Department for Work & Pensions

Department of Health & Social Care

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GOVERNMENT SOCIAL RESEARCH
Social Science in Government

Understanding private providers of occupational health services

An interim summary of survey research

April 2019

DWP/DHSC ad hoc research report no. 72

A report of research carried out by IFF Research on behalf of the Work and Health Unit.

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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 form 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 private market, 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

The Work and Health Unit (WHU) commissioned IFF Research to conduct a telephone survey of private providers of occupational health (OH) to understand the services they offer, their capacity for delivering the services, their workforce profile and any skills shortages, and how they market their services. This interim report contains a high-level summary of the findings from this survey. A total of 103 OH providers took part from a sample of 322.

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 (Section 2.1). The most commonly offered services were advice about workplace adjustments and assessment of fitness for work for ill employees. Two services stood out as the most commonly commissioned: health surveillance and assessment of fitness for work (Section 2.1).

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 (Section 2.2).

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 (Section 2.3).

Nearly all OH providers (96%) said their OH support interacted with NHS provision, most commonly recommending employees go to their GP or specialist treatment (Section 2.4).

Four in ten (39%) providers had capacity to support fewer than 200 individuals at any one time, and most had only a small number of employees (17% were sole traders and 43% had one to nine employees). The majority of OH providers (82%) subcontracted to additional members of staff on a regular ongoing basis (Section 2.5).

On average, two-thirds (64%) of employed or subcontracted staff were medical professionals (e.g. doctors or nurses). Eight out of ten (78%) felt they had the right balance of medical and non-medical staff. However, just under half (44%) of OH providers had roles they were unable to fill, most commonly OH nurse or physician roles. They felt this was due to a decrease in medical professionals with OH experience in recent years (Section 2.5).

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Acknowledgements

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We are very grateful to the guidance and support offered throughout by the Policy Analysis and Research team, and particularly to Dr Bola Akinwale, Maisie Payne and James Hudson.

We would also like to acknowledge and thank all the research participants for giving up their time to participate in interviews and providing valuable information on their experiences and views.

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.

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
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
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, 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
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

Abbreviations

CCG	Clinical Commissioning Group
COHPA	Commercial Occupational Health Providers Association
CPD	Continuing Professional Development
MSK	Musculoskeletal
OH	Occupational Health
SEQOHS	Safe, Effective, Quality Occupational Health Service
SME	Small or Medium Enterprise
WHU	Work and Health Unit

1 Introduction

The Work and Health Unit (WHU) commissioned IFF Research to comprehensively map the existing provision of occupational health (OH) and musculoskeletal (MSK) services available across the UK. WHU is a UK government unit which brings together officials from the Department for Work and Pensions and the Department of Health and Social Care, to lead the Government's strategy to supporting working age disabled people, or people with long term health conditions enter, and stay in, employment.

As part of this research, WHU commissioned a telephone survey of private providers of OH to understand the services they offer, their capacity for delivering the services, their workforce profile and any skills shortages, and how they market their services. This interim report contains a high-level summary of the findings from this survey.

The survey aimed to speak to as many private providers of OH (i.e. excluding NHS provided services) across the UK as possible, as an attempted census. In total, 103 OH providers took part in the survey. A sample of 322 OH providers for the survey was drawn from three sources:

- 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) accreditation[1]
- Publicly available list of OH providers registered with COHPA (Commercial Occupational Health Providers Association)[2]

The survey achieved a 32% completion rate and was similar in profile to the starting sample, meaning that the findings are representative of the starting sample (which was assembled from multiple sources, to optimise coverage). 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 it is possible to conclude that the research included a good 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 and responses to the open-ended questions have been reported qualitatively.

[1] https://www.seqohs.org/

[2] http://cohpa.co.uk/

This survey forms part of a wider piece of research about OH and MSK. The research will also include a survey with Clinical Commissioning Groups (CCGs) about the MSK services they commission, and in-depth case studies with OH providers and the employers and employees that they support. The full results of this research, which will include findings from the survey with CCGs and the case studies as well as more in-depth analysis of the findings included in this report, will be published later in 2019.

2 Main findings

2.1 Services and packages offered

Overall, private providers of OH offered a wide range of services. On average, providers offered 9-10 different occupational health services (see Appendix 1: full list of OH services and frequency they are offered by providers). Larger providers were more likely to offer a wider range of services, however this was not statistically significant. The most commonly offered services were advice about workplace adjustments or return to work plans (offered by 94% of providers) and assessment of fitness for work for ill employees (offered by 90% of providers). When asked about the most frequently used services, two were notably more common: one-third (33%) of providers reported that 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).

This breadth of services was reflected in the variety of 'off the shelf' packages[3] offered to employers. Just under half (45%) of providers offered 'off the shelf' 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. However, 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).

2.2 Commissioning

Almost all OH providers (97%) had some services commissioned by employers.[4] Providers felt employers had two main motivations for commissioning their services. These were:

- meeting legal responsibilities (44% of providers commissioned by employers said this was the most common motivation); and

[3] 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.

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

- 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%).

On average, 51%[5] of employers commissioning OH services 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.[6] 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)[7] we surveyed: six out of ten of these providers had not been commissioned by any SMEs.

Around half (54%) of OH providers had some services commissioned by individuals. The most common reasons OH providers were aware of for individuals contacting them directly was for statutory medicals and safety-critical assessments. 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.

Only 8% of OH providers had some services commissioned by CCGs.

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, with few clear patterns to comment on.

Payment structures for OH services followed a similar pattern to commissioning. Almost all (97%) of providers had been paid for OH services directly by employers, and half (49%) had been paid directly by individuals. Payment for OH services via health insurance was relatively low compared to other payment structures: one-fifth

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

[6] Young and Bhaumik, 2011, 'Health and well-being at work: a survey of employers' https://www.gov.uk/government/publications/health-and-well-being-at-work-rr750

[7] 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

(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.

2.3 Involvement of employers, line managers and individuals

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

Line managers were involved more often than not, although not all the time: 65% of providers reported that line managers were involved in assessments of fitness for work in most or all cases, and 68% reported that line managers were involved in most or all cases of workplace adjustments or return to work advice. Line managers' involvement was usually limited to the point of referral at the start of the process, and at the end when sharing the final advice. 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. 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.

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.

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. 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.

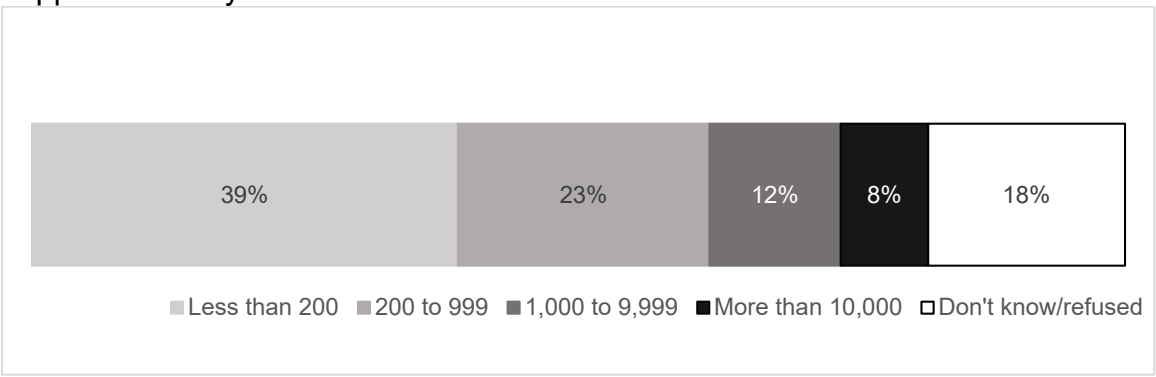
2.4 Interaction with the NHS

Nearly all providers (96%) said that their OH support interacted with NHS provision in some way. 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 (71%) said that their support complemented NHS treatment, or was part of the follow up to fit note advice (70%). A third of providers (34%) 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.

2.5 Workforce and capacity

A substantial proportion of providers had relatively small-scale capacity: four in ten (39%) OH providers had the capacity to provide OH support to fewer than 200 individuals at any one time (Figure 1). As might be expected, there was a relationship between the size of provider and their capacity: larger 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 1: Capacity of OH providers in terms of number of individuals could provide support to at any one time



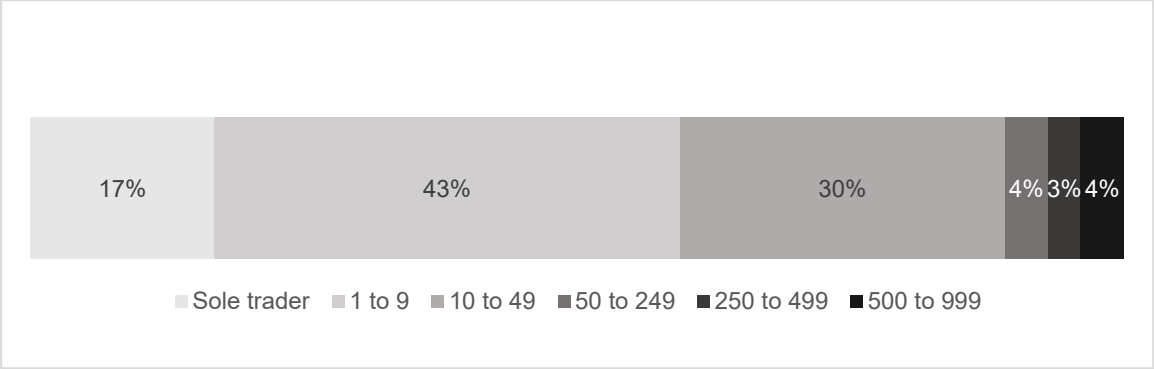
Base: All OH providers surveyed (103)

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.

Most of the OH providers had a small number of direct employees. Just under one-fifth (17%) were sole traders, and four in ten (43%) had one to nine employees. Three in ten (30%) had between 10 and 49 employees (Figure 2). Only one in ten (11%) had more than 50 employees. The majority of providers (82%) subcontracted

additional workforce requirements on a regular ongoing basis. This was mostly on a small scale, with half (55%) regularly subcontracting to fewer than ten individuals.

Figure 2 : Number of staff directly employed by OH providers



Base: All OH providers surveyed (103)

On average, two-thirds (64%) of employed or subcontracted staff were medical professionals. Eight out of ten (78%) felt that they had the right balance of medical and non-medical staff. However, over two-fifths (44%) of providers had roles they were unable to fill. Most commonly, the unfilled roles were OH nurses or OH doctors. 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.

2.6 Ensuring quality of service

Seven out of ten (69%) OH providers captured data on the outcomes achieved through their support in all or most cases. Most of those that captured outcome data found it useful: nearly three-quarters (72%) rated the outcome data they collected as an eight or higher out of ten (where ten meant ‘extremely useful’). They felt the data they collected allowed them to demonstrate the quality and effectiveness of their service and helped them to establish trends in health issues. There was a wide variation in the types of outcome data collected. Most of this data related to the results of the specific 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.

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, this finding should be caveated that one of the three sample sources for the survey were lists of those with or working towards SEQOHS accreditation meaning that there may have been over-reporting of accreditations. 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 systems they had in place were effective in ensuring quality of service. Evidence cited for this included positive feedback received from clients, internal audits, and high rates of client retention.

2.7 Marketing

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

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.

Four in ten (37%) providers did no form of marketing, with many mentioning they felt received enough business without it.

3 Conclusions

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 customers 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 2.1)

While employer-led commissioning dominated, commissioning by individuals was relatively common. OH providers believe 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. when they need to comply with the legal requirements of their industry or to reduce sickness absence. OH providers also believed that improvements to productivity, health and wellbeing were key secondary motivations. (Section 2.2)

While line managers were perceived to be of key importance to the success of OH provision, and were involved more often than not, this involvement is not as effective as it could be: providers noted the efficacy of their involvement varied according to the line manager's engagement and understanding of OH and the employee's issue. (Section 2.3)

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: larger 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. (Section 2.5)

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 approximately half of OH providers. (Section 2.5)

OH providers believed that collecting outcome data was useful in monitoring and proving their quality of service. A variety of outcome data was collected for these purposes. (Section 2.6)

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 2.7)

Appendix 1: full list of OH services and frequency they are offered by providers

Table 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)