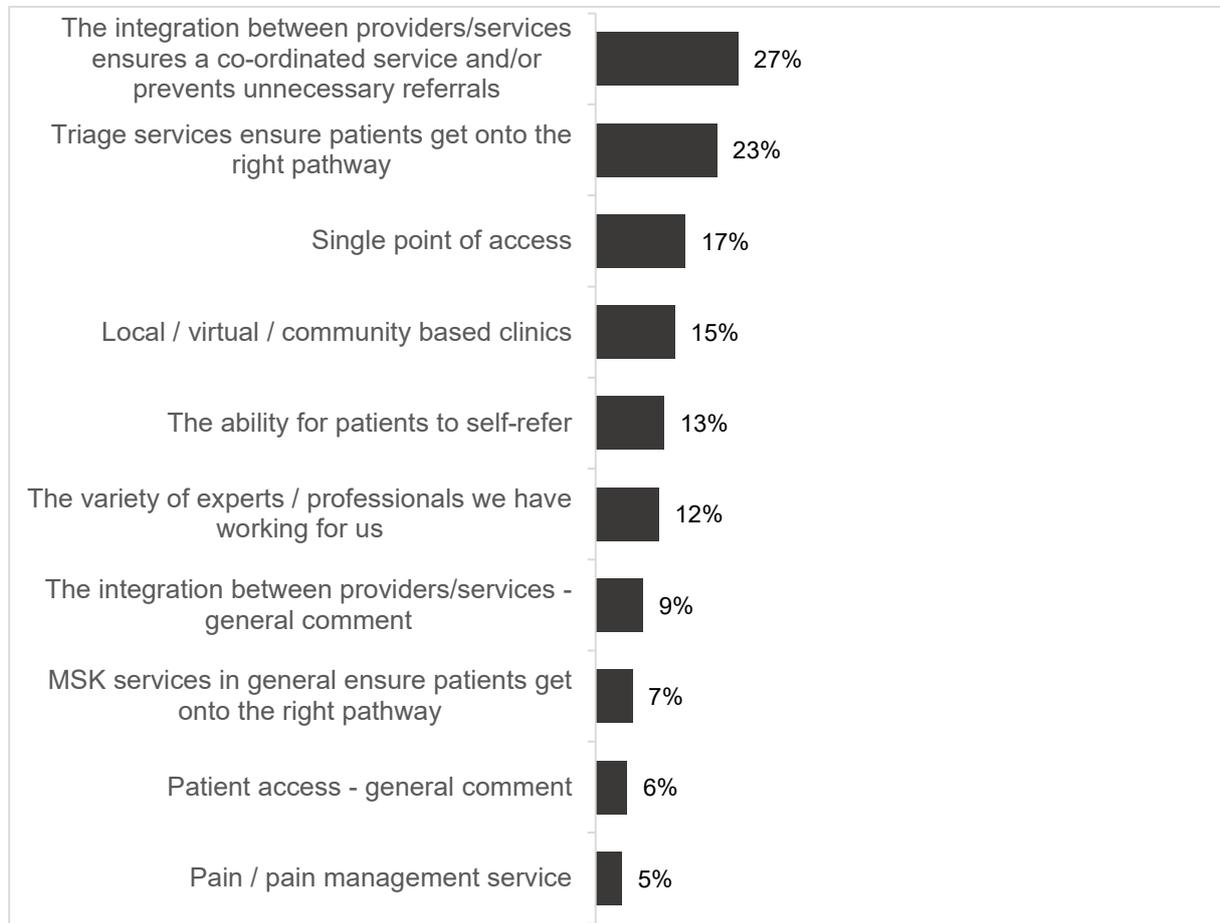
When asked which elements of MSK service commissioning worked well (Figure 6.12), the most frequently mentioned elements related to efficiency, and ways in which patients could access treatment.

Efficiency of the referral process was a key theme for MSK leads. The most frequently mentioned element was how integration between services ensured a co-ordinated service that prevented unnecessary referrals and led to treatment of patients in a timely manner. This was mentioned by over a quarter (27%) of MSK leads. Just under a quarter (23%) felt that their triage services were successful at making sure patients were put on the right pathway; and 17% felt that the existence of the single point of access (the point at which patients are triaged after being referred to the service, for example by the GP) in itself was an element that worked well, as it provided an efficient way for all patients to be referred.

Ways in which patients could access treatment was another key theme that emerged. In addition to the aforementioned ‘single point of access’, the existence of local, virtual and community-based clinics (15%) and ability of patients to self-refer

(13%) was identified by some MSK leads as something they felt worked well in their MSK service commissioning.

Figure 6.12: Elements that work well across MSK commissioning as a whole (top ten only)



Base: All MSK leads whose CCG commissions MSK services (86)

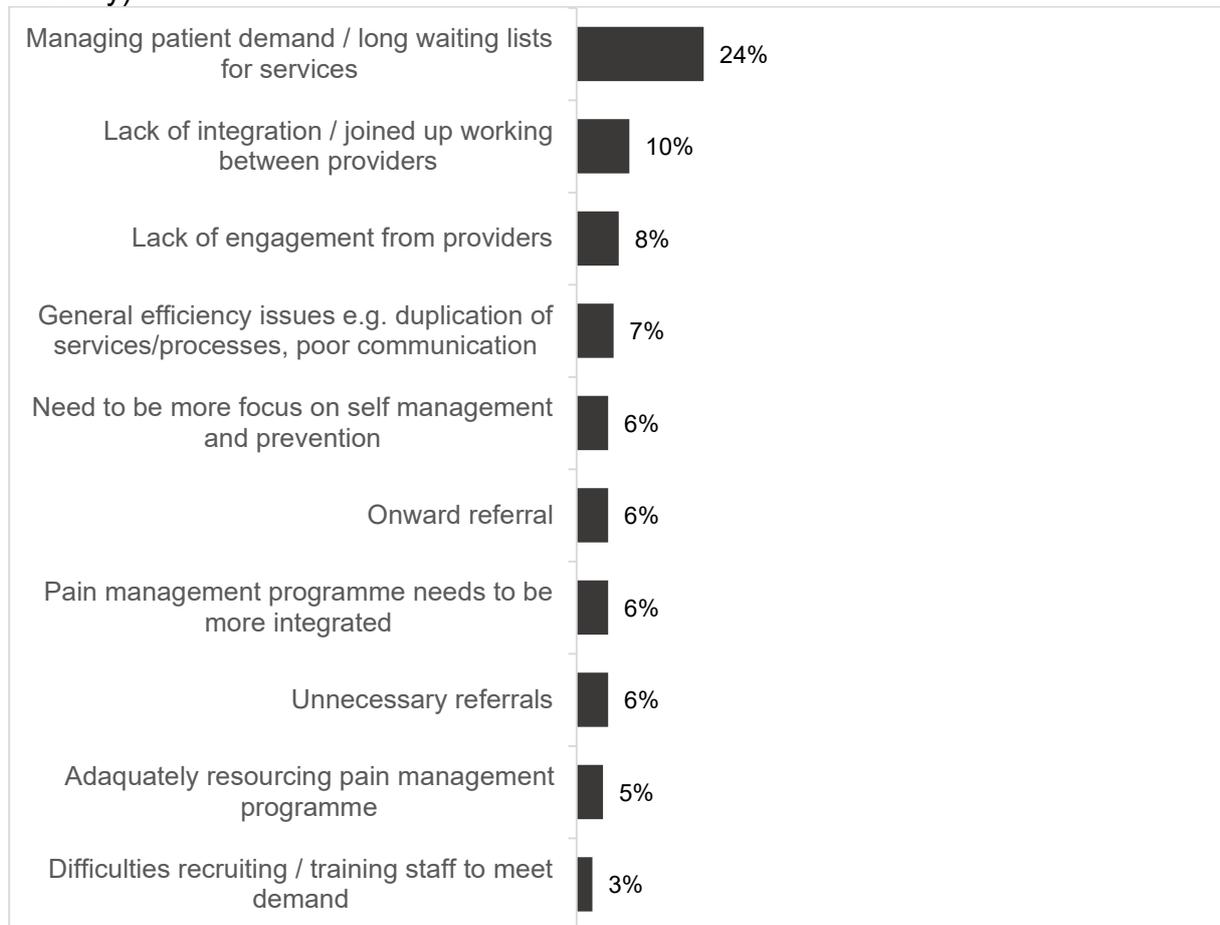
6.7.3 Areas for improvement in MSK commissioning

Managing patient demand was by far the most frequently mentioned element of MSK commissioning that MSK leads felt worked less well (Figure 6.13). A quarter (24%) of MSK leads mentioned this.

Other features identified by some MSK leads as working less well mirrored some of the themes that emerged from the elements that worked well, namely integration, efficiency and referrals. These included a lack of integration and joined up working between services in the CCG (10%), efficiency issues including duplication of services and poor communication (7%), onward referral to treatment (6%) and unnecessary referrals (6%).

Other elements mentioned by a few MSK leads were a lack of provider engagement (8%) and insufficient focus on self-management and prevention (6%).

Figure 6.13: Elements that work less well across MSK commissioning as a whole (top ten only)

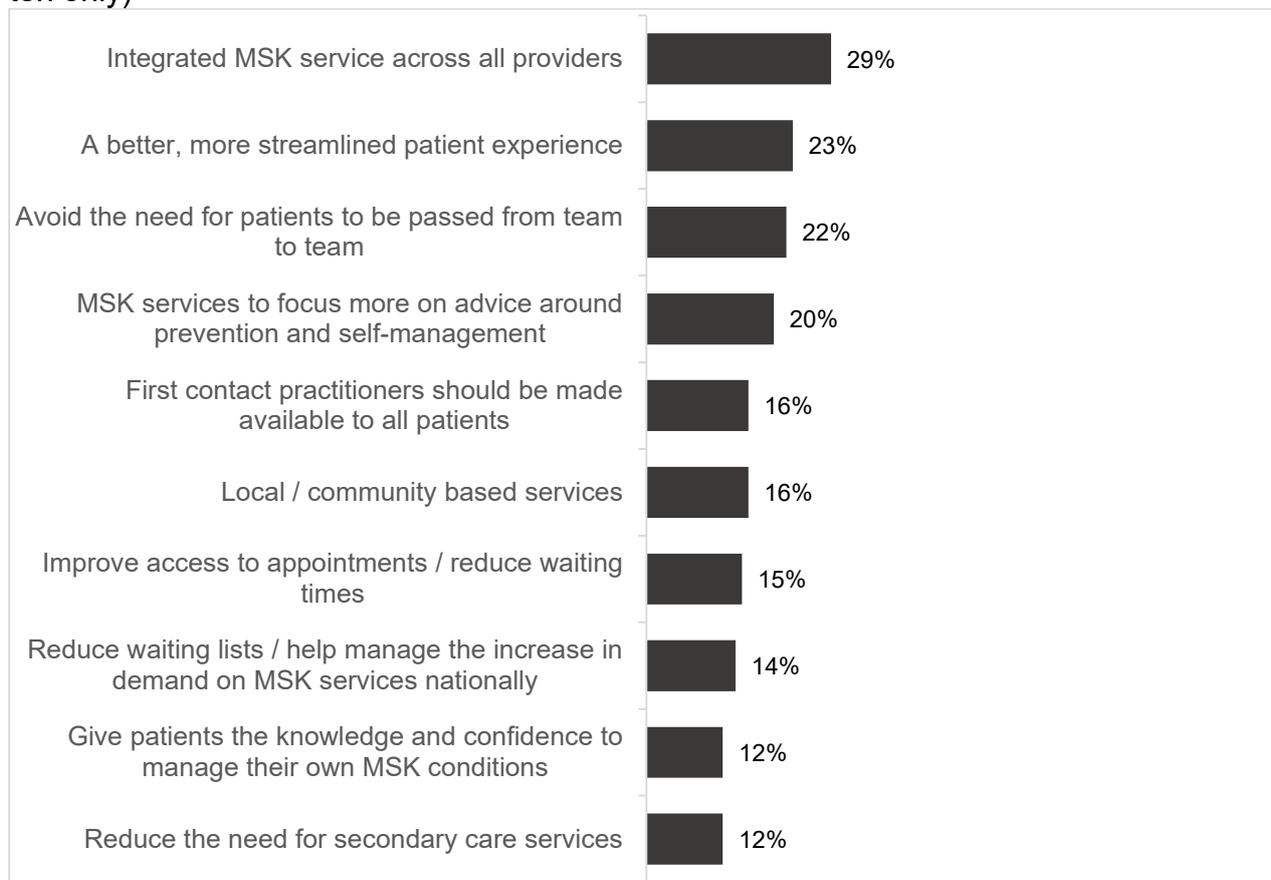


Base: All MSK leads whose CCG commissions MSK services (86)

When MSK leads were asked about the improvements they would ideally like to make to their MSK commissioning, integration and efficiencies again emerged as key themes (Figure 6.14). Three in ten (29%) wanted to improve the integration of MSK services across all providers. Over a fifth had efficiency of the patient experience in mind: 23% would like a more streamlined patient experience, and 22% to remove the need for patients to be passed from team to team.

One-fifth (20%) reported they would ideally make improvements to their services to increase their focus on prevention and self-management.

Figure 6.14: Improvements would ideally make to MSK service commissioning (top ten only)

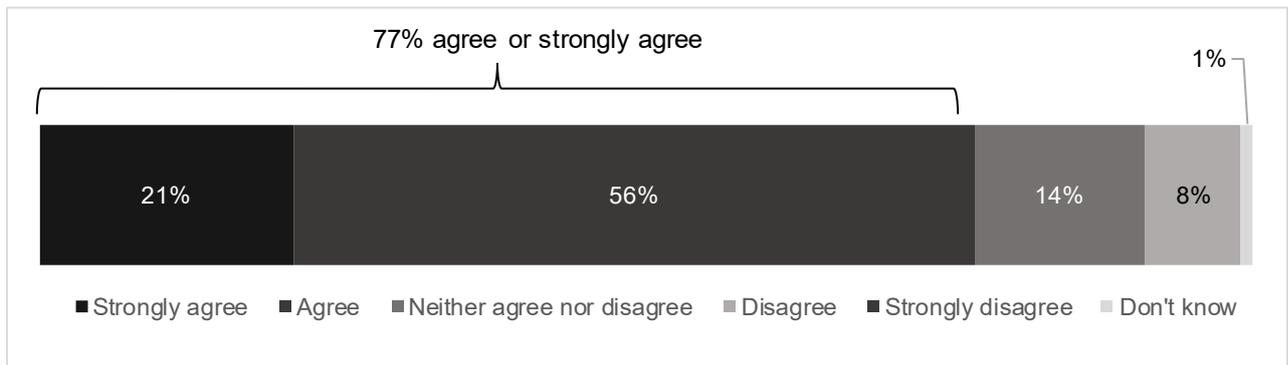


Base: All MSK leads whose CCG commissions MSK services (86)

When asked about the extent to which they felt that their CCG’s MSK services were integrated with other local health services, three-quarters (77%) of MSK leads interviewed agreed that the MSK services commissioned were integrated (Figure 6.15). However, only a fifth (21%) strongly agreed, suggesting most MSK leads considered the services to not be as integrated as they could be. Less than a tenth (8%) disagreed that the MSK services are integrated.

The repeated mention of integration and efficiency emphasises that these themes were of high importance to MSK leads in their MSK commissioning and suggests a slightly mixed picture; these aspects were more often cited as things currently working well, but were sometimes cited as shortcomings. This suggests that some CCGs are succeeding in integrating services and enhancing their efficiency, while others are struggling – and indicates that lessons could potentially be learned from those CCGs that consider themselves to be doing well in these respects.

Figure 6.15: Agreement with the statement ‘The musculoskeletal services are integrated with other local health services’



Base: All MSK leads whose CCG commissions MSK services (86)

6.7.4 Measuring performance of MSK services

All CCGs that commissioned MSK services reported that they gathered knowledge and data about how their MSK services are performing. The vast majority of CCGs did this by collecting service statistics or management information (98%), for example re-admission rates (Figure 6.16), or surveyed patients about experiences and outcomes (90%). It was also common for CCGs to conduct formal service audits (80%) and hold informal feedback sessions with healthcare professionals (79%). Lead CCGs were significantly less likely to hold these sessions, only 73% of lead CCGs held these compared to 91% of non-lead CCGs. Around half (55%) of CCGs conducted surveys among healthcare professionals.

Other methods of gathering knowledge and data on the performance of their MSK services, such as having regular meetings with MSK providers, were rarely mentioned by CCGs.

Figure 6.16: Methods CCGs use to gather knowledge and data about how MSK services are performing



Base: All CCGs that commission MSK services (110)

6.8 Use of specific occupational and vocational-related support

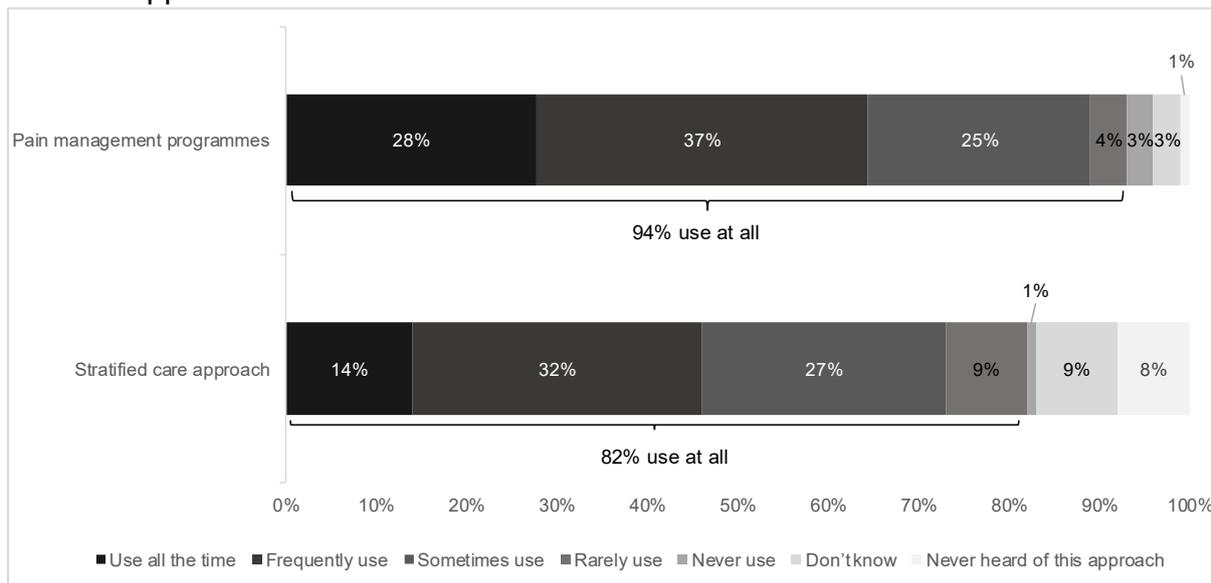
MSK leads were asked how frequently, if at all, their CCGs make use of two approaches identified during the scoping stage of the research. The approaches identified were: the stratified care approach, which stratifies patients according to disability risk and delivers an appropriate level of care depending on the intensity of an individual's condition; and pain management programmes, which support patients living with chronic pain to learn ways to deal with the pain that affects them in their day-to-day life (see chapter 3).

The majority of CCGs used pain management programmes: almost all (94%) of CCGs commissioned this service (Figure 6.17), and two-thirds (65%) used it on a frequent basis.

Stratified care was also used by most CCGs (82%), although less frequently than pain management programmes: only four in ten (46%) used it 'all the time' or

'frequently'. CCGs in predominantly urban areas were statistically significantly more likely to have used this approach compared to rural areas (91% vs. 82%).

Figure 6.17: Extent CCGs make use of approaches to occupational and vocational-related support



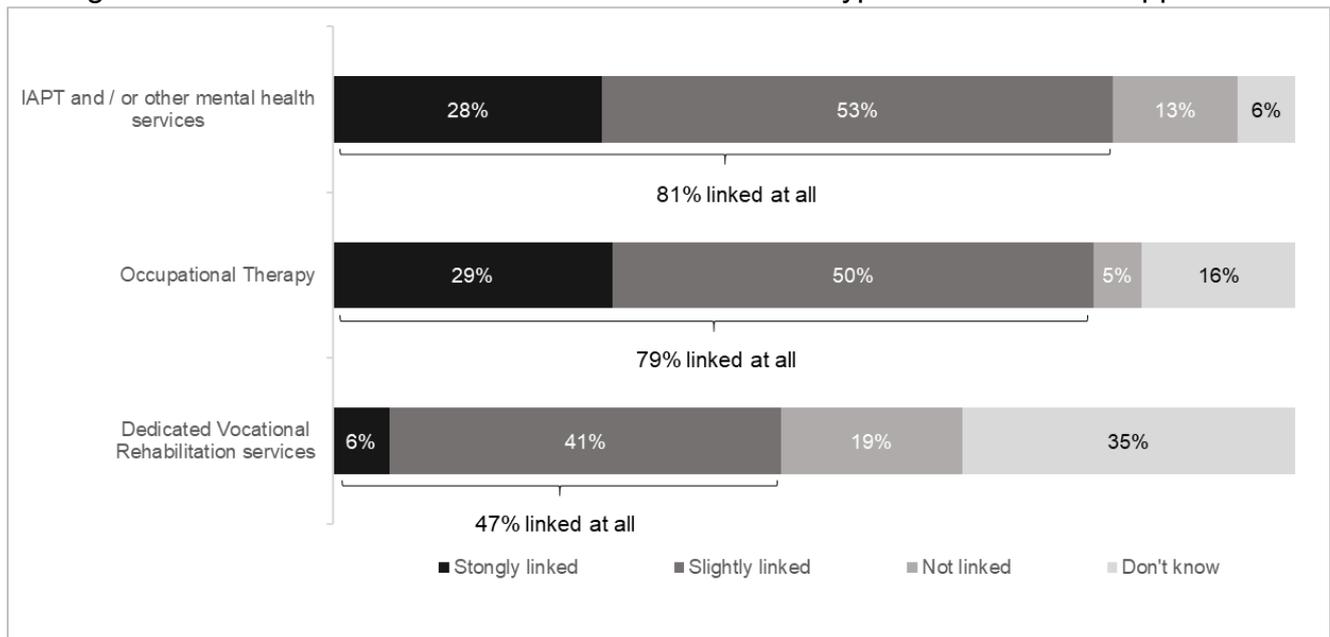
Base: All CCGs (111)

MSK leads were also asked the extent to which their MSK services were linked to three forms support that could be used in a vocational context: Improving Access to Psychological Therapies (IAPT) or other mental health services; dedicated vocational rehabilitation; and occupational therapy (Figure 6.18).

It was rare for CCGs to say that they did not offer IAPT/other mental health services or occupational therapy: only one-in-twenty (4% and 5%, respectively) said they didn't offer these forms of vocational support. Dedicated vocational rehabilitation services were slightly less common, with a quarter (23%) of CCGs not offering such services.

Around four-fifths (81%) of CCGs which offered IAPT or other mental health services had links between such services and their MSK services, and roughly the same proportion applies with occupational therapy (79%). In each case, just over a quarter (28% and 29%, respectively) had strong links, and around half were slightly linked (53% and 50%, respectively). Just under half (47%) of CCGs which offered dedicated vocational rehabilitation services had links between such services and their MSK services, with only one-in-ten (9%) strongly linked, and four-in-ten (41%) slightly linked – however it should be noted that over a quarter (27%) of CCGs did not know the extent to which their MSK services were linked with dedicated vocational rehabilitation services.

Figure 6.18: Extent to which MSK services linked with types of vocational support



Base: CCGs which offer IAPT or other mental health services (107), CCGs which offer dedicated vocational rehabilitation services (86), CCGs which offer occupational therapy (105)

MSK leads were also asked about the way in which MSK services were linked with these approaches. MSK leads that had links between their MSK services and IAPT or other mental health services reported they were most commonly linked by referring MSK patients to IAPT (46%), working with pain management services (40%) and part of a holistic approach of multi-skilled teams (15%).

Among those MSK leads that had links between their MSK services and occupational therapy, it was reported that these services were – as with IAPT or other mental health services – most commonly linked through patient referrals where appropriate (41%), through both of these services were delivered by the same provider (28%), and – again as with IAPT or other mental health services – part of a broader holistic approach of multi-skilled teams (13%).

7 Conclusions

Models of service provision: OH providers believe that it is of considerable importance to tailor their services to the specific needs of the employer, which is reflected in the wide range of services and packages on offer. The services most likely to be commissioned by customers⁶¹ were health surveillance and assessment of fitness for work. Both services related to monitoring the health of staff in relation to their job role (Section 4.1).

Commissioning: While employer-led commissioning dominated, commissioning by individuals was relatively common (Section 4.3). Experts we spoke to felt that health and safety legislation has seeded the idea among employers that, as long as they are meeting their legal obligations, they don't need to do anything else about employee wellbeing; meaning that, in the experts' view, commissioning of more holistic OH provision has become the province only of more 'enlightened' employers (Section 3.1). Evidence from OH providers largely supported this. They believed that employers and individuals are most commonly motivated to seek OH support by obligation, or reacting to issues affecting the business, rather than aspiration, i.e. using OH support when they need to comply with the legal requirements of their industry or to reduce sickness absence. OH providers agreed that improvements to productivity, health and wellbeing were secondary motivations (Section 4.3).

The majority of CCGs reported that none of their services were commissioned specifically with employment needs or vocational rehabilitation in mind; although there were specific exceptions to this: MSK physiotherapy and specialist pain clinics were more commonly cited as being commissioned on this basis (although still relatively rare), typically because these services were known to have a better chance of getting people back to work (Section 6.4). CCGs also commonly tailored MSK services to the health needs of the working age population. This was more often related to accessibility, such as flexible appointment times or locations, and informed by perceived public demand, than driven by best practice or expertise (Section 6.3).

Access to provision: OH provider findings indicated that Small and Medium Enterprises (SMEs) are under-represented in the OH provider customer base: around half of employers commissioning OH providers were SMEs, in the context of 99.9% of UK businesses being SMEs, and one in ten providers had not been commissioned by any SMEs in the past 12 months (Section 4.3). This was in line with expert perceptions that SMEs are less likely to have provision in place (Section 3.2). Experts also perceived lower coverage amongst self-employed people (Section 3.2). Half of private providers confirmed that individuals (as opposed to employers) do commission their services, usually in the context of wanting to prove to potential employers they were safe to work in the role (Section 4.3), although this does not

⁶¹ Whether employers, individuals, insurers or other customers

provide a sense of the extent of this commissioning across the self-employed population.

Interaction with employers and managers: Experts felt that the attitudes towards and understanding of OH among employers, and individual managers, have considerable influence on the effectiveness of OH interventions (Section 3.3). OH providers agreed with this viewpoint, but while line managers were perceived to be of key importance to the success of OH provision, and were involved more often than not, it was felt this involvement is not as effective as it could be. Providers noted that the involvement of line managers and other employer representatives was often limited to the start and end of the process; and that the efficacy of the line manager's involvement varied according to their engagement with and understanding of OH and how the employee's health condition interacts with their working situation (Section 4.4).

Interaction with NHS provision: While nearly all OH providers said their OH support interacted with NHS provision and the majority felt their support complimented NHS treatment or acted as a follow up to fit note advice, some noted resistance or delays when contacting GPs, as in their experience GPs did not consider OH a priority (Section 4.5). This was in line with expert suggestions that traditionally the NHS focus was primarily on treating conditions and symptoms, rather than on what the intervention allows the individual to do, which has left a legacy of work outcomes not always being considered in care provision. (Sections 3.1 and 3.2).

Capacity: Most OH providers are small scale businesses, with relatively few members of staff, and reliant on subcontracting some of their workforce requirements. Accordingly, small scale providers had smaller capacity in terms of numbers of individuals they could provide OH support to at any one time: bigger OH providers were able to cater to larger numbers of individuals. The small-scale nature of OH providers is potentially reflective of the size of demand for OH services: despite most being small scale only one-fifth of OH providers were delivering services at full capacity (Sections 4.2 and 5.1). In summary, demand did not appear to be exceeding supply, however of the available OH market capacity, 89% had been taken up over the previous 12 months.

OH specialist staffing: Findings suggest that a potential large threat to the future of OH provision is the reduction of qualified OH physicians and nurses in recent years, which has led to unfilled roles for over two-fifths of OH providers (Section 5.5). Providers reported that they were most likely to have vacancies in the most specialised roles and that these were the hardest to recruit for, particularly nurses with an OH specialism (Section 5.5). There was also a gap between the number of fully-funded training posts available and the number that had been filled (Section 5.4). This was in line with expert suggestions that historically major employers provided a key source of specialist OH doctors, by recruiting General Practitioners (GPs) and training them to meet their business's needs; but that the past 20 years, have seen major employers cutting costs and often outsourcing to commercial providers. These providers typically rely on OH specialists trained under the 'historic'

model, and as a result, the pool of UK OH expertise is perceived to be dwindling (Section 3.1).

One expert suggested that specialist training within private OH provision was rare, and that they instead 'poach' NHS trained staff. While the majority of private and NHS OH providers reported having access to funding for training of staff, the fact that NHS OH departments were notably more likely to provide training (Section 5.4), and that the most common previous employment of staff being NHS-based (Section 5.5) somewhat corroborates this.

Monitoring quality: The majority of OH providers believed that collecting outcome data was useful in monitoring and proving their quality of service. A variety of outcome data was collected by OH providers for these purposes, mostly the immediate outputs of the services provided, such as sickness absence data, rather than data designed to measure the success of the interventions (Section 4.5). All CCGs that commissioned MSK services reported that they gathered performance data for their MSK services, most commonly service statistics or management information but also, more commonly than among private OH providers, surveys of patient experiences and outcomes (Section 6.7).

Marketing: OH providers had limited need to use marketing to attract their customers. Targeted marketing to specific sectors was rare, and a substantial proportion of OH providers did no form of marketing at all (Section 4.7). This may be because most OH providers are small scale businesses, reliant on subcontracting some of their workforce requirements, with limited desire to attract new customers.

8 Appendices

8.1 Case study example of employer commissioning a private provider

Employer background

The employer is a large provider of health and social care services. The only risks identified are generic workplace stress and these can differ by role – for example being a porter, nurse, healthcare assistant, consultant etc.

Previously there was an internal occupational health manager, but it was found that the structure was not fit for purpose – the division was too big for one person to support. A decision was made to look at outsourcing and the subsequent move to the OH provider has been perceived as a success.

Managers are given absence management training and receive support from HR and the OH provider. An internet page also holds standardised documents and further information on occupational health protocols.

There are other courses for all employees to give tools and techniques to deal with absent employees such as managing short- and long-term absence, how to have discussions about health issues and what to look for in terms of patterns of absence. The employer also offers a free telephone counselling helpline, as well as face-to-face counselling sessions for its employees. All line managers are provided with tools and training to manage short term and long-term staff absence.

Overview of OH provision

The OH provider carries out assessments over the phone or, if deemed necessary, face-to-face. If a face-to-face meeting is felt to be required, this will be done either at a medical clinic close to the employee's residence or near the workplace. A report is generated and sent to HR. HR meets with the provider on a quarterly basis to discuss the offer and any changes needed. A regional HR manager describes the relationship with the provider as open and flexible:

“What's good about the relationship with [our provider] is that they will respond quite rapidly to questions, queries, concerns that we have either about process, about an occupational health report or advice that's been given. They will listen and they will take on board comments and do whatever investigations they need to do and, sort of, close the loop then with us.” Regional HR manager

Referral Process

A manager will gain consent from an employee to seek OH advice and offer them the Employee Assistance Programme (EAP), which is a free counselling helpline. In the case of long-term sickness absence, with the support of HR, the line manager gains consent from employees to seek OH advice. Information is gathered by OH about the condition, external medical interventions, desire to return to work and adjustments needed.

A referral will be drafted by a manager and agreed by the employee. An appointment will then be made within a set period of time with their manager ensuring all the correct information is supplied. A report will then be returned to the line manager for discussion about further steps.

. Assessments may happen over the phone or in person, the latter in a clinic close to the employee's home.

Employee story 1

Steve⁶² has worked as a physiotherapist for 35 years and been with the organisation for over seven years. Steve says he was aware of the OH offer before he needed their involvement.

Last year he contracted bacterial meningitis and was hospitalised for one month. During most of this time he was in an induced coma. He lost a lot of weight while in hospital and was very weak. Overall, he was off work for just over a year. He remained in communication with his employer while he was off work and describes the relationship during this process as very good. Because Steve was absent from work for a long period of time, the HR manager agreed a regular interval for Steve's line manager to contact him and check for any new information or updates with regards to recovery and likelihood of returning to work.

"We're always encouraging line managers to keep in regular contact with employees on long-term sick, because in our experience... unless we keep in contact with people, it can be hard for that individual to then return to work, and it keeps them updated in terms of what's going on in the workplace, any change or concern." Regional HR manager

When he felt ready, Steve contacted his line manager to discuss his return. The line manager notified HR who made a referral to OH. OH and the line manager met with Steve to discuss a phased return to work. An assessment was carried out by OH and a

⁶² Please note that no real names have been used in any case studies

report generated. OH recommended Steve gradually increased his hours and that he has regular meetings with his line manager to flag any further support needs.

Steve has a very positive relationship with his line manager, HR manager and the wider leadership group. He feels the process was as smooth as it could be (and notably better than his previous experience of OH with a prior employer) and that his line manager did everything she could for him:

“I think my line manager has done everything she had to do, she knows me as well, you know. And she offered me anything that’s [available], everything they’re supposed to do.” Employee

Employee story 2

Sarah has been a radiographer for 13 years and has been with the organisation for a year. Sarah suffers from sarcoidosis which affects her joints, eyes and lungs. She was aware of OH generally as she received substantial support from them at her previous employer. She feels the OH support was better in the previous organisation, but this is partially due to a very close relationship with colleagues and her manager.

When her condition first flared up since starting her current role, she felt management were unsupportive because they did not understand the condition. She was referred to OH, who understood the sensitivity of the issue and scheduled a face-to-face meeting. Sarah says she was reassured by this meeting:

“He knew what Sarcoidosis was, which is always a help, when somebody understands your condition... I was telling him what symptoms I have, and then he [was immediately] suggesting things what would help me [be] better at work.” Employee

OH recommended she reduces her working schedule to three days a week and reduces the traveling she does to a minimum. They also recommended installing air conditioning in the rooms she works in as the medication she is on increases perspiration. The employer has adhered to the travel restrictions. Although Sarah now works three days a week, the employer has not permanently changed her schedule, so she does not know in advance what three days she will be working. Air conditioning has not been introduced but the organisation has carried out a risk assessment of the room, which took temperature into account. She is waiting for the outcome of this. The process took around five months from the start of the flare up to receiving recommendations from the OH provider; in this period, she had ten days off work.

She describes the involvement of her line management as minimal, especially since she was referred to OH. She feels more involvement from her line manager would have made her feel more supported. Overall, she feels the process was slow and although the meetings with OH were very positive she is frustrated that the recommendations were not fully taken on board. She feels her management have been slow to respond to OH’s recommendations because they do not understand how painful her condition is:

“Just because you can’t see [the condition], doesn’t mean [I’m] not suffering.” Employee Sarah’s regional HR manager had a different experience of the process. They felt the process was smooth and that the line manager was highly competent in handling the situation. The line manager made the HR manager aware that Sarah had had a flare up and the HR manager made a referral to OH. After this the HR manager stepped aside and all communication went through the line manager, with the HR manager ‘on hand’ if further support was needed.

“I think that line manager connection is really important. They’re the ones who need to carry out the adjustments, they’re the ones are closest to all of their teams and understand what all of the members of the team need and, in these situations, how they balance, you know, advice on adjustments with what they need to do for the rest of the team.” Regional HR manager

Outcomes and lessons

The two employees’ stories perhaps highlight the importance of working relationships to the success of OH. In Steve’s case, he had worked for the organisation for a long time and had close relationships with his line manager, HR manager and other colleagues. The process appears to have been defined by an open dialogue and trust. Sarah on the other hand was reasonably new to the organisation and did not have as positive of a relationship with her line manager. The HR manager appears to be unaware of the nature of the relationship and was confident taking a step back in the management of the process. Sarah appears to have wanted more involvement and understanding from senior leaders throughout the process.

HR believes OH support was integral to Steve’s return to work, but points out that perhaps the most important element was Steve’s own dedication to work:

“I think he always gave us the impression that [Steve] wanted to return to work...It helps with communication during the long-term sick absence period when you know simply, he is keen to get back to work.” Regional HR manager

Sarah’s regional HR manager feels the turnaround time from referral to implementation could have been quicker. She explained that in her experience it can take up to two weeks for the assessment appointment to take place, with another wait of a week to receive the report his timing was dependent on availability from the OH provider. The HR manager feels speeding the process up will make employees feel more supported, especially if they are unable to carry out their tasks while they wait for the assessment and recommendations. The HR manager also feels the provision could be slightly better tailored to the organisation and that the recommendations could be more pragmatic for them to implement:

“We’re one of many customers and sometimes it does feel a little faceless and you really do have to work terribly hard sometimes to get a pragmatic view. They will be processing lots of information for lots of people, and sometimes, it’s where you might

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need a more pragmatic discussion with someone. The process doesn't allow for that, so [sometimes you feel like you are] just in this big machine... Generally, I'm happy with it, but it does feel like faceless processing⁶³." Regional HR manager

Despite this, the HR manager feels the current solution is far better than relying on the patient's GP, which they have done in the past, as GPs cannot be expected to consider the specifics of a patient's working environment and how this interacts with their health.

⁶³ During the case study review process, the OH provider wanted to add that they had not received the criticisms expressed in this paragraph and that all of their clients are welcome to speak to the relevant clinician if they have any queries.

8.2 Case study example of employer commissioning a private provider

Employer background

The employer designs and manufactures military and industrial components and interconnect solutions, including cable assembly, over-moulding and electronic packaging. There is the use of chemicals in production, which is a known risk. There are also issues around stress. There have been changes to management recently and some employees feel they are under too much pressure.

Originally the OH provision was delivered via telephone interviews, but the subsequent reports were not found to be helpful. The company researched the option of having somebody on site and they moved to having a medical nurse available on an everyday basis. Employees could go in for informal discussions, but the service was being misused (for example, employees presenting with medical issues that were not work-related or impacting their work). They then decided to move to having somebody on site 2 or 3 days a month, which they now have with their current OH advisor.

Overview of OH provision

The OH advisor (a sole trader), began by being on site once a month and referring over the phone as well as face to face. It was found that absence levels were going up so the employer wanted somebody on site more regularly and could build a relationship with the employees. Telephone consultations are used for more straightforward cases, but it was felt to be crucial to have the option for OH to meet with employees in person, as previous experience with telephone consultation only had been poor. The aim of the OH provision is to tackle absence issues by improving staff wellbeing and therefore having the provision on site, allowing staff to build trust in the provider, was seen as important.

Provision is tailored to the employer. If an employee wants to see OH they raise it with their line manager, who then makes a request to the HR manager who makes the final referral. If they do not want the line manager involved employees can speak to the HR manager directly but they cannot self-refer. The HR manager believes OH is highly valuable to their business, but that most employers are unaware of how it can help them and how to implement it properly:

“There's not enough people who understand how occupational health can help their business...there's no consistent approach on how these things should be done.” HR manager

Referral Process

The referral process is divided into three parts: case management referrals for absence, health, and performance related concerns; surveillance for hearing tests, lung function tests, biological testing, support with training and policy development; business development for attendance management training and training to support a business with health-related initiatives.

An electronic referral form will go through an encrypted portal to ensure data protection. Managers will have a conversation with the employee and then complete the form – a copy of which will automatically be sent to the employee. Liaising with the manager, the OH advisor will then discuss with the manager whether there needs to be a face to face or telephone assessment. The process will be explained and once it has been agreed and consent obtained, the advisor will conduct a general discussion with the employee about work, social life and general health, before speaking more specifically about the issues at hand.

The previous OH nurse was directly employed and felt she was more accessible to employees then because they could self-refer. However, this system was changed because it limited the opportunities to involve management in recommendations.

Employee story 1

Linda has been with the company for three years and is a customer service representative, dealing with large overseas accounts. When a colleague left the company, she took over their accounts as well, putting her under a lot of pressure. Eventually she found herself unable to cope and was absent for three weeks. At the same time, her husband was diagnosed with dementia. His condition quickly deteriorated, and he went into full time day-care.

Linda describes her relationship with her line manager as poor and this led to her problems going unresolved for longer than might otherwise be the case. She raised her concerns about her workload early on, but her line manager informed her nothing could be done to help and rejected a request to reduce her hours. Linda felt her line manager implied she was not going to be able to carry on working. She eventually raised her concerns with her HR manager, who made the referral to OH. Linda's awareness of what OH could offer was low until they met and at first she was sceptical:

“My perception of occupational health, I was always a bit wary. I thought the company will view it badly, [I] thought they wouldn't be on my side.” Employee

Linda found the conversations with OH very helpful and supportive. OH suggested Linda try a flexible working schedule and reducing her hours. OH convinced her that going part time would be beneficial to the company as well, as they could find someone to job-share the role, rather than lose her entirely. She also informed Linda of her rights in terms of benefit payments and how to find a carer for her husband. Linda met with

her HR manager following the meetings with OH to discuss the recommendations and was informed that the company has a flexible working policy, which Linda is considering applying for.

Overall, Linda feels the first stage of the process was difficult, due to her relationship with her line manager. She believes the process would have been quicker and easier if her line manager had proactively made suggestions of ways to help, rather than Linda having to eventually go to HR. Once she did, she feels the process was joined up and supportive and she is very positive about the role of OH:

“[It’s good] to know that there’s somebody there that is going to help you and not just the company.” Employee

Employee story 2

Oliver works on the production line and was rushed to hospital with pain in his legs. The HR manager stayed in touch with him regularly during this period and eventually made a referral to OH to make recommendations for returning to work. At this point he was still physically unable to work and a second referral was made at a later point. The HR manager remained involved throughout the process, along with the plant manager and line manager. The process took five to six months in total.

Oliver was eager to return to work, but the HR manager was unsure whether he was physically able to. OH made a plan for a phased return and made recommendations for a maximum number of hours and shifts he can work, which the HR manager sticks to closely. They also made Oliver aware of Access to Work and helped him apply. Access to Work provided him with support to get to and from work.

Oliver was also given other adjustments, such as additional breaks and the ability to sit down while he works. He was also taken off night shifts as these were felt to add additional pressure. Oliver’s line manager was involved throughout the process and felt the recommendations were communicated clearly to him. To the line manager, the process - involving him, HR, the plant manager and Oliver – was joined up and worked effectively.

Outcomes and lessons

In both Linda’s and Oliver’s cases, the HR manager thinks OH helped them remain in work. She also believes that having OH as a neutral third party was valuable. In Linda’s case this made her more comfortable opening up about her difficulties, especially given her previous experience with her line manager. OH was also able to explain the business case for offering a flexible working schedule (rather than running the risk of losing a valuable employee). In Oliver’s case, OH’s role as a neutral third party meant they had the authority to ask him to return to work at a sustainable pace. The HR

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manager believes Oliver otherwise would have risked returning to work too quickly, in order to prove himself.

In both Linda and Oliver's case no sick leave has been needed since OH's involvement.

At an overall level, the provider has also designed and delivered training for all managers on how to better support staff and reduce absence.

8.3 Case study example of employer commissioning a private provider

Employer background

Employer is a large education and care provider. Its services include residential and day-care services to adults with complex medical and social needs.

Employees are at risk from injury from service users. There are also concerns around stress and anxiety in the workplace. The organisation offers extensive Manual Handling training, as well as Health and Safety training. They have less support on offer for mental health issues, and the HR manager believes they therefore see more of these problems among employees.

There was an external supplier of OH but there were problems such as staff being cleared for work when they shouldn't have been. Referrals were increasing so there was a director-level decision to try and get a more holistic OH provision.

They previously employed a full-time OH nurse but found that people misused the service to avoid the absence policy. People would go for inappropriate reasons in place of their own GP. Since then the employer has had to 'push back' a little on why people access OH, and moved on to their current OH provider.

Overview of OH provision

OH has been used strategically to reduce absence. Over a decade ago, staff absence was found to cost the organisation £1.5 million a year and this was unsustainable to maintain. OH was then made an integral part of the organisation, including recruitment. As part of the recruitment process, all candidates now complete an OH assessment to determine whether they are physically and psychologically capable of carrying out the work. For ongoing staff, the OH provider is onsite once a fortnight.

Assessment reports are sent to the HR manager, who then shares it with the employee, line manager and other relevant managers. In more serious cases, HR will also attend all meetings with the employee:

“Obviously if you're talking about somebody who's been off long term and we've asked for occupational health advice about their future fitness to return to the job and whether that's likely and therefore whether we're looking at an ill-health dismissal, then obviously HR would be knees deep in that. All of those meetings would be held with us. So, it's individual.” HR manager

Referral process

A member of HR staff takes responsibility for the OH referrals. They are available to offer advice to managers regarding making a referral and guiding managers in managing attendance.

If somebody is unwell, they communicate with their line manager and paperwork will subsequently end up with HR. They will then contact OH if it turns out to be a long-term issue or if somebody is looking to return to work. The approach has recently changed in that senior management used to oversee referrals, but it is now line managers as it was felt senior management left too much of the onus on HR. HR then coordinate the appointments and informs the employee of the details. HR also receives the reports back and may arrange another meeting with line manager and employee to go over recommendations of report.

Employees are also able to self-refer and are encouraged not to wait until they are unable to come to work (in which case the line manager will often make a referral anyway) but to proactively self-refer if they are experiencing difficulties carrying out their work. They are also encouraged to discuss risk assessments with line managers before self-referring to OH, as this can ease the pressure off the provider.

Employee story 1

Jonathan has worked as a care officer for a year and a half. He suffered a fall at work and injured his back. He saw a GP approximately a week after his accident and was referred to physiotherapy. He was absent from work for a few months. His line manager remained in contact with Jonathan throughout the absence and says he felt confident Jonathan would be able to return to work once he had recovered.

When Jonathan returned, he was dependent on medication to manage the pain. After a few months the pain increased, and he took time off work again. This was a concern to his line manager, as it suggested the injury could be an ongoing issue. The line manager felt he needed more information about the extent of the injury and how best to manage it. At this point, a referral was made to OH. Jonathan had no awareness of OH before their involvement in his case.

OH recommended that Jonathan take a seated role while he recovered, and he was moved to a receptionist role. During this time, he received physiotherapy treatment through the NHS and further tests to exclude damage to his spine. Once he was feeling better, another referral was made to OH who, following a new assessment, cleared him to go gradually back to his original role (initially through shadow shifts until he was ready to fully return). The process from the second period of absence to full return to work took approximately seven weeks.

Being allowed to shift to a seated role meant he was able to remain in work while he recovered. As he was no longer eligible for sick pay after being off for several months

the financial impact of staying in work was important. Jonathan is positive about the process and feels well supported, although he wishes he knew more about OH and what they could offer before he met them.

Employee story 2

Josh has worked as a care officer for 18 years and been with the organisation for 11 years. He has psoriasis, which recently deteriorated and started impacting his work. To some extent the deterioration was caused by work. The work can be stressful, and to support his family he works up to 70 hours per week. Diet also contributes and Josh says he was not taking the proper precautions with regard to his psoriasis.

As the condition deteriorated, his skin and fingernails were extremely sensitive, and because the job is very physical, he was in a lot of pain. He says he is very self-conscious about the condition and therefore had not previously mentioned it to any colleagues or his line manager. He eventually got an injection to help with his skin, but the injection made him ill and he was absent from work for four days. This triggered his line manager to schedule a meeting with himself and HR and it was only then they realised the severity of Josh's condition. A particular concern was that the medication he was taking for the condition was a controlled substance⁶⁴.

An appointment was scheduled with OH. Following the OH assessment, regular meetings with a nurse were arranged to monitor the situation and to check for side effects caused by the medication. The line manager ensured Josh did not have to take any clients swimming and that he was able to wear long sleeved shirts to work. The line manager also monitored the extent to which Josh was adhering to the diet and exercise recommendations put forward by his GP.

Josh waited two weeks for the appointment with OH and the whole process took approximately one month. Josh says he felt relieved after telling someone about his problems and that the support he received from his line manager was very helpful.

Outcomes and lessons

Josh's line manager believes the OH provision allowed them to make the necessary adjustments to his role and he has not had any sickness absence since. She also believes the experience improved Josh's relationship with her and with HR.

In Jonathan's case, his repeated periods of absence were a concern to the employer and OH was valuable in managing the return to work. Because the injury was sustained in the workplace it was felt to be particularly important to have independent advice and guidance.

⁶⁴ Some prescription medications are controlled under the Misuse of Drugs legislation (<https://www.nhs.uk/common-health-questions/medicines/what-is-a-controlled-medicine-drug/>)

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The HR manager believes the OH offer works fairly well, but believes they need a more substantial service. The HR manager believes having the OH provider onsite one day per fortnight is not enough. They have concerns around mental health and stress management in the workplace and believe having OH on site more often can help employees build trust in the provider and use their services more proactively. The OH provider could also help the organisation improve staff wellbeing as a proactive measure, according to the HR manager.

Overall, the physical nature of the work makes it very challenging to accommodate for health problems and the organisation often finds they are unable to adhere to the recommendations made by OH:

“It’s very difficult here, because a lot of the adjustments that you could probably make to facilitate an earlier return to work are not possible...What we get a lot is, this person could return on light duties, we don’t have that, because 85%-90% of our workforce is literally looking after human beings with complex needs. In terms of alternatives that we can offer people, there aren’t any...In our admin and support services, which I fall into, there’s [fewer] absentees as well, so there are [fewer] gaps that need filling. So, those roles just don’t come up.” HR manager

According to the HR manager, the value of OH is having an objective, independent third party to liaise between employees and management. They have had some difficult cases with employees who do not want to return to work and having OH do a rigorous assessment and determine whether there are any barriers to the person returning to their role has been invaluable. OH is also used to help the organisation identify whether or not an employee is covered by the Equality Act, and this determines how their sickness absence is dealt with.

8.4 Case study example of employer commissioning a private provider

Employer background

The employer is a scientific research facility that includes a large cohort of staff. Most staff are scientists, who conduct scientific research in laboratories, often working with chemicals. Other staff members include engineers and technicians who are dealing with more manual issues such as driving forklift trucks and other logistical matters; and office-based staff such as the HR, finance and IT departments. They are a large employer with over 500 staff.

As well as typical workplace-based risks, the controlled scientific environments provide a theoretical risk of ionising radiation and exposure to certain chemicals in a fast-paced and technical work environment.

The current OH provider has only been in place for the past eighteen months. Prior to that, was a system where referrals would be made on a case-by-case basis seeking medical advice to support employees but there was a lack of control over the agreements and issues created by delays in paperwork. A tendering process was undertaken with a list of required criteria to select the new provider.

There is also an EAP (employee assistance programme) where staff can get confidential advice from qualified counsellors.

Overview of OH provision The OH provider offers a range of occupational health services including preplacement screening health surveillance, sickness for work medicals, case management for sickness absence, wellbeing, consultancy services, specialist risk assessment from a health perspective, and training. They also offer emotional resilience interventions and early intervention both by telephone and face to face. In addition, they work as a subcontractor to larger OH providers and also work for some independent HR services; and this accounts for roughly a quarter of their workload.

The provider works in four main sectors – education, local government, technology and healthcare (though smaller providers and not the NHS). Provision is always funded by the employer and not by individuals or insurance companies. Commissions come from health and safety or human resources departments in larger organisations or from business owners if a smaller organisation. This will begin with commissioning a couple of appointments and either continuing on an ad-hoc basis or commissioning full services that can be tailored to their needs.

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Ad hoc services are the most popular where after an assessment a price is issued for the most appropriate condition. For more involved commissions, staff will be put on site. This would usually be a day or half a day of nurse or doctor time where they would pay a daily rate and undertake a number of different services such as medicals, workplace assessments, referrals or meetings with HR. Health surveillance programmes are generally tailored to employers and there are regular meetings with HR and health and safety officers to discuss any potential issues and discuss interventions that might be useful.

Almost all the services provided are directed advice and recommendations about employees who have been referred. The recommendations are thorough and may include adjustments in the workplace, working hours, or approaches to a phased return to work. The employee may be signposted to other services or if private healthcare is available, a referral will be suggested if appropriate. In more complex cases, there will also be a meeting with a line manager to discuss how to manage the individual's case.

For the employer in this case study, an OH physician is on site once a week where they will conduct ionising radiation medicals, monitor any changes in levels of risk. They also offer more general OH services, for example there are plans to have some emotional resilience training and there are one on one meetings for some of the more complicated OH cases. If required, there will be referrals to get some more specialist support. One of the main reasons they were chosen by the employer is their use of a portal system which allows for a highly efficient referral process. It also makes things much easier to track and monitor.

Referral process

The referrals are carried out by HR, who are notified by the line manager when there is a potential issue (a typical trigger is a period of sickness absence). HR then checks with the employee (and the line manager, where relevant) whether they are happy to make a referral to the OH provider. Employees can also approach HR directly.

The HR representative described the line manager's involvement in the referral process as follows: *"I think, you know, sometimes with different situations it can be quite a tricky thing for managers to manage (the referral process), but in this particular situation, I think it wasn't necessary, really, for the manager to do much more than what he'd already done, which was to find out what the issues were, where we can best support the individual, both before and after, and to speak to HR about it and discuss things with HR."* HR Manager

In cases of sickness absence, a digital service is used to inform the employee of the referral and to make the employee an appointment for triage by a physician.

Employee story 1

Andre had good awareness of the company's OH support because she works in the HR department. She broke her ankle in a freak accident outside of work. After initially thinking it was a sprain, Andre undertook first aid measures over the weekend but was unable to attend work on Monday due to the pain. Andre subsequently had an x-ray and the fracture was confirmed.

She was signed off work with a doctor's note for eight weeks and notified her line manager, with whom she kept regular contact. Once Andre was cleared for work, she was still unable to drive or walk so a call was arranged between Andre, her line manager and the OH consultant where it was agreed that she would work from home, which she did for three weeks.

In this time her line manager had discussions with the Deputy Head of HR to decide what would be best for Andre and how they cover any absence, or duties she currently couldn't fulfil.

Andre was offered physiotherapy through the NHS but was told that there would be a 20 week wait, so instead she used a private physio that she paid for herself. During this, time she had a weekly review with her line manager and a review with her employer's OH provider. Public transport wasn't a viable option, but a co-worker was able to provide a lift. The Safety Health and Environment team conducted a risk assessment on Andre's first day back looking at a fire evacuation plan.

Once the physio agreed that Andre could drive, she was discharged and returned to working as normal. She had existing neck and back issues that were part of an ongoing discussion with her line manager and the OH provider. The OH provider recommended that the employer provide her with a standing desk to help with the spinal issues and also the foot recovery.

Employee story 2

Ken's role mostly involves designing software. He had previously had a negative experience of OH when dealing with his Asperger's diagnosis and found them to be impersonal. He was therefore pleasantly surprised with his interactions with the current provider and found them to be a good advocate, willing to work for what was best for him, whereas ordinarily he would be inclined to struggle on and not complain.

The incident discussed for this case study occurred eighteen months ago when Ken fractured a shoulder in an accident outside work. After having physio with no great success for six months, Ken was scheduled for surgery. He was subsequently signed off sick for six weeks but did continue to work from home in that time feeling that he needed to keep his brain active for the sake of his well-being.

Understanding the provision of occupational health and work-related musculoskeletal services

From the point of the injury, Ken had regular communication with his line manager who was empathetic and concerned that the injury did not become any worse. Ken initially went for a private consultation to find a treatment pathway because the NHS waiting list was too long. He was referred back to the NHS, but this was quicker than if he had gone through the NHS initially.

Following surgery Ken went to his GP for assessments to see if he was fit for work. Although not supposed to be working, he did work from home despite reservations from his line manager. When Ken was able to return to work a couple of days a week, HR instructed him that there would need to be a meeting with the OH provider. He found the experience extremely positive and found a nice balance between his physical capabilities and state of mind and desire to return to work. His line manager and the HR department were regularly updated with surgeons notes and other reports

Having returned to full time work, there are still some OH recommended precautions in place to manage potential risk such as Ken not having access to areas of confined space and lone working because of the weakness in his shoulder.

Outcomes and lessons

Both employees' experiences have been extremely positive. Having successfully phased back into fulltime work, there are still longer-term measures in place to ensure continued comfort and negated risk caused by the injuries sustained. The current OH provider is certainly seen as an improvement on the previous with the support and care offered cited as one of the main benefits. An element of OH that was perceived to be important was the validation from an independent professional of employees' conditions and time taken off work.

For Andre this manifested most positively in feeling supported and having some potentially stressful administrative tasks taken away from her. For example, appropriate news of her condition was shared on her behalf with her permission giving her one fewer thing to potentially cause stress.

For Ken, having somebody take responsibility for the treatment he needed and negate his natural stoicism was the biggest positive. This manifested both in managing an effective return to work with appropriate measures and convincing him of the potential long-term risks in trying to come back and do too much too soon.

One of the lessons to emerge from these case studies was how important effective communication is and how generating a wider organisational awareness of health issues, particularly mental health, is working effectively to remove stigma and ensure employees are aware of, and getting, the support they require. Also bringing in the OH provider from the very start is beneficial as it creates a more direct pathway tailored to the employee and their role than if it is left to the employee to convey their situation to a GP.

8.5 Case study example of employer commissioning a private provider

Employer background

The employer is a GP surgery with one main site and one smaller branch surgery. Employees are at risk of health issues commonly associated with office environments, including eye strain from computer screens, repetitive strain injuries and back problems from workstations, but there is no cause for heavy lifting or other physical risk.

The employer previously had a contract with an OH provider where a visit would be conducted once a year to carry out a risk assessment of work spaces, such as for working with vaccines, as well as administering flu vaccines. The same OH provider no longer provides this service and the employer no longer has a named contact for their provider. In its place, the employer has email contact with the OH provider, although they much preferred their previous arrangement. The fees for this service are covered by the NHS Local Medical Committee.

Overview of OH provision

The OH provider employs around 35 members of staff – a mix of full and part time. There are also around 90 contracted doctors and nurses. Having become SEQOHS accredited, the provider has a contract with the NHS and provides OH services to GP and Dental practices as well as a wide range of other public and private sector clients.

One service offered is pre-employment screenings where an employee's fitness for work is assessed, which may also include health surveillance. Other services include vaccinations for medical practitioners who may be interacting with patients, workplace assessments, home assessments, counselling, psychotherapy, and management referrals for short- and long-term sick leave. They also work with a partner company providing Employee Assistant Programmes.

The provider engages contractors and specialists on a regular basis but work with them through the same format as their own employees. They will provide a price list and any services that are used will be taken from the amount that is paid to the OH provider.

Around 15-20% of consultations are done over the phone and the rest in person but there are plans to bring in video consultations this year.

Referral Process

The OH provider registers employers on their online system and a manager will complete a manager enquiry form, highlighting the issues. An appointment will be arranged and an OH physician or nurse will attend, with subsequent medical action if required, such as a visit to the employee's health physician recommended as seen fit.

Individual employees can also self-refer and sign up to specific services using the online portal. The NHS wanted a consistently delivered OH model, which this supplies.

Employee story 1

Michelle works at the branch surgery but spends one day a week at the other site. She began to suffer with pain in her elbow and her hand was swollen and she wasn't able to use it. Michelle was signed off for a total of five weeks while she recovered and received NHS treatment.

She only came into contact with OH after she returned to work., She requested a workstation assessment as her GP suggested this could be the cause of her elbow pain and because she wanted a professional opinion that she could take to management. The outcome of the assessment was recommendation of a chair to provide lumbar support. The employer declined to buy the one that OH specifically recommended, opting for another chair that they bought after a significant delay, due to budget issues, which Michelle found very frustrating.

Outcomes and Lessons

Given that the employer did not fully follow recommendations and the significant delay, Michelle was disappointed with the outcome. Her feeling is that budget limitations mean that the OH process is always likely to be limited as there is no money available to implement the recommended changes.

It is likely that Michelle will have another OH assessment but is quite disillusioned about the likelihood that it will improve her situation. Her elbow has improved but Michelle is still having ongoing issues with her neck and back.

In terms of what else could be improved, Michelle feels that line managers could act more quickly. The front line OH practitioner commented that she has little interaction with line managers suggesting that there could be better lines of communication.

8.6 Case study example of employer commissioning a private provider

Employer background

The employer is a DNA sequencing company with a mixture of engineering and administrative staff. There are health and safety protocols in place to prevent and treat physical injuries and there is planned investment in mental health awareness training. Although there are some physical challenges, the main perceived risks are to mental health. The environment is one of high pressure, for example pressure to reach ambitious sales targets.

The HR team is quite small so help in identifying ways to make the work environment safer and providing support to employees has been necessary, particularly with a diverse workforce and workloads. An OH worker offers a range of services in the workplace but is also available to make home visits where necessary.

They had initially trialled an online OH service when the employer had fewer staff but didn't feel it offered the support that their staff needed. The face to face aspect of OH provision was thought to be important, so they found a provider who could offer that interaction.

Overview of OH provision

The OH provider is a small organisation with five directors and a further sixteen staff members. There is no marketing team and the company is run by clinicians offering a personable and intimate service. The staff are multi-disciplinary with a mix of nurses, technicians, physiotherapists, security and administrative staff.

They are currently working with around 30 employers on a regular basis and then a further 70-90 clients on a more ad-hoc basis. Each Occupational Health Advisor is assigned their own caseload of clients and tailor their services to what the client needs and can afford.

They work with a variety of employers from schools and farms to engineering companies. The services provided are typically management referrals and there are also technicians who will carry out health surveillance such as respiratory, dermatology or hearing damage for critical workers, machine and manual workers, but the majority of OH work is case management and the caseloads are predominantly mental health issues.

They do not have Care Quality Commission (CQC) accreditation which means they are unable to work with self-employed individuals and have to work with employers. The employer will always pay, sometimes on an ad-hoc basis or sometimes as part of an annual or two-year contract. These services will be tailored and the OH provider

becomes adept at knowing the exact environment and idiosyncratic needs of each client.

Referral process

Referrals are normally triggered by HR either by a sickness absence trigger or from a line manager. The provider has a portal on which HR will upload a referral form with the consent of the employee. A member of the HR team is 'heavily involved' in booking appointments with the OH nurse. HR will meet with an employee and explain that they think they should be referred to OH. The most common reason is mental health where employees have been signed off by their GP. The implications and necessary involvement from their manager are explained and then a meeting with the nurse will be set up and a report follows around a week later.

The OH provider will then either see them at the next clinic held at the employer or make contact if more urgent. Following an assessment, a full report will be given to HR with the consent of the employee. This is typically reported face-to-face to allow a comprehensive explanation of what is needed and why, for example a phased return or ways to manage stress and anxiety.

Employee story 1

Katrina works in finance administration and has been with the company for eight years. She had a period of absence due to both physical and psychological conditions. She underwent surgery for muscle damage but she feels stress and anxiety were having a greater impact on her work. She has a child with a severe health condition.

She was aware of the OH provision and found good flexibility with HR who were helpful and proactive. She found that the stress of the job was exacerbated by the speed with which the company has grown.

HR were very helpful in setting up the initial OH meeting and the OH practitioner then handled the situation 'perfectly', liaising with HR and senior management and ensuring that necessary steps were carried out. This included 'checking in' with Katrina before and after a GP appointment (as a result of which she was signed off for stress) and recommended ways of managing sleep, which had become an issue.

Katrina was off work for six weeks because of the surgery and then a further two weeks for the stress. Her line manager was involved and kept in touch via text and email to check on Katrina as did the HR director.

Employee story 2

Monica has worked at the company for thirteen months as a commercial data analyst engineer. She suffered from chronic sinusitis and several conditions flared up at the

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same time which led to depression and anxiety. Having been prescribed medication for a sleeping disorder, Monica suffered a bad reaction which worsened her anxiety and depression and impaired her performance at work.

She contacted the private healthcare provider for the company to organise surgery and discuss OH options such as how recuperation was to be handled. Once the surgery was scheduled, Monica's line manager put her in contact with HR and OH to make arrangements for a recovery period and staged return.

OH were in contact to check on Monica's recovery and they would speak once a month. They offered advice over whether to use the NHS or private health insurance to get treatment. She stopped the medication that was causing the negative reaction, started antidepressants and had cognitive and analytic therapy to manage depression and anxiety. OH also recommended activities like long walks, yoga and more fruit in Monica's diet.

After returning it was agreed that Monica work on a self-contained project that was not time critical and did not have heavy contact with end users. After this light duty period, there were very regular catch ups which were helpful as due to her autism, Monica can often misunderstand things, particularly instructions. Monica attended a private clinic which was able to confirm a diagnosis of ADHD – something that wasn't available to her on the NHS as somebody over the age of eighteen.

Since that diagnosis, Monica has had regular contact with OH, receiving advice and recommendations.

Outcomes and lessons

Katrina had considered leaving her job because of stress but found reassurance from OH and felt that they had influenced positive changes. She also mentioned that she would have found it beneficial to have been in contact with OH before her sickness absence due to stress, as this could have potentially been avoided.

As a result of OH Monica felt that there was continuity and constant contact and encouragement – somewhere that she could go to talk. She did feel that there could be a bit more information and reminders for people that the OH provision is there and that there could perhaps be some sort of portal that employees could access (only HR can use the current portal) in order to get into the system. Emails with information about OH are sent, but it's unclear how many employees fully understand these.

Monica is still seeing occupational health and they are continuing to monitor her condition. She had also considered leaving her job and taking time off but now feels supported by the integrated system between OH and HR.

It's felt that HR and OH have good communication and feedback effectively to management but that there could be more mental health awareness and neurodiversity

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training for managers. There is scope for warning signs being spotted earlier and OH being involved sooner as a result.

8.7 Case study example of employer commissioning a private provider

Employer background

The employer offers recruitment and human capital management solutions to other businesses. There are no known risks other than stress. Employees will be working to ambitious sales targets and some find this very stressful. All managers attended an ACAS training course on stress and mental health in the workplace and an HR representative says this made a significant impact and that managers are much better equipped at recognising warning signs.

The employer is able to carry out basic in-house ergonomic assessments but will make a referral to OH if these do not resolve the issue.

As of five years ago there was no OH provision. Upon moving to a new building, they made use of an OH service in the same building but found the service to be lacking. When the contract was due for renewal, they went with an old contact who has set up an independent OH service.

Overview of OH provision

The provider offers a range of services, including pre-employment screenings, in-work wellbeing initiatives and return-to-work management plans. They currently work with approximately 50 employers. As part of their service, the provider offers sickness absence management, occupational health clinics, health surveillance, disability advice, ergonomic screenings and advice on reasonable adjustments. The provider charges per service, rather than offering a subscription price because the numbers of referrals from employers vary considerably. They offer both telephone and face-to-face consultations but because of the cost to the employer they reserve face-to-face consultations for more complex cases, such as long-term sickness absence.

Referral Process

The OH provider requires the employer to gain consent from the employee before a referral is made. In some cases, line managers will specifically request a referral to OH. In other cases, line managers merely raise a concern about an employee and HR identifies OH as the appropriate course of action. HR will schedule a meeting with the employee and raise a referral to OH as a possibility. A referral form will be completed and sent to the provider who schedules a meeting with the employee. An assessment report is shared first with the employee, who gives permission for it to be shared with HR and line manager. The report is usually shared within five working days of the assessment being conducted.

The employer also takes into account the frequency and duration of short-term absences using the Bradford Factor, and if there is cause for concern further discussions will take place between the HR and/or the line manager, and employee. Depending on the outcome of the discussions, this may trigger a referral to OH if it is felt that further support is needed.

Employee story 1

Teresa is an account manager who has been with the organisation for a year. To Teresa, the reasons she was referred to OH are unclear. It was suggested to her during a meeting with her HR manager. The HR representative asked how she was feeling about work and she answered that she was unhappy in her role. She had voiced frustrations to her line manager previously and been promised changes to her responsibilities. She explained that she was feeling anxious about coming to work and HR referred her to OH. Teresa could not see how this would help, as in her opinion the issue was not health related, but rather to do with job satisfaction.

Teresa had a phone call with the OH provider, and it was during this call she was told her absence had triggered a referral. She admits she has been absent from work more in this role than in previous roles but says this is merely down to catching more colds and flu than normal. She was surprised and upset that concerns over her absence had not been communicated to her. She was uncomfortable with some of the questions asked by the OH provider and felt they could have been more supportive or understanding. In a separate interview, the HR representative says she was not overly concerned about Teresa's absence and that it was performance rather than absence that triggered the discussion.

Teresa describes a poor relationship with her line manager, particularly in the last six months. She says she has voiced frustrations over her role and that these have not been taken seriously. She describes a lack of trust in her line manager and HR representative.

In Teresa's experience, being referred to OH was merely 'a box ticking exercise' and it has not had any impact on her work.

Teresa's HR representative says OH's involvement was positive and that it has positively impacted her work. According to HR, Teresa was referred because she was acting 'out of character'. She was off sick more than usual and appeared stressed and irritable at work. HR believed she was struggling with stress, and that this was impacting her sleep and therefore her overall health. She is aware that Teresa was upset by the referral and thinks she saw it as a punishment for poor performance. While Teresa did not feel OH's involvement impacted her, HR feels it had a significant impact. One of the recommendations was for HR and Teresa to meet and discuss a 12-month plan and expectations, which they did recently. She also believes Teresa was able to speak freely with the OH provider, because he is independent and that this was a relief to her.

Employee story 2

Tanya is a delivery coordinator and has been with the organisation for four years. She has epilepsy which is often triggered by stress. During a particularly stressful period at work, she experienced a number of seizures. She saw her GP who adjusted her medication. During this period, she had to take time off work, partially to recover from seizures but also to cope with side effects from the medication increase.

Tanya's HR representative was informed by her line manager that she was underperforming and appeared to be very stressed. She had been given feedback on her performance previously and her line manager felt it was time to involve HR. Tanya found the discussions with her line manager to be stressful and difficult.

During their meeting, the HR representative discovered the impact the seizures had had on her performance and how a fear of further seizures was contributing to her stress levels. She suggested Tanya sees OH. According to Tanya, the aim of involving OH was two-fold; to understand what can be done to avoid further seizures and to establish a process for when a seizure does happen. While her relationship with her line manager was difficult, Tanya feels the conversations with HR were very supportive and understanding.

"I think HR supported me very well. I think my line manager at the time made it feel like I was a bad person for being unwell and having sick leave, but I think HR, sort of, supported me more...It was quite disheartening because you put a lot of time and effort into everything you do at work, and then to think that your line manager' is disappointed in you, in something that you can't control, is actually quite demoralising." Employee

The HR representative is unaware of Tanya's poor relationship with her previous line manager. She feels OH's involvement was timely and that feels the recommendations must have been effective as Tanya is now performing at a higher level.

Tanya was unaware of the OH offer previous to her referral. Although she describes the experience as positive, she does not feel OH had an impact on her work. She already felt she knew enough about her condition, what triggers it and how she should respond to a seizure and she does not think the OH consultant could add much to this. She does however think it was helpful for her colleagues to learn more about the condition and how to respond appropriately when she is unwell.

Outcomes and lessons

In both Tanya and Teresa's stories, perceived poor performance was a trigger for HR to consider a referral to OH. In Teresa's case, one of the recommendations from the OH assessment was also related to performance management. In both cases, poor relationships with line managers had a negative impact on the employee's overall experience and in both cases the HR representative appears to be unaware of the influence of this relationship.

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According to one of the HR representatives interviewed, OH can be a useful bridge between the employer and the NHS. In the past, the employer has tried to engage with GPs directly to gather information about how a condition may influence an employee but this process was slow and difficult. According to the HR representative, the OH provider has a better understanding of what information they need and are better equipped to communicate with GPs. The provider agrees that OH can be a bridge between the employer and the GPs but says in most cases GPs are not interested or do not have the capacity to engage.

8.8 Case study example of employer commissioning a private provider

Employer background

The employer is a public organisation operating in the education sector. There are no known risks and the main health issues tend to be mental health and MSK related.

As a public body, they have to have OH provision and are only permitted to use certain organisations. They will periodically review which OH provider to use through a tender process.

The HR representative says OH is generally used in cases of long-term sickness absence or where there is uncertainty over how an employee should best be supported. The organisation also uses a separate ergonomic assessment provider. They have had this service from an OH provider before, but found the quality was not as good and that the service tended to be outsourced anyway, and therefore quite expensive. An employee assistance service provides health checks and mental health counselling. The organisation has also organised resilience training sessions, mental health first aiders and offers an internal helpline for employees to use for any issues facing them in the workplace.

Although the OH service feels quite generic and set up to work with much larger organisations than this employer, the recommendations and reports generated have always been of a high quality and the HR representative is broadly satisfied. They regularly gather feedback from employees who have been referred to OH, to ensure the service is appropriate.

Overview of OH provision

The OH provider offers assessments and support for a broad range of health issues, from physical conditions to mental health conditions, neuropsychology and cognition assessments. They offer both ad-hoc support for specific cases and ongoing support packages. In total the provider serves around 400 employers and see approximately 15 employees per week.

All employees are Occupational Therapists and all have a BSc in Occupational Health Therapy. As a general rule, all staff will have started out in the NHS and been on rotation for the first years of their career. They then will specialise and, in most cases, undertake further training, such as a post graduate degree or ad-hoc training. All referrals from the employer comes through HR and the provider will almost exclusively deal with HR representatives. Sometimes line managers attend meetings, and the OH director is aware that they have a role in disseminating the recommendations from the assessment, but their dealings are mostly with HR representatives.

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The majority of their cases involve ergonomic assessments. In some cases, they offer recommendations for returns to work after long-term absence. Their assessment reports will include recommendations for adjustments, including equipment needed. They will also highlight whether they recommend the employee separately sees their GP or a specialist for more guidance on treatment.

The OH provider sends a follow up survey to all employees that receive support to collect feedback.

Referral Process

All employees have a work station assessment when they begin and become part of an informal ergonomics network that they can contact to discuss any potential issues. There are also helplines for employees to call as part of a wellbeing at work programme. An online 'hub' on the HR website is accessible 24 hours a day for support on general wellbeing.

If the manager and employee agree that an OH referral is necessary, the manager will send the provider a referral form and subsequently a date will be made for an appointment. Following this, they would have a private discussion about what the current issues are and develop an understanding of the employee's needs and role. The OH provider tends not to know much about the case until they have read the referral and had the meeting with the employee.

Employee story 1

Keith is a team administrator and has worked in the organisation for three years. He was experiencing back pain and this made sitting at his desk very painful. He had to take breaks to go for short walks and describes himself as 'quite moody' because of the pain. He was aware of OH and knew of other colleagues who had used the service. However, his perception was that OH was for more serious cases, such as severe disabilities and long-term sickness absence. He therefore did not consider requesting a OH referral himself. The pain gradually got worse until one day he was unable to get out of bed and was experiencing shooting pains down his legs. He had an emergency appointment with a GP and received medication to deal with the pain. He was absent from work for a week. During this period, he spoke to his line manager who suggested a referral to OH. Keith had recently changed his line manager and the relationship with the previous manager was poor. Keith thinks he would have found it difficult to discuss his health problems with the previous line manager but with his new manager the conversation felt supportive. The line manager suggested OH could make an ergonomic assessment to *"make it comfortable for me when I got back"*.

Keith met with OH on his first day back. After a discussion about the issues he was experiencing the OH professional carried out an assessment of Keith's workstation and sent a report to him and HR. A new desk was ordered but because of assessment

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taking place before Christmas it took a month before the desk was installed. The new desk allows Keith to stand up while working, which he is hopeful will make a difference. Overall, Keith's experience was very positive:

"My manager suggested the support straight away - the business were proactive, I don't think there was anything else they could have done really." Employee

Outcomes and lessons

Keith is positive about the interactions he had with OH, but beyond this he thinks knowing the support is available if he ever experiences other illnesses or issues is invaluable. He feels that knowing OH support is available makes staying in the organisation long term more attractive:

"It's good to know that you could be looked after if need be." Employee

8.9 Case study example of employer commissioning a private provider

Employer background

The employer is an energy provider, and the service provided by this division concerns smart energy – specifically, the installation and servicing of smart energy equipment in customers' homes.

As a physical job, installing boilers and other equipment, there is a risk of physical injury – particularly back injury. There are also mental health risks as engineers will visit customers who are financially or physically vulnerable which can be a challenging experience. There is also the stress of completing gas and electrical safety checks knowing that mistakes could potentially cost lives.

The employer has a number of internal resources in place to help support employees with their health and wellbeing. There is a health toolkit, a web link that offers advice on general wellbeing, dietary advice, and exercise tips. Staff are also signposted to external organisations for more specialist support such as financial support charities. Discussions around health and wellbeing are also integrated into line manager and employee general catch-up meetings.

The workforce is predominantly male and within the past 18 months more staff have started to open up about mental health issues, whereas in the past staff would cite 'back issues' as the cause of sickness absence. The company has invested in mental health first aiders, which has gone a long way to help addressing this issue. A selection of employees have been trained so that employees have the option of talking to somebody confidentially who isn't their manager.

The employer selected their current external OH provider as it was felt that they offer a collaborative way of working between employees and management. Employees are encouraged to take ownership of their health and wellbeing, for example through regular exercise, but at the same time they are encouraged to actively seek OH support when needed. This is in contrast to a previous OH provider where the employer felt there was greater emphasis in referring employees to physiotherapy, whereas it was felt that the issues could be managed sooner.

Overview of OH provision

The OH provider exists initially as a helpline offering support and advice to both employees and their managers. They might offer some initial health advice, or more usually, take the case on. This will involve sending a support pack of suggested actions based on the condition described (for example stretches for a bad back) and if there is no improvement there will be an OH assessment. The service is available anonymously

if desired. If an employee is off work for 48 hours, a conversation is triggered where the OH provider will contact them to discuss the issue and see if any advice or support is required.

They provide a bespoke service that puts a level of ownership onto the employees. It's a collaborative approach where they expect, for example, the employee to keep up regular exercise so as to get the most out of assessments, physio, CBT or other services. They will also manage the case when it comes to return to work, providing detailed updates to managers, capability assessments and helping to tailor duties.

Referral process

Individual employees can self-refer to the OH provider or they can raise an issue with their line manager who will make a referral on their behalf. Employees can decide how much they would like the OH provider to share with their line manager – they also have the option to access the service in complete confidence.

Employee story 1

Tim is an engineer who fits gas and smart metres as well as some more specialist engineering works and has been doing this for thirteen years.

He was aware of the OH support that was available but had never thought to go and look for it as he did not previously identify a need for it. His initial perceptions of OH were negative; he had associated them with the disciplinary process.

“You think, ‘Well, this is just them trying to find out, and it’s probably them looking for a way to sack me because they say I’m not capable of doing my job.’ So, that’s what you get in your head and that’s what I think everybody has in their mind about Occupation Health because they know of the stories where ‘Such-and-such, he got sacked’”.

Employee

His mother passed away unexpectedly which led to a deterioration in his mental health at which time his line manager recommended OH support but Tim chose not to pursue it.

After belatedly seeing a doctor and feeling improvement, Tim then suffered a physical ailment, which triggered further mental health issues. He awoke with a painful ear and continued to work having taken painkillers. He suffered hearing loss in one ear and then the other before starting to have issues with balance and realised he was no longer safe to drive or work. Tim phoned in sick and went to the doctor who saw swelling but was told to leave it for a week. In the meantime, his dizziness worsened and he began to google symptoms which had a very negative effect on his mental health.

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Living alone and having a lack of face to face contact was perceived as a potentially negative effect on his mental health so his manager attempted to maintain contact as often as possible without being invasive.

Tim's manager referred him straight away to the OH provider who contacted Tim and initially echoed the doctor's prognosis that it was an infection and rest would be the best thing. The provider also suggested a counsellor who got in touch with Tim and had regular contact that he found extremely helpful. They would speak for an hour and did so about six times which was reassuring and calming. He was asked which information he was happy to have shared with his line manager.

After an MRI, it was found that there was a lot of fluid in Tim's ear and Time was eventually prescribed medication that rectified the ear problem relatively quickly. Once he was fit to return to work, the OH provider suggested reduced hours but the nature of the job meant this wasn't possible. Instead they arranged a reduced allocation of work and a suspension of cover of emergency call-outs because of the soporific side effects of Tim's medication. Guilt at not doing his share of the night work was a burden for Tim, but again the counselling support he received helped to cope with this. He didn't feel that the company could have done any more to assist him or have made his recovery any quicker. The whole issue lasted about three months and Tim felt supported but not pressured.

Being off work for an extended period created some financial pressures, so he was put in touch with a financial support charity who were able to provide advice and support.

Outcomes and lessons

For Tim, the most immediately positive outcome was the counselling and reassurance he received. He also found that the NHS had long waiting times, and that the OH provider's involvement helped to speed up his recovery.

From a management perspective they feel they could have been more supportive and praising of Tim's return to work. His sickness record has improved substantially in the past twelve months compared to the year before and it's felt that this could have been further highlighted. The contact from Tim's manager and the OH provider were felt to be the main success of this episode both in making him feels supported and help him recover and to deal with the problematic elements of his treatment.

A general learning point has been that understanding of everything that OH can provide is still quite low. There is a sense that the provider is there to get employees back into work when actually they are there to aid the recovery of the employee. People need further education that the aim is recovery and not simply getting back to work.

Since moving to this OH provider, employees need to be more engaged in wanting to help themselves and that has been a challenge but ultimately more effective than the previous, more prescriptive OH provision. There are improved conversations between

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the manager, the employee and the OH provider which has led to a more bespoke and effective provision.

8.10 Case study example of employer commissioning a private provider

Employer background

The employer is a manufacturer with a warehouse, click-and-collect centre and retail store. There is also a production plant on a different site. The employer's environment is a noisy, high-paced production line with risks of injury through manual work. In addition, there are instances of drug and alcohol abuse among employees.

There used to be an on-site OH 'drop-in' centre but this proved to be ineffective due to frequent disruptions. Two years ago they moved from using an NHS provider to a private provider and they have tailored support to fit the company. The business requires monthly health surveillance support as well as help with workplace injuries, stress and anxiety caused by work on a fast-paced production line, and issues with drug and alcohol abuse.

Overview of OH provision

The OH provider is an external organisation that offers a range of services from typical OH functions like medicals, case management, health surveillance, and blood testing to services with more of an educational element, for example teaching on OH courses at University. They also offer wellbeing workshops for companies and have qualified counsellors who are able to provide fast response psychological trauma teams, and other psychological services. There are currently between twenty and thirty consultants with an administrator working part time.

For regular clients, a standardised model is offered which includes a mobile clinic once a year to conduct all health assessments. On top of this there may be additional services requested such as air monitoring or a visit from an occupational hygienist. For case management, consulting meetings are held in which examples of best practice are given as well as instruction on some of the legal aspects.

Referral process

A referral arrangement process has been agreed between the employer and OH provider that may be instigated by either an employee or by a manager on their behalf.

For a set fee there will be a day a month provided to cover health surveillance and referrals. This includes the hire of a mobile booth but there may be an extra day paid for to cover any additional health surveillance. There may also be telephone referrals but self-referrals have stopped because of the difficulty of fitting these into the one day of OH presence.

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The provider will send the relevant specialist to the site that requires an assessment or consultation. For example, somebody with Hand Arm Vibration training will be sent to assess workers on the construction line.

The health surveillance is driven by legal requirements and include lung function tests, hearing tests, and fitness of tractor/forklift drivers.

Employee story 1

Paul worked in a physically demanding vehicle dispatch role and had an accident at work that meant he could no longer carry out manual work. His employer redeployed him to an office-based role, without the involvement of OH. Paul subsequently had a hernia operation and experienced complications from this resulting in a further operation. It was at this point that he became involved with OH; this was largely due to Paul experiencing anxiety and depression as a result of his operation.

The agreed outcome of the OH process was a phased return to work and regular monthly sessions with an OH practitioner. In addition to this the OH practitioner explored how the working environment could be altered to better meet the physical and mental health needs of Paul. As a result of this, Paul was encouraged to take walks to help cope with periods of stress, was able to take flexible leaving and arrival times to facilitate appointments, the removal of all manual labour tasks, provided with a dedicated parking space and a relaxed dress code.

Further, the OH provider served as a mediator between Paul and the employer. They compiled reports to be shared with HR and Paul's line manager. They also helped the employer understand the situation and engender trust that the issues that Paul was suffering with were genuine. They were also able to offer explanation of the issues in layman terms and make sense of medical jargon.

Paul had limited awareness of the available OH provision but has had a positive experience and feels that there should be increased awareness of OH provision available through employers. His preconception was that their role was to check things are alright or to get rid of problematic employees rather than being on the employee's side.

Employee story 2

Jack works in the factory on the production line and suffered with a cocaine addiction. The results of this were frequent days off work, being late as well as being moody, irritable and difficult to work with.

Jack didn't have any awareness of the OH support available, which is in keeping with the report of a frontline practitioner who cited low awareness and understanding of occupational health as an obstacle to carrying out health surveillance. In the case of

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Jack, he was very suspicious of the process and thought that sharing information might lead to it being used against him.

Jack had an 'attendance meeting' to discuss his poor attendance record around the same time as a drug and alcohol amnesty within the company. During the attendance meeting, Jack admitted to the drug problem and was subsequently referred to a meeting with OH on their next site visit where they discussed the issue.

The only adjustment that needed to be made was covering Jack's place in the production line while he went to his hour-long OH sessions. These were initially monthly and then bimonthly before being discharged once the OH therapist felt they were no longer needed.

Outcomes and lessons

In Paul's case, there was frequent communication between OH and HR and the only area where things didn't feel 'joined up' was communicating with his GP. Despite this the OH nurse did contact Paul's GP to increase the dosage of his antidepressants.

According to Paul a major benefit was the lines of communication through OH to HR and the trust that this engendered that he would be supported and not punished. OH provided an independent party to confide in. Paul said that were it not for the OH process, it is likely he would have left work.

Jack had been regularly coming in late and missing roughly a day of work a week but since the OH referral has only taken two more related sick days, which were taken with full disclosure to his line manager. In this case the OH nurse wrote to Jack's GP to request expedited referral to drug & alcohol testing programme. They also encouraged him to go to drug counselling and see his GP while providing support when he was on waiting list. He said without her encouragement he wouldn't have gone to see the GP. He described OH as a "stepping stone" providing a "push" and "help" to access other support.

One of the lessons the company has learned in the past couple of years is the importance of OH as an unbiased party and the need to educate the workforce about what they do and how they can help. Although it wasn't the case in these two examples, there can be resistance from employees who think that OH exist to 'catch them out'. There can also be issues from line managers who might have reservations over performance targets. It is therefore important for OH to work efficiently with good transparency so that managers don't feel like they are losing contributions from their workforce unnecessarily.

Another lesson is that awareness of OH provision needs to improve, especially on the production line. Office workers receive regular emails while on the shop floor the only real signposting is on noticeboards and these are often overlooked because of the reservations that employees have towards OH. Engagement with OH has led to greater

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general awareness of mental health issues and drug/alcohol testing among employees and subsequent addiction support.

The company are currently looking at new OH offers such as training for line managers on how to identify health issues and respond to them personally, in addition to training mental health first aiders.

8.11 Case study example of employer commissioning a private provider

Employer background

The employer is a national utilities company, with a turnover of more than £1 billion. Their activities include operation, maintenance and transportation. A key part of the workforce are front-line engineers – their jobs can be high risk, pressured and dangerous. Safety is a major focus, accident and injury rates are key performance indicators; they run safety roadshows for employees.

The employer's annual report states board-level interest in health and wellbeing. There is also new focus on reducing stigma around seeking help for mental health issues, for example setting up a volunteer scheme training employee to support their colleagues.

Overview of OH provision

The provider is a small organisation set up over 30 years ago by a GP who qualified as an occupational physician. In the past the provider was also able to employ doctors with OH experience but now has just one additional employee, previously a medical secretary, who fulfils the roles of manager, receptionist and has been trained as a technician (e.g. in audiometry).

The provider works mainly for employers in the construction, primary and utilities sectors. Work has evolved to provision of 'holistic' OH services for a small number of employers (around 10) based on their needs, for example case management, advice on well-being at organisational level, health surveillance, drug and alcohol testing, absence management. Relationships with employers (their HR departments and line managers) are thought to be personal and good.

Referral process

Employees have to be referred via their HR department, in writing. Typically, a referred employee would receive a face to face consultation and a report would be issued to the employer and the employee – this could consist of a return to work plan, a rehabilitation plan, referral (e.g. to a physio or counsellor) and / or a recommendation for a change in duties or for retirement. If required they follow up with employees for 'quite a long time' after the initial meeting to help with transitions back to, or out of, work.

Employee story 1

Peter had been a team manager for 10 years, and with his employer for 20 years in total. He found the work '*pressurised*' and thought given the nature of work all employees '*will get stressed at some point*'. A disciplinary issue with a member of his

team and personal issues left him struggling to sleep and contributed to his level of stress. This situation continued for several months before any action was taken although the OH provider thought he had been referred much sooner, within six weeks.

Although Peter thought of his line manager, Sunil, as approachable, and as a manager himself was aware of his employers' OH provision it was Sunil who first raised concerns with Peter rather than the other way around. Sunil feels over the last few years their employer has worked to increase awareness of their OH provision and he was accustomed to directing employees to the programme as well as using their online service. Peter found Sunil reassuring - he referred him to OH provision, told him he could have time off if necessary and suggested Peter see his GP.

Peter saw the 'company doctor' within a couple of days of speaking to Sunil. The OH provider reported Sunil spoke to him directly to arrange this and that through his involvement with the company he was already aware of a 'situation' impacting on Peter. He diagnosed Peter with anxiety and organised counselling (paid for by the employer) which started within a couple of weeks. Peter has found it very helpful to speak to the counsellor as she was a professional who had experience of helping people facing similar problems.

"I've got to say the company, between my manager, the company doctor and then the counsellor, I just felt like someone's actually listening to me." Employee

Although Peter would have liked to have started the counselling sooner, overall he was happy that it was less than a month from referral to support – compared to the wait of at least two years his GP advised he would have faced with the NHS.

The OH doctor reported he followed up with Peter part-way through the counselling sessions, and Peter confirmed this had happened. He also monitored progress through the counsellor and Peter's manager. Peter's counselling is still on-going. The provider felt Peter and Sunil were comfortable discussing the situation, and he was unsure about any HR involvement after the initial referral.

Outcomes and lessons

Awareness of OH provision, the experience of his line manager in dealing with such situations and Sunil's ability to directly contact the OH provider ensured the process was smooth and referral to counselling relatively quick – once the referral to OH provision was made. The counselling has helped Peter to stay in work.

"I just feel as if something would have transpired that would have stopped me coming to work." Employee

Peter feels the help he received has helped him support his own team members when they feel under pressure. With hindsight Peter has also found exercising as useful as

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the counselling and thought promotion of how exercise can benefit mental health would be useful, as well as support and motivation to exercise e.g. classes during work hours.

8.12 Case study example of a large employer's in-house OH service

Employer background

The employer is an international construction company. The company has an in-house OH department and OH is an integrated part of management practices. According to a line manager, the organisation has made an effort in recent years to ensure all managers are trained on how to access the in-house OH service, what it is and isn't to be used for and what employees can expect from the service.

There are two overarching objectives to the employer's in-house OH provision. The first is to mitigate against health risks in the workplace and the second is to support employees with underlying health conditions.

Employees in construction come into contact with dust and raised noise levels which could negatively impact health. Health surveillance therefore forms part of the OH offer and makes up 20% of their provision. Despite this, the employer's OH offer has the individual in mind and caters for a range of OH health support needs.

All staff delivering OH have OH training and some have a medical background, often a nursing degree. The OH team are predominantly home-based and travel to the various sites within the business as needed.

Referral process

All referrals are made by line managers through an online portal; employees are not able to self-refer to OH. Line managers may seek informal advice from the HR business partner before submitting a formal request via the portal. Although most referrals are sound, there have been cases where line managers and employees mistake OH for an 'in-work GP' and make inappropriate referrals. OH therefore works closely with managers to ensure they are aware of how to use OH effectively.

The employer has also standardised the referral process and as a result the line manager feels more confident using the provision:

"It's made my life as a line manager a lot easier because... You want to make sure you're doing the right thing for the business as well as the right thing for the employee and making sure they've got the right support." Line manager

A referral will contain information about why OH support is needed and what services are expected from them (i.e. return-to-work support). Following a referral, the

practitioner will carry out a telephone assessment with the employee and respond to the manager with conclusions and recommendations. As a general rule, there is no follow up to the initial assessment. The OH practitioners interviewed feel their role is to provide one-off advice and recommendations, and that it is the role of the line manager to monitor the employee on an ongoing basis. It is rare for the practitioner to meet face-to-face with employees as they predominantly work from home to reduce overhead costs.

Employee story 1

Claire has worked in the business for five years. She is a delivery manager and this is a predominantly office-based role. She had arthritis in her hip for two years until she had a hip replacement surgery. OH was involved in her return to work following the surgery.

Claire had some awareness of OH as it had been mentioned during Health Awareness weeks organised by the employer. As a manager, she has also referred drivers to OH. She was however unaware that OH could help with her kind of condition. She says she mainly associated OH with help for mental health issues and for support for those in physical roles with an injury that made them unable to fulfil their duties. Being in an office role, she did not think she was eligible for support.

She was aware that it is standard practice in the company to make a referral to OH after long-term sickness absence. The OH practitioner contacted her over telephone to discuss her return to work and Claire found the conversation helpful.

Although she believes she would have returned to work regardless, OH provided her with useful support and reassurance. Claire believes seeking OH support at an earlier stage would have made her realise how serious her condition was and therefore seek treatment sooner. She also thinks seeing OH before the surgery to discuss her return could have helped her return even sooner.

Employee story 2

Kate is a manager overseeing business analysis and has been with the organisation for approximately two years. She broke her leg in an accident and was in hospital for an extended period of time. Kate was eager to return to work but struggled to commute on public transport with her injury. She contacted her line manager as soon as she felt ready to return and specifically asked for a referral to OH.

As a manager, Kate has referred other colleagues to OH in the past. At the time of her injury, Kate was of the impression that the role of OH was to help those in more physical roles and not those in office-based roles. She however thinks the business has made an effort to rectify this since.

She spoke with the OH practitioner over the phone and describes the conversation as very constructive:

"They were really helpful and good at probing the right kind of issues and things that might be difficult and things that I could think about in terms of accessibility." Employee

The OH practitioner suggested she worked from home for a period and gradually increased how often she was coming to the office over the course of a month. They also arranged for a car she could drive to work to avoid public transport. OH followed up with her after a few weeks to make sure the return was going smoothly.

According to her line manager, OH enabled Kate to return to work as soon as she was able to. He was somewhat concerned that Kate would return too quickly and having OH insist on a phased return was helpful.

"I would say that particularly with such a prolonged absence as it was it enabled her to get back up to speed at a pace that was right for her and also that she wasn't overloaded when she did come back. There was care taken to ensure that she was able to just focus on some background activities and not be forced into operational issues from day one...It enabled her to just come back without any stress and I'd say that was the biggest benefit." Line manager

Outcomes and lessons

Claire is positive about the support she received, but believes the business can be clearer about how OH can help and for what types of conditions:

"[We could be] more aware of what [OH] can do for you either before or after or during any illness...In my head it was always you go to OH after you've come back or if you can't do your job because of it but I'm sure there's bits in between when they've been really invaluable...a bit more internal promotion would be good as to how they can help, the other things that they do other than the obvious." Employee

In Kate's case, she does not believe earlier intervention from OH would have enabled her to return sooner. She does however believe it would have alleviated some of the stress she was experiencing around being on sick leave and returning to work. As she was coming to the end her sick leave allowance she was worried about losing pay unless she could return to work and speaking to OH about her return may have reassured her.

According to the senior OH decision maker, the focus of the in-house OH offer has shifted in recent years from a medical focus to a focus on functionality or ability. The OH decision-maker believes a challenge for the future of OH is that the NHS and many of the universities that offer OH training focus too much on medical conditions, rather than on an individual's ability and the adjustments that can be made to job roles.

The OH practitioners suggest line managers sometimes have misconceptions about the role of OH. They say some line managers expect OH to give them instructions on what to do when their role is actually to provide information and advice so the manager can

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make an informed decision themselves. They feel line managers need to have the confidence to manage their own teams and use OH as one of their tools to do this:

"My role it's about providing functional advice, it's about giving managers [information about a] person's ability [so they can] go away and think what can you do with them and get them back to work." Line manager

"That feedback is essentially a tool for managers and HR to be able to speak with the employee and put a plan into place. " Line manager

8.13 Case study example of NHS in-house OH service

Employer background

This NHS Trust OH department provides OH services to almost all NHS employees and students in training across the local area, as well as for a small number of private sector commercial clients. The department employs around 40 staff on a full- and part-time basis, including 5 consultants and 8 qualified OH nurses. The department is to a large extent self-funded.

As well as an ongoing process of internal auditing, members of the OH team meet on a regular basis with representatives of the Health and Safety committee, Executive Workforce Board, and other senior figures across the Trust, with the goal of ensuring that the services that the OH team provide are as well-suited as possible to the developing needs of the Trust, as well as improving communication across departments.

“Senior-level dialogue is absolutely key” HR lead

All new employees at have an appointment with the OH department, in which a full health check is carried out and employees are made aware of the OH service and how to access it. Awareness of the OH department is also raised through the distribution of leaflets and frequent training of and liaison with managers and HR. A senior nurse at the department also attributed high levels of employee engagement with OH to their location on the hospital site directly opposite the canteen, which “encourages people to pop in”.

Referral process

They apply a mixture of ‘stratified care’ and ‘stepped care’ approaches to management referrals; under the ‘stratified care’ approach, a nurse triages referrals and allocates them to either a nurse or a physician depending on the complexity and urgency of the case; and under the ‘stepped care’ approach, a nurse who has been assigned to a case following the initial triage may escalate particularly complex cases to doctors. In some cases, the triaging nurse will send a management referral back to the relevant manager if the initial referral is lacking information or deemed unnecessary – for instance, the OH department would expect:

“A reasonable amount of information from the manager about the job that people do, the hours that they do, the reasons for their absence, dates, and reasons for sickness absence over a couple of years so we can build up a picture” Senior nurse

The OH department has put considerable work in recent years into increasing the quality of referrals from management, through developing an improved referral form and holding mandatory sickness absence training sessions for line managers in conjunction

with HR and trade union representatives, both to alert them to the benefits and availability of OH referrals and to provide guidance as to proper procedures.

Employee story 1

Sharon had recently been promoted to a senior site manager role with responsibility for managing the allocation of beds. Her job involved long hours and high levels of stress, and she described it as:

“Like plate spinning ... the minute you lose one you’ve lost the lot” Employee

Sharon was struggling with the demands of the position, which saw her working 90-hour weeks, sleeping on the hospital site, and neglecting all commitments outside of work. This was having a negative impact on her physical and mental health, resulting a combination of hypothyroidism and psychosis (*“my life started to unravel”*). At a point of particular crisis, she emailed what she described as a “cry for help” to the counselling and mental health arm of the OH department. To Sharon’s disappointment, there was no response to this email for 7 weeks.

In the interim Sharon went off on sick leave, with a note from her GP. For the initial period of sickness absence, Sharon was off work for 12 weeks, during which period she was seen by both primary care and mental health services in the local community. Under the Trust’s sickness absence policy, Sharon ‘triggered’ as needing a referral to OH after having four weeks of continuous sick leave. Sharon was then referred to OH after discussion with her line manager. After triaging, Sharon was invited to an hour-and-a-half appointment with a specialist OH nurse. There was also regular contact between OH and Sharon’s GP.

Sharon went back to her job once the GP and OH nurse had decided she was fit to return to the same job as before, although she wasn’t discharged from OH as they felt they needed to monitor how she was coping with returning to her position. Within 10 weeks, due to the pressures of the role, Sharon was once again in poor physical and mental health and returned to sick leave. While around 70% of referrals at the Trust are tied up following a single consultation, Sharon’s case fell into the 30% of more complex cases which require follow up appointments

“It tends to be the probably more significant health issues [which have follow up], so you [can see] some of your more significant mental health issues, chronic or deteriorating health situations where you perhaps will review people a couple of times” Senior nurse

At this point, Sharon’s was escalated to a physician (an example of the ‘stepped care’ approach, following the initial ‘stratified care’ triage). After several conversations with Sharon, the OH team, in tandem with the HR department, advised ‘redeployment’ - Sharon would have a 12-week window to find another position at the Trust which was more compatible with her health needs. As sometimes happens, Sharon involved her line manager in her meetings with the OH physician (in cases where there is friction or

disagreement between parties, the OH counselling service may act as mediators in a joint meeting). With the requirements of Sharon's health condition in mind, a new role was found for her in the IT department. The redeployment specification was written in partnership between HR, the OH physicians, and Sharon herself, and tailored to her requirements, and the job roles Sharon were offered were reviewed by the OH physician.

Before returning to work, Sharon, her new line manager, and HR developed a Wellness Action Plan⁶⁵, which led to the formulation of a kind of charter under which all parties agreed how they would manage Sharon's symptoms, including e.g. regular one-to-one catch ups with her new line manager, a pattern of working from home on certain days, and clear achievement milestones. After 3 months in the new position, with no re-emergence of symptoms, Sharon was discharged by OH.

Outcomes and lessons

Sharon attributed the success of the process to the emphasis on openness among all parties:

"It was all done in a very open way ... I think that's a key to its success" Employee

This view was echoed by the HR lead. She also stressed the importance of the "holistic approach" taken by the OH team, which looked at her entire lifestyle and its interaction with her work, including what she would do with her free time after moving to a less time-intensive position in the IT department.

While Sharon did stress that she was "very fortunate" to have had an extensive support network and very supportive manager she attributed the success of her case, and ability to stay working at the Trust, in large part to the quality of the care she received from the OH department:

"The end goal for me was to be at work and to remain at work well and I, so far, have had no absence this year" Employee

The 7 week waiting time for a reply from the mental health OH team was later fed back to HR as part of the department's process of self-evaluation and auditing, and she went on to serve as a case study for them, allowing Sharon to feel reassured that her poor experience would be learned from and actions would be taken to prevent a similar situation from happening again.

While Sharon has now been discharged, the procedures and processes developed to help manage her health in work remain in place, and she knows that if needed she can self-refer. Although the OH department also stress the importance of advertising self-referral as an option, and this route is not widely taken up by employees: in 2015-17

⁶⁵ A tool adapted from a model developed by MIND.

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there were 1,582 self-referrals, compared with 3,533 management referrals. This suggests that further work is needed to spread this message.

8.14 Case study example of NHS in-house OH service

Employer background

The employer is a hospital unit who have their own internal OH service. Frontline medical staff may be affected by a lack of resources, heavy workload and a pressured environment. The employees in this case study work in a unit for adults with challenging behaviour and there is a high risk of physical, verbal and sexual assault.

The HR department advises line managers on OH referrals and action required from the OH provider's report. 'Huge' caseloads mean HR is dependent upon line managers to act upon their recommendations and there is limited oversight of how policy is implemented.

The OH department is part of an NHS hospital, providing an in-house OH service, but also operates as a 'mini-business' providing services to other public or private organisations. It is one of the largest OH providers in its region. For NHS clients they provide immunisations, absence management and advice, as well as in-house health and wellbeing activities for the hospital.

They use a 'biopsychosocial' model to assess cases and aim to 'facilitate and empower' employees to return to work, stressing the importance of everyday activity.

Around 60% of staff are healthcare professionals. They have a sizeable clinical workforce of around 15 but struggle to hire senior skilled staff – they have to recruit at more junior levels and train staff up. They provide internal and external, structured training but funding is limited for national OH specialist qualifications.

Referral process

Usually line managers refer cases to the OH-service, though they do cater for self-referral this is rarely used.

Employee story 1

Lesley is a senior staff nurse. She reported struggling due to a lack of staff and management support and feeling 'burnt out'. She received 'criticism' of her role following a serious assault on a colleague by a patient. This led to insomnia, loss of appetite, a 'low' mood and Lesley was unwilling to work in the ward where the incident occurred.

Lesley had prior knowledge of her employer's OH provision through referring others but suggested it was a colleague, Maria (not her line manager at the time), who advised referral a few weeks after the incident. Maria, through supportive of the request, reported that it was actually Lesley who requested she make the referral.

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Lesley had a consultation with the OH provider over the phone and had one face to face meeting. She was referred to a telephone counselling service which gave her advice she followed to decrease her stress (e.g. exercise, discussing with others). She would though have preferred more face to face sessions with a specialist experienced in helping people affected by assault or challenging patient behaviour. The OH provider report they do offer face-to-face counselling if needed, but employees have to start with a phone consultation to meet their budget demands.

Lesley reported she waited around eight weeks for the telephone counselling (once she spoke to the OH provider she had to wait around three weeks for an appointment). Maria felt the turnaround was much quicker – 10 days from referral to report, and found it ran smoothly.

Lesley did not take any time off and felt she largely 'got through it herself' by talking to family and colleagues, as well as the psychologist at her workplace – this may have been partly due to the gap between the incident and the telephone counselling.

Employee story 2

Frances has been a nurse with the hospital for over a decade, part of her reason for returning from the private sector was the support available should she be ill. She was 'bullied' by her line manager. Their team frequently refers staff to OH services but Frances explained that her line manager did not refer her until three months after her first absence. The HR team's advice of immediate referral for staff absence related to stress, anxiety or depression appear not to have been followed. Frances felt she should have been referred much sooner, and that if she had had their advice during her first period of absence she should not have become so mentally unwell.

Frances felt the OH provider gave her strategies to help her return to work and improve her mental health (e.g. keeping physically fit). She turned down the offer of counselling (she had undertaken it in the past and didn't think it would help in this situation) but found it useful talking to the OH as an independent listener. Separately, she spoke to a consultant who prescribed medication and regularly saw her own GP.

OH encouraged Frances to see a phased return to work as part of her recovery. Frances found the OH service 'really good' and largely attributed being able to return to work to their advice. She subsequently saw a specially trained colleague twice and wished she had been aware of their services earlier. The HR department were aware of her case their only involvement was through her line manager.

Outcomes and lessons

Staff feel fortunate to have access to OH services. Those who have used them have found them useful. OH provision helped avoid absence, and aided return to work. HR and provider staff are aware of the tension between providing sufficient time to recover and meeting high demand for staff.

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Delays in referral may add to ill-health and prolong absence unnecessarily but despite their knowledge of the service, employees may feel uncomfortable requesting referrals or speaking to their line manager. There is a case for promoting other referral routes, e.g. self-referral, referral by a colleague or an independent team. Similarly, referral and follow up support is largely at the discretion of line managers, thus greater HR oversight may be beneficial in some cases.

8.15 Case study example of self-employed access to OH

Employer background

The patient in this case study has been a self-employed performer for most of their working life.

She was directed to OH support via a voluntary organisation that looks after the interests of self-employed performing artists. Many of the individuals they look after are self-employed, students, or working as employees within an arts organisation.

Overview of OH provision

The provider is a healthcare charity that provides medical advice to people working and studying in performing arts. They provide advice to help prevent work-related health problems and also help overcome any problems that do arise.

Services include free clinics offering advice about the physical and mental demands of a career in performing arts; free information resources such as factsheets to help people in the arts care for their health; a directory of practitioners with expertise in performing arts healthcare; training for performers, educators, students, employers and other organisations in essential skills for maintaining good mental and physical health; and research projects in the field.

Practitioners wishing to work for the charity apply with a demonstration of their experience in the field. The clinics are voluntary although the charity provides a small honorarium and clinicians undertake the work alongside their other professional commitments. They can specify the nature of their clinic, either tailoring them to their medical expertise or their understanding and experience of a specific art form.

These clinics are often seen as a 'one-stop shop' as there is no provision for follow-up and no offers of treatment, although they may refer on to another specialist if they feel treatment is required. People will attend for an assessment, often as a second opinion following a trip to a GP or similar, to get some expert advice that is more tailored to the specificities of their profession. From here, they will either receive advice, or they may be signposted to services in the NHS or elsewhere. It is a small minority of vulnerable cases that will be seen after a one-off consultation.

The organisation is self-advertising and uses channels such as the Musician's Union or charities such as Help Musicians UK or One Dance UK.

In this case, Dr Jones works with musicians because he has an understanding of their performance, training and environment. He typically sees two types of patients: one that has already received some advice or treatment, and another that has used the charity as the first port of call. The first type will discuss treatment pathways they have already

been recommended or undertaken to see if there are any industry-specific elements that could be added to improve treatment. The second type will present the problem and the clinician will analyse the issue within the context of their musical vocation.

Referral process

The OH provider is well-known within the industry so artists and performers will most likely self-refer or be signposted by somebody else within the industry.

Employee story 1

Harriet has been a professional brass musician for thirty years and has also taught in schools. As a freelancer, she has worked with orchestras for around a quarter of her time and spent the rest in schools. She has suffered from depression and burnt mouth syndrome but as a self-employed individual felt compelled to go to work even when she felt she couldn't. Harriet contacted the OH provider to seek support. As somebody who isn't based in one location access to support could be difficult, but one of the benefits of the provider was the confidentiality and choosing her own provider meant she did not need to notify head teachers which could have caused accompanying stress of not being employed for further work.

Harriet had good awareness of the provider, *"Well, because I'm a Musicians Union member, the Musicians Union are very good at flagging up this service so, any Musician Union member that doesn't know about it should be ashamed of themselves"*

Prior to getting in contact with the OH provider, Harriet had a drawn out and mostly unhelpful journey. Harriet had ignored the burnt mouth symptoms for six months before being prescribed mouthwash by her GP which she said was unhelpful. The GP had never heard of burnt mouth syndrome and didn't appreciate that she was a musician. From there she waited 8 months to attend an allergy clinic and finding that there was no allergy, and waited a further 5 months to attend a dental hospital. They identified that there was an issue which Harriet saw as "a huge turning point because I didn't feel it was all in my head".

It was after this that she decided to contact the OH provider. Under the provider's umbrella, Dr Jones was able to give information on a psychotherapist that could help using CBT which is currently ongoing.

Outcomes and lessons

Harriet has currently been to two private CBT sessions with the therapist recommended by the charity and has another scheduled, although the financial cost is a burden. Harriet says she *"was sceptical of how much this could help at first but then - I thoroughly enjoyed it and really surprised myself"*

Understanding the provision of occupational health and work-related musculoskeletal services

She has found that this has allowed her to open up to a neutral party about her issues and has helped her to relieve stress by being able to say 'no' to offers of work (previously she felt pressurised to take everything on due to the insecurity of freelance life). The burnt mouth syndrome has also improved because the CBT has helped her not to think about it as much anymore.

In terms of lessons, Harriet felt that it would be helpful to have a mental health professional involved in the consultancy with the NHS. She wishes she had gone to the provider sooner but had thought they specialised in physical health and not also mental.

She thinks that being self-employed excludes workers from normal colleague networks and that not feeling settled in any one working environment makes it harder to discuss mental health issues, and that doing so might have an impact on future employment.

8.16 Full list of OH services and frequency they are offered by providers

Table 8.1: Frequency with which providers offered specific OH services

Advice about workplace adjustments or return to work plans for ill or sick employees	94%
Assessment of fitness for work for ill or sick employees	90%
Pre-employment/post-offer of employment health assessments	88%
Support with health risk assessments	83%
Ongoing health assessments available for any employees (even if not ill or sick)	83%
Health promotion or healthy lifestyle schemes	83%
Support with health surveillance	82%
General advice on organisational policy or procedures to help with legal compliance and business objectives	79%
Training, instruction or capacity building e.g. for managers or leaders	65%
Clinical interventions to manage health risks, e.g. vaccinations	60%
Knowledge management support such as sickness absence record keeping and data analysis	53%
Providing rehabilitation or treatment services e.g. physiotherapy or cognitive behavioural therapy	49%
Connection to wider services or support to address psychosocial issues, e.g. debt counselling, marriage counselling	42%
Case management	2%
Provision of medical records for civil prosecutions	1%
Mean average number of services offered	9.5

Base: All OH providers surveyed (103)

8.17 Number of OH professionals employed by private and NHS providers

Table 8.2: Number of nurses employed or subcontracted by OH providers

		1-5	6-10	MORE THAN 10	TOTAL PROPORTION EMPLOY ANY IN THIS WAY
REGISTERED NURSES UNDER PART 3 OF THE NMC REGISTER (SCPHN OH)	Directly employed full time	49%	8%	4%	62%
	Directly employed part time	37%	3%	3%	43%
	Subcontracted	27%	3%	3%	33%
NURSES TRAINING TOWARDS REGISTRATION UNDER PART 3 OF THE NMC REGISTER (SCPHN OH)	Directly employed full time	16%	--	--	16%
	Directly employed part time	8%	--	--	8%
	Subcontracted	3%	1%	1%	5%
NURSES WITH OTHER POSTGRADUATE OH QUALIFICATIONS (BUT NOT SCPHN)	Directly employed full time	21%		1%	22%
	Directly employed part time	15%	2%	1%	17%
	Subcontracted	6%	1%	1%	8%
NURSES WITHOUT OH SPECIALISM OR QUALIFICATIONS	Directly employed full time	16%	3%	--	19%
	Directly employed part time	18%	2%	--	20%
	Subcontracted	5%	1%	--	6%

Base: All private and NHS OH providers that participated in workforce survey (156)

Table 8.3: Number of doctors employed or subcontracted by OH providers

		1-5	6-10	MORE THAN 10	TOTAL PROPORTION EMPLOY ANY IN THIS WAY
OCCUPATIONAL HEALTH PHYSICIANS	Directly employed full time	25%	4%	1%	30%
	Directly employed part time	40%	1%	1%	42%
	Subcontracted	31%	4%	4%	40%
REGISTRARS IN TRAINING TO BECOME OCCUPATIONAL MEDICINE SPECIALIST	Directly employed full time	10%	1%	1%	12%
	Directly employed part time	6%	1%	--	6%
	Subcontracted	2%		1%	3%
DOCTORS WITH OTHER OH QUALIFICATIONS	Directly employed full time	4%	1%	1%	5%
	Directly employed part time	12%	--	--	12%
	Subcontracted	7%	1%	1%	9%
CLINICAL PSYCHOLOGISTS WITH OH SPECIALTY	Directly employed full time	6%	--	--	6%
	Directly employed part time	6%	1%	--	7%
	Subcontracted	7%	1%	--	8%
DOCTORS WITHOUT OH SPECIALISM OR QUALIFICATIONS	Directly employed full time	2%	--	--	2%
	Directly employed part time	3%	--	1%	3%
	Subcontracted	1%	--	1%	2%

Base: All private and NHS OH providers that participated in workforce survey (156)

Table 8.4: Number of other OH roles employed or subcontracted by OH providers

		1-5	6-10	MORE THAN 10	TOTAL PROPORTION EMPLOY ANY IN THIS WAY
OCCUPATIONAL THERAPISTS	Directly employed full time	3%			3%
	Directly employed part time	3%			3%
	Subcontracted	1%		1%	2%
OH TECHNICIANS OR HEALTHCARE ASSISTANTS	Directly employed full time	24%	3%	3%	30%
	Directly employed part time	17%	2%		19%
	Subcontracted	7%	1%	1%	8%
PHYSIOTHERAPISTS	Directly employed full time	12%	1%		12%
	Directly employed part time	13%	1%		14%
	Subcontracted	12%	3%	3%	17%

Base: All private and NHS OH providers that participated in workforce survey (156)